

POSITION PAPER

## Who's My Doctor Today?

KEN COX

*Emeritus Professor of Surgery, former founding Head, School of Medical Education, and Director, World Health Organisation Regional Training Centre for Health Development, University of New South Wales, Australia*

**ABSTRACT** *Clinical practice is not always user-friendly. Specialisation fragments patient care across different investigations and modes of management. Increasing hospital throughput, especially by day surgery, diminishes the time available for students and other health professionals in the team to interact with the patient and verify the appropriateness of the care plan. Patients are at a serious disadvantage in ensuring that their concerns are understood, and in negotiation of which management plan would optimise the outcomes they seek.*

**KEYWORDS** *Specialisation of clinical practice and hospitals, fragmentation of patient care, demystification of management options, medical subcultures and beliefs, patients responsibilities.*

Getting medical care can be a real nuisance for a patient when you go from one doctor to another to diagnose what's wrong and decide what to do about it. Mrs Mary E visited her GP with a "fluttery heart" and some muscle weakness and weight loss. He sent her to one laboratory for thyroid function tests, to a radiology practice for X-rays of her neck and heart, and to an endocrinologist who could collate all the bits of information.

Once upon a time you went to your local doctor, the one-stop-shop, when you were unwell. Nowadays, if you're seriously ill and go into hospital, you don't even know the names of the doctors looking after you—until you get their bill! How has all this happened? Can patients get back to having just one trusted doctor again?

Address for correspondence: Ken Cox, OAM, MD (Hon), MA, MB, MS, FRCS, FRACS, FACS, 8 Vernon Street, Hunters Hill, NSW 2110, Australia. Tel: +61 2 9817 2902. Fax: +61 2 9817 5457. E-mail: Ken.Cox@unsw.edu.au. Website: <http://Med.unsw.edu.au/MedEd/KenCox.htm>

What has happened is obvious enough to doctors. For a century medicine has been inundated by exponential growth of scientific knowledge that doubles about every 10 years (and less than three years in genetic and HIV research). Medical students face a new vocabulary around 50,000 facts and 30,000 concepts in basic sciences, and another 55,000 clinical facts and concepts!

New knowledge opens up fresh possibilities for diagnosis and treatment, but with many knock-on effects. Somehow doctors have to turn this growing knowledge and technology into improved healthcare. The most obvious medical and hospital responses are specialisation of practice. No-one can keep up with everything. The years of training within each specialty grow longer, adding three to six years to the five or six years of the medical course. Every specialty differentiates further into subspecialties.

Some specialties deal with an organ (heart, eyes, ears, joints, lungs, kidneys). Some focus on a disease (diabetes, cancer, arthritis, stroke). Some concentrate on a narrow age range (new-borns, infants, adolescents, elderly). Some look into our orifices, or take radio-images of hidden organs, or inject dyes into arteries looking for blockages. Some work in "backrooms" looking down a microscope at pieces of tissue or a blood film, or making biochemical tests; many of these doctors never see the patient.

Not only is the patient passed from one doctor to another, but their places of work may be scattered around the city and suburbs. Not having a car, Mary needed 13 hours all told to get to and from those referrals. Doctors often amalgamate into groups to provide a spread of clinical and investigational skills within one building, but are now accused of anti-competitive behaviour for doing that. Current corporatisation of some private practices rings alarm bells for those who fear that corporate profit will be at the expense of public and private health care funds.

Public hospitals provide a supermarket one-stop-shop, with specialist clinics, investigational departments and various treatment facilities covering most maladies. City hospitals don't always provide general practice clinics, however, except for university Departments of General Practice or Community Medicine. People often use the hospital's Accident & Emergency service as their general practitioner, especially on the weekend.

But city hospitals are shifting their roles to being high-tech locations for special investigations and surgical procedures. Higher turnover, procedural practice is most obvious in day surgery. In this "assembly line" medicine, specialists play an "instrumental" rather than a "management" role. Hospitals may not include management of the whole patient in the procedural specialist's tasks on the sick organ. Only occasionally do hospitals look outside their walls to explore how patients contracted the diseases that bring them in. Links into the community are often only for arranging after-care, and not for prevention of future disease. Doctors often say, "I deal with whoever comes through that door. It's not my job to go out and find people who might get sick tomorrow".

