Lessons from nostalgia

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Clin Med JRCPL 2002;**2**:263–266

The present administration has not completely abandoned the policies of the period 1980–1995, which despoiled what was in 1970 a well-functioning and economical national health service (NHS). I had the joy of working as a physician in the service from the beginning until the early 1970s, after which I became a functionary in the then Department of Health and Social Security (DHSS), something which I also contrived to enjoy, but with greater difficulty. From this I was rescued in various ways which are not relevant to the present purpose. But my unusual blend of clinical experience and exposure to departmental administration perhaps qualifies me to be more than a spectator of the present discontents (which are of course magnified by pressure groups and by the media, and also exploited by politicians, often to their unintended disadvantage).

Even apart from the political turmoil, the NHS in 1948 faced real initial difficulties. The demand for care, once it had been made free of cost at the time of need, was grossly underestimated; rancour did not die away overnight and a very large and complex system did not emerge fully armed like Pallas Athene from the head of Zeus. But over the next 25 years the service gained the trust of patients, and the strong support of doctors. However, in the early 1970s new treatments, which were effective but also costly, together with increased ill health in an ageing population, brought increased demand and consequent costs with which funding failed to keep pace.

The National Health Service Reorganisation Act of 1973, introduced by Keith Joseph, was the first major step in a long series of vain attempts to improve function by tampering with structure. This Act abolished the boards of governors, which might have proved a rational way of favouring selected hospitals; and created the short-lived area health authorities. Worse was to come in the 1980s. Advised by a confident manager who apparently could not tell the difference between a business and a service, or appreciate that in a service a consensus style of management might be more effective than 'line management', Margaret Thatcher, the then Prime Minister, set in train the process which led to the disastrous reorganisation of the early 1990s, the central step in which was the introduction of the 'internal market', a device which has helped to give the USA the costliest health care system in the world.

These events, which I have outlined briefly, have been described thoughtfully and readably by Charles Webster[1]. Using the extensive material garnered during the compilation of the official history of the NHS up to 1979, he has produced in *The National Health Service: a political history* a book which remains authoritative but is free of the shackles of official history.

New Labour deserve credit for recognising, admitting and to an extent palliating the underfunding of the NHS in comparison with other developed countries; and for doing away in part with the internal market – though not, unfortunately, the unnatural divisive 'purchaser–provider' split. They deserve no credit for their enthusiastic recourse to private funding: funding from general taxation is visible, equitable and accountable; private funding is opaque, uncertain, and likely to prove expensive – finance companies are not charities. But the weakest part of the Milburn plan lies in the selection of 'best' hospitals. The 'league tables' focus on the mechanics of health care, which are important, but not the most important aspect of health care, which is outcome. For hospitals, good outcomes largely depend on the relative affluence of the areas from which their patients are drawn, and on admitting from among them, by accident or even design, those most likely to do well. The actual quality of care depends on the calibre, training and morale of doctors, nurses and other health professionals. In comparison, sharp management, keeping the books and public relations 'spin' are of small account.

What might be the key steps in repairing the damage? There can be no rapid fixes, but over time real effort must be made to enhance the professionalism of 'health professions'; to increase their influence on the running of the service; to establish a clear method of handling possible complaints; to remove the internal pseudo-market; to increase local influence on health care; to shift to some degree energy and resources from the pursuit of the bad (a small minority) to the creation and encouragement of the good; and to re-assess the legitimacy of a consumerist approach to health care. Some of these have already been touched on, but I would like to comment more fully on the effect of consumerism on health care, and on the role of health professionals in the NHS.

Consumerism

When I qualified in 1936, paternalism ruled – doctors gave 'orders' for patients to 'be under'; and the worst doctors added the insult of arrogance to the injury of a fee. Something had to change; and a milestone on the way came in Ian Kennedy's Reith Lectures[2] in which, speaking as a surrogate for patients, he said: 'We must be the masters of medicine'. So now the talk is all of 'partnership', 'fully informed consent' and 'patient autonomy'; and the government show no wish to be left behind in these pursuits. Prior written consent for feeling a pulse or looking at the tongue is apparently on the cards.

Might there be the merest scintilla of a possibility that things might have gone too far in this direction? The work of most doctors entails many consultations with patients (or 'encounters with clients', as sociologists would say). Are doctors to start off by saying, 'Please sign this before I touch you'; or, as seems more likely, will they delegate what to almost every patient must appear as a formality? A lawyer might well question the validity of written consent so obtained, and require 'witnessed consent'. And the consent, however obtained, would be useless in the vast majority of circumstances, and probably invalid when it was actually needed.

When I was in practice, I always saw it as part of my duty to see that the patient understood the nature of their illness, and the rationale for and implications of any recommended procedure. The history, examination and investigations required to establish these matters appeared to me to be justified by the patient's decision to consult me. But the concept of 'implied consent' is anathema to those who look at the ethics of practice through windows.

