Stuart Patterson Lecture

2012

What is wrong with Health Care: The 3 M's

(Speech for Australian RACGP Conference)

Dr Clare Gerada

Thank you for inviting me to talk to you today.

It's a great honour for me, and also for the Royal College of General Practitioners, whose chair I've been for the last two years.

You'll probably be aware that my time in office has coincided with a series of monumental health reforms in England.

I know you're going through changes yourselves.

Today, as well as the reforms I want to also talk about the deeper questions that the reform process has raised for me over the past year or so.

Questions about the nature of general practice and our role in caring for patients.

So a talk in two parts:

1. NHS and recent upheavals

2. What matters most to patients?

Let me start then by telling you about our health service reforms.

Have you heard of them?

The medical profession was almost unanimous in its opposition to the Government's bill, which was passed this year.

And I am proud that the RCGP was the first medical college to have the courage of its convictions to come out publically against it.

Later, our united front included the British Medical Association and almost all of the medical, nursing and other royal colleges.

So why this overwhelming opposition to the bill?

To answer this you have to understand what the NHS means to our country.

Remember the London Olympics?

Did you see the opening ceremony?

The NHS emblazoned in lights – and nurses jumping up and down on bed-trampolines?

It was a reminder to us all, back home, that our NHS is a national treasure.

There wasn’t a dry eye in the house.

When the NHS was launched 64 years ago, it was based on three

core principles:

That it should meet the needs of everyone.

That it should be free at the point of delivery.

And that it should be based on clinical need, not the patient's ability to pay.

These three principles have been at the heart of our NHS ever since.

But the Health and Social Care Act has, in the eyes of many, been a major step in the undermining of these principles.

I'll give you three reasons for the overwhelming opposition to the Act.

The first is the privatisation of health care.

The health bill was dubbed 'Lansley's Monster' by the British Medical Journal. (For those of you who don't know, Andrew Lansley was the health minister who masterminded the bill).

The bill removes the government's obligation to provide

universal free healthcare for people living in England.

And it puts in place a legal framework for a commercial system

in which the NHS is reduced to the role of paymaster to

any number of 'willing' providers – from small local health charities to multinationals liked Virgin and Serco.[i]

Control for provision and finance of our health service will move

into the hands of non-governmental players,

and all this is concealed behind the publicly trusted NHS logo.

The idea has been presented as a way to enable the best of the small,

local organizations (such as charities and cooperatives),

to work together to contribute to the system.

And this would be no bad thing,

but a market-based, competitive spirit will ensure that only the fittest

– and most powerful – survive.

Before the Health act, we had a National Health Service that was truly national.

The reforms have removed the 'National' from our National Health Service, and have left us instead with a number of competing health systems.

As I warned in my conference speech to my College last year,

"I worry we're heading towards a situation where healthcare will be like a budget airline.

There'll be two queues:

one queue for those who can afford to pay,

and another for those who can't.

Seats will be limited to those who muscle in first.

And the rest will be left stranded on the tarmac".

This can't be right.

After all, no one chooses to be sick.

I believe that in the UK we must hold fast to the principle that good healthcare should be available to all, regardless of wealth.

The second reason for opposition to the health bill is that it was a genuine surprise.

During their election campaign, the Tory opposition promised the electorate there would be no more pointless, and expensive, top-down

reorganisations of the National Health Service.

So these radical changes to our NHS came as a genuine surprise,

and a shock, to us.

No country I know of reforms its health service as frequently as the UK.

We've had a major change every 5 years.

Yet despite reassurances, following their election, and within days,

the Conservative-led Coalition government announced the

largest ever reorganisation of the NHS.

So large that our current NHS Chief executive said:

“you could see it from outer space”

They introduced a huge and complicated bill.

One that I described in my conference speech this year as:

Longer than a Tolstoy novel.
Rushed through at breakneck speed.

The third reason that it was so unpopular was that

we were told the reforms were necessary to improve outcomes.

Yet during the 2010 election, the NHS didn’t even feature as an election issue because it had improved so much.

The OECD[ii] reported that when it came to health care,

“The UK is one of the best performers in the world…..”

And the irony is, before the bill, we had one of the cheapest,

most efficient health services in the World.

