Jaffna Medical Association

Prof. C. Sivagnanasundaram Oration - 2011

Towards an Effective Care: Patient as a Person

by

Dr. S. Sivayokan MBBS, MD

Consultant Psychiatrist,

Teaching Hospital, Jaffna.

Sunday, 6th of November, 2011 at 8.30 am

Public Library Auditorium, Jaffna

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Towards an effective care: Patient as a person

The President and council of JMA, the chief guest Prof. Rezvy Sheriff, our special guest Dr. Banagala, members of the family of Prof. Sivagnanasundram, my teachers, colleagues, friends, ladies and gentlemen,

I am privileged to deliver the (third) Prof. Sivagnanasundram Oration in this prestigious forum. I would like to express my sincere gratitude to the President and the council of Jaffna Medical Association for giving me the opportunity to deliver the Prof. Sivagnanasundram Oration for 2011. I have chosen a topic, which I believe suits very well to the theme of the sessions – Blind spots in contemporary medical practice, and reflects the teaching of Prof. Sivagnanasundram to us.

Prof. C. Sivagnanasundram

Prof Sivagnanasundram qualified from the University of Colombo in 1955 and served in the state's Health sector, in different capacities. In 1965 he joined the Department of Community Medicine, at the University of Peradeniya and rose up to the post of Associate Professor.

When the Jaffna University opened its medical faculty in 1978, he was invited to the Faculty to be its first Professor of Community Medicine, the post he held until his untimely demise.

He was the corner stone in the establishment and development of the Department of Community Medicine and the Faculty of Medicine of the University of Jaffna. He was one of those who laid the foundation stone for the medical faculty building at Kokuvil on 29th November, 1979.

He had been the Dean of the Faculty of Medicine, a member of the University Council, Acting Vice Chancellor, member & examiner at the Post-Graduate Institute of Medicine and also a member of its Board of Management

His contribution to Public Health and Community Medicine is immense. He pioneered several Research projects.

He was an international consultant to the World Health Organization and also the Ministry of Health in the Kingdom of Jordon. A guidebook for Paramedics prepared by him in 1981, has been translated into Arabic and used as a training manual for Paramedics in Jordan. As a consultant on Health Services Research, he has served in Malaysia, Bangladesh, North Korea, Mongolia, India, Myanmar and Zimbabwe.

He had been actively taking part in several Academic bodies such as the Jaffna Medical Association and the Jaffna Science Association.

His book on 'Learning Research' has had two editions and is widely used across all medical schools and among post graduate students in Sri Lanka. In addition, he has over fifty publications in National and International medical and public health related journals.

He shined not only academically, but also literarily as a writer, an actor and a critique. He was given the nick name of Nanthi by the famous Indian scholar Rajaji.

He was a voracious writer in Tamil and English. He started writing at the tender age of thirteen. Since then he has written a number of short stories, novels, dramas, educational materials, spiritual articles and popular columns.

He has published seventeen books in Tamil. Four of his Tamil books are on preventive medicine for lay people, two for children, two on spirituality and one a Handbook for teachers on Sri Sathya Sai Education on Human Values.

Prof. Sivagnanasundram is a keen observer. His Tamil novels and short stories portray the characters he met in his daily activities. Each one of his short stories gives both a potent and introspective message. Most of his stories have embedded health messages. He introduced his medical experiences into the Sri Lankan Tamil literature.

He had a dynamic personality and was a creative genius. His extraordinary talent extended beyond his academic excellence. For several years he was the "Radio doctor" for "Radio Ceylon".

He was also an actor. He has acted in over 50 stage and radio dramas. He has also acted in a lead role during the early stages of the Tamil film industry in Sri Lanka, in a Tamil film "Ponmani" directed by Dharmasena Pathiraja. Recently, he appeared in a guest role in the documentary film directed by the same director, Dharmasena Pathiraja.

Prof Sivagnanasundram was very happy to teach Health to the layman and carry on with health promotion even under trying circumstances. Even under adverse conditions he always strained to maintain high standards of Health care and education in the places he worked and in the Medical Faculty.

He helped in the development of several people he met in his life. Like many others in this audience, I too was fortunate to know him and learn from him. During my professional career he had always supported me in my efforts as a guide, advisor, admirer and a critique. He contributed a chapter to our book Muthumai (elderly).

He wanted me to produce his drama Kurangukal (Monkeys), which I was unable to fulfil. During his last days he shared many things about his life, which had an impact on me about the outlook of life in general.

His last novel Nampikkaikal (Hopes) portrayed the expectations and conflicts among the medical profession and the community. It gives me great pleasure to deliver this oration on a topic which was very close to his heart.

