**Title - Patient is the King; but is the King amenable to 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 litigations 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 be potentially useful in decision making is stressed. At the same time the fall outs of their unnecessary intrusions into the doctor’s clinical expertise and suggestive capabilities needs to be recognized and tactfully encountered to build and maintain trust in the doctor-patient relationship.

The doctor-patient relationship has long been considered special and sacred.1 A resounding 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 bloom 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 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 interests.

A reasonable way to tide 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 all possible options (whether it be diagnosis, treatment, prognosis or harm) and helps 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 to him about the prognosis and what we were doing for him. 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 about 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 on 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. In 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 even when the treating physician is not considering such choices 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 potential role in patient care.

In the example of 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. Can 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 that such findings (if any) may not hold any significance in terms of diagnosis, treatment or prognosis is like the dressing on the salad. 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 doctor-patient relationship therefore is trust. Building and maintaining trust as well as regaining lost trust are onerous tasks that require deliberate use of good communication, honesty in conversations and willingness to accept 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 were 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.

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