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WHICH WAY AHEAD?: I WANT MY DOCTOR TO..... THE MECHANICS OF MARKET RESEARCH FOR MEDICS IN THE MILLENNIUM: SPECIAL COMMUNICATION

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SUMMARY

A brief description is given of the changing politico-social structure today involving medicine and especially the cosy personal doctor-patient relationship of the past which has now become triangular involving Managed Health Care Organisations in many cases. The Medical Practitioners' and Dentists' Board (the Board) appointed the Ethics Conference Committee largely composed of non-Board members to collect and collate information of what doctors, paramedics and the lay public expected from their doctors today. It is planned that the Committee's Report summarising this information would form the basis of the new guidelines to modern ethics to be published by the Board later. In this paper the mechanics, funding and production of the report are described but not the contents of the report which is still being considered by the new Board.

INTRODUCTION

To coin a phrase at the end of the second millennium "We live in a changing world"; change brings disturbance, distress and even pain. We can often see the way ahead more clearly if we look back to see where we have come from.

The current century has been labelled the century of the common man and increasingly the common woman. At the beginning of the century, society had a vertical hierarchical structure where the person at the top, be he a king, dictator or president, passed his orders down to the toiling serfs below.

This was echoed in the attitude of doctors to their patients. The doctor was regarded as an omniscient, powerful benign father figure who issued instructions to the patient who, in due course, paid the doctor his fees. In hospital this hierarchy was maintained, with the doctor as the all powerful father figure, the maternal nurse as the mother component and the patient was treated as a child and was expected to conform to his role.

The doctor of course was largely unable to alter the course of the disease but he developed a close personal caring relationship with the patient and he was held in high regard in the community. This is perhaps best reflected in Fildes' famous painting "The Doctor" reproductions of which adorned the surgeries of many practitioners in Victorian times.

It showed a pensive worried doctor gazing at a sick child laid out on chairs in the living room of a private house. The implication was that he had spent all night with the patient and as dawn was breaking it looked as if the patient was not going to survive.

This theme was said to have developed in the artist's mind after his own Doctor Murray had spent most of one Christmas morning away from his own family to attend the artist's eldest son Paul who

unfortunately did not survive. At least the doctor tried and showed he cared by being present and supporting the patient and his family.

Now at the end of the century things have radically changed. We live in a more horizontal society where the people through organisations such as the professions, trade unions, political parties, churches and non-governmental organisations, pass information and their wishes up to the government of the day. Certainly in urban areas of Kenya, patients are better educated and are claiming and exerting their rights as market driven consumers.

Of course doctors have been very much affected by this. Scientific medicine has made great strides forward and with modern investigations and drugs, doctors are able to do much more for their patients than in the past.

But in this more scientific era of controlled trials, specialised clinics and hospitals, the old cosy private and personal relationship with individual patients has gone. A further factor interfering with that old relationship is the emergence of health maintenance organisations (HMO's) which come between the doctor and the patient.

Essentially the individual or group of individuals pay a regular premium to the HMO for specified benefits generally paid direct to the care team. The partnership of two individuals has become one of the three units, which has benefits and also disadvantages in as much as the HMO run by lay persons, controls, to some extent, the management of the patient to ensure cost effectiveness.

The aim of such organisations is to apply modern business and industrial production methods to medical care to increase efficiency and effectiveness at controlled cost. The production aim for patients is improved health for the individual and community. The model is

attractive but life is more complicated than that comparatively simple industrial concept of turning out sausages or bottles of soda or beer. The patient is often presented as the consumer exerting his own choice. But the patient is a producer as well as a consumer, especially in these days of chronic incurable diseases such as arthritis, asthma, diabetes and hypertension.

The individual patient is basically responsible for his own health and life style at the individual level and also at community level and can do a lot to help himself.

By having an effective relationship between the patient and, the health professionals, not only doctors, much can be achieved by incorporating the patients views and preferences in treatment, which results in higher satisfaction and compliance.

This process has affected the doctor-patient relationship profoundly and also the ethics involved in the relationship. Mystic dogma has been replaced by scientific uncertainty. The doctor's power over his patient is being eroded and passing to the patients individually and in groups. The modern trained nurse is an effective partner in the health team and is increasingly taking over some of the work done by the doctor to the satisfaction of some of the patients.

