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REFLECTIONS

Subtle influences on decision-making in medical practice

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There are many external influences, beyond the direct medical diagnosis of an illness, that affect how we manage patients in medical practice. Take for instance, the effect of receiving a gift from a patient, which ethically is discouraged but is sometimes unavoidable.

We often accept these gifts from patients in good faith as genuine acts of gratitude. I have a patient who holds a senior position in a government department and at the end of one consultation she handed me a small packet saying it was a gift to thank me for my care. I said she did not need to give me anything but I felt it would offend her and be inappropriate to decline the gift. It was only at the end of the day that I unpacked it to find a gold-plated pen engraved with my name. It is not the sort of thing that you can give back. The consequence of this was that I felt a sense of obligation and, almost unconsciously, gave her extra attention at the following consultations.

Although I try to remain impartial, on reflection, I have a tendency to be easily influenced. I can live on a compliment for weeks and am ready to have my ego stroked at any time that you should wish to do so.

I also used to think that I was objective with my prescribing and that the pharmaceutical representative just liked me for my sparkling personality. They are such appealing people and I like all those executive toys that they give me. The problem now is that some Woke spoiler has drawn up a code of ethics so there are no more branded pens, pads or staplers on my desk.

Apart from the subtle influences of gifts and advertising there are other influences on our decisions that are even more deeply hidden in the labyrinths of our occupied minds.

It is well known that many of these non-clinical factors affect the doctor's decision making process, such as the patient's age, culture, race and gender. It is difficult to disentangle each factor's power to independently affect a clinical decision.

As an example the social status of a patient, especially very wealthy or influential patients, is often a powerful and unacknowledged influence on the way physicians manage patients. The literature on the effect of social status on medical encounters is understandably sparse. Physicians don't like to think that they are affected by a patient's social status however, in the real world, they are influenced in the same way as the rest of society.

During an epidemic of mild spring encephalitis (headaches, muscle pains and mild temperature) I found that I had treated three white Afrikaans patients differently because of their status. The first was a police constable who I cared for at home, the second was a nursing sister who I admitted to my local cottage hospital and the third was a medical colleague who I referred to a specialist in the nearest city. They all had the same symptoms, signs and diagnosis but I had subconsciously managed them differently because of their status.

Little is known about how the mind thinks about our social status. It is a so-called *abstract domain*. For instance most of us feel uncomfortable when treating a medical colleague and his or her family and occasionally we may have to deal with *fame status* such as a local sporting hero or a television star as well as the social hierarchy of the "lords of the manor".

These judgements and assessment of each other are a characteristic of most high-functioning primates on this planet. The doctor, on the other hand, is often unaware of these other subliminal influences on his or her impartiality.

As the patient enters the consulting room his or her clothing, hairstyle, accessories and manners are noted mostly by pattern recognition and when the patient speaks, after a sentence or two, it is all over. They are then profiled, sorted out and packed away into social boxes in the physician's subconscious mind. These are complex interactions between the physician and the patient and much is due to unconscious and unquestioned stereotyping (called *social patterning*).

Medical decision-making can therefore be a function of *who the patient is* as much as *what disease the patient has,* although we aspire to be non-judgemental and value free.

Yet, we obviously cannot completely eliminate our personal beliefs, cultures and backgrounds. For instance research has shown that some doctors are prejudiced against obese patients

but this is not a one-way street as the research has also shown that patients have less trust in obese doctors.

Many of the other ill-defined factors that influence us are difficult to identify during a busy day. A previous bad experience, often called "I got burnt once", may have a very strong influence on one's subsequent practice. Another constant fear is that of litigation, which is well known for its cause of over investigation and excessive referrals and cross-referrals.

Another of the strongest influences in a medical encounter is when a patient is physically attractive to the treating doctor. The patient may be treated with, shall we say, more enthusiastic and biased care than normal. This can progress into a mutual attraction, which may annihilate objectivity and rational communication.

It is difficult to always be vigilant and unbiased in the daily routine of medical practice. The research on physician variability in the choosing of interventions is both well known, erratic and alarming. At times we need to step back and reflect on how we are reacting to the varying influences that impact on the care that we give to patients.

It is about the unspoken and unrevealed relationships that occur in that most personal of human encounters, the medical consultation, which is practiced in that most secret of places, the medical consulting room.