Overview

This presentation starts with explaining the context of the patients and doctors and their perspectives. This will be followed by exploration of difference of expectations and conflict of interests. The last part of the oration will discuss the contemporary issues and the way forward.

Introduction

The prime interest of medicine is vested in treating the patients to the best of the physician's ability. Many years of hard work has been invested to finally become a doctor, and another set of years is needed to become a specialist or subspecialist. It takes more time and ripening wisdom to develop the understanding and patience to relate to patients as persons, to mature into a good doctor, *vaithiyar*. These long years of gathering the necessary knowledge, experience and the attitudes help an individual to become part of the prestigious profession. Witnessing a fellow human's agony, listening to their stories - the good and the bad, helping them to overcome their illness and sufferings, and transmitting whatever knowledge and experience acquired to the next generation are considered as great life opportunities to doctors.

However, in the middle of ever increasing sub specialties, scientific advances, evidence based practices and the highly sophisticated investigations and interventions; it appears that the prime core of medicine, the patient, and the prime duty of the physician, respecting the patients and alleviating their sufferings are undergoing a paradoxical shift. While concentrating on the newer scientific inventions and developments in order to prevent and treat medical ailments, there is a growing tendency to miss the holistic understanding of the patients in their bio psycho social and cultural context.

Methodology

It is in this context that this oration is trying to explore and understand the psychodynamics of the patients and doctors in the cultural matrix. The information gathered from participant observations, case histories and discussions with the peers and public is presented and analyzed. The author, not only being part of the medical profession, but also belonging to the same culture as the people who seek help from medical profession, will utilize an auto ethnographic method, that of a native or insider looking critically into his own milieu (1), and try to analyze the behavioural patterns of the patients and doctors. Literatures were surveyed in order to have an understanding about parallel developments and viewpoints in other parts of the world.

Being a Patient

Who is a patient? Is it someone who is having a health problem? With the current understanding of the broader definition of health, many of us fit within the criteria. Is it someone who is having an illness? An illness with a known or unknown pathology - an abnormal structural or functional problem of the body, mind and soul? Or is it someone who is sick and shows all the sick related behavior. Hughes (2) discussed about Parsons views of the norms governing western

sick role behaviour as: 1) the sick individual is not responsible for their illness; 2) exemption of the sick from normal obligations until they are well; 3) illness is undesirable; and 4) the ill should seek professional help. It is the last one, when a person seeks professional medical help, that he/she receives the label as patient. According to the Oxford online dictionary the term patient is defined as a person receiving or registered to receive medical treatment.

When someone develops an illness and seeks the services from the medical profession; that someone does have a name – first name, middle name and a surname, a known gender identity, an ethnic background, a religious faith, a tradition; a cultural background; sometimes a profession..... In other words he/she has all the identities of a fellow human being. But unfortunately, the system we are within tends to ignore these identities and tends to adapt inanimate values towards patients. As a result, a patient is seen as a vehicle of pathology, labeled with an illness trademark, or identified with his/her bed number. In extreme examples, patients are being addressed in subhuman words.

No one chooses to become a patient. And many do not enjoy their illness. Of course, there are few who adopt an illness behavior or sick role for their inner or outer needs. But the great majority fall ill without any ulterior motive. An illness can produce unpleasant and unbearable symptoms and make the person suffer from it. An illness can affect the routines of the persons and disturb their functional abilities as well as those around them. An illness can affect the quality, and in some, the quantity of the life. A life without illness is the richest life a person can have. This is expressed in a remarkable Tamil proverb as *Noyatra vazhve kuraivatra selvam.*

Being a patient itself is a unique experience. Since illness is considered as abnormal, being ill also carries considerable

stigma. The stigma could be negligible for some conditions like flu, uncomplicated fever, migraine and hypertension, irrespective of their severity and the potential risks of dangerous outcome. On the other hand the stigma is very high for conditions like mental illness, HIV infection, leprosy, tuberculosis and sexually transmitted diseases. Many other conditions carry moderate amount of stigma. The stigma associated with illnesses hinder people from seeking appropriate help early in the course of the illness or continuing a regular follow up and medication if that is needed. Rarely, being ill can gain respect and attention for a person who has been neglected or ignored.

The illnesses also cause a state of inferiority to those who suffer. The sick person is considered as someone who cannot enjoy a healthy, rich and productive life. This inferiority can sometimes be associated with undue sympathy. The feelings of sympathy and inferiority may be expressed in phrases like "Poor fellow", "She is weak", "No he can't. He is disabled", "Don't disturb him. He is dying". The same can infect the persons with illness, so much so, that it may even undermine their abilities and become demoralized. The phrases like "Sorry, I can't walk", "No sugar please", "Unlike earlier, now I am weak" may express their low self-esteem. Since health and normality is mainly looked through the windows of absence of illness and full functionality, those who do not fit into that category are losing their dignity. But it is essential that accepting the illness and managing it properly too should be considered as a healthy behavior and state of wellbeing.

