

itself into some sort of health advocacy group – this would be a breach of its Constitution – many who attended the Congress should have been inspired to think again about their role in their own social setting. To what extent can they make a difference, at least to the quality of the debate about justice in health and social care? Can they find a way on influencing national policy? What NGOs might they join, where advocacy and activism are a core activity?

A final issue relates to the interweaving of the Arts into the Congress programme. This has been a feature of IAB Congresses since the one in Australia in 2004, when its President, Paul Macneill, set a powerful example, which has been followed – to a greater or lesser extent – ever since. Bioethics is frequently described as inter-disciplinary, but this is usually referring to the inter-relationships of Philosophy, Theology, Law, Medicine and Social Science in its scholarship. But incorporating the Arts, or, more broadly, the Humanities in its discourse makes a profound change. Such a change opens up the issues of Bioethics to the imagination and the emotions as well as to the mind. This broadening of the discourse was done very effectively in Bangalore, and it gave the lie to the simplistic notion that all that is needed in morality is rational argument. Certainly, we cannot do without rationality, but reason alone cannot help us to be moral agents in the richest sense of that specifically human capacity.

Conclusion

It was a privilege to attend this Congress, as well as a great pleasure to spend time again with my good friends from India (and from many other countries too). But the main personal reflection from this experience is an awareness that we must learn from what we have heard over these days of bombardment with experiences and ideas from all sides. For me the lesson is a simple one: the time is short and we must do our best to make *some* difference in this unjust world. We must seek to counter the gloomy prophecy of W B Yeats in his poem, *The Second Coming*:

*The best lack all conviction,
While the worst are full of passionate intensity. (1)*

It need not be like this! But that is up to us, those of us who claim to be really concerned with Bioethics. Inspiration to make a difference can surely come from these few days in India.

Note:

- ¹ For full range of papers, see: <http://www.worldcongressofbioethics.org/documents/Program.pdf>

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The patient is king: But does the king accept wise counsel?

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Abstract

Trust is the most important component of the doctor-patient relationship. This relationship has evolved substantially from a sacred paternalistic bond to a very prejudiced, consumeristic link. Changes in legal systems have brought medicine into the purview of consumer litigation and therefore the patient is the king akin to the consumer. In this short paper, the implications of the rights of the patient from a consumer point of view and the issues related to its use/misuse in daily interactions is discussed. How patients could potentially participate in decision making is stressed. At the same time, the fallout of their unnecessary intrusions into the doctor's clinical expertise and advisory capabilities needs to be recognised and tactfully countered to build and maintain trust in the doctor-patient relationship.

Keywords: patient - doctor relationship, paternalism, consumerism, trust, good communication,

The doctor-patient relationship has long been considered special and sacred.⁽¹⁾ A fundamental principle of this relationship is Trust which in turn is built upon warm rapport, good communication and mutual acceptance of each other's strengths and weaknesses.⁽²⁾ This relationship was not built overnight; it has taken centuries of personal sacrifices and professional commitment to win the hearts of ailing men, women and children. A million oaths have been pledged after Hippocrates to ensure that doctors treat their patients honestly, compassionately, selflessly —and most importantly —with no intention to harm. This relationship has been under duress for quite some time, and it has become more relevant than ever to regain trust lest it should crumble forever.

Before the emergence of the four principles of ethics and the rise of evidence-based medicine, patients relied heavily on advice from their physicians to start, stop or change a medicine. It was also considered an unwritten dictum to religiously follow the physician's opinions on what tests may need to be performed to arrive at a diagnosis. Times have changed and patients confront their physicians with a

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To cite: Basheer A. The patient is king: But does the king accept wise counsel? *Indian J Med Ethics*. 2019 Jul-Sep;4(3) NS:228-29. DOI:10.20529/IJME.2019.048

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remarkably high background knowledge about their ailments, possible diagnoses, potential treatments and their harms. Thanks to the internet and social media boom, the average patient today has access to as much medical information as an experienced physician.⁽³⁾ To make matters worse, there has been growing distrust between the doctor and his patient; the doctor wary of legal suits and consumer activism, and patient suspicious of the doctor's potential conflicts of financial interest.

