

2004 Runme Shaw Memorial Lecture: Professionalism – A Concept in Need of Nurturing

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Introduction

It is a great honour to be invited to deliver the Runme Shaw Memorial Lecture. I am grateful to the Runme Shaw Foundation for their support of this lecture. Mr Runme Shaw was by all accounts a most engaging man. To have been so successful in business he must have been a very hard worker and also highly knowledgeable and skilled, the attributes of a true professional. He amassed a considerable fortune and was able to enjoy an attractive lifestyle. However, he was also a very generous man who was noted for his philanthropic acts in this community. Figure 1 shows him with a group of disadvantaged children who were the beneficiaries of his generosity. I will contrast Mr Runme Shaw's generosity toward these children with the treatment of some disadvantaged children in my country. I will show a number of news items and images from Canada and from other countries to illustrate the importance of the theme that trust is essential to the survival of medicine as a self-regulating profession.



Fig. 1. Mr. Runme Shaw with disadvantaged children.

I congratulate the Academies of Medicine of Singapore and Malaysia, who are joined in this conference by the Academy of Medicine of Hong Kong, for focusing their annual conference on Continuing Professional Development and on Professionalism. I congratulate you for linking these topics in this conference. I was delighted to read the vision statement of the Academy of Medicine of Singapore,

which refers to promoting and maintaining the highest professional standards of competence and ethical integrity, thereby providing the highest quality of patient care.

I cannot claim any very direct connection between our College and the Academies of Medicine of Malaysia and Singapore. We do have an indirect connection with Hong Kong, if not with the Academy of Medicine there. The Right Honourable Adrienne Clarkson, our Governor General, and a fellow of our College, was born in Hong Kong. She and her family escaped from Hong Kong as refugees at the time of the invasion in 1942 and found their way to Canada, where the family has been very successful. Adrienne Clarkson became a highly respected television journalist particularly in programmes related to the arts, and became our Governor General 3 years ago. At that time, she also became a fellow of the Royal College of Physicians and Surgeons of Canada.

Canada is proud of its acceptance of both refugees and immigrants from this part of the world over the years. They have contributed much to our country, as exemplified by the appointment of Governor General Clarkson. One of my major themes today is trust. I shall show you that the trust of the Canadian public in our system for considering refugee claimants has been weakened recently, when I deal with the importance of trust in public institutions.

The Meaning and History of Professionalism

Let us consider the meaning of the terms “professional and professionalism”. How does the public define a professional? In general, the Canadian public considers the “professional” as the opposite of an “amateur”, for example in sport. A professional is someone who is paid to perform an activity and has superior skills.

Figure 2 shows two typical young Canadian boys enjoying Canada's national pastime of ice hockey as amateurs. They are playing hockey just for the love of the game. Figure 3 is a picture of Jarome Iginla, one of hockey's elite goal scorers. This 26-year-old is a typical young Canadian because of his love of ice hockey. He is also a typical Canadian because he is the son of an immigrant from

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Fig. 2. Amateurs: Canadian boys enjoying the national pastime for love of the game!



Fig. 3. Jarome Iginla – Canadian hockey professional.



Fig. 5. Petworth House, Suffolk, ancestral home of the Percy family, a symbol of trust.



Fig. 6. Holbein's portrait of King Henry VIII, founder of the Royal College of Surgeons of London, from Petworth House.



Fig. 4. *Hinc Sanitas*, (From This, Health). Sculpture in the courtyard of the Royal College of Surgeons, Edinburgh.

Africa. He starred for Calgary in the recent Stanley Cup play-offs of the National Hockey League, and will undoubtedly star for Canada in the World Cup of Hockey to be played in August and September this year. There is no doubt that he is a professional, for he earns an annual salary of 7.5 million dollars. His professional status depends on his superior knowledge and skills and his very strong commitment to his “profession”. He stands out because he is a team leader with a strong commitment to others for the common good. Some members of the public would refer to him as a “real professional”.

The Oxford English dictionary defines a profession as “any calling or occupation by which a person earns his living” but also refers to the more usual definition of “a vocation in which a professed knowledge of some department of learning is used in its application to the affairs of others and applied specifically to the three learned professions of divinity, law, and medicine and also sometimes to the military profession”. It then goes on to define professionalism as the body of qualities or features as competence, skills, etc. that are characteristic of a profession or professional.

The concept of the physician as a healer has its roots

extending back to Hippocrates. However, the concept of a professional is a medieval one, with its origins in the craft guilds. In medieval England, skilled workers banded together in guilds that held monopolies, granted by officials of their towns and cities, on their particular crafts. They maintained standards of training and performance that the public could rely on. In several cities, these guilds shared a common hall that was often closely associated with local governments.

