PRESIDENT'S ADDRESS – AUCKLAND MEDICO-LEGAL SOCIETY

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THE DEMISE OF PROFESSIONALISM? Some thoughts on the role of professional values and professional discipline in improving patient safety.

In 1996 I was appointed deputy chairperson of the Medical Practitioners Disciplinary Tribunal and, in May 1997, I presided over the first hearing of a professional disciplinary charge laid against a registered medical practitioner under the Medical Practitioners Act 1995. In 1999 I was appointed chairperson of the Tribunal. My term as chairperson is due to expire in September this year and I am not seeking reappointment. Ironically, if I was to be reappointed it is likely that I would also preside over the last hearing of the Tribunal as it is proposed to replace the Tribunal with a new professional disciplinary tribunal – the Health Practitioners Disciplinary Tribunal – currently proposed to be established in 2004.

The Health Practitioners Disciplinary Tribunal is intended to be an "overarching" disciplinary tribunal. It will deal with charges brought against health practitioners from a number of the health professions including dentists, nurses and midwives, occupational therapists, optometrists and opticians, physiotherapists, psychologists, chiropractors, medical laboratory scientists, dieticians, podiatrists and pharmacists.

The new legislation is also likely to provide for the increased participation of lay persons as members of the new disciplinary tribunal.

It is currently proposed that the tribunal comprise two lay members, and two health practitioners with a legal chairperson presiding. Thus, the majority of the members will be laypersons. In this address, I will make some personal observations and comments about what I regard as the dilution of professionalism and professional values, and also the role and function of professional discipline in the context of the current debate around the "culture of safety", vs. the "culture of blame". Finally, I consider possible implications for the professions, the professional disciplinary process, and the public generally.

As a precursor to the discussion, it is necessary to consider "what is the role of professional discipline"? In terms of the Medical Practitioners Act, from which the Tribunal derives its powers, the answer is relatively straightforward – it is a mechanism for ensuring that medical

practitioners are competent to practice medicine, and it is the process for sanctioning medical practitioners who are determined to be guilty of a professional disciplinary offence. The principal purpose of the Act is to protect the health and safety of members of the public; in practical terms, it is a quality assurance mechanism and, given that the majority of the members are currently also doctors, professional discipline is a process of peer review by which the profession censures its own members for actions which offend professional standards.

Because the professional disciplinary jurisdiction stands apart from the general civil and criminal law, professional standards should not necessarily be judged by the same criteria which would be brought to bear in relation to criminal acts or civil wrongs. In general terms, each professional group is the arbiter of what constitutes acceptable professional standards. However, in New Zealand, the professional disciplinary model typically seen in other jurisdictions such as Australia, Canada, or the United Kingdom, has been, in my view, distorted to a significant degree by the almost total prohibition on civil suit against doctors. This has resulted in significantly different expectations and demands on the professional disciplinary process in New Zealand and as a result, the role and function of the professional disciplinary process in New Zealand has come under unique pressure and scrutiny.

The result of the statutory bar is that the public's expectation appears to be that the professional disciplinary process should function as a de-facto personal injury-tort jurisdiction, providing compensation and redress for negligent care, mishaps and/or other professional misconduct. It is my view therefore that the general public has heightened expectations as to what the Tribunal, and its predecessors and successors can, and should, deliver.

In broader terms, the professional disciplinary process, and in particular professional sanctions, derive from the special status accorded the profession; the privilege of self-regulation requires that the profession take responsibility for weeding out the "bad apples" and/or for sanctioning practitioners who have caused harm or injury to patients, or whom have otherwise breached the standards of the profession.

As particular occupations, most notably law and medicine, attained professional status the professional organizations perpetuated "guild-like" values and practitioners were required to become members of occupational associations, such as medical societies and colleges that, by virtue of state licensing requirements, had the authority to set standards of practice and

to monitor and regulate individual practitioners, thereby controlling entry into the professional market in the process. These organizations could claim that they were acting for the public's protection by ensuring the integrity of the profession and by defining and refining professional standards.

"Professionalism" signified the formal recognition of mutual trust between the professional group and the larger public. The work of the traditional learned professions was understood to require significant individual discretion, and therefore was thought to require a stronger sense of moral dedication than most occupations.

This was particularly the case in the context of the physician-patient relationship, for obvious reasons. It was the community's trust in the ability of the professional organizations to maintain and enforce collective standards that lead to its devolving authority onto the professional associations to control key aspects of their market and working conditions through licensing and powers to impose sanctions for departures from professional values and standards.

However, commencing in about the mid-60's in New Zealand, and successively through the late 1980's, the 1990's and now currently with the proposed new legislation, a steady but inexorable erosion of the professional organizations' authority has occurred. A number of reasons have been advanced for this incremental shift from independent professional organizations and self-regulation to external, non-professional, control.

For example, the expansion of the profession and professional organizations and the increasing complexity of medical practice and technological developments fuelled a steady increase in healthcare expenditures, which while initially greatly enhancing the power and prestige of the profession, also involved medicine with economic and political developments that outpaced its willingness and ability to address the larger public dimensions of its own success.

Add to this the increasing recognition (especially post-WWII) of medical ethics and patient's rights, particularly the right to self-determination. Published in the 1980's, Paul Starr's book "The Social Transformation of American Medicine" described the career of medicine as a long ascending curve towards achieving the autonomy of a well established "sovereign profession" followed by time of internal conflict and descent. Starr's account also called

attention to how much the history of medicine's professionalisation has always intersected the shifting alliances among competing social interests in American politics.