A reasonable way to tide over the crisis is to apply the principles of informed decision making and shared decision making.⁽⁴⁾ The doctor uses his clinical expertise and available evidence to provide the patient with all possible options (whether it be diagnosis, treatment, prognosis or harm) and helps the patient make the ultimate choice. While this is a practical, ethical and respectful method, an interesting question that arises is whether the patient (read consumer) is the rightful king? And can the "king" demand anything that is available and within his capacity? An example could make this very clear. A few months back I attended to a patient with an acute stroke. We admitted him to the intensive care unit after an MRI scan that showed an infarct. The patient's son was very anxious, and I explained the prognosis to him and what we were doing for his father. A couple of days later, the patient became much better and we decided to move him to the ward. The son enquired whether the clot in the brain had reduced, and requested that an MRI scan be repeated before he is moved out. I discussed the difficulties in assessing that (both clinically and by imaging) as well as the futility of the exercise given that it would neither change treatment options nor his prognosis (now that he was showing steady improvement). Nonetheless, the son seemed unmoved and persisted in his request. The cost involved also did not seem to be a limiting factor in his case. So, we put him through the scan; it provided no new information except that the intensity of the MR lesion had changed owing to time elapsed since the stroke. I had a strong urge to make a sarcastic comment, "I am sorry that we couldn't find anything interesting in the repeat scan!" But better sense prevailed, and I requested my registrar to inform the son about the scan.

Such instances are not uncommon, and I believe they could be on the rise given the exponential growth in technological acumen of patients and their relatives disproportionate to their "real education" in terms of risks, benefits and ethics of medicine. Over the next few days, I wondered if the meaning and scope of patient autonomy had become distorted. Patients do have the right to make informed choices, but does that mean making irrational, unnecessary choices which the treating physician is not considering at that given point of time? What are the consequences of letting patients and relatives decide what tests need to be done for their diseases?

As doctors, we must not be prejudiced about our patient's ability; sometimes their curiosities and queries help us perform tests that could enable a diagnosis. In our busy schedules, we are likely to miss ordering a scan, a blood test or a urine examination. At least a couple of times I have requested

ultrasonograms of the abdomen when my patients discussed with me whether they might help with their diagnoses. Therefore, such unsolicited discussions on investigations may have a potential role in patient care.

In the example of the repeat MRI scan, what are the consequences of finding something ominous on the repeat scan? Let us say the repeat scan showed a hemorrhagic transformation of the infarct. Could the patient or relative sue the doctor for poor judgement and patient care? Should the doctor feel bad that he had not thought of doing a repeat scan; should he feel ashamed that the discussion to do the scan was initiated by the relative, failing which the new finding could have been missed? These are questions that probably each of us would require to ponder over and deal with at an individual level. Such complex situations are best tackled by an honest discussion with the patient and relatives. Suggesting that as a doctor with experience you believe that a particular test is not required is probably what everyone can easily do. Going a step further and accepting that despite your experience and belief, there is always a small probability of finding something on the test, makes the discussion much more meaningful. A cautionary word — such findings (if any) may not hold any significance in terms of diagnosis, treatment or prognosis. Nonverbal cues suggesting "I know this better than you," "Well, if you say so..." are best consciously avoided. Most patients are good at numbers; in fact, it is quite easy to convey and convince most patients using percentages and proportions. Providing easily comprehensible data of benefit versus risk should be tried wherever possible.

The overarching theme of the doctor-patient relationship therefore is trust. Building and maintaining trust as well as regaining lost trust are onerous tasks that require the deliberate use of good communication, honesty in conversations and willingness to accept one's omissions and shed prejudices. Today as physicians, the greatest challenge we face is "communication inertia", the lack of motivation to communicate. Our bitter experiences could have played a part in creating this inertia. All the same, we must strive to overcome that inertia and start the process of honest and evidence-based dialogue with our patients, if we are to rebuild trust. Once that is done, it is easy to accept that the true king is the patient indeed, but the counsel of his physician makes him a wise king.

Competing interests: None. No funding has been received for this paper.

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