OCCASIONAL PAPERS

Choice and responsibility in the NHS

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ABSTRACT – Patient choice is becoming the centre of health policy in the UK and other countries. But there is ambiguity about what choice means. As the term is used in everyday life, choice is the foundation of the doctrine of patient consent. The doctor is responsible for choosing appropriate treatment, and the patient is responsible for choosing (for consenting to or refusing) what is offered and accepts responsibility for that choice. That simple and ethically acceptable doctrine is being replaced politically by consumerist choice. But consumerism in healthcare is incompatible with a publicly funded service. Moreover, consumerism changes the locus of responsibility from the doctor to the consumer (the patient). The doctor will cease to have the values of a professional and will become simply an agent of the patient's demands.

KEY WORDS: choice, consumerism, equity, motivation, professionalism, responsibility

It is widely believed by politicians of all persuasions that patient choice is the answer to the ills of the NHS. Two claims are commonly made: patients want more choice and granting them choice will improve the performance of the NHS. As Patricia Hewitt, former secretary of state for health, said, patient choice will be at the heart of an evolving NHS in the next decade.[1] But do patients really want more choice, and what are the wider implications of the choice agenda for the NHS and indeed the profession of medicine?

Do patients want more choice?

The first question has at best an uncertain answer. According to the consumer magazine *Which*, 89% of respondents agreed that access to a good local hospital was more important than having more hospitals to choose from.[2] And the UK Public Administration Select Committee advises caution rather than a wholesale embracing of the language of choice.[3] It is therefore by no means obvious that more choice is at the top of the public's NHS wish-list. These are empirical matters with uncertain and variable answers.[4,5] More interesting are the wider issues raised by the choice agenda.

Choice in everyday language and contexts

It is important to stress at the start that choice is a term in ordinary language and its meaning is governed by linguistic conventions and assumptions. In ordinary language a choice is what we make when, for example, we look at a restaurant menu. A range of options is presented on the menu and the diner chooses which dish to eat. This ordinary concept of choice entails four conditions, encapsulated in the acronym FAIR:

- freedom – it is not in the true sense a choice if the person is coerced
- alternatives – such as different options on the menu
- information – such as a brief description of the dish
- responsibility – the chooser takes responsibility for an informed choice from alternatives.

This understanding of choice in ordinary language is the basis of the traditional concept of consent in healthcare. In the traditional concept of consent, the patient is offered treatments with a reasonable prospect of benefit compared with harm and risk. The doctor gives information about the various treatments and the patient is free to consent to or refuse each of the treatment alternatives, and is responsible for that choice. The General Medical Council (GMC) makes it clear that the doctor must offer only those treatments where it is expected that the benefit will exceed the harm or risk, and the doctor must avoid offering 'those treatments where there is no net benefit to the patient'.[6] Once the patient has chosen from the treatment options offered, the doctor's responsibility is to carry out the treatment to which the patient has consented.

This traditional model of consent became widely accepted in the second half of the 20th century, and it can be seen to be a logical extension into medical contexts of the everyday notion of choice. Moreover, the model has proved ethically acceptable, and has had good moral consequences, including shared responsibility for decisions.

Consumer choice

The ordinary notion of choice (which entails consent) has, however, now been extended in the context

of the 'free market'. This extended notion of choice or 'consumer choice' has five conditions which can be encapsulated in the acronym CHARM.

Competition. In the free market, there are two kinds of competition in which consumer choice occurs. The first is competition to attract customers between the suppliers of goods and services. For example, there is now competition between different companies who sell gas and electricity. The second sort of competition occurs between the consumers themselves and the supplier. The consumer wants the best deal possible and the supplier wants the best profit possible. Competition is thus an essential feature of consumer choice. It must also be remembered that effective competition in the free market requires advertising.

(Protection from) harm. Partly because of the cut-throat nature of competition the law has to provide safeguards. Thus, toys must not contain lead and cars must be safe on the road. In order to reduce harm and protect the consumer from deception the information provided about the goods and services must be adequate and truthful.

Alternatives. In the free market the range of alternatives is limited only by what it is possible to provide. In fact, the consumers actually drive the range of goods and services which are available as alternatives. No other person or agent is responsible for limiting the range of alternatives which is available to the consumer.

