

Patients' Expectations: Provider Dilemmas

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During the Second World War, while the Government of Canada was busily engaged in decision-making and activities aimed at the defense of the free world, a small department within the Canadian federal bureaucracy was equally busily engaged in laying the foundation for the defense of the health of the Canadian people. In consultation with bureaucrats from the provinces, physicians from the Canadian Medical Association, and consumers, were carefully formulating plans for a public health insurance program to be enacted for peace time. Although implementation of these plans was delayed for over a decade, the events during the war years were significant because they captured the tone of the Canadian spirit and the Canadian value of equity, particularly equity in health care.

Thus, the passage of the *Hospital Insurance and Diagnostic Services Act*¹ in 1957, the report of the Royal Commission in 1965 recommending medical insurance, and the medicare legislation of 1967² were only the fruition of a process long in motion. As Malcolm Taylor has so eloquently stated about the end result:

*It is impossible for anyone under the age of forty today, protected as we now are with a full panoply of social insurance programs, to appreciate, or perhaps even to comprehend, the threats to individual and family independence and integrity that characterized the thirties and extended, to declining degree, into the forties and fifties. But to millions the threats had been real and, for hundreds of thousands, had come to pass.*³

After long years of labour, the ultimate passage of these pieces of legislation resulted in two policy directions germane to this paper: a gradual increase in public expectation about the health care system and demands for service, and an affirmation of the division of labour in health care. I will discuss each of these topics, looking at outcomes and recommendations for change.

I. RISING CONSUMER EXPECTATIONS

With the advent of universal hospital insurance and medical care insurance, the consumer's right to health care and to equal access to that care became assumed.⁴ As technological developments reached astounding proportions in the post-war years, through the sixties and seventies, and continuing through the eighties, the miracles of modern medicine were expected to be available to the average Canadian, if required, as soon as they became known through the media. Consumers have come to expect reasonable access to a wide range of health services, even if they reside in remote areas, even when the services are costly, even though health care practitioners to provide the "needed" service may be in short

1. S.C. 1957, c. 28.

2. *Medical Care Act*, S.C. 1966-67, c. 64.

3. M. G. Taylor, *Health Insurance and Canadian Public Policy* (Kingston and Montreal: McGill-Queens University Press, 1987) at 2.

4. J. L. Storch, *Patient's Right* (Toronto: McGraw-Hill Ryerson, 1982).

supply, and even though many of the available technologies for treatment and diagnosis have not been shown to be effective.

More problematic is the fact that the public has come to expect a certain type and style of service. The introduction of hospital construction grants in 1947 and hospital insurance programs in 1957 led consumers to expect that real health care (which is, by and large, more equatable to illness care) occurred in hospitals. After years of care in the home, home care came to be perceived as second class care. Institutional care became the norm, and aptly so given the expensive, not-very portable equipment best suited to central location in a health care facility. Hospitals also acquired a life of their own, requiring staffing and organization to function. With science upheld as a dominant value, medical science clearly required the presence of medical practitioners who retained their traditional ascendancy. The passage of the *Medical Care Act* in 1967 only served to re-enforce the value of medical care, mainly physician's care, as the North American, Canadian version of health care.

Thus, the consumer came to expect fast access to a physician — both general practitioner and specialist — and care within a hospital when ill or otherwise incapacitated. In fact the sick role became etched into the Canadian health care consumer's way of thinking through these public programs. You may recall that the sick role was described by sociologist Talcott Parsons in the mid-fifties.⁵ The sick role embodies four criteria:

1. *sick persons are not blamed for their illness;*
2. *sick persons are exempt from the performance of their normal duties;*
3. *sick persons are expected to want to, and to try to get well; and*
4. *sick persons are obligated to seek competent help.*

"Competent help" is normally restricted to medical practitioners and this restriction was underscored in Canada by medicare, which normally honours only billings from physicians — other health care practitioners are rarely recognized as providers of primary (first contact) care.

Dependency created by the system is not easily shed. The sick role demands are very real. Few consumers have the courage to not seek competent help and to try to deal with health problems themselves. Further, most consumers are obliged to have a physician certificate if absent from work for a number of days. Rarely would a nurse or physiotherapist or social worker be eligible to confirm the illness. Society and the health care system also foster continued dependency by restricting access to healing measures — drugs, non medical practitioners, information, etc. Many of these restrictions were imposed for public protection. But are they justifiable? Or are they mainly designed to protect professional territory?

