

## **“Patient centered care, high tech with a soft touch”**

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*Journal of the Ceylon College of Physicians, 2016, 47, 3-7*

Members of the Board of Trustees, Past Presidents, Members of the Council, Fellows and Members of the Ceylon College of Physicians, distinguished invitees, ladies and gentlemen,

It is with honour and humility that I accept the Presidency of the Ceylon College of Physicians (CCP). As I stand here, I am deeply conscious of the responsibility bestowed upon me to advance the vision of the College. It is with a great sense of privilege that I fall in line with my predecessors, all of whom were outstanding clinicians and academics of this country. Their tireless efforts over many decades have elevated the medical profession to the position where it stands today. I wish to pay my gratitude and dedicate my address to all the past presidents and councils for their noble contribution to the College and the community. I would especially like to thank the immediate past president and his council for the great work carried out during 2015. I am confident of my capacity to take the CCP to greater heights with the support of the newly elected council and the membership.

On the 25<sup>th</sup> of July 1967, a group of eleven pioneering physicians met at the Consultants' Lounge of the General Hospital, Colombo to establish this prestigious organization. From its inception, the CCP has worked to promote professionalism, ethical conduct and best medical practice for improved patient care. The CCP has advocated for ethical medical research, continuing medical education and collaborative partnerships with other colleagues across international medical and allied health organizations. The CCP is the apex professional body advising the Ministry of Health in formulating health policies and implementing healthcare delivery systems.

Leading the College of Physicians will be a challenging task. Keeping with the College's long standing traditions, I look forward to carrying out an outstanding programme planned by my capable and dedicated council themed “Patient Centred Care: high tech with a soft touch.” The annual academic sessions will be held from the 22<sup>nd</sup> to 24<sup>th</sup> of September and will include multi-disciplinary educational programmes

focusing on developing the clinical skills, soft skills and research skills of trainee physicians. In addition, the needs of outstation physicians working in resource limited settings with some of the country's most disadvantaged groups will be addressed in regional academic meetings.

On this occasion, it is the responsibility of the incoming President to address the membership on contemporary issues relating to medical practice. I would like to use this opportunity to highlight two areas close to my heart. The first is to further enhance the CCP's role in undergraduate and postgraduate medical education directed towards the founding of future physicians of Sri Lanka. The second is to promote patient centred care in this fast paced and high tech clinical environment.

### **Undergraduate and Postgraduate Medical Education**

Medical education in Sri Lanka began in 1870 with the establishment of the Colombo Medical College at the General Hospital, Colombo. This later became the Faculty of Medicine following an affiliation with the University of Colombo. Nearly a century later, in 1962, a second medical college was established at the University of Peradeniya. In subsequent years, six more medical colleges were established at Karapitiya, Jaffna, Ragama, Sri Jayawardenepura, Rajarata and Batticaloa. Together, these schools graduate approximately 1000 new doctors each year.

A new era of medical education was born when the Postgraduate Institute of Medicine (PGIM) of the University of Colombo was established in 1976. It is to the great credit of the past and present directors of the PGIM that post graduate training through this Institute has evolved from local recognition for the employment of consultants in the state sector in 1980 to its current international standards *par excellence*. Those involved in postgraduate medical education are similarly commendable as they engage in this work on a nearly voluntary basis over and above their busy clinical schedules.

I had the privilege of being an undergraduate of the Faculty of Medicine, Colombo. I consider it a great blessing to have been taught by the eminent teachers of the Faculty as well as the General Hospital,

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Colombo. In more recent times, I have had the pleasure of teaching students at Karapitiya, Colombo and Sri Jayawardenepura the key principles of rheumatology and medical rehabilitation. I have cherished these experiences and take great pride in seeing those I have taught blossoming into outstanding clinicians in their own right, a sentiment that I know that many of you in the audience share.

The Sri Lanka Medical Council, Postgraduate Institute of Medicine, Faculties of Medicine, Ministry of Health, doctors and medical students, all have a complementary role to play in advancing medical education and clinical practice. Our vision of producing trustworthy medical professionals whose first concern is the patient, relies on our collective efforts.

