The components of consultation

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A lack of clarity about the real nature of any given medical consultation could be one factor in the decline of public confidence in medicine. It affects the trust implicit in such engagements and diminishes their therapeutic worth. When patients meet their doctors, will they see a shaman; an insurance agent; a welfare worker; a government official; or the police?

THE SHAMAN/PRIVATE AND PERSONAL PHYSICIAN

What people really want to see is a magician/physician. The shaman will know, better than the patient, what has been wrong so there is no need to delve into the history. With a potion or an incantation, the sickness will melt away. Failing a magical solution there could be a very private word or many more into the private doctor’s ear since the doctor’s time is at the disposal of a patient’s capacity to pay for it.

There do remain vestiges of a contract that was once truly private and confidential. Those vestiges are what the recent General Medical Council admonitions sought to guard, but without making clear how vestigial they are. In the idealized contract, a patient approaches a practitioner for advice or treatment in exchange for a fee. The fee will be met from private funds, and the practitioner assumes that the patient can afford it or will perhaps modify it according to ability to pay. No one else is a party to this transaction; advice and privacy are bought together. No record is required beyond a word or two of aide-memoire in the doctor’s notebook. The therapeutic elements in the contract are the technical knowledge and resources immediately available to the physician and the powerful, personal, investment by the patient in the worth of the consultation. Both the technological and the psychological—placebo if you like—effects are conjoined. Few people can afford to pay for such medical services, for serious conditions, out of their current funds.

Since doctors might decide not to charge everybody, or might scale their charges to individual means, they could also be seen to be munificent. Such is the historical basis of a medical consultation that is still, somehow, a fantasized basis for all doctor–patient encounters. On the debit side, total privacy allowed the possibility of unsupervisable medical practice. The regulations of the profession were put in place, in part, as a guard against the exploitation of the privacy. On the other hand, it could be the physician who is exploited, spun a tissue of lies, and there is not much in place to defend against that. The new-age shaman is the hypertechnician with a heart of gold, right up to date, micron accurate, evidence-based—as sharp as a magician and as likely to be found.

INSURANCE AGENT

Since most people cannot pay for medical care out of current funds, some sort of insurance is needed. Insurance plans provide a system of finance that includes elements of investment, hire purchase, and gambling. There is an accumulation of capital and interest to pay the bills. The insurer hopes that the prudent premiums are never needed. The insured shares that hope but might feel tempted to recoup the premiums whenever possible. With this alternative way of financing medical care, other people necessarily scrutinize not only the activities of doctors but also the medical conditions and the private circumstances of their patients. Regulation and scrutiny are necessary in order to be certain that the condition being treated is an insured risk and that the treatment itself is permitted under the plan. This controls the practitioner’s options if he or she wishes to work under a plan. Further controls ensure that neither the practitioner nor the insured make false claims. The bill for medical service must now include the practitioner’s fee and costs, the running costs of the plan, the cost of policing the process, and the insurer’s profit. These services can offer a quasi-private service as extensive and as opulent as the national way of financing medical care, other people necessarily scrutinize not only the activities of doctors but also the medical conditions and the private circumstances of their patients. Regulation and scrutiny are necessary in order to be certain that the condition being treated is an insured risk and that the treatment itself is permitted under the plan. This controls the practitioner’s options if he or she wishes to work under a plan. Further controls ensure that neither the practitioner nor the insured make false claims. The bill for medical service must now include the practitioner’s fee and costs, the running costs of the plan, the cost of policing the process, and the insurer’s profit. These services can offer a quasi-private service as extensive and as opulent as the insurance plan allows. Privacy is, nevertheless, broached in several ways with the passage of information needed to run the plan. Insurance businesses must limit their liability and will deny cover for certain risks and curtail services if costs mount. Insurance is too expensive for many individuals to cover themselves at all, and others can afford only limited protection. Health insurance is sometimes an element of employment remuneration. In this way, employers also become privy to the details of their employee’s health—for example, when an employee becomes uninsurable. Insurance providers may require those they insure to...
refrain from certain unhealthy practices. Insurers may refuse to cover high-risk recreational activities and require special premiums for dangerous work. All these constraints increase the invigilation and decrease the privacy of the insured.

Tensions can now arise between the doctor and the insured about the interpretation of a given sickness in terms of the insurance plan or about failures of health maintenance by the insured. Inevitably the practitioner is regarded, to some extent, as being less the agent of the patient and more the agent of the insurer. Some people are less likely to tolerate minor ailments when they know that premiums are paid for a service that might offer relief. This inevitably creates a burden on the plan.

WELFARE WORKER

Welfare medicine is an extension of an insurance scheme where the citizens who are earning take up the financial risk but all citizens are covered. The former National Health Service was a model of that. The paradox is that the non-contributors are likely to be the heaviest users. There was no ceiling placed on the risk. Healthcare was available to citizens irrespective of the scale of the likely burden they posed individually—sometimes through risk-taking behaviour or neglect of personal health maintenance—or their capacity or willingness to offset it through work. There was no limit to the scale or duration of treatment, care, or management. There are still no generally acknowledged, widely disseminated, overt, rules against abuse of the scheme. No practitioner could confidently deny any citizen who appears to be flagrantly violating the communal spirit of the plan.

