EDITORIAL

The Profession in the 21st Century

Sir Graeme Catto

It is a great pleasure to be invited to give this lecture coupled with the name of Sir George Alleyne. I always feel somewhat apprehensive when delivering eponymous lectures – all the more so when the named person is not only still living but present in the auditorium. George Alleyne is a distinguished Barbadian scholar whose work as the Director of the Pan American Health Organization and in the field of HIV is known not only in the Caribbean but throughout the world. *"Success"*, Sir George has said, *"is 1% genius and 99% elbow grease"*. He is the Chancellor of the University of the West Indies and serves on the task force on healthcare in the Caribbean, with a schedule that remains truly impressive. We are both renal physicians but there the comparison ends. I hold Sir George and his achievements in the highest regard.

The focus of this lecture is the future rather than the past, but I want to start with a quote from Hippocrates. *"First of all I would define medicine as the complete removal of the distress of the sick, the alleviation of the more violent diseases and the refusal to undertake to cure cases in which the disease has already won the mastery, knowing that everything is not possible in medicine"*.

I want to contrast that with part of the text of a graduation address that I recently gave; *"the science will change, society's expectations of you will change, but people don't change. They will trust you when most burdened by ill health and worries. That need for trust and humanity in medicine is unchanging"*. While I don't claim to rival Hippocrates' prose style, it does seem to me that the sense of the two quotes is similar and yet they are separated by more than 2500 years.

So what, if anything, is the problem? Life expectancy continues to increase. Outcomes for the common ailments are improving. Applications for medical schools continue to increase and standards required for entry have never been greater. Public interest in medicine is high and currently more than 90% of patients continue to trust their doctor but dissatisfaction persists.

At times it is difficult to separate perception from reality. Throughout the world, there is a debate about what health service citizens have a right to expect and how that should best be financed. It is, I think, difficult to separate a health service from the other political institutions of a country (social services, local government *etc*) but we continue to be faced with the paradox that as other industries have become safer in recent years (for example travel, oil exploration, construction) medicine has become apparently more dangerous. Patient safety is assuming a higher profile when health priorities are assessed. More women are entering medicine and the cultural shift to ensure that services we deliver are truly patient-centred is no longer controversial.

Yet doctors worldwide remain unhappy. In part that may be explained by a loss of autonomy although I suspect that few doctors disagree with the recent increase in patient autonomy. More likely I think the unhappiness is associated with increasing accountability and bureaucracy as health service costs come under increased scrutiny.

Of course, public expectations continue to rise. Information is now widely available in newspapers, magazines, on television and the internet. Doctors are no longer gate-keepers of that information store. An increasingly educated public is well able to appreciate the benefits and risks of modern medicine but perhaps like me are becoming wearied by the exaggerated claims made by some doctors and politicians. The changes in our society with increasing consumerism are here to stay.

'*Medicine*', as Sir Cyril Chantler has noted, *"used to be simple, ineffective and relatively safe. Now it is complex, effective and potentially dangerous"*. Some of the problems, however, relate less to the complexity of modern medicine than to neglect of well established organizational and cleanliness principles. In her recent Reith lectures, Baroness Onora O'Neill has commented on our propensity to focus on failure. As a society, we tend to pay less attention to things that are going well than to those that are causing problems. Trust is an important if fragile component of the doctor-patient relationship and one that remains valued by most patients. The popular press throughout the world has in recent years concentrated on poorly performing doctors and there has been increase in both criminal and civil litigation. Nevertheless, the concept of risk is poorly understood and patient safety is many times more likely to be put at risk by failures in complex health delivery systems than by poorly performing doctors. On the other hand, the damage done to the medical profession by a small number of bad doctors is such that they must be dealt with quickly, effectively and fairly.

For many people in the developed and developing world, healthcare has never been so good, but I suspect that we all agree that it could be better still. Throughout the world, governments, the public and the profession have been

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thinking more about professionalism and how the social compact between doctors, patients and the government of the day might need to be changed to reflect our changing societies. Some have suggested that the term professionalism is somewhat pompous and outdated; after all, most people in modern jobs feel that they offer a professional service. Some, I suspect, feel that the word is sometimes used in a somewhat defensive way – *"a conspiracy against the laity*" – as GB Shaw suggested almost a hundred years ago.

