# *Editorials*

## PATIENT POWER

OF all the possible encounters with different professionals, few are more threatening to a person than seeing a doctor. Some symptoms are potentially serious, many more appear so, and most consultations engender some anxiety for the patient. Few patients know exactly what to expect and rarely in our society are people in a position where intimate parts of their minds and body are exposed and examined. Now that general practice is concerned with the home, the work, and family relationships, almost any question may arise. Indeed the speed at which conversations develop in the consulting room has to be seen to be believed.

Furthermore, a patient often faces his doctor feeling physically weak and emotionally upset. He may, moreover, be under pressure from his family to attend or to accept advice. All this adds to his vulnerability.

Such vulnerability creates a corresponding responsibility for doctors—both individually and collectively. They must learn to understand their patients' fears and feelings, and their difficulties in expectation and communication. Sometimes in the past, doctors have adopted unthinkingly a rigid and authoritarian position. The challenge for general practice now is to evolve—and evolve quickly—a relationship which secures for the patient appropriate power and responsibility while retaining for the profession, power to innovate and to improve quality.

### *Administration*

As the organisation of society and the profession have both become more complex, so have the rules governing the way in which patients and doctors meet.

Much has happened since patients simply went to the shop of their apothecary. Subjects which now attract particular interest are the right of patients to choose or change their doctor, to make complaints about him or her, and the degree of control exerted on doctors and their practices.

Some commentators have assumed recently that patient power is necessarily good and power held by the medical profession is necessarily bad. The lessons of history suggest that this is a dangerous over-simplification. In the early years of the nineteenth century many working men's clubs employed their doctor directly and held great power over him. History, however, reveals that this power was more often used to keep costs down, rather than to raise the quality of care.

Similarly many of the developments which have done most to improve the quality of general practice in the twentieth century have arisen directly from the professions and not the public. The founding and development of the College of General Practitioners is a notable example. Such professional endeavours are expensive and the expenses of the College are borne exclusively by doctors and not by the public. How much practical support does the public give to those seeking to improve general practice?

### *Choice of doctor*

In 1911 the public, the profession and the State agreed on the principle of free choice of doctor. This arrangement is paralleled in most professions except teaching and social

work. It gave the patient considerable power—although such power could only be exercised occasionally. When patients chose between many single-handed doctors, general practitioners were isolated and seen by the public as weak members of a strong profession.

Today patients often see their doctors in purpose-built premises and supported by a strong and growing team. Simultaneously many of the technical achievements of specialist medicine such as heart transplants are being questioned. People now see the medical profession's dilemmas exposed on television and know the doctor's doubts. Today the general practitioner is more likely to be seen by the patient as a strong member of an uncertain profession.

Furthermore three trends are now combining to deprive the patient of his choice of doctor. First, as group practices grow, so the number of different practices falls. In many small towns, and in rural areas, general practices are powerful monopolies and everywhere competition for patients—so prevalent in the 1940s and 1950s—is fast disappearing.

Secondly, many theorists, especially young doctors, regard traditional practice boundaries as anachronistic. Having a dozen doctors visiting the same street is sometimes seen as an expensive luxury. Zoning in medicine, as in education, is now being openly discussed. If this were to be introduced the patient might be denied any choice of doctor at all.

Thirdly, some practitioners now openly reject the concept of personal doctoring, and regard the group and the team as the focal point of care. In these practices intergroup loyalty may override loyalty to the Patient. Patients will not then experience a close personal relationship with their doctor and be unable to influence the pattern of care provided.

Those who see this reduction of choice by the patient as a welcome illustration of the growing power of the profession are short-sighted. Free choice of doctor is a valuable safeguard to the profession as well as to the patient. Knowing that every time one sees a patient he has chosen to come *and to remain* in the practice is a useful basis of trust. Conscript patients who cannot escape are less likely to benefit from a family doctor's advice.

Furthermore, history shows that a temporary gain of power by any one group in society is soon met by a firm reaction. Is it not already clear that as patients lose control over their doctors individually, so they are simultaneously demanding—and receiving—greater power over them collectively?

*The power of the public*

In the new reorganised National Health Service the proportion of the medical profession in the governing committees has been sharply reduced. In the old executive councils half the members were drawn from the professions and they elected their own chairmen. In the new regional and area health authorities the chairmen are laymen appointed by the Secretary of State. The voice of the doctors has been reduced to about three or four on committees of about 15 or 20.

These new health service authorities will own all the health centres and will employ the community physicians, district nurses, health visitors and all the secretarial and reception staff now employed by local authorities. How long will it be before these new authorities carry out detailed inspections of health centres? In one of today's papers Woods, Patten and Pyper report a questionnaire asking patients how much power they should have in deciding policy in health centres. These fascinating questions will be posed more often in the future.

A government committee is also examining the role of the General Medical Council

which has power to regulate the profession. Here too a reduction in the proportion of doctors on the Council may occur in the future. Other trends such as the introduction of a Health Service Commissioner and public concern about the position of the consumer vis-à-vis all state services suggest that the reduction of the collective power of the profession will continue.

Could it be that the more complex and more rigid structure that general practice is adopting will be matched by a more complex and more rigid machinery for regulating the relationship between a family doctor and his patient?

*The clinical relationship*

The management of a patient—especially in general practice—is not now a short simple technical procedure, but an exercise in options. Particularly in the long-term care of chronic handicap in children, adults and the elderly there is rarely one single right course. Instead there is a series of choices. Moreover, many of these choices cannot be decided by the doctor alone, but each needs to be proposed and discussed with the patient and often with the family.

All this means that the doctor becomes less authoritarian and less rigid. He must be prepared to discuss choices much more frankly with his patient. Patients in the future will be required to participate more and so accept much more responsibility.

It would be sad if in the future a powerful professional machinery came into continual conflict and confrontation with an equally powerful machine representing patients' interests. Endless committee meetings at area level are not the best answer to these problems.

Since both patient and doctor basically want the same thing, the best possible service for the patient, the ideal point of resolution is where it all starts and ends—in the consulting room.

Front-line medicine must continue to be patient-centred and personal. The patient's choice and preference and the patient's personality must become more, not less, reflected in the pattern of care. Patient power and doctor power should be harnessed together in the consulting room.

Then patients would themselves be members of the health care team.