Why family doctors should not advertise

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SUMMARY. Medical care is a form of production of values, but not of commodities. This article argues that advertising as it is normally understood is not appropriate to general practitioner care. Acceptance of advertising by the medical profession would assist in the commercialization of a currently non-commercial relationship between doctors and patients. We should refuse to take this step and accept our responsibility to devise better futures than the market has so far been able to provide.

Introduction

THE publication in March 1988 of a government green paper on restrictive trade practices,[1] including traditional restrictions on self-advertisement by doctors, signalled a general review of all economic activities aimed at maximizing competition throughout society. Present legislation spares professional services, but:

> 'There will be no exemptions for these sectors and professional services automatically carried across into the new legislation, without the merits of each exemption having been carried out afresh. Whilst open to argument about retaining any exemption, the Government intend to end as many as possible and to make sure all sectors of the economy operate as far as possible under the incentives of competition.'[1]

The message to doctors is clear; either we yield our protected corner to the rule of the market, or we assert some alternative view of the kind of society we want to live in.

The legal profession has customarily been regarded as a parallel case, and lawyers seem to be embracing commercialism with little difficulty. Their monopoly on conveyancing and the job distinctions between barristers and solicitors are examples of profitable restrictive practices which cannot easily be defended in the public interest, but losses are offset by the increasingly litigious world of commerce we seem to be entering. Are doctors a similar case? The private charges permissible to general practitioners in the National Health Service, including £10.50 for signing certificates for disabled drivers, £13.75 for validating cancelled holidays and £21.25 for completing a cremation certificate, are of the same nature as conveyancing. Arguments about the dignity and social value of these and other private charges are unconvincing, but for the most part medicine really is different; not a trade, but a social service.

Historical origins of the exemption of the medical profession from free business competition

In a country which retained many feudal privileges dependent on social rank, the nineteenth century distinction between professions and trades was extremely important to the embryonic medical profession, above all to the physicians who only reluctantly consented to join surgeons and apothecaries to form a single profession. Doctors were not recognized as gentlemen (for example, at court) until the 1880s, and the early social history of the profession is dominated by its determination to secure gentlemanly status.

The Medical Act of 1858 was clearly intended to regulate and disguise medical trade so as to stabilize the existing hierarchy of physicians, surgeons and apothecaries within an expanding and socially ascending profession, and to defend the economic interests of established practitioners against outsiders and newcomers within a strongly protected market. The *Medical register* excluded all other kinds of medical practice, an important step at a time when qualified practitioners were inaccessible to most of the labouring population whose day-to-day medical care was in the hands of part-time, unqualified attendants of various kinds. As Jeanne Peterson wrote:

> 'Authority came to the experts as the public was increasingly closed off from knowledge of their work. The power of the experts was not the power to do, but the power to know, and therefore to judge... In the face of *laissez-faire* ideals and the competition of a modern market place, the professions created a special place for themselves in which "modern" science justified a "traditional" structure of authority and social relations. Universalism born of professional ambition and esoteric skill gave exclusive power to the possessors of knowledge, who perpetuated the old vertical connections of dependency and patronage in the name of expertise.'[2]

The 1858 act defined the profession, and handed over its corporate regulation to the General Medical Council, which defined unprofessional conduct through its own legislation in its own courts. Throughout the rest of the nineteenth century the General Medical Council had to wage war against open medical profiteering, mainly through action against self-advertisement. This partially limited medical commercialism, but also reinforced the tendency of doctors to communicate with the public one at a time, within the consultation. If doctors had anything to say to the rest of society they had to speak through their royal colleges or the British Medical Association. The social role of medicine was frozen into an uncommunicative posture, and doctors who tried to reach their local populations for constructive social ends risked arraignment by the General Medical Council.

Dual character of advertising

The purpose of advertising is to increase the sales of a commodity by making the public aware of its existence and attributes and by advocating its alleged advantages over market competitors. Advertisers claim that this dual function, to inform and to advocate, is neither divisible nor contradictory, but once the object becomes the sale of a commodity, advertising moves from informing to influencing, then to promoting and finally to competing. Even within the strict prohibitions of the General Medical Council, NHS general practice before the 1966 charter, when virtually all income came from capitation, was highly competitive.

