The individual patient and evidence-based medicine – a conflict?

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Abstract The doctor–patient relationship is characterised by clinical situations that reflect different degrees of impairment of the patient’s quality of life on the one hand and different degrees of threat to the patient’s life on the other. Typical patterns of these situations from absent or minimal to severe impairment of well being or threat to life are described. With regard to this, the doctor–patient communication is still suffering from considerable deficits. For the latter, a possible philosophical framework and reason is given. The potential of evidence-based medicine to ease this conflict by bringing into the game the current best-available scientific evidence is discussed, and some inherent serious limitations of evidence-based medicine are shown. Besides these drawbacks, doctors are usually very reluctant and lazy to integrate evidence-based results into their daily practice. In the author’s view, evidence-based medicine is a reasonably new tool. However, it should not yet be overestimated in its potential to influence and improve daily clinical practice.

Key words Evidence-based medicine · Doctor–patient relationship · Conflict

Introduction

What is characteristic of the individual patient–doctor relationship? How does evidence-based medicine (EBM) add to this situation? This article deals with the questions whether EBM modifies and possibly improves the relationship between the individual patient and, of course, the individual doctor. It is not the intention of this article to describe the origin and development of EBM, which, in addition to a detailed philosophical description of this subject go beyond the scope of this article. Rather, the bilateral relationship with its different aspects are discussed. In addition, the potential but also the limits of EBM in this situation are illuminated. The conclusion summarises the role of EBM as a conflict or an adjunct in daily clinical practice.

For reasons of importance, the patient aspects will be described first. It is the patient who seeks the doctor’s advice and help and not the other way around. Why does a patient see the doctor? The background of quality of life, its dimensions and possible impairments can be applied to describe this scenario. In addition, the 5-D (disease, disability, discomfort, death, dissatisfaction) pattern of White is useful to describe typical clinical situations as depicted in Fig. 1 [16].

In situation A, a patient presents with a “simple” and not life-threatening impairment of quality of life, i.e. groin hernia, gall-stone disease or haemorrhoids. Usually, a simple surgical treatment offers improvement of well being. Sometimes, the impairment of quality of life is so minimal (i.e. inguinal hernia) that patients are al-
most “forced” by their general practitioner to have surgery done, instead of coming of their own accord.

In situation B, a more or less impending threat to the patient’s life adds to the impairment of well being. Treatment can save or prolong life but a certain price in form of morbidity or even mortality has to be paid. Clinical examples are: organ transplantations, major amputations, chronic inflammatory bowel disease or most forms of surgical cancer treatment.

In situation C, real alternatives exist as almost equal treatment options with comparable morbidity and mortality. Examples are the treatment of arterial occlusive disease by endarterectomy or bypass, surgery or nuclear medicine for autonomous nodules of the thyroid and pouch or simple reconstruction after total gastrectomy for cancer.

The situation D represents the typical trade-off in a sometimes difficult situation of clinical decision making. A successful surgical treatment offers a significantly better quality of life but carries also a higher risk of morbidity or even mortality. A clinical example is pouch reconstruction or simple ileostomy after proctocolectomy for polyposis or ulcerative colitis. Analgesics versus endoprosthesis for osteoarthritis of the hip is just another example.

In situation E, the patient is incurably sick and medicine is only palliative. Improvement of quality of life is the relevant endpoint of surgical treatment. Nowadays, a situation “F” could almost be added, meaning that patients show up for prophylaxis, prevention or for a “routine check-up” of their health state.

Needless to say that there can be a considerable overlap and mixture of the standardised situations in clinical practice. Therefore, the display in distinct situations is at least somewhat arbitrary. Nevertheless, impairments of well being in combination with a threat to life guide patients to their doctor. The dimensions of quality of life reflect the patient’s motivation to seek medical advice. Various diseases influence the pattern of symptoms, emotions, as well as physical and social functions in a very different way. Even harmless diseases or symptoms such as gall-stone disease, haemorrhoids or constipation can have a very strong negative influence on the well being of the patient [14]. Physicians on the other hand do not have a good impression of how strongly a disease negatively influences the quality of life of the patient. Even worse, doctors only have a very vague impression of how badly patients are doing [3].

What about the doctor’s side of the coin? Which human qualities and characteristics do doctors bring into the game? Generally and basically, doctors, I assume, have a certain interest in patients and diseases. The motivation to do so is empathy and compassion for the patient and also a general interest in medicine with all its facets as a science and an art. In the optimal situation, this is rewarded by trust and thanks from the patient. The basic requirement to learn medicine – as any other academic profession – is simply the necessary intelligence or intellectual capacity to deal with multiple and complicated information, desires, emotions and other thoughts.

To be able to work in this profession, doctors first need a thorough education at a medical school or university. They simply need vast amounts of knowledge. Furthermore, they have to be educated and well trained in how to deal with the emotional and psychological problems that patients present to them. After university education and beginning their professional career, doctors will collect experience in how to deal with individual patients, so that a doctor who has been practising medicine for 30 years will have a different approach relative to a beginner. This will also be reflected by the different speed and routine doctors can apply to solve clinical problems.

Finally, the simple everyday emotional balance of the individual doctor will influence how the clinical practice of individual patients happens. If the doctor has a good day, things will probably run in a much smoother way.

In summary, good doctors need some qualities to treat their patients well: motivation, intelligence, emotional balance, empathy, routine and, of course, knowledge and competence. This is their part and duty in the arena of dealing with the individual patient. Knowledge and the ability to deal with evidence are the target of EBM. How does the latter improve knowledge and competence and add to patient treatment?

The patient–doctor interaction – a communication problem?

How does the patient–doctor interaction work? Is it a satisfactory relationship – for both sides? In a hypotheti-