What do people expect from their doctors?

Michael Boland

Surprisingly few people seem to worry about the technical competence of doctors. What they worry about is their doctor’s ability to understand the patient as a person and provide the right guidance. Financial, legal or managerial techniques seem powerless to ensure that this demand is met. The solution should be sought within the medical profession itself.

It is said that Lord Reith, when asked whether the British Broadcasting Corporation gave people what they wanted, replied “Yes, but we also try to give them what we think they would want if they knew it existed”. The quotation highlights the conflict between what people want – that is, their expressed needs – and their real needs, objectively determined. What do people say they want? Is that what they really want? How are their real needs identified? How can they be assured that their real needs are being met?

The English poet, W.H. Auden, described his ideal doctor thus:

Give me a doctor partridge-plump,
Short in the leg and broad in the rump,
An endomorph with gentle hands
Who’ll never make absurd demands
That I abandon all my vices
Nor pull a long face in a crisis,
But with a twinkle in his eye
Will tell me that I have to die.

Clearly, patients expect medicine to be something more than the mere application of medical science to the human condition.

What people want

The simplest way to find out what people might want or expect from their doctors is to ask them. Curiously, where this has been done in Britain, respondents have not emphasized technical competence as one might expect. It seems as if they assume that any qualified doctor is competent. Perhaps they think that some professional watchdog is ensuring that technical standards are maintained. For whatever reason, most respondents wanted:

– a doctor who would listen;
– a doctor who could sort out problems; and
– the opportunity to see the same doctor every time (1).

The message seems to be that people want personally relevant health care delivered by a doctor who knows them well and which addresses their particular problems. By inference they do not want health care which is pursuing some medically defined agenda, or is delivered by an impersonal team.

Doctors have often been accused of paternalism as expressed in the saying, “doctor knows
best”. Yet there are doctors who adopt a totally permissive attitude by prescribing “a pill for every ill”, referring to specialists and certifying sickness on demand. Responsible doctors who practise in systems where patients can move freely between competing colleagues know to their cost that good quality is not always popular. In an ideal world, individual patients would make health care decisions for themselves but would do so having considered the comprehensive information and advice provided by their doctor. This is the true definition of “consulting” a doctor, that is to seek advice which is not binding and which does not involve a transfer of responsibility.

This central task of medicine was elegantly summed up some years ago by Sir James Spence:

The real work of a doctor is not an affair of health centres, or public clinics, or operating theatres, or laboratories, or hospital beds. These techniques have their place in medicine. The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is the consultation, and all else in the practice of medicine derives from it (2).

It is this delicate balance between patient autonomy and the appropriate use of expertise which lies at the heart of our relationship with patients.

The perspective of the primary medical generalist

As a general practitioner, my perspective is that of the primary medical generalist, defined as a specifically trained doctor of first contact, competent to make an initial decision about any problem presented to him or her and capable of providing continuing, comprehensive and coordinated care to patients and their families (3). I work in a health care system where the general practitioner acts as the “gatekeeper” to secondary and tertiary care. In Ireland and the United Kingdom, most specialists see patients only on referral from a generalist.

The World Bank estimate for per capita expenditure on health care in Ireland in 1990 was US$ 876 – modest when compared with the US$ 2763 per capita spent in the United States, but extravagant when compared with the less than US$ 10 per capita in sub-Saharan Africa. This shocking disparity in levels of resources makes any generalization about people’s wants and expectations somewhat unreal. Even in societies where spending is high, equity and quality of care are not assured. A substantial part of the United States population is uninsured, and those who can afford health care become victims of excessive investigation and treatment (4).

In global terms there is a spectrum of need for health care. At one extreme is the universal action required to prevent death for whole populations. At the other is the assistance which individuals require to optimize their health. The former is the task of public health, the latter that of the generalist. Both are needed – even in the least developed parts of the world.

The rediscovery of the essential role of the generalist in health care is quite recent. The explosive growth of specialism in medicine which followed the Second World War was accompanied by a parallel decline in the status of the generalist. In many countries primary medical generalists virtually disappeared. Now spiralling health care costs and the perceived unresponsiveness of hi-tech medicine
to the real needs of people have forced a reappraisal. A growing proportion of the peoples of the world are now demanding personal medical care on a scale that few countries can afford. In response, governments everywhere are recognizing the pivotal role of the primary medical generalist in both meeting and moderating that demand.

This should not be confused with the increased emphasis on primary health care, generally summed up in the Declaration of Alma-Ata on health for all. The enormous disparity between the developed and developing world in terms of resources available for health care was such that the population-based approaches of public health medicine seemed most appropriate in global terms. Millions of people shared common problems and health care needs which could be addressed by mass action. Laudable progress has been made in this area but it is not a substitute for the personal medical care which people will continue to want and expect.

**Quality in medical care**

It might be said that what patients ought to want and are entitled to expect is a professional service of the highest quality. Quality has been defined as "fitness to the purpose", but what is the purpose of the medical service? WHO suggested four goals for health services:

- to achieve equity;
- to reduce the possibility of premature death;
- to reduce the possibility of disease and disability;
- to encourage self-actualization (5).

Equity means a just distribution of services according to need. The demand for health care almost always outstrips supply and this results in queuing, contentious criteria for determining urgency, and the use of money and influence to jump the queue. To ensure equity, individual doctors should be free to order their work and ration their time in a way which allows them to judge urgency. However, those judgements must be open to external scrutiny so that their fairness can be assessed.

Doctors in turn have a responsibility to negotiate honestly with patients about the need for medical intervention. It is bad practice and dishonest to appear to accept a patient’s demand for a service and then effectively deny it by placing him or her on a long waiting list. This is just another way to opt out of the unpleasant task of saying no.

Judging the extent and urgency of a patient’s need for intervention is a core activity for the medical generalist. It is based on knowledge not only of the clinical condition but also of the individual affected, and his or her family, work and community circumstances. People have a right to be treated as individuals and to choose an intervention tailored to their needs. They also have a right to know if nothing effective can be done to solve their problem, and be helped to tolerate or accept that situation.

Once the decision to intervene has been made, a good generalist can offer independent advice on the options available. Where this includes referral to other health care services, the generalist, acting as a ‘care broker’, will be able to provide an overview of their quality and accessibility. Given the complexity of the
services now available, this is essential not only for patients but for providers, so that their services are not inappropriately overused. Once a decision to refer has been made, the doctor will issue a specific request for the required service including a summary of all relevant information, and sometimes also make a case for urgent or special treatment. Patients need such an ‘advocate’ to help them secure equitable treatment in most health care systems today.

The next two goals – to reduce the possibility of premature death, and to reduce the possibility of disease and disability – may appear self-evident. People obviously want to live longer and live better. It becomes more difficult when they are asked if they want to live longer or better. Yet that is often the choice which a modern medical intervention has to offer, and it cannot be made on clinical grounds alone. Much depends on the patient’s personality and beliefs, and on the family and social circumstances. A good primary medical generalist should be able to help the patient by clarifying the issues to be considered and placing them in a personal context. In this process, generalizations made out of context – such as those contained in protocols, consensus statements and clinical guidelines – are relatively meaningless. What the patient needs is a doctor whom he or she trusts, with the skill to assist in making strategic life decisions. These include such things as the making or breaking of intimate relationships, planning a family, opting for a career, choosing retirement, or adjusting to chronic illness, bereavement or impending death.

The patient also needs to build a personal relationship with one doctor which will last over time. It has become fashionable to advocate that primary care services should be delivered by a team, but what patients want is one professional with overall responsibility, however many others with special skills may be involved. They are entitled to expect consistent advice and accountability through a single channel of communication. (To receive care from a team of six professionals can require as many as 21 lines of one-to-one communication when all the possible combinations are considered.) No one wants to be cared for by a committee. Core teams must be kept small, with only one primary generalist who should normally be medically qualified.

