The Hobbit Takes Two

The Hobbit has finally hopped on the Facebook bandwagon. You can add her as a friend at http://www.facebook.com/profile.php?id=100002494936582. The following two articles were originally published on the Hobbit's Facebook page on 3 and 14 July 2011 respectively.

Flaccid Truths to Keep Your Practice Going: The Logical and Inevitable Demise of Trust

A patient came to see me recently with a painful ingrown toenail. I see ingrown toenails quite frequently in my practice and have become quite adept at removing them. It's the nature of my Middle-earth practice – Orcs and Ogres have poor nail hygiene, and Elves, with their long and thin toes, are quite prone to them too.

For patient confidentiality purposes, let's call my Elvish patient Johnny. Johnny is a sprightly 340-year-old wood elf. He has been seeing me for the past 20 years or so for various mild ailments. Otherwise, he is fit as a fiddle. Today, he stepped into my consultation room with an expression that was somewhere in between a frown and a wince. You can always tell he is in pain when the tips of his pointed ears turn red.

He showed me his ingrown toenail. There was some paronychia around the nail with a small collection of pus and it was obvious it had to be excised. I would usually perform a digital block with lignocaine injections at the base of the toe, with the help of a rubber band acting as a tourniquet. The whole procedure usually takes about five to ten minutes.

But today was different. I started out by enumerating the various benefits of the procedure and the consequences of not going through it. This of course included the piercing pain Johnny was experiencing round the clock, as well as the possibility of getting chronic osteomyelitis from letting the infected ingrown toenail persist. Frankly, from the look on poor Johnny's face, I didn't think he needed any convincing.

Next, I told him the risks of the procedure and those of the local anaesthesia as well. Of course, the risks included cardiac arrhythmias and sudden cardiac death from the lignocaine injection, as well as me possibly leaving behind tiny bits of my scalpel blade behind in his flesh for the next 400 years (Elves can easily live that long and scalpel blade construction is not what it was with these blasted new foreign talent Dwarves we are getting nowadays). Even though the chances of these occurring were remote (at least one reported case of retained scalpel bits), I thought I should tell him because of the severity of these possible risks. I also told him about the other usual stuff like the chance of recurrence, ugly nails, keloids, infection, fever, pain, allergies to dressings and so on.

I also diligently jotted down all these benefits, risks and complications on his card. I then went on to the alternatives. I could refer him to another doctor or to the nearest Accident and Emergency in Middle-earth. And since his ingrown toenail was not quite life-threatening at this juncture, I told him he could go home to think about it a day or two before deciding on whether he wanted to go through with the excision of toenail or not. I also told him that he could do nothing.

Johnny was flabbergasted and exasperated. The Elves are never good with hiding such feelings. He uttered impatiently, while trying to contain his frustration and anger as much as his otherwise congenial Elvish nature would allow him to, "What's wrong with you today, Doc? Just go through with the procedure and get the blasted ingrown toenail out. It hurts like hell!"

I then asked him, with all the equanimity of Sir William Osler, to acknowledge on his patient card with his signature, that he agreed to the excision and he fully comprehended the risks, benefits, complications and alternatives which had been listed on his patient card to evince his comprehension.

He signed the card quickly. The process had taken 25 minutes. I then took another ten minutes for the excision, including applying dressing.

He came back the next day to have the dressing changed. I could tell he was rather unsettled by something, so I asked him, "Is something wrong?"

"About yesterday, why did you have to go through the litany of risks and complications before the procedure, some of which were utterly remote and unnecessarily troubling? For goodness' sake, it's just a blasted ingrown toenail. I'm 340 years old and have seen more than my fair share of ingrown toenails in Elves." He looked completely nonplussed.

"It's what my medical council demands of me nowadays, so that you can be considered to have given informed consent, if not I may run the risk of being found to be guilty of professional misconduct."

He winced a little as I removed the old dressing.

"Does it hurt?"

"Not as much as your bloody long-winded and scary consent taking process yesterday." He took a look at what he signed the day before, and muttered, "Bloody stupid and ridiculous."