Responsibility. The consumer, having been protected from harmful goods and provided with adequate and truthful information about the alternatives, bears responsibility for choosing the goods.

Money. When the consumer hands over money the transaction is completed.

Consumer choice and the NHS

This concept of consumer choice is now widespread in the developed world. In wealthy nations there is a belief in consumer choice, almost as some kind of human right. Governments in the UK and elsewhere have tried to tap into this belief and are trying to model all public services on the consumer choice basis.

Does consumer choice work in the NHS? In answering this question we shall bear in mind that the NHS as a service has two essential features: it is publicly funded and provides healthcare. Assuming these features the consequences which logically follow from introducing the consumer choice model into the NHS will be considered. Many of these consequences have already followed, and the issue worth discussing is whether they are morally desirable.

Competition

Competition is already noticeable. Hospital trusts compete to acquire business, and the government has artificially inflamed competition not only by encouraging the creation of independent treatment centres but also frequently by subsidising them financially to make sure that they are viable.[7] At the same time, patients are encouraged to get the best deal by consulting league tables which claim to show which hospitals and consultants are performing well. Such league tables give information about, for example, waiting times and methicillin resistant *Staphylococcus aureus* infection rates. But there are some problems associated with trying to introduce competition in the NHS.

Equity. Many patients are elderly and cannot travel. They will therefore be disadvantaged in attempting to travel to the much-vaunted centres of excellence. Secondly, by definition patients are sick. The sicker they are the less able they are to travel and perhaps the less energy they have to exercise their competitive role in getting the best deal. Thirdly, patients who require urgent care via accident and emergency (A&E) services are in no position to exercise much choice as they will probably have to go to the nearest service. It is impossible to choose the best hospital with the shortest A&E waiting times or best clinical performance. So it would seem that very sick patients are those least able to avail themselves of consumer choice.[4]

Economic consequences follow from the need to provide enough competing services. The requirement for multiple providers tends to entail the provision of spare capacity and this is very expensive. Furthermore, it appears that taxpayers' money has been used to subsidise independent providers in order to artificially create the competition.[8] Both the high cost of having spare capacity and the subsidy of independent providers, all using taxpayers' money, are significant moral problems in the health service. Healthcare is inevitably rationed in the NHS and resources spent on the creation of competing services are therefore not available to provide treatment and care. The creation of competition is therefore not cost effective.

Quality of care may be jeopardised in a competitive market. The providers are trying to achieve the goal of providing a service at the lowest possible cost. This imperative is overwhelmingly likely to compromise the quality of patient care and safety. Government rhetoric speaks of driving up standards of care. But those who work in the service know that, in reality, the necessity to drive down costs, or at least to provide a service within the national tariff, works contrary to the interests of improving the quality of care and patient safety. This consequence is obviously of great moral importance in the NHS.

Advertising. Competition does not work without advertising but advertising goes against the whole professional tradition. Imagine commercial breaks saying, 'Come to us for a hip replacement – because you're worth it!'

Competition in the context of a publicly funded NHS therefore leads to inequity, needlessly consumes resources, compromises the quality of care, and inevitably leads to advertising which is at best undignified and distasteful (and is currently not allowed by the GMC).

Protection from harm

Consumer choice requires that the goods and services provided must not in themselves be harmful and the consumer must be provided with adequate and truthful information about them. At first sight, it would seem that this condition would safeguard patients from harm in the NHS. But this does not follow. In consumer choice in the NHS the patient would actually be able to choose from all the technically feasible options. So it would be possible for patients to choose treatments where the harms and risks exceeded the benefit in their case.

Now it might be claimed that this situation would never arise in the health service because patients would not be allowed by doctors to choose treatment options where doctors expected harm and risk to exceed benefit. In recent years, however, some trends have shown us how such a development could take place. For example, the GMC guidance on provision of cardiopulmonary resuscitation (CPR) states that 'you should usually comply with patients' requests to provide CPR, although there is no obligation to provide treatment that you consider futile'.[6] This sentence implies that if the patient wishes it, it might be acceptable to attempt CPR even when doctors know it will not work, simply because the patient wants it. Indeed, we know that relatively few attempts at CPR are successful but the GMC guidance informs us that we should usually attempt CPR if the patient asks, simply because they wish it. The British Medical Association gave similar advice.[9] There are other examples of this trend to give precedence to choice over minimising harm. To the extent that this is happening it is a departure from the bottom line of all medical ethics: *primum non nocere*.