Citizen members of this insurance plan have never been asked to comment upon it save at the remoteness of polling for the government to run it. No proportion of the gross national product has ever been specified as setting the scale of its budget or the limits of its costs. All governments find it burdensome. No poll has asked citizens what limits might reasonably be placed upon the services provided, or what services are most wanted. The only real regulator of costs is that the allocation of its funds be as small as is politically feasible and expedient. The burden was limited at the onset by slight administrative costs, at the expense of a slight administration. The NHS relied upon inherited good will and corporate strength, at the expense of conservatism; and on the absence of insurer profit, at the expense of office efficiency. A salaried service for doctors reduced the temptation to undertake a medical activity for profit rather than to meet need. That also reduced professional competition. It tacitly allowed senior doctors to determine what should be treated under the scheme.

Now, every service is enjoined to be as economical as possible in terms of cash expended. However, the savings could be illusory because more money has to be spent later or because the costs are shifted to another department of government. These transferred costs are not accounted. Squabbles ensue between agencies as to who should bear them. This leads to increased administrative costs in several departments, together with failure to provide the required service. This in turn leads either to neglect or else to expenditure in an inappropriate service.

All practitioners still perforce participate in a form of regulation by rationing, though denial that rationing takes place means there can be no regulation of it. The arbitrariness of rationing means, for example, that a single vital procedure needed in the entire life of one person might be delayed or withheld while frequent users regularly generate great costs throughout their lives. Costly abusers of the service are not identified because no one dares to do so—for fear of seeming to be politically incorrect.

No other insurer would remain ignorant of the total use of its services by each of the insured and allow completely unmonitored use of its services. (Just imagine such a situation in car insurance.) There is no ‘healthcare card’ that allows costing each of the permitted users of the scheme. Such a card would monitor their needs and utilizations and debar would-be usurpers.

The service, like all public healthcare across the world, is overstretched to the point of collapse. In Britain, the healthy population that should have ensued from Bevan’s proposals for the NHS proved mythical, or perhaps less a myth than a moving target. There can never be a natural limit on NHS expenditure and no government dare be seen to say so and impose one. No government has yet had the nerve to even suggest that the citizens should express views about it.

In enterprises where there is no apparent product or saleable service, measures of success and efficiency are elusive. That difficulty is also seen in government departments, the civil service and the armed forces. To assume that public health can be managed as though it were the product of a business is a fundamental error. A profit perspective alters the motive of a service in crucial ways. The focus shifts from providing the service (even one from which a living can be made) to making money. In current practice, NHS trusts are not given the task of making money, only of spending less.

The right outcome of a medical consultation might be inaction rather than action. The proper, accountable, response to a potential patient’s demand under an insurance plan (such as the NHS) might be to refuse it. If only action is counted as work, this interferes with clinical decisions and courts unnecessary interventions. Despite the interposition of a professional management, patients are likely to perceive
all the conflicts as being between them and the doctors. Considering privacy under such circumstances is ambitious. Mountains of papers, letters, files, reports, are moved about by large numbers of staff who are often hired sessionally or for brief periods. Lack of continuity of staff exposes patient information to several times more people than need be.

No particular level of plant or resources is uniformly provided. No particular standard of care can be expected, other than that which avoids litigation as far as is economical. Facilities for privacy may not be available for sharing the deepest tragedies. When the public feels degraded, disappointed, and denied, anger and resentment are directed at the staff at the interface. To deal with this, a widely advertised complaints system is in place. The cost of that, in real terms and in anguish to the staff of an already overburdened service, is uncountable.

GOVERNMENT OFFICER

Statutory and administrative obligations of doctors are further sources of potential conflict with the public. In a public health service, doctors are civil servants in direct contact with the public. If it is an aggrieved public, they will suffer assaults and vilification as much as other civil servants do currently. Their most frequent obligation to the State is to administer sickness certification. When a claim for sickness is made that a doctor thinks unreasonable, there is a moral and a statutory obligation not to provide one. A patient who finds a general practitioner’s standards unacceptably high can move, to the doctor’s financial disadvantage, to another who might be less particular. The effect is either a loss of patients to doctors with low standards, or a general decline in doctors’ motivation to arbitrate in these matters. Similarly, doctors arbitrate on suitability for driving vehicles and piloting aircraft. Careers, salaries, and whole working lives are at issue. Medical certification is required to arbitrate a mass of financial support to the impaired people who, at times of unemployment, rely upon it heavily. Being seen to deny these allowances, even when the claims are flagrantly false, adds to a negative image of doctors.