From a cultural point of view, a patient is considered as a sufferer, which is also reflected in the medical writings and referrals as "so and so is suffering from this condition ..." As patients are usually seen through a suffering point of view, they usually receive sympathy rather than empathy. They will be considered as weaker persons and

given reduced states of fitness and competence. They may receive certain extra privileges – not always, but usually during the acute phase of the illness. In many instances, patients are blamed as if they are solely responsible for their illness, ignoring the complex interactions of various factors associated with the onset and manifestation of illnesses.

The experience of having an illness is not at all a pleasing one. Many illnesses cause pain, discomfort, anguish and functional difficulties. There is always an associated expectation of wanting to know what has gone wrong. The illnesses do create a fear about possible unfavorable consequences. The sickness influences behavior, daily routines of a person and his or her family and community. It may restrict the freedom of movement, choices of food, pattern of activities and the preferred life style. Various DOs and DON'Ts will be in place. Medications, needles, doctors' appointments, hospitalization, investigations - both simple and invasive, and the medical interventions become part and parcel of a sick person's life. In simple terms, when an illness strikes a person, the person cannot have a care free life.

An illness strikes not only an individual; it also imprints its effects on the family of that person. When someone falls ill, one member of the family, or sometimes the whole family will become care givers. They have to cancel their routines and reschedule their activities. Additionally, they have to shoulder the responsibilities the sick person had in the family. In daily wagers, it is not only the sick person, even the care givers too will lose their income; and with the illness - related expenses, it doubles the burden. When a child becomes ill, it affects the overall family tune. Terminal illness too will play a detrimental role in the family. When an illness becomes epidemic, like the dengue Jaffna had in the early part of 2010, it not only creates panic and rumours, but also affects the productivity

of the community. During the chikungunya outbreak in 2007, the whole community became handicapped.

There are differences in how patients express their symptoms and ill health. Many do not have adequate medical knowledge and adapt their own ways of narrating their illness experiences. Some may come out with novel descriptions of their experiences which may create confusion in understanding their illness to doctors. However, there are certain set of words and phrases available in each culture, with a specific meaning about their sufferings. These words and phrases are collectively called idioms of distress (3) (4). Having a reasonable knowledge of idioms of distress will help doctors understand their patients' issues. Usually, idioms of distress explain the psychosocial issues of a sufferer. Many idioms of distress in the South East Asian cultures focus on expressions related to the body. As such expressions like *vayitraip paththi eriyuthu* (burning in the stomach) and *eeral karukuthu* (liver is scalding) do not mean peptic ulcer symptoms or chronic liver cell disease but they reflect some other psychic distress (5).

As we see in our day to day practice, some words and expressions carry many meanings and patients use many expressions that may appear as one symptom to a medical doctor. For example, the expression as *thalaiyidi, thalaivali, thlaikkuththu, thlaiyammal, and thalaikke etho seyuthu* would be interpreted as the symptom headache by a medical person. It is imperative for the physician to be familiar with these different verbal expressions and what they mean and signify (behind the words). What is more evident is that the expressions of illness are influenced by the media, culture, life events and the expectations (5).

The expressions are also shaped by the attitude and the reactions of the doctors. Patients reflexively learn to pick up the non verbal

cues of the doctors and modify their presentations accordingly. For example, patients will express cardiac symptoms to a cardiologist and abdominal symptoms to a surgeon. In some instances, patients start out with many different symptoms but start modifying them depending on what they perceive as important to doctors. Some patients seem to develop their skills to make the doctors nervous by their presentation.

Culture too has various explanatory beliefs about the causation of illness. And patients bring these beliefs into their presentations. They may narrate their stories from their explanatory belief point of view. Hence, presentations like "he doesn't have any problem, but you know he has had this gas trouble for the past two days and...." are not uncommon. Beliefs on karma, bad period, planetary positions, sorcery, food habits, cold and hot are very common in our culture. Doctors are expected to understand these concerns and filter the information which helps them to diagnose a known illness.

In whatever ways the patients present, the doctors with their body of knowledge, tools of investigations and years of training are able to identify an underlying pathology and plan appropriate interventions. However, while focusing on the discovery of pathology, certain other areas may be neglected and become out of focus.