I have always felt that bedside learning is a salient part of medical education (Figure 1). Indeed, bedside teaching has been shown to improve trainees' skills and knowledge in history taking, physical examination, clinical ethics, professionalism, communication, empathy and role modelling.<sup>1,2</sup> Sadly, bedside teaching is on the decline due to competing priorities and an over reliance on technology.<sup>2</sup>



**Figure 1.** Bedside teaching in the early 1900s. Image courtesy of McGee S (2014) Bedside teaching rounds reconsidered. *JAMA* 311(19): 1971-72.

Some of us here today will remember being a student of the late Professor K. Dharmadasa, Professor of Medicine, at the University of Colombo. We all knew him to be an outstanding clinician who managed his patients with minimal investigations. In

addition to being an astute clinician, Professor Dharmadasa was a dramatist. He mimicked heart sounds, murmurs and breath sounds to the great amusement of the learner. Even today, those sounds echo in our minds as a testament to his skill as an educator.

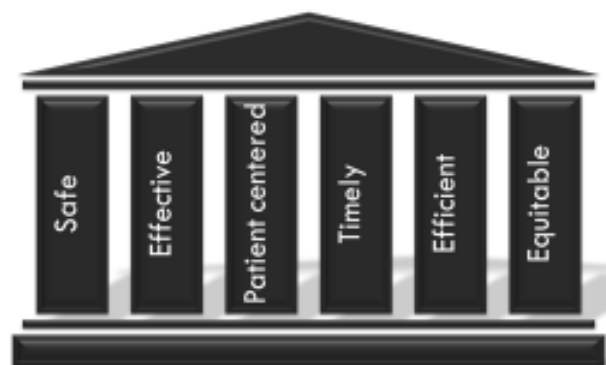
The current landscape of medical education is vastly different to that in which many of us were trained. This is why I strongly advocate for the College to prioritise medical education, particularly those practical activities, such as bedside teaching, that form a platform for knowledge transfer from our most experienced clinicians to the next generation of doctors.

Many of you are aware that the PGIM will introduce a novel tool-kit for better assessment of trainees' clinical practice, including the mini-clinical evaluation exercise (mini-CEX), the direct observation of procedural skills (DOPS), the multi-source feedback (MSF), the case-based discussions (CbD) and the Acute Care Assessment Tool (ACAT). It is imperative that the College works closely with the PGIM during this significant transitional period. Thus, our academic events during the year will focus on building our members' knowledge and confidence in the use of these tools.

### Patient centred care

Now, I wish to move on to the second part of my address. The 2016 theme of 'patient centred care' is timely, appropriate and an important part of the global discourse on ensuring high quality health care. The term 'patient centred care' has been in use for decades, but its meaning is not well understood and even less well implemented as part of routine patient care.

A landmark report by the Institute of Medicine in 2001 titled "Crossing the quality chasm: a new health system for the 21st century"<sup>3</sup> put forward patient centred care as one of the six pillars of high quality health care (Figure 2).



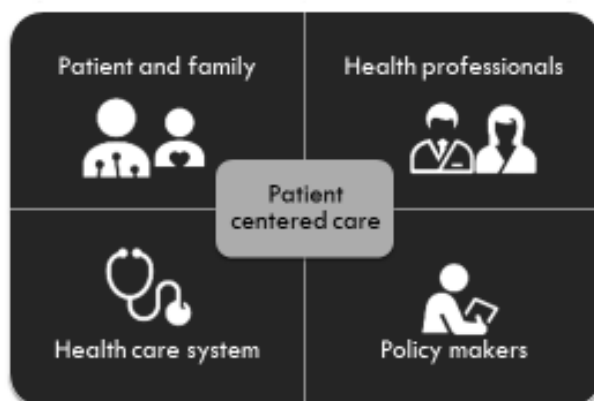
**Figure 2.** The six pillars of high quality healthcare as described in the 2001 IOM report entitled 'Crossing the quality chasm'<sup>3</sup>

The report went on to say that there is a core need for health care to be:

- **Safe:** avoiding injuries to patients from the care that is intended to help them.
- **Effective:** providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- **Patient-centred:** providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- **Timely:** reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.<sup>3</sup>

I contend that true patient-centred care requires major gains to be made across all six of the pillars of high quality care set out in the IOM report.

