Trust, standards and healthcare quality: a case of babies and bathwater?

Antony Franks[1] Ian Watt[2] Phil Ayres[3] Karen Jones[4] Colin Pollock[5] Paula Whitty[6] John Wright[7]

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INTRODUCTION

The last few years have not been too comfortable for the members of many professional groups. Concerns about behaviour, propriety, effectiveness, public safety and, in the case of the public sector, cost have resulted in significant scrutiny of the position and role of professionals. One manifestation of this scrutiny has been a growing tendency to establish and impose external standards of practice embodied in codes of conduct or legislation.

This issue has had its most recent airing in the fifth report of the Shipman Inquiry.[1] Historically, the majority of professionals have relied on internally derived and self-managed standards of care; witness the concept of a basic set of 'ancient virtues' at the heart of a medical ethos.[2] The growing trend of externally imposed standards raises the question as to whether the possible resulting disempowerment will lead to professionals relying less on their intrinsic mechanisms of quality improvement—which, it could be argued, are the mainstay to underpinning safe and effective practice. Are we throwing the baby out with the bathwater?

From the point of view of the patient their long-term interests are likely to be best served by a timely response from the doctor. An internalized professional ethos to act in the patient's best interests would support this. An over reliance on external mechanisms of quality improvement might see professionally derived internal mechanisms atrophy and cease to influence behaviour. In the example of Box 1, a doctor may fail to respond to a patient's vague history of chest pain simply because there are no external drivers to do so. A timely completion of a routine follow-up appointment might be all that the external standards require. The patient may well be satisfied and unaware of the implications of his vague symptoms being passed off. A weakened professional ethos may no longer be able to guide professional practice in those areas where external standards are absent (and perhaps could never even be applied), and hence the quality of patient care would suffer.

PROFESSIONS, STATUS AND POWER

The healthcare professions comprise a highly motivated workforce whose professional status is approved and formally legitimized by Government through statute. In the UK this legal relationship is made more complex by the role of the State (in the guise of the National Health Service) as employer, given that most healthcare professionals work in this sector. 'Old style' professionalism is seen by some as an imbalance of power (between patient, professional and employer) and by others as an efficient way of assuring the quality of care with minimal bureaucracy.[3] Current critics of the latter arrangement are likely to point to recurrent failures of quality of care and its implicit paternalism as strong arguments for seeking a new type of relationship between the State and healthcare professionals. Whilst every professional is clearly seen as owing a duty to an individual patient this, at times, could come into conflict with the duties of 'fellowship' embodied within individual professional groups. The complex role played by organizations such as the British Medical Association (i.e. health advocacy and powerful trade union) is an explicit example of these inherent conflicts.[4]

VARIATION, FAILURE AND THE ROLE OF STANDARDS

What is sometimes referred to as the 'threat to the professions' has a number of origins. It is not restricted to healthcare professionals but is generally reflective of a changed political and societal attitude to the distribution of power in society.[4] Furthermore, in the case of the public sector, it is also associated with a perceived ability of the Government, as funder, to achieve change directly through implementation of new policy imperatives and contractual negotiation. High-profile failures of self-regulation have undoubtedly had a part to play in effecting such a change in attitude. It is difficult to be sure to what extent the focus (by the media and the Government) on failures of

[1]Public Health Physician (retired); [2]Professor of Primary and Community Care, Department of Health Sciences, First Floor, Area 2, Seebohm Rowntree Building, University of York, York YO10 5DD; [3]Deputy Medical Director, Leeds Teaching Hospitals NHS Trust, Trust HQ, St James's University Hospital, Beckett Street, Leeds, West Yorkshire LS9 7TF; [4]Acting Head of Organizational Development, National Clinical Governance Support Team, North Tyneside PCT, Equinox House, Silver Fox Way, Cobalt Business Park, Newcastle upon Tyne NE27 0QJ; [5]Deputy Regional Director of Public Health, 5th Floor East, City House, New Station Street, Leeds LS1 4US; [6]Senior Lecturer in Medical Care Epidemiology,Centre for Health Services Research, University of Newcastle, 21 Claremont Place, Newcastle upon Tyne NE2 4AA; [7]Operations Medical Director, Bradford Royal Infirmary, Bradford, West Yorkshire BD9 6RJ, UK

