Shoe on the Other Foot

By Prof Foo Keong Tatt

Introduction

I had cervical spondylosis for more than 20 years, and developed weakness in my right dominant hand a few years ago. Thus, I became a patient for some time in 2010, and would like to share what I observed and my thoughts on various aspects of life as a patient and a doctor.

During the time I was a patient, I went to the 7th Asia Pacific Medical Education Conference (APMEC), which was organised by the Medical Education Unit of Yong Loo Lin School of Medicine (YLLSoM) and held from 6 to 7 February 2010. The theme of the conference was: Excellence in Medical Education, Quality in Healthcare, and attending the event helped me to reflect further on being a patient and doctor.

The then Dean of YLLSoM, Prof John Wong's message during the opening address was: "Teaching is an important part of our career as a doctor. We need to teach so that the next generation of doctors are better than we are, only then can we improve."

In addition, the Director of Medical Services, Prof K Satku's message was: "To translate excellence in medical education and medical science (technology) to quality in healthcare, it is important that we teach the art of Medicine, professionalism in Medicine, not just the science."

In real life practice, treating the disease is a science, but managing every individual patient is an art. No two patients are alike, and the doctor has to balance the probabilities of risks and benefits in whatever decision made for the patient.

As a patient, I appreciated these messages more than ever before, even though I had been advocating them for some time and have been practising Medicine for the past 45 years!

Back to basics in the art and science of Medicine

What is professionalism in Medicine?

A professional is one who makes a promise to society: to treat with competence and to care with compassion, and whatever he does is always in the patient's interest.

If you are the patient, you will be comforted to be treated by a professional!

The words *profession*, *professional* and *professionalism* come from the Latin root word, *professio*, which means a public declaration with the force of a promise. The profession makes a promise to the public to deliver something to society. What is this promise?

The Boy Scouts, as a movement, promises to do their best, to do their duty to God and country, to help other people at all times and to obey the ten scout laws.

For our medical profession, what is our declared promise to the public? What is our commitment?

Commitment

My interpretation of our commitment, as healthcare professionals, to the public is fundamentally: "to improve the care of our patients". That was the core purpose we worked out in one of Singapore General Hospital's (SGH) retreats more than ten years ago, and it should remain the same today.

We do not just treat; we care. We do not just care; we strive to improve on the care.

In order to treat, we need to be competent. To be competent, we need to keep up with the science of Medicine, which is constantly changing. Therefore, we need to be committed to lifelong learning and attend continuous medical education (CME) programmes. To care, we need to be compassionate. We need to not just sympathise but also empathise with our patients, to understand their anxiety and fears. We need to communicate and counsel. This is the art of Medicine.

To improve on the care by the profession as a whole, just keeping ourselves up to date is not sufficient. We need to teach so that the next generation can be better than we were, and to do research to add on new knowledge.

As professionals in Medicine, the public expects us, at the minimum, to care for our patients. Whatever we do should be done in the best interest of the patients. Only then can we win their trust and respect. Only then will the patients believe in us. Believing and having trust in their doctors is an important part of patients' healing process.

SGH's motto: "We Care"

How good are we at it?

Caring starts the moment the patients walk into our clinics and are greeted by the reception staff. It is often refreshing to be greeted with a smile, but how often do we see it? While I was a patient, I went through many departments in SGH, Tan Tock Seng Hospital and private clinics; my assessment is that it can be improved!

A simple smile was so difficult to get, as it was seen less than 50% of the time. Often, one was kept waiting while the receptionists were busy doing something else. The first important matter on their minds seemed to be financial counselling, instead of greeting the patient respectfully and making him feel at ease.

I often tried to arrive on time, but was prepared to wait, as I understood how difficult it is to keep to the appointed time. If patients can be informed how long the waiting is going to be and why there is a delay, it would be a plus so that they can plan ahead for other commitments.

While our doctors were professional in that I was greeted appropriately, what can be improved (which is something I am guilty of too), is that during consultation, we should turn off our handphones or ask the nurses to answer any calls. Only real emergencies should be allowed to interfere with the consultation. It is very distracting and not caring on our part to interrupt the consultation process due to a phone call, especially if it is for something not important and the patients can hear what we are saying to the other party.

Patients are often ignorant or have preconceived ideas of what they are suffering from, and need proper explanations about the diagnoses and plans for further management. Do not presume that they know or understand, even if they are medically trained! I thought cervical spondylosis was such a common problem and the diagnosis would be simple, but in real life practice, it was not so simple!

Fundamentals of clinical practice

Patients do not come with diagnoses, but with symptoms and signs. Diagnosis is important, especially if you are considering surgical intervention. You need to be accurate in your diagnosis and predict the natural history so that you can weigh the risks of intervention with the natural progression of the disease.