When a person (and his family) confronts with an illness or is informed about a diagnosis, it is usual to expect a range of anxiety reactions. An overwhelming apprehension and sense of fear may develop and trouble the person and his/her family. This fear reaction will continue during the process of investigation and initial phase of the treatment. Hospitalizations will increase the anxiety. When someone develops a serious life threatening condition or a stigmatizing condition there will be an initial shock and denial, followed by a series of emotional reactions. The reactions soon

travel through a low mood, dysphoria and later set into depression. It is well known that when a patient develops depression as a co-morbidity, that will negatively influence the outcome of the primary illness. Patients with severe depressive reactions may not cooperate with the investigations and treatments, causing ill feelings to the treating team. They tend to lose their coping abilities and may not comply with their treatments and other health needs.

Some tend to have a persistent preoccupation about their illness. They want to know more about their illness and possible treatment options. They may want to have second and third opinions. Some even worry about having a serious illness in spite of repeated investigations and reassurances given by their doctors. It is well known that around 30 percent of patients present to the health institutions with hypochondriasis or medically unexplained symptoms (6).

Before coming to terms with their illness, some may develop anger towards outsiders. A person with dengue may blame the authorities for not controlling the mosquito properly or find fault with the doctor who has been consulted for the first time for not detecting the illness early in its course. Patients and their families often have difficulties in understanding the differences between individual course, prognosis and outcomes, not only in relation to developing an illness, but also in relation to their coping abilities and other individual characteristics. They tend to compare themselves with someone with the same condition and expect the same line of development in the course of their own illness.

People who lose their body parts, as in the case of amputation of a limb for example, may develop a typical grief like reaction on top of the well known phantom phenomena. They may take their own time to accept the reality and readjust their lives.

Some patients may develop denial or stubbornness towards their treatment. It could be due to their personality traits but there are also possibilities of an underlying depression, loss of hope, wish for dying and suppressed anger feelings. In contrast, some patients acclimatize to their illness and show sick role behavior quite early in the course of their illness. In fact, some may like to have their sickness and keep on maintaining their symptoms and continuing their follow up visits. From a psychological point of view, there is a possibility of seeking attention, manipulating various systems or enjoying the secondary gains of their illness.

Pain needs extra attention since many conditions are associated with pain. Pain has been defined by the International Association for the Study of Pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage" (7). Pain is always subjective and it is the patient's perceptions, expectations, and beliefs about pain that are the driving force behind the patient's pain experience. When pain becomes persistent, it often accompanies various types of aversive emotional and cognitive effects, which are likely to lead to deterioration of private and social lives. Results showed that these patients demonstrated high emotional distress, moderate cognitive dysfunction, and ineffective interpersonal interactions (8)

It is important to recognize the patients' feelings in a hospital environment. For many of us the hospital is like our home and we are quite familiar with the physical structures and daily routines. But for a patient who rarely visits hospitals, the hospital environment is totally strange, as if he is in a new country. The physical space, orientation, the language, routines, ground rules and the hospital staff... everything is new to the patient. The children, in particular, may experience and show reactions against separation anxiety.

When a patient comes to the hospital, the patient (and family) may already have some prejudiced ideas about doctors, nurses, support personnel and about the hospital system itself. These prejudices and the perceived fears, myths and false information may evoke perplexity and cause problems to the patients and their treating team. In many circumstances, patients are not informed adequately and things are taken for granted. Thus, patients may feel 'no control' over the events happening in the hospital environment. Being a passive recipient, complying with requests with uncertainty and not being able to exert the assertiveness builds up frustration.

The hospital system is designed to treat patients merely as patients! As a result, the patients tend to lose their identities, and personal preferences. They will receive their food from a common menu. Some hospitals even provide a common dress to their patients. Many hospitals expect their patients to sleep in a well lit ward environment. There are problems in cleanliness and other hygienic measures. There are problems in addressing the privacy of each and every patient. Further, patients are expected to reveal their stories in public, sometimes in front of a huge audience, show their body parts with minimum privacy setting, maintain uncomfortable positions for longer period, and sign various papers and give consent without proper explanation and prior discussion. Everything may be done in a hurry. These all contribute to the overall hospital experience. In general the hospital environment is perceived as an unpleasant environment by many patients. And this is understandable.

These are some of the psychological reactions which may occur among the patients towards their illness and hospitalization. When we see our patients, we should also pay sufficient attention to these possible psychological responses.

When a person falls sick, becomes a patient and consults a doctor, we can expect to see certain behavioural patterns, which may even be considered as 'peculiar' by the medical profession. There is a strong belief among patients that doctors have the necessary knowledge and skills to alleviate their sufferings. Many patients are really not bothered about the name of their illness; rather they expect some remedies to alleviate their distressing symptoms. This magical power of doctors is being considered as supernatural and in many eastern cultures doctors are being worshiped as demigods. This behaviour in turn creates undue pressure on the doctors to remain in their positions as demigods and to do something to reduce or alleviate the symptoms.

