DIFFICULTIES IN THE DELIVERY OF HIGH QUALITY FAMILY MEDICINE

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Medicine is a fascinating and challenging career which, in Britain, attracts many of the cream of young people to study in medical schools - or at least it did before the British government tried to change doctors into "accountants" managing million pound funds and buying and selling services. Many people see that attraction of dealing with a subject relating to life and death and major life incidents, as well as having the opportunity to get to know people over a long period through the ups and downs of life. The academic challenge of medicine is also very attractive.

There are, however, problems. For instance Julian Tudor-Hart has described the inverse care law (1) which applies in almost all health delivery systems. This states that the more needy a person is, the worse the quality of medical care which is made available to him. Thus the articulate middle class wealthy family which, on the whole will be very healthy, has enough intelligence to work the system to receive good medical care. The sick, poor, tired single parent usually receives a far lower standard of care.

Then there is the law of halves (2). This again was described by Tudor-Hart - he described it in the context of the treatment of hypertension, but there is evidence that it also applied to many other chronic illnesses. The law of halves states that only half of all hypertensives have been diagnosed as such. Only half of the hypertensives who have been diagnosed are under regular surveillance and only half of all those under regular surveillance are well controlled.

Then there is the matter of compliance. It has been estimated that only 20% of patients prescribed a t.d.s. course of medication for five days completes the course or takes the course properly. Twenty five percent of all patients with epilepsy who continue to have fits do so because of poor compliance (3). In a survey of patients with epilepsy in 1988 Zostle found that 60% of all adults surveyed had either stopped taking their medication for at least three days, discontinued them altogether or changed the dosage for at least three weeks in the three months surveyed (4).

So what do we make of all this? We have the picture of young people going into a career with high hopes. We have the picture of a superficially challenging career where one can effect much change for the good. But on the other hand we find that help is not getting to the people who need it. We find that patients' problems are not being controlled properly. We also find that patients are listening to our advice and instructions but are not complying with them.

I have a postgraduate trainee, Daniel, who has just started with me. He is bright eyed and keen. However, I know that recently a survey was carried out among a large cohort of doctors who had been qualified for five years. It was found that 40% of the doctors in the survey wished they had never taken up medicine and 28% were depressed (5). Part of the reason is the conundrum that we have just been describing. How do I stop this happening to Daniel? How do I explain these phenomena and how can we manage this problem for our patients and for all the other young Daniels entering medicine all over Europe?

I would like to deal with two particular problems in the delivery of health care today which go some way to explain the phenomena we have talked about. The first is the difference between doctors' agendas and patients' agendas. The second is communication.

AGENDAS

Firstly then I would like to talk about agendas. In any consultation the doctor and the patient have an agenda. Let's take the simple problem of streptococcal tonsillitis. Having made this diagnosis the doctor's agenda is to make the patient better, to eliminate the streptococcus, to provide adequate pain relief, to give the patient necessary time off work and to protect the patient against the

longer term effects of streptococcal infection, such as rheumatic fever and glomerulonephritis. The patient's agenda is to get rid of the pain in his throat and feel better. To fulfil the doctor's agenda the patient will need to take penicillin four times a day for five days minimum. To fulfil the patient's agenda he may only need to take the penicillin for one day - so that is what he will do.

We have briefly mentioned compliance problems with epilepsy. The doctor's agenda when treating a patient with epilepsy may be to give the patient the optimum treatment to abolish his fits. The patient's agenda may include a few drinking bouts, he may not want to take his tablets on holiday and he may get fed up of taking the tablets at all. So he will not comply. Who is right - the doctor who wants to abolish the fits or the patient who wants to lead life his way? The patient usually does not tell the doctor that he is not complying with treatment.

Let us look at two more complicated problems with agendas and compliance. Firstly the old lady who lives alone. The doctor goes to see her and finds that she only has heating in one room of her house, she is too disabled to get to the shops and does not always have enough food in the house. She has multiple small mats all over the house over which she could trip. The doctor goes to see her and tells her that she might trip over the mats and so she must take them up. He tells her she must heat all her house properly. He arranges for her to have meals delivered and he advises her that she really should move out of her house and live somewhere more suitable. The patient thanks the doctor and refuses all help. Why is this? Perhaps she is just a difficult old lady. On the other hand, if one looks closer one finds that this lady was born in the house where she is living and has lived there all her life. She is not going to move out except in a coffin. She cannot afford to heat the whole of her house. She enjoys cooking such as she can still do and hates the mass produced taste of the delivered meals. The mats lying around which are such a danger to her - potentially tripping her up, were given to her by her much loved husband who died last year. There is no way that they are going to be put away. The doctor's advice is correct but useless. If the doctor is young and inexperienced he may become angry and discouraged at the rejection of his advice.

