

# The patient–doctor partnership over 60 years and the role of the royal medical colleges

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**ABSTRACT – The key to any successful healthcare system is the recognition of the inseparable partnerships between the individual patient and their doctor. Diseases can be studied in populations but in contrast, patients are individuals and must be respected as such. There are several reasons why this partnership has been eroded as the NHS evolved over the last 60 years. Until the importance of this partnership is recognised, quality of patient care will not improve. There is an urgent need for government, management, the medical regulators, the profession and patients to work together, mutually respecting and trusting each others' complementary skills, responsibilities and needs. Consultation with any of these groups alone has not and will not resolve the problem. The colleges working with patients now have a leading opportunity to ensure that whatever changes are introduced into the NHS, this crucial partnership is recognised as the enduring linchpin in quality medical care of patients.**

Despite the enormous changes, for better and worse, that have occurred over the last 60 years in the evolution of the NHS the fundamental issue for patients has not changed – their need for a strong and secure equal partnership with their doctor. Of course many other relationships can and do work well. For example, care delivered by district nurses in the community and care by specialist nurses, physiotherapists and others in selected fields of medicine. However these do not replace the need for well-trained doctors with diagnostic and therapeutic knowledge and professional understanding, to integrate the whole body of information, so that quality care plans can be developed which are suitable and agreed with the individual patient.

This partnership between the individual patient and their doctor must be nurtured in any successful healthcare system and there must be mutual understanding and trust between the roles of the professional doctors and the NHS management teams, including government (Fig 1). The quality of professional medical practice and training standards have been developed by the medical royal colleges over decades (in some cases over centuries) and is regulated independent of government by the General

Medical Council which now has a majority of non-medical members.

The NHS is a model of healthcare management funded through taxes by the Treasury and was developed to provide free healthcare on the basis of need to everyone in the UK. It is managed by the Department of Health (DH) and they in turn are accountable to the secretary of state, appointed and accountable to parliament.

The success or failure of the NHS in the end will depend on the subtle balance between the role of the professionals and politicians/management caring not for themselves but for the patient–doctor partnership. If either of these two components waiver or tries to dominate the relationship the NHS model will fail. As Baroness O'Neill said in her Reith Lectures:

*If we want a culture of public service, professionals and public servants must in the end be free to serve their patients rather than their paymasters.<sup>1</sup>*

## The role of the royal colleges

The primary role of the medical royal colleges is to maintain the quality of medical practice by professionally trained doctors in the care of patients. They are independent bodies and are not trades unions who act in the personal interest of doctors. The colleges promote quality through well-researched reports, by setting training programmes for various types of generalist and specialist doctors. They ensure these standards are achieved through a range of formal examinations which are compulsory before doctors can practice in various capacities or become members of their college. They also assist in setting standards internationally and they advise government by working through the DH or directly with politicians when necessary. It is crucial to the NHS that these channels of communication work freely and well and it is the responsibility of doctors and government to ensure that these channels are maintained.

The Royal College of Physicians (RCP) has been addressing standards of care for patients for nearly 500 years. Its role in the NHS has extended over just 60 years – some 12% of its lifespan. The NHS is only one model of healthcare; the RCP as an independent

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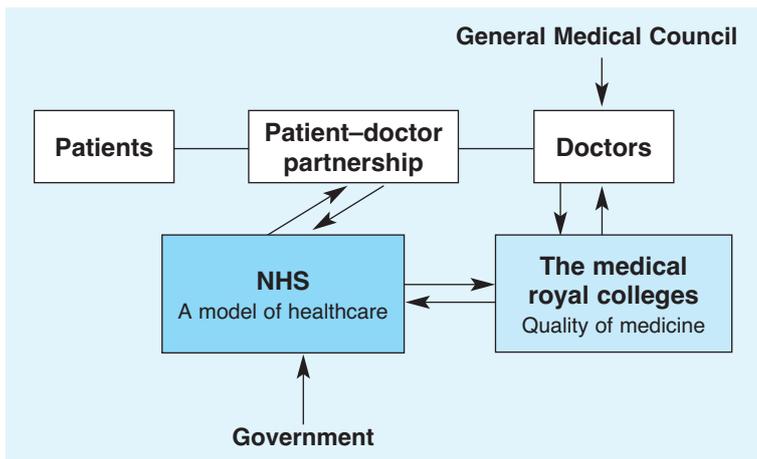


Fig 1. Healthcare and the NHS: aims and ideals.

body is about professional standards in medicine in its entirety and this responsibility extends far beyond any one management system.

