

Reflections on “Going the Extra Mile”

Dr T Thirumoorthy and A/Prof Goh Lee Gan share their views on the two patient encounters that A/Prof Cheong Pak Yean described in “Going the Extra Mile” (page 28).

Gaining Deeper Insights into Personal Values and Professional Culture

By Dr T Thirumoorthy

Thoughts on “From complaint to compliment”

Reflecting on narratives of clinical encounters enable us doctors to gain deeper insights into our personal values and professional culture. Through this anecdote, one learns that we doctors often work on assumptions. This can serve us well in our busy schedules, as it allows us to take shortcuts in finding the causes and solutions. Assumptions can however lead us to conundrums in relationships and clinical work. Doctors assume that patients have symptoms or illnesses, and that they come to us to unravel the causes and find the cures. Very often, patients already know their diagnoses and even the treatments needed, and seek us out as gatekeepers to facilitate the solutions. The patient in this encounter wanted a referral letter for physiotherapy, as entry to the service was probably based on a referral system or for insurance reimbursement. The factors that lead to good clinical outcomes include a good doctor-patient relationship and meeting patients’ expectations. We should ask patients about their expectations at each encounter, which will help steer us away from working on assumptions. One effective way to do so is to ask patients routinely about the 3Es – Expectations, Emotional impact and life Events surrounding onset of illness – at the end of the history-taking.

As doctors, we value and take pride in our diagnostic and therapeutic skills. This is understandable as we have invested significant effort in our careers, even burning the midnight oil and overcoming numerous clinical examinations. Naturally, we may undervalue the other

services that we provide to our patients. For example, we often degrade the important skill of writing a good referral letter and disparage it as being the work of a postman. Is this the reason why our referral letters are often a bane rather than a help? Writing a clear comprehensive referral letter is not only beneficial to the patient’s care but is also a joy to the receiver. A reorientation of values attributed to the various aspects of our work is definitely worth consideration. We need to find fulfilment in all aspects of our work, as long as it serves the best interests of patients, and builds their trust and confidence in doctors and the profession. Even spending some time helping elderly or disabled patients put on their shoes and socks after a physical examination can be meaningful work for a doctor.

The third point that came from this tale is that we doctors handle intense human work and therefore need to be aware of emotional irritant triggers. As doctors, we value fair play (ethical principle of justice), and thus patients who reveal that they are gaming the system for their selfish ends will often provoke our displeasure. In this situation, the patient had help from within the system to enable him to access physiotherapy without going through the official pathway. Such a conflict of values (fair play versus abusing the system) can rupture the doctor-patient relationship. As individual doctors, we are impotent in maintaining the integrity of the healthcare system. Systems issues are complex adaptive challenges that cannot be fixed in the clinic or at the bedside, and are best resolved at another forum elsewhere. Do we then defend the system against abuse,

or do we serve the best interests of patients as long as it is not unlawful and not unethical by professional standards? In this story, the clinician became aware of the tension in the encounter and its consequences (metacognition and reflection in action). Experience allowed the clinician fast and quick reflection in action, and he changed course to writing a referral letter to the orthopaedic department instead. This narrative reminds us that by lending ourselves to the concept and skills of mindfulness and reflection on and in action, we can gain good judgement that can turn a potentially bad encounter into a compliment.

Thoughts on “Joy to my heart”

This story made me aware that we doctors can subconsciously crave for positive encounters that reward our emotional labour. After all, we are only humans, with human feelings and needs. Such encounters also help prevent us from mental exhaustion and burn out.

We doctors like patients who share the same values as us. The doctors’ culture encompasses being conscientious, hardworking, stoic, self-reliant, responsible, going to work even when ill so our colleagues will not be burdened, self-motivated, and an achievement-oriented work ethic. When there appears to be a *value conflict* – for example, when patients ask for medical leave for what appears to us minor illnesses, it gets our tails up. When we encounter patients who share our values (*value congruence*), we often go the extra mile in being kind, friendly and helpful. This is the human doctor.

The statement that we can always remain *value neutral* in our professional encounters needs re-examination. Our professional ethics expects us to be objective, not to impose or exhibit our values in clinical encounters. As doctors we may not agree with nor condone some of our patients’ values, but we have to at all times respect and uphold patients’ values, as long as they do not result in breaking the law or breaching our professional ethics. Being aware of our own values and culture, and that of others, helps us achieve *cultural competency* in our clinical encounters.

