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**How to Choose a Doctor or Surgeon?**

Professor Martin Elliott and Dr Neil Bacon

The most important human activity is decision-making, because it is through the choices we make that we create our lives and become ourselves.

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**Introduction**

Tonight’s lecture is going be a little different from those I have previously delivered for Gresham College. Firstly, and as you have already experienced via our survey tool, you, the audience, have work to do! Secondly, we are going to allow more time at the end for discussion of the complex issues involved; after all it is *your* choice that interests us. Thirdly, I have asked someone else to join me in presenting tonight. His name is Dr. Neil Bacon. Neil is a renal physician who has a professional interest in how patient choice can be used to improve healthcare. We are both immensely grateful to Rose Thompson, a philosopher and Gresham audience member who has helped us with research and ideas.

We like to think we can choose our healthcare carefully on behalf of ourselves, our friends and family, but even as doctors, with inside knowledge, these choices can be difficult because of lack of appropriate facts. We fall back on recommendation and reputation. There are several different types of choice that, in theory, we could be involved in1:

* choice of treatment (**what & why)**
* choice of individual health professional (**who**)
* choice of appointment time/date (**when**)
* choice of which provider (**where**).

**Do you want to choose**? Did you even know you could choose? What information do you need to make a choice and if you do make a decision to see someone in particular, or to go to a specific hospital, are you allowed, in the NHS, to exercise that choice in the same way you can in the private sector? If you choose not to choose, then are you happy to allow someone else, for example your GP, to make decisions on your behalf? Or should you just trust the system to deliver and look after you, because that is what it is there for?

We know that there is considerable variation in quality and safety across the NHS. Here are just two examples. There is a four-fold variation in the urgent cancer referral rate across England depending on which GP practice you are registered with (<https://www.nao.org.uk/report/delivering-the-cancer-reform-strategy/>). This variation could result in a significant number of unnecessary deaths. Similarly, the processes and outcomes of care for diabetes are also highly variable across the country. Indeed there are five-fold variations in the incidence of amputation or death due to the disease (http://www.rightcare.nhs.uk/index.php/nhs-atlas/diabetes/). These data come from the NHS Atlas of Variation, and it is well worth reading, but perhaps not at bedtime.

With variation like this, your choice could be important. If you could choose, could exercising it have an impact on the people and organisations that care for you, and the outcomes they deliver?

**Medicine as a Market**

The way doctors and patients relate to each other has changed greatly over the last 50 years. There are two reasons for this. Firstly, a deeper understanding of medical ethics and the wider acceptance of the principles of patient autonomy; secondly, your **right** as a patient to make your own decisions about treatment, based on information made available to you. The *ethical* basis for choice has been supplemented in recent years by principles of choice based on *market economics.* Consumerists believe that by allowing patients to choose what they need at the price they want, market competition will both constrain costs and optimise quality.

Historically, affluent patients had an unlimited choice of which physician to care for them. The choice was limited only by availability and by what the patient could afford. Medicine was a business2, with physicians, and later surgeons, being independent practitioners free to charge what they wanted. Medicine was carried out in a market, and the poor were losers. In much of the world, this remains the case. The NHS, formed in 1948, was a game-changer; a non-market structure with equity of access and ‘free at the point of delivery’ being its cornerstones.

In the latter part of the 20th and early 21st centuries, market-orientated thinking, respecting consumer choice, has become dominant in many aspects of human life, and healthcare has not been exempt. Here are just a few examples of enterprises which are built on the principle customer choice, including some relating to healthcare:

1957 Which Consumer magazine launched

1994 Amazon founded - ratings and reviews for everything you can buy

2000 TripAdvisor founded - ratings and reviews for hotels

2000 TopTable founded - ratings and reviews of restaurants

2008 iWantGreatCare founded - ratings and reviews of doctors, GPs and hospitals

2008 Patient Opinion founded -reviews of hospitals

2010 NHSChoices - adds reviews of NHS hospitals

To understand the rationale for this cultural shift, we need to define what is meant by the term ‘*market’.* For those who want to read more about this, Anna Dixon and her colleagues from the Kings Fund reviewed the topic beautifully in 20101, and we have shamelessly plundered their very well written work for parts of this talk.

The standard neoclassical model of a *perfect market* involves well-informed, rational consumers acting in their own best interests by systematically choosing which goods and services to buy, and who to buy them from, in a way that maximises their own well-being (‘happiness’ or ‘utility’). If there were *perfect competition*, the supply side of this market would have enough existing or potential providers such that competition would force down the prices close to the marginal costs of production. However, there is a theory of *contestable* markets that doesn’t demand large numbers of suppliers, and, as long as any supplier can join the market, then the very threat of competition will produce efficient outcomes. In other words, consumer and providers *both* act in self-interested ways, which result in socially optimal quantities of things or service being traded.

Real world markets are not ideal, and the ‘failures’ of health care markets were described by Arrow in 19633. Dixon and her colleagues modified data from Morris et al 20074 to create the table reproduced below which summarises the characteristics of health care markets.



Traditionally, the asymmetry of available information (discussed in more detail later in this essay) means that patients may choose hospitals and doctors on the basis of *perceptions* of quality rather than on hard data. Even if choice is available, patients are heavily reliant on the *reputation* of a provider, and that information is itself gleaned from relatives, friends and colleagues. Thus the health ‘market’ (in its current form) does not behave like a neo-classical market, but something much more complex, in which the balance between choice and competition less clear.

**Politics**

Why then did ‘choice’ become such an important political issue in the NHS? Some element of choice existed right at the beginning of the NHS, when each adult was allowed to choose their GP, dentist and optician, each seen as an ‘intelligent’ gateway to the wider health service. Prior to this, most people had no choice simply because they could not afford it5. In 1972, under the Conservative government of Edward Heath, the concept of patients as ‘consumers’ was introduced, based on an ideological belief that the private sector was always a better option. Policy makers held the view that choice, within a viable market, would not only make users more engaged in our own healthcare, but also, through competition, drive up the quality of service delivered and increase efficiency. We will explore the relationship between choice and competition in more detail.