So now we have a far more complex situation where the doctor may still claim to be the leader of a team concentrating primarily on the patient. The Medical Practitioners' and Dentists' Board controls medical practice in Kenya and its role is two fold: to advise doctors and safeguard society.

Recently the Board felt that the ethical guidelines last revised in the 1970's under the chairmanship of Dr. Martin Oduori needed updating. The Board therefore appointed a group of doctors and a lawyer to consider the situation and give advice culminating in a two day ethics workshop in Nakuru held from 18th-20th September 1999.

This paper considers how this committee approached the problem. I will not give details of our report to the Board as the new Board is still considering it and has not pronounced on it, they have had other matters on their collective mind recently.

ETHICS CONFERENCE COMMITTEE (ECC)

The Board intentionally appointed doctors, dentists and others from outside the Board; a list with brief biographical details is given in Appendix A. The ECC had numerous meetings and decided that what we needed to do was to find out what doctors thought in general terms; what was their place in modern society and to consider various difficult controversial items such as termination of pregnancy, modern research and euthanasia. We felt we were not competent to say what doctors and dentists all over the country felt in 1999, so we must go out and ask them on their home ground.

The Board fully agreed with this approach and with its help we were able to raise funds so that we could visit all the main towns in Kenya (Appendix B).

MECHANICS OF WORKSHOPS

We were fortunate that there was an infrastructure available in the Kenya Medical Association (KMA) with its divisions scattered in all the main areas of the Republic.

This was a happy co-operation of the Board and the KMA which we hope will continue in the future. The World Bank, World Health Organisation, Kenya Medical Research Institute (KEMRI) together with the Board provided Kshs 1.3 million. Expenses mainly went on travelling, accommodation and Board allowances for the ECC, meals, stationery and other sundries making up the balance.

We stressed that the Committee was going to participate minimally in the various meetings, local people were going to do most of the talking. So we picked a number of basic subjects for study and comment (Appendix C). Each member of the committee was apportioned a number of these to be his special concern. We felt that there were too many important subjects to be discussed in one day so we split them up into two groups. After a subject had been discussed in three different areas, we felt we had enough information on these particular subjects so we changed to others.

As the consumers i.e patients in modern life are expressing their views and wants more clearly and urgently, we felt as doctors we could not ourselves give a complete answer to what the patients wanted. As doctors we may like to think we know but surely the best people were the patients themselves to say what they thought and wanted. So we made a point of asking the local KMA divisional Chairman to invite three groups of people to the meeting.

a). Medical and dental Practitioners, b). Paramedics including Health Insurance providers, hospital administrators, pharmacists and radiographers. c). Lay people unconnected with the above groups representing the community: ministers of religion, business leaders, politicians, birth attendants and anyone interested. Lunch, morning and afternoon tea and stationery were provided out of ECC funds but not travelling nor accommodation for all the delegates. At the final meeting at Nakuru, small travelling and accommodation allowances was made to the delegates. At each meeting, when the number were sufficient, the delegates were divided into four groups who appointed a chairperson and rapporteur. A member of the ECC acted as facilitator and guide to the topic discussed.

The chairperson or rapporteur made a summary of the decisions of that group, the last session was plenary when each group spokeswoman presented their group's views and the whole meeting debated the subjects and tried to reach definite conclusions.

From these reports the ECC prepared summaries which were available for detailed debate at the final conference workshop in Nakuru. The ECC encouraged persons who had attended the earlier meetings and

taken part in the discussions to attend the final conference as they had shown an interest and had some background information. However, others were not excluded, it was for the local groups to decide.

We were planning to have more delegates for the final meeting but money was getting low so we had to restrict the numbers somewhat. The final ECC report was quite a comprehensive document comprising 54 pages and was delivered to the retiring Board on 13th October 1999 just before they retired.

ECC TRAVELLING

We decided early it was practical to travel by road to Nakuru and Embu but chose air travel for the more distant areas. This method proved quick, convenient, less tiring and appreciated by all. We generally travelled to our destination on Friday afternoon or evening and checked in at our hotel generally the site of the meeting. Often local representatives were waiting at the airport or hotel to welcome us, a courtesy we much appreciated. If not, we made contact with local organisers and finalised plans for the coming day. We aimed to start proceedings at 9am and finish at 5pm and the ECC travel back to Nairobi on Sunday when flights were available.