A patient centred health care system, with conscientious clinicians and dedicated auxiliary health workers has much greater capacity to improve the health, wellbeing and longevity of those who receive care. The success of such a system depends on four stakeholder groups. They are the patient and the family, health professionals, health care system and policy makers (Figure 3).<sup>4,5</sup>



**Figure 3.** Four components of a patient centred system of health care.

In a high functioning patient centred system of care their respective roles could be described as follows:

- **The patient and family** are treated as partners in patient care. Clinicians share critical information with the patient and his/her family, seek out their input in decision making and tailor treatment to the needs, concerns and preferences of the patient. In a country like Sri Lanka, where the social support system is less well developed, a patient's family takes a great deal of financial and social responsibility for the patient's care. It is imperative that we, as clinicians, acknowledge this role and spend additional time engaging with family members and subsequently supporting them in caring for their relative.
- **Approachable, open minded, competent health professionals** who have the capacity to assess the patient's clinical needs within the context of their social situation. Clinicians need to allow time to explain treatment options and implications to patients and their families before a decision can be made.
- **A well-integrated health care system** at the clinic, hospital and the health administration levels that supports clinicians, patients and their families to engage in a dialogue about the patient's care. This can be achieved by managing clinician workloads so that they have additional time to listen to the patient and family members, drawing up management plans that include periodic review, developing procedures that are sensitive to patients' cultural and social background, language proficiency and information technology literacy. For the system to be adaptive, hospital administrators need to periodically analyse service performance to identify the barriers to care, areas for improvement and assess patient satisfaction. Finally, objective indicators of the quality of care and strength of the doctor-patient relationship need to be incorporated into data systems for on-going monitoring of progress.
- **Appropriate governance** that supports the implementation and funding of patient centred health care systems.

Policy makers are best placed to set specific performance targets that enable health administrators to check progress towards a model of health care delivery that is safe, effective, patient centred, timely, efficient and equitable. A national policy that articulates the vision for patient centred care, alongside other indicators of progress is a necessary foundation for a patient centred health system.

In a lower resource setting like Sri Lanka, we are less able to replicate some of these complex systems. Instead, we need innovative and collaborative strategies to achieve these outcomes.

Now I wish to highlight in brief the challenges of balancing “high tech with a soft touch” when delivering health care to patients. Medical professionals today are overwhelmed with new technology. There is an ongoing concern that adopting these new technologies will dehumanise the doctor-patient relationship.

However, these concerns are not new. In the 1700s, physicians were concerned that the invention of the stethoscope would create a distance in the relationship with the patient by allowing a physician to listen to the patient's heart at arm's length rather than by placing an ear on the patient's chest. Similar concerns were raised at the invention of the sphygmomanometer in early 1900s. None would argue that these devices are now an integral part of contemporary medical practice.

Despite continued concerns, medicine remains a field of great technological innovation. Recent advances with automated systems in laboratory medicine and radiological imaging are excellent examples of this.

During my postgraduate training at the professorial unit of the General Hospital Colombo in 1986 and 1987, I witnessed the establishment of the Renal Research Laboratory by Professor Rezvi Sheriff. His concern was that the reports issued by the main biochemistry laboratory were “incredible” and “too unreliable” to make decisions about patient care. Under his guidance, the new laboratory established protocols for reliable reporting in renal functions and other biochemical tests which, in turn, led to improved care for hospital patients.

Many government hospitals have taken strides in the direction of reliability since these early days. Funded by the Ministry of Health and supported by

the hospital directors, laboratory consultants and allied health staff, many of these laboratories now have high tech automated analysers with robust quality assurance protocols in place to generate accurate reports for clinical biochemistry and haematology services.