The concept of an ‘*internal’* market within the NHS emerged from the writings of Professor Alain Einthoven of Stanford in the 1980’s, and is well described in David Owen’s book “Our NHS” (1982, Pan Books, republished by Macmillan 19886). In 1988, the then Prime Minister, Margaret Thatcher, set up a small ministerial group under her chairmanship to review the NHS. The members were the Chancellor of the Exchequer, Nigel Lawson, and his number two, John Major; the Secretary of State for Health and Social Security, John Moore, and his number two Tony Newton. Moore and Newton were later replaced by Kenneth Clarke and David Mellor. The five met at least weekly until the publication in January 1989 of the White Paper ***“Working for Patients”,***which marked the official start of the internal market within the NHS.

Much of the thinking behind the development of that market was based on an assumption that resources for health care would always be limited, whilst demand and capability would grow, so some form of rationing (implicit or explicit) was inevitable. Market disciplines of supply and demand were thought to be advantageous, and the purchaser:provider split (purchasers bought care from providers) was adopted as policy. The concept of GPs holding funds, ideas developed by Alan Maynard and Marshall Mariner, emerged in parallel to these overt market concepts and Kenneth Clarke included the ideas in the 1989 white paper “Working for Patients”7. The basic idea was this; if GPs had the cash, they could buy care on behalf of their patients, after all, they (the GPs) surely knew from whom to buy it. Inherent in this is the concept of choice; someone had to choose the correct option. Margaret Thatcher, in a filmed statement to NHS managers in 1989, said this *“We aim to extend patient choice, to delegate responsibility to where the services are provided and to secure the best value for money.”* **(**<http://www.margaretthatcher.org/document/107565>**).** Patients were to be given the choice of appointment times, where to be seen and treated, and a choice of meals when in hospital. The genie of patient choice was now fully released from the lamp, but so was the suspicion that this was opening the door to privatisation of the NHS.

Whilst there was theoretical choice, it is worth pointing out that *before* the introduction of the internal market, GPs were free to refer to **any** NHS provider. After the internal market was introduced, purchasers (health authorities), in order to save money, actually **restricted** the ability to refer out of area. Only the minority of GPs who were fund-holders, and who thus took on purchasing responsibilities, were free to refer to any provider without restriction. It is hard to imagine how the poor patient could get to grip these rules when under the stress of a new diagnosis or the need for surgery.

The idea of bringing market-based reforms into the NHS continued under the New Labour government of Tony Blair. Indeed one could argue that the process was accelerated after a series of pilot projects (starting in 2002). However, those pilots were aimed at maximising the use of NHS capacity to reduce waiting lists. The patients concerned were already on a waiting list; therefore the rather limited ‘choice’ available to them was to be treated more quickly at another institution. The hospital with the waiting list did not suffer any penalty; indeed, getting the patient off its books was a bonus. There was little stimulus to improve efficiency and productivity, as there would have been in a true market.

In 2006, patients needing to be referred to a specialist were to be offered a choice of four or five providers (hospitals). In 2007, a web-based service called NHS Choices ([www.nhs.uk](http://www.nhs.uk)) was launched as an information source to support patients’ decision-making. And after 2008, patients in England referred for a non-urgent hospital appointment by their GP could choose any listed hospital in England, including independent sector providers – so called ‘free choice’ of providers. Choice was enshrined in the **NHS Constitution** in 2009, but has been modified slightly in subsequent iterations. At the current time8 9, the NHS pledges that it is coordinated around the needs, convenience and **choices** of patients, their carers and families. Under the NHS Constitution, patients have the following relevant rights relating to choice:

* The right to access clear and comparable data about the organisations that provide their care, so that they can make **informed choices** about their care.
* The right to **choose** the organisation or team that provides your NHS care when you are referred for your **first** outpatient appointment with a service led by a consultant.
* A right to information where there is **a legal right to choice**.
* The right to **choose** the GP practice you would like to register.
* Within your GP practice the right to **choose** which particular GP you would like to see.
* The right to be involved with decisions about your care and treatment.

Despite the presence of these rights within the NHS Constitution, there is another player we need introduce who can influence your ability to exercise your choice. That player is the CCG, Clinical Commissioning Group. There are 211 of these, and they were set up as part of the Lansley reforms in 2012 and are a development of the idea of GP fundholding. A general practice has to be part of a CCG. They control almost 70% of the NHS commissioning budget, and have the responsibility to buy acute and community services on behalf of their populations. They were supposed to be clinically led with strong GP representation. Because CCGs control the budget and set a tariff, they can either limit the choice available to you if you want to cross boundaries to another area of the country, or at the very least, make the process difficult. They may not want you go to the place of your choice if it is more expensive, whatever the quality of service or outcome. For example, if the CCG has a deal to refer patients to one specialist centre, but the referrers and their patients in one of the CCGs secondary providers want to send patients to another, who wins? Conversely, there are some areas of the country where Trusts are finding that they can increase their income by marketing to attract new patients, with support from their CCGs. For a recent, somewhat critical, review of CCGs see Holder et al10.

The assumptions upon which the policy of patient choice was based are as follows:-

* **All**patients are given the opportunity to choose their provider and their consultant.
  + There are **enough providers** nearby to allow a legitimate, meaningful and valid range of choices; and patients have equal means to access this range of providers.
  + Choices are based solely on **the quality of care**, thus creating competition based on quality.
* Patients fully **understand** what ‘good quality care’ entails, are **equipped** with the information needed to decide this, and are **motivated** to engage in this process.

So that is the background to patient choice. Inherently, it seems like a really good idea and indeed there emerged some evidence (not since replicated) that the 2006 introduction of competition between hospitals resulted in a fall in the 30-day in hospital mortality rate for acute myocardial infarction11. We choose so many other things in our lives, why not the most important thing…our health? Let’s see how it works in practice, and along the way we will ask you to make choices with us, using your voting devices, so please have them ready.

**Choosing a General Practice**

Since the NHS was founded, everyone has the right to a GP, and will be allocated one if necessary. But we have the right to choose our GP surgery, sometimes called primary care provider. We may register near home, work, both, or anywhere else in the country should we so wish[[1]](#footnote-1). There are limits to these choices, however, and it is at the discretion of the GP surgery as to whether they take on ‘out-of-boundary’ patients. GP’s have no obligation to provide home visits to patients registered from out of their area, and this may result in exclusion of patients through factors out of their own control. Thus, those who may require such visits (elderly, disabled or those who may require frequent urgent care) may have their choice effectively limited.

