Doctor-Patient-Relationship: Ethical and Historical Perspectives

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Outline

- General situation of Doctor-Patient-Relationship in current China
- Study on Cancer decision making and its implication to DPR
- Historical analysis: based on document about DPR in Qing Dynasty

Rebuilding Patient-Physician Trust in China SYMPOSIUM 10-11 October, 2015

Harvard Center Shanghai

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Poster Abstracts

Patient–physician trust in China: a workshop summary

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For more on Rebuilding Patient-Physician Trust in China see http://ghsm.hms.harvard.edu/rebuilding-patient-physician-trust-china

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Abstract

Background Patient–physician mistrust has become deeply embedded in medical clinics within a wide variety of settings, including many in China. The purpose of this research was to develop a series of actionable policy recommendations to rebuild patient–physician trust in China.

Methods Our interdisciplinary group included experts in medicine, public health, philosophy, ethics, law, regulation, China studies, anthropology, sociology, and communications. Recommendations were identified by team members and presented at a two-day workshop at the Harvard Center, Shanghai, China. The group divided into three teams (medical education, ethics and law, and healthcare systems) in order to revise and finalise the recommendations.

Findings We identified a total of 18 recommendations focused on medical schools, ethical guidance, legal systems, and health systems to rebuild patient-physician trust. Medical education recommendations included a requirement for medical humanities as a core component, promotion of experiential learning and community–medical school partnerships, and improvement of evaluation of medical humanities education. Ethical and legal recommendations included encouragement of more transparency in doctor practices and the healthcare system, creating laws to promote mandatory medical error reporting, and acceleration of the development of neutral procedures for recording and resolving medical disputes. Healthcare systems recommendations included promoting healthcare systems that facilitate and acknowledge caregiving, transitioning from red packets (gifts to physicians) and towards higher physician salaries, strengthening primary healthcare systems, and establishment of non-punitive systems for error reporting in hospitals.

Interpretation Several educational, legal, ethical, and healthcare system reforms to rebuild patient–physician trust are feasible. Our recommendations go beyond the healthcare sector alone, suggesting that policy responses within education, legal, and ethical norms are also critical. The presence of mistrust should not be misconstrued as an errant medical system, but rather as an opportunity and a responsibility to rebuild patient–physician trust. Our recommendations are relevant within the Chinese context and in other transitioning healthcare systems.

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Contributors

JT wrote the first draft of the Abstract and organized the project along with BW, JN, and AK. All team co-authors made contributions and approved the final version of the Abstract.

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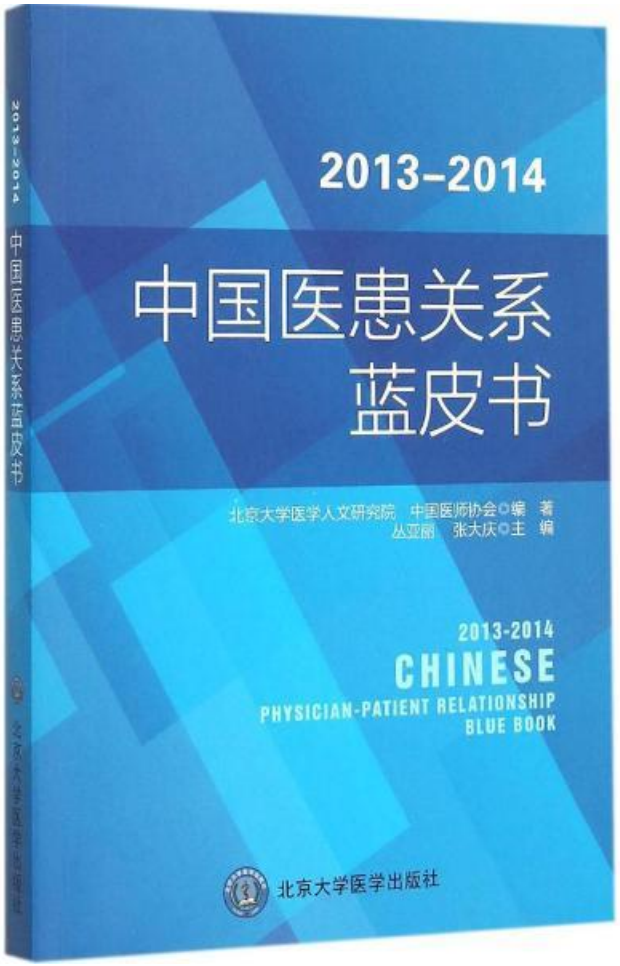