This sculpture (Fig. 4) of a surgeon's hand holding a scalpel *Hinc Sanitas* (From this, health) emphasises the superior knowledge and skill of the surgeon, as being important for health. It stands in the courtyard of the Royal College of Surgeons of Edinburgh, a professional organisation that is celebrating its five hundredth anniversary next year. It still stands for innovation and excellence in surgery. It is the oldest of the postgraduate medical colleges. It was founded in 1505 with the incorporation of barbers and surgeons, one of the craft guilds of Edinburgh under the control of the town council. Subsequently, several royal charters were given, notably by George III in 1778 and by Victoria in 1851. Local and national governments have recognised the value of professional organisations of

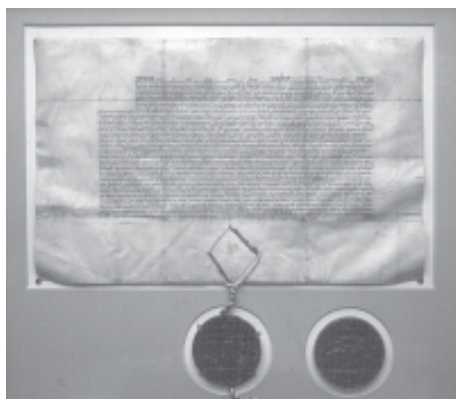


Fig. 7. Charter of the Royal College of Physicians of London (1518).

- it demands of physicians
 - placing the interests of patients above those of the physician
 - setting and maintaining standards of competence and integrity
 - providing expert advice to society on matters of health
- self-regulation is granted by society
- essential to this contract is public trust in physicians
 - trust depends on the integrity of both individual physicians and the whole profession

Fig. 8. Requirements of the social contract.

physicians for 500 years. We congratulate the Royal College of Surgeons of Edinburgh on its very long tradition of excellence. Its prime purpose remains as it was 500 years ago – the promotion of clinical excellence on the basis of education, training, and lifelong learning, a purpose that is shared by all of the Colleges and Academies represented here today. These Colleges exist with considerable powers because of the trust of the public and of Governments.

Figure 5 is a picture of Petworth House, one of the greatest of the country houses in the South of England. This house symbolises the fact that institutions survive and flourish because of trust. It has been in the inheritance of branches of the Percy family for nearly 1000 years. It sits in the middle of very fine gardens and it has the finest private collection of art in the United Kingdom, particularly of paintings by van Dyck, Constable, and Turner. Much of the contents of the house have been donated to the National Trust. However, that is not why I refer to it as a symbol of trust. Detailed examination reveals that the house has been modified over the centuries. Although a few members of the Percy family languished in the tower of London, the family and this estate, this house, and its priceless collection of art grew and flourished over several hundreds of years, in part because of the degree to which a series of monarchs trusted various members of the Percy family. Great institutions survive and flourish because of trust.

Figure 6 is a copy of one of the most famous paintings in the Petworth collection. It is Holbein's famous portrait of Henry VIII. Why does King Henry look so proud? He became famous for a number of things, including his rather large number of wives, but he also had many accomplishments as a monarch. In my view, he should be most proud of having founded the Royal College of Physicians of London in 1518. Figure 7 is a picture of the Charter of the Royal College granted by Henry VIII. Henry's emphasis was on an organisation of learned men professing in good faith and on the protection of the public

that would arise from this professional organisation. The medical profession, and patients in many countries, owe a great deal to the models established by the Royal Colleges in the United Kingdom. Most of us who are participating in this conference are here because of the commitment of similar organisations to professionalism and to continuing professional development.

Professionalism in the Modern Era: Medicine's Social Contract

In the modern era, leading up to the millennium, concerns in many countries that the professional model was being eroded led to the Professionalism Project of the European Federation of Internal Medicine, the American College of Physicians-American Society of Internal Medicine Foundation and the American Board of Internal Medicine Foundation. Two key consultants in the development of this project were Drs Richard and Sylvia Cruess, of Canada's McGill University. There was very broad international co-operation in this work that resulted in a document, a Physician's Professional Charter that was published simultaneously in the *Annals of Internal Medicine* and *Lancet*.¹ It has been endorsed by several postgraduate colleges and academies, including the Royal College of Physicians and Surgeons of Canada. If your academies have not endorsed this charter, you may wish to consider doing so, as a basis on which to develop and nurture the concept of professionalism among your members. The core concept defined in this charter is that Professionalism is the basis of medicine's contract with society. Figure 8 details the commitments required of physicians in return for the granting of self-regulation by society. It also specifies the crucial role of public trust in physicians as essential to this contract. This trust depends on the integrity of both individual physicians and the whole profession.

