

Effective Health Delivery

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Editorial

Effective health delivery should be influenced by two key factors; patients and teaching, but is frequently adversely affected when politicians make health care reforms, forgetting that patients are at the centre. Yes, cost and resources are important, but patient-centred services and care must be the guiding light. The most important duty of physicians is to put patients first and ensuring that there is a future generation of doctors trained to take over their roles, remembering that they have failed as medical teachers if the new generation are not better doctors than they have been.

In the 1950s onwards there was a move from doctor-centred paternalistic care to patient-centred care. Take the example of truth disclosure. In 1950 a survey in the USA of 200 cancer and non-cancer patients revealed that 89% would prefer to know the truth if they had cancer [1]. Conversely in 1961 a survey of 219 USA physicians stated that 90% did not tell cancer patients the truth regarding their diagnosis [2]. It is interesting how this attitude changed, as a similar study of 264 USA physicians in 1977 found that 97% always told the truth [3]. Some may argue that this was a change in society.

At the same time in the UK, the Hungarian Psychotherapist, Dr Michael Balint, who worked in the Tavistock Clinic, central London, wrote about the doctor-patient relationship in his book, "The doctor, the patient, and his illness" [4]. The crux of this was the 'partnership' between a doctor and a patient or if one prefers the new terminology, the health care provider and user. Many others were to pick up the baton that the patient was the center of the consultation, not the doctor and their agenda or the health care institution for which they worked. Now training emphasizes the importance of exploring ideas, concerns and expectations in a consultation, hopefully coming to a shared understanding with the patient and having an agreed negotiated management plan.

A "patient centered" consultation should be where the doctor very much takes a more passive role and is directed by the will of the patient with all possible treatment choices provided where patients are empowered to decide. This change was not just in general practice. The late Dame Cicely Saunders who is attributed as the founder of the modern hospice movement coined the phrase 'total pain' in the 1960s which she referred to as the physical, psychological, mental, emotional, social, as well as spiritual [5]. This, together with Balint and changes in society was one of the many factors that led to the current holistic approach in patient-centered care.

Medical education is the key to ensuring patient-centered care. It was Abraham Flexner who was to have the most important early influence on medical curriculums, originating in the USA. In 1908, the president of the Carnegie Foundation, Henry Pritchett, selected Abraham Flexner, a school teacher with skills in educational theory, to visit and review the then 155 medical schools in the USA [6]. This was

prompted by the American Medical Association (AMA) forming the Council on Medical Education (CME) in 1904. The CME made two proposals which were to influence medical curriculums in both the USA and UK until the present time. First, it was proposed that students should be selected for entry into medical school on the basis of education requirements prior to entry into medical school. Second, that undergraduate training should be divided into what some schools still call 'pre-clinical' studies (biomedical and laboratory sciences) and then 'clinical' rotations or attachments at designated teaching hospitals. The curriculums of many medical schools now still adopt this approach to their teaching.

However, medical teaching now is rapidly changing with the introduction of early clinical experience on day 1 as it is the patient who should be at the center not the science, important as it also is to ensure competent doctors. But more than this, teaching communication skills remembering that the commonest cause of patient complaints are poor communication skills. The best teachers are our patients and most illness occurs in primary care where it is managed and so medical teaching is rapidly moving into the community in which students can observe and experience more of the patient journey, not just the snapshot that happens in hospital. Students need more experiential learning through face-to-face time with patients and less 'classroom' teaching.

It is important to be aware of the distracters that all doctors increasingly face and which compromise patient-centered medicine. These are administration, management, a pre-occupation with leadership, the third person in the consultation, the computer and inputting data into it, which is not necessarily directly related to the patient in front of them. Similarly the time spent adding information into ever expanding electronic portfolios, managing the rising tide of emails and attending back-to-back meetings relating to reform agenda of healthcare institutions. Patients need time with ever increasing complexity as a result of an ageing and frail elderly population with multiple co-morbidities who want easier access to doctors, adequate resources for their treatment, continuity of care and where appropriate the doctors most powerful tool, reassurance. One can see that doctors' agendas are driven by forces different to patient needs and wants.

For family medicine to be effective, it should be both an art and a science and may be defined as, "Scientific skill with loving-kindness" [7-9], which is the motto of the Royal College of General Practitioners of the UK, New Zealand and Australia; "Cum Scientia Caritas." The challenge for primary care is the need to reconcile through training the accelerating advance of technological medical knowledge and skills, 'scientia', with a caring and compassionate relationship, 'caritas'. Unfortunately, the environment is constrained by intense competition for resource allocation and the rising expectations of medical care. Furthermore, preparing trainees for the change in service role with secondary care moving into the community and so the increasing care

and complexity of patients with long term conditions and associated multiple co-morbidities. The future improvement of health care requires primary care practitioners and their teams to be competent and caring and to be advocates for their patients and ensure an effective patient-centred approach in partnership with specialist colleagues working in secondary and tertiary care.

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