



The Business of Doctoring

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REVIEW

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The core business of medicine is the consultation. During the consultation one human being responds to another in distress. Most doctors spend more time talking with people than performing surgery, prescribing pills or ordering tests. The extent to which the doctor succeeds as a communicator may even govern the 'success' of any procedure performed, if we define success as relief from the condition causing distress. As human beings our ability to benefit from what is offered to alleviate our symptoms is limited by the extent to which we feel that we have been heard and supported with empathy. It has been demonstrated that the human body has the capacity to heal and that healers are limited by their capacity to facilitate that process. That is not to say that 'talking' can spare us the need for other interventions. In this review the author examines the factors that impact on the medical consultation with particular emphasis on the scope for harm when the consultation is interrupted.

Communication skills

Those doctors who underestimate the importance of communication skills are prone to litigation or complaint. There are ample examples of patient dissatisfaction that have arisen from poor communication skills or where a failure to communicate effectively has also cast doubt on technical ability. Here are a few examples of patients' comments from the internet¹. Although there is no way to corroborate

these accounts. They are presented here as examples of what

patients have said in public.

Canada

Family doctor:

I have diabetes, and went to the doctor to get test results. He would not provide them to me. Instead, he chose to tell me that I was too fat and my sugars were high (they weren't) because I eat junk food and don't exercise (I walk four miles a day). He would not listen to me, and wanted to change all my medication ... he is a ... uncaring individual.

Ireland

General Practitioner:

I found this doctor very uncaring asked the patient I was accompanying, who is hard of hearing "are you deaf?" and when she did not answer the question to his liking he then said "it's not a hard question". Also this patient was still in recovery from a second stroke and was not feeling very well when he expected her to repeat her whole medical history as if she was a computer. Again he had no patience when she did not answer quickly enough or to his satisfaction ... He never once asked how she was feeling instead asked three times "why are you here?"

USA

Psychiatrist

Did not feel that she listened, she would ask questions and then talk over you when you began to respond, and was very cool (not the warm, fuzzy feeling you might expect from someone in the mental health field). I can't vouch for her competency, as we were so put off by her attitude.

Australia

Surgeon

Laughed at my problem, told me something completely different to what my problem was and was trying to force medication that I was allergic to.

Scotland

General Practitioner

While initially she appears to be a caring concerned GP, in



time she proves that to be a front. She cannot cope with confrontation. She either lies about patients to her colleagues, or she at least has a dreadful memory of what she has done, said or agreed previously. She messed up my medications and prescription several times and despite being proved wrong she has a total inability to apologise for her behaviour.

England

Plastic Surgeon

I travelled from overseas to have a rhinoplasty by [this doctor] in '08 which resulted in a very noticeable scar on one of my nostrils. It looks as though a 5mm wedge has been carved from my nostril. In the first PRE-op consult he was pleasant & positive. In the POST-op consult, when I pointed out the scar to him, his exact words to me were: "Don't be one of those patients who nit-pick"! He then became very cagey and short with me. It was extremely uncomfortable and, ridiculously, I felt bad for pointing out the mistake. He offered no advice on how the scar might be improved or rectified. I then returned to my home country where I saw another surgeon who said what had probably happened was that the stitches had fallen out as they had not been inserted correctly, thus causing a gaping hole. I decided to write to [this doctor] to ask for my money back so I could get the scar rectified.

The main focus for complaint in the examples above appears to be the doctor's failure to communicate effectively. A number of models exist to describe and explain the consultation, especially in primary care.² They describe what occurs on that occasion and offer a plethora measures for the quality of that encounter. It has also been demonstrated that consultations where patients were more satisfied appeared to patients to have lasted longer than they actually were.³ Patient concerns about the time spent with them may be as much about the quality of that time as the number of minutes recorded.³ It can be concluded that patients want to feel that their doctor is interested in them.

General Practice

In healthcare systems where access to specialists is via referral from a generalist, patients present to their general practitioner (GP) with undifferentiated conditions.⁴ In these circumstances the cause of human suffering can be in any or any combination of the physical, psychological or social domains. Furthermore Bayes' theorem suggests that patients who present to generalists are unlikely to have significant pathology, most people who consult a GP are more likely to have a so-called minor self-limiting illness.⁵ The troublesome symptoms, which may be related to a physical condition often hint at unsatisfactory psychological and/or social circumstances.⁶

Therefore the 'best' doctors are able to empathise. That is why computers are unlikely to replace doctors. A computer may be able to suggest a diagnosis of clinical depression from the signs and symptoms entered diligently onto a database. However a computer cannot touch, it cannot express compassion with human eyes or faithfully reproduce the changing inflexions of the human voice. A computer can only analyse data entered on the recommended path or in the prescribed language. A machine is not able to respond to the non-verbal cues reflected in the eyes or in the tiniest signals humans are able to decipher from our posture, facial expression and tone of voice.^{7,8} A computer cannot tolerate uncertainty or offer comfort while the cause of the problem is uncertain or likely to resolve in time.⁹ The skilful medical practitioner can do all of these things but also perform surgery when required.