The fourth goal is to encourage “self-actualization”. This means helping patients to achieve their full potential – to live life to the full. At first sight this may appear to be an overambitious and unrealistic objective. Yet most clinicians will admit that in attempting to provide some patients with what they wanted and expected, they have induced a crippling doctor-dependence which has led the patient to play the role of a lifelong invalid. In negotiation with their patients, primary medical generalists as the doctors of first contact have a powerful influence in defining the boundaries of health and illness.

They also define the necessity for medical intervention. Many common conditions, such as depression, dyspepsia, and arthritis, exist as so-called “illness icebergs”. Among those affected, only a minority ever present to a doctor, while the majority tolerate their symptoms and practise self-treatment at home. The size of that majority is determined by the prevailing expectations with regard to medicine. If they are too low, many people who could find help will not seek it; if they are too high the demand for treatment will outstrip the resources of the health services.
Such is the size and number of these “ice-bergs” that the potential growth of health services and their cost has no limit. It cannot be contained unless patient independence and autonomy are recognized by doctors and patients alike as fundamental goals of health care.

It has been argued that health and not illness is the proper focus of a “health” service. Advocates of health promotion, disease prevention and early detection have been very successful in putting forward this total population approach in which everyone becomes a patient. There is no disputing the fact that poverty, poor nutrition, and social deprivation are major determinants of mortality and morbidity, but there is little evidence that increasing health awareness generally is either desirable or cost-effective.

Whatever the validity of the message, the public have undoubtedly been convinced. Consequently, excessive and sometimes dangerous amounts of physical exercise, obsessive concern with minor degrees of obesity, extraordinary manipulations of diet and the compulsive use of check-ups and some screening tests are widespread. Sadly, many people believe that these interventions are beneficial, and expect their doctors to collude with them in what amounts to a growing health neurosis. Furthermore, because these ideas constantly link health to lifestyle, a new morality has emerged. With it there comes a new dread of risk factors and a new guilt brought on by self-indulgence. Needless to say, this has little to do with the goal of patient autonomy and independence and the real hallmark of health, which is the freedom of never having to think about it.

**Ensuring that quality care is delivered**

Given that the quality of a service may be measured by its ability to deliver on the four fundamental goals just reviewed, and that that is what people might want and expect, how can they ensure that they get it?

There was a time when doctors were trusted and respected by the people on the basis of their title and status. Anyone registered or licensed as a doctor of medicine was assumed not only to be competent but to have a special vocation for medicine. In return for this commitment, doctors enjoyed a privileged position in their community similar to that reserved for priests and nobility. The very existence of the Hippocratic oath reinforced the feeling that to enter medicine one had to be not merely qualified, but “ordained”. Not surprisingly both the rise of democracy and the general rejection of authoritarianism have undermined that status.

The behaviour of some doctors has also contributed to this decline. Their accumulation of personal wealth, their avoidance of work regarded as distasteful or dangerous, and their obsessive pursuit of biotechnical progress without regard to its financial or human cost have all damaged the reputation of the profession generally. Self-regulation remains the hallmark of an independent profession. Yet the regulatory bodies seem unable or unwilling to discipline the offending doctors. As a result, public confidence in them has been shaken. The people, or more accurately politicians and others acting on their behalf, are now seeking other ways to regulate doctors.

One approach is to create an internal market within the health services so that providers...
of services compete for the contracts of purchasers. By a process of natural selection, competition is expected to favour those who offer the best service at the best price. The patient as consumer is supposed to exercise the power of choice. However, in some countries secondary care services are accessible only on referral, in which case choice is exercised by the general practitioner on the patient’s behalf. As a means of regulating the profession, the internal market approach is seriously flawed because the position of the patient as a consumer is weak. Patients often feel they cannot question care which is offered free of charge at the point of use. If, on the other hand, they have paid in advance by contributing to private or public health insurance, they are subject to what economists call “moral hazard”: regarding health services not as a product to be purchased but as an entitlement to be collected. As a result they are, at best, unconcerned with cost.

Furthermore, in most countries patients are poorly informed about the available health care choices. Indeed it is a curious fact that even in highly educated societies ignorance of basic medical science is common. Finally, patients are inherently weak as consumers because often they are simply too ill or worried to make complex health care decisions.

Another new approach to regulating the profession has been the introduction of performance contracts. In simple terms, governments or insurance companies acting in the name of the people use formal contracts of employment to specify the standards of performance they want and expect. Doctors who comply are rewarded financially or through added investment in their practices. Those who don’t are penalized financially or otherwise disciplined. Unfortunately, this form of control can have an effect quite opposite to that intended. Where contracts specify clinical standards they are chosen in response to political pressure groups or current fashions. Scientific evidence is ignored. Achieving the targets becomes an end in itself. This can only be done at the cost of those aspects of care where framing explicit standards is not possible. Eventually doctors adopt the attitude that if it’s not in the contract they won’t do it. Independent responsibility is thus undermined and professional morale declines.

Litigation is also a growing phenomenon in many parts of the world. Medical malpractice legislation has been used to control medicine in the United States for some time. As a means of ensuring quality it has failed. “Defensive medicine” involves much needless investigation and it can become enormously expensive. Yet another solution is to establish a vast bureaucracy of external assessors who scrutinize records and statistics of practice activity. Their methods are biased in favour of checklists and measurable quantities. The subjective and qualitative aspects of care – valued so highly by patients – are inaccessible to such an approach.

I suggest that quality assurance is best left to the profession itself, provided that the public can be satisfied that effective self-regulation is being implemented and that membership of the profession is dependent upon it. Professional performance must be scrutinized but this is best done by other doctors. The quality of care must be reviewed, but not piecemeal. It should be looked at in the round, using methods which question total patient management and the values and attitudes on which it is based.
This form of peer review should become an integral part of the professional task, with sufficient working time allotted to it. It requires skills which should form a central part of the physician’s education and training.

References

Discussion

The market knows best
Kyoko Imamura

Like human relations anywhere, the doctor–patient relationship in Japan is conditioned by the culture in which it exists. Relatively little is known internationally about the Japanese medical system, partly because of the language barrier between Japanese and other researchers and partly because of the difficulties involved in perceiving the elements of a society’s cultural background. Such a lack of communication may waste precious experience which could otherwise be used to prevent the repetition of mistakes.

Examples of unnecessary repetition can be seen in the latest efforts to reorganize public health care in Europe, where supposedly innovative practices have been the norm in Japan for half a century. World health statistics show that Japan gets better results at lower cost than other countries. Is this because Japanese doctors and their patients have a particularly good and mutually beneficial relationship? Perhaps, but not necessarily.

Market-driven health care

In Japan, where the health service is run on a private basis but financed with public funds, each doctor is an entrepreneur and eager for sales. The vital principle of capitalism is as active in health care as in any other business, and is unimpaired even by recession. Competing in the marketplace on the basis of cost and performance is taken as a matter of course. Like any business people, doctors have to keep their costs as low as possible (because reimbursement from insurance is fixed and shopping at a discount from wholesalers is the way to grow a marginal profit).

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And they have to see as many patients as possible: a typical clinic in which there is a doctor with a few staff and no beds must deal with a few hundred patients a day. Of course, many of these do not need to see the doctor but pick up a prescription, receive physiotherapy or get a regular check-up by automated analysis.

Where these pressures of cost and performance are allowed to regulate doctors, they may dispel the bureaucracy from which state-run health services tend to suffer. “Health for All” could be promoted with a marketing strategy just like any supermarket product, though this approach would run the risk of bankrupting the national health system.

