Thoughts on the 3Cs

Those C Words

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What has gone wrong with the medical practice here, that the professional altruism that used to be conveyed in the word 'patient' is deemed less important than the retail connotation in the word 'customer'?

The First C

The patient had just undergone a haemorrhoidectomy and there was some oozing from the wound-site: not so unusual. The on-call houseman had seen her at 0630hrs that day to reassure her that it was not a major problem. During the morning round, she had looked fine, as my MO and I examined the other patients in the cubicle before stopping by her bedside. I recalled her browsing a CLEO magazine.

She appeared fine, too, when we spoke to her and asked to see her wound. Yes there was some oozing, but nothing out of the ordinary. "Don't worry, you are well, the bleeding will stop", we said in turn.

I was writing in the case notes when I realised she had closed her eyes, and tears were flowing from their sides. Walking to the side of her bed, I said, "Don't worry, its OK, don't worry." I was facing her, so I did not see her right hand move, but I heard the sound and turned just as the tissue-paper box she had thrown struck my MO's chest with a dull thud. "I am never coming to this hospital again!" she yelled.

She never said sorry. Not during that entire day, and even after she was discharged.

The phrase 'sometimes when it rains, it pours' certainly described that week of the tissue-paper box incident. Just two days before, I heard from another colleague that a patient had threatened to write a complaint letter against me, for speaking to him over the phone about his discharge plans, rather than seeing him face-to-face. Silly me, I thought I had gone out of my way to help him, by speaking to him over the phone when I was post-call and out of the hospital, instead of making him wait for the duty doctor. Silly me, to have expected him to know that I had actually "worked" during my "off-time" for him. It occurred to me that this was the same man who had been seen snuggling up with a woman on the hospital bed after his wife left.

But I digress. My MO initially did not want to bring up the "tissue-box" matter to any higher authority, but I was glad he eventually decided to tell the Consultant, who in turn asked us to inform the relevant hospital Authorities. None of us personally knew who these Authorities were then, as we had not been briefed previously about their identities.

When I related this incident to my family, some members thought we should just have let the matter rest "as nobody was physically hurt". Afterall, as my Mum said, "When people are sick, they feel stressed." But the issue here is not about whether anyone was physically harmed. That is not the point. The point is that this lady, a well-educated person by the way, had knowingly abused a staff of the hospital. Yes, certainly she was bothered by her illness, but did that excuse her behaviour? Just because I am not happy with the speed of the auto-teller in the bank, does it mean I can throw something at the cashier?

Who knows what would happen the next time she gets admitted and is similarly 'stressed'. It might not be a tissue-paper box, it might be kidney dish with needles inside.

Later that day, I discussed the issue with a member of the senior nursing staff who quipped, "Some people in subsidised wards want A-class treatment." But again, is that actually the point? Firstly there is nothing wrong with the treatment this woman was getting. Anyway, medical treatment should never really differentiate very much between `classes of wards'. Secondly, in any case, abuse of a staff member is wrong regardless of the level of subsidy being received. And this is worse if the abuser (patient) were educated and well-off as chances will be if they are in a higher class ward - for what is the point of education and wealth if not to cultivate civility and manners.

Even later that day, I was paged to see the same patient - stat - because, as the helpful SN put it, "She says she is not feeling well, and I think you should see her because she might complain."

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Really, I kid you not: that was what I was told. I am sure the SN who called me had good intentions, but it sounded to me like the reason I was being urged to attend to my abuser, was so that she would not have another reason to abuse me again, although this time by complaining. The Americans have a really great term for it: it's called `getting screwed'.

So from one single patient, I had two doses of that first C-word: 'Complaint'. Why does it keep popping up in our lives, like some pimple that refuses to go away? The reason is found in the other two C-words.

The Second C

Here is another C-word I was introduced to that same week: 'Circumspect'. This is with regards to that libidinous man I mentioned earlier, and came from another friend with good intentions, when he heard me speculating aloud whether the person's complaint might be sufficient grounds for a suit for defaming or besmirching of professional reputation of the doctor. I was asked to be circumspect, in the sense of weighing the overall perspective when dealing with possible complainants.

