MEDICAL PRACTICE

*Personal Paper***A patient's charter**

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The outrage provoked among many doctors by last winter's industrial action and its effects on their patients implies that patients are entitled to high standards of consideration, that those attending them are expected to do so with selfless dedication, and that this is the type of treatment it is assumed they normally receive. These beliefs are mostly justified—but there are occasions when patients are treated with neither compassion nor dignity and instead become the object of insensitive and inconsiderate behaviour if not of gratuitous rudeness. In these circumstances patients (with their relatives) seem to be viewed as if they were less responsible, adult, and intelligent than those caring for them with the result that real communication becomes impossible and is replaced by pseudo-communication where patients are talked about or at but not with.

These occurrences may be dismissed as rare departures from otherwise high standards of practice. But they are not uncommon, and, while sometimes of no great moment, they have a vitiating effect on professional conduct and morale and can lead to bruising consequences causing their victims to avoid further investigation and treatment.

It is likewise tempting to blame the NHS or the doctor's changing role in society today for these forms of mistreatment or to discount them as the paranoid clamour of a few oversensitive or overdemanding individuals. Yet they occurred before the inception of the NHS and can be found both inside and outside it now. Members of the medical and nursing professions are by no means exempt (see for example the experiences¹ of Kyle), confirming that there are other factors responsible which limit

the possibility of useful identification with the patient's experiences and serve to reinforce the "them and us" myth.

Although these problems continue, they seemingly provoke little change in established medical and nursing attitudes and procedures. However disquietening the account² of the way patients are treated, it can serve apparently only as an abreaction or rueful anecdote, but not as a motive for improvement in their care. A recent inquiry³ reported patients complaining, among other things, of being woken too early, treated as "cases," and of unsatisfactory communication with their doctors—all cliché complaints 40 years ago but likely to remain so 40 years hence. No one seems surprised by the continuing existence within the same service of a high level of empathic care and understanding in some units and an obtuse or hostile attitude to the patient and his family in others.

Recommendations

Long-term changes in medical education will be needed to achieve fundamental alterations in attitudes, but as a start patients could be given a charter containing their minimum rights. Among the practical arrangements that should be guaranteed are the following:

(1) No patient should be made to feel fearful, thwarted, guilty, or infantile by clerks, telephonists, secretaries, or receptionists being irritable or by their need to "protect doctor." Possibly a less traumatic alternative might be the use of automated self-processing methods.

(2) No patient or relative should be interviewed in a consulting room that is not reasonably sound-proofed, or is too hot or too cold.

(3) At follow-up visits no patient should have to accept a frequent change of doctor as if the developing relationship with his physician had no importance to his treatment and welfare.

(4) No patient or his relatives should be required to wait longer than an hour as a maximum for any medical service or attention.

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(5) No patient should be woken before 7.30 am. The traditional grounds for starting their day earlier are no more or less valid than those used to exclude women from all-male colleges and medical schools.

Longer term, the educational changes that will be needed include a review of nursing and medical curricula to correct the balance between their scientific and experiential components. A new subject should be introduced into the curriculum: the social and psychological determinants of interactions between health professionals and patients, including harmful forms of care-giving and their causation. Both the qualifying examination (SRN, MB, BS, etc) and the specialist examinations (FRCS, MFCM, MRCP, MRCPsych, etc) should include obligatory questions on these topics. Departments for the study of staff-patient relationships will be needed in medical and nursing schools, and they might be funded perhaps by the royal colleges, the Patients' Association, the TUC, and the Institute of Health Service Administrators. The significance of grief, illness, admission to hospital, and surgical procedures should be discussed in general textbooks, and, for example, accounts of conditions such as glaucoma, emphysema, or colostomy should include their effects on the patient and his family, and on his nurse and doctor.

Conclusions

The practical measures I have suggested will bring comfort to the patient and boost his morale; but they will not be enough unless there are also changes of bias in educational aims and understanding of the power and range of the factors that determine patient care.

The achievement of these objectives might seem a daunting task, but to do nothing means turning a blind eye to behaviour that falls short of acceptable levels at times, has a damaging effect on professional wellbeing, and places an added burden on patients. As doctors we are no different from our patients despite our efforts to prove otherwise, so that enlightened self-interest—if nothing else—should provide a powerful incentive towards improving the quality and consistency of care.

References

- ¹ Kyle, D, *British Medical Journal*, 1969, 1, 246.
- ² Mackintosh, J P, *British Journal of Hospital Medicine*, March 1978, p 282.
- ³ Royal Commission on the NHS, *Patients' Attitudes to the Hospital Service, Research Paper No 5*. London, HMSO, 1978.

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Today's Treatment

Drug induced diseases

Drug-related disease and the kidney

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The effects of drugs on the kidney can show themselves clinically in only a few ways. Some drugs may have more than one effect, and genetic predisposition may determine which renal syndrome or sign may occur first. No list of drugs can be totally exhaustive with respect to renal toxicity, and therefore in any patient presenting with renal disease awareness of this possibility is of major importance. It is difficult to quote figures about the incidence of overall renal drug toxicity, which varies from country to country. In Britain analgesic nephropathy is responsible for about 5% of cases of end-stage renal failure, whereas in Australia the figure is nearer 21%. For the nephrotic syndrome drugs account for 1-2% of all cases. Whether a drug induces renal toxicity may depend on total dosage given, duration of such exposure, and whether there was pre-existing renal impairment. For those patients who need drugs known to have a nephrotoxic potential monitoring of either serum

concentrations—for instance, gentamicin—or evidence of developing renal damage, such as gold, penicillamine, and amphotericin B, is clearly important.

Acute nephropathy (acute renal failure)

The number of drugs capable of causing an acute nephropathy seems limitless. Drugs may be responsible for between 20-30% of acute renal failure cases. Acute nephropathy may present as (1) acute tubular necrosis (direct tubular toxicity), (2) acute renal arteritis, (3) acute glomerulonephritis, (4) acute interstitial nephritis, or (5) acute tubular obstruction (acute intrarenal obstruction). Drugs incriminated aetiologically for (1) include penicillins; gold; aminoglycosides (for instance, gentamicin, kanamycin, neomycin); metals such as the mercurials, bismuth, antimony, and copper; solvents such as carbon tetrachloride, tetrachloroethylene; and glycols; and other drugs such as salicylates, amphotericin B, cresol; and finally items such as snake venom and mushroom toxins; for (2) anticonvulsants, penicillins, sulphonamides, thiazides, and intravenous amphetamines (drug abuse); for (3) sulphonamides, penicillin, and hydrallazine; for (4) phenindiones, sulphonamides, ampicillin, rifampicin, para-amino salicylic acid, metals (gold and bismuth), thiazides, and phenylbutazone; and for (5) cytotoxic agents used in the treatment of reticuloendothelial proliferative disorders and tumours leading to hyperuricaemia and precipitation of urate within tubular lumina, methotrexate

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