

## Consumerism in the doctor-patient relationship

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### Editor's note

*The author, a child psychiatrist, agrees with Kennedy that the differentially inadequate provision of medical services to the poor and disadvantaged needs greater consumer control to remedy it. He claims that 'instances of poor practice are sufficiently common to be of legitimate public concern'. Nor can doctors simply expect the public to trust them - trust must be earned. To this end he urges self-audit, more public accountability, encouragement of consumer involvement through patient participation groups, and 'a readiness to share problems and decisions on a basis of partnership'. By openness and cooperation doctors will, moreover, reduce the prejudice and aggression of the media.*

In his sixth and last Reith Lecture Kennedy asserts that in medicine the consumer is the patient (1); further that there is a conflict of interest between consumer and doctor; a conflict between the rights of self-determination and responsible participation in decisions that affect the patient's life; and a paternalistic tendency of the doctor to undermine his autonomy in this regard.

He asserts that the consumer should, therefore, have a role in establishing standards in medical practice; monitoring performance in the light of those standards; and creating means of redress and sanctions for the breach of standards.

He examines the activities of various institutions that preside over these functions such as the General Medical Council and Royal Colleges; peer review and the scope of medical audit; the community health councils; and the Ombudsman. He finds all the existing mechanisms wanting in some respect on grounds of protectionism and exclusiveness. Of its very nature the profession cannot claim, he says, that its self-regulatory functions protect the public since in the last analysis doctors are judge and jury when conflict arises. However, he finds litigation, although desirable in some instances, an inefficient, clumsy and expensive form of consumer protection and advocates a new method of supervision and sanction in which the consumer would play a large part and which, in view of the resistance of the profession, the consumer would have to initiate. As to the nature of this new mechanism he is unspecific but since this would require organised action to establish

he is implicitly calling for political and governmental action to redress what he sees as an inequitable situation.

What evidence is there for these assertions? Are standards being set which fall short of the ideal? Does performance not match up to those standards? Is it true that poor practice passes unchecked and that adequate redress is denied the patient? In any event is all of this sufficiently frequent or serious to warrant change in the existing system?

Again what evidence is there that patients wish to take more responsibility for the activities of their doctors and what special competence do they possess to intervene in such matters which are often technical and complex? Surely there are situations where the doctor's training equips him to know best.

Patients wish to trust their doctors. Consumer surveys regularly place doctors and nurses at the top of the rank order of occupational esteem. Much good practice relies on this trust freely donated on the understanding that the patient's position is protected by the accountability of the doctor to various public bodies which wield sanctions in the interests of the patient. To question this is to undermine that trust. Litigation may unfortunately be necessary in some instances but a ten minute chat with the doctor will deal with the vast majority of cases. To suggest wider use of litigation to keep doctors on their toes is an unnecessary and malicious attempt to undermine the doctor/patient relationship. To go further and suggest 'a wholly separate method of supervision . . . with power of suspension or removal from practice of those found to be incompetent' where 'the consumer will have to be prominently represented' sounds very like a kangaroo court. Because of the delicate and confidential nature of much medical work, the importance of public confidence and of professional reputation, such action would paralyse doctors in the performance of their duties and deter patients seeking help as surely as any extension of USA-type litigation. This may be what Kennedy wants - is it really the wish of the average British patient?

How can we decide between contrary assertions of this kind? In seeking to define the balance of power in the doctor/patient relationship and to decide whether a shift towards the patient is desirable we need evidence. Unfortunately the doctors' assertion that all is working well is difficult

to verify because the evidence is concealed or difficult for the outsider to obtain. Public complaints to health authorities, community health councils, family practitioner committees, or the GMC are dealt with usually in secret. The minority dealt with by the GMC are tabulated and published in highly schematised form but only the doctors and administrators can be aware of the scale of the problem and no systematic feedback to the public is undertaken.

So far as standards of practice set up by the profession are concerned Kennedy underestimates the valuable work done by the Royal Colleges in promoting high standards through their training and examination schemes: and in general practice since the beginning of this year all GP principals have had to complete a formal vocational training scheme.

What appears to be lacking is an equivalently powerful commitment to follow up and support once a practitioner is let loose in his speciality. Peer review is an attempt to meet this. However, most doctors resent the implications of medical audit; they feel that once qualified, and having sacrificed a great deal of time, gratification and earning power to do so, they should be free to practise their profession as their training, experience and 'clinical judgment' dictates. Although paying lip service to refresher courses the majority in non-teaching situations will continue in autonomous practice and without much contact with other doctors until they retire. This is particularly true of single-handed GPs. Attempts to encourage or cajole such doctors into updating their practice through the efforts of postgraduate medical centres often founder upon apathy, overwork or complacency.