The Commonwealth fund, a respected US think tank,

has consistently ranked the NHS highly on a range of measures –

for example, it finds that people in Britain have

some of the fastest access to GPs,

the best co-ordinated care,

and the fewest medical errors,

of the 11 high income countries surveyed[iii].

So, there was no consistent, rational explanation for why these changes were deemed necessary,

other than the ideological belief that the “market knows best”.

Dr Jacky Davis, co-chair of the NHS Consultants Association summed up the situation like this:

“After the passage of the unwanted, unneeded and deeply undemocratic NHS bill, we no longer have a national health service.”

So, to sum up, these reforms were

not wanted

not needed

and so complex that no one could explain them,

not even their architect, Mr Lansley!

And to make matters worse, these reforms don’t come cheap,

yet were launched during a global economic depression.

And, their introduction has led to massively increased costs and reduced services.

So….no problems then.

Only time will tell how disastrous they will be for our country.

Not surprisingly, I learnt a lot last year.

Going through the upheavals has taught me a lot about structural reorganization, but – more than this – it has reminded me about what really matters to doctors and patients.

And so I come to the second – and I think more important –

part of my talk today.

To share with you what the experience has taught me.

Let me give you a little background.

I became a doctor because I was inspired by watching my father at work.

He was a single-handed GP in the East of England.

He worked very hard.

He taught me that medicine was a vocation –

that to be a good doctor, you had to give something back to your community.

In fact our home was the surgery.

Our front room doubled as the waiting room,

and I have memories of peering over the banister

and watching patients come and go.

And I used to go on home visits with him – something that would be unthinkable now.

He took me to see patients in the post-war slums of Peterborough –

we visited homes with no bathrooms, or inside toilets.

We saw children in filthy clothes with measles and whooping cough.

I have a vivid memory of him going out on night calls with his pyjamas showing underneath his trousers.

He taught me a lot about what it meant to be a good doctor –

that to be a good doctor you have to listen, and be kind.

He taught me that medicine is an art, underpinned by science.

I understood what he meant, even then as a little girl,

watching him practice.

It's easy to forget that medicine is an art, as well as a science.

Sound clinical judgments are the result of personal relationships,

as well as scientific knowledge.

Textbooks can never prepare us for the uniqueness of

every patient we encounter.

So if we're going to provide personalised care,

we have to learn to use our judgment.

Scientific knowledge, technical skills and compassion are

the toolkit of our profession.

Learning to strike the right balance between the science and art of medical practice is isn't easy.

I'd like to read you something…

"The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine —

or to put it more bluntly, they are too "scientific" and do not know

how to take care of patients . . .

I wonder if you can guess when this was written?

Not in 2012, but in 1927, in the USA.

By Francis Peabody, professor at Harvard[iv]

He goes on…

“The good physician knows his patients through and through, and his knowledge is bought dearly.

Time, sympathy, and understanding must be lavishly dispensed,

but the reward is to be found in that personal bond which forms

the greatest satisfaction of the practice of medicine.

One of the essential qualities of the clinician is interest in humanity,

for the secret of the care **of** the patient is in caring **for** the patient”.

Across the world, we are facing something of a crisis in general practice, with GPs under increasing pressure to focus on the disease rather than

on the patient, on the science rather than the caring.

And in today’s world, the art of caring is under pressure, as medicine increasingly becomes a numbers game.

I’d like to tell you about three Ms – the first of which is **measurement.**

(1. Measurement)

We're being measured to within an inch of our lives – both doctors and patients.

We’re seeing ever-increasing levels of surveillance and control over biometric diversity –

our weight, height, blood pressure, blood sugar

cholesterol, kidney function, mood state, bone density…

All are being measured, recorded and returned to us in

a giant feedback loop that keeps us coming back for more.

It's almost as if there is some law, an 11th commandment:

"If it can be measured, then thou shalt measure it."

This distorts our relationship with patients.

Perhaps this more marked in the UK,

where our Quality and Outcomes framework returns 30% of our income to us in performance-related pay.

We see constant reminders flashing up on our computer screens

telling us what we haven't done.

There's a hidden stranger in the consulting room,

watching our every move from inside the screen.

I recently received an email from a young doctor working in South London.

He describes two 10-minute patient consultations.

The first was with a young man who had pain from numerous gunshot wounds, and post-traumatic stress disorder as a result of witnessing his parents' murder in Sierra Leone.