Until recently the professional leaders who dominated the General Medical Council chose to condemn virtually all attempts at local public health education as advertising. They inhibited efforts by progressive general practitioners to advocate higher standards, particularly attempts to popularize successful pioneering ventures which might embarrass their more complacent colleagues. NHS general practice seems designed to preserve and protect obsolete standards of care, by guaranteeing reasonably good pay and lifelong job security in return for unverified clinical skills.[3] It also seems designed to guarantee a cheap service for the government, because responsibility for investment has been left to the general practitioner as an independent contractor.

The General Medical Council's traditional hostility to any local public role for general practitioners has begun to crumble over the past decade because of the rise of television documentaries about health, because of fundamental shifts in the nature and effectiveness of medical care, and because of new ideas about the social function of medicine. A local public role for general practitioners is beginning to be imaginable,[4,5] but this development has nothing to do with commercial advertising in a competitive market, instead it has become possible only because competition for larger lists has declined.

Arguments for a free market in general practitioner care

Most of our professional customs were originally designed to create and defend a protected market, shielded from public criticism. Whereas in the rest of Europe and the United States of America episodic fee-earning practice, first entirely private but later financed by the state, encouraged vigorous competition for patients and therefore promoted investment, the Insurance Act of 1911 established a system of care for industrial workers as the foundation for British general practice, though competition for patients was still encouraged by the capitation system. In 1948 the NHS extended the Lloyd George panel to the whole population, eliminating virtually all competition for private patients in general practice. Developments since then have reduced the capitation element, discouraging competition even further.

This historical development has been presented as a process of professional de-skilling and disinvestment, resulting in a relatively secure and well-paid but clinically stagnant area of medicine, whose principal function is to control access to 'real' care by specialists in hospitals, on behalf of governments concerned chiefly to restrain costs.[3] According to advocates of this view, a reverse process of re-skilling and renewed personal investment in general practice could be encouraged by stripping away the gentlemanly pretensions of the old medical professionalism, affirming the virtues of open competition and introducing methods of payment linked to performance. The security hitherto guaranteed by the NHS to virtually all general practitioners, however poorly they perform, would disappear as patients would decide where they prefer their money or taxes to be spent. General practitioners anxious to maximize their incomes would regain an interest in attractive premises and bedside technology. Even if this entire package could not be implemented immediately (and no serious observer denies that the present service is at least cheap by international standards), reform of the restrictions on advertising would be a first step on the road.

Social functions of general practitioner care

The implications of advertising by specialists for the UK's uniquely structured, rational and (by international standards) cost-effective referral system have been excellently presented by Marinker,[6] and are not considered here. Apart from the threat to referral, effective arguments against medical trade and advertising do not rest on the traditional assumptions of medical professionalism represented by the 1858 Medical Act and the General Medical Council, except in one particular. Though the Medical Act finally legislated for a single medical profession, this view was contested in the parliamentary committee which prepared it. Some members suggested that a less qualified grade for everyday care of the poor might be a cheaper and more realistic alternative. The British Medical Association successfully resisted this proposal, using the following argument:

> 'Every attempt to create an inferior grade of medical men of limited education and with aptitude only for the ordinary exigencies of practice should be resisted. Disease affected people wherever they were, and so the same degree of medical skill should be available for everyone.'[7]

Implicit in this argument was recognition of a fundamental human right to effective medical care, limited by contemporary science rather than the purchasing power of patients. It was, of course, in the interests of the profession that its scope should be as wide as possible, but acceptance of this argument by the political establishment of the day meant that it recognized that this human right to care was an important social function of medical professionalism, a stabilizing factor in an otherwise divided society. Only 10 years after the Chartists and the revolutions throughout Europe, social stability was an important issue, as it is again today.