Doctors who run their own clinics (about 30% of the total) sometimes accept extra-contractual work if it adds to their reputation as trustworthy health professionals, and thus eventually brings them more customers. In this respect they aim, like any other business person, to get a larger share of the market. For doctors employed by hospitals there is not usually a contract specifying the amount of service they are to provide, such as so many operations per year, but they are expected to participate fully as team members in a common enterprise. As soon as they can obtain a large enough bank loan, these doctors leave the hospital and open their own clinics. Thus doctors in Japan naturally understand health care as a business, and to succeed in it they need to find out what their customers expect of them and respond as adequately as possible.

Quality control

The health service could be expected to fail in its task of trading for life without good quality control, to keep its scientific standards high. But how can we tell if they are high enough? Of course, doctors can obtain the latest information by reading the journals and going to conferences, but there is no way to prove that they are always getting reliable information or providing consistently good service. Establishing an external regulatory body is liable to be both expensive and ineffective, especially if such a body does not have the authority to enforce high standards. Mortality and readmission rates are often used as a rough indicator of quality, but this is not done in Japan because patients can move freely from one health centre to another, and are not subjected to strict criteria for admission.

Insurance companies do not have much say in quality either. They reimburse each service purchased at a standard rate, regardless of the quality with which it was provided. They pay the most for the latest technology, and cover the extra cost by paying less for older practices. This produces the anomalous situation in which a young surgeon who does a number of quick keyhole operations at a day surgery is paid more than a team of senior surgeons working together for hours to fix complicated fractures in older patients in a hospital. Prices are apparently set without any scientific rationale or consideration for quality.

Quality is hard to assess, but quantity is obvious, and limiting it, for instance by making people wait in queues, would seem infamous in Japan. If there has been no outcry about the arbitrary control of pricing by insurance it may be simply because the patients, or consumers of health care, do not usually know how much they cost. Also, they are not well placed to judge the appropriate-
ness of the care they receive because of the overwhelming difference in the amount of medical knowledge doctors and patients have at their disposal.

**What is the secret of Japan’s success?**

Then how can Japanese people be so healthy at a relatively modest cost? There are several possible explanations, but I think it is because the patients have control over what they purchase and which doctor they consult. In earlier times, when Western medicines were not available and herbal medicines were of no use for acute disorders, people had no choice but to depend on their doctors. With health insurance, a range of choices became affordable, and with health promotion, scientific information became available as well. If a patient feels the doctor is performing poorly, he or she can try someone else or try doing without one.

Self-care is not such a new idea. In the Confucian tradition, your body is a gift from your parents and to let it be harmed is to show disrespect to them. At home and at work alike, people are taught and encouraged to take care of themselves. In addition, sick-leave means loss of productivity, so Japanese companies are eager to keep their employees healthy, by getting everyone to do gymnastics every morning, for instance, and subsidizing mass check-ups at the clinic. This employer-driven health promotion probably benefits the employee’s family as well.

In addition to this kind of health promotion, individuals can exercise their right to consult a specialist. In Japan, doctors are not divided into general practitioners and specialists: every doctor has several years of training and experience in one specialty or another, and there is no restriction on how they refer their patients to each other. The patient decides which doctor to go to first, and then if necessary either tries someone else or accepts a referral. The nationwide insurance system makes this process of selection relatively free from financial worries. Japanese people normally hope to find the meaning and joy of life in their work, so they are serious about staying healthy in order to do this, and willing to learn about their health and pay extra if necessary. This means they are demanding customers, and doctors who cannot meet their expectations are liable to lose their jobs.

To summarize, what makes Japan different is that the patients are in control of their own health. Although they may not be really well informed medically, they can usually find out enough to make choices which they feel are for the best. As successful private entrepreneurs, doctors are keen to establish good customer relations and win new business. The question of who should control the quality of care remains unanswered and so for the time being it has to be the patients themselves. After all, demanding end-users should be good for any business, because they will always be looking for the best possible value for money.
Medicine without mystique

Lowell S. Levin

The professional dominance of medicine in society and of physicians within the social structure of medical care has been studied in the industrial world (1), and can probably be documented in many developing countries as well. So while the specifics of Dr Boland's comments may not be ideally suited to all situations, the underlying assumptions they refer to do have broad implications.

Patients do not want paternalism

As Dr Boland points out, "The essential unit of medical practice is the occasion when ... a person seeks the advice of a doctor whom he trusts". The operative word is trust. Trust, however, comes precariously close to "faith", which by definition requires the patient to set aside matters of doubt, inquiry and critique in favour of acceptance, obedience to a higher authority, and compliance. On the other hand, if "trust" is the product of decision-making by a knowledgeable and fully informed patient then we can expect an adult-to-adult relationship without paternalism with its sequelae of "crippling doctor dependence". Greater balance of power between physician and patient would certainly help to contain costs associated with inappropriate demands for physician services. Dr Boland rightly notes that such pressures for more services and rising costs "cannot be contained unless patient independence and autonomy are recognized by doctors and patients alike as fundamental goals of health care".

But there is more than costs at stake. The quality of care itself can be improved by enlisting the patient as an active partner in care, not merely as a passive recipient of a service. While that could mean trouble from the point of view of physicians who bemoan the apparent decline in the mystique of medicine as a therapeutic agent, there are other physicians who can attest to the benefits of an informed, participatory patient. The maintenance of the patient's integrity as a self-confident person is essential in healing. Physicians diagnose and treat; if anyone heals, it is the patient. Without the full participation of patients, the stage is set for iatrogenic complications, both physical and emotional.

People want from their doctors something "more than the mere application of medical science to the human condition", Dr Boland avers. Yes, people do expect humane, civil treatment. But increasingly we are seeing signs that people want less as well; less of a role for physicians beyond the competence for which they are trained. I doubt if most doctors are trained to help the trusting patient make "strategic life decisions ... [including] such things as the making or breaking of intimate relationships, planning a family, opting for a career, choosing retirement ... ", which are among the examples of a general physician's role suggested by Dr Boland. The appropriation of these social functions by the doctor merely perpetuates a perception of medical paternalism which people today are less inclined to accept.

Much has changed since the Cartwright & Anderson study reported fourteen years ago and cited by Dr Boland. Of course patients still want a doctor who listens; a doctor who can sort out problems; a "personal" doctor who will provide continuity in care. But we can no longer (perhaps never could) assume that the patient has no concern about the doctor's competence and the quality of care generally. There is a growing public awareness that all medical care is not equal in quality;
that errors in judgement and the potential for malfeasance is a reality; and that quality control left totally in the hands of health professionals is simply inadequate. People increasingly want to be part of quality control, starting with full access to their medical records as a basis for their informed judgement about their condition and the course of their care. Many governments now acknowledge this right, although even in some cases of more liberal access there remain ambiguous exceptions, for instance when the doctor believes that seeing the record might harm the patient. Withholding information from the patient for any reason may not in the long run be a “humane” course of action, if this contributes further to the erosion of the patient’s capacity to control his or her health destiny. Continuous record review by patients and opportunities for patients to add their own notes could actually improve the quality of patients’ medical records. The benefits of demystification far outweigh the remote possibility of harming (or alarming) the patient by full disclosure of information.

**Patient’s responsibilities**

What is the patient’s responsibility? What is the responsibility of a consumer of any product or service? The first obligation is to know as much as possible about when to seek the service or product. The consumer—patient must know how to use these resources judiciously, recognizing both their potential benefits and their limits. Patients should be responsible for fairly judging the quality of the product or service, and communicating their evaluation to the provider in a manner conducive to the maintenance of quality performance. Patients certainly are under no legal or ethical obligation to remain silent when they are shut out of an effective role in decision-making or dissatisfied with their care. None of these responsibilities, however, should diminish the clear requirement that patients should fully disclose all information relevant to diagnosis and the course of treatment prescribed.