The Normansfield enquiry (2) shows most clearly how easy it is for an autocratic doctor to ignore criticism and remain quite isolated from peer or any other kind of review until an intolerable consumerist antagonism develops.

Clearly the consumer has the right to expect maintenance of standards through closer scrutiny of continuing practice. If the doctor's peers cannot ensure this who should?

Standards of practice change constantly in the light of medical advances and of changes in the environment within which medical care takes place. In view of the length of time and autonomy of the practice, together with the power the doctor wields in people's lives one must conclude that the interests of consumers would be met by greater public accountability in the form of medical audit; so thought Merrison (3).

No other equivalent public position is so protected from external scrutiny or from democratic checks and balances. Good practitioners already review their work implicitly or explicitly; they have nothing to fear from, and much to give to, their colleagues, as well as to those who evaluate their work.

What about means of redress and sanctions? Two aspects of medical practice are relevant here: first, the distribution of medical resources and personnel by geographical area and speciality; second, the whole area of etiquette and consumerist choice in relationship to the governing institutions of the profession.

*Inequalities in health* (the Black Report) (4) depressingly illustrates the differential uptake of services by socio-economic groups and its impact on perinatal mortality amongst other indicators. It appears at least possible that the face of modern technological medicine which reflects the vested interests of prestige specialties actively frightens off the most vulnerable consumers and is not conducted with their special needs in mind. This is confirmed by Dr Brian Jarman's report on Inner London Medical Services (5) which demonstrates the drain of medical resources away from the deprived inner city areas, where the need is greatest, to private practice or to more attractive areas of the country.

Dr Cochrane from the MRC Epidemiology Unit in Cardiff (6) has shown that the quality and quantity of care varies wildly in hospital as well as community care from one part of the country to another, affecting issues ranging from the availability of abortion to the length of hospital stay. The teaching hospitals suck up disproportionate amounts of health resources, stunting parallel developments in community care amongst the surrounding population.

From the consumers' point of view the availability of resource may be absolutely deficient, not because the funds are unavailable, but because their distribution and delivery as health care is controlled by vested and unaccountable interest groups. The consumer has no control over teaching hospital or prestige specialty expenditure; he cannot control the distribution of medical personnel into needy areas and specialties. It is no comfort to say that administrators and politicians appear to have little control either. It is clear that the medical profession, in successfully defending its autonomy against managerial constraints by arguing that it needs that autonomy so as best to defend its clients' interests, has failed to do so for its most vulnerable clients. These are the consumers whose voice needs most particularly to be heard.

Private medicine is expanding rapidly. This would appear to promote consumer choice, and it is always defended on this basis by doctors who wish to practise it, as giving a better service and thus maintaining competitive standards in the NHS. However it is clear that the middle class consumer benefits differentially as with a little ingenuity and more money he engineers his way around the inequalities and inefficiencies of public health care. In all classes the pregnant, the mentally ill, the handicapped and the elderly have little such choice,

being poor actuarial risks; and the very poor have no choice because they cannot afford to pay for private medicine. Dr Jarman's report clearly shows that the spread of private practice actually works to the detriment of NHS consumers in a monopoly medical situation.

There is now some evidence of growing resistance to a health service managed by administrators and doctors which presumes to deploy taxpayers' money in their interests without consulting them; or through a process of consultation which is so long-winded and distancing as to remove any feeling that their interests have been taken into account (7), (8). Influential single interest groups have supported this movement: MIND has been active in questioning the treatment of the involuntarily incarcerated mentally ill (9); the National Childbirth Trust (10) and the Maternity Alliance (11) in questioning both the use of induction and the drive towards total elimination of domiciliary childbirth. There is increasing public interest in the questionable practices of medicating gifted children to damp down their activity (12); of drugging deprived adolescents in children's homes to control their behaviour (13); and of keeping alive the incurably and terminally ill (14). These are legitimate areas for consumer concern and the media have not been slow to follow this up to the dismay of many doctors who feel that discussion of such issues should remain under their control; hence the recent controversy over the BBC TV *Panorama* programme about brain death and organ transplantation.

Donald Schon in *Beyond the Stable State* (15) quotes examples of how public and private client services alike may strive to capture the 'ideal client' who most nearly fits into the service the treatment agency has to offer, the consumer's needs having to conform to the available service rather than the service tailoring its strategy to fit the client's needs.

