

The doctor, the patient and the relative

Commentary by **Anil Pilgaokar**

The patient, an elderly woman, was persuaded by her family to visit a doctor for a general check-up for various complaints. She was accompanied by her close relative, who was slightly familiar with medical issues. At the patient's request, the relative also accompanied her to various tests. The doctor prescribed a long-term drug therapy.

Before each consultation, the relative told the patient to ask any questions she had, but the patient did not have any. The relative had read about risks associated with the drug therapy, and expressed these reservations to the doctor, in front of the patient. The doctor responded that while there was a small risk, this drug was necessary, and when monitored carefully it was safe. Also, the therapy had to be continued for at least two to three years in order to have any effect. "Don't start the treatment if you're not prepared to do that." He concluded saying that the decision was "up to you". When asked about the importance of lifestyle changes, the doctor mentioned the role of diet and exercise, but indicated that these had limited value. The doctor addressed most of his comments to the relative rather than the patient, even after being told by the relative that the patient could understand English.

When later, the relative asked the patient her opinion, the patient expressed a general uncertainty, indicating that the relative should make the decision. The relative asked if the patient had listened to the questions, and to the doctor's answers. Then the relative stated that it would be okay to follow the doctor's advice.

Over the next year, the patient's symptoms improved considerably. She had occasional anxieties about symptoms, for which she would call her relative up. The relative tried to encourage her to phone the doctor on her own, but the patient preferred to have her relative phone with such queries, and accompany her to the

doctor if necessary. The patient sometimes mentioned the doctor's visits in front of her family. Her children knew about the general course of treatment.

One year later, when the patient returned for a routine check-up, the doctor suggested that the drug be switched to a new formulation which had been available in Europe for eight years (as opposed to 50 years for the current drug). This drug was not available in the US, but had recently become available in India. Available studies suggested it might have fewer risks than the older drug, and it was easier to take (one pill a day). The doctor also added, pointing to a drug brochure, that he had been told that this drug caused fewer uncomfortable side-effects, though this had not "yet" been proved.

The relative asked how long this therapy would continue. The doctor said that ideally, therapy should be life-long.

The relative had recently read journal articles, which felt the drug was overused, the benefits exaggerated and the risks under-played. A recent study had noted risk were higher after five years of use. Further, the relative had often heard that one of the benefits of using older drug formulations is that they are better studied, and their risks are better understood. The relative's own feelings ("If this was my own mother") were that the old drug should be retained, but stopped after five years, and also that the doctor should emphasise the value of life-style changes for the health condition.

The relative felt obliged to express these reservations to the doctor, since she felt responsible for the patient starting, and, now, continuing treatment. However, she did not want to raise these questions in front of the patient, as she did not want to agitate the patient with such uncertainties. At the same time, she did not feel she should speak to the doctor directly without consulting other family members.

So the relative presented her opinion

to the patient's children, and asked them their opinion. She also told them that she was not sure if her hesitations were well-founded, and was ready for the possibility that the doctor would convince her that the change in treatment was the right choice. The children supported the relative's proposal to go to the doctor and ask questions without the patient's presence.

When the relative accompanied the patient on the next visit, she told the patient she wanted to speak to the doctor first, and went into the consulting room. She told the doctor she hesitated to express reservations, but felt she had to because of the peculiar position she was in. ("This is how I'd feel about it if the patient were my mother.") She also told the doctor that she did not want to raise these questions in front of the patient because she did not want her doubts to confuse the patient. She wanted the doctor to hear her doubts, to either convince her or be convinced as to the drug and the duration, and then to speak to the patient. She said she respected the doctor, and also the relationship between the doctor and patient. She told the doctor she had spoken to the children, and that they supported her opinion.

The doctor listened with visible irritation to the relative, and responded abruptly: "Just because a drug is new is no reason to avoid using it. Why are you afraid of progress? The new drug probably has fewer side-effects as well." Then he picked up the phone and asked that the patient be sent in.

When the patient entered, the doctor told her, "Your relative doesn't think you should be taking this new drug, and I want you to be here. First of all, just because a drug is new you don't have to be suspicious of it. You have to change with the times. Second, you definitely need the drug, whether the new one or the old one, and I believe you should take it for the rest of your life. Now, you make your decision." At this point, the relative felt the doctor had undercut her efforts to address

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valid doubts in a thoughtful way, and that the patient was being somewhat agitated by the doctor's statements.