Once this social function is accepted, it is easier to understand the now unconvincing mixture of altruism and humbug in our profession's traditional attitude to medical trade and advertising. At a time when only the barest living was available from the state and only rich patients paid well, doctors had to develop trade at the top of the market, while giving care as a non-commercial public service to the less affluent. The subsequent history of British general practice for the mass of the population has moved through three successive stages: industrial club practice, the Lloyd George panel, and finally the NHS. Each has taken us further from the private market and closer to universal provision according to need, with the bills met by society as a whole through taxation.

As long as general practitioners provide a responsible personal service there is a point beyond which more patients must mean less care. This limits the market for traditional care, though not for the less personal, polyclinic style now adopted by health maintenance organizations in the USA. Independent contractor status for general practitioners has ensured a cheap service, but the consequent poverty of resources has had to be rectified by government investment, meeting most costs itself but having little control over how they are used, as in the 1966 charter. General practitioners have generally invested their own money only where they could expect a reasonable economic return, that is, where the value of buildings under the cost-rent scheme was certain to appreciate, and where local populations were expanding in size and prosperity;[8,9] thus in the inner cities and de-industrialized provinces, where investment was most urgent, it was least likely to be made. The fact that only about 15% of all general practitioners employ their full quota of reimbursable ancillary staff, with slightly more than half the potential ancillary workforce actually employed,[10] shows that this brake is still effective. Experience of the 1966 charter also shows that government can invest in general practice if it wants to; business investment by general practitioners is not the only or necessarily the best way to modernize primary health care.

The medical consultation as a unit of social production

Virtually everyone agrees that the basic unit of the medical process is the consultation, in which people who need care meet health professionals who can initiate its provision. Central to the argument of all advertisers, commercializers and privatizers is the assumption that this basic unit conforms to the normal consumer–provider model. According to them, the NHS is merely an obsolete survival from the past; some kind of system had to be provided for industrial workers and the unemployed, but it was not, and was never intended to be, of a quality any advertiser would boast of. Now that most of the nation is said to be rich, this system can be left to the remaining poor as a last resort in emergency. This idea is not new; after its apparently irreversible defeat in 1948 it was reintroduced by Lees[11] in the early 1970s, and has now become almost conventional wisdom, hav-

ing considerable influence, albeit in the modified form of consumerism, on the liberal left as well as the conservative right.

The consultation is indeed the elementary unit of medical production. This can take the form of commodity production; that is to say, the doctor can behave as an expert provider, selling a service to patients as passive consumers. The principal intended product of a commercial consumer–provider consultation is profit; that is its ultimate purpose, and for the good medical businessman, better health is a byproduct. However, this is not a correct description of the consultation as the Royal College of General Practitioners has developed it and most British general practitioners now understand it. The intended product of a medical consultation is health, health improved or health so far as possible conserved, through shared understanding of the nature of the health problems patients present. Both patients and professionals have to contribute to this process; it is, whether we always recognize it or not, a 'meeting between two experts' for production (of health), in which consumptions (of drugs, procedures, and so on) are not an end but a subordinate means.[12] In practice, doctors are the effective consumers (and targets for advertising), because they take the decisions that ultimately determine costs.

The consultation as a joint process of production of social, not merely personal values, is seen particularly in two situations: diagnosis, and the management of continuing problems. Hampton[13] confirmed what experienced clinicians have always known, that about 82% of diagnosis depends on histories given by patients, about 7% on clinical examination, and only 9% on laboratory tests and other technical procedures. The critical skills of care, which largely determine success or failure in attaining real health outputs, depend more on communication than on technical skills; on time spent in shared definition both of the nature of a problem and of realistic solutions in personal and social contexts which only the patient can provide. This is true even for areas of care like surgery which obviously depend on specialized technical skills, because these can only be effective if they are applied appropriately to the right people at the right time.

