What responsibility do we have towards our patients?

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Summary

All healers have a common responsibility to their patients. The author discusses this statement by dividing this responsibility into 4 areas: understanding your patient, understanding yourself, creating a therapeutic relationship and understanding your discipline.

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Curriculum vitae

Guy Parr studied at UCT where he obtained a BSc (Med) in 1970 and MBChB in 1973. After internship at Groote Schuur Hospital, he spent 2 years in Europe, with various GP-locums in London. He returned to the RSA and after being a Medical Registrar at Groote Schuur (1977–1978) he started as a GP in Claremont. He is interested in academic medicine, family therapy and holistic medicine. Guy is married with 3 children and when he has time free from work and organising the Congress for 1988, he loves sailing and running.

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As family practitioners our work is largely pragmatic and not philosophical, and we tend to view the world from this position. Although our practices may differ, we all practice the craft of medicine using individual methods that may be difficult to standardise or quantify but which embody the same principles and should achieve the same ends. As healers we all have a common responsibility to our patients.

As healers our main task is to help a patient towards achieving an independent state of health in which his full potential can be realised. The patient role is seldom chosen, whereas the healer voluntarily assumes this role and in doing so takes on the greater responsibility for what occurs in the healing process. The responsibility is heightened by the immense power and cudos society gives us in this role.

The four main areas of responsibility which all healers have, are:

1. To understand the patient
2. To understand himself
3. To create a therapeutic relationship
4. To understand his discipline

1. Understanding the patient

Who is the patient? The individual who seeks help never exists in vacuo and may not be the real patient; is it the depressed mother with the difficult infant? Is it her unemployed husband who is drinking too much? Is it their impoverished and poorly educated transitional community? Or is the real patient the sick society that practises discrimination and unequal distribution of resources? As healers we need to understand the validity of General Systems Theory to health, the importance of social and family dynamics on the individual patient and not to fall into the trap of treating the symptom as the disease.

What does this patient need? The presenting problem may not reflect the patient's real needs and we need to distinguish between the two and establish what the illness means to the patient. A heavy smoker may want an antibiotic as a quick fix for his bronchitis, but what he really needs is help to develop a less destructive way of coping

with life stresses. What are the sick family's needs? Illness may cause a major crisis of adjustment for the family. A chronically ill father may lose both his income and status as head of the family, the increased burden on the mother may cause added stress for her, inadequate parenting, impaired family interaction and may manifest as behaviour disorders in the children.

The GP's main task is to help a patient towards achieving an independent state of health in which his full potential can be realised

Illness may sometimes present a solution to an inadequate individual who chooses a sick role to escape from unmanageable life stresses. A man with chronic low back pain may see this as a solution to his inability to cope with his job and family, and may want his wife to assume the dominant role in the family. If she accepts this role the couple may tacitly collude in a maladaptive family response that converts a temporary physical disability into a chronic family disease.

Unless the doctor understands the meaning of the illness to the family and the family's needs, his attempts at healing will be inadequate and frustrating. This reinforces the idea that the illness is incurable and that the healer is also inadequate. It may also result in alienation of the family from the doctor and lead them to seek alternative care.

What about the community as a patient? In Africa we need to recognise the huge health discrepancies:

- Destructive life style diseases associated with smoking, food and alcohol abuse, lack of exercise, are leading causes of premature death in affluent South Africans.
- Diseases of poverty affect 73% of our population. The life expectancy in Africa is 47 years (cf 72 years in Europe) and 50% of Africans die before their fourth birthday from diseases linked to poverty, poor housing and malnutrition.

Health in developing communities is more dependent on socio-economic factors than the provision of medical care. Demographic studies have shown that birth rates and infant mortality are dependent on per capita income rather than provision of antibiotics and contraceptives. Responsibility for health care in these communities requires the doctor to extend himself beyond the traditional medical model into social and political fields.