I agree with Dr Boland that in an “ideal world” patients would assume full responsibility for making health care decisions, seeking and using intervention from their “consulting” doctors. The question is how do we get to this ideal world? And how do we do so without contentiousness and confrontation? The responsibility for answering rests heavily with the physicians, who now have de facto control over the relationship with patients, and in some aspects, legal control as well. Physicians can, for example, encourage patients to make lists of questions and concerns and bring them along to the consultation. A relative or friend of the patient might be welcome in the consultation as a resource and advocate of the patient as a way of reducing the stress some patients experience in medical consultations.

Some view with alarm what appears in some countries to be a rising tide of health consumerism, the movement to democratize medical care as one of the last exclusive bastions of authoritarian public service. Dr Boland appears ambivalent about just how much independence and control patients and the public at large should have. On the one hand he applauds “patient independence and autonomy ... as fundamental goals of health care”. On the other, he sees limits to this power when it comes to public involvement in quality assurance which he believes is “best left to the profession itself”. Yet Dr Boland
admits that medical self-regulation has failed to assure quality, as “the regulatory bodies seem unable or unwilling to discipline ... offending doctors.”

The maintenance of the patient’s integrity as a self-confident person is essential in healing.

Would patient and public participation in quality assurance help or hurt? As scientists we should be supporting studies that can answer the question. Why not evaluate the potential contribution of lay people as members of medical audit systems? Ordinary people just might bring a useful social dimension to the evaluation of medical care and its outcomes. We shall never get close to understanding the full benefits and possible negative consequences of wider consumer involvement in medical care unless we experiment with new strategies for patient and public participation.

To start with, we should balance our concern about how much patients trust their doctors with a concern about how much doctors trust their patients. Dr Boland seems to have some doubts about the competence of patients in matters of health. For instance, they should know more about when to seek medical care; they should be less demanding about medications; they should have more realistic expectations of medical care; they should be more critical about the benefits of health promotion advice, and they should be less ignorant about basic medical science. Indeed, I had the impression that Dr Boland’s paper was substantially focused on the question: “What do doctors expect from their patients?”

Certainly, however, Dr Boland has provided an excellent stimulus for discussion of a central issue, perhaps the central issue facing modern medical care: how can we effectively join the unique resources of patients and doctors in achieving the ultimate goal of high quality, safe, equitable and cost-effective care? There is no going back to the earlier, and still too prevalent, authoritarian model of the doctor–patient relationship. The question now is how to reorient the entire health care system towards a more participatory model of service. Health professionals might usefully seek the advice and counsel of the public and of the individual patient who, after all, have the greatest stake in the quality of health care. It can be and should be a win-win situation for doctors, patients and the public.


The rich expect more than the poor

A. Geldenhuyse

In the Republic of South Africa there is a component of advantaged citizens and a much larger component of disadvantaged ones living mainly in a rural environment, with little access to appropriate medical care. The expenditure on health care comprises 8% of the gross domestic product and up to 50% of this is spent on the 20% who receive private care, either self-funded or by way of medical aid or insurance. The remaining 80% must be taken care of by the state.

One of the matters being debated in the drawing up of a new National Constitution is the inclusion of the right to equitable health care for all. How to achieve this is an ongoing
debate and, in line with current world thinking, the emphasis is on primary health care.

Dr Boland puts the case very well when he points out that the demand for health care always outstrips the supply. At present, distribution is regulated by long queues waiting for treatment and for admission to hospitals. Equity in health service is the ultimate goal but should not be achieved by a lowering of standards and facilities. Reverse discrimination, by which people who can afford it are denied the treatment they need, must also be avoided.

**Expectations of the disadvantaged**

People’s expectations are determined to a large extent by what they know. The rural disadvantaged population is not exposed to much information about health, and many of them resort in the first instance to traditional healers. This is due not only to ignorance but to cultural traditions and is also common among urbanized citizens.

Traditional healers will probably always form a part of primary health care in South Africa. Their patients usually only seek help from modern doctors when traditional methods fail. Formerly, recourse to healers was frowned upon, but now their value is more widely recognized, especially for behavioural and social problems. The challenge is to find ways to cooperate with these healers, and teach them to refer patients to doctors when necessary. Many employers now allow their workers to use sick leave to consult such healers.

When patients who have been unsuccessfully treated do get to a doctor, they are often very ill, as well as uninformed, and in no condition to make demands or enter into discussions about their treatment. They expect surgery or medication and hope someone will be able to explain to them in their own language what is wrong with them and what the treatment entails. It is always surprising to see how trustingly patients put themselves in the hands of a doctor. Many people still appear to assume that a licensed physician must be wise and competent.

**Expectations of the advantaged**

The expectations of the advantaged, mainly urbanized population are quite different. So much information on medical matters is provided in the popular press and on radio and television that most people have a fair amount of knowledge on their condition and how it should be treated. There is no longer a blind trust in the doctor’s ability. He or she has to earn it, and in this respect is on a par with anyone else who makes a living by providing a service. It is not a free market, however, as in most countries fees are controlled by agreement between professionals.

Though many codes of ethics drawn up by the medical profession in different countries do exist, there seems to be a feeling that ethical standards are declining. It is worth noting that as far back as 1905 Sir William Osler stated that a steady decline in ethics was occurring. It is probably still true, however, that unethical doctors are the exception.

*Patients are often very ill, as well as uninformed, and in no condition to make demands or enter into discussions about their treatment.*

Nevertheless, a sick person who consults a doctor is in a vulnerable position. The relationship depends on trust. This makes it doubly important that the profession should be trustworthy, and earn the respect it needs. The patient has a right to expect that the
doctor is a well trained professional who can become a valued friend and adviser. For this, learning alone is not enough; there must be an education of the heart. Honesty, availability, confidentiality and full individual responsibility for the patient can also reasonably be expected.

**A matter of costs and justice**

Unfortunately, much discussion of medical matters now necessarily centres on costs. The public as a whole is becoming unable to afford treatment, and many individuals are being financially crippled by medical bills. It is therefore important for these matters to be discussed between patient and doctor. The doctor can assist the patient, for instance, in choosing more reasonably priced hospitals and medicines, and cutting out unnecessary tests. This can be done without detriment to the treatment received.

Finally, a dissatisfied patient needs a forum in which complaints can be heard. Obviously, there is always a court of law, but this is usually prohibitively expensive.

Where the medical profession values its image, it should, and in many instances does, provide channels for complaints, dealing with them through its own professional associations which can apply peer pressure and if necessary take disciplinary action.

We may conclude that what patients expect from their doctors is quite reasonable, and well within the scope of the accepted practice of good medicine. The tragedy is that so many people in the world have no access to even a small part of this ideal. ■

**Soaring demand, limping supply**

**Jemal Abdulkadir**

Patients may differ in culture, concepts, knowledge, attitudes and personality but they are one in their expectations of the physician: they seek a true healer. They are looking for a person who differs from the rest of the species not only in his or her special knowledge and skills but in depth and breadth of understanding, tolerance and receptivity at all times of need. However, this ideal is not commonly fulfilled even in the developed countries where the physician:patient ratio is comparatively high.

The problem is more complex in most developing countries, where the supply of physicians is grossly inadequate. In such situations the primary concern of the patient is to be able to reach any physician, while that of the physician is to get through an overwhelming daily workload with woefully inadequate ancillary and technical support.