Perhaps the laws and regulations governing restriction of medical/health products need review to determine the "best interests of the consumer". Why, for example, should a consumer not be able to consult a nurse as point of first contact and referral? Should an

5. T. Parsons, *The Social System* (New York: The Free Press, 1951).

experienced parent not be able to obtain medications she or he knows a child needs without bounding the family up to pass through the checkpoints to treatment? Do the potential harms of childhood antibiotics or decongestants clearly outweigh the benefits of allowing the parent greater access through their friendly neighbourhood pharmacist? And what about the chronically ill person with periodic needs for medication for symptoms of the problem and its remedy which that person now knows better than anyone else? Do sick people always need to pass through the "gate" to obtain remedies for illness?

It is mainly since the mid-seventies that consumers began to question the health care system in any substantial way. Led by the women's movement, challenges to the institution-focus and the physician-focus were raised. Women began to question why their own knowledge about a healthy process, such as childbirth, should be medicalized with the requirement of physician attendants rather than a midwife's attendance; and why the birth process needed to occur in hospitals only. Their complaints eventually became the basis for other types of consumers to critically evaluate the essence of their own wisdom and understanding of health and disease. Ivan Illich⁶ became one of the most vocal critics of the health care establishment in his charge of a medicalization of life, and his call for a demedicalization of life events and health care. Illich pointed out that we have made medical care a requirement from womb to tomb by emphasizing prenatal care, and by requiring a physician to pronounce death. In a somewhat humorous attack on the practices surrounding death in intensive care, he compared the physician's role as that of an umpire at a ball game who determined whether the patient could leave the game (of life) or not, and when and under what circumstances that patient might leave.⁷

These numerous complaints and challenges about the system, including challenges within the system, have resulted in a curious mix of consumer expectation and demand. On the one hand, consumers expect equal access to any and all health care available. On the other hand, they demand a more powerful voice within the system. They reject paternalistic decision-making because the majority want to make decisions about their own body and its treatment. At times, they even want greater permission to function outside the system, that is, to have access to pharmaceuticals and equipment to allow them to engage in meaningful self care, and to be free to consult practitioners of choice within the system without being required to pass through the "gate" of physician entry (or exit for that matter). This latter concern is demonstrated in the Right to Die movement, which is becoming even more prominent since we have entered the 1990s.

Clearly, some of the rules and regulations need serious evaluation since effecting a less restrictive system could not only restore to consumers confidence in their ability for self care for many of their health problems, but could also result in a much less costly health care system.

II. THE DIVISION OF LABOUR AND ITS EFFECTS

6. I. Illich, *Medical Nemesis* (London: Calder and Boyars, 1975).

7. *Ibid.* at 147.

Professions are those groups in society that essentially profess to have superior knowledge and skills which they pledge to use for the benefit of others. These particular assets set them apart from others and establish the type of service they will render to society. What has puzzled many who study the medical profession is the way in which tasks are divided in health care — the division of labour in health care. There seems to be no comparable professional grouping in which one profession exercises such authority over other professional or occupational groups. Its existence presumes a common base of medical knowledge with one group (physicians) having a superior dose. Medical history contradicts this notion. For example, Paul Starr⁸ shows how physicians were able to maintain authority and control of health care even when the effect of the application of their rather primitive knowledge and skill was negligible. Others have shown how midwives and other practitioners were forced out of practice, or forced into a marginal position in health care, because of the power and influence of medicine as a profession. In addition, not all health professionals would agree that their knowledge emanates from medical science only. Thus, it would seem that the way in which tasks are allocated in health care rests as much on social, political and gender issues, as on knowledge and technical expertise. In this division, medical dominance is clearly established, including medicine's "control over the content of medical care, over clients, over other health professions and over context of care."⁹

As noted earlier, the development of the Canadian health care system affirmed the pre-existing division of labour in health care by establishing the *Medical Care Act* in 1967, designed to compensate physicians for their services. Few other health professionals have been considered for funding under this Act which became the *Canada Health Act*¹⁰ of 1984. This division of labour is problematic for physicians, other health professionals, and consumers, and is evident in institutional structures and in community health agencies.