The first to promote free healthcare for all was the British Medical Association (BMA) in 1929. The proposal was to extend insurance of families of workers as well as the workers themselves covered by the Lloyd George National Insurance Act 1911. The Emergency Medical Service was planned in 1936 and implemented in 1939 when bombing of London and other cities became a reality in the second world war. In 1940, Sir Robert Hutchinson, President of the RCP, asserted the rightful position of the royal medical colleges as advisers to government (thus establishing the relation between the profession and government shown in Fig 1) before the NHS itself became established.

The Beveridge Report (1943) introduced various social reforms including the concept of free healthcare for all in the UK. The governing body of the RCP supported government at this time on this concept and the National Health Service Act 1947 was created. The BMA, representing the majority of general practitioners (GPs), was against the terms and negotiated a compromise for GPs to become independent contractors; an arrangement, which still remains. The support for the NHS by the RCP was varied. Many ex-service doctors, who were more used to the disciplined framework of employment in the armed forces, were generally in favour. They were being demobilised and were desperate to find consultant posts. Under the circumstances they were willing to accept employment anywhere in the UK, a major contributing factor which resulted in well-trained and experienced doctors staffing the NHS throughout the country.

### Early days of the NHS

The early management arrangements were relatively simple. The hospital budget was historically based, it was managed by a small number of relatively poorly paid administrators and the doctors were a dominant voice in what care should be provided. The quality care for patients depended on the commitment of

individual consultants and there was minimal quality control or accountability.

The management of hospital patients was based on small clinical firms headed by the consultant who was responsible for his own group of patients. In teaching hospitals these were often part-time appointments which allowed them to continue with their private practice. They were supported by a full-time registrar who was gaining experience before being considered for a consultant appointment. They in turn were supported by a full-time houseman (they were mostly men) who served six-month appointments virtually without time off. Housemen cared for a small number of patients who were in hospital for quite long periods of time. Only limited emergency resuscitation measures were possible, the night sisters were very experienced, and selective about when we were called and we therefore got a reasonable amount of sleep. There was

a highly experienced resident assistant physician who was usually around until midnight and there was great support from other members of the 'doctor's mess'.

The NHS in the early days was cost effective (around 6% of the gross domestic product (GDP)) compared with other countries where up to 10–12% of GDP was spent on healthcare. Patients had real freedom of choice in that they could ask to be seen by any consultant at any hospitals and consultants themselves had no constraints on who to treat. There was, of course, inequality of standards around the country where specialist services were of variable standards, but this was in part compensated for by the free access to tertiary care hospitals and specialist services clustered around teaching hospitals for anyone who was willing and able to travel.

The royal colleges were responsible for developing training standards and setting the examinations to assess competence, which were compulsory for all consultants. The training periods were longer than today and designed to allow doctors time to acquire experience as well as knowledge. Consultants were often appointed between the ages of 38 and 40. Most consultants at teaching hospitals spent time in research, often in America, during their training and most acquired their doctorate of medicine through the research they had undertaken. They often continued their research as consultants and clinical research flourished. Professional morale was high.

There were, however, a number of disadvantages to the NHS which became apparent within a few years. Little attention was paid to cost control and few attempts were made to educate doctors of its importance. Some doctors had a paternalistic attitude towards their patients and did not encourage discussion or explanations.

