Self-regulation part of the deal

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The recent NZMA South GP CME in Dunedin was a highly successful event and one of the most interesting and provocative sessions was the medico-political session led by the NZMA on professionalism. There were five speakers and each presented a different perspective.

The first speaker was Professor Jim Reid from the University of Otago who outlined the attributes and commitments of professionalism. The attributes reflected the relationship between medicine and society; a societal contract with expectations and obligations on and to both, which forms the basis of doctor/patient trust.

The commitments by doctors include integrity, compassion, altruism, continuous improvement, excellence and working in partnership with other members of teams.

The interesting aspect is this current definition of professionalism is very little different from that espoused by Oslo in 1901 when he said patient expectations mirror societal expectations of medicine; and physicians are committed to health and wellbeing of individuals and society through ethical practice, self-regulation and high levels of personal behaviour.

In other words, doctors get to self-regulate, set their own practice and enjoy high levels of trust as long as society feels they are acting in the best interests of the patient and society.

When, or if, society no longer believes this to be the case then we will see outside regulation of medical practice.

The second speaker, Penny Andrew, is both a doctor and a lawyer and her perspective was on the drivers of professionalism. She spoke about internal drivers which include self-regulation and autonomy - the right to control membership, to clinical autonomy, to practise and to set professional standards.

But these rights to self-regulation and autonomy are in the public expectation that doctors will perform for the public benefit. Public and government perception, as to the degree to which this occurs, defines the degree to which external controls (drivers) are imposed on the profession.

Often these external drivers are in the form of barriers and disincentives - including government regulation, erosion of privileges, financial penalties/incentives and control of clinical practice.

The erosion of privileges will occur if there is a collective failure by the profession to deal with substandard members or if there is a collective failure to honour the duty of public service.

Financial incentives such as PPP schemes tend to crowd out intrinsic motivation, especially when they reward individuals not teams, are controlling rather than rewarding or reward specific tasks. Control of clinical practice includes the use of clinical pathways and the use of evidence-based guidelines.
For me, the most powerful message was, unless we, as a profession, can demonstrate publicly that we are performing our public duty, we will become a service industry under government control of all aspects of conduct and competence.

I am sure you can hear the nails in the coffin as well as I.

The next generation's perspective was provided by a current GP registrar, who added an extra component to the attributes and commitments of professionalism. Not only did she mention competence, trust and the importance of relationships - between colleagues, individual patients and the public, but she added self-care. She felt self-care did not detract from professionalism or commitment, but acknowledged the life-work balance that reflects the thinking of generations X and Y.

The patient perspective was provided by an authentic patient, who commented that being a doctor was more than just a business.

She went on to describe those aspects that matter to patients that we might not even think about - such as ease of access into the surgery, clear labelling of rooms including the toilets, the positioning of the reception desk and the layout of the waiting room.

She noted that not only does the doctor assess the patient both verbally and non-verbally, but the patient does the same thing in return. That mutual assessment leads to interaction that develops into trust. That trust is critical because, in her view, the quality of the healthcare determines the patient's quality of life. Food for thought.

NZMA chair Paul Ockelford spoke about the Code of Ethics that underpins our professionalism. There are 12 principles and the first is that patient wellbeing is your first priority; number 12 is upholding the standards of the medical profession. These principles are a guide to the way in which we respond to the challenges of professionalism in the future and they must remain relevant and meaningful, reflecting societal change and expectation.

What we, as a profession, need to acknowledge is society's perception of our professionalism is changing - we do have increasing external controls on our clinical practice, government regulations and financial incentives, and erosion of our privileges. Are we already a service industry as contended earlier in the article? Or can we retain our professionalism by demonstrating publicly that we are worthy and deserving of the public trust that has been historically been placed on us?

The choice is up to us.