I smiled and replied, "I have no choice."

"Of course you do, Doc. I trust you. I have been seeing you for 20 years!"

"It's not so simple." I applied the new dressing, gave him a pat and saw him off.

It's really not so simple. A good practice requires a good doctor-patient relationship. We always say that it's important that our patients trust us. But that's only half the story. It is equally important that doctors trust their patients. But with recent events in Middle-earth, I cannot afford to. I still want to trust my patients, but my entire practice, my livelihood, and my family's livelihood depends on me staying professionally alive. And hence I can no longer afford to trust my patients. All it takes is for one of them to turn around and say, "I did not give informed consent even though I have signed that I did", and I am dead.

Some folks say consent taking is not a form but a process. That's true. But consent is also documentation. And it's pretty obvious some wise guys have decided for all of us that a patient's signature and a form is no longer enough.

Some folks also say that specific circumstances lead to specific decisions and conclusions peculiar to those circumstances, so the principle of precedence may not hold here. Unfortunately, that is at best an opinion unless it is tested and tried again in the courts, and seriously, I wouldn't want to be the guy who puts this to the test.

Not only do patients and doctors need to trust one another, but colleagues should as well. How can there be trust if I cannot even depend on a relatively senior trainee and colleague to diagnose an acute abdomen? My colleagues in the hospitals now tell me they now trust no one anymore, and the workload and decision making keeps escalating upwards to the senior staff. Private practice seems the only plausible escape.

By all means, promote transparency and accountability. But we all also know that once trust is lost, it is extremely hard to get back. The fact remains that for trust to happen, the system and regulatory authorities must do what it can to foster this trust and not undermine it. The clear and present threat of professional misconduct is enough to radically change how doctors trust patients and colleagues. Call it *kiasuism*, prudent risk management, or whatever.

As far as my medical practice goes, I can no longer afford to trust. It's logical and inevitable, brought on by external events beyond my control.

For the record, in the past, my usual charge for the excision of an ingrown toenail was about 80 to 100 bucks. I charged Johnny 140. That's for the 25 minutes I needed to get "informed" consent, which I could have spent otherwise seeing another patient. Thanks to some doctors making decisions and setting standards for the whole profession, Johnny had to pay another 40 bucks which I derived no satisfaction from making. Like most doctors, I have to make rent and pay salaries and there's only so many hours in a day. So much for healthcare cost containment and improving productivity.

It's really not so simple, Johnny.

The Wonders of the English Language: Reading the Lines Carefully

Reading today's letter by the Ministry of Manpower (MOM) in the *Straits Times* Forum (see page 13 of this issue), in response to an earlier letter by SMA President Dr Chong Yeh Woei, is an exercise in the appreciation of the precision of the English language. Let's take a look at a few statements found in MOM's reply.

"However, in order to take sick leave with pay, the Employment Act states that an employee needs to obtain a medical certificate from a company or government doctor" – what this means in real life is that, for paid medical leave, the Employment Act states that an employee needs to obtain a medical certificate (MC) from a company or government doctor. If you see your own family physician or private specialist, good luck.

Even if "MOM would like to reiterate that employers should recognise medical certificates issued by any registered medical practitioner for the purpose of being absent from work due to illness", it doesn't mean the employee would get any pay while away, although the employer "recognises" the MC. So MOM's bottom line is at best, the recognition of "unpaid leave", when an employee sees a doctor who is not a company or government one.

"This is only a minimum requirement to the employer, and does not stop an employer from recognising a medical certificate from any doctor" – that means recognition of MCs is at the employer's discretion and NOT obligatory.

How much protection an employee really gets from the word of legislation found in the Employment Act, should he produce an MC from a doctor who is neither a government nor company one, remains to be seen. And really, how good an MC that comes without pay, is for you to conclude.

This is wonderful civil servant-speak, of the sort that I thought PS21 (Public Service for the 21st Century) was supposed to get rid of. But then again, this is 2011. Oh well... SMA