VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Caveats about collaborative health

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In July, Fiona Godlee asked whether we were ready for collaborative care,¹ highlighting an essay by a US author, Michael Millenson, that elegantly argued for moving beyond “person centred” healthcare to collaborative approaches.² UK public health services have their own advocates in this movement—notably, the Royal College of General Practitioners, the Coalition for Collaborative Care,³ and NHS England’s House of Care framework.⁴

I generally support this movement. As more people live with long term medical conditions, it surely makes sense for them to be more informed and more involved in identifying their own treatment plans and goals. It also makes sense for them to manage these in collaboration with clinicians, while becoming more “activated” about their own health and care.

It’s likely that such partnerships between doctor and patient—each with valid expertise and experience—will improve decisions and continuity and move us away from traditionally paternalistic approaches. As Millenson highlights, patients may increasingly expect this. After all, so much healthcare information is readily available online, and people are increasingly able and likely to access their own health records. And they already use the web to help make decisions in other areas of life, bypassing professionals.

Why, then, would I have any reservations?

Firstly, we should never assume that all patients want such supported self management approaches or want to use technology. If we’re serious about choice and control we must respect people who want to see doctors face to face, to hand over many decisions and trust them as expert information sources and system navigators. Patients aren’t somehow misguided if they do this.

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Secondly, I don’t agree with the MP and columnist Michael Gove that people “have had enough of experts.” As a doctor, I’m as much a layperson in any non-medical encounter as patients are with me. I find it not disempowering but reassuring. I’m glad that the Crossrail tunnel is being built by seasoned

engineers and construction managers. I can read up on the law, but I’d rather have a barrister steeped in courts and trials defending me than defend myself. And I think that trained teachers know a lot more about education than people who happen to be parents. If recent governments had taken more notice of civil servants and “technocrats” we might have avoided many a mess—the bungled Brexit negotiations, for example.

Finally, perhaps because US society hinges more than European societies on individualism and autonomy, Millenson doesn’t mention the responsibilities doctors have in a public universal service to consider use of scarce resources, population health, and the care of all patients. It can’t be a free for all on the basis of want rather than need.

Allowing vaccination rates to drop will harm herd immunity. Giving out unnecessary antibiotics precipitates dangerous resistance. Offering costly scans that add little value, operations that are unlikely to work, and treatments with no empirical evidence—or an extra few days in hospital for someone stable enough to leave—deprives another patient of resources.

In such circumstances medical paternalism, and stewardship of the keys to treatment, is right and proper. We must put collaborative health in the context of a cash constrained system designed to provide collective coverage to the many. In other words, individualism has limits.

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- 2 Millenson ML. When “patient centred” is no longer enough: the challenge of collaborative health: an essay by Michael L. Millenson. *BMJ* 2017;358:j3048. doi:10.1136/bmj.j3048 pmid:28679500.
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