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Medical mismanagement or patient vacillation?

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Author's abstract

Ian Kennedy extols the virtues of self-determination by patients: they should make their own decisions about medical treatment after being given advice by their doctors; for doctors to make such decisions on their patients' behalf is authoritarian and unacceptable (1).

I present a case where, despite thorough consultation and counselling, the decisions made by the patient and supported by her doctors were found to be consistently inappropriate to her changing lifestyle.

Case report

Mrs A C first presented at the age of 32 requesting reversal of sterilisation. She had married at 18 years, had four children over the next five years and had been sterilised one year later. Her marriage ended in divorce three years after this when she was 27; she formed a new relationship and after a further five years requested reversal of sterilisation. She was seen with her partner by a senior gynaecologist at two different hospitals (she was referred from the first in view of a long waiting list). With some reservations both agreed that her request was reasonable. Unfortunately she had developed an atypical cervical smear and underwent the operation of cone biopsy. As a result there was a further delay of 18 months prior to tubal re-anastomosis to reverse her sterilisation.

The patient presented again two years later with excessive bleeding and requested a hysterectomy. Her second marriage had by this time ended – partly, she claimed, due to her failure to conceive.

Continued at bottom of page 181

Continued from page 178

to sleep. The doctors have made tremendous adjustments – some would say excessively so – in implementing the responsible but minor controls of abortion demanded of us by our society. The ethical decisions may be indeed haphazard and idiosyncratic but this is precisely because we are part of a haphazard and idiosyncratic society. The similarities in birth control practices of Catholic and non-Catholic populations in Western Europe show the strength of societal pressures.

When we get on to informing the patient, attitudes again are changing. Thirty years ago most patients were content to let the doctors do as much as possible of their worrying for them. Now with the diminished status of doctors (partly overdue in an egalitarian society, partly explicable via the sociology of envy) we are trusted less and are required to tell more. We try our best but some of us will be brutal and some evasive. There is however good, if anecdotal, evidence that we are increasingly being as honest and at the same time as kind with our patients as we can manage: and I am perpetually being humbled yet inspired by the courage and humour of our patients, when one shares a difficult situation with them.

Although they loom closer, we have not yet got a clinical ombudsman, clinical audit is not yet routine, informed consent difficult to achieve, and litigation may well prove a more effective education tool than the post-graduate lecture. Some doctors may be conservative, dedicated to the concealment of their ignorance, dogmatic, selfish, unimaginative and even paranoid. Yet as a profession we have exposed ourselves to over-production of doctors, unemployment and redundancy; we have accepted one of the lowest living standards of doctors in Western Europe; and except in the city centres we work harder and die quicker – we do try.

We may be greedy – irreverent registrars once demonstrated a positive correlation between the length of the consultant's car and the length of his NHS waiting list – but we are still dedicated, intelligent, and as incorruptible a crowd as you will meet anywhere, so that although the doctors are ghastly at times, I am still proud to be one of them. Some teaching hospitals may resemble 'hermetically sealed cocoons' but if we are all that isolated, could it be that we are sometimes more sinned against than sinning, more victim or target rather than mass manipulator?

To me at any rate this seems likely. It is no excuse, but there are more dishonourable roles than scapegoat.

Reference

(1) *Inequalities in health.* (The Black Report). London: DHSS, 1980.

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off the intrusion of lay assessment of clinical matters, since only doctors will be involved in the consideration of a patient's complaint. I, like Mr Kennedy and other distinguished authorities (4), (5), believe that the Health Service Commissioner should be able to investigate complaints involving clinical judgment.

To doctors 'medical audit' is another red rag to a bull. I should like to see a system akin to HMIs in the schools world. The 'inspectors' would be drawn from the medical profession (as is, in part, the Health Advisory Service which monitors conditions in long-stay hospitals); they would not have the power of life and death over doctors, but one would expect their opinions and recommendations to be taken seriously. The Patients Association put this suggestion to the Merrison Committee of Inquiry into the Regulation of the Medical Profession (6), but it fell on stony ground – like so many other proposals from outside which doctors regard as threatening. Mr Kennedy is so right about their attitude in general.

But there is hope. The medical schools are becoming more enlightened in their curricula; the patient no longer is regarded in them simply as a system of bones, nerves, flesh and so on, but also as a fellow human being. In addition consumerism in the general environment (even if less pervasive now than formerly) does rub off on medical students and young doctors, and on other professions, tradesmen and industrialists, so that in that sense, but by osmosis rather than through an act of conscious choice by doctors, consumerism will have its effect.

References

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(2) Kennedy I. Consumerism in the doctor-patient relationship. *The Listener* 1980 Dec 11: 777–780.

(3) Department of Health and Social Security circular HC (81) 5, April 1981: Annex Part 11.

(4) Ackroyd E. Complaints against the medical profession. *Poly Law Review* 1981; December.

(5) First Report from the Select Committee on the Parliamentary Commissioner for Administration Session 1977–78. House of Commons. 16 November 1977 HMSO.

(6) Report of the Committee of Inquiry into the Regulation of the Medical Profession. (The Merrison Report). Cmnd 6018. London: HMSO, 1975.

Continued from page 179

She was admitted for hysterectomy only to discover that she was five weeks pregnant. She was delighted with this news. Unfortunately her new partner left within a few weeks of this discovery. The patient therefore returned with a request for termination of pregnancy using the same grounds as first used in her request for sterilisation.

She was referred to the medical social worker for reports and the opinion of a second gynaecologist was obtained. Both felt that she had been a victim of circumstances rather than indecision and that an additional child would place an intolerable strain on her at a time of great uncertainty. Nonetheless, they were impressed by her determination and independent nature. It was therefore felt that she had good grounds for her request and termination was performed forthwith.

Comment

This lady made a series of decisions with the support of medical staff which were subsequently found to be wrong. The dangers of sterilisation under 30 and in relation to an unstable marriage (although undetected in this case) are well recognised (2). However, it is rare to see patients who have undergone reversal of sterilisation requesting termination of pregnancy or further sterilisation.

It is significant that the patient had a delay of 18 months between presenting her case for reversal and the operation, so she had considerable time to reconsider. It is difficult to see how counselling could have been improved to avoid this series of events, although the outcome might possibly have been predicted. Suppose the actual course of events *had* been predictable, should the patient nevertheless have been allowed to make her own decision, as Kennedy advocates? Would this be a proper use of scarce NHS resources?

While there is no question of apportioning blame, this case would be welcome evidence to those who oppose the full availability in the National Health Service of operations for social, cosmetic or other indirect medical indications. In fact it is presented to illustrate the difficulties in decision making for such operations, the unpredictability of social circumstances, particularly marital relationships, and to question the appropriateness of leaving difficult decisions to patients rather than to their doctors.

References

(1) Kennedy I. Consumerism in medicine. *The Listener* 1980 Dec 11; 777–780.

(2) Winston R M L. Why 103 women asked for reversal of sterilisation. *British medical journal* 1977; 2: 305.

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