In general, patients are happy to listen to their doctors' advice and instructions. They allow doctors to intrude into their life and become their guide and companion. But sometime this has gone beyond an 'acceptable level' and they develop a dependent relationship with their doctors, demanding the doctors to advise on everything and take decisions on behalf of them.

During consultations and communications, patients want to talk to their doctors. In other words they want their doctors to listen to their stories, usually a long story in an ad hoc chronological order. One of the reasons for people to choose the private sector in Sri Lanka is that they 'believe' that their doctor will listen to them more in the private sector! They tend to forget the time factor and do not to worry about presenting their problems in an order which points towards a diagnosis. They simply wander on their stories, agonies, fears and expectations. They want their doctors to be kind and empathetic towards their sufferings. They want to be examined gently and informed about their illness, reasons, treatment, consequences and other advice. Sadly in many settings these expectations may not be fulfilled by the doctors.

Cultural influence

The beliefs and other constituents of culture shape the patients' perspective about their illness and colour their expectations about a doctor. Eastern culture reinforces the belief that doctors should be treated like Gods. They are the creators, saviors and destroyers. According to the Hindu mythology, Brammah, Vishnu and Ruthran all three are there in one single doctor. No wonder patients make a total surrender to their doctors. Even in other religions, illness has been seen as an unwanted element, which could be relieved by God's grace. The Hindu tradition, in which worshiping Gods in different forms is common, there is a particular version of Lord Shivan, Vaitheeswaran, who primarily functions as a physician, alleviating his devotees' sufferings. The term 'Vaithya' has the meaning of both physician and treatment. There are many Vaitheeswaran temples around us in Sri Lanka and in India. Similarly, in the ancient Greek tradition, Asclepius is considered as the god of medicine. In contrast, some illnesses are considered as a result of certain God's and Goddess' anger. And people worship and propriete those angry deities to find relief from their 'illnesses'. Similarly in many religions, the priests and the clergy have been functioning as healers of people's sufferings.

It is true that people may delay the diagnosis and lose their early treatment options by engaging with many kinds of traditional healing systems available in their cultures. However, we shouldn't forget that we, as practitioners of western medicine, are only at one point of their tortuous help seeking behavior. Many of us still believe 'evil eyes' and other forms of traditional belief and protecting systems. Tying holy threads, wearing holy ashes and other religious markers, and various forms of vows are fairly common even among the medical practitioners.

Since doctors and patients share the same cultural beliefs, theoretically there shouldn't be any communication gaps or frictions. However, in reality, there are many observable gaps and failures of expectations between the patients and doctors.

Conflict in expectations

If we consider patients' expectations, patients expect their doctors to behave as demigods and offer magical, miracle and instant treatments. They find it hard to wait for the response to occur even though they would have waited for long period before seeing a doctor. They may expect immediate remedies for their years-old or months-old problems. In a hospital setting, they may expect to be seen by a specialist or a senior doctor on a daily basis and failing that they may show their disappointments both verbally and nonverbally. In a ward setting many patients will have some information to reveal only to the senior doctor. Many do not like to be seen or examined by junior doctors or students. Furthermore, they always would like to go home early.

On the other hand if we consider the treating team's expectation, we could see a huge difference in their expectations. The treating team would like to have what they call 'good patients'. The good patients make fewer troubles to the treating team. They are polite and kind towards their treating staff. They should not ask unnecessary questions. Certainly, it is understandable that the treating team may not have suitable answers to all the patients' questions. What is more important is that the good patient should not say 'NO' to anything. Being assertive and asking clarifications may be considered as annoyance. The anxiety of the relations will be seen as an unwanted component in the management. In addition, the patients are expected to maintain good hygienic measures, irrespective of the facilities available in the hospital settings.

Ironically, in government hospitals, the treating team, though having the prime duty of assisting their patients' health, may sometime not like to receive too many patients. Thus, on some occasions, patients are seen and perceived as unwanted objects.

We can also observe that the treating team too wants a speedy and favourable outcome among their patients. The team becomes upset and uncomfortable if the outcome goes in an unfavourable path. In general, the doctors and their team may not prefer to be challenged emotionally. The therapeutic dilemmas are not always welcomed. It is believed that many doctors are not geared enough to deal with their dying patients or their relatives.

It is obvious that the patients and their treating teams can have difference of expectations not only about the outcome of an illness, but also about a series of other concerns. We all agree that these differences and the conflict of expectations should be taken into account and dealt with. Sensitiveness and careful planning is needed to minimize or resolve these issues.

