



In Harm's Way

How 'health promotion' has damaged the relationship between doctor and patient

Brian Bedkofer

A great deal of scrutiny has recently been given to the problem presented to medical practitioners (and less recently to nurses) by violent patients. Clearly, something has eroded the relationship between patient and doctor.

Following the fatal attack on Dr Khulod Maarouf-Hasan in Melbourne in 2006, a nationwide Australian survey by Cegedim Strategic Data revealed that 83.3 per cent of GPs had been verbally abused by a patient, 43.3 per cent threatened and 12 per cent physically abused.

The Australian Medical Association and the Royal Australian College of General Practitioners both have position statements on personal safety for physicians. Among the suggestions made are that the taxpayer should fund (via incentive payments) infrastructure changes to improve practitioner safety and that safety protocols should be linked to accreditation. Other suggested measures include practical activities such as staff training, tracking of patients who have perpetrated repeated violence in general practice settings, enhanced cooperation with police and the judiciary and the involvement of patients in achieving a safe working environment.

However, not only does there appear to be no evidence that physicians and staff may actually be protected by any of these measures, but they may ultimately lead to increased costs to consumers (or taxpayers). At the same time, one-size-fits-all solutions will ensure that wastage is maximised.

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Strangely, nobody has suggested why this problem may have arisen in the first place, other than to link it non-specifically and dubiously with increasing violence in the wider community.

From demand to prevention

There was a time when medical practice was demand driven: patients presented with a complaint for which the doctor attempted to find an explanation and prescribe a treatment.

Prevention, however, is now all the rage. One of the reasons for the modern focus on prevention is the limited success in identifying the root causes of the remaining scourges such as heart disease and cancer. Another reason is because governments believe that preventing the emergence of disease, rather than simply treating it when it presents, is the best strategy to limit the costs of taxpayer-funded health schemes—and the harm that increases in taxation may do to a government's electoral prospects.

A critical result of this focus on prevention is that while the traditional role of the law was to intervene only when the actions of one individual threatened another, intervention now increasingly occurs when individuals harm themselves or they are harmed by chance (through the fault of no other person). Now, issues such as smoking, alcohol and obesity have been added to governments' agendas.

The end result is a programme of social control masquerading as health promotion.

Rather than simply presenting the facts, physicians have become the guardians of public morality, interrogating patients about their lifestyle choices, and making them feel guilty about making 'bad' choices.

Obviously, the role of the medical profession in these health promotional activities is critical. The concept of health as the new religion fits well with the bias of most physicians; physicians are generally comfortable with the idea that a happy and virtuous life must necessarily equate with a healthy one. Nothing is more important, that is, than good health and any choice that is inconsistent with the maintenance of good health is a bad choice.

But health preventive activities do not, of course, *prevent* the occurrence of illness. In many cases they merely delay its appearance.

The emphasis placed on preventive care has also resulted in the introduction of a large number of new Medicare item numbers and incentive payments through which medical (and non-medical) practitioners are increasingly able to access the public purse.

This has resulted in a windfall for many practices as the use of computer templates and the judicious employment of ancillary staff has enabled the generation of the paperwork necessary to access the not inconsiderable funds on offer. Where such interventions were necessary in the past, of course, they were done without these item numbers—and whether anything further has been achieved by their extensive uptake is extremely doubtful. The financial benefits, however, have provided considerable (and much needed) rises in the income levels of many practitioners—particularly those working in large group practices.

Doctors are now paid by the government to disseminate and act upon health promotional messages which (they may or may not know) are often of dubious validity and, rather than concentrate on people who present with a particular illness, much of their precious time is now taken up in doing 'check-ups', getting patients to fill in questionnaires and dealing with anxious patients who want to be screened for some illness that they have heard about and think they might or could have.

In those cases in which the patient does present with a particular malady, the doctor invariably

raises some additional matter that is on his agenda (often because of the related payment incentives) but not on the patient's.

Much of this activity is facilitated by the medicalisation of life so that the government may justify exercising control over all aspects of it. By describing health in a meaningless, content-free way such as a 'state of complete physical, mental and social well-being' and by classifying behaviours (such as eating or drinking too much) as 'diseases', what was previously the province of personal choice has become the province of the medical practitioner.

