

Scenes from Postgraduate Life

Technology and the doctor/patient relationship

In the mid-fifties I spent a pleasant year in the Department of Gastroenterology at the University of Michigan in Ann Arbor. The attractive campus was modelled architecturally on Cambridge and amongst the medical staff were some world famous personalities including Reuben Kahn (developer of the Kahn Test) and Howard Conn, who first described the syndrome which bears his name. I worked with Basil Hirschowitz (a South African who had come to the States via the Central Middlesex Hospital) at a time when he was developing the fiberscope, the precursor of our present-day fiberoptics. I was with him when the mucous membrane of the duodenum was endoscopically visualized for the first time. To those of us who had been brought up on the rigid gastroscope of Hermon Taylor (who visited Ann Arbor while I was there), this was a tremendous advance.

Unfortunately it has not fulfilled our expectations and thirty years later, there is still doubt concerning its impact on outcome both in haemorrhage and dyspepsia. This realization prompted an interest in the wider field of technology assessment which Bryan Jennett¹ has reviewed in a typically masterly fashion in his Rock Carling Monograph of 1984. I would like to look at one small area where there is a risk of the burdens detracting from the benefits – the effect of technology on doctor/patient relationships.

A hundred years ago, when the physician 'knew everything but could do nothing' (as opposed to the surgeon 'who knew nothing but could do everything') the doctor/patient relationship or the bed-side manner (as it was then known) determined, in large part, the doctor's reputation. It could do little more than provide charity and comfort but it was in fact an important form of treatment. It remains today the interface between provider and recipient of health care; its importance is not diminished and the outcome in many different situations may well depend on its successful functioning. It can still act as a therapeutic agent. It may replace investigation but additionally it serves as a catalyst, a facilitator and a co-ordinator, as well as compensating to some extent for the isolation which characterizes so many urban communities. It is a vital factor in any form of health provision, but until recently attracted little attention in the undergraduate or postgraduate curriculum.

Fortunately for the patient (and his or her relationship) the pendulum is swinging and we are now as much concerned with attitudes as with knowledge and skills. Recent General Medical Council deliberations²

have dwelt particularly on those areas which relate to the doctor/patient interface. The increased prevalence of and interest in psychosocial situations have fuelled this concern, as have the escalating variety, expense and sophistication of technology with the associated publicity and patient expectations and, additionally, a resurgence of feeling for humanity as opposed to science.

The doctor/patient relationship is based on the part of the doctor on expertise, authority and humanity and on the part of the patient on expectation and trust. The doctor has the greater responsibility for its development; it should remain under his or her control but he or she must remember that it is a partnership and be receptive to the patient's input. The professional contribution will depend on personality, knowledge of patients' psychology and behaviour, skills and attitudes. The doctor's personality should reflect an interest in people tempered with compassion, warmth and humility, and his or her knowledge of patients should extend to their beliefs in health, their expectations, their preferences, their desire for independence, their trust, shame, fears and guilt. Of all the skills required, by far the most important is the ability to communicate, to be able to talk, listen, observe, and to develop understanding and insight. He or she should be authoritative, but allow the patient to share in the decision-making process; he or she should have a large capacity for empathy and sympathy.

But what is technological medicine and how may it obstruct these developments? The term merely means the use of tools; it may be high or low, old or new and is concerned with techniques, machines, drugs, buildings or human agents employed in the health care scene. The introduction of Laennec's stethoscope was resisted because it interfered with the *physical* doctor/patient relationship. Most modern technologies are more disruptive of the *behavioural* aspects. A meaningful relationship may be made impossible by the patient's physical or mental condition in which case the doctor/relative relationship should take over. The acutely ill patient is more likely to tolerate invasive innovations and be temporarily less concerned with relationships. This is acceptable. What is not is a disregard of the interface in the pursuit of a technology.

By what means can the interface be impaired in the less ill patient? At the top of the list must come interference with communication – visual, aural or tactile. This distances the patient from the doctor,

removes his or her ability to be involved in decision making and leaves him or her isolated to cope with expectations and anxieties. For their part, the doctors lose the controlling influence. When this situation arises from reliance on some form of monitoring it is not the fault of the technology but of those who use it.

I well recall the experience of a colleague who spent four days on a ventilator following an episode of status asthmaticus. Excommunication was his biggest concern. In his case, the isolation was largely the result of his condition but in many situations it occurs because the technology has been substituted for the doctor. Invasive monitoring restricts the patient's independence and impairs dignity, while the need for contact with the doctor may be replaced by an investigation. The patient's expectations must always be considered; subjecting him to a technology unexpectedly may produce a more difficult situation than if it was anticipated but not received. There is the risk that the magic of a new process will cloud the clinical situation. Muttered comments at the time of the technical examination will have an adverse effect on the patient.

The doctor, the patient and the patient's relatives must have a full understanding of the technology, its benefits, its limitations and its hazards. The doctor must have a clear idea as to why he or she wishes to invoke a particular investigation. Does it affect management or outcome, will it confirm the diagnosis, will the patient benefit, what is the morbidity, what is the cost? Is it just being employed to meet patient demand or a current fashion? Technology may be used as an escape from decision making, more tests leading to more anxieties. Human substitution may impair relationships; a deputizing service (instead of a sympathetic family doctor) or a protective receptionist will physically distance the doctor from his or her patient. In all areas of medicine a meaningful liaison may be superseded by a prescription often unwanted by the patient – a state of affairs which led Richard Asher³ to say 'Despair is better treated with hope not dope'.

As a postgraduate dean, I am particularly concer-

ned with the educational implications. Bryan Jennett⁴ said two years ago 'The main impediment to the rational use of medical technology is not poverty but ignorance'. It is to this ignorance we should address ourselves. I would suggest that the doctor/patient relationship is being harmed, not by technology but as a result of its misuse; by the doctor/technology and the patient/technology relationships. It follows from this that both the general public (and the media) as well as the medical profession are in need of education. With regard to the former, they should know what technology can and cannot do. Their expectations and their faith in technology might then assume more reasonable proportions and they, like the profession, could think in terms of need rather than demand. As far as the medical profession is concerned we must press for the adequate evaluation of all forms of technology both high and low, new and old. Armed with this information we would then be in a better position to put new developments into their proper perspective, to give patients realistic information and to invoke technology only when it has a good chance of achieving patient benefit.

It is now twenty years since I first sent a patient from my district hospital to London for a pacemaker implantation. While having a temporary wire inserted, she enquired of the cardiologist how many of these particular operations he had done. He replied somewhat modestly that he thought it was about 300. He thought she was intending to compliment him on his expertise but instead she merely said that if he had done that many he ought to know to keep his patient's feet warm and would he mind covering them up. She made it quite clear that as far as *she* was concerned humanity was not to be sacrificed in the interests of technology. She might have said that the cardiologist had a poor bedside manner. We would say that there had been a partial failure of the doctor/patient relationship. Postgraduate and continuing education should aim to foster this interface and thereby prevent the development of cold feet – physical or psychological!

R.C. King
 Postgraduate Dean
 South East Thames Region
 British Postgraduate Medical Federation
 33 Millman Street
 London WC1N 3EJ, UK

References

1. Jennett, B. *High Technology Medicine. Benefits and Burdens*. Nuffield Provincial Hospitals Trust, London, 1983.
2. General Medical Council Education Committee. *Draft recommendations on the training of specialists*. London, 1986.
3. Asher, R. The sedation and stimulation of man. *Lancet* 1958, *i*: 954–956.
4. Jennett, B. Irrational use of hi tech. *Hlth Soc Serv* 1985, *94*: 708–709.