This social contract is based on three fundamental

principles, and these principles lead to a number of defined professional responsibilities.

Fundamental Principles and Professional Responsibilities Underlying Medicine's Social Contract

The first principle, that of the primacy of patient welfare, simply means “putting the patient first”. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

The second principle of patient autonomy requires that physicians help patients make informed decisions about their treatment. Decisions are made by patients, and patients' decisions must be paramount, as long as they are in keeping with ethical practice and do not lead to demands for inappropriate care.

The third principle, the principle of social justice, requires physicians to promote justice in the healthcare system, including the fair distribution of healthcare resources. Physicians should work actively to eliminate discrimination, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

For convenience the professional responsibilities that arise from these principles and are defined in the Physicians' Charter may be grouped under three headings and are detailed in Figure 9.

- Commitments to patients by the *physician as a medical expert*:
 - professional competence, individual and collective
 - improving quality of care
 - scientific knowledge
- *Ethical commitments* to patients:
 - honesty with patients
 - patient confidentiality
 - maintaining trust by managing conflicts of interest
- *Commitment* as an advocate for society:
 - a just distribution of finite resources
 - improving access to care

Fig. 9. Professional responsibilities of physicians arising from the social contract.

Alternatives to the Professional Model for Healthcare

Freidson, a scholar who has extensively studied and written about professionalism has pointed out that there are alternative models for healthcare systems that apply to organising any work.² While the professional model consists of a group of individuals with a social contract who are self-regulating, there are two other alternatives. The free market model developed by the early American philosopher, Adam Smith, conceives of free and unregulated competition, with fully informed consumers (patients) acting in their own

best interests, and with workers (physicians and other providers of health services) motivated to maximise their profits. In the rational legal bureaucracy model popularised by Max Weber, there is hierarchical control by tiers of managers, in large firms or government agencies, employing formal supervisory and personnel policies.

The Market Model

Under the market model, healthcare providers offer their services. Members of the public choose the best and most cost-effective services of practitioners and are willing to pay for them. Ineffective practices or procedures are recognised as such by the public and are not accepted. Practitioners of lesser quality are recognised and are not sought by patients. Various kinds of organisations and bureaucracies minimise the extent to which this model applies to any line of work and certainly to healthcare. That is a good thing, primarily because even in this era of availability of information, it is difficult for the public to assess some aspects of quality care. It can be a dangerous model when applied to the health professions. As an example of this, I will describe the background of a recent Canadian news headline:

“Woman claiming to be midwife charged in infant's death”

The news item describes the case of a person who presented herself to the public as an experienced midwife for women who prefer natural childbirth. In June 2004, an infant of a breech presentation died during a home delivery. The paramedic who was called to the scene reported to the police that the “midwife” was not a licensed practitioner. There is a professional College of Midwives in the Canadian Province of British Columbia, where this event occurred. This College maintains standards of education and practice and licenses qualified individuals. The unfortunate mother who lost her child was not aware that there are relatively untrained and unqualified persons as well as qualified professionals whose competence and integrity are assured by a professional college. A properly trained and qualified midwife should have recognised the breech presentation and immediately called for transfer to a hospital and delivery by an obstetrician. Although qualified professionals are sometimes guilty of incompetence and errors, the risk of these is substantially reduced when the professional is trained and evaluated according to high standards and maintains that competence in practice by adhering to standards for continuing professional development.

The Rational or Legal Bureaucracy Model

Under the rational or legal bureaucracy model, control of the providers of healthcare by managers and officials aims for predictability and efficiency. The objective is

standardised, reliable service at reasonable cost. The disadvantages of this model are inflexibility, sometimes perfunctory treatment of consumers, and often surprisingly high administrative costs relative to the expenditures on the actual provision of care. Perhaps this model is best developed in some of the managed care organisations in the United States. However, it can exist in all systems of healthcare delivery.

A recent Canadian news headline illustrates the point:

“Cut Costs, Minister Urges Hospitals”

The minister of health made a statement in which he advised hospitals to reduce administrative costs; the hospitals responded that they could not maintain services, let alone reduce waiting times. Patients and healthcare professionals are caught in the middle. Most physicians now work in a fusion of the professional model with a bureaucracy, but our treatment of the individual patient must still be according to the concepts and defined responsibilities of professionalism. At times, this requires us to be the patient’s advocate in dealing with the bureaucracy, and we must not shrink from that professional responsibility. At the same time we must accept our professional responsibility of working with the bureaucracy in patients’ interests.