If there were a significant difference in quality between GP surgeries, offering a choice would inevitably disadvantage those who did not qualify, were rejected, or who might not be able to travel to a better quality surgery further away. This does not seem entirely fair, since those who could not exercise their choice because of rules might feel ‘disenfranchised’. Furthermore, this policy has also been attacked for permitting certain vulnerable people to ‘fall between the cracks’ of NHS care, as they may easily be struck-off their GP’s register, and are not *automatically* covered by their nearest GP surgery.

Fears that GPs may cherry-pick patients or give registration priority to easy/uncomplicated cases in order to maximise their income have largely proved unfounded. There is some, perhaps inevitable, social inequity though. GP practices in more affluent areas tend to have patients who require fewer visits, and therefore find that their resources stretch further than in areas where there are high rates of chronic diseases linked to socio-economic factors, e.g. (heart disease, obesity, mental-health issues.) This enables patients in affluent areas to have more time in their consultations.

If there is a choice of GP practices in our area, and if they have capacity and are in theory willing to take us on, how can we differentiate between them? What information might we need to make a choice and where would we find it? How accurate and up to date is it? What does good look like? Is it to do with the proximity of the surgery, its comfort and facilities, range of services, waiting times, communication skills of the staff, accuracy of diagnosis, promptness and appropriateness of referral, or quality of follow up and screening? Is there a comparethepractice.com anywhere? Do we rely on word of mouth? Perhaps the data available to support the NHS Atlas of Variation could and should provide such guidance.

The majority of people simply choose their **local** GP1, apparently with little thought to these variables. This could be because the choice is in fact limited…there are no other practices available, or they are so full one is simply grateful to have access at all. Or it could be that they rely on the good old-fashioned concept of ‘Trust’ in all doctors to be good enough to do what they are supposed to do. Capacity is an issue in all areas of the NHS at present. Or it could be that convenience trumps all other aspects of choice. Since choice is barely exercised at this level in the system, it clearly cannot have any real impact on the quality of service delivery; there is no stimulus for an unpopular practice to improve.

If a patient has chosen to go to her local surgery, but finds she doesn’t get on with the GP she has chosen at random, should she be able to do that? And what should she look for in a doctor? How easy is it in practice to find relevant information? Is such a choice offered up front, indeed is that offer itself a measure of quality? How easy is it for her to feedback her thoughts on the first GP so that he or she has the opportunity to improve? We all have our own stories to tell about how easy this is. Given that we know that choice of GP really does matter, so should the views of their patients.

**Choosing a Secondary Provider**

A secondary provider is a hospital, or equivalent service, to which you are referred from primary care. You have the right to choose which hospital to go to (from any in England) and which consultant-led team treats you, at least for the first outpatient appointment9. The Choose and Book system, which was launched in 2006, was replaced in 2015 by NHS e-referral (<http://www.hscic.gov.uk/referrals>**),** with NHS England aiming for 100% of GP practices to use the system. The service was designed to allow the patient to select time, data and location of their appointment *from a list of what is available.*  It got off to a very shaky start, with over 33 major glitches identified on its first day (<http://www.computerworlduk.com/news/applications/nhs-warns-of-33-known-issues-with-e-referral-service-launched-today-3615745/>). And it is very hard to find out how well it is being used. The last report on their website is from June 2015, and the data are difficult to interpret. I asked the e-Referrals service for up to date information, and this was their reply:

“*Unfortunately, we are still developing a National Utilisation reporting solution and a limited number of professional user-facing reports that will be released as soon as possible. It is these reports that would show current utilisation of the system. As you have already noticed, the latest report currently available is June 2015. Currently there is no confirmed publication date for more up to date data. If you did require some information from specific organisations, you should be able to approach these individually as their NHS e-Referral Service data is now available to them via the key extracts mentioned above*.” This did not prove easy!

It is questionable whether being able to choose appointments at specific times at specific hospitals really equates to ‘freedom of choice’, and it certainly gives little choice relating to anything that might predict quality, safety or efficacy of care, let alone long-term quality of life. Our freedom is actually limited; in the same way we are limited only to be able to buy what a shop has in stock. At least with shops, we can choose to go to one with more or different stock. If our choice is limited in this way, it resembles more the choices available to customers in the GUM store in communist Moscow; “there is plenty of choice, but this is all we have available”. We are **not** free to choose outside the options presented to us. As Burgess et al have stated12, competition can provide too little quality or variety, too much or just the right amount.

In healthcare, and especially in the NHS, there is an implicit assumption that providers are meeting certain basic standards, as the service (market) is highly regulated. Provided the bar is set high enough, you would be safe going anywhere, and choice only becomes relevant if you are either seeking excellence or avoiding other factors. Going ‘local’ should be satisfactory. But is the bar set high enough? The Care Quality Commission (CQC) is tasked with assessing and publishing the quality of providers of care, and does identify providers on a range from ‘needs improvement’ to ‘outstanding’. Indeed the CQC has over the last few years put a number of hospitals into “special measures” declaring them “inadequate”. But are the CQC reports either taken into account by your GP when referral takes place or offered to you for your consideration?

If the GP doesn’t tell you about it, how would you know where (or even whether) to look unless you had a fair amount of inside knowledge? NHS Choices was established to help you with such decisions, and here are some examples of what the data look like on the website. Would you be given time in your GPs 8-12 minute slot to consider such data, or even be given access to it? Would you feel confident enough to challenge the GP to show you the data if he or she did not? Or ask for a delay in making the referral until you had done more homework? Perhaps not. Most of us are pretty scared and many feel disempowered in the presence of a professional; especially accountants and head teachers in my experience!

NHS providers are frequently short of **capacity.** They are struggling to meet rising demand, and the Government has limited the amount of money it wishes to give to support healthcare. For us to be able to exercise **real** choice of provider, money for our care would have to follow us to that provider, which would have to have enough capacity to accommodate us. Popular hospitals would need to be able to expand, and unpopular ones would either have to shrink, close or improve. The market is simply not working like this. Commissioners (themselves with constrained resources) want to limit demand in popular hospitals by restricting the **quantity** of care they can provide (the money for which should theoretically flow with the patient in an internal market) and by limiting the ability to enlarge premises (by restricting capital). Capital is just not made available in this way. And politicians are, as we saw from my talk on the Bristol Scandal, at the very least unwilling to support the closure of hospitals in their constituency.

There would of course be a societal cost (jobs, moving house, capital projects etc.) associated with such shifts of capacity and provision, and in some way5 we (the public) would have to be prepared to work out what we are willing to pay for, either directly or via taxation. Choice, even if available, is complicated.