Riddle,[14] an American specialist in diabetes, has reviewed the generally unsatisfactory state of management of chronic disease in the USA, and suggested five steps needed to apply in practice the advances in medical science of the past two or three decades:

> 'Management [of chronic disease] is a process which can be divided into five steps. All the steps must be completed if management is to be as satisfactory as possible. They have a logical sequence. Completion of the later steps reinforces the earlier ones, so management improves with time. Each step must be recognized as part of the overall plan, not overvalued for itself.
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> 1. Acquisition by the health professionals involved of an adequate base of information about the disorder.
> 2. Acceptance by the patient of primary responsibility for coping with the disorder and maintaining health.
> 3. Learning by the patient of the physiology, complications, and details of treatment.
> 4. Negotiation between patient and health professionals of general goals and specific objectives for management acceptable to both.
> 5. Assessment of success in meeting the objectives using quantitative measures understood by both patient and health professional. '

There is consistent evidence from many different sources that standard procedures for effective management of illness, particularly of chronic illness and health risks, are incompletely, inconsistently, intermittently and irrationally applied to general populations, with many people more or less completely without care, and others receiving duplicated care from conflicting sources. This is true not only in the UK but even more in the USA, despite expenditure of roughly four times as much per head of population in a highly competitive and (in practice though not always in theory) advertised system commonly supposed to set a world standard for quality. Wilber and Barrow[15] first described the 'Rule of halves' for the management of high blood pressure on a population scale in the USA in the early 1970s: half of the people with high blood pressure were not known, half of those known were not treated and half of those treated were not controlled. Deficiencies of the same order of magnitude have been found wherever the management of virtually any chronic disease has been audited in whole populations.[16] In general, the greatest deficiencies are found where there is greatest need, a paradox which tends to be most pronounced where medical care is sold and advertised as a commodity in a free market.[17]

For improvements in health outcomes, the biggest advance at lowest cost is likely to be attained not only by extending unplanned screening procedures to respondents in the general population and then repeating them on demand, but by organizing effective, continuous follow-up for problems that have already been identified. The detailed analysis on which this conclusion is based comes from studies of blood pressure control,[18] but the model appears valid for other chronic conditions which account for most treatable morbidity and mortality today. Continuity of care and personal responsibility have proven effects on patient compliance and therefore on health outcomes;[19] NHS patients are registered with the same general practitioner for an average of nine years, a priceless national asset for any care system really concerned with effectiveness as well as cost.

The British tradition of primary care provides registered populations and therefore the possibilities, and I think growing realities, of continuity, personal responsibility, and planned care, the real preconditions for application of Riddle's five steps. The essential framework and the beginnings of appropriate professional attitudes and accountability already exist in the present system, but they might not survive any sustained reversion to a 'free' market in which competing providers were encouraged to boast of skills to the public.

Cost implications of commodity care and consumerism

Where health care providers compete on a commodity market, their natural tendency is to magnify their own skills and ignore those of their patients, and to maximize sales without regard to social or even biological need. Although the word doctor originally implied a teacher, the historical root of the relation between doctors and patients has been popular demand for doctors not to teach, but to do. The more technical and episodic the procedure, the more easily it could be packaged, promoted and sold to consumers, whose only responsibility was to pay. As simple, often placebo procedures were replaced by potentially effective but costly techniques indiscriminately applied, fee-for-service systems therefore had an inflationary effect on both treatment and investigation, augmented by pressures of potential litigation which are themselves in part a logical consequence of selling medical care as a commodity in a commercial market.[20,21]

Health maintenance organizations in the USA, apparently much in the minds of present government ministers, were an attempt to escape from this inflationary spiral, by adopting many of the principles of the British NHS; medical pay unrelated to items of service, in which profits available to augment professional incomes are maximized by economy of treatment and in-

vestigation. The organizations have in general competed for affluent employed populations and their considerable advertising investment has been directed accordingly.

Consumerism and democratic control

Consumerism may now be becoming a new consensus political philosophy uniting the major political parties, in much the same way as the NHS did in the 1950s. The conventional political choice may become either consumerism in a free market, the evident preference of the present government, or some kind of state-supported consumerism extended to parts of the population too poor to exert effective economic demand, the choice to which all the opposition parties appear to be drifting. This consumerist consensus appears to accept the idea that such power as ordinary people still have to control the society in which they live lies only in their choice of consumptions and their choice to spend money, either their own or whatever they may be granted by more or less compassionate taxpayers in a competing market.