The Professional Model

The important characteristic of the professional model is that individuals with specialised knowledge and skills define the work of their profession and the qualifications required to perform it. They establish standards and credentials that assure the public of high-quality care. Professionals are dedicated to the work they do, rather than primarily to income or to maximising the profits of corporations or minimising the costs to government. They hold a monopoly over providing certain services, which is dependent on having the required defined knowledge and skills and a monopoly over establishing these qualifications. They are self-regulating and they supervise the work of their colleagues and exert discipline on them as required. This autonomy is both permitted and enforced in most cases by the state.

The basis for attacks on the medical professional model is the allegation that professional monopoly is used mainly to advance selfish economic interests. It fails to ensure benefit to consumers, and professionals are inefficient and their work is unreliable and unnecessarily costly. This allegation shows lack of trust on the part of some members of the public and government officials in the medical professional model. In Canada, where there is currently a shortage of physicians caused by government policies of a decade ago, this includes the unjustified allegation that



Fig. 10. Jordin Tootoo – An Inuit hockey player.

organisations like our College conspire to prevent qualified doctors from practising. This makes good press, and we have found the media to be unresponsive to our attempts to correct the misperceptions they have helped to create.

Consequences of Loss of Trust in a Profession: the Example of the Clergy

Certainly, the basis of the acceptance of the professional model is trust, and the threat to its continuing existence is the weakening of this trust. Betrayal of trust can lead to serious consequences. I am going to give some examples from what has happened to other “learned professions” in Canadian society

Figure 10 is an image of another young professional hockey player named Jordin Tootoo. He is the first Inuit to play in the elite National Hockey League in North America. The Inuit are the group of only about 70,000 to 100,000 aboriginal people, referred to in the past as Eskimos, who are scattered through our vast Canadian northern wilderness. There is plenty of ice on which to play hockey! However, the population is so scattered that the organisation required to develop superior skills is relatively lacking. So this young man can be very proud. Jordin Tootoo’s accomplishment is the source of some national pride as well. His stated aim is to inspire Inuit youth to stay in school and follow their dreams. The Inuit are among the most disadvantaged of Canada’s peoples. Unfortunately, Canadians cannot be as proud of their treatment of the Inuit and other aboriginal peoples in schools as they are of Jordin Tootoo and his accomplishments. There have been serious betrayals of trust by members of the learned professions.

In 1925, Canada made the misguided decision that the best future for aboriginal children was assimilation into the population of Canada. This assimilation would be accomplished by taking them out of their families in remote northern communities and settling them in residential schools in southern communities, where they were mainly taught by religious professionals. In the 1990s, it was

learned that there had been a shocking betrayal of trust in these residential schools. Children were physically, verbally, and sexually abused by the clergy into whose care they were entrusted. When many of these children suffered the results of this abuse later in life, thousands of lawsuits developed against the churches and against the Government of Canada. Finally, a financial settlement was reached, amounting to several hundred million dollars, that was contributed to by the Government of Canada but also by the four Christian churches involved, and some of this cost was passed on to the individual parish churches. This led to the bankruptcy and closure of a number of churches who were not involved in the abuse scandal. Support for, and attendance at, Christian churches is sharply falling in North America. Loss of trust in the clergy may be a contributing factor. Only a small minority of the profession is thought to be guilty of betrayal of trust, but the reputation of the whole profession has suffered. There is a lesson here for our profession.

Loss of Trust in the Medical Profession

Public trust in the medical profession has also been eroded by high-profile cases of sexual abuse of patients, and certainly also by disasters resulting from the work of physicians with inadequate knowledge or skills. Trust has also been eroded because of well-publicised ethical failures in the financial sphere. Some of these cases have involved actual fraud, as in the case of doctors billing insurance companies or government agencies for procedures they did not perform. Fortunately these cases are rare. In my view, they may contribute less significantly to loss of trust in the profession, and threats to the professional model, than the more subtle and widespread abuse of trust and departure from professional ideals that arise from the failure to recognise and manage conflicts of interest.

Conflicts of Interest in Relationships with the Industry

Consider some of these recent headlines:

In *USA Today*: “Drug researchers bankroll ethics guidelines on ‘freebies’ – AMA effort intends to remind doctors of rules for accepting handouts”.

In *The Financial Times*: “When sweetening the pill is illegal: US regulators look at methods used by drug companies to sell their products to doctors”.

In *The New York Times*: “High tech stealth being used to sway doctor prescriptions”.

