Risk Communication in Healthcare

Editorial note:
The complete version of the lecture on "Risk Communication in Healthcare" can be downloaded from the MOH website at http://www.moh.gov.sg/corp/about/newsroom/speeches/index.do

"In 1961, in the United States, a survey was done asking US physicians what their usual policy was regarding telling the truth to terminally-ill cancer patients. Eighty-eight percent said their usual policy was not to tell the patient if the diagnosis was a malignancy. They were concerned that the news would upset the patient and following the Hippocratic tradition, they did not want to upset the patient. Less than 20 years later, in 1979, a similar survey showed the percentage had shifted dramatically from 88% to 2%."
- Dr Balaji Sadasivan, 17 October 2004

Traditionally, doctors have adopted a paternalistic role in the doctor-patient relationship, and patients seemed satisfied with this arrangement. In recent years, however, there has been a shift in attitudes. Communication is no longer a one-way process. Increasingly, there is shared decision-making as patients begin to take on a more active role in their medical treatment, and doctors are expected to respect their need for information and self-determination.

It is with these in mind, that Dr Balaji Sadasivan, Senior Minister of State, Ministry of Information, Communications and the Arts, and Health, delivered his lecture on "Risk Communication in Healthcare" at the Singhealth Scientific Meeting 2004 on 17 October 2004, at the Swissotel Stamford.

PATIENT AUTONOMY

"The Hippocratic Oath says that the physician should benefit the patient and protect him or her from harm. It is based on a paternalistic philosophy. Paternalism is an action that is taken for the benefit of another person and that is done for the welfare of that person. This is what parents do for their children. Medical paternalism is part of the Hippocratic tradition. This tradition does not factor in benefit based on the patient's judgment...

"Patients were told what would be done. They rarely were asked to make a choice. The choices were made for them. Patients appeared satisfied with this approach. In the Hippocratic tradition, the doctors communicated much empathy, sympathy, care and concern but the physician made the decision for the patient."

In the present day, however, medical ethics is based more on the concept of patient autonomy and the patient's right to know and decide using his free will.

Dr Balaji reminded doctors that "the SMC Code upholds the principle of patient autonomy and right to self-determination. Except for unusual situations where the doctor can still apply the concept of therapeutic privilege, it is the general rule that it is the patient and not the doctor who will be in control. It is therefore very necessary for doctors to communicate risk to patients so that the patients can make the right decision. When patients make the wrong decision or have a wrong appreciation of the risks, or when the outcome does not match their expectations, patients may get upset, setting the stage for complaints and medical litigation."

Moreover, the need for risk communication increases with the risk of the medical specialty.

HOW TO COMMUNICATE RISK

Dr Balaji elaborated on four general rules to risk communication:

Rule 1:

"Respect the patient. The patient is an intelligent person trying to make the best decision as it is his health, and his life that is at stake. Avoid patronising language and medical jargon. Avoid being simplistic: operation – good; No operation – bad. This insults his intelligence because he can comprehend complex ideas if it is explained to him in non-medical language. Patience is needed and more than one round of explanation may be necessary. It is always better to spend time with the patient than with the lawyer from the medical protection society.

Rule 2:

"Be accurate. The information must be factually accurate as well as accurate in a subjective emotional sense. Conveying emotional accuracy is an art and often it requires presentation of the same information in different ways. For example, when the mortality risk for a surgery is 5%, this same information can be presented in different ways. If the patient said: "Doc, 5% is too risky", the doctor may respond that without surgery, the patient is almost certain to die but with surgery, 19 out of 20 patients do well and so the odds are in the patient's favor. On the other hand, if the

Page 5 ►

◀ *Page 4 – Risk Communication in Healthcare*

patient said: "Doc, 5% is low risk", the doctor may state that the risk is not low because 1 in 20 patients dies after surgery. If 20 such operations are done each month, on average each month, there will be one death. The aim of presenting risk in different ways is to convey to the patient the correct subjective appreciation and insight into the risk."

Rule 3:

"Empower the patient. For example, before surgery, patients can be given a spirometer to reduce their risk of chest infection. A spirometer is a plastic device with three columns and a ball in each column. When the patient inhales, the balls will go up. With a weak effort – only one ball goes up, with a strong inhalation, two balls go up and with a really strong inhalation after practice, all three balls will go up. This is something patients can work on to help themselves. Empowerment makes patients feel they are part of the team in control of their health. It is easier to communicate risk to a patient who feels he is a member of the team than to a patient who feels he is the object of interest of the team."

Rule 4:

"Always end on an optimistic note. Patients need hope. No matter how bleak things look, find some light at the end of the tunnel. Sometimes this can be truly difficult. For example, if the prognosis for a condition is a life expectancy of six months, the situation is bleak. But even in this instance, an optimistic note can be found. Since statistics apply to the group and not to the individual, doctors will always have a patient who has done better than the average. An anecdote about a patient who has beaten the odds gives patients hope."

STAYING CURRENT

Effective risk communication also means that doctors have to keep up with changes in knowledge and recent developments. Dr Balaji gave the example of breast cancer screening which has been conducted for many years, and which he believed to be a good programme. The current controversy arose because of differing medical opinions on the recommended age for screening. Yet others have taken the position that screening has no value.

"If we continue with the paternalistic Hippocratic tradition, then clinicians will continue to make the decision for Singapore women on who should go for screening without consulting the women screened. However if we believe that women are less willing to accept a paternalistic approach and believe in their autonomy and free will, then our risk communication must inform each woman about the controversies before they decide if they wish to proceed with screening.

"Since the issue is controversial, just like the recommendations from the different prestigious organisations, which are not uniform, Singapore women may not all make the same choice given the same information. In order to make an informed decision they would also expect to be told the results of screening in Singapore. If we believe in the autonomy of women and their right to express their free will, we will give them choices after we have communicated the risks to them. But this will require a mindset change in doctors and their attitude towards patient rights.

"Public attitudes have changed and they expect us to respect their autonomy. The public's expectations are reasonable and justified and we must strive to meet those expectations. This we can only do by improving our risk communication skills." ■