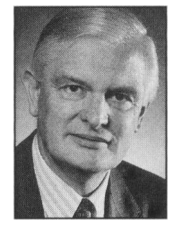
Medicine beyond 2000 - Trust me I am (still) a doctor



Sir Donald Irvine CBE
President of the General Medical Council
London

Change and its impact

Our professionalism is shaped and influenced by the context in which we work. First and foremost, medical knowledge and skill continue to expand in a geometric progression. So, in truth, we can only guess at what new discoveries lie ahead within the professional lifespan of young doctors starting their careers now. Equally challenging is the revolution in information technology which will have far-reaching implications for the practice of medicine in ways we are only just beginning to see. What, for instance, will be the impact on the doctor/patient relationship when most patients have direct access through the Internet to the database of knowledge which is the foundation of our professionalism?

One effect of rapid scientific and technological advance has been to drive subspecialisation in medicine further and further. If this trend continues, will it be possible to hold medicine together as the distinctive entity it is today, or will it come apart? All of us want the benefits of the best science for our families and ourselves when we become ill. Yet, at the same time, many of us yearn to retain the humanity associated with traditional doctoring. Will it be possible for patients to have it both ways in future? Indeed, will they always want to?

As if that were not enough, patients' expectations of medicine continue to rise. Given the complexities and pressures of modern practice, doctors often see these expectations as unreasonably demanding, and at times too critical and too testing of our performance. Yet we could look at it another way. Patients' greater expectations flow from our successes; the question, therefore, is how to maintain the confidence already there.

Compounding these changes are the political issues around the rising costs of health care, in particular how society is to pay for the many good but costly things that modern medicine can do, the total bill for which seems to exceed the limit of our willingness as a society to pay.

Last, but by no means least, there are the ethical dilemmas. Scarcely a week passes now without practical ethical questions arising which flow from medical advance - in genetics, in the ability to sustain life artificially, in the more familiar areas of consent and confidentiality, and so on.

Any one of these areas of change would be a challenge to handle. Taken together, it is not surprising that doctors find professional life so stressful. So, looking ahead, can we find better ways of handling and coping with a professional life in which continuous change will be the norm rather than the exception?

There are many important consequences of change. Here are three examples

First is the fact that now, more than ever, the patient has come centre stage. The consumer, if I can describe patients that way, is king. For doctors used to being in the driving seat, that change can be difficult.

Secondly, we are likely to see more flexibility, on a scale that we have not experienced in our lifetimes, in the structure of health care, in the way we develop and use our buildings and technical plant, and especially in the way we organise the work. For doctors this will imply a re-appraisal of what really distinguishes medicine from the many other health professions, when increasing numbers of non-medical health professionals have a role in clinical management. Is it, at its most elemental, the science and art of diagnosis? Similarly, as doctors we will surely have to look anew at how we reconcile the ethos of personal responsibility, linked with the one- to-one relationship between doctor and patient, with the future operational necessity for effective team-working. Certainly in medicine, we have still to reconcile these apparently contradictory requirements satisfactorily.

The third consequence focuses on accountability. For doctors, as with other professions, we are moving inexorably towards more emphasis in future on accountability, on the means whereby the quality of care can be steadily and incrementally improved and explicitly assured. This implies the development of

© The Ulster Medical Society, 1998

attitudes of openness and responsiveness so that more light is shed on how and why we take the decisions we do, and on the effectiveness of our care, especially of our personal and team-based clinical performance.

Public Perceptions

So how do patients see their doctors today? What does the public think about the performance of the medical profession? It is actually quite difficult to say, but what evidence there is from opinion polls, from the image of medicine on television, from analyses of complaints, from a wealth of anecdote - sometimes crystallised by the press - and from we ourselves when we listen to what patients say, seems to suggest three general messages.

First, people in this country have a high respect for the medical profession In the United Kingdom. People seem to believe that in the main they enjoy a good standard of medical care, particularly at the technical level, and that we are honest and trustworthy. That good standing is an immense asset; the medical profession in many other countries is not so well regarded.