Box 1 **An example consultation**

A doctor has just finished a routine consultation with a patient and at the door the patient mentions a vague history of recent chest pain. The appointment has over-run and there are standards for clinic timings to be met. The consultation has not included enquiry about cardiac symptoms or risk factors (it was for a minor dermatological condition).

Should the doctor call the patient back and undertake a full assessment (either there and then, or at least at a later date) or pass the symptoms off and not follow up further?

healthcare truly reflects the concerns of the general population who still rate doctors, and the NHS, highly in terms of trust and satisfaction respectively.

One part of this process concerns attitudes to variation in performance. This is, of course, a natural phenomenon—50% of doctors perform below average at any one time. However, it is generally acknowledged that there should be minimum explicit standards (as in National Service Frameworks), thus making some form of variation acceptable. Reliance on minimum standards runs the risk that all will achieve no more than an acceptable mediocrity; it is at this point that a professionally driven ethos of improvement would be expected to drive 'better than average' performance. Such an internal or professionally derived doctrine may be the baby we risk throwing out.

Considering a number of the high profile failures referred to above, it is worth asking whether the problem was one of failure to meet the necessary standard(s) or the failure of the existing regulatory mechanisms to act in the face of evidence that standards were not being met. This matters, since appropriate responses might be focused on the best way to make current regulatory processes work better, or on mechanisms for detecting the failure to meet the standards.

WHERE SHOULD STANDARDS COME FROM?

Standards may be externally imposed, as embodied in the core and development standards for the health and social care planning framework for 2005–2008. Alternatively, they may arise internally within the professional community as an evolutionary process responding to societal attitudes and expectations. The first approach has the advantage of clarity and explicitness but threatens autonomy and may not be as strongly espoused by clinical professionals; such standards may be more susceptible to imposition as a response in the short term without addressing the potential conflict with existing standards. This 'external origin' approach requires assessment, checking, and assurance and is at heart a regulatory process based on a concern for maximizing sensitivity (i.e. detection of every failure).

The second approach (based on internal origins) is slower, possibly often lagging behind societal expectation, often implicit but may be more robust and complied with. One possible problem with the acceptability of externally imposed standards is the perception that they derive from a different set of core values[6] to these 'internal' ones. The latter are based on peer pressure and role models, but may be seen as embodying the self-serving power of professions and specifically the paternalism of the medical profession. This approach is based on trust (of the individual and by society) but with penalties for failure to adhere to the standards. Trust carries with it the potential benefit of economy of systems of regulation but the risks that the trust may not be justified.[7–9]

These two approaches (internal and external standards) are not mutually exclusive. Indeed, reliance on the one to the exclusion of the other is probably unsafe. As already stated the biggest danger of a reliance on external standards is that there is a gradual atrophy of internal mechanisms. The issue does not get discussed; role models are not made explicit. It simply becomes a matter of sticking to the rules. The system is unresponsive except to failures (and then may 'over-correct'); the importance of training and education in the development of internal standards is diminished. There is a legitimate concern that, because of the high-profile failures of self-regulation, any positive benefits of professionalism get ignored. We do not know whether there would have been more failures of care if there had not been in place an internal notion of professional standards amongst doctors. Is there a danger that understandable concerns about failures of self-regulation may blind us to the intrinsic benefits of professionalism? Smith has drawn attention to the apposition of trust and transparency and made the point that trust is an active, not a passive, phenomenon.[10]

TRAINING AND EDUCATION—THE FORGOTTEN ELEMENT?