It is not the first time I have heard this advice, though perhaps not using the exact word. Even as a student, I had heard seniors tell me, "Sometimes it is better to bend over backwards for difficult patients, because you do not want to waste time answering complaints." Fortunately during my housemanship, I almost never felt I had compromised myself by 'kowtowing' to unreasonable folk, just so as to avoid `owning the complaint'. Perhaps it is because most of my patients had been from B2 and C wards, and most of the time, they seemed genuinely appreciative of our efforts. So I never really had the dilemma of wondering whether I should stand my ground and fight it out for my honour, or to compromise for the sake of expediency. But it is unlikely to be the case for others. In fact our circumspect attitude of not standing up to unreasonable demands or complaints, gives the impression that we tacitly agree with the complainant. In the long run, this will lead to even more ridiculous demands on medical and nursing staff.

But doctors do not have it as bad as nurses. Many times I have personally witnessed patients talking very reasonably to me, while being downright rude to the nurses. A friend who works in KKWCH recently told me she overheard a parent telling her SN, "You shut up, you are only a nurse, I don't want to hear what you have to say."

Of course, not all complaints against medical staff are unreasonable. Probably a large proportion is understandable, if viewed in the context of expectations, or perhaps differences in expectations of patients and doctors.

The fact that junior doctors generally find having to deal with 'paying-class' patients unrewarding, is the simple reason that such patients have expectations not unlike those of a guest who has checked into a hotel, or a person who has paid a large sum for a designer gown. Unfortunately, doctors themselves do not expect to be treated like a waiter or a cashier, to be at someone's beck-and-call.

Such expectations of the patients are partly created by some aspects of the service mentality that have all but infiltrated into hospital culture. This brings us to another C-word: 'Customer'.

The Third C

In the hospital where I served most of my housemanship, service quality is emphasised partly in the form of hospital 'basics'. For instance, 'Customer incident action forms are used to record and communicate every incident of customer dissatisfaction. Every employee is empowered to resolve the problem and to prevent a repeat occurrence'. Also, 'Instant customer pacification will be ensured by all. React quickly to correct the problem…'. There are twenty such exhortations, and everyday I hear my nurses pass them on, along with their usual nursing reports, sort of like a 'reminder of the day' saying. So far, I have not heard Clinical Departmental meetings start with any of the above.

The spirit of these exhortations (to provide excellent service) cannot be faulted, and there is nothing wrong with wanting to make people feel better. But when I first came across these basics, the semantics disturbed me somewhat, specifically, the use of the term 'customer'. Are the words 'customer' and 'patient' wholly interchangeable? Do they convey the same meaning? When I spoke to the Corporate Communications Manager of the hospital about this matter, she was genuinely surprised that I found the word 'customer' inappropriate. She said, "I think when we treat patients as customers, we give a higher level of service."

So 'customer' and 'patient' are not interchangeable. Indeed, if my Manager's views are reflective of many involved in hospital administration, then `customer' is a desired level that administrators want medical staff to aspire to, in treating patients.

What has gone wrong with the medical practice here, that the professional altruism that used to be conveyed in the word 'patient' is deemed less important than the retail connotation in the word 'customer'? This is too complicated a topic to be discussed in mere paragraphs. Suffice to say there is little point in pointing fingers when the paradigm shift has already occurred.

It is probably very fitting to recall at this point, the question that the former Editor of the New England Journal of Medicine, Arnold Relman, asked in the early 1980s to an audience in the University of North Carolina. He said, "The key question is: Will medicine now become essentially a business, or will it remain a profession? Will we act as businessman in a system that is becoming increasingly entrepreneurial, or will we choose to remain a profession, with all the obligations for self-regulation and protection of the public interest that this commitment implies?"

I hope the choice is still up to us. ■