17th Gordon Arthur Ransome Oration: Patient-centred Professionalism

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When sickness strikes we all need doctors. People everywhere know that the quality of medical care can affect the outcome and possible consequences of illness, and at times mean the difference between life and death. Illnesses can make patients frightened and vulnerable, and bring their defences down. These are the reasons why all patients want good doctors who are properly skilled and fully up to date, who really know what they are doing. At the same time they want doctors who will respect their dignity, their privacy and their right to decide about their treatment, doctors with whom they can empathise and who will care for them as people, doctors whose personal integrity is beyond question. Patients need and are entitled to doctors who have all these attributes. Such doctors they would regard as thoroughly patient-centred and therefore thoroughly professional. Such doctors they can trust. And trust is vital to them. After all, in terms of diagnosis and treatment they have no one else to turn to, nowhere else to go.

This places an awesome responsibility on the medical profession. In fact, most doctors are deeply conscientious in discharging this responsibility through their own idealism, sense of service and self-discipline – literally self-regulation – in their own practices. We know that because surveys of patients' experience and opinion tell us that so many patients think well of their doctors.

But doctors are not all like that, all the time. Some are clinically inadequate, some cannot communicate, and some cannot relate appropriately to patients. Hence, the duty placed on the medical profession by the public to regulate itself by making sure that every licensed doctor practices in accordance with the standards that it says are necessary and, where a doctor does not, to act promptly and decisively to protect patients from possible harm. This collective responsibility is equally part of our professionalism.[1] So professionalism has two limbs to it, one relating to our personal responsibility for our own competence, attitudes and conduct, the other relating to our collective responsibility, to which we must all contribute, to make sure that clinical teams and professional bodies function as they are expected to. This holistic view of professionalism goes with our claim to be a profession with all the privileges and status that attach to that. It is the essence of our part of our regulatory bargain with the public.

Some doctors are very concerned that as a profession we have not taken our collective regulatory obligation as seriously as we should. However, many more doctors still do not understand that obligation. Others do, but refuse to accept it because self-interest or their desire for professional solidarity overrides their sense of public duty. The consequence has been stalemate, resulting in a significant gap between the public's legitimate expectation of safe, ethical practice from all doctors for all patients and the reality that a small proportion of patients do not get this. Doctors who, for one reason or another, are thought to be performing poorly or are even unfit to practise – yet are still practising – cause this gap. For example, in the UK and the USA, the proportion of such doctors has been estimated at about 5% of the practising workforce. This means that in a country of reasonable size, several million people are put at avoidable risk without even knowing it. Looked at through patients' eyes, this is simply unacceptable. On any terms it is morally indefensible.

How timely it is, then, that in the Congress this week we are about to discuss various aspects of professionalism in medicine. It is appropriate, and it gives me great pleasure, to couple the Congress theme of professionalism, and my remarks to you now, with the name of Gordon Arthur Ransome whose memory we celebrate this evening. Dr Seah Cheng Siang, who gave the first of these commemorative orations 32 years ago, described Professor Ransome as the founder of modern medicine in Singapore and Malaysia. Trained as a neurologist, he was by all accounts a fine clinician, possessed of the very qualities that win the respect and confidence of patients. He was an ideal role model for students. And he contributed hugely to the institutional and academic development of medicine in this part of the world. In particular he took the lead, with like-minded colleagues, to foster high standards of medical practice by founding the Academy of Medicine under whose auspices this Congress is being held. In every sense, Gordon Ransome was a true professional of his time.

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Rethinking Professionalism

Ransome would have recognised that professionalism is the outward visible expression of our medical culture. It reveals our values – shows what we stand for – and how we behave and perform. Traditionally our professionalism has portrayed medicine as we thought it should be, as seen through doctors' eyes. Indeed, in the last century, the regulatory bargain – or contract – between the profession and society was based on the public's belief that self-sacrificing doctors were all knowing and totally dedicated to their patients, and so could be virtually exempt from normal accountability. This helps to explain why our understanding of our professionalism has always been implicit – we all think we know what it is but can never quite say. Hence, as Richard and Sylvia Cruess have pointed out, the medical community has never seen the need, until very recently, for itself to analyse and digest the fundamentals of its own professionalism.[2] So, it was left to the social scientists, beginning with the groundbreaking work of Rosemary Stevens, Margot Jeffreys and Eliot Freidson in the 1960s and 1970s, to provide the most coherent and intellectually rigorous insights. They and others who joined them were the outsiders looking in. They brought a fresh eye, a non-medical view of doctors even though at the time most doctors were not minded to heed their messages.