The real alternative is a society in which people distinguish themselves from other animals by their creativity and their capacity to produce, not merely to consume; a more human and stable society based on participative work, in which the most important and complex values produced by society, such as education and medical care, cease to be handled in the same way as simpler, more primitive commodities, such as shoes and hair spray. These complex values would be understood as social products, jointly produced by local people and by local professionals who serve them. Elements of political power could begin to be centred on individual and small group participation with teachers, doctors, and other skilled public servants, in producing the social values that will define the nature of the society in which we want to live. An important part of this process would be communication, not only at a personal level in a more labour-intensive, relatively less technical service with a new emphasis on unhurried thinking, listening and explaining, but also at group level, using all the means of communication made possible by modern technology. This would of course use many of the tools of advertising, but it would not be advertising; in the broadest sense, it would be education, including a far more vigorous promotion of the positive ideas of the new general practice to the public, nationally and at neighbourhood level.

Full recognition of this new relationship by our profession, and by the public it serves, would for the first time permit the full and economic application of continued advances in medical science. This difficult process can only be impeded by the disintegration of our profession into competing entrepreneurs, and self-advertisement is a first step on this road. We should give a lead to society, by refusing to take this step and by accepting our consequent responsibility to devise better futures than the market has so far been able to provide.

References

1. Department of Trade and Industry. *Review of restrictive trade practices policy: a consultative document (Cm 331).* London: HMSO, 1988.
2. Peterson MJ. *The medical profession in mid-Victorian London.* London: University of California Press, 1978: 286.
3. Honigsbaum F. *The division in British medicine: a history of the separation of general practice from hospital care 1911–1968.* New York: St Martin's Press, 1979.
4. Hart JT. *A new kind of doctor.* London: Merlin Press, 1988.
5. Mant D, Anderson P. Community general practitioner. *Lancet* 1985; **2:** 1114-1117.
6. Marinker M. The referral system. *J R Coll Gen Pract* 1988; **38:** 487-490.
7. Brotherston J. Memorandum of evidence in the BMA. In: McLachlan G, McKeown T (eds). *Medical history and medical care.* London: Oxford University Press, 1971.
8. Bosanquet N, Leese B. Family doctors: their choice of practice. *Br Med J* 1986; **293:** 667-670.
9. Bosanquet N, Leese B. Family doctors and innovation in general practice. *Br Med J* 1988; **296:** 1576-1580.
10. Hart JT. Practice nurses: an under-used resource. *Br Med J* 1985; **290:** 1162-1163.
11. Lees DS. *Health through choice: an economic study of the British National Health Service. Hobart paper no. 14.* London: Institute of Economic Affairs, 1961.
12. Tuckett D, Boulton M, Olson C, Williams A. *Meetings between experts: an approach to sharing ideas in medical consultations.* London: Tavistock, 1985.
13. Hampton JR, Harrison MJG, Mitchell JRA, *et al.* Relative contributions of history-taking, physical examination and laboratory investigation to diagnosis and management of medical outpatients. *Br Med J* 1975; **2:** 486-489.
14. Riddle MC. A strategy for chronic disease. *Lancet* 1980; **2:** 734-736.
15. Wilber JA, Barrow JG. Hypertension — a community problem. *Am J Med* 1972; **52:** 653-663.
16. Hart JT. Measurement of omission. *Br Med J* 1982; **284:** 1686-1689.
17. Hart JT. The inverse care law. *Lancet* 1971; **1:** 405-503.
18. Weinstein MC, Stason WB. *Hypertension: a policy perspective.* Cambridge, Massacheusetts: Harvard University Press, 1976.
19. Ettlinger PRA, Freeman GK. General practice compliance study: is it worth being a personal doctor? *Br Med J* 1981; **282:** 1192-1194.
20. Quam L, Dingwall R, Fenn P. Medical malpractice in perspective. I - The American experience. *Br Med J* 1987; **294:** 1529-1532.
21. Quam L, Dingwall R, Fenn P. Medical malpractice in perspective. II - The implications for Britain. *Br Med J* 1987; **294:** 1597-1600.

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