Being a doctor

In the path of understanding the patients' perspectives and behavior, it is important to revisit how we, as doctors, perceive ourselves and our patients. It has already been discussed how culture is influencing patients' presentations, expectations, and other behaviours. Similarly, the same culture is giving extra privileges and undue power to doctors. Doctors are placed second only to God. These cultural influences condition the doctors' attitudes and behaviours. Doctors tend to believe that they have more power than others. Their assistance to healing is misunderstood as the magical power of saviors. The sense of savior is more than a sense of self confidence about their skills. It creates conflict of interest in the medical profession. The doctors acquire more and more power

through years of experience and their continuous educational efforts. The idea of and craving for power creates heightened emotional significance - an egoism, sometime to the level of overvalued ideas and this may end up with a possibility of abusing those powers. When we believe that we have the power, then that belief will be followed by the other belief that we are special than others and that leads to expecting more privileges. The Sri Lankan culture is prepared to give extra privileges to doctors; accordingly, even a new doctor becomes quickly acculturated to the privileges and if it is not given, he/she may be displeased over it.

Our training and role models taught us a patronizing attitude. We believe that we are more potent than our patients. And as such, instead of encouraging our patients to take decisions for themselves, we may force them to accept our advice. Unconsciously we enjoy making them dependent on us. While discussing about the different power roles, Szasz and Hollender (9) proposed that patient passivity and physician assertiveness are the most common reactions to acute illness; less acute illness is characterized by physician guidance and patient cooperation; and chronic illness is characterized by physicians participating in a treatment plan where patients are given the bulk of the responsibility to help themselves.

As doctors, we consider our job as a 'yeoman service' to the people. This service mind-set can shadow our respect to fellow humans. It is the 'cultural trap' which talks about the service of doctors; only doctors. Culture does not use the term service for many other professions. When people praise our services repeatedly we too are entrapped within that mindset. Perhaps that could be considered as the underlying reason why at times we develop anger and resentment towards our patients. According to Haffetry, (10) physicians often react negatively to dying patients, patients they do not like, and patients they believe are complainers.

One of the biggest 'advantages' that we are 'blessed with' is that the culture blindly accepts that we are busy; too busy even to talk to our patients. We have busy schedules in our life which may lead us to overlook the needs and expectations of the patients and our own families. In our setting, many of us have become workaholics and ignore the other social responsibilities of a doctor as a professional and as a common man. Like an alcoholic, the workaholic qualities restrict our pleasurable activities only within our work-related life. Many of us hardly mix up with our relations, rarely contribute to social obligations, hardly voice for all the mishaps around us. Our contributions to the community, society and country are indeed questionable. In this regard, doctors are blamed by extremists for their prime interest on money making (2).

All these characteristics may influence our viewpoints towards our patients. And we become more and more dehumanized. When we lose our humane qualities, the patient will be merely seen as objects with illness or cases. The 'caseness' helps us to restrict ourselves with whatever specialty we are adhering to. According to Talcott Parsons, a well renowned social scientist, Physicians exemplify the shift to "affect-neutral" relationships in modern society, with physician and patient being protected by emotional distance (2). While this emotional benumbness or callosity is helpful in making objective judgments and carrying out needy procedures, it also carries a risk of dehumanizing the medical practitioner. Hughes, in his writing, pointed out that many critics suggested that medical schools and residencies socialized physicians into "dehumanization," and place professional identity and camaraderie before patient advocacy and social idealism (2).

Medicine is considered a science and an art. The core of the art does not only stop with our skills on various procedures. The core of the medical art, whose magic and creative ability have

long been recognized as residing in the interpersonal aspects of communication, is the doctor patient relationship (11).

Since this relationship or communication itself is effective in identifying and more importantly, treating the ailments, it has received an honour as therapeutic relationship. Good communication skills are essential to have a better doctor-patient relationship. Being non-judgmental and accepting the patients with their illness, strengths and weakness, and likes and dislikes are important in maintaining a professional relationship. Making sure about the quality of the communication is also important. In one study, 75% of the doctors surveyed believed that they communicated satisfactorily with their patients, but only 21% of the patients reported satisfactory communication with their doctors (12).

The spoken language we select, the body language we express, the attitude we show, the openness towards our patients, and the kindness of a caring professionalism will play an imperative role in a good therapeutic relationship. Apart from the basic communication skills, a range of other skills are also important. Thus, skills related to interviewing techniques, empathy, active listening, and looking at the patient's problems in a wider context contribute towards an effective and efficient doctor-patient relationship.