Today, we are in a different world. In my practising lifetime, medicine has altered out of all recognition. Advances in science and technology have given us the ability to do wonderful things, but also to do more harm. Information technology is itself transforming practice. At the same time there have been dramatic changes in the social context and the practising environment especially in developed countries. For example, so much of medical care is based on clinical teams and micromanaged through clinical guidelines and clinical governance. Clinical governance, incidentally, is the term used to describe how we improve and assure clinical quality at the workplace. Angela Coulter has given an excellent description of how, in our consumer world, patients' traditional deference to doctors is being replaced by assertive patient autonomy.[3] The fact that the Internet has given everybody direct access to the database of medicine simply reinforces it. One result is pressure from some patients for a more equal partnership between doctor and patient. Another is that the public now sees the delivery of good medical care as an entitlement rather than as an expectation. For them minimalism will no longer do. And doctors are not immune from change. For example, they have their own ideas about the balance to be struck in their lives between work, family and leisure, which cuts across the traditional view of the self-sacrificing professional I mentioned earlier. I could go on, but you know the story.

No wonder, then, that we are having to rethink the basis of our professionalism as we move from a deeply entrenched doctor-orientated view of professional values to a patient-centred culture that is much more in tune with contemporary society. We are beginning to see the value of doing this with the public and patients rather than on our own. There is much to learn from each other as we discover that things that patients and we both value are in danger of being sacrificed on the high altar of cost-containment, political ideologies, managerial efficiency and control, and commercialism.

The passage towards the new culture has been by no means smooth. Consider, for example, the angry public reactions that are now more likely to occur in cases where medical regulation has failed to protect patients and the equally angry reactions of some doctors to a public that seems to them to be strong on asserting its rights and short on facing up to its own responsibilities for healthy living. And there is the resistance of many doctors to the public demand for greater accountability and more transparency from the medical profession. But these responses have to be put into perspective. The predominant message is positive, one of optimism, as more and more thoughtful and socially aware doctors and eminently reasonable and increasingly well-informed citizens take the initiative and work together, in a kind of coalition of the willing, to try and establish a new relationship, a new contract between the medical profession and the public.

In the remainder of my talk, I want to summarise some underlying problems, what we can do about them, and how we might move forward.

Underlying Problems

Let me start with the problems. I have suggested that patients' respect and trust for individual doctors does not normally extend to the profession's institutions. Here the reality or the public's perception of self-interest – which may result from unconscious institutional bias or be intended – arises from the profession's failure to make self-regulation work for all patients. It is the public's perfectly natural response to our comparative neglect of this part of the healthcare system.

This has certainly been our experience in the UK where a growing loss of public confidence in professional regulation – but not in British doctors generally – followed several serious clinical failures that culminated with the tragedy in paediatric cardiac surgery at the Bristol Royal Infirmary, which is one of our foremost teaching hospitals. At the General Medical Council (GMC) disciplinary hearing in 1998, which was held in public, everyone heard about doctors' dismissive attitudes to warnings about suspected poor practice, the ostracism of whistle blowers, ambivalence

about evidence-based practice and clinical audit, an autocratic approach to team working, and strongly paternalistic attitudes to consent to treatment. The result was bitter comment about the arrogance of the medical profession and the ineffectiveness of the GMC in protecting patients because of its doctor-centredness. The force of the public's angry response to these behaviours was reinforced by the impact of several other cases of bad practice, and one of serial killing by a doctor, that surfaced at about the same time. Together, they shook the profession.