As long as these constraints continue, quality of care will remain a distant dream in the face of gross inadequacy in the supply. Take the factor of population growth which consistently negates all development inputs. When I was in school in the late 1940s, we learnt in our geography lessons that the population of Great Britain was about 50 million and that of Ethiopia about 12 million. The population of the former is still at about the same level while that of Ethiopia is now about 55 million, an increase of nearly 500%! The number of doctors in Ethiopia was not more than 30 then, now it is about 2000. So, one can even say there has been an improvement in doctor to

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population ratio. However, simple arithmetic can be deceptive. The fact is that 50 years ago most people did not think of seeing a doctor when they fell ill. They tried traditional medicine, or holy water or stayed in bed and hoped for the best. Now the situation is different. The majority of the population, regardless of accessibility, want to see a doctor, have investigations and get drugs, preferably in the form of injections. In this respect, one could say that the gap between supply and felt need had in fact widened.

When I first returned to Ethiopia after my MD degree from McGill University I wanted to be a general practitioner. I was sold on the magical combination of the art and science of clinical medicine. I wanted to diagnose and treat most diseases and use specialists or technicians as my helpers in the area of their specific skills. But I changed my mind within a short time for two reasons. One was that it appeared there would be no provisions for practice outside of a hospital setting for a long time to come. I did not see an acceptable role for a general practitioner in that setting. At the hospital of my first posting I was used as a pair of hands at the initial sorting out station for the general outpatients or as a fill-in wherever there was shortage of assistant staff. The second reason was that I realized it would be a very demanding and frustrating job without adequate supportive services of which there were very few. So, for a while I entertained the idea of taking pathology but later opted for internal medicine (glorified general practice) and in the course of time developed a special interest in endocrinology, particularly diabetes.

The place where I now work is a tertiary referral and training centre at the Faculty of Medicine and Black Lion Hospital. In reality I am engaged in primary, secondary and tertiary work all mixed together, because there is no effective referral system. Facilities are still rudimentary, the physical condition of the hospital is deplorable, even simple tests are often unreliable and there are no intermediary facilities between the patient and myself. My junior colleague and I see 45 patients or more in the morning at the weekly referral follow-up clinic. We recently calculated that the average net patient–doctor contact time was a little over 8 minutes per patient. In such a situation we try to concentrate on the essentials. While we attend to the patient in front of us our innards are in knots over the crowd still waiting to be seen. Occasionally on the wards we strike the ideal patient–doctor heart-to-heart tune, but such moments are few and far between.

The nearest thing to personalized medical care in a country like Ethiopia for the foreseeable future is within a well-organized health team with the doctor as the leader and other members of the team sharing diagnostic and therapeutic decisions according to their level of competence. Patients will then be at ease and happy to deal with any member of the team in subsequent interactions with them and will even appreciate the facilitation of management of their health problems that such an arrangement can offer. In contrast, restriction of the choice to a single individual in a situation with a severe shortage of doctors will lead to frustrations and delays with detrimental consequences for the patient.

The place of general practice in Ethiopia’s health care system is still undefined. There are very few incentives to attract young doctors to it as a career. As a result most of them see it as a temporary occupation to be endured until
they can seize the first specialty training opportunity that comes their way.

Will the time come in our environment when something approaching the ideal patient–doctor relationship can be realized? Yes, perhaps when a sense of responsibility governs the country’s reproductive activity and the population explosion abates, when the brain drain subsides, when general practice becomes the prestigious, attractively remunerated and adequately supported specialty that it deserves to be, and when the individual’s active and enlightened participation in self-care becomes a reality.

Inhuman care for humans?

D. J. Weatherall

For centuries journalists, cartoonists, novelists and playwrights have castigated the medical profession for its pomposity, inhumanity and cruelty. But although doctors may always have had a limited facility to treat their patients as humans, there is no doubt that the current medical scene is highlighting important deficiencies.

Cure versus care?

Oncology is a good example. Patients are often subjected to the most intensive protocols of chemotherapy, some of which require them to be taken to death’s door in an attempt to eradicate their tumours. A hundred years hence we may look back on all this in the same light as we do on bleeding and cupping today. But this is what is currently believed to be the most effective way to manage these diseases; in almost every field of modern high technology patch-up practice, patients are pushed to the extremes of their endurance, and not always for reasons that include a careful appraisal of what is meant by the quality of life.

Patients’ problems are compounded by current systems of medical care because they focus on the disease and are not geared to support very sick people. Above all else, those with distressing chronic or terminal illnesses need continuity of care – that is, the attention and friendship of one doctor whom they can come to trust and with whom they can share their hopes and fears. Yet this kind of relationship is all too rarely available to them. Too few consultants exist to look after the increasing numbers of patients undergoing periods of intensive treatment or who are in their final illness.

Patients in hospital are looked after by continuously changing teams of doctors and nurses, a pattern of care that also spills over into general practice, where the chances of them always seeing their own family doctor are equally limited. Managerial efficiency and an increasingly rapid turnover of patients, while they may make for impressive statistics, do not necessarily reflect a caring attitude on the part of doctors. At the same time patients and relatives are much more demanding than they used to be and, not unreasonably, expect more time and explanation of their doctors. Thus it is not surprising that the deficiencies in caring, as against concern for curing, are being accentuated.

How do people learn to be human?

To what extent are our shortcomings a reflection of the pattern of medical education? Many of the criticisms levelled at doctors are

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not about their clinical competence; rather, they seem to reflect a deficiency in the basic skills of handling sick people as humans, poor communication, lack of kindness, thoughtlessness, and, in short, all the facets of good interpersonal relationships that society has a right to demand of its doctors. Can such attitudes be taught? And even if they can, given our poor track record who is to teach them?

Concerns along these lines have led to radical revisions of medical education in several countries. In Britain the General Medical Council suggests that there should be less emphasis on the basic sciences and more on ethics, communication skills, and the social sciences, with earlier exposure to patients and their families (1). Few people would disagree that two years spent in the company of a corpse is not the most imaginative introduction to a profession that, more than any other, needs to develop the skills of talking to distressed people.

On the other hand, and as argued so cogently by Downie & Charlton (2), the social sciences have their limitations with respect to understanding the needs of patients as people. An undue emphasis on one particular aspect, whether it is economics, politics, religion, or ideology, can distort a student’s view of human behaviour. And social science deals with groups, not individual people. Thus while some of these changes may help to produce more caring doctors, they may be of limited value in encouraging the broader pastoral aspects of medical care.

In Britain young people who want to become doctors have to make up their minds at the age of about 15, from which time they are, in effect, narrow specialists. They undergo five or six years of intensive and mind-numbing training in medical school and then an even longer period in hospital or in general practice. Many come from comfortable homes, few will ever have been patients themselves, and even fewer will have experienced much of the world outside their immediate circle of family and friends. From the age of 15 their time for genuine relaxation and reflection, reading, enjoying the arts, learning about the world at large, and meeting people from other walks of life will have been strictly limited. It is not surprising that many of them have difficulties in adapting to the day-to-day needs of patients of diverse backgrounds and emotional requirements and widely differing reactions to adversity.

And, given the pressures of medicine today, there may be little time to correct these deficiencies later in their careers. Have we, albeit unwittingly, evolved an education system that, from the very beginning, is destined to leave many of its products ill-equipped to deal with the multifaceted needs of sick people? We must think again about the early years of a doctor’s education. Should we be following current trends in many American schools and directing future medical students towards a much more broadly based education, encouraging them to do something completely different before entering medical school, and shortening their undergraduate course? In other words, how can we try to ensure that our trainees are more rounded people before they enter medical school and that they remain so?

Undoubtedly a core of facts required to practise medicine, together with communication skills and an understanding of social and ethical issues, can be taught – a process that can be continued during postgraduate training. But, except by example, no medical school can teach a young person how to understand-
ing and caring. This can come only from experience of life. Perhaps it is this above all that we have neglected as we push our brightest young people through the hothouse of modern medical education without giving them time to reflect on what their profession is all about.