While many have written extensively about professionalism, Lord Phillips has encapsulated my thoughts when he wrote: *"It seems self-evident to me that the essence of professionalism is to be able to call upon the honour, probity and principled judgement of the practitioner. A self-respecting, fully functioning profession would surely profess just that and deal with the inevitable failures"*. But he continued: *"... but if professionalism is to be changed in some way then we have to think very carefully about what would replace it. The alternative, mainly external regulatory dependence, implacably leads,* as Fred Hirsch acutely observed over 25 years ago, *to a rising mass of codified petty regulation, swollen by the need for rules to enforce rules and to counter their avoidance! The very equality of treatment such regulatory complexity is nobly designed to ensure, in fact makes it impossible. What is more, state regulation in such areas is apt to drive out self-policing and the force of individual conscience."*

Medical regulation has been around for almost 150 years; the General Medical Council was formed in 1858 in the United Kingdom. Self-regulation was really the only option in the 19th century. Doctors hoping to raise standards formed an association or Council. Colleagues either abided by the rules and were registered and so were able to work as doctors, or did not and had to seek other employment. With the very rapid developments in medical science in the second half of the 19th century, the public and politicians quickly understood the importance of modern medicine and wanted to become involved in regulating the profession. That in turn led to the concept of "professionally-led regulation", in cooperation with the public. With better information on what doctors do and on patient outcome, there is a need to improve the evidence base and move away from opinion as quickly as we can.

The General Medical Council was the first of these independent regulators to be established. The purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We have four principal functions: standards and ethics, education, registration and fitness to practise. These functions, however, are linked. It is important that we as a Council, together with the public and the profession, establish what is expected of a doctor – and that is encompassed in our guidance, *Good Medical Practice*. Education, both undergraduate and postgraduate, is not an end in itself but rather a mechanism of ensuring that doctors are able to meet those standards. We maintain a register of all those able to practise medicine in the United Kingdom and as part of our Fitness to Practise procedures take action against those doctors whose standards of practice fall below an acceptable level.

We are not the only organization that regulates medical practice. There are many other regulating authorities dealing with different aspects of healthcare but the General Medical Council deals with the individual practitioners.

The ways in which doctors are regulated have been under debate throughout the world recently. There are a number of factors involved including medical scandals, rising patient expectations, new management arrangements, increasing costs, changes in education and training and the very great increase recently in medical migration. Within the UK, that debate has been continuing for much of the last decade. Starting with the report into the poor results of paediatric cardiac surgery at The Bristol Royal Infirmary, including a number of medical scandals and concluding with Harold Shipman, the mass murderer, a number of enquiries and reviews have been published. Recently, the Government has produced a White Paper entitled *Trust, Assurance and Safety* which has brought together many of the conclusions from these enquiries and indicated a constructive way forward.

The need to end uncertainty in the regulation of the medical profession was felt by the public and politicians as well as by the profession itself. In brief, the General Medical Council will remain independent of the Government and accountable to Parliament. Its four integrated functions remain unchanged and the medical register will become the authoritative source of information on doctors. In order to help bridge the perceived gap between what happens locally and the complex referral process to the centrally based General Medical Council, a scheme of "GMC affiliates" will be piloted. These individuals will be trained by the General Medical Council but work locally and provide information both on problem cases as well as expressing an opinion as to whether or not individual doctors are performing satisfactorily. Finally, and after ten years in gestation, revalidation is to become a requirement for all doctors. The need for doctors to demonstrate on a regular basis that they are up-to-date and fit to practise is no longer controversial in the UK. Revalidation itself will be divided into two components. A licence to practice will be reviewed every 5 years to bring objective assurance of continuing fitness to practise, while all specialists including GPs will be required to demonstrate that they meet the standards that apply to their particular specialty; these standards will be set and assessed by the Medical Royal Colleges and their specialist societies and approved by the General Medical Council.

Fortunately, there is increasing awareness that regulation exists in four or perhaps five layers. The first and most important is personal regulation. No system will succeed without the individual doctors working in accordance with their conscience backed as necessary by the collective con-

science of the profession as expressed through the General Medical Council or its equivalent. But doctors work in teams and each member of the team must have some responsibility in ensuring that the other members are performing appropriately. Similarly, those who employ or contract with the doctors have similar obligations, often avoided until recently in the UK, and then finally the General Medical Council has responsibilities for national regulation. As I indicated before, there are important international dimensions to these concepts; medical migration is likely to remain with us for many years to come.

I remain optimistic that within the UK and I suspect more widely, there is a strong desire from the public, from politicians and from the medical profession itself to ensure that the system is well regulated. The scandals of recent years have, if anything, united us in common purpose and I believe that implementation of the concepts contained within the British Government's recent White Paper will be widely supported. Similar arrangements are being put in place in a number of other countries.

I began this lecture with a quote from Hippocrates and I want to finish with a quote from Sir Robert Hutchison who wrote this little prayer in 1953 and I believe it remains relevant today:

"From inability to let well alone
From too much zeal for the new
And contempt for what is old,
From putting knowledge before wisdom,
Science before art
And cleverness before common sense,
From treating patients as cases
And from making the cure of the disease
More grievous than endurance of the same,
Good Lord deliver us.