It is problematic for *physicians* because it places upon them a sometimes overwhelming burden of responsibility for ensuring that the technical aspects of care are beyond criticism, as protection against malpractice suits. Witness, for example, the fears felt by obstetricians or family practitioners providing maternity care about threats of legal suit.

Another problem with the dominance of physicians in the division of labour is the over-emphasis thereby placed on medical science, especially those technologies aimed at cure. This means a devaluing of the less technical aspects of care, and a de-emphasis on the softer sciences, such as empathetic and nurturing knowledge and skills.

The division of labour is problematic for *nurses, pharmacists and other health professionals* because it does not permit them to maximize the application of their particular knowledge and skills. They commonly know far more than they are permitted to put into practice. Further, in many hospitals today, there is a tendency to introduce systems to measure worker productivity in ways that are often demeaning to professional judgement and professional practice. Health professionals find that the patient's emotional and spiritual needs

8. P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books Inc., 1982).

9. D. Coburn, "The Development of Canadian Nursing: Professionalization and Proletarianization", (1988) 18 Int'l J. of Health Services 437.

10. R.S.C. 1985, c. 6.

are not counted as significant against the more measurable indicators of incisions, infections and length of stay. For nurses, physiotherapists and others there is a growing grief in not being able to provide as good a quality of care as professional standards dictate.

For *patients*, the division of labour is also problematic in restricting their access to the practitioner of their choosing. And with the introduction of attempts to rationalize systems of care in hospitals, such as Diagnostic Related Groups or the Case Mix Index, patients often experience a sense of loss of caring in hospital care, and a sense of rapid and depersonalized movement through and out of the hospital system.

Clearly then, the current way in which tasks are divided in health care results in poor deployment of human resources, and in less effective patient care. Yet, while politicians and bureaucrats "cry wolf", with gloomy predictions of insufficient resources, there is an extreme reluctance to challenge the current structures in health care that perpetuate ineffective use of human resources. For example, numerous studies have demonstrated the effectiveness of nurses as primary care givers in wellness and illness care of the elderly, and in the care of healthy women in prenatal and postnatal care. Yet, these human resources are vastly under-utilized due to attitudes and regulations restricting such practice. As more than one health management specialist has noted, society does have sufficient resources for our elderly if we choose to use those we have already allocated to health care in a more effective way. The statistics on patient compliance, suggesting that a large percentage of patients do not comply with recommended treatment, should be enough to prompt us to re-examine ways of providing effective care.

Finally, an obvious dilemma resulting from a division of labour that emphasizes medical science over other sciences is the lack of attention to illness prevention and health promotion. For many decades, the proportion of funds devoted to prevention and promotion out of the total health care dollar has remained at approximately 5%. This figure betrays the low value placed on illness prevention and health promotion strategies that frequently tend to be more effectively and efficiently accomplished by health professionals other than physicians.

CONCLUSIONS AND RECOMMENDATIONS

The Canadian Health Care system is recognized world-wide as an excellent system. It is, however, experiencing a problem of apparently insufficient resources while at the same time there is significant under-utilization of human resources. This discrepancy calls for an evaluation of the emphasis in health care, and for a careful examination and realignment of health professional roles and responsibilities. Such an examination requires attention to cost effectiveness to determine practice which is based on defensible options rather than practice based on tradition. Consumers, too, should be assisted towards greater self-reliance and responsibility by receiving more and better information to enable them to make wise choices.

To effect these realities, a number of significant changes must occur. First, both the public and health professionals will need to modify their expectations of roles of practitioners and modes of care, and permit practitioners of various kinds to become eligible to be primary

care providers. Hospital care will have to cease to be the norm of "good care". Second, patterns of health professional education should be changed to allow doctors, nurses, pharmacists, physiotherapists, nutritionists and others to study together to learn to value each other's contribution to health care. And finally, legislation should be changed to ensure that existing professional legislation does not hamper individuals from providing care for which they are trained and that allows consumers freedom to engage in greater self care. This latter goal can only be accomplished if regulations related to pharmaceuticals and other medical products can be relaxed, if gatekeeper functions are reduced, and if consumers share responsibility for mishaps. Accomplishing these several changes should lead to a more humane, less costly and more satisfying system of care for provider and recipient alike.