LESSONS LEARNED

1. The committee must have at least some dedicated members who will devote time and energy to the project and be willing to be away from work; this applies to any committee of course.
2. Be as independent as possible within the limits imposed by the appointing authority, the Board. We worked closely with the Board and two board members on the Committee but mostly we were non-Board members as envisaged by the Chairman of the Board. Dr. Baraza was most helpful in this respect always available for consultation and help but intentionally taking little part in our ethics discussions so that we had a much appreciated freedom to conduct our affairs and spend our funds as we thought fit.
3. The committee must be balanced within the limits of the remit. We were composed of clinical, academic, legal, administrative and financial members, who welded together into a well functioning team.
4. The committee should know early on what money is available and work out a careful complete budget. Ideally the money should be provided. Fund raising should not be a major item on the agenda as it would detract from gathering information and the prime purpose of the committee.
5. A structured plan is necessary to attempt to provide a solution to the problems presented by the appointing authority, otherwise discussion tends to be meandering.
6. The committee should have a definite time schedule. Adequate time should be allowed for organisation but should not be opened as it is too easy to put off working on the project.

7. It was decided early on that the approach should be along the lines of workshop where as many people as possible could give their opinions rather than high powered lectures from professors and other superior persons from Nairobi. It was found that local individuals wanted to air their views and perhaps this opportunity was one of the items most appreciated by them. They felt that the Board was human and really interested in their affairs and problems. The Board earned a lot of good will in this way. The general public, especially in towns, have definite views about such subjects as euthanasia, termination of pregnancy and female genital mutilation (i.e female circumcision). They wanted to know more about the medical set up and their rights as patients.

8. Good communication is essential amongst the members of the Board and with the periphery. We realised this was one of the weaker points in our arrangements. People at the periphery must be properly prepared and briefed for the best results to be obtained.

9. A final report must be made to the appointing authority (AA) which, hopefully, will act on the recommendations made in the report. Tactfully the committee should encourage the AA to take action if it is dilatory in doing so.

CONCLUSION

So where do we go from here? A generation ago two Russian words were added to the English language. The English language like the people are quite willing to assimilate foreign words into the language and absorb people into their community unlike the French who wish to keep their language "pure".

These words were: *Glasnost*: Implying more open government and wider spread of information in public affairs. *Perestroika*: Restructuring or reform of the economic and political, system. This seems to me the stage we are approaching in public life in Kenya now. Surely these words also apply to the medical and allied professions. The medical profession is taking a "bashing" here as elsewhere in the world. Will things ever be the same in Britain after the Bristol saga where paediatric cardiac operations continued long after there were worries about the results? How many patients did Dr. Shipman kill apart from the 15 about whom we know? How about the worldwide scientific fraud being uncovered, as well as the deaths of many from medical mistakes? In this country we have the Chesoni case saga and halfan the antimalarial perhaps causing the death of Kwanza member of Parliament, George Kapten, on one Christmas morning. What about the hospital patient who died because it was alledged that the doctor was watching football at the time he should have been treating patients? *Glasnost* is indeed opening a can of worms, if not snakes, one of the symbols of medicine.

With *perestroika*, imperial Russia broke up into a number of separate states and ceased to be a superpower. Is this going to happen to the medical profession?

After the inevitable initial turmoil perhaps more people are now living happier and more contented lives than previously in Russia. As a nation we are entering a period of adjustment, restructuring, turmoil, stress and reconstruction. Health workers are very much affected in this process.

Perhaps we doctors will eventually have a better relation with our patients when we recognise them as legitimate equal partners together with the help of HMO's and the ancillary services all with the communal aim of maintaining and improving the health of the nation.

I end with an aphorism for the medical profession one that is not particularly original. Adapt adopt or die: We can cope if we have the right vision or goal.