The other area of medicine that aids in the diagnosis and treatment of disease is radiology using imaging techniques such as X-ray radiography, magnetic resonance imaging (MRI), nuclear medicine, ultrasound, computed tomography (CT), and positron emission tomography (PET). These services have expanded from diagnostic to therapeutic and interventional radiology.

These high tech devices and technologies come at a cost. Many see this cost only in terms of rupees and cents. It is true that these technologies require capital investment and recurrent expenditure. However, there is another, more subtle cost, and that is the doctor-patient relationship. With so many technologies at our finger tips, each marketed to us as a panacea for ensuring high quality clinical care in a timely manner, physicians have less time to focus on the human interactions that are so central to this profession.

For a patient, a physician's soft touch and gentle word is far superior in eliciting the main symptoms of disease;<sup>6</sup> followed by gentle physical examination to arrive at a diagnosis. Taking a medical history is not only a clinical necessity; it is an opportunity for the physician and the patient to build genuine rapport with each other. In the hands of a capable and conscientious clinician, the patient is given a voice and is able to narrate his story from the beginning without interruption. At the same time he is guided to provide details of the symptoms most relevant to the condition at hand. A physician should develop a routine of physical examination which combines speed with thoroughness, carried out as gently as possible, without disturbing or exposing the patient more than necessary. Very ill patients must be examined with special care and consideration. Under the theme of patient centred care for the upcoming year, I will use the platform of my presidency to promote communication skills, ethics and attainment of the highest professional standards through planned academic activities.

Ladies and gentlemen, this evening I would conclude my address with the story of one of my long standing patients known as Ms T.N.

### Box 1. A clinical case study highlighting a story of courage

Name: Ms. T. N. from off Walasmulla.

Born: 1992

Mother, a school teacher and father an ex serviceman

In 1997, she presented to the Teaching Hospital, Karapitiya with fever and joint pains of 4 weeks duration. A diagnosis of systemic juvenile idiopathic arthritis was made. She had an optimum response to steroids, was followed up in the paediatric clinic for three months and was discharged. She remained well for six years. In 2003, she presented to the Lady Ridgeway Children's Hospital, Colombo, with a relapse. Her ESR was 135 mm, WBC 24,500 with 84% neutrophils and serum ferritin was above 2500. She was negative for rheumatoid factor, antinuclear factor and double stranded DNA. Her bone marrow was normal. She responded well to steroids again but needed a daily maintenance dose of prednisolone in addition to disease modifying drugs. She attained menarche at the age of 14 years but developed secondary amenorrhoea. Investigations revealed an elevated TSH and she regained regular menstruation with the replacement of thyroxine.

She relapsed again, six weeks prior to the GCE

Ordinary level examination with a florid polyarthritis. Once again she responded to a prolonged course of high dose steroids. She changed her sleep-study patterns to counteract the disability of morning stiffness. She slept between 5pm to 9pm, studied between 9pm to 3am and slept again from 3am to 6am. The Secretary to the Ministry of Education allowed ten additional minutes for each of her O level examination papers as she found it difficult to hold the pen due to inflamed fingers. She passed the O level examination with distinctions in all the subjects. She developed progressive deterioration in walking during the next two years due to avascular necrosis of hips and secondary osteoarthritis. In her first attempt at the GCE A Level Examination she narrowly missed selection into medicine. At this time she walked with the aid of crutches. Undeterred, she did her A Levels again and obtained the requisite grades for medicine. The possibility of hip replacement surgery was discussed at length with the patient and family. She was exempted from the leadership training course. She underwent the right hip replacement prior to entry to the medical faculty in January 2014. The left hip replacement was carried out during a three month vacation in July 2014. Her disease is now in remission with prednisolone and tocilizumab. She obtained 2nd class upper division at the 2<sup>nd</sup> MBBS examination in July 2015.

This evening, I have reasoned that high quality care is achieved when technological advancement and patient centred care meet. In the words of Hippocrates, may we all "remember that there is art to medicine as well as the science".

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