The consequences of choice at this level can also act as a **perverse incentive**. Hospitals are fined for having long waiting lists or taking too long to get from referral to treatment (£300 per patient after 8% breach of 18 week target, £5000/patient for 52 week breach). Thus if a hospital loses patients because they don’t choose to go there, the hospital can feel *rewarded* because the potential problems of long waiters or breaches of referral times go away, along with fines associated with them. This improves neither quality nor efficiency. For patient choice to be effective, the money really would have to follow the patient, and that money would not only be used to treat the patient, but as capital to expand the chosen service.

Whilst some hospitals struggle to meet the demands of patient choice, in other parts of the NHS this does happen. For example, some patients with mental illness can - and do - choose where to go for their treatment, and the money **does** follow the patient - meaning that Trusts *do* want to actively compete, knowing that if they can offer a better service, and if patients get to know about it - then the patient will choose to travel for their care, and the Trust can use the additional funds to expand a popular and effective service. For some specialist treatments for depression, patients will travel hundreds of miles to get the best treatment - if they know they have the choice, and if they have the information on which to make that choice.

Many hospitals do not have either the management or physical capacity to compete for patients, although in my experience, the medics working within the system would love to compete in this way, despite being salaried and not receiving bonuses for volume. Problems for the hospitals yes, but tonight we are concerned with the patient.

If our hypothetical patient needs hospital care, how should she choose which hospital to attend? The last (Coalition) Government recommended, in the Patient Choice Framework[[2]](#footnote-2), that patients consult their GP and the NHS Choices website. That website gives the following advice[[3]](#footnote-3): -

*“You should think about any treatment that could follow on when your GP refers you. For example, if you expect to be prescribed a simple course of medication, your choice of hospital may be based largely on convenience, such as how far away the hospital is, waiting times and parking facilities.*

*If you're likely to need an operation, such as a hip replacement, your choice will probably be based on other factors. Clinical ratings such as infection and mortality rates may be more important, especially if results vary significantly between hospitals. You should choose your hospital according to what's most important to you.”*

The patient is advised that, if they don’t want to make a decision of hospital during their GP consultation, they can do so via the **e-referral service** after they have conducted further research. Here we hit our first problem. Our hypothetical patient is young, and almost certainly digitally literate, but if she was old and living alone without much support, and didn’t have computer, a smartphone or access to the Internet, how realistic is it that she would be able to do the necessary research. And is the concept of such research easy to grasp?

At first sight, it seems somehow incongruous that NHS Choices – the website supposedly promoting choice based on **quality** of care – is suggesting that patients choose their provider based on **convenience** of access & waiting times. Perhaps this **is**what the government means by creating a ‘patient-centred NHS.’ Happily, there is some evidence to support the idea that these factors are most important to patients. A survey, commissioned by the Department of Health in 2007, showed13 that geographical location and convenience of access to the hospital ranked highest by far when making the choice of where to be treated for elective care, with 64% of respondents saying that this was important to them; compare this to only 17% putting quality of care, and 8% noting quality of staff as an important factor in their decision of which hospital will carry out their treatment. This suggests that patient choice of provider – if based on factors which patients actually deem to be the most important – will **not** necessarily result in driving up quality (which the current patient choice agenda claims), but may simply improve the car parking arrangements at the hospital! Although not at GOSH, where there isn’t any parking!

The choice of which hospital to attend is made more difficult for the patient by the fact that there is **uncertainty** about what is being chosen. Patients do not know for certain that they will need hospital treatment, nor exactly what will be required. Thus the choice of team at the first appointment is itself uncertain. There is also **uncertainty** over the relevance of the information provided to make any choice. Burge et al14 report that patients regard information pertaining to the clinical quality of *the individual consultant* as being the most important. This is rarely available. More often they can identify the average performance of a hospital say via the CQC summary reports, but rarely differentiate the excellent from the bad *within* a hospital or service. It is not surprising that there is scepticism about the current concept of patient choice. As Callahan argues15, the fundamental question is ‘*whether thinking of the patient as a savvy consumer could ever make sense in the face of complicated, emotionally charged illnesses and complex decision-making situations’.* Yet of course for the vast majority of healthcare decisions the choice is not being made “in the face of a complicated, emotionally charged illness”, nor is it indeed always that complex - choosing between electricity providers is likely to prove infinitely harder for a healthy person than choosing their new GP.

Your GP has to be **willing** to offer you choice, since he or she will be the agent of referral. GPs it seems are more directive when specialist treatment is clearly needed1, and are obliged9 to be so if the treatment need is urgent, for example if cancer is suspected.

The GP exists in a community, and in the old days would have developed close, sometimes personal, relationships with the local hospital and its staff. Since we are all creatures of habit, it is easy to understand why patterns of referral become fixed, and why GPs may be reluctant to break these patterns and refer elsewhere. If patient choice is to work, one would think these attitudes must change. Yet the GP is often used as an advocate, and (one hopes) knows the outcomes of secondary providers better than the patient, referring not on the basis of cronyism but as a true advocate. In the modern era, such relationships appear less common, and general practice has become more difficult. Referral patterns have the potential to be dictated by the CCG than individual GP or patient choice.

Sixty four percent of patients offered a choice at the time of referral opted for their local provider. Only 17% of patients said that their ability to choose a hospital was a top priority. So let’s consider for a moment what information one of the patients amongst that 17% might need to make a rational and informed choice. Several years ago, Lord Ari Darzi set out core quality values which should be met by the NHS. They were **safety, effectiveness and experience**, the last relating to the quality of service. They remain the domains against which institutions should be judged, but I would add another; efficiency. As a patient, I want to be sure that not only are the three core criteria met, but also that my journey through the institution is smooth and without delays. Comparative data should be good enough to be fair and credible, but perfect data will never exist. Nonetheless, it seems likely that providers, if scored or ranked on the basis of public or patient feedback, would have strong incentives to improve their quality12.

How hard is it to find out information in these domains about the services you might want choose from. Let’s look for safety data. What would you want to know if you were having your prostate operated on (at least those of you who have one)? Infection rates? Rates of complications such as impotence or incontinence? The overall chance that you’d be cured of your cancer if that was the diagnosis? These would all seem to be pretty basic, standard questions to ask about the operation you are about to have. Yet how hard these data are to find.

