Difficulties with dependency

AS the doctor/patient relationship continues to be analysed, so a lengthening list of facets of that relationship becomes identified for separate consideration. Patient/doctor dependency is one such facet which has attracted interest recently, particularly as doctors now see more patients in the earlier stages of disease or patients without any disease at all during health/promotional consultations.

A state of dependency on others is not in itself unnatural. All children are dependent on their parents to some extent and babies are totally so. There are many conditions where patients are wholly dependent upon doctors, notably all those who have lost consciousness, or who are undergoing any form of general anaesthetic. In some of these conditions patients depend on doctors for medical attention to maintain life itself. It is not, however, these situations which are currently being questioned, but rather the commoner, everyday conditions involving patients and doctors, the feelings they engender in both parties, and the objective need for medical care at all.

The topic of dependency thus relates both to the sociological concept of the sick role and to the various personal and organizational factors affecting entry to the health care system. Stott and Davis (1979), in their recent model of the consultation in general practice, describe "area B, help-seeking behaviour", as an aspect for analysis quite separately from management of the presenting problems of the patient, the management of continuing problems, or opportunistic health promotion in the consultation.

Arousing expectations

How readily patients will seek advice depends not just on their symptoms and how they feel, but on the significance of these as they perceive them. It may also depend considerably on the pattern of medical behaviour which they have experienced in the past and their expectation of medical intervention, which itself needs to be analysed and weighed objectively. Thus the doctor who invariably investigates inevitably creates expectations amongst his patients of the appropriateness of investigations. Such expectations may or may not conform to the current value judgement of the medical profession as a whole.

In practices where 11-year-old girls are routinely offered rubella immunization, families will soon come to expect this for their other daughters. If parents are given a prescription for a cough linctus every time a child coughs, it is not surprising that doctors' surgeries soon become filled with coughing children. The unspoken medical message of a 'pill for every ill' may be interpreted by patients that as far as symptoms and doctors are concerned it is appropriate to call for all.

All this places a great obligation on doctors to weigh in the balance whether to investigate or to treat at all. Not only must they evaluate the pros and cons of the test itself, including its efficiency, use in decision taking, cost and potential adverse reactions, but they have the further complication of setting up expectations for the future and so creating a form of doctor dependency.

Such patterns of behaviour may seem relatively unimportant for individual patients or families, but may make enormous differences in medical workload over a year and can easily amount to hundreds, if not thousands of consultations. Some doctors enjoy having patients who are dependent on them, whilst others like helping their patients to avoid dependence. The biggest single variable in this respect is not so much the characteristics of the patients, but the attitudes of the doctor, as Greig argues today (p.628).

Since millions of pounds of Health Service money are involved, it is surprising that the health and research authorities are not actively promoting research on the attitudes, training, and consulting techniques of general practitioners who are reporting *falling* consultation rates.

Health system

The system of health organization in each country affects dependency. The traditional fee per item of service, that is, a fee per consultation, remains the commonest method of paying the doctor in most Western countries. It has the theoretical advantage of rewarding the doctor for work done, but has the serious theoretical disadvantage of acting as an incentive for the doctor to encourage patient dependency. Conversely, the salaried system and the capitation fee method have the theoretical advantage of encouraging the doctor to diminish patient dependency, but have the serious theoretical disadvantage of financially rewarding the doctor for neglect.

Hospitals and general practice

Patients in hospital are often dependent and at times totally so on medical and nursing care. One of the

reasons why entry into these institutions is disliked so intensely by many patients is this dependence on others. Being undressed, lying down, and being controlled by others in a strange environment is a classic recipe for dependence. When invasions of privacy, both verbal and physical, occur frequently as well, it is hardly surprising that one of the characteristics of hospital patients is passive acceptance and toleration of dependency.

Because hospital doctors mostly see patients in a state of relatively great dependency, they may become more accustomed to it than colleagues who work with patients on their own territory, such as their own homes. Hence, intensive analysis of the appropriateness or inappropriateness of each form of doctor dependency, its rights or wrongs, has become an intellectual fascination principally of primary physicians. Such analyses now suggest that many hospital activities, especially admission itself, extensive investigation and frequent follow-up, may be potent methods of creating dependency.

Future

The advent of systematic preventive medicine or anticipatory care introduced a new dimension and a new conflict to the problem of doctor dependency. While general practitioners on the one hand are making great strides in reducing doctor dependency, particularly for minor medical ills for which health care at home is both logical and appropriate, they have simultaneously started to introduce a whole new range of settings in which patients are now being trained to be more doctor dependent than in the past.

Systematic case finding for hypertension is now common, and more and more fit, middle-aged adults are finding themselves being investigated, supervised regularly, and advised to take drugs on a long-term basis for a condition for which they often have no symptoms. In sociological terms they are being made doctor dependent. The onus must be on the profession to justify this change by the harsh standard of improved outcome, that is, by demonstrating a decrease in morbidity and mortality, as indeed it is now trying to do.

An important group of patients are the middle-aged women who become emotionally dependent on their doctors. They have emerged as one of the principal challenges for primary care in Western societies. How such problems should be managed is a topic of immense concern. In the 1940s such patients' real problems were often undetected and cloaked under psychosomatic labels. In the 1960s psychotropic drugs, which produced a new set of dependency problems, were all the rage. In the 1980s the same problems are increasingly being managed by non-drug psychotherapy, sometimes by other members of the primary health care team, and particularly by doctors through the technique of counselling.

Counselling today, in its commonly used sense, has the aim of helping the patient to help himself. This seems to offer, at present, the best theoretical chance of avoiding undue dependency. Counselling, when coupled with a firm policy of never prescribing unless it is really necessary and only investigating when the results are really relevant to management decisions, can help patients to take care of themselves far more than has been usual in the past.

Doctor dependence is sometimes inevitable and sometimes appropriate. In both hospital and general practice, however, it is all too often an unhealthy aspect of the doctor/patient relationship.

Reference

Stott, N. C. H. & Davis, R. H. (1979). The exceptional potential in each primary care consultation. *Journal of the Royal College of General Practitioners,* **29**, 201-205.

Watershed in training

THE Fourth National Conference for vocational trainees was held at the University of Exeter from 15 to 17 July 1980. Previous conferences had been held at Newcastle, Edinburgh, and Oxford.

The conference was attended by about 200 trainees, representatives of many of the postgraduate educational organizations, and several regional advisers in general practice.

The three-day meeting, reported in this issue (p.636), sought to look at some of the important aspects of British vocational training and in doing so to involve as many trainees as possible.

During the months before the conference, a lengthy questionnaire was distributed to about 3,000 trainees in the British Isles and over 1,400 were returned in time to be processed on the university computer before the conference. The presentation of the results of the questionnaire by a team of five trainees and ex-trainees formed the academic highlight of the meeting.

Only two thirds of the trainees thought that their trainer gave "value for money in terms of teaching", and trainee satisfaction correlated strongly with the amount of teaching time per week the trainees thought they were getting. Standards in the training practice were also a cause for concern. Although about half the trainees reported that they had the use of a consulting room for themselves, more than half were dissatisfied with their practice libraries and almost two thirds