So what went wrong? Last year I told the story in my book entitled *The Doctor's Tale: Professionalism and Public Trust*.[4] The key points were summarised in a paper published on the 6 September 2004 in the *Medical Journal of Australia*.[5] It is a case history of a profession containing many deeply conscientious people which was nevertheless inward looking and given to excessive protectionism and complacency about patient safety. I am reminded of Edmund Burke's words when he said that "*all that is necessary for evil to succeed is that good men do nothing*".[6] How true! Of course there were whistle blowers, of which I was one. But the resistance to change was too strong, which is why it took a disaster to galvanise action. Let me give you some of the underlying reasons and see if any of them resonate with you, for Britain was by no means unique.

First, there was the general point that the profession had remained wedded to a 19th century professional culture when society was changing profoundly. So, in the 20th century, the profession was vigorously progressive and successful in developing medical science and technology whilst remaining deeply conservative on matters of attitude and human relationships about which patients care greatly. Attitudes to paternalism, communication and patients' consent exemplified this.

Second, the profession was introspective and given to listening only to itself. It heard only what it wanted to hear. In particular, the public had no effective means of access to it other than through patients' complaints. So, there was a widening gap between the profession's ambivalent approach to accountability and transparency – and even a denial of the need for it by some – and the public's increasingly explicit requirements. Hence, for example, the growing public criticism of the profession's secretive attitude to risk and to the disclosure of information that would shed light on doctors' personal conduct and performance.

Third, there was – and still is – the curse of misplaced collegiality, by which I mean the tendency of the profession to close ranks in the face of perceived adversity. Think, for example, of the instinctive response "*there but for the grace of God go I*" in the face of clinical error. This is not, incidentally, an argument against collegiality which, when well directed, is one of the strengths of the medical culture because it gives professional identity.

Fourth, there was disruptive tribalism aggravated by specialisation. One important consequence was that professional institutions tended to act in isolation and be tactical. There has been no history of co-ordinated strategic planning, of the profession as a whole looking ahead, of not being taken by surprise. With such diffuse and variable leadership, the profession therefore lacked a clear sense of vision and direction about fundamental professional responsibilities.

Fifth, the profession's regulatory mindset was to react to serious problems after the event rather than to try proactively to anticipate them through early recognition, diagnosis and action. Hence, the ad hoc nature of the arrangements for supervising the quality of medical practice at the point of service delivery and the highly variable and ineffective systems to deal with problem doctors.[7,8]

And last, there was a longstanding, strongly collusive relationship between successive governments and their NHS (National Health Service) managers on the one hand, and the medical trade union – the British Medical Association – on the other. One result was the tolerance shown to a residuum of poor general practice by successive governments and our NHS because of persisting manpower shortages. That situation persists today despite all that has happened.

Other countries have had their share of similar experiences although the press has been more restrained. For example, there has been an equally serious failure in cardiac surgery in Canada. In the US, Rosemary Gibson has described most disturbing cases in her excellent new book *Conspiracy of Silence*.[9] Last month, Faunce and Bolsin reported 3 recent examples of institutional clinical failure from Australia where, like Bristol, there was a poor institutional and professional culture of self-regulation, error reporting or investigation.[10] The norm is that, everywhere, the public has to tolerate an unacceptably high level of variability in physician performance and conduct. Only a handful of countries have attempted to address this issue systematically through clinical governance and re-certification, and none have gone for mandatory relicensure through revalidation. However, that is about to change in Britain, as I shall explain in a moment.

Implementing Patient-centred Professionalism

So, is there anything that can be done about this situation? Of course there is! In a profession with so many talented people in it, most of the outstanding problems are capable of resolution provided that we have the necessary will. The starting point is for the medical profession and the public together to put patient-centred professionalism at the heart of their vision for the future of medical care. The realisation

of that vision must become the profession's first and overriding priority. It must take centre stage in professional life, practice, education, regulation and research. It has to become the first objective on which personal and institutional energies are focused. Nothing short of that level of commitment and effort will do because the first duty of the profession is to make sure that it delivers what it is supposed to do.

And what would this mean in practice? It means the profession has to accept that patients are entitled to be seen only by good doctors, not by doctors whose standards are barely acceptable. This applies particularly to specialists and general practitioners whose practice is unsupervised. Today, we know much more about what we mean by "good" practice, what the parameters and competencies are, and how to distinguish between acceptable and unacceptable practice and practice which is in some way a cause for concern. But equally, it means adopting a new, positive approach to evidence-based practice, to teamwork, to clinical audit and external scrutiny, to transparency and proper accountability, to a new order of openness about the performance of individual doctors, and a new attitude to the reduction of medical error. These need to be seen as professional virtues rather than as threats. For regulators, it means a radically different approach to the promotion, demonstration, assurance and dissemination of good practice and the protection of patients from poor, unsafe or unethical practice through robust, proactive medical regulation. The time for equivocation and fudge is over.