For a knee ligament repair, how do they fix it, how many does your surgeon do of that operation, what is the success rate and what do they mean by that? How many fail and how many need a re-operation? How many of your selected surgeon’s patients get infections, or a late arthritis risk? Perhaps most importantly, do other patients say the surgeon has improved their quality of life, are they glad they had the operation, and would they recommend the surgeon to others with a similar problem?

Given that all these things have a direct bearing on the quality of life of the patient, it is sobering to think that most people spend more time reading reviews to choose the hotel for their two-week summer holiday, than they do researching about the outcomes, safety and quality of the operation they are about to have.

Of course, there are many other factors which should influence your choice. For example, the predicted length of stay and the quality of post-operative rehabilitation or shared-care services. These make up what is described as a *care pathway*, a core feature of service provision, and one of the most difficult about which to find coherent information.

These data would be what I want to know as a doctor, and I would ask around or look them up as best I could…although it is likely to be just as hard for me to find as you. The NHS recommends NHS Choices as your primary source of advice. Let’s try it for both prostate and knee. Opening up the NHS choices website (http://www.nhs.uk/pages/home.aspx), we are able to filter our search for hospitals by postcode, consultant, procedures or departments but not, interestingly, by ‘patients like me’. If we filter by postcode, the resulting hospitals are listed in order of proximity, with seven data fields relating to the quality of the hospital. We are able to select a shortlist of a few hospitals to narrow our search and then compare them side-by-side. We may then order the data by any of these fields; for example, I can choose to list results in order of which hospitals have the best user ratings. This has the advantage of allowing me to define my search according to what I deem to be most important. However, there are limitations because of the way the data are presented. For example, when I choose to sort by user ratings, a hospital with just one rating of five stars appears **above** a hospital with 253 ratings & a four and a half star average. Furthermore, many records have incomplete fields, so cannot give a reliable & comprehensive picture of the quality of different providers available, even according to these limited criteria. Submitting selective data could be seen as gaming, and is clearly inappropriate. Should we trust a hospital that doesn’t submit complete datasets?

The quality indicators presented on NHS Choices may simply be the best available at present. The current list of datasets is available at this URL; <http://www.nhs.uk/aboutNHSChoices/aboutnhschoices/how-we-perform/Pages/datasets.aspx> . Perhaps we should be grateful for what is there, and patient enough to see it improve over time, but the quality indicators only scratch the surface of the detail I would like (as a doctor) in order to make choices.

Patient feedback is available on the NHS Choices website, but has been open to abuse **(**<http://www.bbc.co.uk/news/health-26229041>**).** There is within, and give access to relevant outcome data of individual specialties the NHS Choices page a *beta* product called ‘my NHS’ **(**<https://www.nhs.uk/Service-Search/Performance/Search>**),** which does provide some interesting feedback data. Navigation is pretty straightforward, and I leave it to you to judge whether the information is presented in a way you like. There is a great deal of missing information, and the number of specialties and procedures covered is limited, but it is a start and hopefully will improve. Unfortunately, I can’t find anything about a number of common procedures, for example prostate surgery, and nothing at all about the work I do. I have to know my way around the literature to find that.

It is not clear how much NHS Choices is actually used by the population, although of those that do use it only 2.3% do so to compare and contrast doctors or services, with over 60% just looking for more information about their disease, itself a telling statistic. So perhaps we should ask our patient to rely on the advice of the GP. Sadly, in a recent survey16, only 60% of 2,729 respondent patients given a referral by their GP were offered a choice of hospital. With only 8-12 minutes being allocated for a GP appointment, it is hard to believe there is anything like enough time for an appropriate in-depth discussion of the comparative records of various providers17.

One begins to question whether it is currently in the interests of the NHS to foster the principles of choice in a resource-limited environment. One wonders whether the government might actually regret offering choice or quietly pull back from the implementation of policies that deliver it, in order to meet the efficiencies that they demand. Of course, a counter argument is that if patient choice was given **more** importance, and money really made to follow that choice, ‘failing’ hospitals would be driven to greater efficiency and those which were popular would have to become more efficient to cope.

**Choosing an Individual Clinician**

I have already indicated the domains of information I would like to explore to identify a good place to go for my treatment. Amongst cardiac surgeons, there has been much debate about whether outcomes should be reported by hospital, by unit or by individual surgeon. Eventually, we have agreed to publish certain data (concentrating on mortality) by individual surgeon, and these are made available via the Internet, although by a far from easy route. The data themselves are not terribly easy to understand without some degree of medical, statistical or scientific training. One also needs to be digitally literate to find the data, and comfortable with flying around website after website to get to what you need.

The controversy over whether to report by unit or surgeon remains. We often operate on difficult cases together, rather than as individuals, and in some centres this has become the norm. The decisions that lead up to surgery are shared with physicians and no surgery takes place without anesthetists and intensivists, so to allocate results purely to the surgeon seems a bit naïve. However, it is what people have come to expect, and surgeons themselves trade on the quality of their results so it seems to me rather disingenuous not to make those same results available to the public. The situation is a bit clearer in relation to procedures which are surgeon-dependent throughout the pathway of care, for example joint replacement. Surgeon-specific results have greater relevance, and data on orthopaedic surgeons are both easier to find and relatively straightforward to understand, but it remains hard to find out how good they are at managing many, particular, conditions.

When we cardiac surgeons started to publish our data, back in the 1970s, we were motivated by a general desire to do what we did better and to become aware of who was getting good results, so that we could learn from them. We also wanted to have ammunition that we could use to influence health policy makers to increase our resources. We did **not** start from the market principle of trying to increase our market share, the number of patients we saw. Competition was *internal* and professional rather than external and market–orientated. There was no fee for service, and indeed more patients equaled more work, in an already busy and understaffed environment.

As time has gone on, we have become more aware of patients wishes to have more information about their disorder and how we treat it, and for them to be assured of the risks they might need to take and the outcomes they should expect. The Bristol Scandal and the subsequent Inquiry clearly demonstrated the need to make outcome data available so that poor performance could be both identified and corrected. The concept of rewarding good performance has never been on the agenda; that is assumed to be a professional *raison d’etre.* Even though performance data are now available, evidence suggests that **fewer than 10% of patients look at it**, and as we have said, even fewer approach it through NHS Choices.