Waste of time is not a negligible evil to busy people; but there is a more serious objection to exposing medical practice to the full force of consumerism. This has been set out thoughtfully and clearly in a book on clinical judgement[3] written by a moral philosopher and a general practitioner in combination. (The notion that joint authorship with a doctor might be helpful does not often occur to 'opinion formers' on health care.) Kant maintained that 'proper choices' (exercises of autonomy) should be rational; and, using language as a weapon, dismissed choices not grounded on reason as 'heteronomous'. However, J. S. Mill included among proper choices those based on simple preference, with no necessary rational basis. To clarify the distinction, Downie and Macnaughton[3] point out that someone buying shoes can demand a particular pair, even if the salesperson has advised that they are unsuitable; that is the ethics of consumerism. In a medical consultation, the patient can refuse a treatment proposed by the doctor – that is his/her right, but that right does not extend to demanding a treatment which the doctor advises as being unsuitable or even harmful. To say 'yes' to such a demand would be to follow the ethics of consumerism. To say 'no' is proper, even mandatory, within the ethics of professionalism. In the particular case of the doctor–patient relationship, within which the training and experience of the doctor should make him/her the more expert, the professional ethic is surely more appropriate ethically than the consumerist one, as it is less likely to lead to harm. A similar preference could be reached pragmatically, on grounds of health economics, or of the effect on waiting numbers and times used by government as a crude index of 'performance'.

For doctors and others in health care, unbridled consumerism wastes time, and may be a minor nuisance on that account. Much more important are the risks to which it exposes patients. For all the emphasis laid on informed consent, that is much less critical in the all-important outcome than properly informed choice. Such a choice is not best made by surfing the net, or by 'walk-in' or 'direct' facilities; but by discussion with someone who has the necessary training and knowledge to give sensible advice. Of course, there are injuries and ailments for which a simple approach is adequate; and with an established problem 'skill-share' makes an appropriate contribution. But there are also difficult problems, and sometimes what appears to be a simple problem can become difficult; in such cases, a proper consultation early on can save much future trouble.

Professionalism

The image of professionalism is much less important than the actuality, but it may not be insignificant in its influence on public esteem. So it has to be conceded that the professions, and perhaps medicine in particular, are not well portrayed. At one extreme, the 'hospital soaps' display quotidian miracles; at the other, bizarre incidents of malpraxis (and at least one serial killer) are emphasised repeatedly, with no explicit caveat that they are totally unrelated to the actuality of ordinary practice, or indeed to each other. Limited reassurance may come from surveys which indicate little change in expressed views on doctors and nurses. The government, however, appear more susceptible to criticism of doctors by pressure groups and the media, and in response have set up costly surveys and organisations which do little for the generality of health care except to make it more difficult. (I except the National Institute for Clinical Excellence, which at least has a clearly defined function.)

To be a member of a profession is to enjoy a privilege, and to accept a duty, which is to put the interests of one's 'client' above one's own. As always, the ideal is bounded by what is reasonable. That applies to all professions. For the doctor and nurse, individually and collectively, the specific duty is, as Sir Alan Parks put it, 'to maintain clinical standards in the interests of patients'. Now we all at times fall well short of the ideal; but still it is better to have an ideal at which to aim than simply to pursue the main chance. In my view, ideals of the type I have tried to outline have not been supported by the increasingly mercantile and managerial style of the NHS in the past two or three decades.

To give specific examples, when things went wrong clinically the consultant saw the patient or relatives directly, instead of the 'complaints procedure' being formalised and bureaucratised. This did not, of course, annul the patient's civic right of recourse to the courts; but it commonly satisfied (and helped) those whose complaint truly represented a wish to lessen the chance of

recurrence of a similar incident. Similarly, consensus management ('Cogwheel' for those who remember it) included an advisory group of doctors, whose views carried some weight; whereas the Griffiths system of 'line management' could be caricatured as a low-resistance channel centred on Whitehall. Local representation was real – appointments committees in our hospital were chaired by a splendid Mancunian called Alderman Onions.

When I entered the DHSS as Chief Scientist, I chose an advisory rather than an executive role, and was much criticised for doing so. But I still believe that people brought into an organisation because of a particular expertise are in a truer, and possible more effective, position if they elect to be advisers rather than executants. Even in the clinical situation they should be giving advice, and not dictating. The same principle applies, I believe, to the role of doctors and other health professionals in the running of the NHS. They should be giving advice, based on their training and experience, not exercising on-line responsibilities for which they have not been trained, even if they may have had a late-life injection of business jargon.

These are serious matters. But relations between 'professionals' and 'administrators' used to be informal and unthreatening (as of course they can still be, given a bit of common sense). To give a trivial example, I once told our hospital secretary (formerly in the Civil Service in India) that he should have printed a certain memorandum on rice paper, so that he could more conveniently eat his words.

References

1. Webster C. *The National Health Service: a political history.* Oxford: Oxford University Press, 1998.
2. Kennedy I. *The unmasking of medicine.* NSW, Australia: Allen and Unwin, 1981.
3. Downie RS, Macnaughton J. *Clinical judgement: evidence in practice.* Oxford: Oxford University Press, 2000.