After they left, the patient asked the relative, "What do you think I should do?" The relative then went to another doctor, who said, "Your fears about new drugs are unjustified. The deciding factor when thinking about which drug to take is not whether a drug is new or old, but whether the patient has problems with the drug she is already on. Since she doesn't, she should stay on the old drug." This doctor, too, felt the drug should be taken life-long, though the family physician stated that the situation would be reviewed after five years.

This case study is being presented without consultation with or permission from either the doctor or the patient. The facts here are based on the relative's perceptions. This is being done because the relative believes that the dilemma has been identified as such by her, and not by the patient. Asking the patient for permission would mean creating an issue where maybe no issue exists.

Also, while a very tense situation occurred, the relative does not feel that circumstances warrant a change in doctors, and will therefore continue to accompany the patient to the same doctor. In such circumstances, the relative feels that to challenge the doctor amounts to threatening the existing doctor-patient relationship.

Response : The facilitator's role

As "net practice" is essential to Test Cricket, so is debate on hypothetical case studies on ethics essential to the practicing physician. Hypothetical case studies provide space for free debate without offending either doctor or patient. This case study - though 'real' in itself - can serve as a hypothetical case study. The identities of doctor, patient and the relative are unknown. Nor does one know the doctor's (or the patient's) version of the case presentation. One does not know the disease of the patient or the drug therapy (i.e. the benefits vs. risks). Many things must be imagined, and a number of assumptions must be made,

in order to debate this subject. We must also be aware that these assumptions could be misplaced.

I get the picture of a competent patient (the relative tells the doctor that "the patient can understand English" and he may as well address the discussion to the patient), who is apprehensive and seeks the relative's moral support. I also get the picture that the doctor felt it was okay to address the discussion to the relative (This could be because that is how the patient would like to have it).

The ethical questions that one can raise, and my responses:

Is the participation of the relative (on behalf of the patient) in order?

I believe the relative's role, as a *facilitator* is acceptable. I understand (from the case presentation) that the relative's role as a facilitator was at the instance of the patient and to that extent is acceptable.

(In the days when more physicians had family practices, the doctor often accompanied the patient — at the instance of the patient — to facilitate their meaningful participation even though he had already earlier discussed the case with the consultant. He more often than not served as a moral support for the apprehensive patient)

If the facilitator holds a fiduciary relationship with the patient, the participation should help matters both ethically and practically. *However, if the facilitator exceeds this role and directs the patient's decision making process in any one particular direction and even partially subverts her autonomy, it may not be ethically permissible.* The presentation (albeit the relative's version) gives the impression that this was not the case.

Is the doctor's behaviour, first in addressing the discussion to the relative rather than the patient and later during the suggestion to change the drug therapy, acceptable? Was the doctor by focussing discussion with the relative rather than the patient - a competent patient at that - being disrespectful to the patient? Did the doctor sacrifice the patient's autonomy?

The picture here gets clouded. "Don't

start the treatment if you're not prepared to do that." He concluded saying that the decision was "up to you" This would indicate the doctor's effort to ensure that the patient understood the problems associated with the drug therapy and opted for the therapy through autonomous decision. However, despite the relative's cue that the patient understood English (and therefore the doctor may rather focus discussion to the patient) the doctor chose to address the relative.

What is more difficult to understand (and appreciate) is the doctor's reaction to a perfectly valid query [The relative wanted the doctor to hear her doubts, to either convince her or be convinced about the drug and the duration, and then to speak to the patient]. As a professional, the clinician is expected to be responsive (as against reactionary) to the patient (and by extension of the mandate to the facilitator). Further, if the doctor had good reason to change the therapy (on which the patient for a year was doing well), it ought not to have been difficult to explain this to the patient. For over a year the doctor seems to respect the role of the relative as a facilitator and suddenly takes a hostile stance when questioned. "**Now make your decision**" to me sound more like browbeating than promoting autonomy. Somewhere the doctor's ego is hurt or — worse — the doctor is promoting the new drug and is pushing hard to enlist patients on to this new drug. It comes as no surprise that the second doctor's opinion endorses the relative's line of reasoning.

Is it ethically correct to discuss the case study when neither the patient's nor the doctor's permission is sought?

I believe it is perfectly all right to discuss the case here when the identities of all the actors are completely protected. Transparency demands that the position (the relative's perception) be explained as the editor has done here.