In Britain, we began this journey 10 years ago. The good news is that we have made huge progress largely because of the jolt given to the profession and government in 1998 by the Bristol tragedy. The government, employers and the medical profession have followed a 2-pronged approach. One has been to strengthen institutional systems for improving and assuring quality in hospitals and primary care through much better arrangements for creating national clinical guidelines and reliable clinical governance. The other has been to modernise medical practice, education and regulation around the principles of patient-centred medical care. The model for the latter is deceptively simple yet seriously radical. It consists of a national, patient-centred code of practise that has been tied to medical licensure to secure universal compliance throughout a doctor's career.

The new GMC code – called *Good Medical Practice* – was designed from the outset to unify the profession around the basic duties and responsibilities of a doctor agreed between the profession and the public.[11] First published in 1995, it stands today as our national standard of patient-centred professionalism. For individual doctors, it is a public affirmation of their values and standards. In fact, both the profession and the public have warmly welcomed it so it clearly reflects a substantial measure of mutual understanding. It is in use in one form or another in several countries around the world. I see its shadow in the ethical code produced by the Singapore Medical Council.

We have learnt the hard way that codes that are simply advisory, that are not systematically implemented, are virtually useless. Indeed they are worse than useless because they can raise false expectations that have no hope of being realised. So, for us, the embedding of the code into professional life is every bit as important as the code itself. This has proved to be by far the biggest challenge because it has meant abandoning some deeply entrenched attitudes and ways of working in professional practice and in medical education and regulation.

So, what does embedding mean in practice? Essentially it is using the code – *Good Medical Practice* – as the basis for all aspects of registration and licensure. It means making sure that all those joining the medical register in future attain the standards expected, that those on the register continue to practise in accordance with them, and that doctors who fail to comply are disciplined, placed under supervision whilst remediation is attempted, or if necessary removed from practice altogether. It means imprinting *Good Medical Practice* onto the whole of medical education so that the system is capable of producing doctors with the desired qualities. And it means incorporating the code into doctors' contracts of employment to underpin employers' local systems of credentialing, clinical governance and appraisal.

Alongside the code, the most fundamental change has been the adoption of revalidation as a means of achieving virtually continuous relicensure.[12] Revalidation begins in 2005. It is the process through which doctors have to demonstrate regularly that they remain fit to practise in their chosen field. In addition to demonstrating good practice, it will help with the early identification of sub-optimal and poor practice about which further things must be done. The areas to be covered by revalidation and the basic standards for it are set out in *Good Medical Practice.* As part of the process, the Royal Colleges are responsible for indicating acceptable and unacceptable clinical practice in their respective fields. The keys to successful revalidation will be in the evidence of competence, performance, conduct and health that the doctor offers, in the rigour of the assessments made of that evidence, in the standards the GMC is prepared to accept, and in the transparency of all the processes essential to the building of public trust.

The evidence demonstrating compliance is crucial. For the vast majority of doctors who are in employment – mainly in the NHS – we decided early on that the evidence should be drawn where possible from the place of work

through clinical governance. Evidence of professional development is part of that but of itself not enough. The original intention was that the evidence would be rigorously reviewed at the doctor's annual appraisal, and every 5 years the GMC would decide whether to revalidate taking account of the totality of the evidence and comment made on it during appraisal.

Mature doctors, not used to being held to account and unfamiliar with modern methods of performance assessment, find revalidation challenging and threatening. So there is much to be done to make the transition smooth, particularly by making the collection of evidence about their practice as easy as possible. They need to see that regular performance feedback is a positive aid to their professional development and their satisfaction with professional life. Colleges and Academies could be very helpful to their members with this.