Study on Cancer decision making and its implication to DPR

Supported by National Funding of Philosophy and Social Science, 2013-2016

选题来源

问题：家属的参与程度是否高于病人？

特殊性：家属的参与成为一种必须

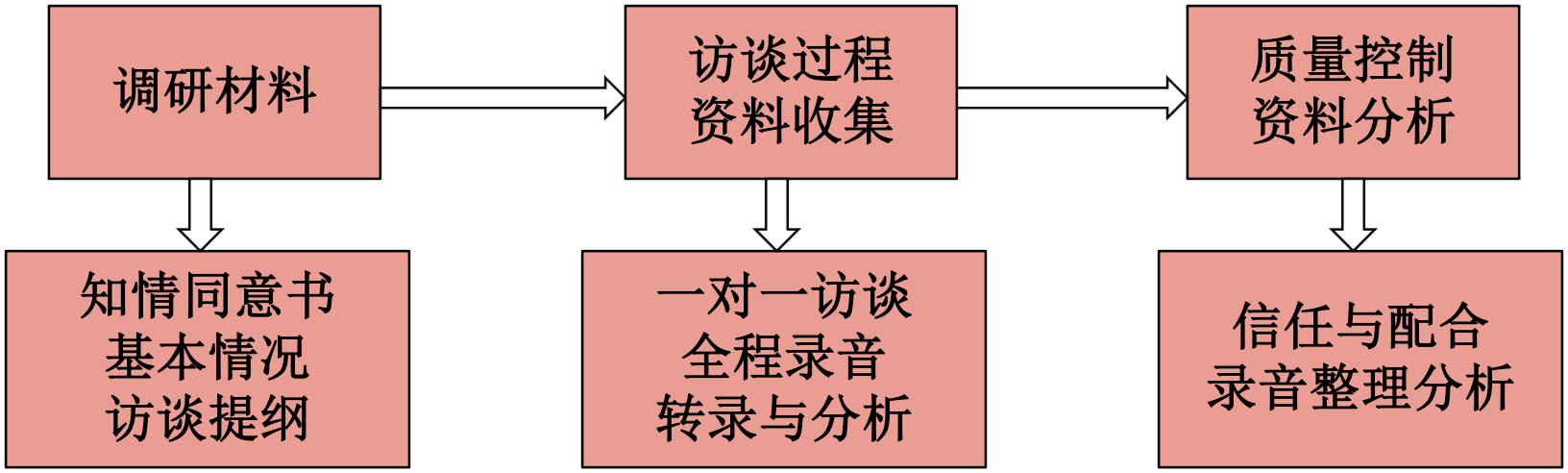
现状：病人参与程度低

Methods

- **Design**: Qualitative interviews
- **Setting**: Beijing Hospitals
- **Participants**: N=11 doctor and separately with each N=11 interviews with patient, family triads, a total of 33 interviews.
- **Data collection procedures**: Interviews
- **Analysis**:

研究对象与方法

对象	限制
地点	北京医院肿瘤内科，北京医科院肿瘤内科
病人	患有恶性肿瘤的成年病人，有行为能力，部分或全部知晓病情
家属	清楚病人病情以及治疗情况、参与病人治疗决策
医生	受访病人的主治或主管医生
数量	15组（病人、家属、医生为一组）



