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The image of the patient in their relationship with general practitioners

IN the current vogue for television series about medicine, doctors and hospitals (I counted 14 on air this week), the 'extras' are the patients. In much the same way as the animals in series about vets, the patient is a much-neglected character.

If these television programmes echo an outmoded view of patients as the hosts for illness and disease, then what is their current image within the profession of medicine? And what should be their role and status in the contemporary doctor–patient relationship? This television image may not be true in the real practise of medicine, but it makes one wonder about the role and status that is currently accorded to patients. So many academic studies of 'patients', as opposed to illnesses, position them as 'sufferers' or 'copers' of an illness, or the recipients of treatment as in studies of compliance, rather than as active agents (and collaborators) in the maintenance of their own health.[1] Even the term 'patient' has connotations which are taken for granted, but which enshrine a view of passively undergoing medical treatment.

In research conducted some 10 years ago,[2] one source of satisfaction for GPs was as 'family doctors', who participated in 'seeing their patients into and out of the world'. While GPs have on-going relationships with many of their patients, the scope for individual personal relationships is changing, despite the best efforts and intentions of many GPs, as practices seek to meet the demands from the National Health Service (NHS) administration, which has engendered more of a business mentality in general practice and health services.

Since the 1980s, the patient has become a 'consumer' of medical services. This reflected the prevailing culture and increased assertiveness of the individual in business dealings which empowered the consumer and, for example, turned rail passengers into customers. It is evident that the power relationship between doctor and 'patient' has also changed for all time. In transactional analysis terms, the traditional parent–child relationship is no longer viable. This is not to say that it did not have advantages, and probably little consideration has been given to the role this relationship played in limiting demand in the NHS, which is a major issue for all governments. In our research on patients' attitudes and expectations in the treatment of RTI,[3] we found that British patients are among the least 'demanding' for antibiotics out of the nine countries studied, which may come as a surprise. The fixed, long-term relationship, created by the British system of registering with one particular GP or practice, was instrumental in stopping patients shopping around, which in other countries raised their expectations of obtaining antibiotic treatment.

The issue is how should GPs react to this changing status of their patients as consumers: How should they interpret the new relationship, what changes do they need to implement in order to handle the altered status, and how can they positively develop the relationship in a way that is mutually viable and satisfying?

It is all too natural to feel depressed and alienated as working practices and relationships change around doctors without their instigation and beyond their control. The consumer-supplier relationship can easily appear as master–servant to the overworked and stressed employee in any business. One automatic reaction and self-defence mechanism is to develop stereotypical images of patients that focus on those who cause the most grief (demanding, manipulating, exploiting, off-loading, leaning, neurotic, aggressive, and so on) and to overlook the ordinary majority.

In response to the changing relationship, the focus should be on the range of needs which patients are seeking to satisfy in their relationship with the GP and their expectations of the doctor. It is then up to GPs to decide how best to meet those needs and which of them are an acceptable basis for the doctor–patient relationship.

In any analysis of the best way to handle the evolving doctor–patient relationship, we need more in-depth information about the patients' perspectives on the consultation and their aims as active agents in their own medical welfare. The paper by Cromarty entitled 'What do patients think about during their consultations? A qualitative study',[6] published in this issue, shows that the real patients of 'middle England' do not fit many of the stereotypes. They are concerned about the doctor's time, respect the value of it, and limit their consumption to what is 'fair' (in terms of the demands on their GP and the needs of fellow patients) despite their eagerness for insight into their condition. They seek to maintain a good, long-term relationship with their GP.

The main need for the patient in the consultation is for self-understanding of the complaint and its implications for their well-being. However, what Cromarty's paper shows is that patients need to be able to satisfy themselves about the information and advice they are being given. Patients, and consumers

generally, no longer take what is said on trust so they scrutinize the doctor's behaviour for signs and meaning. The proper response for GPs (as in other businesses) is to examine what are the best ways of giving patients confidence. The patients' criteria for a satisfactory consultation depend more on the social skills of the GP than their medical expertise.

At first sight, Cromarty's paper may not seem to comply with the experiences of inner cities; however, many practices in those areas will recognize the same characteristics in their patients. It is not of importance whether Cromarty's type of patient exists everywhere, or in what proportions, but it is necessary to recognize that there is a range of doctor–patient relationships in any practice and to evolve a range of strategies to handle the expectations of these different types of patients.

There is a potential repertory of approaches towards patients: sharing control and giving patients choices (e.g. over whether to have a prescription); moving responsibility back to the patient for their own health; establishing 'contracts' with difficult patients; and making the requirements for what is expected from patients (e.g. non-smoking) more explicit. However, it still seems that the approach adopted is characteristic of the doctor's style and personality rather than a repertory which each GP judiciously applies to meet the needs of different patients. The challenge is to adopt an approach to fit each particular doctor–patient relationship and the varied needs of the patients from each consultation. Cromarty's paper makes a start by producing in-depth typologies of the real needs of patients on which differential relationships can be built.

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We are pleased to welcome Dr Graham Dunn, who became the *Journal*'s new statistical adviser at the end of July. Dr Dunn received his PhD at Herriott Watt University, Edinburgh. He is currently Head of the Department of Biostatistics and Computing at the Institute of Psychiatry in London. At the end of the year, he will take up the post of Professor of Biomedical Statistics at the University of Manchester. Dr Dunn has recently written a textbook on evidence-based medicine (Dunn and Everett, 1995), and is co-editor of a new international review journal, *Statistical Methods in Medical Research.*