We sometimes overlook the fact that the therapeutic relationship is applicable in different settings other than the traditional interviews. We continue our relationship with our patients during the examinations, medical procedures – both invasive and non invasive, simple and complex, crisis situations, like informing about a diagnosis or a bad prognosis, and complex emotional settings, like dealing with a dying child and various life saving procedures. The relationship also takes place in dying or dead patients. Similarly, we may have to relate with the immediate family members and

care givers. It is important that we should keep on maintaining all the good qualities of our relationship which has definite purposes and its own limits.

It is generally believed and accepted that we should not exceed the limits of our relationships. It is a fine balance of showing kindness and concerns and at the same time maintaining a distance from our involvement. Many ethical bodies forbid seducing or having sexual relationship with our patients. Similarly, accepting presents and dinners too is tricky. We should have extra cautiousness about recognizing transferences and counter transferences. As we are all aware, transference in a patient is an unconscious search for and an identification of a lost relationship in doctors or other treating team's members. And if it occurs from the treating team side, it becomes counter transference. Transference and counter transference need not be considered as wrong or unusual. What is essential is that we should be able to recognize and properly deal with it.

Issues

In recent days, more and more public concerns are raised towards the insensitiveness about our profession. Medical profession, in general, seems to ignore many things which are considered as important by patients. We do not pay adequate attention towards the setting of our interview, examination and other procedures. As discussed earlier, patients may be deprived of having their identities, preferences and privacy. The infrastructures, furniture and the working environment are designed to safeguard the interest of the treating team and policy makers. Patient's disability, in all sense, is not considered satisfactorily in the health service provision. In general, our services are not fully centered on patients and their families; rather they have been designed to satisfy the wishes and needs of the service providers. It always hinders the qualities of our service provision.

The need of having communication is something that we all tend to miss during our relationship with our patients. However, doctors who communicate well with their patients do earn good reputation from the public. The popular sayings like "if you talk to that doctor, half of your illness will disappear" reflect the importance and expectations of having good communication.

In Sri Lankan setting, there is a huge lapse in giving adequate respect to the patients, sharing information with them, and taking joint decisions. There is blindness about the medical related and other individual rights of the patients. Numbness prevails about patients' economical problems and the cost of sophisticated investigations and branded prescriptions.

There are extreme criticisms towards the medical profession. I am quoting one such here.

Professionalization grants physicians a monopoly on the definition of health and illness, and they use this power over diagnosis to extend their control. This control extends beyond the claim to technical proficiency in medicine, to claims of authority over the organization and financing of health care, areas which have little to do with their training (2).

The importance of alleviating our patients' fears, anxieties and the need to discuss our views about whatever they believe is missing in our day-to-day practice. Studies have shown correlations between a sense of control and the ability to tolerate pain, recovery from illness, decreased tumor growth, and improving daily functioning (11). Similarly, enhanced psychological adjustments and better mental health has also been reported in the same paper.

Even with all the bulk of knowledge we have and the latest and modern skills and apparatuses, we may not be able to satisfy our patients' needs and expectations unless we consider the importance of strengthening our therapeutic relationship. Patients' satisfaction is an important issue in health care nowadays. In this regard, the literature provides ample evidence that patient's satisfaction provides a positive outcome. One study revealed that satisfaction with waiting time, and nursing and physician care influences overall satisfaction with emergency room service (13). Ironically many specialist consultants, who have had a chance to work in western settings and earned good name there, tend to acculturate their practices after coming back to Sri Lanka.

As discussed earlier, there are always problems in maintaining good quality doctor-patient relationship. An interesting example is available from the work of Hayes-Bautista (1976) who studied the bargaining between the patient and the doctor over treatment. According to him, the patients were observed using "convincing tactics" of demands, disclosure that the treatment has not worked, suggestions, and leading questions. If these did not achieve the desired change in treatment, they turned to "countering tactics" of arguing that the treatment is too weak, too powerful, or insufficient. To augment their authority, the doctors used tactics of wielding overwhelming knowledge, medical threats about the consequences of ignoring advice, disclosures that the treatment may take longer to work for the patient, or a personal appeal to the patient as an acquaintance. The outcome measures of this game in a theoretic situation were 1) continuation of the relationship; 2) patient termination of relationship; 3) physician termination; and 4) mutual termination (2).

In Sri Lanka, the private sector is now only slowly developing as a separate entity. All these years, and even now, in many parts

of the country there is an overlap between the private sector and the government sector for the simple reason that the resources in the private sectors do also work in the government sector and use the government sector resources to treat the patients who have initially come to the private sector. This complicates the systems, practices and viewpoints, and even creates frictions among working colleagues and with the public.