The second was with an older man, who was experiencing work-related stress, marital problems and some erectile dysfunction.

The doctor writes:

“While the computer was flashing quality and outcomes framework data to collect, I was engaged in managing the pure existential pain of being alive, manifesting, to varying degrees, in some physical condition and subjective distress.”

No Quality and Outcomes Framework scores to be had here!

Now, I'm going to do two role-plays, which are excerpts from an OSCE[v] in which two medical students are being examined on their ability to question a young unmarried Muslim woman following an episode of unprotected sex.

I want you to listen to what is said – and what is not said.

Student 1 (passed with good grade)

Student: So... what’s been happening since then?

Have you had any problems in yourself?

Have you had any problems going to the toilet or anything like that?

Patient: No.

Student: Ok, have you, erm... had any discharge from down below?

Patient: [shakes head, whispers] ‘No’.

Student: So it’s just really that you’re worried that something’s happened.

Patient: [Nods]

Student: OK... I’m going to ask you about a bit more about what... went on, OK. Erm... what actually happened that that day when it all happened?

Student 2 (failed):

Student: Any rashes or...

Patient: No, I don’t think so.

Student: Discharge... have you yourself had any discharges at all?

Patient: No.

Student: Any, erm... irritation down there?

Patient: No.

Student: Any pain when you’re passing water?

Patient: No.

Student: Erm... any blood in your urine?

Patient: No.

If you were the patient, which doctor would you prefer?

And what did you see?

The patient's body language and minimal responses suggest a degree of self-disgust. The **first candidate** paid attention to this, and responded by moving away from the medical agenda. She stopped asking the standard questions, and instead allowed herself to be led by the patient's narrative.vi

The **second student** misses the subtle cues – even though (and precisely because), she relentlessly follows the 'correct' biomedical agenda.

(This consultation would have scored highly on QOF though!)

The 'biomedical agenda', which is so relentlessly pursued by the second student, seems to be at odds with all that we know to be good practice.

And yet it is what we are being increasingly asked to do.

Measurement does, of course, have its benefits –

in standardising care and minimising risk.

But if the balance swings too far in favour of this kind of data-measuring

I worry that we will lose sight of the real skill – and the art –

of being a good doctor, which is based on building a relationship

with the patient, not on measuring biomedical markers.

(2.) Which brings me to the second of my 3 Ms – closely related to the 11th commandment: the **medicalisation of life**

What is the effect of all this measuring of our vital statistics?

It is fear.

Not just the fear of death or dying,

which is perhaps what drives us to take the tests we are offered,

but the fear of making the wrong choice.

The fear of the lurking disease we might have stopped in its tracks,

if we had only been more vigilant.

Our bodies have become the enemy –

full of silent threats waiting to be discovered.

And it's not only our patients who feel this fear –

Doctors increasingly face the threat of litigation if we miss something.

So we measure and monitor everything we possibly can,

just to be 'on the safe side'.

We increasingly ask ourselves: 'what if?' instead of asking 'what is?'

Looking at the endless possible consequences of not doing something – driving ourselves to act, "just in case".

We are constantly driven to prevent disease before it has started.

As the GP Margaret McCartney writes in her book "The Patient Paradox":

"I am no longer there to make people better,

I am there to find out what risk factors for disease that they might have

or could have, despite their feeling well and having no complaints at all."

For example, a women of my age should routinely be taking

aspirin, HRT, a statin and vitamin D.

Why?

Margaret argues in her book that too much testing of well people, and not enough care of those who are sick, has dire consequences.

It increases health inequalities, stifles our professionalism,

and harms both those who need treatment and those who don't.

What's going on?

We've never been healthier, or lived longer [vii.]

We are less likely to die from untimely disease than ever before.

And yet the medicalisation of everyday life means that

even the healthy among us are summoned to the surgery,

and prodded and examined and monitored, 'just in case'.

In my area, in the drive to find the 'hidden sick', we've been told to

search our records for all those aged 65 years and over who have been foolish enough not to attend the surgery in the preceding 2 years.

This isn't to congratulate them and make sure they stay away,

but to pull them in and run them through a series of tests –

in essence admonishing them for having the temerity to stay well.

It's a bitter irony that the more people are exposed to contemporary health systems, the less well they perceive themselves to be. [viii] [ix.]

I'd like to know how introducing more fear into people's lives –

how making people feel less well than they otherwise would –

constitutes good healthcare?