In *The Wall Street Journal*: “Doctors on the run can ‘dine n dash’ in style in new Orleans - drug companies pick up tabs and make sales pitches”.

In *USA Today*: “Drug firms spend big bucks on doctors, get results”.

In Germany, where accepting gifts from industry is prohibited by an anticorruption law, a very high-profile series of criminal prosecutions has occurred and was widely publicised. In this case, 3000 physicians and SmithKline Beecham were prosecuted for giving and receiving gifts that ranged in value from 50 to 25,000 Euros and included even computers and cars.

The issue is important because pharmaceutical marketing is big business. One estimate is that more than \$13,000 per physician is spent annually in North America on marketing drugs to physicians. Marketing drives formulary and prescription practices, sometimes in the wrong direction. In Canada, drug costs have risen rapidly and now exceed payments to physicians. Higher drug costs may limit resources available for other components of healthcare. From the point of view of the medical profession surviving as an independent, self-regulating profession, the issue of conflict of interest is also important because the public, via the media, learns about marketing schemes, and public trust in the profession may be weakened.

Marketing schemes and inappropriate relationships with industry may influence not only individual prescribing practices, but also the advice given to other practitioners from opinion leaders, the addition of drugs to hospital formularies, and the use of specific medical devices and prostheses.

Pharmaceutical companies buy influence by some rather obvious means such as expensive dinners and holidays at expensive golf resorts in the guise of CME conferences. Some other devices that may be more difficult to recognise and where there may be some shades of gray at times include the creation of drug trials that are really marketing ploys, the payment of speaker fees to individuals who are not really speakers, or where the fees are exorbitant and inappropriate for the contribution made, and the payment of phony “research grants”, where there is no real research. Even subtler, however, is the support of genuine research that can lead to gratitude and perhaps preferential treatment of industry by individual clinical investigators and by

Table 1. Relationship Between Authors of Clinical Practice Guidelines and the Industry⁴

Relationship	% of authors (95% confidence interval) (n = 100)	Mean no. of companies (Range)
Any relationship	87 (80-94)	10.5 (1-37)
Travel funding/honorarium	53 (43-63)	5.4 (1-16)
Speaker honorarium	64 (54-74)	7.3 (1-20)
Educational programme support	51 (41-61)	4.7 (1-36)
Research support	58 (48-68)	6.7 (1-26)
Employee/consultant	38 (28-48)	5.7 (1-21)
Equity	6 (1-11)	1.8 (1-4)

institutions. Lemmens and Miller of the University of Toronto have described legal and ethical issues that arise when individuals receive grants and payments for recruiting patients into drug trials.³

Another potential conflict of interest arises when opinion leaders, who contribute to the development of clinical practice guidelines, have relationships with the pharmaceutical industry. Choudhry and colleagues at the University of Toronto recently surveyed 100 authors of clinical practice guidelines.⁴ Results of their survey are shown in Table 1. Eighty-seven per cent of respondents admitted to relationships with an average of 10.5 companies. A majority of these were with companies whose products were directly relevant to the guidelines under consideration. These relationships ranged from receiving grants and honoraria to being paid consultants or having equity in the firms. Relationships between industry and opinion leaders in particular should be disclosed, especially when opinion leaders determine the criteria for conducting and reporting clinical trials, writing editorials and therapeutic guidelines and serving as editors of scientific journals. Of the guideline authors surveyed in this study only 7% believed that relationships influenced their recommendations, but 20% believed that relationships influenced their colleagues' recommendations! Other surveys have shown that physicians believe that gifts from industry do not influence their own behaviour, while suspecting that gifts influence their colleagues. In such surveys, most physicians also indicate that they have ethical concerns particularly about interactions that involve CME conferences and travel.

Some physicians respond that there is no evidence that any harm arises from these questionable practices. However, there is a good deal of evidence that gifts to physicians are effective in changing their behaviour. Formal studies of marketing influence have been published with the following disturbing findings:

- Physicians say they learn from medical sources, but their knowledge reflects promotional claims.
- Contact with pharmaceutical representatives is associated with doctors recommending drug for formulary (sometimes appropriately).
- Prescriptions track promotional visits, not consensus recommendations.

The pharmaceutical industry has also provided evidence that gifts are effective. An industry publication has documented that promotional dinners result in an 80% increase in sales. Some of this may be appropriate prescribing, but we do not know how much. However, the strongest evidence from the industry is the large amount of money they spend on promotion. In Canada, this is about one billion dollars annually. We should ask ourselves if the industry would spend these amounts of money on travel

and golf, if this practice is not effective.

