# From the Editor

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## Frustrations in clinical practice

> *To each one of you the practice of medicine will be very much as you make it – to one a worry, a care, a perpetual annoyance; to another, a daily joy and a life of as much happiness and usefulness as can well fall to the lot of man.*
>
> (William Osler)[1]

Many of the best and brightest students across the globe are attracted to a career in medicine, with a thrill of the expectation that they will experience a life of 'happiness and usefulness' in the care of those who need them. On the day of graduation they are prepared to accept professional responsibilities to their patients and the institutions in which they work. Yet today there are numerous obstructions to the ideal. Imbalance between rights and responsibilities of government, patients and doctors is damaging the key interface of clinical practice – the doctor–patient relationship. Frustrated expectations in clinical practice together with increasing imposition of the rights of the individual, which so often mitigate against the rights of the majority, can diminish the 'daily joy' of practice, and can lead rather to a 'perpetual annoyance'.

The government focus on a patient-led service is in fact threatening to destabilise the doctor–patient relationship. The government's concept of a 'personalised health service, one in which the patient takes control of decisions about the prescription of medicines and the selection of surgical procedures', is in the words of a *Lancet* editorial, 'manifest nonsense'.[2] Two essays by young physicians (winner and runner-up of this College's Teale Prize) published in this issue of *Clinical Medicine*[3,4] exactly illustrate the imbalance of rights and responsibilities in the NHS. Patients and governments overwhelmingly have rights, while doctors carry the burden of frequently conflicting responsibilities with inadequate rights. They are responsible not only for many individual patients, but also for their colleagues in the teams in which they work. Patients' rights must be respected, yet they must appreciate that what they perceive as their 'rights' may conflict with other considerations, such as those of other patients. Doctors are now also frequently presented with government targets which can can and do lead to conflict with best clinical practice.[5] These simplistic concepts – rights and targets – may at one and the same time deceive the public, whilst disenfranchising the very patients they are aiming to help.[4]

### *Doctors' rights*

While doctors are burdened with heavy and much regulated responsibilities, their rights have been neglected in part due to the simplistic emphasis on patients' rights. Doctors after all have a right to working conditions appropriate for the delivery of optimal care for patients by their healthcare teams. It follows that they should be involved at the outset in planning new developments, and should be able to influence the infrastructure needed to support their work. The failure of the NHS to provide doctors with high-quality secretarial and clerical support is a long-standing disgrace which often results in wholly inadequate, sometimes nonsensical, communications with patients and the wider public. At a recent outstanding College conference, 'A Shared Agenda',[6] Sir Nigel Crisp did indeed observe the duty of our managers to provide an appropriate working environment for doctors and healthcare teams, but he did not elaborate. Yet in the Healthcare Commission's recent report, *The state of healthcare 2005*,[7] while patients' needs are given appropriate emphasis, there is no acknowledgement of the needs of those delivering healthcare services.[8] Indeed, a recent comment from

the NHS Alliance observed that all frontline clinicians may have been neglected in planning and running local services to the point that 'instead of beiing in the driving seat, they could get dumped at the roadside'.[9] And it must in the past have been political correctness which led to the destruction of the doctors' mess, the only place left where doctors could communicate professionally and – so essentially – in confidence with each other.

### *Doctors and managers*

Managers and doctors certainly share a common goal, and need to work more closely together in planning for their specific needs – a necessary collaboration, all too frequently neglected. Indeed, the critical gap between management and medicine[10] can result in poorer outcomes for patients when care becomes 'chaotic and unsystematic'. Dame Carol Black has suggested the introduction of a specialty of medical management, which could enhance both expertise and relationships. At present, the shifting sands of middle managers of variable quality who frequently come and go can make it difficult to develop the mutual trust which, as in any relationship, is the key to success, and always damaged by over regulation.[11].

### *Redressing the balance*

The imbalance of rights and responsibilities needs to be addressed if morale among healthcare professions is to improve. Doctors too require rights, while patients also have responsibilities to follow advice agreed within the partnership of the consultation. Whilst of course retaining the option to question advice, patients must also consider the rights of doctors who have to care for others. They also need to respect doctors' skill and expertise; Tallis has suggested that we may need to renegotiate with society as to where expert authority exists.[12] This College's Working Party on Professionalism, and its Patient Involvement Unit, are perhaps uniquely placed in examining this balance and helping to maintain the doctors' 'happiness and usefulness' in their daily practice.

## References


1 Osler W. The student life. In *Aequanimitas with other addresses.* London: HK Lewis, 1926:443.
2 Editorial. The unspoken issue that haunts the UK general election. *Lancet* 2005;**365**:515.
3 Reckless I. Patients and doctors: rights and responsibilities in the NHS (1). *Clin Med* 2005;**4**:499–500.
4 Smith M. Patients and doctors: rights and responsibilities in the NHS (2). *Clin Med* 2005;**4**:501–2.
5 Comment. Targets can kill. *Sunday Telegraph*, 10 April 2005:22.
6 Goose M. A shared agenda: doctors and managers. *Clin Med* 2005;**4**:510–13.
7 Healthcare Commission. *The state of healthcare 2005.* London: Healthcare Commission, 2005.
8 Editorial. Will consumerism lead to better health? *Lancet* 2005;**366**:343.
9 NHS Alliance. You can't run the NHS without frontline clinicans. Press release, 8 September. London: NHS Alliance.
10 Edwards N. Doctors and managers: is there a problem? *Clin Med* 2005 (in press).
11 O'Neill O. Accountability, trust and informed consent in medical practice and research. *Clin Med* 2004;**4**:269-76.
12 Tallis R. *Hippocratic oaths: medicine and its discontents.* London: Atlantic Books, 2004.


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# Erratum

**In the July/August 2005 issue of *Clinical Medicine*, there was an error in the CME Haematology paper, 'Strategies for reducing the exposure to donor blood', by Mike Murphy, page 337, col 3, para 1.**

The following sentence:

'The incidence of viral transmission of HIV, HBV and HCV is 4.58, 0.41 and 22.09 per million blood donations, respectively'

should have read

'The incidence of viral transmission of HIV, HBV and HCV is 1 in 4.58, 0.41 and 22.09 million donations, respectively'.