The service was often under-managed and run by very small numbers of poorly paid administrators with few management skills. This led to the service rapidly becoming under-funded. Indeed the first review of the cost of the NHS took place in 1956 just eight years from its inception. In order to balance the books there were long waiting lists for treatments especially elective surgery: rationing in disguise. There was undoubtedly consider-

able variation in the range of services available in different parts of the country and lack of equality of care was of great concern to patients and politicians.

As the NHS evolved it came under increasing pressure. The primary cause for this was the huge advances taking place in medicine and its treatment. The development of a range of antibiotics transformed the management of infections. Similar transformations occurred in almost every branch of medicine including the management of critically ill patients in intensive care, advances in anaesthetics, cardiac resuscitation and open heart surgery, childhood leukaemia, medical treatments for peptic ulcers and keyhole surgery.

As treatments became more complex so specialisation increased and the capital costs of special units, equipment, and professional and support staff all increased. In turn this led to an increased demand for better management and better paid management teams. All this was reflected in greater demands by patients whose expectation naturally rose. In response government and politicians felt compelled to intervene in attempts to reassure patients and control costs.

In spite of repeated attempts to reorganise the NHS in a series of radical changes, very often swinging like a pendulum first in one direction and then back again, things reached a head in the early 1990s when government felt that the only way to solve the problems of the NHS was to run it on business principles with hospitals competing for trade and funds. Of course while business, like efficiency, has much to offer in terms of management, sick patients cannot be run as a business where unsuccessful lines are simply discontinued.

At the same time there were many undesirable consequences. For example the compulsory targets on costs and performance were often in conflict with medical priorities and quality of treatment of individual patients. Multidisciplinary teams often meant that patients did not know who was ‘their doctor’. The erosion of patient–doctor partnerships (which should be the cornerstone in any healthcare service) is the most serious consequence of the recent upheavals to the NHS. Real patient choice has not materialised. Government has attempted to take over many of the responsibilities previously undertaken by the professional bodies including handling of the basic and higher medical training programmes. They have also distanced themselves from professional advice on quality of care. This has distorted the balance between the professional bodies and government (Fig 1) which in turn is having serious consequences for the patient–doctor relationship. It is not surprising that the morale of senior and junior doctors is low and many juniors are leaving to use their skills in other countries. This is uneconomical and if allowed to continue, is potentially disastrous to quality of care in the UK.

At the same time the NHS has also come under pressure from other quarters. The European Working Time Directive (EWTD) to drastically reduce the working hours for junior doctors necessitated the introduction of shift work. There is much evidence that in spite of attempts to prevent it, continuity of care for patients and the training of junior doctors have been seriously compromised as a result of EWTD. The DH rulings to radically reorganise and reduce the length of clinical training for doctors has resulted in the earlier appointment of relatively inexperienced consultants who themselves recognise that this puts at risk the quality of care of patients.

### The solution

Firstly, There must be acceptance that patients’ individuality is of supreme importance to the patient–doctor partnership which if disregarded is at the government’s peril. Secondly, there must be understanding and trust in the complementary expertise and responsibilities of doctors, management and politicians. This can be nurtured if doctors acquire greater understanding of the principles of management and managers need to gain far greater comprehension about the basis of professional medical practice and the real needs of patients. Both of these require time and appropriate postgraduate courses. Thirdly, all parties must understand with great humility that our knowledge base in medicine is incomplete and the best we can do is to work together for the sake of the patients optimising with respect each others skills. In order to achieve this there is much for the doctors themselves to do. There is a great need for an accepted leadership so that they can speak with a united voice to government on professional issues and they must rise above their individual specialist or personal interests. They must also insist that their views are heard. On the other hand government must be prepared to listen, include and take heed from proper representation from professional bodies in their decision-making processes. Above all healthy debate and different points of view must be recognised so that neither the profession nor government should expect simply to ride roughshod over the other. They together would then be in a strong position to tackle and make compromises over some of the major financial problems threatening to destroy a wonderful healthcare system which has survived, somewhat precariously, for 60 years.

### Reference

- 1 O’Neill O. *Called to account*. Reith Lecture. London: BBC, 2002.