Time for sharing responsibility in caring

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Modern life is accelerating generally and particularly within the National Health Service (NHS). The Royal College of Physicians has already published guidance on how the consultant physician needs to respond to change1. This article reflects on the ‘time cost of responsibility’ and ‘responsibility for the value of time’. *Time*, like energy, cannot be created but it can be exchanged! The health economists’ concept of ‘opportunity cost’ implies that if you make one choice, you reduce your options for choice thereafter. In terms of time – because there are still only 24 hours in a day – the principle of ‘opportunity cost’ applies particularly rigidly. *Responsibility*, implies a range of meanings from legal liability to moral stewardship; this article is concerned with the latter.

The argument presented here is that the economics of healthcare policy need to take into account the full cost and consequences of the best use of physicians’ time. I do not presume to suggest how my physician colleagues should use their time. It is, however, appropriate to consider the value as well as the cost of the time a physician and patient spend in the clinical encounter, so that the outcome for patient, physician, NHS and society is optimum. Closely linked to this is the responsibility of physicians to become involved in establishing the ‘big picture’ of the sociology of health and medical care.

Sharing responsibility within the NHS

The 50th anniversary of the NHS in 1998 was also marked as its rebirth as (in the words of Prime Minister Tony Blair) ‘a modern and dependable service’. This year sees the establishment of the National Institute for Clinical Excellence (NICE) on 1 April, and the implementation of the principle of clinical governance throughout the NHS3. It is not the purpose of this article to examine the political motivations and financial background that determined the timing of these reforms. Given the accumulation of time commitments – for management, audit, research and development, ethics, continuing professional education and other committee work – there is a significant ‘opportunity cost’ associated with these developments which threatens the personal satisfaction and commitment essential for wise decision making. At the heart of medical care is the quality and duration of *time* set aside for the clinical encounter between patient and physician or other healthcare professional.

Time for listening, searching and communicating

In 1978 Professor Charles Fletcher, known for his pioneering work in communicating with patients and the public on television, published a book entitled *Talking with patients*, which was followed ten years later by a sequel, *Talking and listening to patients*. Both books emphasised that communication should be a two-way affair, rather than doctors simply telling patients what they want them to understand or do. Time for listening is an essential component of the encounter, which needs to be defended in order to secure the most appropriate clinical decisions.

A recent study of the clinical encounter in the USA showed that, on average, doctors interrupted their patients’ narratives after only 23.1 seconds. Eager to ‘bring them back on track’ (ie, to meet the clinical agenda), physicians did not allow patients the opportunity to express their concerns at interview. When patients were allowed to complete their narrative, however, the average additional time needed was only six seconds. There is merit in listening to the narrative of illness not only for the clues to diagnosis but to establish that there really is congruence of the patient’s and physician’s agendas. This appreciation of narrative is being brought to our attention by primary care physicians who generally have even less time for interviewing patients than hospital physicians. The argument that repeated contact increases the chance of the doctor knowing about a particular patient’s problem is diminished if the patient does not see the same doctor each time, though future innovations in patient records might help in part. Central to the doctor’s role, whether primary care or consultant physician, is the need to uncover the cause of the distress. More listening and more explanation obviously takes longer, particularly when motivational interviewing is used with the aim of changing behaviour harmful to health.

The new information strategy for the NHS is encouragingly visionary and will change the way physicians practise in the future. The presence of the computer as ‘oracle’ brings a new dimension into the clinical encounter for both doctor and patient: the process effectively becomes a three-way affair. Metaphorically, the presence of the ‘oracle’ establishes the presence of a ‘higher power’, reinforcing the fact that the physician is neither omniscient nor omnipotent. However, whilst Sullivan and Mitchell found that the presence of a computer during the clinical consultation reduced patient-initiated conversation, it is equally likely in our information age that patients may search the Internet and come up with more specific or up-to-date information about their condition than is immediately available to their physician. When the National
Library of Medicine in the USA offered free Medline access in June 1997, the number of searches leapt ten-fold. Last year, a survey of US Medline searches revealed that 30% were undertaken by the public (including students), 34% by healthcare professionals and 36% by researchers. The opportunity for a better informed public brings the promise of health gain. There are, however, time and cost consequences to the NHS if the public is misled by incorrect information, or become unduly anxious by misinterpreting correct information. This challenges the physician to develop a partnership with the patient in the search for relevant information and to help by interpreting it appropriately in a spirit of patient advocacy.

As Professor of Medicine at the University of Liverpool, who worked for many years as a general physician, it occurred to me that the patients who had seen several physicians in a variety of specialties and who still had an undiagnosed problem, were those who perceived themselves not to have had a 'fair hearing'. They felt they had been misunderstood or were unable to accept what had been offered at previous encounters with the medical profession. This would seem to be particularly pertinent for patients who suffered from somatisation disorders.

