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The patient as consumer

WHAT are the ethical issues implicit in the current vogue for describing the recipients of health care as 'consumers', and the attendant claim that the introduction of a market in health care provision will enhance 'consumer choice'? The characteristics of a market (or trading) relationship between two parties have been usefully summarized by the philosopher Robin Downie[1] as follows:

1. The trading parties are each attempting to maximize their own self-interests.
2. They have information to guide them on this.
3. The parties are free to choose whether they will trade or not.
4. The consumer and the producer each bear their own costs.
5. The relationship is a competitive one in a double sense: producers are competing with consumers to maximize their profits and producers are competing with other producers to attract consumers.
6. There must be a legal framework to ensure fair competition.

It is evident that the recent white paper, *Working for patients*,[2] is based on a market philosophy. For example, patients are to be supplied with the kind of information which will allow them to be more selective in their choice of doctor and it will be easier for them to shift their 'custom' from one practice to another (items 2 and 3 above); practitioners will be rewarded for maximizing their profits in budgeting (item 1) and will be generally more directly accountable for all items of service (item 4); practitioners will be encouraged to compete for patients and to bargain with hospitals, thereby creating competition between hospitals (item 5); profiteering and malpractice will be controlled by enhanced medical audit and by various form of administrative and political control (item 6).

The claim that patients will benefit from such changes has been challenged by noting the inappropriateness of the trading analogy in health care provision. William May has drawn a contrast between contractual and covenantal relationships.[3] In the former each party should be able to ensure adequate protection of self-interest; contracts itemize reciprocal obligations, and cease to be binding when the conditions are not fulfilled; the parties to a contract each enter freely into the relationship and neither is at an undue disadvantage in terms of dependency upon the other or in terms of inability to secure full knowledge of the situation. But, as May points out, serious accident or illness inevitably places the patient at a disadvantage in any relationship where the recipient of services is expected to look after his or her own interests. The patient is a vulnerable person, not a trading partner, and frequently can neither gain access to all relevant information nor act in a wholly independent manner. Hence, a covenantal relationship is required, that is one which offers an open-ended commitment to the other's welfare, and which sees the professional relationship as an expression of care for the needy or disadvantaged. Codes of medical ethics, like the Hippocratic oath, have thus stressed commitment to the patient beyond any thought of personal gain as a fundamental tenet.

Nevertheless, some theorists have contested the claim that a special relationship is required in health care provision, and that a market philosophy will inevitably diminish the quality of care provided. Downie[1] finds himself as much at the mercy of professional expertise in having an emergency repair to his car or to his gas central heating system as in having an emergency operation on his body — of course he accepts a difference in degree of vulnerability, but not one in kind — and so argues for an indivisible morality of non-exploitative service, which does not draw class

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distinctions between professions and trades. The reality, Downie argues, is that we are all in the business of selling services: the recipient must be protected both by legislation and by a society which teaches moral responsibility. Robert Veatch[4] sees no virtue in the language of covenant, indeed suspects that it encourages a paternalistic attitude. Veatch suggests a 'triple contract', in which the obligations of practitioners to patients, to fellow professionals, and to society as a whole will be clearly spelled out. The vulnerable patient is thus to be protected by a kind of medical bill of rights.

The debate continues, but it should be noted that none of the theorists quoted here supposes that making the patient into a 'consumer' will enhance choice and quality of care. The vulnerability of the recipient of health care is surely incontestable, and it is hard to see how competitiveness between providers can do other than increase it. A possible advantage of market forces is that, because the doctor is encouraged to outline and explain possible courses of treatment, the patient is more involved in his or her own care, and less of a passive recipient of what is given. However, this advantage is likely to be taken up only by the more confident and articulate patient, and possibly the patient whose condition is less urgent. Market forces might therefore serve to put the more vulnerable patient at a still further disadvantage. If patients are to be turned into 'consumers' by legislative fiat (and this appears to be the inevitable outcome of the white paper), a central issue is whether there will be the mechanisms — either political or professional — for ensuring equity of provision of what are not, after all, consumer goods, but some of the basic necessities of life.

Another central issue concerns the widespread acceptance of the patient as consumer. This will encourage public understanding of the transaction between doctor and patient as a trading relationship, with all the implications which this entails, leading to an erosion of the trust which must exist between patient and doctor, if the therapeutic relationship is to achieve its full potential. Thus, although it has been constantly asserted that the white paper[2] pays more respect to the individual autonomy of the patient by widening choice, in actuality its philosophy of consumerism will enhance neither the choice nor the quality of medical care. On the contrary, there is a real danger that, by undermining the whole basis of the doctor–patient relationship, it will lead to a reduction in both quality and choice. One cannot trade in trust and commitment: one can only create structures which either enhance or destroy them.

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The future for practice nurses

IN *Promoting better health* in 1987, the government stated that the role of the nurse in the community is fast developing, and better use can be made of their skills and experience.[1]

The roles of practice nurses, community nurses and health visitors have fluid boundaries, the differences reflecting the differing views of their employers, as well as personal and professional preferences. General practitioners employ practice nurses for specific tasks which health authority staff may be unable to undertake. In fact, there is evidence that some nurse managers restrict the range of tasks that community nurses may perform.[2] General practitioners often feel nurse managers do not share their aims and direct employment of the practice nurse by the general practitioner provides the mechanism for rapid decisions about patterns of work, so permitting adaptation to the changing needs of the practice without the need to negotiate change with community nursing managers.

No precise figures are available, but in England there are in excess of 4000 practice nurses. This figure has doubled over five years.[3] There continues to be debate about who should employ the practice nurse. The community nursing review recommended that these nurses should be employed by the district health authority,[4] a view supported by the Royal College of Nursing, and one which reflects the difficulties in accepting that one profession can be employed by another,[5] while acknowledging the flexibility and innovation which is possible when nurses are directly employed by a practice.[6]

General practitioners have rejected this recommendation of the community nursing review because of concern about the possible loss of control over the role of practice nurses. This rejection overshadowed another apparently radical recommendation of the review — the introduction of an independent nurse practitioner into primary care. The concept of the nurse practitioner was initially derived from North America, and the separation of the role from that of the practice nurse is now less distinct. Key tasks that have been described for nurse practitioners include: interviewing patients, diagnosing and treating specific conditions to an agreed medical protocol; referring to the general practitioner patients whose medical condition lies outside agreed protocols; conducting screening programmes; and referring patients for further nursing services. Many practice nurses undertake all of these tasks already.

Stilwell[7] found that patients consult a nurse practitioner appropriately, and that the presenting problems are managed without further referral in one third of consultations. She concluded that nurses could have a much larger and more autonomous part to play in patient care. A comparison of the work of a nurse practitioner with that of a general practitioner has shown that nurse practitioners can be a valuable extra resource for the development of new areas of care, rather than a cheaper substitute for a general practitioner.[8] Evidence exists that an organized programme, including a nurse with specific responsibility for adult prevention, is likely to make an important contribution to the recording of risk factors, and to the follow up of patients with known health risks. Better management of chronic disorders in general practice can be achieved with the support and coordination of a nurse.[9] Clear evidence exists for the development of the role of the nurse in primary care, especially in the areas of preventive and anticipatory care.[1,4,10-12]

Aside from the present fragmentary situation for employing nurses in the community, what are the pressures for change in practice nursing?