Where people may be held responsible for unacceptable 'behaviour' they cannot, or so the argument goes, be held equally responsible for some 'disease' or 'illness' from which they suffer. As Thomas Szasz once noted, there is never a question about whether a particular individual may actually like and choose to drink, smoke, take drugs or be overweight—the patient simply suffers from a 'disease' and must be treated.

A good general practitioner is now expected to actively enquire about the sex lives of patients, whether they might be subject to domestic abuse or engaged in child abuse, whether they smoke, gamble or drink or take forbidden substances and so on and on.

Answers to some of these questions could result in referral to a range of authorities, including the police. These referrals, furthermore, may be based not on what a patient is known to have done but on what he might do or might have done. Individuals may be reported on scant evidence—often because scant evidence is all that is required, or reporting is mandatory, or there are significant legal risks for the physician attendant upon failure to report.

Governments, for their part, are very pleased to be able to make use of doctors to perform these tasks; doctors are well placed to carry out surveillance and deliver the messages approved by government and its agencies, since so many citizens see their doctor at least once a year. Who better than their friendly physician to ferret out what patients are up to, advise them about the wisdom of their choices, refer dissidents for counselling, or report them to the appropriate authorities?

The theme for this year's Family Doctor Week (22–28 July) was *Your GP: Part of the Family*. However, as a result of the changing nature of medical practice, your GP, rather than being a part of your family, has, to a significant extent, been converted into an agent of the government.

As doctors have moved away from being paid by the patient to being paid by the government, they have moved from having a commitment to the patient to having a role in tackling the problems of 'society'.



Instead of treating illness and respecting the autonomy of the individual and the privacy of personal life, they are increasingly expected (and financially manipulated) to conform to the dictates of political correctness. Rather than simply presenting the facts (as currently known), physicians have become the guardians of public morality, interrogating patients about their lifestyle choices, making them feel guilty about making 'bad' choices and acting not to satisfy the patient's wants but to satisfy the demands of the state.

While many patients have come to accept that this is a proper role for the doctor, others have come to regard their doctor with some apprehension—even with hostility and suspicion. Many find these questions impertinent and simply none of the doctor's business—particularly when they come, as they often do, from someone who is younger and less mature than the patient being interrogated.

When doctors believe that it is a part of their job description to enquire actively into a patient's sex life and so on, to inform on their patients and to collaborate with the local police and a whole range of other government agencies, it is not surprising that many patients become abusive and even physically violent.

Some of the most serious attacks have occurred when practitioners have

been acting in the role of the government's drug police. Surprisingly, many practitioners are actually keen to extend this kind of role through capitation and fundholding schemes—several of which are currently run by the General Practice Network (formerly Divisions of General Practice).

Roughly speaking, these are schemes whereby the health care needs of individual consumers in a particular geographical area are funded through access to a managed pool of funds. The managers of these funds then become the subject of consumer anger when they must be rationed in some way. Government is, of course, happy to have somebody else appear to be responsible for these kinds of decisions.

It is natural, therefore, when doctors are increasingly seen to be aligned with government rather than with their patients, that patients should be more inclined to vent their frustrations on doctors. And these frustrations must inevitably increase as it becomes increasingly difficult for individuals to live the lives they choose—because, for example, they are not permitted to exchange a shorter and less healthy life for a more enjoyable one when taxpayers bear a large proportion of the costs of an individual's unhealthy choices.

This does not mean, however, that medical confidences should never be broken or that doctors should not en-

gage in health promotional activities. Instead, it needs to be recognised that the doctor–patient relationship has been progressively poisoned as control of the relationship has shifted to the government.

It is not at all evident that the changing role of the doctor has been for the better, either from the perspective of the individual or of the community as a whole. When doctors are expected to manage the social as well as the medical complaints of their patients, it is little wonder that their relationships with patients can be torrid—and that they may be subject to abuse and attack. Not only have these changes placed doctors in harm's way, but they also have a great deal to do with the workforce 'crisis' which general medical practice now faces.

All of this brings us back to the 'non-specific' link between violence towards physicians with increasing violence in the wider community. In fact, there is nothing non-specific about this link at all.

Violence towards physicians is simply another manifestation of the incivility and anti-social behaviour that a number of authors have identified in relation to the welfare state.

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