Finally, when thinking about agendas I would like us to think about opiate abuse. This is an increasing problem throughout Europe. In Britain there are about 200,000 people who are known to be abusing drugs. Frightening figures emerge from countries such as Germany, Switzerland and Italy. Probably only Holland has developed a logical way of looking at this problem. Here, above all, there is a divergence of agendas between doctors and patients. The doctor's agenda for these people is that they use clean equipment if they inject, that they reduce and come off their opiates and that they develop social stability. For this reason patients are fed into opiate reduction programmes. They are given clean equipment on a rigidly controlled swop system of new equipment for old and they are fed into social work programmes to stabilise their lifestyles. The opiates they are prescribed are gradually reduced.

The patients' agenda is to get more drugs, and as much injecting equipment as they can free of cost. Thus patients cooperate with the start of the doctor's reduction programmes and even go along to see what they perceive as the naive social workers a few times because this gets them free drugs. When the doctor starts reducing the dose of the opiates the patient simply goes back to the street market where drugs are freely available all over Europe and buys more.

So what are we saying? ... We as doctors can analyse a situation, we can do tests, we can have conferences. We can be sure in our own minds about diagnoses, therapies and prognoses. We can prescribe medicines and rehabilitation programmes, but if all this does not fit in with the patients' ideas, lifestyles and agendas, the patients will usually be very polite, they may thank us profusely and tell us we are very good doctors, but they will not comply with the treatment.

COMMUNICATION

Clearly then, we must find out more about what patients want and what they see as a good outcome. Here, however, we run into another problem. Some time ago I organised a research project with five other colleagues to look at how we communicate with patients. The project was published in the British Medical Journal (6) with a further follow up study published in the British Journal of General Practice (7). We looked at patients' perceptions of why they consulted the doctor, how ill they thought they were, and what they perceived happened in the consultation. We found some interesting facts. Only one third of patients coming to the doctor came because of the severity of their symptoms. Others came because of worry or because of other unrelated factors taking place in their everyday lives. They presented their symptoms as the ticket of entry. So accepting the symptoms and investigating them would miss the problems worrying two thirds of the patients who sought a consultation. Doctors and patients perceived completely different things going on in the consultation. The doctors thought they listened, supported, gave advice and examined patients. Patients thought they were told they would get better, given a prescription and perhaps referred to a consultant. The doctors perceived that they were helping patients to help themselves. Patients perceived that they were being told what to do - a problem if the agendas were different. Only 28% of patients knew what was wrong with them before the consultation, and this only rose to 32% after the consultation - thus suggesting that the consultation had little educational value. When one looks at what patients thought was the cause of their illness they stated that external factors like infection, trauma and stress caused their problems - things which were not under their control. When one looks at what doctors thought were the cause of the patients' problems,

doctors perceived far more problems to be caused by the patients' lifestyle - obesity, smoking, alcohol and lack of exercise - factors under the patients' control.

This study produced disturbing results. It seems that the doctors and the patients differed in their perceptions of why the patients had come to the doctor, what was the cause of the problem and what went on in the consultation. The consultation seemed to have very little educative value at all. One really wonders what communication went on, if any, in the consultation or was it a matter of the blind talking to the deaf. If you don't think this happens with your consultations I challenge you to repeat this project in your unit.

So what do we say to all this? There are major problems in the delivery of health care, partly because what we as doctors want and what patients seem to want are often totally different and partly because we don't seem to communicate in the first place. There are two ways of looking at this. We can say that it is extremely annoying. Here we are, doctors with many years of hard training behind us, working night and day for the good of patients and first of all they don't listen to what we say, then they don't carry out our instructions. Subconsciously, I believe many doctors think like this and get into a dominantly adversorial relationship with patients.There is no mileage in this.The patient's life belongs to the patient. We can only have as much effect on that patient's life as he or she allows us to.