Examine the work of the specialist. Specialists deal with patients referred by other doctors, and already partly diagnosed. As a selected group, these patients are more likely to have serious or even life-threatening diseases. They may need technical procedures or treatments that focus on organs and diseases. To do this (often dangerous) job safely and thoroughly with minimal uncertainty, specialists seek the maximal detail about the extent of disease in each patient (often with many investigations), and about the patient's capacity to cope with the planned treatment.

Specialists know more about "their" diseases and possible treatments than anyone else. But all patients know more about their illness and its consequences than all doctors do. Many specialists are reluctant to negotiate treatment options. Expertise carries its own authority. But the specialist's focus may be limited to their personal effectiveness in curing a particular set of diseases. What they know about their impact on the patient's life and work may be incomplete. Fortunately, specialists in private practice usually follow up their patients more closely, and progressively learn the consequences of their treatment decisions.

Hospital specialists may choose not to deal with the whole patient within the limited time available. Partly, the patient is referred with a diseased organ to be fixed—in effect, the organ is referred with the person attached! Partly, how the patient copes at home or at work may not be seen as part of the hospital's job. The consultation may be a temporary relationship with a *patient as stranger*. Partly, the referring practitioner is expected to help the patient fit back into their local context of family and community support. Often, the responsibility for the whole patient remains unclear, however, until underlaps result in something going wrong.

Specialists are sometimes criticised for thinking more about the disease ("the Ca colon in Bed 26") than the patient as a fellow human being. Communication of bad news can be abrupt or insensitive or clumsily phrased. These unhappy stories have decreased; but a doctor's deliberate emotional detachment may be perceived (often accurately) as a cold heart. Unfortunately, empathy is not taught well, or modelled, in teaching hospitals. Who is responsible for the patient's feelings, the patient or the doctor? Is empathy in the contract, or an optional extra?

Research in specialist fields burrows down from the diseased organ through successive biological levels to the cells, their biochemistry and even their genes. This tunnel vision constructs a progressively more detailed understanding of the mechanism of the malady. Specialists, consequently, work within a subculture that assumes that the world is knowable and controllable, a "clockwork universe". The organ focus emphasises the hospital as a technical "body shop" and the specialist as "body mechanic".

Outside hospital, generalists relate to their local *patient as neighbour*, handling a broader range from serious diseases to mild and temporary concerns of which about half remain under-diagnosed. In contrast with specialists, they

tolerate uncertainty, waiting for short-term maladies to recover spontaneously. Generalists specialise in shrewdly recognising early signs of serious disease, in knowing what infections are going about, in referring patients to appropriate specialist colleagues, in health promotion, in screening for early disease, and in linking ongoing patient care with local community agencies.

In contrast to specialists burrowing deeper, generalists work upward from the sick organ to the whole patient, and from there outwards to family, work and society. Within this uncontrollable world, generalists must try to optimise both cure and care. Their long-term relationships with families can build a deeper awareness of each other's skills and vulnerabilities.

Non-procedural specialists (rheumatologists, endocrinologists, paediatricians, dermatologists) work between these extremes. Many manage the long-term care of their patients and often their families, say, with asthma or kidney failure or diabetes, within a relationship closer to family medicine. In parallel, many generalists develop special experience and expertise managing serious maladies as well as specialists can.

These different work patterns should not be read as good guy/bad guy scenarios. Specialisation around new knowledge offers better-informed care. But when doctors focus on diseases, and patients focus on their illness, expectations can differ.

The job is often the culprit. Doctors see their job as interpreting an illness story as a disease story that explains what has gone wrong. Patients are concerned about its implications for their life and work, and want that clearly understood. The specialised services hospitals provide are not necessarily what the patient is seeking.