主要问题及归纳


1
2
发现
3
4
家属的参与程度大于病人，家属的意愿更加容易得到医生的重视
病人与家属的不一致主要体现在两个方面:生活质量和对不同价值的权衡
病人普遍被不同程度的隐瞒，病人、家属与医生对隐瞒存在不同的看法
医生的自我保护：当家属的决定违背病人的利益时医生可能不会干涉

QUAL Interviews: Key Findings

1. Doctors want to avoid any conflict/potential disputes with family members. The consequences of a dispute will be an argument publicly in the hospital, the family member or patient becoming physically aggressive and violent towards the doctor, the the family complaining to a chief administrator, and this being included in the doctor's evaluation, or the family would file a lawsuit. (Actually, this is relatively uncommon, and the family usually loses in these cases, and that it takes a long time to get an answer).

QUAL Interviews: Key Findings

2. Doctors generally do not want to take responsibility for the decision, and prefer for the family to make the decision. The potential implication of this is the problem of "truth-dumping"

3. Sometimes the cost of treatment influences the family's decision about what treatment for the patient to take because they must consider the financial burden on the family.

4. Family members underestimate the patient's ability to accept the diagnosis of cancer

QUAL Interviews (contd.)

5. In the majority of cases, even after the patient has been told, the doctor and family will know more information than the patient. The information given to the patient is often filtered by the family based on their interpretation about what treatment choice should be made. Thus, the decision about treatment will be made "together" but the family will filter the information given to the patient so the family's choice makes the most sense.

6. If the doctor feels the family can be trusted, and will not likely cause some kind of problem, then doctor will be more like to tell the family his/her opinion about which treatment to choose.

QUAL Interviews (contd.)

7. If the doctor feels as though the family is not capable of making decisions, eg, low literacy, elderly status, the doctor will be more likely to tell and share decision making with the patient directly.

8. All patients in the sample were told they had cancer, but disclosing the diagnosis occurred over time as a process.

9. It is hard to hide information from patients in this day and age, but partial truth is still able to happen.

家属参与治疗决策可能的负面效应

- 医生的自我保护问题
- 家庭关系的敏感化
- 病人自我感受负担

Limitations

Sample is probably biased since conducted the interviews in Beijing hospitals.

This matters because family members from outside areas will only make the trip to Beijing if they are highly motivated for the patient to be treated.

Also, all participants in study were introduced by participating doctors. So, there may be selection bias for patients who are most cooperative with the doctor.

Discussion

- Doctors are averse to getting into a dispute with family members
- Patients may only get partial information filtered by doctor and family
- Difficult to hide information from patients in this day and age.
- Disclosure of information appears to be a process
- Family heavily involved in decision about treatment
- cost to the family is a significant concern

Historical analysis: based on document about DPR in Qing Dynasty

Doctor, patient, family, in Qing Dynasty

- 病人生病后，家属去请医生，即，患方自由择医，医生被动地提供医疗服务。
- 病人这方全家都参与医疗过程，而且握有最终决定权，也因此胡美医生书中有一章名为《家属控制了医疗》。
- After the patient is ill, the family members to ask the doctor, that is, the patient is free to choose the doctor, the doctor passively to provide medical services.
- Patients of this family are involved in medical process, and holds the right to make the final decision, therefore Hu Mei doctor in the book has a chapter called "families control the health care".

Doctor, patient, family, in Qing Dynasty

- 如此一来，医疗过程便变成全家参与，又与多位医生磋商协调的复杂过程。西医程瀚章便生动地描述：“至若慢性之病，又以甲医无效，改就乙医，乙医无效，更就丙而丁而戊”。
- 在这微妙的关系中，病人虽有自己的意见，医者却与家属联合阵线，配合行动。
- As a result, the medical process will become a whole family, but also with a number of doctors consultation and coordination of complex processes. Western medicine doctor Cheng Hanzhang vivid described: ” If turned to chronic disease, and treatment is invalid, then to the second doctor. If it is invalid, then but change to doctor C and D and E".
- In this delicate relationship, even if the patient has his own opinion, but the doctors and their families united together, they cooperate with each other.