Perhaps patients are simply not aware that these various websites exist, or we are just not advertising these services enough. Or maybe the data presentation is so poor that people are put off by it. Or could it be that you, the public, just don’t give a toss and assume that we are all competent and good? Mid-Staffs and Bristol would argue that we are not all equal. It cannot be wrong to publish clinical outcomes, and to do so in a way that increases both the quantity of the data available and also the quality of its presentation and interpretation. We can always make excuses for not making the data available, but we are, after all, your servants and the service we give you should surely be open to your scrutiny. And it is a salutary reminder to doctors and politicians that it was the voice of patients and their relatives (aware of deficiencies in care), and subsequently amplified by the local media, which played a major role in revealing the fatal shortcomings at both Bristol and Mid-Staffordshire. Thus, the fact that for the vast majority of NHS care it remains near impossible to find any comparable information on outcomes and safety, becomes a major worry for those passionate about the future of the NHS.

**A doctor who smiles**

No matter how much statistical data are available to judge the *technical* performance of doctors and teams, there is good evidence that patients place more weight on *qualitative* data, personal recommendations and experience. The use of these sources mean that people cannot always be relied upon to choose rationally18. As David Flum, a US surgeon put it (at a meeting in Manchester last year at which we were both speaking on Surgical Outcomes), *“it continues to shock me that patients will drive past the hospital with the best results to get to a doctor who smiles”.*

I have quoted before in these lectures the old adage about private medical practice; to be successful, you need to obey the ‘3 A’s’ rule, namely **Availability, Affability and Ability…in that order.** Such adages emerge from experience, and are reflected in the public’s views. An excellent bedside manner and good communication skills **are** key to meeting patients’ expectations. And it is not surprising that ‘poor communication and failure to take account of the patient’s perspective are at the heart of most formal complaints and legal proceedings’19 .

The importance of these ‘soft’ aspects of performance to patients in England was brought home in a survey by the Picker Institute in 200713, asking patients to rank what the thought the ten most important aspects of care were: here is that ranking

1. The doctors know enough about my medical history and treatment
2. The doctors can answer questions about my condition and treatment in a way that I can understand
3. I have confidence in the hospital staff who treat me
4. The Doctors wash or clean their hands between touching patients
5. The nurses know enough about my medical history and treatment
6. Before my operation or procedure, I get a clear explanation of what will happen
7. The risks and benefits of my operation are explained to me in a way that I can understand
8. The nurses wash their hands between touching patients
9. The rooms and ward are clean
10. The doctors and nurses are open with me about my treatment or condition

Seven of these 10 factors relate to communication, and three to the hygiene standards of the hospital. These results suggest13 that a truly ‘patient-centred’ NHS would place a high priority on communication, patient- professional interactions, and treating patients as individuals. Patients rate many [aspects] of the current patient choice agenda - such as choice of hospitals or admission dates - among the **least** important (74th and 76th out of 80) aspects of care. Patients clearly wanted to be treated as individuals and to have the importance of communication respected. Certainly, in my own experience as a medical director, poor communication features most highly in patient complaints. The King’s Fund report of 2010 reproduces1 their own study, based on searching Google for ‘what matters to patients’, again highlighting values which we can all recognise as important in such relationships. The resultant pie diagram is reproduced here:



So if this is what patients actually want, and regard as good, and if, as we have seen, they tend to forego the opportunity to learn more about the *results or outcomes* of care, then where on earth can they get information that allows them to differentiate one doctor or service from another?

Well, there are some ‘products’ on the market which help provide such data and this is where Neil Bacon comes into his own. Neil founded iWantGreatCare in 2008, to make it easy for patients to give feedback directly to their doctor, surgeon, GP or to rate and review their hospital. Every single rating and review is shared on an open, public website with the aim of ensuring that patients and the public can be far better informed about who will be caring for them, operating on their child or managing their mother’s Alzheimer’s disease.

It has been called the TripAdvisor of Health, and whilst there are now nearly 3 million reviews on the site, there is still a lot of work to be done if this aim is to be realised. Whilst other sites, including NHS Choices and Patient Opinion allow patients to feedback on their hospital or GP practice, only iWGC enables you to give feedback on **individual** doctors, dentists, nurses or physiotherapists.

Initially, and in the same way that some surgeons resisted the publication of data on individual cardiothoracic surgeons, a number of doctors were opposed to the opinions of patients being made available online for other patients to see. However, over the last eight years there has been a huge shift in the opinion of the medical profession and a realisation that transparency and sharing information can benefit both the patient and the doctor. Indeed, 360 degree feedback from patients is now a mandatory part of revalidation with the GMC.

Based on personal ratings and reviews, the service allows for qualitative and quantitative data to be generated, with the aim of enabling patients to directly compare one service or doctor against another, to find the sort of GP they think they will best get on with, or to have a better understanding of the neurosurgeon who might shortly have his hands inside their head.

Some doctors now have hundreds of reviews from their patients, and often say that patients tell them that reading the words of other patients was a reassurance ahead of their consultation and reduced their anxiety.

However, to be really effective requires that large numbers of patients rate and review the care they receive, and these things typically take more than a decade to develop. It took TripAdvisor more than 12 years before it really had enough hotel reviews to become a really useful way to choose where to stay.

Whilst there are many thousands of reviews for some hospitals, for others there are a mere handful. The whole area of ratings and reviews of doctors is still very much a project “in progress” and will likely take five or so more years before it will have the volume and depth of qualitative and quantitative data across the majority of doctors and surgeons to become a robust way for patients to choose their doctor.

Academic studies in the US and here in the UK show clearly that ratings and reviews from patients accurately predict safety and quality, if patients give a hospital a five-star rating then that hospital is far more likely to have better survival rates, lower risk of infection and to deliver a better experience. So solving the challenge of getting more patients to rate and review their doctor, GP or hospital could be far more important than just helping find patients find the surgeon they want, the data collected has the potential to become an early warning system for the NHS, a “smoke-detector of safety” that can predict risk, prevent harm and protect patients from poor care.

The potential power and importance of such data makes it even more frustrating that the out-dated communications systems in the NHS often act to make it harder for patients to provide feedback on their care: you are more likely to get an email from your bank or airline asking for feedback, than you are from your surgeon or hospital. The vast majority of NHS communication with patients is still by sending letters in the post, when email communication would make adding a review of care as simple as clicking a link in an email. Individual doctors (and some innovative hospitals) are getting around this by emailing their patients - and in turn seeing very high response rates as the vast majority of patients are only too happy to help improve their NHS by giving detailed feedback on what could be improved for the next patient, or just saying what was particularly great about the care they received.