A recent consumer survey of GP practice in one area, unpublished and because of the sensitivity of its contents probably unpublishable (personal communication) canvassed 2500 largely middle class people for their opinions about their general practitioners. The respondents (consumers) almost universally criticised their GPs for difficulty of access; long waits for appointments; failure to carry out house visits by day and especially by night with excessive use of deputising services; the inappropriate use of receptionists as guardians and prescribers; and in general a lack of interest in the consumer as a person. They also complained of the excessive use of prescribing as a stand-off. Individuals had made complaints to the Family Practitioner Committee (FPC) without results; GPs carried on as if invulnerable to criticism or sanctions because more often than not a perfunctory enquiry led to a carefully chosen defence of the doctor - 'another

demanding patient complaining of unsubstantiated trivia'.

It appears that FPCs are particularly open to criticism; there are indeed external non-medical representatives on these bodies but it appears they have little influence and rarely is action effective. Like the GMC only gross instances of negligence and malpractice are vigorously followed up. The GMC appears still to be far more concerned about advertising, adultery and alcoholism rather than with the more numerous damaging instances of rudeness, lack of human sympathy, control of access, withholding of information and general non-cooperation with others, especially other non-medical professionals.

Furthermore, in the case of general practice the Health Commissioner is not empowered to enquire into the activities of GPs in so far as they are not NHS employees, rather private contractors to the service (16).

Many consumers are afraid to make complaints for fear of being struck off lists; they also know they can be taken on to another list only by grace and favour of the GP. This system again adversely affects the most vulnerable and medically demanding consumers - the elderly, the mentally ill, anxious families with young children, the handicapped.

I believe that instances of poor practice are sufficiently common to be of legitimate public concern. Should change be left to the medical profession? Paternalism in the nature of things cannot continue in the face of protest without seeming authoritarian and oppressive. Only by open discussion in partnership can a mutually satisfying solution be found.

The doctor may still argue that only he is in a position to understand the issues and so the relationship must always be unequal. However, appeals to trust and technical expertise fall wide of the mark. Erik Erikson (17) pointed out that in health basic trust is complemented by basic mistrust. Consumers are not infants to give their trust uncritically; trust must be won and examples of poor practice, let alone unaccountability, give no confidence. The best practice of medicine now requires that consumers in the interests of prevention of ill health and promotion of well being must take more responsibility for their own health and welfare. Uncritical trust is scarcely an appropriate preparation for such a move.

To condemn questioning of the relationship as an attempt to undermine trust is a thinly disguised attempt to stop consumers rocking the boat and capping the vested interests of medical power. While accepting that many medical decisions have a technical element to them there is often an ethical component, as well as a duty on the doctor as a public servant at all times to be open to the wishes and interests of his patient. These components can be straightforwardly shared, as can the technical implications.

Although the eventual decisions may be difficult and at times painful and may not be what the doctor would have wished public service confers duties rather than privileges. Such decisions must be the result of full consultation in partnership; no clinical or ethical decision is so complex that it cannot be adequately defended or explained if it is justified.

Many doctors will fear that more open discussion of their activities and difficulties will leave them open to prejudiced and ignorant public discussion and criticism in the kangaroo courts of press, radio and TV. Such anxieties are real ones and sometimes justified. However the less secretive and the more co-operative the profession is the better informed and less prejudiced and aggressive are the media likely to be. The deliberations of the FPCs and to a lesser extent of the GMC could also with benefit be opened up; aggrieved patients may be just as suspicious of the hearing they get as doctors are. Justice must not merely be done but must be seen to be done if the public is to be encouraged to take responsibility for its health and welfare. To follow the rhetoric of the present government, the public must become more fully informed of the pressures on its medical practitioners and administrators, of the shortcomings as well as the advances.

What of the way ahead? Kennedy leaves the future of consumerism deliberately uncharted. It would be easy to be left with a purely negative view of consumerism as an unwelcome thorn in the medical flesh. The responsibilities of medical practice lie heavily on all of us and take their toll in stress diseases, physical and psychological. Consumer participation through patient participation groups and a readiness to share problems and decisions on a basis of partnership can lighten the burden (18). At a recent conference (October 1981) on 'Community initiatives in health' organised by the Association of Researchers into Voluntary Action and Community Involvement, considerable interest was evident in exploring the significance of consumer initiatives and their relationship to the NHS, especially primary care. An expanded role for the doctor, especially the GP has been outlined in the comprehensive but succinct RCGP publications *Health and Prevention in Primary Care* (19) and *Prevention of Psychiatric Disorders in General Practice* (20). The expanded role of medicine in the fields of prevention and health promotion require a radically different collaborative and enabling role for the doctor which, for its effective deployment, requires that he should take his clients into his confidence and be prepared to see himself as only one part of a greater network of resources which includes patients and their families at the centre, the doctor as secondary and supportive. This we have known all along – all too often we do not act as if we knew it.

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