After two months, many specialists were still not sure of my diagnosis. What appeared to be a straightforward case of cervical spondylosis was not that straightforward, in spite of all the high-tech imaging with MRI scans, nerve conduction tests and electromyograms. Just like lower urinary tract symptoms (LUTS) though superficially, many patients (and not a few doctors) equate LUTS with benign prostate hyperplasia (BPH). Similarly, not all symptoms of the upper arm are due to cervical spondylosis, even though the X-ray and MRI scans may show nasty osteophytes and prolapsed discs. Apparently, these features are very common in old age, due to degeneration. Other deferential diagnoses need to be considered. Just like BPH, not all patients with LUTS are due to the prostate, and we need to exclude other causes, such as neurogenic bladder or even carcinoma in situ of the bladder, before we treat.

Without diagnoses, we cannot treat rationally and predict the natural history of the illnesses. Meanwhile, we can only continue with conservative treatment, such as physiotherapy, which would not do harm but has the potential of improving the condition for cervical spondylosis.

If in doubt, it is better to undertreat and let the natural history evolve, making use of the fourth dimension in our diagnoses. Overtreatment often does more harm than good.

Some of you may not agree with me, but it is my belief that often, whether patients do well or poorly is due to the natural history of the diseases, rather than what we do. A low grade cancer of the prostate or kidney will do well no matter what we do, be it watchful waiting, conservative treatment, or local or radical therapy, whereas a poorly differentiated cancer will continue to progress most of the time, even with radical surgery combined with chemotherapy and radiation therapy. Maybe we can make a difference only 20% of the time. However, it is difficult to define which 20% of patients are going to benefit!

The art of communication

Thus, sometimes it is difficult for us to communicate to patients their diagnoses, and the risks and benefits of the planned treatment for them. More often than not, we are not sure ourselves and can only tell patients the probabilities as we cannot accurately predict for any particular patient. Often, patients will have to place their trust in us, as the doctors, to do the best for them. If we fail to gain the patients' trust and they perceive us as unsympathetic, they will then seek a second opinion.

Communication is a skill which has not been emphasised in our medical curriculum until recently. At the APMEC in 2010, there were a few good plenary lectures on the subject. One important take-home message was: "If you do not communicate, whatever you know does not matter. If you do communicate, you can make a difference!"

Apart from communicating with patients, we need to know how to communicate with our students: how to teach and interact with them.

In our clinical practice, we need to communicate with the other members in our healthcare teams – the nurses, physiotherapists, pharmacists, radiologists, other technicians, and the social workers. They are professionals

in their own right and provide good quality healthcare for patients who cannot function without them.

Some time ago, I stated that nurses are not our handmaidens, but professionals in their own right, and doctors have to work closely with them and also with other allied health professionals. I witnessed their work first-hand while I was a patient, and appreciate their contributions.

At the APMEC, I was happy to learn that there is now a movement in medical schools and institutions which emphasises interprofessional education, and that interprofessional practice improves the care of the patients, just like intravesical prostatic protrusion improves the care of our patients with BPH!

For example, in a ward round, there should be close collaboration between the different professionals and ideally, this should be done as a team. In the acute period, the doctors and nurses are important; once patients' conditions are stable, the nurses would be the prime caregivers; and before discharge, the pharmacists and social workers may be needed to provide advice on medications and follow-up care.

An additional level of communications is among us, the medical professionals. This is done through our daily meetings, CME programmes, the Radiology and Pathology rounds, and also through annual national, regional and international meetings.

Another important aspect of communications is our publications. I have come to realise that it is not enough to just talk at regional or even international meetings. Not many will listen to you unless you get your ideas published.

Over the past few decades, I know that I can communicate with my patients fairly well, as I always make it a point to make sure that they should smile at least once during their consultations. One easy way is to ask how young they are and not how old!

I can also communicate fairly well with the students and young doctors, and I enjoy teaching them the fundamentals of clinical practice and holistic Medicine. The best way would be to tell them stories, like those about a patient with headache, the urologist and the tailor, or the three monks.

But what I found myself lacking in, with regard to communication, is the publication aspect, and in my role at international meetings, where I failed to speak up for my clinical research findings on the natural history of BPH and the rationale for its management.

So while I was a patient and unable to conduct operations, I consoled myself with the fact that I had more time on my hands, and tried to tidy up many manuscripts for publication. I hoped my ideas in BPH management could be published, and prevent many patients from overtreatment and a few from undertreatment.

Conclusion

My time as a patient helped me to appreciate the art of Medicine more and understand the science of clinical practice in real life. Clinical practice in real life cannot be practised with scientific evidence alone. First, we need to make a diagnosis, and understand the pathophysiology and natural history of diseases. Then, we need to know more about every individual patient as a whole, and weigh the risks and benefits for each patient in our treatment. A balanced decision comes with experience, and therefore, senior mentors are needed to guide the juniors as they cannot rely on just the books and journals alone.

This conclusion is not to justify why those who are officially retired, like me, should be re-employed! SMA

References

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