It has been presumed - often by doctors - that patients have difficulty judging the quality of a service, but the evidence actually suggests the reverse is true. The largest studies show that patients are actually rather good at identifying quality and safety of care, and that the opinion and experience of other patients can often be the best way to choose where you are cared for, and who cares for you. Doyle et al[[4]](#footnote-4) from Imperial College London, after reviewing 55 studies looking at the correlation between patient experience and care quality, concluded;

*“Patient experience is positively associated with clinical effectiveness and patient safety…Clinicians should resist side-lining patient experience as too subjective or mood-oriented, divorced from the ‘real’ clinical work of measuring safety and effectiveness.”*

Similar observations were reported in the USA[[5]](#footnote-5). Gao et al[[6]](#footnote-6) from Harvard have published early data suggesting a positive correlation between online ratings and physician quality, and Felix Greaves and the Imperial group have also suggested that hospitals with good patient ratings on the Internet have a lower death rate and lower re-admission rates. Sorting chickens from eggs here will take some time.

As with all new sources of information, much more research is needed to confirm or deny value to the patient, and especially to see if patient opinion really can alter service provision as it does so much in **real** markets. We would do well to support such research; after all we are here for the benefit of patients.

**Asymmetry of information**

Doctors have an inherent power based on the knowledge they hold. This has been attributed to an **asymmetry of information**20. People are frightened to contact their doctor and it is easy to abuse the power one holds. David Main, a veterinary surgeon, wrote in the BMJ in 201321 that this sort of power is potentially destructive. The information one holds as a doctor can be used as a weapon by either releasing it *or* withholding it. Main pointed out that we exchange such information in a totally different way if we are friends meeting as equals, say in a pub. There is more balanced questioning and challenge, as equals. A friend would not see an imbalance of knowledge as a power challenge. Main advocated that professionals should treat their patients “*as if they were their friends*”, a view with which I wholeheartedly concur. In my experience, this is what the best communicators and the most empathetic physicians do naturally, and is maybe one of the factors that patients seek when looking for ‘good doctors’. Pamela Wible, a media-type doctor in the USA, put it[[7]](#footnote-7) in this rather ‘Sara Palinesque’ way,

“*Listen up, docs: Patients just want the real you. Ya know— YOU. The competent and caring you, who really listens with compassion. The real you that talks like a real person and answers people with the honest truth in words they understand. The you that treats patients like family.”*

Information is now much more freely available than ever before. Patients and families have access to almost everything I use, via Google, PubMed and other search engines. An increasing number of medical articles are available for free via Open Access agreements, and individual authors post their papers on such sites as Research Gate or Academia. Specialist societies, both national and international, publish registry data, pooling information from many hospitals and surgeons from around the world. These data are increasingly being made public, and are often ranked or scored. However, you still need to have a fair amount of ‘inside knowledge’ to be able (a) to locate the information and (b) to interpret the data. Whilst the information is out there, it is organised and presented in ways that paradoxically seem to **preserve** the imbalance of power between professional and patient, and sustain the relative asymmetry of information, despite the optimism of some who thought that the Internet would be the great leveller5. Sadly, the data can also easily be misinterpreted, and the consequences for the doctor, surgeon or institution involved can be considerable22.

In my world, all the parents are digital natives; they have grown up in the time of computers and the Internet. Most of the families I see have eventually located the information, after hours surfing the net, but they definitely appreciate my help in working out what it means. I can provide insight and some additional knowledge and experience. But if they had been able to sort out the information for themselves, would they have gone to see someone else, somewhere else?

How much information patients *actually* want has also prompted debate. There is no doubt that it varies considerably from family to family, and probably from person to person. It is not uncommon to be stopped from giving out information by the family saying they don’t want to know more, ‘*you just do what you think is best*’. If I do that, am I being paternalistic; imposing my views on them? Or responding to their needs and demonstrating empathy, a characteristic often sought out by families. Could they have come to the end of their tether because of fright; have I told them too much, and they could not bear to hear any more? Whatever you thoughts on this, it emphasises to me the key importance of doctors and patients working **together** to make decisions, and doing so in a way that respects both. Some doctors do take the view that they are bound to know more than the patient and therefore they should effectively force through the relevant decision. But I think these doctors are increasingly rare, and most of us would rather share decision-making with our patients. The snag is that **to communicate well takes time**, a lot of it, and all doctors in the NHS are under increasing pressure as more and more patients need to be seen. The idea that a GP can go through the complexities of debating treatment options in 12 minutes seems patently absurd, and yet that is what is currently being offered as average appointment duration.

So many factors contribute to the choice a patient and their family have to make, many of which are not limited to the disease or treatment itself, but relate to social pressures like work, education, the needs of other members of the family and so on. These factors often do not emerge on first discussions, but over time and with developing trust. Decisions of such importance as those about ones health should not be rushed, but sadly have sometimes become so as our system comes under pressure. Shared decision making is popular (76% of respondents in one survey13) and appropriate. A more engaged patient is more likely to commit to treatment, take the drugs they are prescribed and turn up to appointments19 23 24. Patients who participate in care-related decisions and who are given an explanation of their health problems are more likely to be satisfied with their care25.

In some settings, patient involvement is effectively compulsory; this is the case in most countries where informed consent is the law. A doctor no longer plays the role of an authority, advising what course of action is best for the patient; now he often simply tells the patient what their options are, leaving them to make a decision and to give (or refuse) their informed consent26. The concept of patient involvement in their NHS care was reaffirmed in the publication ‘No decision about me, without me (2012)27’. However, it appears that a majority of patients are being left to make decisions that they never wanted to make in the first place. Researchers interviewed more than 8,000 hospitalised patients at the University of Chicago[[8]](#footnote-8). When it came to medical decisions, almost all the respondents wanted their doctors to offer choices and consider their opinions. But a majority of patients — two out of three — also **preferred that their doctors make the final decisions** regarding their medical care. The challenges appear to arise not when the medical choices are obvious, but when the best option for a patient is uncertain. In these situations, when doctors pass the burden of decision-making to a patient or family, it can exacerbate an already stressful situation. Peter Laussen, one of the international pool of reviewers I rely on, wrote, after he read this section, **“OMG, this happens every day….we are training a cadre of physicians who will provide options but never make a decision.”**