Although there are “bad eggs” in every profession, I do not believe that many doctors are inherently inhumane or uncaring. Rather, I suspect that, from the time that they decide on a career in medicine until they retire, many of them live in such an overcharged atmosphere, and one in which the demands on them are now so great, that sometimes the central reason for what they are doing – that is, the well-being of their patients – is forgotten. However much we do to ensure that our students of the future are better rounded and educated, our patients will not benefit unless their doctors have enough time to spend with them. This above all is the message that must be conveyed to health economists and governments of the future.


The shaman factor

Y.H. Thong

In his article Dr Boland poses the question, “What do people expect from their doctors?”, pauses briefly to answer it in very general terms, and then launches into a series of persuasive arguments in favour of a central role for primary care doctors in health care delivery. There is no doubt that the regionalized model of health care delivery with the primary care doctor as gatekeeper, as in the British National Health Service and the American Health Maintenance Organizations, is more cost-effective than the dispersed model of health care delivery, where patients have direct access to secondary and tertiary services (1). With medical technology becoming increasingly expensive and governments increasingly unable or unwilling to pay for it, it will become the dominant model where it is not already. The challenge is to make it work better, and Dr Boland puts forward some good ideas about this.

However, I propose to focus on the original question itself, and examine it from a number of perspectives in order to gain further insight into the complexities of the patient–doctor relationship. It may be useful to raise the same issue with a related question: “Why do patients sue their doctors?”. Revealing answers come from the large number of malpractice studies in the United States (2), the most litigious nation on earth. Surprisingly, the primary reason for lawsuits was not the medical injury itself, but the failure of communication. Patients sued because they were kept in the dark, excluded from decision-making and treated with contempt or condescension.

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Even more revealing was the finding that the vast majority of patients who experience medical injury and negligence never sue their doctors. The reasons for this are not known for certain, but a number of plausible explanations can be suggested. Some would have died from their injuries, without relatives willing or able to press charges on their behalf. Others may be ignorant of their rights, or lack the financial resources to sue, although this is less likely, given the large number of ambulance-chasing lawyers willing to charge contingency fees. Still others may have a relationship with their doctors that is personal, caring and respectful, and are therefore disinclined to sue, though cynics would say that this is as rare as hen's teeth. We are then left with the conclusion that patients, in general, are long-suffering and very forgiving of their doctors.

This latter explanation may not be as far-fetched as it seems. Healers have a privileged position in society, because of what is known as the “shaman factor”, whereby a sick person unconsciously confers on the healer a spiritual aura so that the vital elements of hope, faith and trust can play their part in the therapeutic process. This shaman factor resides to some extent in all who put on the mantle of healer, in orthodox and alternative medicine alike. It thus becomes pertinent to ask: “What do patients expect from their healers?”

Under the broad umbrella of alternative medicine can be found a large and diverse array of health practices, beliefs and customs, some surviving from the past, others quite new, but all unproven, otherwise they would have been incorporated into conventional practice (3). Alternative medicine continues to flourish, with high rates of utilization (45% in Australia, 33% in the USA), and satisfaction rates almost as high as for orthodox medicine (80% vs 90%). Even more revealing was the finding that patients in the USA are willing to pay some $10 billion a year from their own pockets for the dubious privilege of consulting these purveyors of unproven remedies. A number of reasons have been advanced for this, including widespread favourable media coverage, a general fascination with the occult and paranormal, and psychological aspects of health-seeking behaviour. Usually, alternative medicine is used as an adjunct to orthodox medicine, and patients express satisfaction with both, so it is unlikely that they are turning to alternative medicine because of the failure of orthodox medicine to meet their needs (4).

What harm is there in alternative medicine, apart from the costs? Actual physical harm has resulted from some forms of alternative medicine, such as toxic compounds or traumatic procedures, and delays in diagnosis can prove fatal. Also, there can be deep disappointment and loss of faith when hopes are dashed by quackery and fraudulent claims (4). However, unproven remedies can still be found in the armamentarium of orthodox medicine as well, and it is the task of the primary care physician to help patients select the most appropriate option for their condition. To do this well, there is a need for information on the clinical effectiveness and comparative cost advantages of medical options, and fortunately this is becoming more available (5).

It is part of the gatekeeping role of primary care to protect patients from the possible adverse effects of unnecessary investigations and treatments, and to ensure the appropriate use of health services. For primary care to succeed and earn the public’s trust, it has to get away from the image of gatekeeping purely as a device for rationing health care.
Young patients need guidance

Marie Sabara

Dr Boland’s emphasis on the doctors’ role as counsellor seems especially relevant for young patients. Adolescent health has become an object of concern only relatively recently, since traditionally this age group has been less exposed to health hazards than both children and older people. With social and economic change have come problems related to addiction, early sexual activity and lack of self-control combined with physical immaturity. These often require the help of physicians as much as of parents. If young people are not properly cared for and supervised during adolescence, they are more likely to be exposed to sexually transmitted diseases, unwanted pregnancies, infanticide, secret abortions with complications, expulsion from school, and social isolation due to prostitution, crime or drug abuse.

The framework of family, school and community used to provide adolescents with valuable advice and a sense of security. In many societies rapid change has brought with it the breakdown of this support system, and the young get much less help than they used to. Where there is no adult control, adolescent behaviour is often characterized by a carefree attitude, independence and freedom of spirit. Apart from its obvious good points, this can have negative outcomes, among which are health problems which require the attention of a physician.

Physicians should be a source of moral and emotional support for young people, as well as professional expertise. They must make a diagnosis and give the appropriate treatment, of course, but they should also listen to their young patients, and help them to understand what is wrong with them. Listening quite often helps to relieve a great deal of suffering, and by the time young people have to see a doctor they are not usually feeling especially carefree and reckless, so they are more open to guidance.

Although there are many specialists in the fields of neonatology, paediatrics, and geriatrics, there appear to be few or none in the field of adolescent health. Yet adolescents are very much in need of people who can help them understand the psychological and social upsets to which they are exposed, and discover their own personality. They need someone who can help them find their way through this transition between childhood and adulthood. When their troubles include health problems, the physician is well placed to provide such help. To do so effectively, he or she needs to be approachable, attentive and supportive, and to win the patient’s trust. This may often involve counselling not only young patients but their parents as well.

Special health services for young people, with appropriately trained staff, would help to overcome reluctance to seek treatment, and to
dispel the stigmatization often involved. They would also provide a setting in which adolescents could meet each other and share their ideas and experience. Such services are quite rare, and in developing countries would perhaps be too difficult to finance and manage. However, medical personnel should be aware that young patients are especially in need of reassurance and support. Nothing is usually gained from making them feel guilty about their condition, or being treated as children who have no right to their sexuality. If, on the other hand, they are welcomed and treated reasonably, they will not find it so difficult to accept care and advice.

Two practical conclusions can be drawn from these observations:

- A Senegalese proverb says *Nit, nit moo y garabam*: “Human ills need human remedies”; but the education of most health professionals is mainly biomedical and clinical. Especially in the case of young patients, whose problems are so directly linked to social phenomena, it is clear that medical training should place more emphasis on the social sciences and a thorough knowledge of the relevant communities.

- Health problems that are now common among the young could be greatly reduced by means of information, education and communication activities. Drop-in centres, run by young people in collaboration with health professionals, could go a long way towards meeting this need by providing basic information on all relevant health matters.

The responsibility of doctors to understand and help their patients as human beings has always been widely recognized. The need for this kind of responsibility is acutely felt by many of today’s adolescent patients.