The other way of looking at this is that it is a disturbing indictment of our lack of effectiveness. It is us who need to change and we have to study and train to effect this change. Let's take communication first. There are many reasons why doctors do not communicate. For instance in medicine we take idealistic young men and women into medical school. We submit them to horrific experiences like cutting up dead bodies and watching young people die. We teach them to detach themselves and live in alittle protected area inside themselves where the terrible outside cannot reach them and hurt them. We then take them and teach them to redefine a situation of terror and enormous anxiety such as a patient with a severe myocardial infarction feeling breathless and faint, in terms of pathology, thereapeutics and calculations about prognosis. The human experience and sharing of the patient's feelings - the empathy is abolished(8).It might affect efficiency and might hurt us.Is it any wonder that we cannot communicate? We convert young men and women into what many people consider emotionally crippled, detached arrogant professionals out of touch with the world of their patients and their own feelings. If you don't think people regard us in this way, read the Independent and the Guardian newspapers, the Economist magazine and October's issue of Le Point from France (9). The personal spin-off from this is the high incidence of divorce, substance abuse (10) and suicide (11) among doctors. What we need is the help of psychologists, communication experts and counsellors to teach us to be humans again. We need to be taught to experience feelings and still not to be permanently hurt. We need to be taught to experience what our patients experience and still to be able to provide logical, well thought out medical care. Then we will be able to communicate with our patients again. Then we will be able to understand their agendas. When young post-graduate trainees come to my practice our first aim has always been to try to undo a lot of the problems that they have experienced in medical school and hospital. To do this we spend time talking about what patients are really experiencing. We video-record consultations and try to see what doctors and patients are saying and doing. We sit in patients' homes and try and take off our medical masks and talk about what illness really means to patients in terms of foreshortened horizons, inability to pick up the children, watching the garden go to rack and ruin, seeing the girls looking at other chaps. We also talk to the counsellor and sit in groups with other young doctors to share these odd and troubling experiences. As career grade doctors I think that we have to submit ourselves to similar training. Video-recording of consultations and peer review, discussion of consulting styles and seeking the advice of the patients themselves all play an important part in this. Psychologists, and counsellors have skills which can be of use to us. Nurses and paramedical workers have been found in various surveys to have better communication skills than doctors - we can learn from them in a group setting.

The question, of course, is: does this sort of learning process change anything? I would like to describe to you how we have changed the way we deal with patients on our list who abuse opiates since we have been thinking and learning in this way. In my practice we look after 40 patients who abuse drugs. We have already considered the differing agendas followed by patients who abuse opiates and the doctors who attempt to treat them. As both parties are often following different agendas the doctor/patient relationship often breaks down with bitterness, recrimination and sometimes aggression. This is not really surprising because in this case the two people involved in the relationship have different priorities. We decided instead of approaching these patients with our agenda that we would sit down with them and openly try to develop a joint agenda and contract. This we did and we developed the following guidelines. Our joint aims were:-

1. To enable opiate dependent patients to withdraw from the chaotic street for drugs and to develop some social stability. To do this we prescribe methadone for these patients.
2. To enable patients to use clean syringes and needles if they are injecting. This is done through a needle and syringe exchange.
3. To enable patients to withdraw immediately from illegal activities such as drug dealing and burglary to pay for their own drugs.
4. To develop a secure trusting relationship with their family doctor where they accept that the only reason they will be rejected from the doctor's list, is for overt

aggression towards doctors, staff, other patients or the premises.
5. When the patient is ready and indicates so - to make considered plans for the major change in their social life needed if they are to attempt narcotic withdrawal. No pressure is put on the patients by the doctors to start this process.
6. Only when the patient requests it, to reduce the level of drug prescription.
7. To accept that many patients have several dry runs before they manage to withdraw from dependency. If this happens the whole process starts again. The patient is not rejected.
8. To recruit what social help one can to support these patients in a major life upheaval.

When we developed this policy of listening to and co-operating with the aims of our drug abusing patients we were accused of selling out to addicts. I published our policy in the Journal of the Royal Society of Medicine in 1987 (12) and there was a lot of correspondence, mostly critical. We measured the outcome. Among the 12 patients I was personally responsible for, two had been dependent on opiates for more than 14 years, four patients had had multiple prison sentences. One patient had had two episodes of septicaemia leaving him with mitral incompetence. One has chronic active hepatitis. One patient had lost part of a limb after attempting to inject into a peripheral vein. One patient had multiple boils when he registered with us. One patient had had four doctors within the previous 12 months, and one patient had not had a GP for a year.

Now two of these patients have regular employment for the first time in years, one further patient has intermittent work. No patient has been convicted for the past four years on a drugs related charge, or a charge involving violence. A couple who are opiate dependent have retrieved their children from care, and live a stable life in a council house. One opiate dependent girl has had a baby and is successfully mothering it. One man has moved from living in a tent on the river bank to living in a council house and has recommenced painting - he is a talented artist.

I think people are wrong to focus exclusively on withdrawal from drugs as the sole objective when dealing with opiate abusers. With our approach, 30% of our patients have decided to come off drugs and succeeded in doing so - in some cases after several attempts. More have come off since.

My reason for recounting this experience with opiate abusers is to make the point that if one can succeed to communicate with these patients and build a joint agenda, then surely one can also do this with the general run of patients.

CONCLUSION

In conclusion, then, we have looked at the problems we have in delivering high quality care to our patients. We have considered that this may be because we are not on the same wavelength and talking the same language as our patients. In turn we have traced this back at least in part to the effect that our training and medical way of life may have had on our personalities and behaviour and have considered what could be done about this. Who was it who said: "Physician heal thyself?"

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