USSR Letter

Choosing and changing doctors

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When a Labour government came to power after the general election of 1945 fears arose that in the proposed National Health Service doctors would be obliged to work on a full time salaried basis. While Aneurin Bevan, as minister of health, formulated his Bill, the profession's negotiating committee drew up a list of seven principles which constituted their fundamental bargaining position. The committee indicated that, provided the impending legislation did not infringe these principles, cooperation with the government would take place.

The third one, which is composite, begins: "The citizen should be free to choose or change his or her family doctor. . . ."¹ This dual right was to become a key element in the NHS as a corollary of Bevan's acceptance that general practitioners should have the status of independent contractors within the state scheme, thus perpetuating an arrangement which had become familiar since the National Insurance Act of 1911. On a point of subordinate interest, the minister emphasised the connection between a patient's opportunity to change doctors and the extent of private practice when he observed that it "ought to keep fee paying within reasonable proportions."²

A Soviet survey

This is not the place to examine the precise bearing that freedom to choose and change doctors may have on the fact that some 98% of the population is registered with family doctors providing services under the NHS. Nevertheless, the existence of those rights within a public service used by almost all patients (for care in the community) is directly relevant to this article since it contrasts starkly with the position in the Soviet Union. There the official view, or at least the authoritative conclusion of one recent article, is that "the introduction of free choice of doctor does not meet their [patients' and doctors'] common interests and is fundamentally at variance with the practice of the Soviet health service."³

As will be shown, that dogmatic sounding statement does not represent a conclusion which derives unavoidably from the empirical data presented in the article.³ But no less important than that difficulty, it seems to me, is the fact that attitudinal research on this subject was actually undertaken and the results published.

Admittedly, for some years now the idea of choice or the "right of refusal," which is its converse, has received occasional mention in criticisms of incompetent and uncaring medical practice. Moreover, consumer preference is now catered for to some extent in larger urban polyclinics, where the staff comple-

ment includes more than one so called "narrow" specialist in disciplines such as ophthalmology, stomatology, otorhinolaryngology, etc, and patients may sign up for appointments with any one they choose. But the arrangement—almost certainly—does not extend to choice of a practitioner in general medicine (*terapevt*), who is responsible for a specific microdistrict (*uchastok*) of the town. Moreover, a polyclinic's head doctor has the power to reallocate a patient as a device of last resort when an irretrievable breakdown of relationships has occurred. From what I have been told, that power is rarely used.

Against such a background of strictly limited choice, in 1982 the authors of the article sought the opinions of a random sample of 1103 patients at 23 of Moscow's polyclinics. The breakdown by socio-occupational groups was as follows: 38% white collar workers, 27% manual workers, 25% pensioners and invalids, and finally 10% students. (The original text gives figures to two decimal places, which I have rounded throughout this article.) Women respondents substantially outnumbered men, the proportions being 63% and 37% respectively. As for the age distribution, 7% of patients were under 19, 22% were aged 20-29, 13% were 30-39, 17% were 40-49, 21% were 50-59, and the remaining 21% were 60 or over.

In favour of choice

The questionnaire completed by patients also asked for information about educational background, on the presupposition that this variable was likely to have a powerful influence on opinion. It seems unnecessary to spell out the precise denotation of the categories used since the nomenclature itself gives a broad indication of the duration of studies and final level of attainment. Thus 32% of respondents had a higher or incomplete higher qualification, 63% had an intermediate or incomplete intermediate qualification, and the remaining 6% had only elementary education.

How attractive did the notion of free choice turn out to be? The findings showed that a little over half—55%—favoured choice of "narrow" specialists (ophthalmologists, etc) and almost half—49%—wanted to be able to choose their own *uchastok* *terapevt*. As for that acid test of a patient's satisfaction with his current *terapevt*, only 13% of respondents wished to change to another at the time of the survey. Incidentally, the authors drew no comparisons between their own results and those of other researchers, which serves to strengthen the impression that they may well be first to research this topic.

A detailed breakdown of the results is presented in the table. As may be seen, they endorse the hypothesis that length of formal education is positively associated with preference for both choosing and changing doctors. Nevertheless, even among patients who had only elementary schooling as many as 46% favoured choice of "narrow" specialists and 35% favoured choice of *terapevt*. Furthermore, the proportion of women wanting to change their *uchastok* *terapevt* was three times the figure for men (though only 18% as against 6%). That sub-

stantial difference between the sexes should help to account for the fact that the prospect of change appeals more to pensioners than to any of the three other social groupings.

Summary of the study's findings

	%, of respondents in favour of:		
	Free choice of "narrow" specialist	Free choice of therapist	Changing uchastok therapist
Social groups:			
Manual workers	43	38	8
White collar workers	68	61	14
Pensioners	47	40	15
Students	61	52	11
Sex:			
Men	53	47	6
Women	56	51	18
Age groups:			
≤ 19	51	49	8
20-29	65	60	13
30-39	62	53	10
40-49	56	51	14
50-59	48	43	14
≥ 60	51	43	14
Education:			
Higher	69	60	15
Unfinished higher	55	45	10
Intermediate	47	42	14
Unfinished intermediate	54	48	9
Elementary	46	35	15

The data have been rounded from two decimal places.