**A reliable explainer**

*Wesley Fabb*

People generally assume doctors are clinically competent, in a biomedical sense, to relieve their symptoms and in many instances to cure them. But, as Dr Boland points out, most people want much more than this; they want their own doctor, one who will listen to them and sort out their problems. Listening requires time. People want their doctor’s time. They may not like waiting for their doctor, but once in the consulting room they want as much time as it takes for the doctor to understand their problem. A Canadian study showed that the most significant predictor of improvement after one year in patients with chronic headache was the patient’s belief that the doctor really understood their problem. Some others would add that patients expect their doctors to explore the meaning of the illness in their life, and help them understand the illness and how it might contribute to their growth. This implies a deep personal relationship between the doctor and the patient.

*People want their doctor’s time. They may not like waiting for their doctor, but once in the consulting room they want as much time as is necessary for the doctor to understand their problem.*

**Clear and relevant information**

At the very least, people want their doctor to explain to them what is wrong in understandable terms, how serious it is, and what they...

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should do about it. As about half of what the
doctor says is soon forgotten by even the
most intelligent, doctors need to be careful
about the volume of information provided, its
complexity, and its timing. As the first pieces
of information given are remembered best,

People expect their doctor to be their advo-
cate, and to coordinate the care given by
other team members so that they do not get
discouraged and lost in the health care
maze.

what the doctor thinks is most important
needs to be given at the beginning. People do
not want to be overloaded with the technical
complexities of their condition. If detailed
explanation and instructions are needed, they
should be provided in writing, after which the
doctor should check to make sure they have
been understood. These communication
issues need to be explored in undergraduate
and postgraduate education and opportunities
given in real and simulated situations to prac-
tise effective communication. There are now
some medical schools which attempt to select
students who seem best fitted for empathic
doctor–patient relationships and good

While people expect their doctors to advise
them about the treatment of their condition,
they may be more unwilling than in the past
to take that advice if it does not coincide with
their own views and beliefs. Some decline the
treatment offered, whilst others demand more
or different medications and insist that if the
doctor will not oblige, they will visit another.
In many societies such doctor shopping is
common. Patients now expect to negotiate
treatment with their doctors, rather than take
"doctor’s orders". People expect too that the
doctor will take into account their environ-
ment when assessing and treating their prob-
lems. The family, the workplace and the com-
munity may be significant factors in the gen-
esis of illness and are often important in
management. While people do not necessarily
expect one doctor to care for all members of
the family, they usually will listen to advice
proffered by the doctor about the health of
other family members and the health of the
family as a whole.

Some expect doctors to go beyond the overt
reason for the consultation and check for
other illnesses, anticipate future illness and
take steps to avoid it. Increasing numbers of
people are expecting the doctor to undertake
screening tests, and many seek advice about
lifestyle. Many doctors feel they have an
obligation to offer such advice; indeed oppor-
tunistic health promotion is advocated by
academic organizations and health authorities.
On the other hand, some people resent being
taken beyond their agenda to issues which
they consider to be their own business, such
as their eating, drinking, smoking and sexual
behaviour, their body weight and their fitness.
Doctors need to offer advice on such matters
prudently, at times and in quantities accept-
able to the patient. It cannot be assumed that
the patient’s and the doctor’s agendas are the
same in the area of preventive care and health
promotion. Where it seems appropriate to the
doctor to share this type of knowledge with
the patient, the sharing is a matter of
negotiation.

Availability

Consumers’ advocates insist on equity of
access to health care for all, at a cost the
individual and the community can afford,
and more control and choice for the patient.
Patients’ rights are being drawn up, and
patient satisfaction surveys are becoming
common. Many doctors too believe that the
autonomy of the patient should be respected,
and indeed fostered in the interests of creating
self-reliant people who can deal with health issues as they arise.

Although people in most countries want to see their own doctor again and again, and hope he or she will be present whenever needed, they usually recognize that a doctor needs time off and are willing to accept a deputy who has access to their record. They accept too that sometimes they need the help of a team of people. But what they do not like is having to consult a different doctor each time they need help, with no one taking ultimate responsibility. Teams are here to stay, but for every patient there needs to be one person to relate to over time, someone whom Sir James Spence describes as a doctor whom the patient trusts. People expect their doctor to be their advocate, and to coordinate the care given by other team members so that they do not get discouraged and lost in the health care maze.

Beyond the patient and the family is the community. Whilst in many developed nations doctors are not expected to be involved in the health of the community as a whole, in developing countries, and indeed in the rural areas of developed countries, doctors are expected to be community-oriented, especially if the basic needs of living are unmet or impaired because of economic circumstances or disasters. Doctors realize that in such circumstances, attention to community issues often brings more benefit than attention to individual needs. The other side of the community coin is the steadily rising level of community participation in health care issues.

To meet these wider expectations, doctors need to be flexible enough to provide, on the one hand, high quality personal care for individuals (and their families when appropriate), and on the other, care for the health of the community. The doctor needs to be able to take a wide-angle view of the community and its health care system as well as a close-up view of a specific disturbance in a patient’s bodily system. He or she needs to be able to see the interrelatedness of all the systems which influence health, and use this insight in diagnosis and management.

Quality

Dr Boland emphasizes the need for quality in medical care, but rightly highlights the drawbacks of quality assurance. There is an increasing preoccupation with management protocols through which external authorities impose behaviour patterns upon doctors, sometimes in a prescriptive, even punitive way, as if natural phenomena were reliably predictable. We know that every individual is different in important ways which affect health, illness and health care. While guidelines can be helpful, we must avoid forcing everyone into the same rigid procedures. For instance, expecting everyone to elicit the same information and take the same approach ignores the evidence which shows that experts elicit less data than the inexperienced, yet arrive at the correct conclusion more often. Patient variability makes a cookbook approach to treatment problematic. In some countries the threat of litigation further complicates the quality assurance issue, and unnecessarily pushes health costs upwards.

The doctor needs to be able to take a wide-angle view of the community and its health care system as well as a close-up view of a specific disturbance in a patient’s bodily system.

Quality assurance therefore must take the wide-angle view as much as it does the close-up. The key question is “What is good general practice?” The consumers of health care, the patients themselves, have opinions about this
which should be heard. Until agreement about it is reached, the danger is that the values and standards of those in power in influential organizations will prevail, while individual doctors, no matter how good a job they and their patients feel they are doing, will be penalized if they do not conform. As Robert Pirsig says in *Zen and the art of motorcycle maintenance*, quality is difficult to measure, but you recognize it when you see it. An overall view of the care the doctor provides for his or her patients may reveal the quality of this care more clearly than an examination in tedious detail of each step taken.

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**Doctors’ views of patients’ expectations**

**Peter Pritchard**

Dr Michael Boland has tried hard to put himself in his patients’ shoes and see things from their viewpoint. Coming from a similar background of northern European general practice, I can agree with much of what he says, but my task is to be critical. Try as we may to empathize and understand our patients’ viewpoint, to what extent is this possible? Can we really understand what it is like to be ill and poor, for instance, or dying?

People would like explanations from their doctor of what their illness really means in terms of the consequences for them and their daily life. Tuckett et al. (1) reported that very few came away with the understanding that they sought. This was a sad finding, for who is in a better position to advise? In a recent consumer survey (2), 48% of the respondents ranked the general practitioner as the most important source of health information. Newspapers and magazines came next with 16%, then television with 13% and pharmacists with 6%.

**Do patients really want part-priests or demigods?**

Doctors tend to be prosperous and secure, and for the most part respected for the work they do. In Britain most people trust their doctor (surveys suggest about 80%, compared with about 5% who trust politicians), but is this trust well founded? It puts doctors in a position of great responsibility, but do they live up to it in providing care that is accessible, acceptable and technically competent? How far should a doctor’s remit run? Should he or she have “the skill to assist in making strategic life decisions, including the making and breaking of intimate relationships”, as Dr Boland claims? Are doctors any better at this than their patients? Would not most patients settle for a competent doctor, not a part-priest or demigod?