It is of interest to note that the high-profile failures of quality have been seen as failures of regulation rather than as failures of training and education (at least to judge from organizational and governmental reactions). A system of external standards based on the need to identify and eradicate serious failures of quality might also derive strength from the belief that there are also internal standards inherent in professions which are assured by explicit inclusion in training and educational curricula. The General Medical Council was embodied in statute and, as such, was susceptible to governmental influence. Surprisingly the Colleges, as the supposed sources of control over standards of postgraduate training, have escaped criticism.

In passing it is noteworthy that no one seems (until very recently) to have suggested that any of these failures lay at the door of the undergraduate educational processes. Surprising since these are probably where appropriate (or inappropriate) attitudes are obtained or even fostered.[11,12]

Teaching about the various elements of professional practice has become increasingly common over recent years, at both undergraduate and postgraduate levels. The aims of such professional development often seek to emphasize both the intrinsic personal qualities deemed to be fundamental to the practice of medicine as well as the external regulatory expectations. However, recent high profile failures of medical practice may result in notions of internal standards on professionalism becoming discredited. We need to better demonstrate through education and training, that internal standards are important, responsive and evolving in order to help counter this challenge. In the face of a regulatory system that might strive ever harder to prevent (as opposed to respond to) failures, we need to enhance the preparedness of professionals to develop and adhere to standards, to act in the face of failure, or potential failure, and not disempower them.

To this end we should seek to celebrate where excellence in medical practice has occurred not in response to external standards but as a result of the intrinsic values and attitudes of medical practitioners. As a profession we need to better use role models and their stories in education and training. We should also try to highlight examples reflecting the positive aspects of medical professionalism for both lay and professional press. Most 'positive' stories in the media describe medical advances that say little about the positive internal standards that drive many doctors.

CONCLUSION

We conclude that both internal and external standards are necessary. A system which attempts to depend solely on externally imposed standards and regulation will run the risk of losing the baby of internally developed and maintained standards with the bathwater of preventable errors, paternalism and professional self-interest. We must continue to educate in, and develop role models for, professional behaviours and attitudes for doctors. These behaviours need to be capable of adapting to and reflecting the needs of society in the 21st century. Internal quality improvement mechanisms must combine with the judicious use of external standards—to maximize the benefits from each, and minimize their disadvantages. Such a joint approach should work better for patient care than either model by itself.

REFERENCES

1 Smith DJ. *The Shipman Enquiry. Safeguarding Patients: Lessons From The Past: Proposals For The Future*, Fifth report. London: HMSO, 2004:1178

2 British Medical Association. *Core Values For The Medical Profession*. London: BMA, 1995

3 Bevan A. A letter to the medical profession. *Lancet* 1948;**2**:24

4 Berwick DM. Medical associations: guilds or leaders? *BMJ* 1997;**314**:1564–5

5 O'Neil O. *A Question of Trust: The BBC Reith Lectures 2002*. Cambridge: Cambridge University Press, 2002

6 Allen I. *Committed But Critical: An Examination Of Young Doctors' Views Of Their Core Values*. BMA: London, 1997

7 Mechanic D. Changing medical organizations and the erosion of trust. *Milbank Q* 1996;**74**:171–89

8 Mechanic D. The functions and limitations of trust in the provision of medical care. *J Health Polit Policy Law* 1998;**23**:661–86

9 Harrison S, Smith C. Trust and moral motivation: redundant resources in health and social care? *Policy Polit* 2004;**32**:370–85

10 Smith R. Transparency: a modern essential. *BMJ* 2004;**328** [doi: 10.1136/bmj.328.7448.o-f] Accessed 20 January 2006

11 Papadakis MA, Hodgson CS, Teherani A, *et al*. Unprofessional behaviour in medical school is associated with subsequent disciplinary action by the State Medical Board. *Acad Med* 2004;**79**:244–9

12 Franks A, Ayres P. Maintaining the quality of medical practice. A system analysis with reference to training of doctors. *Clinician Man* 2002;**11**:67–76