- 与病人自由择医相适应，医生也是择病而医。有些病人为了试探医生的水平，不告诉医生症状，令医生去察色、闻声，如果医生对病人的患病描述不符合病情，病家便辞退此医生。对于此种情况，医家则先探听病家病情，便轻松拆招。对于危症则选择避之。或者自己告起病来，不肯去看病人。
- And the patient is free to choose doctor, and the doctor also choose the patient. Some patients in order to test the doctor, they don‘t tell doctors their symptoms. So if the doctor can not “pass the test”, the patient and family will reject, and “fire” that doctor. In this case, doctors first will easily to deal with, to “know something first ”…. If they think it is risky, they will choose to avoid the risk: pretend to be ill, …. not to see the patient.

- 曾在上海执业的中医陈存仁(1908 一1990)在回忆录中就写到:“一般老医生有时看我所开的药方，总是摇摇头，好像我们方子不对，甚至连正眼也不望一望”。……其实这是旧时上海病人的习惯，病重时常常请两三个医生各处一方来对证一下,但是医生与医生之间往往甲医说乙医不对,乙医说丙医不对,相互讥评,已成习惯。
- Once in Shanghai practice of TCM Chen Cunren (1908- 1990) in his memoirs wrote: ”Generally, some senior doctors sometimes see my prescription, but they always shook his head, as if our prescription is wrong, and not even not took a look at me“. In fact, this is the habit of old patients in Shanghai. When the patient is seriously ill, the family often invited two or three doctors to see the patients. Usually there was inconsistency, no consensus, among the doctors. Among the doctors, A criticized B, and B said C’s medicine wrong.

- 由于医疗的最后决定权不在医家手中，医者不需要独自承担医疗结果。加之庸医的存在，使得对于纠纷的判断比较困难。出现患者死亡，行政判官的心态也多是平息争议，要求医家把所得之财归还病家。对此，病家一般自寻出路：一是徇私报仇，二是诉诸报应。
- The final choice on doctor not in the hands of doctors, and the doctors do not need to bear the medical results. Besides the existence of quack, it makes it difficult to judge the disputes. If patient die, the psychology of judge is just to reduce the fight. They usually required the doctor to give the money back to the family.
- In this regard, the patient and family usually took their own way: one is revenge, the other resorts to retribution.

Implication to current DPR: Individual and Societal Atmosphere of mistrust

- Generalized mistrust at the societal level
- Trust those have "physical" relationship
- 3 A hospital will be more trusted, for they have more high technology. And more doctors with high education
- Generally mistrust, but specifically trust
- ……

From Qing to Now, what has changed?

- 个体——医院
- 县官-法官
- 医生，医学教育培养
- 医疗保障的覆盖和力度

- Individual→hospital
- Judger→legal system
- Medical education, from individual apprentice → medical school, from TCM to Western Medicine
- Health insure coverage is raising…

What has not changed?

- 谁来做决定？谁应该做决定？
- 家属的责任意识
- 病人做决定的权利仍然很弱
- 医生的执业权威

- Who makes decision of treatment
- Family member:they have obligation to involve and dominate decision
- Patient, still lack sense of decision making
- Authority of doctor?

Horizontal: US

- Respect, endurance, calm,…..

(Author unknown. Assaults upon medical men [editorial]. JAMA. 1892; 18:399-400.)

- What US has changed?
  - Medicine, Profession….whole community, training, the "product" of education is in same standard….
  - Liberal education
  - Doctor doesn't have direct relationship with patient----money
  - ……

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Conclusion

- Ethics and legal：
  - 医学引领，需要形成一个医学专业团体，教育。
  - 与社会contract. 需要社会理解医学。
  - 从医学院开始的专业精神教育professionalism
  - 全方面的平等理念的转变。每个人的“理念革命”
  - Right, 医患双方的个人权利的法律保障--
- Culture
  - 启蒙的迫切性
  - 无法短期改变。需要思考哪些是可以坚持的，哪些是发展中需要改变
- ——不能以主观的满意度为评价。要以客观的数据

Thanks