Putting our patients’ welfare as uppermost, even beyond our own and that of third parties, is a challenging principle to put to practice. It is counter-instinctive. We become professionals by incremental developments in a *transformative learning* journey, shaped over a lifetime career. Transformative learning is a multistage and multi-step cognitive, emotional and intuitive learning process. It is self-evident that we need to focus on the journey and process. That is where Narrative Medicine has critical value. ■



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Doing the Right Thing

By A/Prof Goh Lee Gan

THERE ARE many ways to look at the story that A/Prof Cheong has told. Dr Thirumoorthy has mentioned his viewpoints – dealing with expectations, emotional impact and life events. There are other perspectives. Let me share mine – doing the right thing.

Needs and wants

A/Prof Cheong has written about a phenomenon often seen in practice, dealing with patients’ needs versus wants. The first patient in his narrative was well dressed, presumably knew the healthcare system well, and was probably also well connected with ABC Hospital. He had

his own help-seeking strategy. In his mind, his backache required hospital-level care for reasons best known to him. The second patient was a stark contrast. She was not so well versed with what was happening to her. Therefore, she did not know what to request, and left the attending doctor to make the judgement call.

Postman or doctor

As the author recounted, his professional and emotional responses to the two patients were different. The first patient made him feel like a postman. His professional judgement did not matter much, for what the patient wanted was a referral

letter. What the doctor thought the illness to be, was also immaterial to that patient. With regard to the second patient, the doctor was inspired to do what he could because she had symptoms that required his professional expertise. He gladly did his best.

Hippocrates' wisdom

An often quoted aphorism by Hippocrates describes the right thing to do: "Life is short, art is long; the crisis fleeting; experience perilous, and decision difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate." This is still applicable even in practice today.

Doing the right thing

As Dr Thirumorthy said, doctors like patients who have the same values as the doctors themselves. Hence, it was easy for the attending doctor to play the role that the second patient expected of him. Meanwhile, the first patient was an emotional trigger. His request ran counter to the grain of the consultation – the patient had already made up his mind beforehand and simply wanted the doctor to fit into his scheme of things, which was to refer him to the hospital.

What would I have done differently? Back to basics: I would seek out his ideas, concerns and expectations. So my opening response would be, "Okay, I will need to go through the fundamentals of gathering information and deciding if the referral is what you need." Listening intently to the ideas, concerns and expectations would therefore be the immediate activity. A physical examination to rule out red flags would be part of the information gathering.

The next step is a tough one – where the rubber hits the road. My decision is likely to be at variance to his – that since there were no red flags, expectant treatment and watchful waiting might be all that was needed. I would then tell him that from what I could see, the way ahead would be expectant treatment. He would need to return for a review to close the loop, and I would document that he was asked to come back. He could disagree with my plan of management, but I would politely and calmly inform him the approach I took was what we were trained to do – red flags present, refer; no red flags present, symptomatic treatment and watchful waiting. Also, I would remind him that I would have to answer to my bosses about my clinical decisions too, as they might query my actions if the referral was unjustified: "It will not sound right that I tell my employers that my patient asked me to refer." And I would stand firm on that.

**If there is no justification
I cannot refer, and if
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employers, I cannot refer.**

Needless to say, this would entail more energy. It would take more time – maybe twice or thrice the length of the consultation for another patient who quickly accepts my decision. So at the end, it is a judgement call. Obey or do what I think is the right thing?

If it is the latter, then Hippocrates' quote is the roadmap to take. I would do it earnestly and be as value neutral as possible. And I would remember to document the things said and decided. I would remind myself to remain calm, positive, and remember that I am a doctor, so no name calling, no harsh words, just the facts and the commitment to do my best to make this a satisfying consultation, as far as possible. The limit will be NOT to do what I think is NOT right. I would remind myself again: know your Medicine, know the right thing to do. Hopefully, the patient would come over to my side. If not, if he complains, I would have my story to tell too.

You cannot please everybody but you can please yourself

Having said all these, I accept that not all my colleagues will agree with me. Why can't you just write the referral letter? I make no apologies. If there is no justification I cannot refer, and if I cannot justify to my employers, I cannot refer. And in this world, since you cannot please everybody, simply remember to please yourself. ■



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