So this is something we need to watch out for.

Of course, as doctors we are dedicated to doing everything we can

to keep our patients healthy –

but 'health' is more than the absence of disease, and,

in the words of our President, Iona Heath,

"the length of life seems to be valued more than its intensity of achievements".

(3.) My third M is **marketization**.

Through the progress of the Health and Social Care Bill,

I've become increasingly concerned about the effect of marketisation on

the quality, and equity, of healthcare.

I visited the US last year, and saw its damaging effects for myself.

What I found shocked, saddened and inspired me.

I visited the underbelly of American health care –

a State hospital – where I saw patients waiting up to

2 days in a corridor for a bed.

And a publicly funded health centre, where the doctors

complained that much of their time was spent

trying to raise money to treat their patients and stay open.

And I met volunteers from Remote Access Medical,

which began as a volunteer medical service for the Third World

but is now more desperately needed in the US

because the private medical system

has removed the healthcare safety net for its own citizens.

Most Americans worry more about health costs than anything else.

All but the wealthiest find themselves just one serious or chronic disease away from enormous bills, and even bankruptcy.

In fact, up to 70% of all personal bankruptcies in the US are due to

health problems.

And it turns out that the vast majority of these bankrupts are people who actually have medical insurance.

While I was there, I heard stories of people dying from preventable conditions.

I was told of a young man in his 30s who died from a dental abscess, because he couldn't afford health insurance.

He is just one of an estimated 75,000 unnecessary deaths per year

in the US.

It's a topsy-turvy society, in which people who need care,

but can't afford it, don't get it.

While others, who can afford it, end up getting care they don't need.

The Economist calculated that in 2009 alone, the market-driven, corporate-dominated US healthcare system generated around $300 billion of

charges for unnecessary care.

The US wastes a whopping 5% of its GDP on unnecessary health care.

A cost that includes fraud, unnecessary investigations, billing, and so on.

In fact, the United States – the biggest health market in the world – has achieved the remarkable double whammy of having the most expensive health system in the world

– and the greatest health inequalities.

There is so much I could say about the impact of the marketisation of healthcare – but there's one aspect I'd like to focus on in particular today: the increasing commercialization of medicine,

and its focus on choice and competition.

When patients become consumers, doctors risk becoming little more than providers of goods – what Foucault describes as:

"Almost mechanised intermediaries between the pharmaceutical industry and client demand…

that is, simple distributors of medicine and medication."

Markets thrive on choice.

In the UK, Patient choice has been an NHS policy for the last decade and the new Act will accelerate this in England.

Giving patients more freedom to make choices about their healthcare sounds like a good idea, doesn't it?

After all, 'choice' – like 'freedom' is a good thing, by definition, isn't it?

This view is increasingly seen as established wisdom in health policy:

with choice seen as an indisputably good thing.

Like buying a new car.

The logical consequence of this view is that a high-quality therapeutic relationship is one that supports autonomous choice by the patient.

Not necessarily.

Philosopher Annemarie Mol has written a seminal book called ‘The Logic of Care’ based on the study of patient–doctor and patient–nurse encounters in the context of diabetes care.

She argues that good care has little to do with patient choice – and creating more opportunities for choice doesn’t improve care.

Mol argues that choice is secondary to the core business of clinical care, rather than its essence – especially in relation to chronic illness.

She talks about the “art of caring” (x).

What she means by this is that good care is not something that

comes from making well argued individual choices,

but is something that grows out of collaborative and continuing attempts to “attune knowledge and technologies” to diseased bodies and complex lives.

The American psychologist, Barry Schwartz, wonders if the dis-benefits of choice outweigh the benefits.

His work suggests that too much choice can be a bad thing.

It has two negative effects.

The first is that it produces paralysis, rather than liberation – because with so many options to choose from, people find it very difficult to choose at all.

And the second is that, even when we manage to overcome paralysis

and make a choice, we end up less satisfied than

if we'd had fewer options to choose from in the first place.

Schwartz's research found that the more options people are given,

the greater the anxiety, the greater the dissatisfaction,

and the greater the disappointment they are likely to experience.

I found this out first hand recently, when I went to buy a new radio from a well-known department store.

All I wanted was something to listen to the morning news on.