Second, notwithstanding the good feeling people tend to have about 'their' doctor, there are nevertheless many more complaints about doctors' attitudes to patients and colleagues. The commonest cause of complaint is poor communication. A proper dialogue about the cause, direction and progress of illness and care is an expectation too often unrealised. More generally, we are often seen as paternalistic - in some cases to the point of arrogance - and can all too easily convey a lack of respect for patients and other colleagues. Nevertheless, more and more patients in a better educated society expect the courtesies and good manners that have always been associated with the best of practice.

The third perception is about our willingness and ability to protect patients from poor practice when it occurs. There is still a suspicion, fuelled by some very public failures, that things can go wrong and patients can be harmed in situations where problems of performance were known about, and where energetic and active prevention could have avoided tragedy. Hence the public, which believes that by and large we get the basic training of doctors right, now wants to know - with increasing insistence - how we are going to assure them systematically and explicitly that senior doctors, notably consultants or principals in general practice, are really up-to-date, know what they are doing, and are maintaining an optimal level of performance.

So, against a background of general confidence and respect for the professionalism of doctors, there are problem areas which have got to be addressed by the whole profession if we are to continue to enjoy public trust.

Assuring Doctors' Performance: The GMC's Approach

Not surprisingly, the GMC sees effective professional self-regulation as critical to maintaining public trust and at the same time to ensuring that doctors retain that independence of thought and action essential, at the clinical decision-making level, to optimal care for individual patients. To be successful the Council believes that professional self- regulation must become an active process in which every practising doctor is involved; patients depend, ultimately, on the sense of commitment and the conscientiousness of individual clinicians to do their best in all the countless unsupervised clinical decisions that are still at the heart of medical practice.

There are three elements to the GMC's approach[1]:

- to guide doctors on the principles of good medical practice;
- to help doctors maintain good practice through effective local professional self-regulation;
- to protect patients by dealing firmly and fairly with seriously dysfunctional doctors.

Professional standards

The starting point must be our values and standards. Values and standards have always been important in medicine, but until recently much has been implicit. We are now moving into an era where explicitness is the name of the game wherever that is possible.

The GMC took this route for the first time in 1995 with the publication of Duties of a Doctor and Good Medical Practice[2]. There, the GMC sets out, in explicit and positive terms, what the essential attributes of good medical practice are. We expect this guidance to inform everyday practice, and to be reflected in basic medical education, specialist training and the continuing further professional development of all established doctors. Explicit standards make it clear what doctors have signed up to and what is expected, and are the visible baseline against which their performance can be subsequently assessed.

© The Ulster Medical Society, 1998

The GMC guidelines, which have been well received by the public as well as the profession, deal with the generic attributes of medical practice. In addition, explicit clinical guidelines and protocols are becoming part of the litany and armamentarium of practice. As we search for more clinical effectiveness in medicine, clinical guidelines can provide an excellent yardstick of what should be expected. But I believe they should never be allowed to usurp the responsibility of the doctor in making the ultimate judgement in individual cases, and that that judgement should be respected provided always that the doctor can provide proper justification.

The move towards greater explicitness will, in the long term, prove to have been healthy, for it will ensure greater common understanding between doctors and patients. Equally, it will help the medical profession to indicate to the outside world what is, and just as important what is not, possible in medicine at any point.

Maintaining good medical practice

By far the biggest challenge we face is in the arrangements we will need to make in future to assure our patients of good practice in an open and systematic way. Each of us has individual responsibilities: to be competent

- to perform consistently well
- to practice ethically
- to protect patients
- to be an effective team-player.

But as a profession we need to go further than that. We now need to think in terms of assuming some local collective responsibility for standards of practice and performance at the level of the partnership in general practice, or the clinical team, department or directorate in hospital[3]. At one level this would remain a medical responsibility. But, since most of us now practice in multi-disciplinary teams, the notion of multi-professional collective responsibility is beginning to take shape and be explored. The concept of local professional self-regulation is beginning to take shape as a distinct entity.

So what are the characteristics of effective self-regulating teams? Fortunately there are already many examples across the country in every specialty and in general practice. Such teams have common attributes (Table 1) and tend to use a constellation of methods (Table 2). Significantly, such clinical teams are willing and able regularly to test themselves against others, so that they can see how their performance relates to others doing similar work; and they are open about their standards and their clinical results - their performance.