In this group of concerns comes the unusual healthcare engagement where people have to justify their health (rather than their sickness) for insurance medicals and employers’ health checks. All these activities are invasions of privacy that require others to be made aware of the details of another person’s health including their mental health.

Then there are the potential abuses of medications, from simple undue reliance upon, or the unnecessary use of, a product not strictly needed for health maintenance, to the frank abuse of medication, street drugs, or alcohol. The public may be aware that such abuses can require doctors to give information to various authorities.

The return to prominence of lethal infectious diseases has been interpreted as a failure of medical policies rather than a reminder of the opportunism of natural phenomena especially in the face of human frailties such as greed.

POLICE OFFICER

The doctor’s forensic role has lately been glamorized in telefictional accounts of police surgeons and pathologists. Variants of the detective theme show doctors (members of a profession) bringing criminals (members of the public) to account. Scientific evidence and medical evidence (DNA sampling for example) is increasingly cited in high-profile prosecutions. Nevertheless, the intrusive potential of such medical investigations creates unease. More commonly, doctors are witnesses to fact or experts in conflicts between the members of the public at law. What they know is used for the benefit of someone, but against someone else. Sometimes, doctors are asked to construe such issues as what might constitute the best interest of a child.

After many years of denial, medicine became aware that a range of arcane crimes against the person present directly to doctors rather than through the police or accident services. Perhaps as a continuing form of medical denial, these acts have acquired the aura of medical diagnoses and been given allusive names. For an adult, to be the victim of grievous bodily harm is still not a medical category however mute and unconfiding the victim. But if the victim is a child the incident is called ‘child abuse’ and its circumstances are objects of medical and social as well as police inquiry. Other exotica such as ‘Munchausen’s syndrome by proxy’ pretend the existence of a medical condition when, in truth, there is either a crime against the person or there is nothing exceptional. They have to be detected rather than diagnosed. People who commit crimes usually try to evade detection and they will threaten potential witnesses if they can. Witnesses to crime are often ambivalent about reporting it, for reasons including the fear that more harm than good will ensue. Reticence and ambivalence, which are said to characterize child witnesses’ evidence in such cases, are simply the understandable normal response. People who commit crimes are called criminals. Child abuse, however, is committed by ‘perpetrators’. Perpetrator is medico-socialse, perhaps intended to imply some explanatory mental state not extensible to most criminals. If there were some such state, we would need to establish how it might be investigated. Perpetrator resonates with predator and may be of worse import than ‘criminal’. After it is ‘perpetrated’, the abuse is ‘diagnosed’. Diagnosis is not properly applicable to a crime against the person. Injuries are called ‘non-accidental’ rather than ‘deliberate’; or the term is used to convey that they were not intentional. If this is so then they are the business of psychiatry and psychology. Whether
the ‘abuse’ is real or an error, or a deliberately or stupidly
created fiction, the burden of dealing with it falls upon
health service professionals. They carry the corporate re-
sponsibility for being right or wrong in each case. To err in
either direction opens the profession to criticism in an area
that is not strictly the business of ‘health’ but of good and
evil doing in the world. In dealing with it, medicine is
compromised.

The medical profession, caught up in the coils of
criminal processes that are alien to its culture and ethos,
struggles to elude reality by sophistry. The prospect that a
doctor’s powers can extend to arraignment or imprison-
ment, or the removal of a person’s children, materially
affects the interface between medicine and the public.
Conversely, the obligation of doctors to consider the
possibility that the testimony they are given is false or
deliberately misleading necessarily affects the quality of all
their engagements. Doctors are taken beyond witness to
fact, into detection not of disease but of crime. Where
techniques such as surveillance have been used successfully
to save children’s lives they have been frowned upon as
inappropriate to the medical ethic.

The prediction of dangerousness and the protection of
the public from injury by insane or behaviourally deviant
persons have preoccupied the public for some time after
several bad incidents. The profession is not responsible for
the moral and fiscal policies that dictate what the appro-
priate care of these persons should be. The beliefs and the
actions of the insane are liable to reflect the ideas and mores
of contemporary society. In a violent era, with a media
ethos of hyperbole, certain outbursts are liable to be on a
grand scale. So, the profession is seen to fail the public on
that scale.

ENVOI

Members of the medical profession may wish to enjoy the
quiet dignity of the judicious practice of evidence-based
medicine. The public may wish to consult the sages,
accorded the title of doctor. The reality is that when the
doctor engages with the public various ‘components’ of the
medical role emerge, sometimes unpredictably. The result
is that suddenly, radically, the rules of the engagement are
changed. Often both parties are unaware of that change
until the course of action leads to a conclusion that the
patient had not imagined possible. It is surely inconceivable,
they will say, that the shaman is blind; that my privacy
could be violated; that a confidence has been betrayed; that
my insurance does not cover it; that I do not qualify for the
allowance; that my child’s infection has spread despite all
that knowledge; or that I, myself, or a trusted other, could
be responsible for the wretched state of the child.