Clinical practice is not a production line with a new body coming out at the other end. Each management step with each patient requires communication with that ill person, sensitivity to their concerns, keen perception of any clinical cues, alertness to any misunderstandings and misdiagnoses, explanation and persuasion, and integration of each specialised task within a multi-professional team. The "job description" of each health professional in the team may not coincide with this "work field" of what each unique patient needs.

Specialisation fragments the profession and the health care system. Knowing more and more about one area results in knowing less and less about other areas. Mutual ignorance of each other's subject matter is an unintended consequence of specialisation, especially of its constantly expanding research and application. No-one has time to read the medical journals outside their own fields. Communication across professional groups takes longer when doctors don't share work activities or meet in a common forum.

Doctor-to-doctor communication around each patient faces increasing difficulties of understanding each other as they fit their separate pieces of evidence into a diagnosis or management plan. Fortunately, each learns much

about the other's special capabilities during their discussion of how each can help the patient both are looking after. Similarly, communication within each health care team enables integration of each special insight and skill.

Patient care has also fragmented as treatment is separated into self-contained specialised bits. When Mary's investigations showed she had an overactive thyroid gland, her GP gave her three treatment options—surgery, thyroid-suppressing drugs or radioactive iodine. Off she went on two more referrals (and another five hours' travel), to a thyroid surgeon and to a nuclear medicine specialist to discuss the risks and benefits, having already received advice on the drugs from the endocrinologist.

The surgeon advised Mary that most of the thyroid should be removed by operation. The nuclear medicine specialist advised a single dose of radioactive iodine to destroy most of the overactive thyroid cells. The endocrinologist had advised suppression of the excessive thyroid activity with a drug that inhibited thyroid function.

How could Mary decide? If patients are to get the service they seek, "the system" must be demystified. Patients may not realise that specialists become progressively de-skilled in areas outside their specialty. Expecting specialists (or generalists) to be "all things to all men" at the local one-stop-shop is now impossible. Patients must accept fragmented care as an unintended consequence of the very knowledge that is making their physical health better. Each patient must choose the doctor they trust among the specialists and generalists they consult. Building trust takes time and many episodes of contact.

Patients are responsible for ensuring that they get what they came for from the doctor, whether specialist or generalist. But whomever they go to, control over what is done is stacked in the doctor's favour. Doctors know more about diseases and treatments than patients, an asymmetry of knowledge and experience. Doctors can access the system, order investigations, prescribe drugs and arrange hospitalisation, none of which the patient is permitted to do, an asymmetry of power. Doctors and patients each have their motivations and assumptions about the treatment, and these may differ, an asymmetry of values and goals often left unspoken. Consultations are on the doctor's home turf to which the patient is a visitor, an asymmetry of context most vivid in the Accident & Emergency ward. The patient is under threat from the illness and the unknown and is seeking help. The doctor is not disturbed by this familiar situation and is offering help, an asymmetry of dependence on another (Cox, 1999).

Patients can choose the extent to which they become involved in negotiation. Some delegate (or abdicate) responsibility to the doctor. Some discuss with family and trusted friends. Some negotiate the decision with the doctor. Some demand a particular solution. Patients would be wise to examine carefully whether the role they adopt with their doctor achieves what they want done about their malady.

Patients frequently disagree with management plans, more often covertly by non-compliance with the prescribed treatment than in overt argument with their doctor. The patient's choices are not stupid or illogical from their perspective. Patient and doctor function in their separate worlds of work and home. What makes sense to one may not to the other.

Patients rarely give their doctor feedback about poor communication. But if doctor and patient don't listen carefully to each other, neither finds what could be an optimal path to meet both their sets of goals in this illness under these circumstances. Whatever their differences, each must ensure they understand and are understood. That responsibility rests with both doctor and patient. With clear and open interpersonal communication, specialisation can spread a patient's care across many doctors, enhancing its quality without fragmenting it.

Mary chose radioiodine treatment, and has remained well.

## **Reference**

Cox, K. (1999). *Doctor & patient: exploring clinical thinking*. Sydney: UNSW Press.