For doctors, the key to preserving patient autonomy — and patient- centered care — lies not in letting patients make the final decisions alone, but in respecting their opinions and shouldering the responsibility together. And while patients will need to be more explicit and ask for that help, doctors will need to be more mindful of whether patients want them to share information, be directive or hand over the responsibility of the decision. It is naïve to think this is an easy judgment; all patients and all doctors differ from each other, and each has their own stresses to deal with. It is likely that the skill in managing this forms part of what makes some doctors more ‘popular’ with patients as reported in review sites. Launer has said recently28

*“Seeing patient choice in terms of conversation-making rather than decision-making has many advantages. Patients can direct doctors towards what matters, and articulate what they actually want from the encounter. They can do so far more effectively than if the doctor tries to second-guess these things for most of the consultation. The decision about treatment, if needed, arrives though* ***evolution****, rather than being mechanically introduced at the end by the doctor, or offered as a token gesture towards patient empowerment.* ***‘****Patient choice’ is not just about decisions. It can be embedded in every moment of interaction between patient and doctor”.*

Patients depend on a relationship of trust and mutual understanding, which develops from continuity of care and a relationship with individual physicians over time. This is proving increasingly difficult to achieve because of the pressures on general practice, and changing rota patterns in hospitals.

Perhaps the *market* agenda of patient choice, rather than such an *ethical* framework, has ended up creating too much choice, and unnecessary stress.

**Too much choice?**

The debate about paternalism disguises another important issue, which is that many of us suffer from an excess of choice. This has been called ‘the tyranny of choice’26, choice overload, or ‘overchoice’29. Making a decision becomes overwhelming due to the many potential outcomes and risks that may result from making the wrong choice. Having too many approximately equal options is mentally draining because each option must be weighed against alternatives to select the best one30. The amount of time allotted to make a decision also has an effect on an individual’s perception of their choice. Larger choice sets with a small amount of time results in more regret with the decision. And sometimes, opting not to make a decision at all. When more time is provided, the process of choosing turns out to be more enjoyable and results in less regret after the decision has been made31.

Choice in healthcare might also be viewed as discriminatory. After all, we have observed that those with more time, resources and digital literacy have a distinct advantage. The frail and those with cognitive impairment are obviously excluded unless they devolve choice to a relative or an agent such as a GP. Perhaps we should concentrate not on choice per se, but on appropriate investment to provide excellent services everywhere using a standards-based approach. This approach would require that we define the acceptable standards and then discipline the service against those; such an approach is being tried in a number of specialties, including my own. My concern is that neither the NHS nor its political masters would have the will to follow up on such discipline if it required closure of centres or significant service remodeling.

Doctors are competitive, they have had to be to get where they are. We compete for reputation and for academic kudos via the medical literature. Competition drives improvement for many, both at the personal and institutional level. Patient choice could and certainly should, have a role in that competition. I think that over time doctors would compete to get good reviews, in the same way restaurants compete to get stars, and it has been suggested that a proportion of their pay should be dependent on such reviews.

A GOSH parent, Parker Moss, has made some penetrating observations which suggest that we are asking our patients and their families to choose from the wrong menu. We need to give work out how better to define both the services and care pathways we use, and to develop methods of comparison and exposure. Here is what Parker has to say:

*My patient experience is through the eyes of my 7-year-old daughter who is in her 42nd month of treatment for stage-4 cancer (neuroblastoma).  We’ve had a hugely complex pathway, led by GOSH but involving care 3 acute hospitals and a community care provider, requiring specialist care in oncology, radiotherapy, surgery, cardiothoracic, respiratory, renal, a lot of time in ICU and 17 months as an in-patient.  During this period I have been an extremely ‘activated’ carer… which is not unusual for a parent.  After all this time, what information would have made it easier for me to make choices about my care? There is a lot of discussion about choice of doctor…which is something I never experienced.  But on reflection, and having gotten to know the whole oncology team at GOSH and other UK hospitals, I don’t feel that selecting a doctor, or even detailed historical information on the clinical outcomes of my oncology team, would have improved my morale, led to different decisions or effected my daughters outcomes.  The oncology team is a diverse but consistently individually impressive and they work together in a tight MDT, making individual ‘doctor ratings’ rather meaningless.  What I would have valued, and could have led to different choices, is information on the quality of the integration and efficiency of my daughter’s pathway: Will it take 1hr or 4hrs to give my febrile neutropenic daughter an antibiotic when we rush into hospital in the middle of the night? Will the community team have access to the GOSH medicines record? Does my share-care hospital offer emergency access direct to the ward or do we have to go via A&E in the middle of the night? What is the responsiveness of the pain management team? Do MDTs extend to surgery and radiotherapy? Can I and my care team access pathology results electronically and in real time? My conclusion is that I trust the training of my doctors and their ability to access the evidence base where their training is stretched or challenged… but* **an A doctor in a B system can be very harmful***, and I’d like to have been able to challenge and compare the maturity and quality of the integration of my system… assuming a choice of cancer care had been possible. I expect the desire for information on pathway quality would be valued by many patients in complex care… and that of course includes the vast volume of co-morbid and often elderly patients with long term conditions”*

Shared decision-making is the best, and good information is needed for it. We need to work **with** our patients to define what they need to know and how best to show it to them. Process and communication are important, and the health system needs learn to react to patient choice, now the genie has been released from the lamp, or make standards of service high enough that choice becomes irrelevant. To do that, the system itself needs to learn to make tough choices in response to what patients desire, to close weak services and to capitalize and grow strong and popular ones. In my view the current NHS is too complex to be able to respond in this way, and too beholden to political influence.

I hope we have shown you tonight that the concept of ‘patient choice’ is more complex than it first seems. Health care is not a conventional market. Since it is well established that patients want their own local services to be as good as possible, and to see empathetic doctors who can communicate well, perhaps we should strive first to deliver that. Patient choice has yet to make much impact in the NHS, but it could and probably should….if **you** want it to. There is no doubt in my mind that services will improve if more and better information is made publically available. Patient feedback must be included in the published data; you are the customers, and we are your servants. Even if change through choice is far away, the competitive nature of medics and hospitals will continue to make them strive to be the best, provided they know just where they stand and what you, as patients, want.

**And very importantly, if you are not happy, you have the right to, and should demand, a second opinion.**

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