Depersonalised service

The reasons for wanting to change doctor clearly required investigation since they have important practical implications. Some of the reasons cited—namely, inadequate training and qualifications of doctors and ineffectiveness of the treatment prescribed—raise difficulties of interpretation; apparently the authors did not attempt to ascertain to what extent such judgments were factually correct. All the same, there can be little room for doubt about the general thrust of complaints when 55% of patients wanting to change referred to their doctor's "inattention, offhandedness, haste, and distractedness."

That constellation of related complaints, according to the authors' prescription, may be largely cured by a simple formula. "Evidently the majority of reasons," they write, "are entirely capable of elimination through the use of training measures for students in medical schools and for practising doctors in curative-prophylactic units."

It transpires that they also envisage some form of propaganda campaign among the general public. Complementing a greater emphasis on "the deontological approach" for doctors would be "continuous health education explanatory work," whose function, though not specified, may well be to foster a stereotype image of the "model" patient and so alter expectations and behaviour patterns.

In addition, the authors take account of constraints imposed by the organisation within which doctor-patient transactions occur. Among the specific changes advocated are a reduction in the number of persons per uchastok, and lighter work norms in respect of patients to be seen per hour in the polyclinic and when making domiciliary visits. The other recommendations are for nursing help at consultations as a matter of course and for establishing "preconsultation" rooms, to be staffed, it must be supposed, by paramedics. Taken together, these reforms would mean that "the doctor can have more time to devote to patients, to observe them with thoroughness and talk to them on a confidential basis."

Doctors' views

So far only the opinions of consumers have been discussed, but the article has an additional interest since it reports a supplementary inquiry which investigated the attitudes of doctors. As for the background of the 82 respondents, all were

therapevts, 85% were women, their average age was 39, and they had an average of 12 years' service.

Whatever their other aspirations, these doctors' comments show that as a group they would not welcome the introduction of free choice of uchastok therapist. As many as 70% were straightforwardly opposed to the notion, 2% had no opinion either way, and 28% considered it a possibility. Nevertheless, the last mentioned respondents "advanced weighty reasons against such a measure."

Some of the objections, familiar by virtue of their universality, turn on a patient's inability to assess professional competence and the danger of his losing confidence in his medical adviser because of "instability of character" or prolonged illness with a slow recovery. Changing doctors during an illness was regarded as undesirable on the grounds that it can "interfere with the dynamics of treatment," with various harmful results, and may lead to the second doctor, who lacks previous knowledge of the case, misinterpreting specific reactions to treatment.

Other contraindications cited arise from particular organisational characteristics of the Soviet health service. That is to say, free choice of therapist will infringe the uchastok principle, produce unequal workloads, and (this point is conveyed in *officialese*) "will complicate the psychological climate in medical collectives."

Conclusion

Given those difficulties, and other features of the work context entailed by an employee status, it seems justifiable for the authors to write that free choice of therapist is not in the doctors' interest. But to assert without argument that it would not be in the interests of patients is highly questionable, especially since nearly half the sample had declared the contrary—at least by implication. Though the authors might be regarded as progressive by virtue of researching this topic, their assertion surely displays the limitations of an authoritarian "mind set" which fears the multiple consequences of choice; their advocacy of the status quo emphasises the validity of Lenin's holistic perception that "everything is connected to everything else."

References

- ¹ *Br Med J* 1945;ii:833.
- ² Bevan A. Parliamentary debate. *House of Commons Official Report (Hansard)* 1946 April 30; 422:col 57.
- ³ Antipenko ES, Nesinova RV. Ob izuchenii meneni patsientov o rabote vrachei polikliniki. *Zdravookhranenie Rossiskoi Federatsii* 1983;12:16-8.

Clinical curio: "Tempora mutantur," or do they?

I quote copies of two letters:

From the clerks to the Boards of Guardians to my distant predecessor who lived in my house in 1840

"... As the Commissioners' privilege of franking and of receiving letters free has been abolished by the new post office regulations it will be desirable in as much as the omission of prepayments will subject the letters to double postage, that you should pre pay all letters directed to them...."

Received 142 years later by me at the same address from the Department of Health and Social Security (the successors of the Board)

"... The DHSS has changed to public methods of paying postage and, as a result, it is not possible to provide an 'Official Paid' envelope for sending the letter to the patient notifying the proposed date of the medical examination.

"However, a plain envelope, which will need a stamp, is enclosed for you. You may claim a refund of the postage on the same form as you claim your fees."—A D STOKER, general practitioner, Derbyshire.