It is important to make time both for patients to speak and to give them a satisfying explanation. According to recent work, dissatisfaction has much to do with experiences that are perceived to disempower, dehumanise or devalue personal identity to the extent that the individuals feel less confident or less able to perform their usual social roles. To avoid this in the context of the clinical consultation, the patient-physician encounter must evolve from what it is now into a partnership in which responsibility for health and healthcare interventions is shared.

**Time for patient participation: not just ‘consumer satisfaction’**

If having a 'fair hearing' is an essential component of a patient's satisfaction in the clinical consultation, then it follows that patient satisfaction is an essential precondition for reducing the costs to the NHS of complaints and litigation. Litigation continues to be a spur to better practice, but is nevertheless a very high price to pay for both the health service and profession. To avoid practising defensive medicine, we need patients' participation and formal agreement in all decisions that apply to their care. This 'new contract' with patients and public could lay bare patients' and physicians' expectations of the likely outcome of their encounter. Such a contract may or may not involve intervention, but would represent a commitment by physicians to surveillance, thereby securing the most appropriate management for the individual.

**Time to avoid harmful harms: processing ever more patients faster is not the most appropriate form of efficiency**

The paradox of the success of modern medicine is its greater capacity to do harm as well as good. Iatrogenic diseases are not uncommon, and accidents and error will always occur, though every effort will increasingly be made to avoid them. More patients treated means more patients harmed (even if the error or accident rate were to become vanishingly small). In as complex a healthcare system as the NHS, from the physician's and patient's point of view, the important question is: 'is your journey really necessary?'

It is as wasteful for society to intervene too early as it is potentially harmful to the individual to intervene too late. Numbers of patients on waiting lists for particular clinic appointments or operations are not necessarily the most appropriate indices of NHS performance. Waiting list priority scoring systems take the debate further, though their ability to secure appropriate responses to need is not without problems. Accelerating the processing of patients on waiting lists increases demand, but also runs the risk of harming more people even if the percentage harm rate is low.

**Time to assess what physicians need to work to best effect**

There is the risk that consultant physicians will be squeezed by time pressures to the point that they are not able to function as well as they, and society, expect. Consultant surgeons have the benefit of continuing research into operating theatre design and surgical instruments, as well as continuing professional education and training to increase expertise of theatre staff. Most importantly, however, operating theatre time is largely protected. In contrast, physicians who generally 'travel light', risk suffering erosion of the conditions in which they employ their skills – very busy outpatient clinics, busy wards in which other activities may be taking place, and the scattering of emergency admission patients among several wards throughout the hospital.

Time use is at the heart of a physician's performance. Time is also a resource amenable to economic analysis and modelling, so that realistic norms may be set for physician staffing levels, consultation times and provision and roles of fellow healthcare professionals.

**Sharing responsibility with the public**

Medicine has to recognise that it is a social activity in which the intense public interest is a source of harm as well as good. As the 'greatest benefit to mankind', medicine has an intriguing and distinguished history, but twentieth century medicine has become the victim of its own success. Demand is insatiable yet resources are always finite and there is the risk (if not certainty) of the law of diminishing returns operating. Market influences on research endeavour, commercial exploitation of research and direct advertising of drugs to patients, are all likely to feed consumer demand. Perversely, this demand is greatest not from the least healthy, but from those who perceive themselves most able to improve their personal happiness or state of
social functioning through medical intervention. This is neither sustainable nor in the best interests of the health of society. The medical profession must gain a keener awareness of its place in the wider social organisation, particularly at this time of great change.

Time to revisit public perceptions of medicine

In The doctor’s dilemma, George Bernard Shaw caricatures perceptively the medical profession at the turn of the century, in particular drawing attention to what we would now term the ‘opportunity cost’ of treatment when resources were limited. The doctor’s dilemma is whether to treat a brilliant but unprincipled artist or a poor and not very brilliant citizen (who happens to be a doctor). Beyond the scathing references to the personal motivations of senior members of the medical profession, Shaw points to the lack of agreement between observers of the same clinical features, and worse, of the slavish preoccupation with their own favourite pathogenesis (‘blood poisoning’) or treatment by inoculation (‘to stimulate the phagocytes’). This play serves as a mirror in which we may reflect how far our current practices and organisational structures have come since Shaw’s time, and whether our thinking is still restricted by fashion.

Ulrich Beck suggests that the society in which we now live is characterised by ‘reflexive modernity’. This implies a demystification of science – something to which physicians will have to contribute if we are to see a healthier and more health conscious (rather than health conscious) population. It is suggested that a new contract between physicians and the public should include patient advocacy. Unlike in the USA, where the principal motivation (including for promotion of demand) is financial, in Britain there is hope that there are, within the NHS, opportunities for the altruistic idealism of physicians to bear fruit through participation with the public. At the heart of the economics of such participation is the appropriate costing and valuation of time.

Physicians have a key role in changing public perceptions and practices from market consumerism to participation in the promotion of better health and more appropriate healthcare utilisation, but this will take time. Physicians’ time is thus more than a matter of money: it has to do with the core values and functions of medicine.

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