2. The doctor's responsibility to understand himself

Most young doctors leave medical school having been taught a lot about medicine, a little about human beings and almost nothing about themselves. This lack of insight makes them particularly vulnerable to the stresses and demands of the healing role and reduces their ability to cope with patients' needs – a doctor's guilt feelings arising from his inability to accept failure, may cause him to reject a terminally ill patient when that patient needs him most of all.

How vulnerable are doctors? Surveys in Britain show that doctors die from suicide, cirrhosis and motor accidents, 2 to 4 times more often than the general population, and in the USA doctors are apt to abuse drugs from 30 to 100 times more often than the general population! This vulnerability may be due to a combination of role strain (patients demands for us to be superhuman) and a susceptible personality – doctors have been characterised as having obsessive-compulsive personalities with a poor ability to tolerate uncertainty and a desire to please others that often arises from unfulfilled dependency needs. Inability to cope with the stress of a healing role leads to burn-out, self-medication and often inadequate treatment by colleagues.

Birth rates and infant mortality are dependent on per capita income rather than antibiotics and contraceptives

Entrants to most medical schools today are chosen more for their intellectual academic ability than for their human insight. Their training focuses on this, producing good disease-centred scientists rather than patient-centred doctors.

As healers we must understand our own needs for power, recognition, certainty and our need to please – and recognise when our behaviour is aimed at fulfilling our own needs rather than those of our patients.

3. Responsibility to create a healing relationship

Patients often come to doctors with trust and high expectations that we will intervene in their lives and not just treat their symptoms but will transport them back to health. While we may not be able to fulfil this need we should always be able to accept the patient non-judgmentally and to empathise with his need for help in order to create a healing relationship. Many studies have shown that the quality of this relationship significantly affects compliance and the outcome of therapy.

To be good healers we need to be patient-centred, not disease-centred, and we need to understand the intricacies of the doctor-patient relationship. We need to be expert communicators using techniques like active listening, facilitation, open-ended questioning, and understand the patient's non-verbal behaviour in such a way that we know why this patient has come to us, and the patient himself feels accepted and understood.

The ability to create a good healing relationship is dependent on one's knowledge of that individual, his family and his culture. The more culturally remote the doctor is from his patient the less chance he has of establishing this relationship.

The quality of the doctor-patient relationship significantly affects compliance and the outcome of therapy

The breakdown of, or primary inability to form this relationship, leads to alienation of patients from scientific disease-centred medicine. The resulting frustration and anger may lead to litigation or patients seeking "alternative medicine" in the hope of being treated as individual human beings.

4. Responsibility to understand his discipline

Healers often come from very different backgrounds, ranging from conventional medical doctors, physiotherapists, psychologists, etc to the "alternative" therapies like homeopathy, chiropractice, herbalism and traditional African healers. Advocates of "alternative" medicine tend to reject conventional medicine because of its limits. While we need to be aware to these limits and should be able to extend our thinking beyond them, the existence of these limits does not mean that we should abandon the analytical scientific model altogether.

Your inability to create a good, healing relationship will result in your patients seeking alternative medicine

The scientific process has been compared to a map – a survey map represents a scientific abstraction of a territory. Examining the map is no substitute for exploring the territory, and the map is unlikely to inspire us like a landscape painting may do. The map may even be inaccurate or not show important details. However, when we are leading our patients through diseased territory we use abstract scientific maps, not impressionistic landscape paintings, to guide us.

It is our responsibility to explore our territory, to make certain we are using the right maps and to correct and accurately map out uncharted areas. How often do family practitioners use maps drawn up by specialists who are exploring totally different areas?

It is only by analysing and quantifying our disciplines that we can really assess what we are doing and whether it is helping our patients, or not.

Conclusion

Throughout the spectrum of the healing arts, there are areas of responsibility that apply to every person who adopts the role of healer. These are:

- to know his patients and to understand their needs in their broadest context
- to know himself and not to confuse his own needs with those of this patients
- to create a healing relationship so that he can help the patient to fulfil his needs
- to know his discipline so that he can accurately assess what he is doing and how much it is really affecting his patients' health.

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