Patients' preferences need thinking through for the NHS

Editor—Kennedy comments that a mature culture will settle on sharing power and responsibility, on a subtle negotiation between professional and patient about what each wants and what each can deliver.1 But how will clinicians and health policy makers react to patients who want the least effective treatment, which may also be less cost effective for the health service in the longer term?

That this scenario could arise is indicated by the results of our pilot survey among patients with angina of their preferred treatment for coronary artery disease. Patients’ views on the range of invasive to less invasive treatments were diverse. However, although surgical treatments (such as coronary bypass surgery) were generally perceived as effective, they were also described by respondents in negative terms, such as invasive and frightening, and were to be avoided altogether or delayed until they became unavoidable (until the condition becomes life threatening). This attitude was particularly prevalent in women and in older patients (aged 75 and over).

A larger study, including modelling the results on healthcare costs and outcomes, is required next, but the consequences for the NHS of large numbers of patients opting for treatments other than those that are clinically indicated need thinking through.

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Doctor-patient communication in developing countries

Editor—As in the United Kingdom, patients in Guinea consider communication with health professionals important.3 Unfortunately, in developing countries, biomedicine is the dominant paradigm,2 and poor communication is the rule in public services.4 Why does communication weigh so little in health policies in developing countries?

The biomedical model was widely disseminated during the colonial period. Fifty years later, interventions to control disease are still the key delivery pattern for public services. Quantitative objectives predominate and clinical decision making is hyperstandardised at the expense of individually tailored care.

The problem is not limited to public facilities. Although the private sector may have a reputation for offering a better doctor-patient relationship and more confidential care, there are plenty of reasons to doubt the presence of a patient centred approach even here.

- Patient centred care is barely reflected in the medical curriculum in developing countries5
- Private practitioners may have little interest in non-lucrative preventive actions6
- Maximisation of income may conflict with promoting patient autonomy.7

Consequently, shared decision making about case management, an essential element of patient centred care, is difficult to achieve. Greater emphasis on patient centred care could improve communication between doctors and patients in developing countries and increase the effectiveness of care just as it can in developed countries. We urge aid agencies and governments to consider the patient centred approach as the object of a specific initiative encompassing in service training, coaching, and reorganisation of health services for these regions.

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Copying letters to patients

Mental health professionals are in fact likely to support this initiative

Editor—Copying letters to patients is more exciting and more challenging than Essex allows in his perspective.1 How sad that he chooses to single out groups that he thinks make “most objections to copying letters to patients”: administrators, providers of health services to adults, and mental health professionals. He says that mental health professionals rarely communicate with others, commenting that “no one knows what they do, and they can’t be accused of not sending copies of letters if there are no letters.” Mental health professionals have been providing copies of the care programme approach plans to patients and carers for many years. This documentation normally includes assessment of need, the care programme (who is carrying out what tasks as well as including drug treatment and side effects), a contingency plan (what to do to prevent something going wrong), and crisis plans (what to do in a crisis if things do go wrong).

Essex may also not be aware that psychiatrists have been preparing detailed reports for mental health review tribunals for many years and that these reports have been routinely made available to the patient; only on rare occasions is a piece of information kept hidden after an assessment of risk.

I am optimistic that mental health services in general, and psychiatrists in particular, will be enthusiastic supporters of copying letters to patients, provided that the operation of the process is planned properly and rare risk exceptions in which the patient or others could be seriously harmed are carefully articulated.

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Doctors should tailor their practice to cater for individual patients’ needs

Editor—We agree with some aspects of Essex’s article but think that his comments on mental health professionals lack insight.1 Open communication is a crucial part of the therapeutic relationship, and we know patients appreciate having written information about their care.3

A survey we performed of 50 older adult psychiatric outpatients and 38 carers showed that most (89%) wanted a letter about their treatment and care. Essex thinks that this should ideally be in the form of a letter written to the patient. Again, our survey supports this idea as most subjects (72%) wanted their own letter rather than a copy of the one sent to the general practitioner. However, this does not

1 Kennedy L. Patients are experts in their own field. BMJ 2003;326:1278-7. (12 June 2003.)