

## Talk to the patient not the disease

Dr E K Yeoh

*This is an extract from a speech delivered by Dr Yeoh at one of the plenary sessions of the Hospital Authority Convention 1997, which was held recently in Hong Kong.*

I found this quote in something I read recently: "Keep away from physicians. It is all probing and guessing and pretending with them. They leave it to Nature to cure in her own time, but they take the credit ... as well as very fat fees."

We should be doing much better today — particularly in regard to the scientific basis of our medical practice. At the same time, we should be enhancing the art of patient care through programs which nurture a patient-centered culture of services.

To this end, the Hospital Authority has set up training and educational programs for staff, and for patient and their families to enhance psychosocial care of our patients. We have introduced a patient's charter, which aims to cultivate better understanding and better communication between our health-care professionals and our patients. Hospitals have set up patient resource centers to provide support and peer learning for patient self-help groups.

There are numerous other initiatives — specialised patient counselling and bereavement programs; volunteer and community involvement programs; predischarge and home-care programs.

Despite our best efforts, however, from time to time we receive complaints from patients or their relatives expressing dissatisfaction, anxiety and anger. Sometimes, we think the situation will improve if we can all communicate better. I recognise that the actual situation is often more complicated than that.

In life and death situations, which are so common in hospitals, the grief reactions of our patients and relatives are often reflected indirectly in their complaints to our staff and hospitals. The issue is not just about communication. It is about how well we understand the affective, cognitive, and behavioural aspects of these grief reactions.

Recently I was told that some of our patients with incurable cancer complained that their doctors told them nothing could be done for them and they could only wait for death. I am disheartened.

There is so much we can do for these patients. This is why we have developed hospice-care services in the past few years. The crux is: are we treating patients, or are we just treating diseases?

The relationship between the health-care provider and the patient has an immense impact on how effective care and treatment is.

We also have to be aware of how our own stress, frustration and anxiety are transmitted to our patients — affecting their emotional wellbeing and eventually the outcome of clinical care.

Many clinicians are going through dedicated training programs on how to communicate with patients. I recognize that communication is not easy at the frontline, which is basically a battlefield everyday. The often-given excuse for overlooking the psychosocial aspect of our patients is that we don't have time to speak to them. It's not the quantity of time that matters — it's also the quality of time we spend with our patients.

I believe there are four pillars of health care: evidence-based medical practice; the art of care and communication; patient participation; evidence-based psychosocial care.

Medicine is both a science and an art. We just have to remind ourselves every time we see our patients that we are talking to a person, not a disease.

There is a need for us to retrain ourselves in both the art and science of caring and make sure all health professionals can understand, appreciate and alleviate the emotional reactions, helplessness, stress and suffering of our patients when they are faced with life and death situations.

To borrow another quote, Dr Charles Mayo, founder of the Mayo Clinic said: "When I am your doctor, I try to imagine the kind of doctor I'd like if I were you. Then I try to be that kind of doctor."

I am sure we can all do that.

*Dr E K Yeoh is the chief executive of the Hong Kong Hospital Authority.*



## Poor quality Asian clinical trials must end

Professor Johan Karlberg

During the past 20 years I have lived and worked in Scandinavia, the UK, US, Pakistan and Hong Kong. My work is and has been academic in nature with focus on pediatric endocrinology, various aspects of clinical trials and training/supervision of postgraduate students in research methodology. From this viewpoint I would like to discuss why we need more good Asian clinical trials and how we will achieve this.

Good clinical trials can be defined as larger, randomized controlled clinical trials which, in all aspects, comply with international guidelines for good clinical practice (ICH-GCP).

There are three main reasons for making sure such trials are conducted in Asia.

First, disease patterns are somewhat different in Asian populations than they are in Western populations. For instance, some diseases, particularly infectious diseases, are more common in Asia due to environmental and hygiene factors. Other diseases, such as nasopharyngeal cancer in Chinese, are more common in specific ethnic groups.

It follows that some diseases are easier and/or more important to study in Asia than in other continents. The second reason for promoting good Asian clinical trials is that treatment effects, including the dose-response curve, have repeatedly been shown to be ethnic-group dependent. This observation alone demands that in the interests of efficacy and safety any new drug testing should consider ethnicity. This could be achieved by conducting a multicenter trial.

The third reason for promoting more good Asian clinical trials is that most countries in Asia require a local clinical trial before a new drug that is already accepted elsewhere can be prescribed locally.

These studies are usually very small, do not comply with the ICH-GCP guidelines, are not up to international standards and the results are rarely published. Such studies just consume the industry's and society's resources and are unethical because they cannot be used as evidence in clinical practice.

The first step to more good clinical trials in Asia is to ensure that all parties involved follow the ICH-GCP guidelines. The national regulatory authorities must accept only the results of good clinical

trials as evidence in drug registration. Furthermore, they should undertake study-site inspections of some trials every year to guarantee international credibility of the results.

The sponsor — usually an international pharmaceutical company — must train their staff in Asia to understand the reasons for and the importance of complying with the ICH-GCP guidelines for any clinical study involving human subjects. This is not the case today because the vast majority of local staff are focused on marketing pharmaceutical products.

All parties have to respect that good clinical trials are the only solid evidence for the promotion of a certain treatment. Such studies have a very high academic value and high impact on the scientific audience.

For instance, about half of the recent full papers in *The Lancet* are based on good, larger, randomized clinical trials.

One important aspect of ICH-GCP is to ensure that the data is of a high quality. For this reason third-party monitoring of important clinical trials should be accepted. The monitor will help the sponsor and the investigator identify deficiencies in the trial process so they can be corrected.

In many cases, much of the work on a clinical trial is carried out by unqualified sub-investigators. A good monitor will identify this fact early on in the study. He or she will also be able to identify investigators who fabricate data, as was recently reported in some larger clinical studies in the West.

In my experience, the quality of data is much lower in Asia than in the West and so are research ethics.

I would not trust the results of any larger clinical pharmaceutical trial in Asia — or elsewhere for that matter — that does not use a well-trained monitor throughout the whole trial period.

*Johan PE Karlberg is a professor in the Department of Pediatrics, University of Hong Kong and director of the newly established Clinical Trials Center at the Faculty of Medicine, University of Hong Kong.*



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### Publication Manager

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### Publisher

Linda M Jimenez Day

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