Alternatives

If this model of choice were introduced into the NHS then patients would be able to choose from the entire range of treatment options which are technically possible. This is quite different from the current situation where doctors offer only those treatment options which have realistic potential to provide net benefit to the particular patient, and those which have been adequately tested and are judged to be affordable in the context of NHS resources. But, logically, the introduction of consumer choice into the NHS requires that the whole range of treatment be made available to patients. It is difficult to see how this can be achieved either in terms of money or in terms of manpower in the NHS.

Responsibility

In the consumer choice model the consumer takes full responsibility for the choice. In contrast, in the traditional model of choice and consent, the doctor takes responsibility for determining the options which would be offered to the patient, while the patient takes responsibility for consenting to or refusing the various options. The traditional model of choice could justifiably be described as joint responsibility, since each party has responsibility for different aspects of the decision. In contrast, in the consumer model the patient must take full responsibility. The clear implication is that the law would have to be changed to remove from the doctor the responsibility for the outcome of a treatment which the patient had chosen and where the doctor had no right to refuse to provide it. If consumer choice were accepted in the NHS then logically the responsibility must pass entirely to the patient.

Money

Consumer choice would require patients to pay for the treatment they chose. But the NHS is different – every taxpayer contributes to the funding but individual patients do not pay the cost of the treatment they have chosen. The model of consumer choice is logically incompatible with the model of a publicly funded healthcare service. Many of the current problems in the NHS arise out of the fact that what exists at the moment is an inconsistent mixture of the traditional system of state provision and the newer ideas of consumerism. But you cannot graft the new ideas on to the old in this context. The outcome is not a fresh growth but a monster!

The implications of a healthcare system based on consumerism

Finally the implications of consumer choice in healthcare are considered. What would a true consumerist healthcare system be like? It would have three implications of major importance in the ethics of healthcare.

Consent

In the traditional model the doctor offers only those options believed to provide net benefit and the patient consents to or refuses what is offered. In contrast, in the consumer model the patient is requiring the doctor to provide what the patient wants and the patient is then not consenting to the treatment but authorising the doctor to carry it out. The doctor has become merely the agent of the patient. It might be argued that the doctor could conscientiously object to carrying out a treatment requested by the patient when the doctor judged that the foreseen harms and risks were very likely to exceed the benefits. But note the extraordinary paradox: in this situation the doctor has become the one who consents and the patient the one who authorises.

The concept of a profession

A doctor or nurse would become simply a purveyor of goods and services, like a plumber, a garage mechanic, or a shop assistant. A doctor would not be required to have the values of the profession, or to exercise professional judgement. For example, the medical professionalism report produced by the Royal College of Physicians expects doctors to have the qualities of compassion, integrity and altruism.[10] But these qualities do not feature, and would be out of place, in the consumer choice

model. Consumerism has its own ethics and responsibilities, but they are quite different from those of professionalism.

Motivation

Perhaps the most serious consequence of implementing consumer choice in the NHS is that it would lead to a change in motivation among professionals. In the consumer choice model the provider of the service is motivated less by a desire to improve the overall welfare of the consumer than to provide goods and services which will satisfy the consumer's requirements at the lowest possible cost to the provider, thus achieving a financially acceptable profit margin. Indeed, the situation is worse than that. The wages of many sales assistants are at least partly based on commission. In a similar way the salaries of general practitioners at present are at least partly based on their success in performing an assortment of tests on patients to achieve a target coverage. Trust is the foundation of the doctor–patient relationship and patients still believe that their doctor is uniquely concerned with their health. Will this continue to be true when patients are seen to be a means of gaining more income for doctors when they achieve a target?

The fear is that consumerism in the NHS will weaken the unique trust that patients must be able to place in their doctors. Furthermore, it will actually destroy the concept of medicine as a profession.

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