In some countries, Canada included, pharmaceutical and medical organisations have met to agree on ethical guidelines. However, fines levied by pharmaceutical organisations to members who depart from these guidelines are inconsequential. We are also told that physicians ask for inappropriate support, and place pharmaceutical representatives, who must be concerned with potentially negative consequences of refusal, in a conflict of interest.

Returning to the theme of public trust, patients have been surveyed for their views. They believe that gifts bias prescription practices and drive up costs. In these surveys, gifts for personal use and costly dinners and travel provoke more disapproval than gifts for office use.

These observations on the effects of conflicted relationships of physicians with the industry and of the views of the public indicate the need for education at all levels and for the adoption, promotion and enforcement of standards of ethical behaviour.

Approaches to Promoting Professionalism: Sorting out “Bad Apples” and Enhancing the Quality of Good Ones

Specific accountability for the quality of medical practice as reflected in outcomes and education are two approaches to the promotion of professionalism. The monitoring of outcomes is theoretically the most important component of maintaining professionalism, and is understandable to the public. I have no doubt that it is necessary to sort out “bad apples”. There is no doubt that licensing authorities must respond promptly to complaints about doctors' performance and behaviour and must be in a position to monitor both processes and outcomes of practice. However, it can be very difficult to determine whether even substantial variations in outcomes of practice reflect variations in competence and behaviour or other factors. Enhancing the quality of “good apples” through education may be the more important thrust both in providing quality care and in strengthening public trust. Assessing outcomes of practice almost always requires the examination of observational databases that have the same weaknesses as non-randomised comparisons in clinical trials. They may be useful in considering gross variations, but attempts to attribute significance to more modest variations can lead to loss of trust that may be unwarranted.

Risks of Utilising Observational Databases

I will try to develop this thought further by returning to Canada's treatment of refugees. Figure 11 shows refugees from the terrible ongoing conflicts in Sudan taking shelter in Chad. Canada has been proud of its treatment and acceptance of such refugees over many decades, and on a



Fig. 11. Refugees from Sudan.

Table 2. Approval Rates of Applications for Refugee Status in Canada

Board member	Total cases	Accepted	Rejected	Per cent acceptance
A	353	289	64	82
B	315	236	79	75
C	852	596	256	70
D	357	71	286	20
E	210	31	179	15
F	289	20	269	7
G	258	6	252	2
H	73	0	73	0

Table 3. Favourable Outcomes Following Cardiac Surgery

Surgeon	Total patients	% favourable Composite result
1	353	82
2	315	75
3	852	70
4	357	20
5	210	15
6	289	7
7	258	2
8	73	0

per capita basis accepts more refugees than any other country in the world. Recently we have had reason to be concerned about the trust we have placed in the professional politicians, social workers and lawyers overseeing our programme for dealing with refugee claimants. A recent news headline reads:

“If you are seeking asylum in Canada, you may not want to present your claim to immigration and refugee board member H – he rejected all 73 cases he heard from 2001 to 2003”

When a refugee, as opposed to a potential immigrant, attempts to enter or remain in Canada, the risk faced by that person of persecution or death in their country of origin is

given an initial examination by a staff worker and then a final recommendation is made by 1 of 8 members of a board. Table 2 shows the results of a study of the frequency with which board members approved recent claims. Huge variations are obvious. These can be life-or-death decisions, for some of the claimants fear persecution or death if they have to return to their country of origin. Others may not be genuine refugees and are actually potential immigrants who are attempting to jump the queue.

One might wonder about the qualifications of the board members as determinants of decisions. Board member H, the member with a 100% rejection rate, has qualifications that are impeccable: he has a master of law degree and previously worked for the United Nations High Commission for Refugees. Yet he rejected all applicants. A judge analysed board member G’s decisions by country in the 1998 to 2000 period and found that his refusal rates for claimants from Sri Lanka, Bangladesh, Pakistan and China were much higher than the national rates.

As a result of the publication of these results, there is a definite concern about bias and possible unfair treatment of refugee claimants. This observational database may lead to improvements in the process and to closer scrutiny of the work of the professionals involved. However, claimants’ files are not randomly assigned to board members. Looking into these observations in greater depth revealed that some of the board members with very high acceptance rates preferentially received “fast tracked” claimants from war-torn countries about whom there would be little disagreement about concerns regarding death or persecution i.e., the proportion of applicants who were genuine refugees may have been maximised for these board members. The databases are not sufficiently sophisticated to allow absolute determinations about the causes of the disparities. However, the trust of Canadians and of refugees in the professionals involved has been seriously shaken by the publication of these data.