ACKNOWLEDGEMENTS

To the Chairman of the Medical Practitioners' and Dentists' Board via Dr. Okello Agina, Chairman of the Board's Liaison, Protocol and Communication Committee for permission to prepare this paper. Also the Chairman and members of the Board's Ethics Conference Committee for their agreement to the presentation, and consent for me to quote extensively from the final report. I have presented a personal impression of our approach from our different view points and backgrounds but we worked well together as a team. I found it a rewarding privilege to have been a member of such a high powered group and thank them all for their help and support. I feel we produced worthwhile material which we hope will benefit the medical profession and society generally.

Appendix A:

Members of the ethics conference committee (ECC)

1. Mr. Andy Bacon: Administrator and Chief Executive Officer of Gertrude's Garden Children's Hospital Nairobi. He was the initiator and a founder member of the committee and its first Chairman until March 1999 when he handed over to Professor Lore. As a relatively newcomer to Kenya, Mr. Bacon found that he needed guidance on ethical problems which led to the formation of the Committee. Although Andy was relatively new here his grandparents had farmed at Naivasha and Kinangop.

2. Mr. Richard Baraza was the Chairman of the Board at the time. He is a surgeon in private practice based at the Nairobi Hospital. Previously he had worked as a surgeon at the Kenyatta National Hospital and in the United Kingdom. He has been a senior lecturer and Chairman of the University of Nairobi, Department of Human Anatomy.

3. Andrew Hicks is a long time resident and citizen

of Kenya based at the Nairobi Hospital as a general surgeon. He was Chairman of the Kenya Medical Association National Ethics and Standards Committee.

4. Dr. Rufus Kanyongo a private Dental Practitioner based in Nairobi was then current Chairman of the Kenya Dental Association.

5. Prof. Bill Lore, Physician and cardiologist based in Nairobi, Director and Chairman of the Institute of Health Research and Services, a not-for-profit private health organisation. He has had a distinguished academic career both at the University of Nairobi and also at Moi University, Eldoret where he was founding professor of Medicine and Head of the Department of Medicine. He has held high positions in numerous organisations and is Editor-in-Chief of the East African Medical Journal. He took over the Chairmanship from Mr. Andy Bacon in March 1999.

6. Prof. Joseph Mungai was a human Anatomist with a deep interest in socio-cultural aspects of ethics. He had a distinguished academic career ending up as Dean of the Faculty of Medicine and Vice Chancellor of the University of Nairobi. At the time he was Joint Secretary of the Commission of Inquiry on Education in Kenya and Chairman of the National AIDS Committee.

7. Dr. Bonaventure Okello Agina is a private Obstetrician and Gynaecologist based in Nairobi. He was a member of the Board and Chairman of the Board's Liaison Protocol and Communication Committee which was charged with the responsibility of overseeing the organisation of the Ethics conference.

8. Mr. Ambrose D. O. Rachier is one of the outstanding advocates of the High Court of Kenya and a member of the Kenya Medical Research Institute Ethics Review Committee. He has been honorary legal adviser to the Kenya Medical Association for many years.

9. Mr. Daniel Yumbya, Executive Officer of the Board who helped us to understand the government system of administration and financing. Daniel together with Helen Nafwa and Penelope Otieno provided invaluable secretarial back up for the committee.

Appendix B

Group Workshop

Date	Place	Number of participants
24 th April 1999	Kunste Hotel Nakuru	71
15 th May 1999	Silver Springs Hotel Nairobi	50
22 th May 1999	Pandya Memorial Hospital Mombasa	48
12 th June 1999	Imperial Hotel Kisumu	45
26 th June 1999	Hotel Sirikwa Eldoret	39
7 th June 1999	Golf Hotel Kakamega	42
16 th -18 th Sept. 1999	Hotel Kunste Nakuru	40

The first meeting in Nakuru was combined with the Annual National KMA conference. The last meeting in Nakuru was restricted in number as funds were getting low.

Appendix C

Basic Ethical Subjects Studied

Group I A, Consent, Confidentiality, Ethics of research
Group II B, Advertising, conflict of interest family

practices, relationship between doctors patients and society
Group III C, Right to life and right to death, termination of pregnancy and abortion, Human rights, Euthanasia, Doctor relations

Group IV D. General principles of medical practice, relationship of doctors and society, how should public expectation be conveyed to doctors? Ethics of managed health care. It was recognised that some subjects are interlocking so that there was some overlapping but this was not deemed a serious fault at that stage.