Accessibility is not just getting an appointment the same day. The doctor needs to be able to listen and respond, for which few are adequately trained. Patients can recognize instantly if the doctor is a good listener. When my patients returned from seeing a specialist, I asked them “How did you get on?” The reply (usually) came with no hesitation: “He was all right – you could talk to him”. Listening skills are taught to general practitioners in the United Kingdom as part of their vocational training, but should not all doctors and health care staff have this skill? Readers might care to check their own listening behaviour.
against the list of hints shown in the table (by courtesy of The Conflict Resolution Network).

Active listening — some hints

<table>
<thead>
<tr>
<th>Things to try</th>
<th>Things to avoid</th>
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<tbody>
<tr>
<td>• Focus attention on the speaker.</td>
<td>• Avoid talking about yourself.</td>
</tr>
<tr>
<td>• Repeat tentatively, in your own words, your understanding of the speaker's meaning.</td>
<td>• Do not introduce your own reactions or well-intentioned comments.</td>
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<tr>
<td>• Ascertain feelings as well as content (e.g. &quot;How did that affect you?&quot;).</td>
<td>• Try not to ignore feelings. Avoid advising, diagnosing, reassuring, encouraging or criticizing.</td>
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<tr>
<td>• Reflect back, not only to show you understand, but also so the speaker can hear and understand his/her own meaning.</td>
<td>• Dispense with thinking about what you will say next. Avoid parroting the speaker's words, or only saying 'mmm'.</td>
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<tr>
<td>• Try again if your active listening statement is not well received.</td>
<td>• Don't pretend you have understood if you have not.</td>
</tr>
<tr>
<td>• Be as accurate in the summary of meaning as possible.</td>
<td>• Avoid letting the speaker drift to less significant topics because you have not shown you understood.</td>
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<tr>
<td>• Challenge hopelessness and powerlessness subtly (e.g. &quot;It is hopeless&quot; — &quot;It seems hopeless to you now&quot;. &quot;There is nothing I can do about it&quot; — &quot;You cannot find anything that could fix it?&quot;).</td>
<td>• Avoid fixing, changing or improving what the speaker has said.</td>
</tr>
<tr>
<td>• Allow silences in the conversation.</td>
<td>• Don't change topics.</td>
</tr>
<tr>
<td>• Notice body shifts and respond to them by waiting. Then, e.g. &quot;How does it all seem to you now?&quot;</td>
<td>• Resist filling in every space with your talk.</td>
</tr>
<tr>
<td>• Don't neglect the non-verbal content of the conversation.</td>
<td>• Don't neglect the non-verbal content of the conversation.</td>
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Technical competence and power-sharing

Dr Boland in his first sentence states that "surprisingly few people seem to worry about the technical competence of their doctors". Certainly they do not have the tools to measure such competence objectively, but can patients live with the idea that their doctor is incompetent? When they observe signs of incompetence, do they not try to explain them away, so that they can sleep at night? In many situations the idea of one’s doctor being incompetent could be such a nightmare that it has to be suppressed.

When the patient participation group in my own practice was asked to rank eight objectives of primary health care in order of importance, all ranked technical competence first, as did the doctors and staff. Our patients’ third ranking was “more frequent referral to hospital”, which the doctors and staff ranked last. We thought we had the level of referral about right, but the patients thought otherwise. Without asking them, we would never have learnt. Perhaps this discrepancy showed a mistrust in our competence that they could not put into words. I am certain that patients are deeply concerned about the technical quality of care that they receive, but usually feel powerless to do anything about it.

In Britain most people trust their doctor (surveys suggest about 80%, compared with about 5% who trust politicians), but is this trust well founded?

Patient participation gives them some power, but why is it that after 22 years of patient participation in Britain, only about 3% of practices have such an advisory group? Doctors have a lot of power, so perhaps they can afford to share some with their patients.
The power of doctors and patients working together greatly exceeds the sum of the power each has when acting alone (3).

Accreditation of general practitioners and their practices, when it comes (as it surely will), could provide objective measures of certain aspects of a doctor's competence, but can this formal process cover the more subtle qualities such as rapport and empathy? What happens to doctors who fail the accreditation process? Are they encouraged to take up other work? Are they retrained, and is there any evidence that retraining of incompetent doctors is effective? Guidelines are an essential building block of technical competence, and I suspect from Dr Boland's dismissal of guidelines, that he will not be first in the queue for accreditation!

Giving practices in the United Kingdom a budget to buy certain secondary care and community services (fund-holding) has produced a major power shift from hospital-dominated care towards primary care. This brings decisions about care nearer to the patient, reflecting their needs more accurately. Problems are likely to arise when all practices are fund-holding, and downward pressure is exerted on their budgets. The fund-holders will then become the rationers. For a while, there will be pressure to deny treatment that is thought to be ineffective, so the doctor will have to persuade patients to forego popular and traditional remedies. Eventually, the general practitioner will have to refuse treatment which patients expect to receive that is also needed for maintenance of quality of life, or even life itself. This will be a difficult time for everyone.

To some extent the doctor will be the arbiter of need, but should not be the sole arbiter. One option could be to involve the practice population in decisions, so that the hardship is shared. Practices which have a patient participation group can engage in a free dialogue about these issues, so that they are more clearly understood and the problems are shared.

The outlook for future health care provision is not good. Budgetary pressures, set against an increasing elderly population, plus rising expectations and technological advances, all point to increasing conflict for resources. Decision-making at community level, with patients, doctors, nurses and managers included, will be the most effective way of allocating scarce resources, and of exerting pressure for more. The developed world must learn from the developing world about how to use the local population as an asset.

Setting standards: difficult but possible

J.-J. Guilbert

According to Dr Boland: “In an ideal world, individual patients would make health care decisions for themselves but would do so having considered the comprehensive information and advice provided by their doctor.” I agree entirely, and the health education publications of WHO have made abundant reference to this principle since the inception of the Organization in 1948. The trouble is that most of our prestigious medical faculties still give only scant attention in the basic curriculum to the acquisition of skills in the field of interpersonal communication which are essential to good health education.

I find it regrettable that Dr Boland blames the “rise of democracy” for the removal of our profession from its pedestal, and far preferable when he blames the profession itself for not putting its own house in order by means of some kind of self-regulation machinery. Defining an acceptable level of performance for everyday professional tasks is the indispensable first step for enabling doctors to evaluate themselves before being evaluated by others. Dr Boland sees the need for self-regulation but is against specifying performance standards for doctors. His reasons are firstly that it might be done arbitrarily in response to changing political fashions, and secondly that some aspects of care (unspecified) cannot be reduced to measurable items on a checklist.

Unlike Dr Boland, I do not believe that it is impossible to set such standards, I just think it is difficult, which is quite a different matter. It is, indeed, more difficult in the areas of health education or doctor–patient relations than in areas of practical tasks such as “performing an emergency tracheotomy” or making a diagnosis. But our universities have not even reached that point, confining themselves in most cases to measuring the amount of factual knowledge that has been committed to memory. As for the danger of standards being badly chosen and imposed from outside the profession, we can avoid it, as Dr Boland actually does concede, by a form of peer review “using methods which question total patient management and the values and attitudes on which it is based”.

As WHO has suggested (1), such a review can be organized under seven headings which cover the most important aspects of a doctor’s professional functions: curative care, preventive care, health education, management, training of other personnel, research, and teamwork and collaboration with other social development sectors. These functions should be combined with two continuing activities: self-evaluation and self-training. The question that should be asked of the basic training which doctors receive is: does it ensure that the graduates will have adequate skills in each of these nine areas?

I am sure that Dr Boland is well aware of the doubtful quality of today’s courses of basic medical studies. This may be why he is devoting himself to the excellent and indispensable task of continuing medical education as its National Director in Ireland. He deserves everyone’s support. ■


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