The relevance of this recent news item to the risks inherent in assessing medical competence from similar observational databases is shown in Table 3. Imagine that these individuals are cardiac surgeons performing aorto-coronary bypass surgery. The same numbers for acceptance rates of claimants of refugee status that appear in Table 2 would not be credible as crude survival numbers for cardiac surgery, but if we imagine a meaningful composite favourable outcome that lumps survival with the complete relief of symptoms, discharge from hospital after the appropriate interval, and lack of infection or any other complication, the numbers become more credible. None of us would have difficulty in deciding that we didn’t want our surgery to be performed by any one of the bottom five rank-ordered surgeons. What about the top three? If the modest

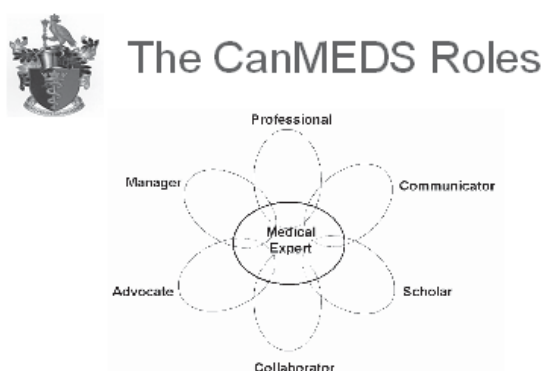


Fig. 12. The CanMEDS Roles of the physician. Defined by the Royal College of Physicians and Surgeons of Canada.



Fig. 13. Alternative portrayal of the CanMEDS roles of the physician, the trunk and its branches.

differences among these three reflected differences in true clinical competence, there would be a risk difference of an unfavourable outcome of 12% between Surgeons 1 and 3. Using the concept of numbers needed to treat (NNT), this risk difference would mean that for every 8 patients that are referred to Surgeon 3 for surgery rather than to Surgeon 1, 1 patient will have an unfavourable outcome. That would be quite significant clinically. However, as in the actual case of the refugee board members, there may be hidden factors that influence these hypothetical results. In this case, Surgeon 1 never accepts higher risk patients for bypass surgery, and thereby assures good outcomes in his practice. On the other hand, cardiologists in the community believe that Surgeon 3 is the most skilled and experienced surgeon, and he will accept higher risk patients on their recommendation because he believes that it is their best chance for survival and for improved quality of life. Using this database as a guide to referral of more patients to Surgeon 1 and fewer to Surgeon 3 would probably cause more overall harm than good for patients.

Part of our professional responsibility should include assessing outcomes of practice both individually and as a profession. However, as this illustration demonstrates, great care must be taken to insure that data are meaningful and do not lead to erroneous conclusions. We need more research on the best use of observational databases and more education for ourselves and the public with regard to their strengths and weaknesses. Assessment of practice outcomes from observational databases including the review of individual practitioners' records is theoretically sound, and probably necessary in some cases, but is practically difficult. Observed gross disparities may be important and must be explained, but more modest variations that could be clinically very important are often very difficult to assess.

Education to Insure Competence and Professional Responsibility

Another approach is education to insure competence, and education should include attention not only to the knowledge and skills required to deal with disease, but also to other competencies, including professionalism. I would like to describe how the Royal College of Physicians and Surgeons of Canada is attempting to promote the ideals of professionalism through education.

Leading up to the millennium our College defined the seven basic roles or competencies required of Canadian physicians of the future. These are usually referred to as the CanMEDS competencies.⁵ The diagram in Figure 12 emphasises the crucial role of the physician as a medical expert, with the other six competencies or roles including the professional role radiating around this central role. Perhaps not all of the other six competencies are of equal importance.

If I consider my own choice of an orthopaedic surgeon to perform my hip replacement surgery a year ago, I was pleased that my surgeon is a scholar whose work is known around the world, that he advocates improving accessibility to joint replacement surgery in Canada, and that he communicates well with me and manages his practice well. But most of all I wanted the best medical expert available whose knowledge and skills were unquestioned!

Another image that could be used to illustrate these competencies in place of the flower is a tree with five of the competencies shown as branches from the very important central trunk symbolising the important central medical expert role (Fig. 13). This illustration would permit professionalism to also have its unique place at the roots of the tree supporting the trunk and branches (Fig. 14). In my view, the professional role of the physician may be equal in



Fig. 14. Alternative portrayal of the CanMEDS roles of the physician: the trunk and its roots.

importance to the medical expert role. Returning to my own example of my hip replacement, I would be uncomfortable if my highly skilled orthopaedic surgeon had a conflict of interest that would cause him to choose for me a particular hip prosthesis supplied by a company who provided him with a substantial gift, whether personal or in support of research, for each prosthesis he inserted. Such conflicts of interest are reported to exist in medicine today.