Similarly, the policy of providing free medical services has also lost its basis. The services, in my view, have lost their equity. There are discrepancies in our service provision and the known and influential persons are treated differently in the hospitals. There is a negative belief in Sri Lanka that unless you know someone you will not get good service in the hospitals, or unless you channel you won't be looked after! Doctors may wash their hands off and say that we are not responsible for the 'system error'. But it is the doctors who are in the forefront of Society, given adequate power and privilege, who should help the policy makers and the monitoring bodies to change the policies and practices.

As we could see, the effects of globalization have started changing traditional viewpoints. There are views and voices about rights and preferences of patients. Litigations have started taking place. Even taking personal revenge against doctors, including killings, have taken place to the demigods. I believe that it is the correct time that we should be more concerned over our medical ethics.

Hippocrates who was and is considered the father of medicine came out with some important ethical principles, popularly known as 'Hippocrates Oath'. He emphasized how a doctor should behave professionally towards his/her patients (14). Though some of the contents in the oath may be controversial, the oath is still considered a valid document and taught in many medical schools. It gives the

medical profession a humane and holistic outlook which is centered on the sick person. The four prima facie principles of the medical ethics - beneficence (doing good for the patient), non- maleficence (do no harm), respect for patient autonomy (patient choice), and justice (ensuring fair and equal treatment) - and the more recently developed Charter on Medical Professionalism (15) need to be considered adequately.

It appears that the blind protection we received from our community is slowly fading off. People have started criticizing the practices of doctors more than they did in the past. Interestingly, the medical insurance schemes are growing in Sri Lanka. Though we have our council which governs our ethical conduct, there is a need that we too develop a self reflecting mechanism about our behaviour and conduct.

We should not forget that the cry of patients' rights and the threat of litigations are encouraged by multiple stake holders. These modern perspectives may push us towards paper work and defensive practice, and if that grows we may gradually loose our dedication towards the profession. I think we need to have a fine balance between these issues.

Way forward

It has been discussed that different barriers and obstacles are there as a fine but often unseen layer between the persons who suffer from an ailment and the persons who have learned and experienced to alleviate those sufferings. Though the layer is thin, it is powerful and detrimental. We have to think of the possible ways of dealing with this thin layer.

Medical education in Sri Lanka is in the process of revisiting

and updating the curriculum. We need to include more patients' perspective in the medical curriculum, both at the undergraduate level and at the post graduate level. Apart from teaching the modern powerful science of medicine, we also should teach the future professionals about the importance of having right attitudes and the view points towards their patients. There should be a mechanism to monitor and assess these qualities among the health professionals.

As doctors we are still enjoying the leadership in our services. Even today, the services and wards are labeled by the name of doctors. The administrators, planning and policy departments and the government are still listening to our voices. In this context it is our prime role to advise and make changes at a collective level. On the other hand, in our own 'working territory' we should ensure providing a good leadership and make our team work according to the minimum standards and respecting the sick persons' values.

When we achieve a certain level of seniority, we tend to lose our opportunities to have a supervisory mechanism. As such, in many circumstances, we are all alone while facing dilemmas and making decisions. There is a possibility that with time we may develop burnout and job fatigue. We may be entrapped in a kind of busy but mechanical life. These all point towards the need of having self analysis and self reflections.

Conclusion

Along with changing world trends and the overgrowth of materialistic consumerism around the globe, and the ever growing sub specialization in the field of medicine, there are growing concerns about the quality of medical practices in terms of understanding the holistic nature of the problems and the persons who present with illnesses. It is in this context I wished to view the patients' perspective, doctors' point of views and the interactions of the

culture and environment; 'the other side' of the issues. We have to be 'mindful' about the issues and keep on continuing our dedication and the interest towards our patients and the esteemed career. We have to be cautious enough not to be engulfed by the machines and mechanisms. The life of our profession lies in the age-old doctor patient relationship.

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When the heart is hard and parched up,
Come upon me with a shower of mercy.

When the grace is lost from my life,
Come with a burst of song.

When tumultuous work raises its din on all sides shutting me out from beyond, come to me, my lord of silence, with thy peace and rest.

When my beggarly heart sits crouched, shut up in a corner, break open the door, my king, and come with a ceremony of a king.

When desire blinds the mind with delusion and dust, O thou holy one, Thou wakeful, come with thy light, and thy thunder

Rabindranath Tagore

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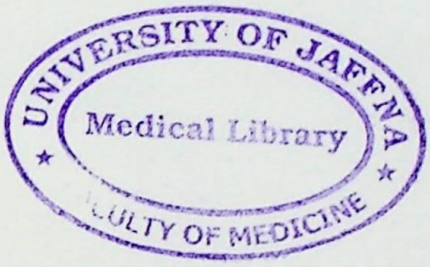

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