TABLE 1

Maintaining Good Practice
Effective clinical teams:
• Show leadership
• Have clear values/standards
• Care for each member
• Are keen to learn
• Communicate well
• Are committed to quality
• Are competently managed
• Are determined to protect patients

TABLE 2

Maintaining Good Practice
Effective clinical teams use:
• Clinical guidelines/operational protocols
• Good systems
• Good data
• Systematic audit of performance
• Feedback/appraisal/professional development
• Risk avoidance methods

I cannot overstate the importance of this local collective approach, and all that it implies. At the GMC we tend to see the failures in medical practice. In these cases, especially where there is a pattern of persistent dysfunction, local collective responsibility is invariably missing.

So, the question now is how the profession can take local self-regulation forwards, based on clinical teams.

One of the keys will lie with the nature of the leadership given by clinical teachers in our hospitals and teaching general practices. In medicine modelling is a very powerful influence. What we do is, for good or ill, often more powerful than what we say. Students and doctors in training acquire habits from the behaviour of their clinical teachers which will often remain with them, or colour their own behaviour, for the rest of their practising lives. I suggest that those of us who are clinicians and teachers need to give much more thought to the picture we present as doctors to

© The Ulster Medical Society, 1998

the outside world. We need to talk more about the kind of doctors we really are, or should be. By addressing such questions of attitude, behaviour and accountability, which are at the top of the public's agenda, we make them part of ours too. The messages are unlikely to be lost on students and young doctors.

Protecting patients from harm, the third limb in the GMC's approach, is about protecting patients from dysfunctional practice. The key elements of the strategy are already clear. In Good Medical Practice the GMC made it an explicit obligation on doctors to identify poor practice where, if it were to continue, patients could be put at serious risk. For practising doctors the action point is in the clinical teams described above. Clinicians and clinical teams, which regularly use internal clinical audit and appraisal, are probably best placed to tackle dysfunctional practice in a colleague when it first arises, before damage is done to patients or the doctor irretrievably. In future, if satisfactory progress towards resolution cannot be achieved at that level, then clinical teams must seek help from someone in appropriate authority who will be in a position to act further. In hospitals this may well be the clinical or medical director; in general practice the director of public health or the secretary of the local medical committee. If local help can then be brought to bear and achieve proper results, well and good. If not, then the dysfunctional doctor should be referred to the GMC.

The GMC, for its part, has recently had its fitness to practise procedures strengthened by the passing of the Medical (Professional Performance) Act 1995. Essentially this gives the Council the power to assess the performance of a doctor at work using a team of three assessors, two medically qualified from the doctor's own speciality and one lay person.

The object of the GMC performance procedures is, firstly, to make sure that patients are protected and, secondly, to help the doctor to be rehabilitated wherever possible and appropriate.

TOWARDS A NEW AGREEMENT

The kind of proactive, team-based self-regulation that I have described needs proper resources. Carried out systematically and thoroughly across the country, it would represent a new element to medical practice. It takes time and effort to do well. NHS Trusts, Health Authorities and Health Boards will need to find the ways and means of valuing and resourcing it as a tangible expression of their commitment to supporting their medical staff providing care at the sharp end. The achievement of management's aims is critically dependent on the sense of professionalism, and commitment among doctors and other health professionals.

Against this background, I believe that the time is now right for a new agreement between medicine, the state and the public generally. It is the medical profession's responsibility to see that professional practice is at one with people's expectations and that self-regulation really is effective. For its part, the state must give doctors the time needed to do a professional job for patients and to maintain standards of practice using modern methods. The proper resourcing of good medical practice - including medical education - must become an agreed given of good quality health care. With such an approach, we can be confident that our strengthened professionalism will keep the public's respect and trust.

REFERENCES

1. Irvine D. The performance of doctors. I: Professionalism and self-regulation in a changing world. London: *BMJ* 1997; **314**, 1540-42.

2. General Medical Council. Duties of a doctor: good medical practice. London: GMC, 1995.

3. Irvine D. The performance of doctors. II: Maintaining good practice, protecting patients from poor performance. London: *BMJ* 1997; **314**, 1613-15.

© The Ulster Medical Society, 1998