Our College has been paying a good deal of attention to the professional competency of the physician in our educational programmes. We define professionalism as the skills, attitudes and behaviours expected of individuals during practice, including the following concepts: maintenance of competence, ethical behaviour, integrity, honesty, altruism, service to others, adherence to professional codes, justice, respect for others, and self-regulation.

Teaching and Learning Professionalism

The College takes the approach that the concepts, ideals, and responsibilities of professionalism can be taught and that the learning and adoption of these can be evaluated. Furthermore, we take the position that teaching and learning require specific objectives, and that evaluation should be specifically directed at the learning and accomplishment of these objectives.

These objectives fall into three categories:

- discipline-based objectives that are determined by the individual specialty committees,
- personal-professional boundary objectives, and
- objectives related to ethics and professional bodies.

As an example of more detailed objectives, those for the third category are shown in Figure 15. Residents must be evaluated concerning their attainment of these objectives. The College now requires evaluation of all residents with respect to their mastery of the professional competency as



RCPSC (CanMEDS) Objectives re Ethics and Professional Bodies

- Know and understand professional, legal, and ethical codes
- Analyse and try to resolve ethical issues: truth-telling, consent, advanced directives, confidentiality, end-of-life care, conflict of interest, resource allocation, research ethics
- Understand and apply relevant legislation that relates to healthcare system to guide practice
- Analyse and deal with unprofessional behaviours in practice, taking into account local and provincial regulations

Fig. 15. Royal College of Physicians and Surgeons of Canada (CanMEDS) objectives – ethics and professional bodies.



Fig. 16. Grandiflora Magnolia at Petworth House.
Petworth House, Suffolk
Ancestral Home of the Percy Family
A symbol of TRUST

well as the other CanMEDS competencies, at the end of every clinical rotation and in the Final In Training Evaluation that is required before any resident is permitted to take the College examinations. Methods of evaluation are open to the programme directors, but include critical incident reporting involving notes and rating forms to which supervisors, peers, and nurses all contribute. We also ask that the educational programmes that are utilised be evaluated using a variety of devices, but this approach is in its infancy.

Each resident is now evaluated with respect to the achievement of professional behaviour using formal ratings scales on the following items:

1. Delivery of highest quality care with integrity, honesty, and compassion.
2. Demonstration of appropriate personal and interpersonal professional behaviours, and
3. Practice of medicine ethically, consistent with the obligations of a physician.

A resident may be given unsatisfactory evaluations with very important effects on their progress toward certification. There is no doubt that evaluation gets the attention of

residents. It stimulates them to think about professional behaviour and it actually influences their behaviour. To a considerable degree evaluation drives performance. It also influences those who are doing the evaluations to look more closely at their own behaviour.

Similarly, accreditation of training programmes in Canada by the Royal College gets the attention of clinical teachers. Some programmes have had their accreditation status reduced to “provisional” because of their lack of attention to the teaching and evaluation of professionalism. The significance of this reduced status is that unless the deficiency is corrected within a defined interval, the College will remove the accreditation of the programme, and it will no longer be permitted to accept residents for training.

The next frontier is clearly more effective promotion of the professional role within the practising community. The requirement for participation in the Maintenance Of Certification Programme for our fellows was an important first step. Our national specialty societies in group learning programmes are beginning to turn their attention to the professional role in addition to their traditional key role in assuring continuing educational programmes that enhance and maintain the medical expert role. Professionalism was the theme of our annual conference last year. Additional efforts by the College to promote the teaching of professionalism include the development of clinical vignettes that are useful for teaching at the local level and are also web-based. We have a task force at work exploring ways of expanding the appreciation of what professionalism means and how this competency can be enhanced in teachers and practising physicians. We admit that we have some distance to go, but we believe that enhancements to postgraduate education programmes and to continuing professional development are key elements.

I chose Petworth House as a symbol of the durability that results from trust. In closing, I would like to show you another image from Petworth House. Figure 16 is a *Grandiflora Magnolia*. The walls of a very protected inner courtyard at Petworth are espaliered with this magnificent flowering shrub which could not survive and flourish in a less nurturing environment. Nurturing is required for most human endeavours that are worthwhile and of superior quality. That is true of the concept of professionalism in medicine. The postgraduate medical colleges and academies should play the key role in this nurturing as they have for 500 years. I compliment you again on holding an annual conference that links professionalism and CPD and I thank you for your attention.

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