Rituals

Much of the consultation is replete with rituals. The greeting, the line of questioning, the physical examination and the issuing of a prescription follow a recognised routine. The experience of the consultation has dimensions in tactile, auditory, olfactory, and visual senses. The encounter is also full of icons that have a deep cultural significance such as the stethoscope, the auroscope and the tendon hammer.¹⁰ However for humans to respond to the healer, the doctor must be attuned to the patient's ideas, concerns and expectations. Wide deviations in details including how the doctor is dressed may, in some circumstances, be unhelpful.¹¹ There are variations in the doctor's style of communication and individual patients are reported to be adept at choosing doctors that help them the most.^{12,13}

Diagnosis and management

The attitude of the patient also has a very marked influence on the outcome of the consultation. This has been illustrated by the decision to prescribe. For example it is recognised that antibiotics are being overprescribed, especially for respiratory tract infections (RTIs). The evidence base to identify which patient will benefit from antibiotics is poor. Non-medical factors seem to play a part in the prescribing decision. A consequence of overuse of antibiotics is bacterial resistance. In adult patients with acute cough with limited signs on examination, perceived patient demand for an antibiotic significantly increased the odds of being prescribed one in general practice.¹⁴ What makes this especially important is that patients who are prescribed antibiotics, even in the context of a troublesome cough frequently fail to complete the course of antibiotics and consequently



promote the incidence of resistant infections.^{15,16} Nor can we be certain that the management of all cases by doctors is standardised. In a study published in 1991, 39 GPs were assessed for their management of a number of standardised 'actor patients'. One such 'patient' was a young woman with diarrhoea. Fifteen actions were considered essential for the appropriate management of her case, in practice the average number of actions taken was only 8.5 with some doctors performing as few as five and others as many as 14.¹⁷

We also take it for granted that a doctor will be able to deploy their equipment to make an accurate diagnosis. The reality as has been demonstrated in research is that misdiagnosis is possible even in the case of experienced and expert practitioners using as standard a piece of equipment as a stethoscope.¹⁸ Similar concerns have been raised about relatively routine practice such as the accuracy with which doctors measure blood pressure where misdiagnosis may result in lifelong and unnecessary prescriptions.^{19,20}

Interruptions

When the consultation is interrupted there is the potential to diminish the value of that encounter. The consultation is being interrupted almost endlessly in the 21st Century. It is said that there are now three involved in any modern encounter with the doctor. The doctor, the patient and the computer.²¹ It is implied that doctors appear to pay far too much attention to their computers. Given what we know of the importance of the consultation doctors who allow computers to interrupt their consultations will diminish their capacity to detect the clues to the cause of the patient's distress that are available when paying close attention to the patient.

The other way in which modern medical practice is interrupted is by the funder of health services. In the hospital setting it was eloquently demonstrated that on average, interns, the least experienced and yet first doctor on-call spent less time in direct care and considerably more time completing documentation and in general administrative tasks.²² The proportion of time interns were observed documenting (22%) was almost double that engaged in direct care.²² Out with the hospital setting in an attempt to contain costs or 'improve quality' many funding organisations, including governments in some cases have sought to enter a cost containment agenda into the medical encounter. The best example comes from the United Kingdom.²³ In Britain doctors are financially rewarded for so-called preventive medicine. That means that as a patient you are likely to be weighed and measured, asked your history of cigarette smoking, counselled about moderation in alcohol consumption, encouraged to take more exercise, recommended to have a flu vaccine, required to give a family

history and have your blood pressure measured before you can tell the doctor why you have taken time off work to visit the surgery on that day. This is the introduction of the public health agenda with a population health focus and not the individual patient focus that was once the hallmark of general practice. There is no conclusive evidence that the adoption of this public health approach is either appropriate or beneficial.²⁴ While there is data to suggest that more people are taking a proactive role in their own healthcare. At the same time there is inconclusive evidence that doctors in primary care are equipped or adept at delivering health promotion advice.²⁵⁻²⁸ This suggests that promoting a trend that encourages doctors to do things that are distracting may result in more people taking matters into their own hands.

In most countries it is likely that people will have more encounters with generalists than specialists. However the nature of general practice in many countries has changed dramatically.²⁹ Funding agencies increasingly require generalists to take on tasks that were once the work of specialists, this includes monitoring patients taking drugs with a high probability of unwanted effects, supporting patients treated for life-limiting illness and treating patients closer to home.³⁰ Doctors in primary care are now likely to maintain databases containing the names of all patients taking a specific drug, suffering from a list of chronic or life-limiting conditions or in need of close monitoring for whatever other reason. Some of this may benefit patients. However when so much 'funder led reform' is neither evidence-based nor evaluated for impact and when doctors' time is spent updating computer databases rather than consulting patients the scope to fail to satisfy people is increasing.

Conclusion

Most patients who consult a generalist are unlikely to have life-limiting pathology. Therefore the doctors' ability to communicate effectively is important not only to avoid litigation and complaint but crucially to make an accurate diagnosis and to be able to negotiate the most appropriate course of action. The process of making an accurate diagnosis and determining the most appropriate treatment cannot be taken for granted. How doctors present and conduct themselves has an impact on their ability to assist their patients. A growing number of interruptions to the encounter when a doctor consults a patient are having an adverse impact on the business of doctoring.



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CONFLICT OF INTEREST

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