As you might imagine, there is still much that is controversial about revalidation. The public wants to be assured that the standards and methods adopted will in fact be robust enough to give them the level of protection they expect, and that they will be appropriately involved in the process. The profession wants the system to be fair and to be as unobtrusive and as undemanding as possible on their time, in an under doctored health service. But we should be optimistic, to believe that these tensions will resolve as revalidation becomes operational and people gain experience.

Looking ahead, it is clear that a systematic, well-coordinated effort will be needed to drive forward the movement to patient-centred professionalism within a timescale that the public will see as acceptable. Ideally, the licensing authority – in the UK case, the GMC – should give energetic leadership because it is at the hub of the professional regulatory system. We hope that the GMC will have the necessary will, imagination and degree of patient-centredness to do this successfully. But other partners have to contribute. For example, the most important thing the Royal Colleges can do to help is to take responsibility, within the framework of Good Medical Practice, for the standard of practice of their own members by making the designation "member in good standing" an indicator of current professional quality to the public. Similarly, we have to look to leadership by the medical schools to spearhead implementation within their areas of jurisdiction, especially through the potentially powerful impact of role modelling by the clinical teaching workforce. All in all what is now needed is resolute implementation in depth.

Others are contributing. Thus, the King's Fund, an independent think-tank, is holding seminars on professionalism that are helping to flesh out the full dimensions of the subject. The Royal College of Physicians of London is giving leadership by setting up an inquiry into professionalism in medicine. And Dr Foster, an independent company specialising in the public presentation of data about doctors' performance, is helping by pushing the boundaries of transparency forward.

The Picker Institute Europe, a charity devoted to patient-centred care, is launching an international collaborative project with professional and patients' organisations who want to develop a second generation of patient-centred codes of practise based on in-depth studies of patient experience and expectation. The National Board of Medical Examiners and the American Board of Internal Medicine in the USA, and the Royal College of Physicians and Surgeons of Canada, who are all leaders in this field, will we hope support this with their counterparts in the UK. This collaboration should help to strengthen regulation internationally, if the output from the studies of patient experience results in a new generation of national codes in each country that are fully capable of being used operationally as the basis for future regulation, education, assessment and quality assurance.

The new UK model for regulating doctors and their professionalism has the strength of covering the whole population. It has inherent flexibility. It should be dynamic, able to adjust to changing societal expectations of doctors and to changes in practise brought about by advances in medical science and information technology. It is capable of being applied in any foreseeable working environment. It is our contribution in the emerging worldwide drive for truly patient-centred medical care.

Lessons for the Future

To conclude, from our experience so far, there are already lessons that will have international relevance in future.

First, it is essential to put patients at the heart of things. I emphasise this because it is easier said than done. Linked to this is the need to involve the public directly in as many ways as possible in the regulatory and educational processes.

Second, is to make the licensing body ultimately responsible for everything that impinges on the professionalism and therefore the fitness to practise of any doctor it has licensed to practise. Where it delegates to others, such as Colleges and specialist societies, Academies, employers and other regulators, it has to be sure of the quality of work done in its name. But it has to carry the can, to be ultimately accountable to the public through the national legislature.

Third, is in the value of a whole systems approach that brings the public, governmental, and professional and employment strands together. That in turn means being

clear about the designation of responsibilities and accountabilities between the various players.

Fourth, is to accept the ethical case for the regular revalidation for all doctors' licenses to practise. Only licensure gives the universal coverage required for full protection of the public. Recertification, because it is restricted to certain classes of doctor, can contribute but can never be of itself sufficient. So the main difference between the revalidation of licensure and recertification is one of coverage. The assessment methods used can be the same.

And last but not least, there is the crucial importance of professional leadership. To make patient-centred professionalism work, and to sustain it, we need leaders in the profession who, in addition to all the usual qualities, will have the will to drive the movement forward and the strength of ethical purpose to see that the public interest always comes first.

At the end of the day, doctors and the medical profession are there to serve their patients and the public. That is what being a profession is all about. Today, that service should be founded on patient-centred professionalism. I am sure that Gordon Arthur Ransome, had he been alive, would have approved. Indeed, he would have been in the thick of it, leading the drive for patient-centred professionalism from the front in Singapore and Malaysia through the medical councils and the Academies of Medicine. So now it falls to his successors to take up the baton.

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