It should have been simple –

But I was offered so many choices:

A DAB digital [what ever that is]

Internet

Wi-Fi

Digital stereo

Clock radio

Different prices

Different colours

Different sizes

The queue for help was too long, and I am impatient.

I became anxious – unable to make sense of the options.

So I ended up not buying anything.

I came home empty-handed, and disappointed.

As Schwartz says in his entertaining and thought-provoking TED (xi) talk on the ‘Paradox of Choice’:

“The tyranny of life is choice… whether that’s 176 different salad dressings or 40 different brands of toothpaste for sale in the average supermarket”.

Do we really want to be offered choices like this about our healthcare, I wonder?

And are the choices we make meaningful when we lack the specialist knowledge to make an informed decision?

In my example, getting help from the help-desk would have taken an hour, for our patients it might never be there….

In health the stakes are higher than they are when we choose between

ten radios, or between different brands of toothpaste.

Schwartz tells us…

“It is no longer the case in US that you go to the doctor and he tells you what to do.

Now, you go to the doctor and the doc tells you,

“Well, we could do A or we could do B.

A has these benefits and risks.

B has these benefits and risks.

What do you want to do?”

And you say,

“Doc, what should I do?”

And the doc says,

“A has these benefits and risks;

And B has these benefits and risks.

What do you want to do?”

And you say, “If you were me, doc, what would you do?”

And the doctor says, “but I’m not you.”

We call this “patient autonomy

Which makes it sound like a good thing

But what it really is

is the shifting of the burden of responsibility for decision making

from someone who knows something,

namely the doctor,

to someone who knows nothing, and is almost certainly sick,

and hence not in the best shape to be making decisions,

namely the patient".

When my mother-in-law was first diagnosed with cancer of the oesophagus, the young doctor breaking the news had to contend with my mother-in-law, my blind father-in-law, and me – all of us frightened.

He offered her choices – he laid them out to her:

Palliation

Operation

Operation and palliation

Radiotherapy

Radiotherapy and operation…

I became anxious – this was beyond my level of expertise

How would we choose what to do for the best?

"What would you do if this was your mother, doctor?" My mother-in-law asked.

There followed a moment of silence

Then… he took her hand in his.

He sat forward, closing the space between him and her

I held my father-in-law's hand

and he told her what he would do.

And we did it.

And that, for me, is a good doctor.

A doctor who listens,

A doctor who cares,

And a doctor who knows what to do.

That's what patients want and need.

So what can we do in the face of the growing influence of

measuring, medicalisation, and marketisation?

In our drive to improve the length and quality of life,

we mustn't lose sight of the relationship between doctor and patient.

A precious relationship, which is at the beating heart of good

general practice.

We must also ensure that the balance between

the science and the art of medicine

isn't weighted too far in the direction of the numbers game.

We have made great strides in the biomedical aspects of patient care,

but we must always remember our roots as carers and healers.

Cum scientia, caritas is our shared motto.

I'm no classics scholar, but it seems to me that – however you translate it – our wonderful motto is a constant reminder to us that our scientific knowledge should always be applied with compassion.

My worry is that policy makers' emphasis on regulation and monitoring, risks creating conditions that are hostile to the cultivation of compassion.

So perhaps it's time for us to re-focus on the immeasurable –

On trust

On caring

On respect

And on kindness.

Thank you.

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[i] http://www.guardian.co.uk/society/2012/sep/20/serco-nhs-false-data-gps

[ii] http://www.guardian.co.uk/politics/2011/nov/23/health-bill-nhs-oecd-report

[iii] http://www.telegraph.co.uk/health/healthnews/8877412/NHS-among-best-health-care-systems-in-the-world.html

[iv] http://www.ttuhsc.edu/som/success/documents/The%20Care%20of%20the%20Patient.pdf

[v] From Measuring quality in the therapeutic relationship, Kings Fund. Heath & Greenhalgh. 2012

[vi] Roberts *et al* 2003, p 196

[vii] http://www.bbc.co.uk/news/health-19410699

[viii] Sen, A. (2002). Health: perception versus observation. BMJ, 324(7342), 860–861.

[ix] http://doctorskeptic.blogspot.co.uk/2012/10/health-its-all-relative.html?spref=tw

[x] The Logic of Care: Health and the Problem of Patient Choice, Mol 2008

[xi] Technology Education Design http://www.ted.com/