According to Starr's narrative, American medicine successfully developed itself into a "sovereign profession" through tight organization and an insistence that physicians, not third parties (including the state), should control how medical services were provided and paid for. Remarkably, according to Starr, American medicine harnessed scientific and technological advances to the small business model of the individual practitioner. This became its professional norm. Medicine's loss of sovereignty came, paradoxically, with its greatest expansion during burse of national enthusiasm for scientific progress that followed World War II. In practice, medicine came to link its reputation evermore closely to its claims to be "scientific" which lead in turn to a heightened and increasingly expensive focus on complex specialization and scientific technology that allayed medicine's former hostility to government involvement.

[[It is interesting to note quite a lot of recent discussion about "post-modern medicine" – the rejection of science in favour of "cultural codes"; the study of the narrative in medical practice, and the recognition of the influence of the environment and the personal in understanding illness – it might be interesting to consider if there is some linkage between the postmodernists and the new disciplinary model and the increased participation of laypersons??]]

In the post-war era, the State was accepted as organized medicine's partner and became involved in medicine through its support of both research and institutional growth, especially of medical schools and teaching hospitals. As Starr summarises this process, "the underlying tension… between a medical care system geared toward expansion and a society and state requiring some means of control over medical expenditures… [*forced a*] redrawing of the contract between the medical profession and society, subjecting medical care to the discipline of politics and markets and reorganizing its basic institutional structure". I suggest that analysis also holds true in the New Zealand context and indeed is even more stark in the context of a high socialized medical model.

Viewed in terms of a contract, the professions gain, and retain, their public credibility by advancing the welfare of the community by contributing specific competence and service: they effectively entered into a contract with the public in which professional social responsibility was an important feature. The reduction of the professional to a mere

technical expert gives professionalism a less effective claim to public legitimacy, and diminishes the importance of the professional voice in public debate.

An American philosopher, William M Sullivan, suggests that the future of the professions may increasingly hinge on how professionalism is understood and practiced. Historically, the legitimacy, authority and legal privileges of the professions have depended heavily on their claims (and their demonstration) of civic performance, especially social leadership in the public interest. As fields such a medicine come under the sway of large, market driven organizations, it is far from clear that the professions will be able to sustain their social importance without re-engaging the public over the value of their work to society at large. If the professions are to have a future, they may need to rest their case on the basis of a civic, rather than a wholly technical understanding of what it is that professionals are about.

The terms of medicine's new contract with society are being dictated by an ideology according to which the mechanisms of the market should form something like a closed loop, from which non-commercial considerations are excluded. By defining all public activities as self-interested, either fixated with controlling costs (public healthcare institutions) or through profit-oriented enterprises (private providers), this powerful trend works to strip away any understanding of the relationships between professions and society, or between professional and client, except in terms of commercial exchange. On this view, the only moral obligation of any enterprise is to maximize economic efficiency. Thus medicine becomes "the healthcare industry", physicians and other healthcare professionals are described as employees or "providers" and patients are redefined as "consumers".

The effect is to weaken rather than strengthen the moral relations that have been essential to healthcare. As such trends advance, little is left of either the standards of professional service, or public confidence in the profession. Yet the professions as institutions depend on the maintenance of a real distinction between financial rewards and the structure of professional norms as traditionally manifested in charity work, peer review, censure and praise, and leadership in community service.

All of these issues are crucial to understanding and addressing concerns about patient safety, and particularly injuries caused by medical error and/or accidents. This is especially the case in the context of the present debate about the culture of safety vs. the culture of blame.

The nomenclature is convenient shorthand for two underlying, and increasingly competitive philosophies:

1. The traditional "professional perspective that medicine is a "sovereign profession" and practitioners are in charge. On this view, professionals should be held personally responsible for patient safety, and should take the blame for injuries, errors or other mishaps. This might be called the "professional sanctions" view. Interestingly, both doctors and lawyers tend to share this perspective, which emphasizes penalties for transgressions, although they might hold very different views about the nature of sanctions – peer review and professional discipline vs. tort liability.
2. The underlying philosophy of the "culture of safety" proponents is newer and systems oriented. The systems view of patient safety sees errors and accidents as the product of systems and/or ordinary human error – the majority of patient injuries are avoidable and arise within systems of care.
3. The traditional approach, of professionalism and professional sanctions blames injuries on individual practitioners errors due to inattention, carelessness or incompetence and puts prime responsibility on the doctor directly involved in an injury, seeking to perfect performance through training and strong penalties for failures. This approach is subscribed to by both traditional and legal medical views – both emphasise individual responsibility, blame injuries on individual shortcomings, and rely on complainant reporting. In contrast, the report "An organization with a memory" prepared by the UK NHS, concluded that an analysis of failures needs to look at root causes, not just proximal events, and that human errors cannot sensibly be considered in isolation of wider processes and systems.
4. In a specific context, the Messages from the Bristol Infirmary Inquiry Team identified factors such as –
    - the absence of a culture of safety in a culture of openness at Bristol Infirmary meant that concerns and incidence were not routinely or systematically discussed and addressed and unsafe practices were allowed to continue unchecked;
    - the physical environment and working arrangements were as important to the safe care of patients as the technical skills of clinicians;
    - the absence of systems for monitoring of clinical care at national or local level put the care of patients at risk;
    - the absence of a systematic approach to learning from things that went wrong prevented effective remedial action from being taken.

And of course, similar systemic flaws have been identified in New Zealand, and I refer in particular to the Reports on Canterbury Hospital and Gisborne Hospital prepared by the two Health & Disability Commissioners, the Report of the Inquiry Into the Cervical Screening Programme, at Gisborne.

Thus, in contrast to the traditional approach, the "culture of safety" movement accepts that professionals make mistakes, not because they are insufficiently trained or sanctioned, but because they are human. On this view, individuals should be praised, not chastised, for reporting mishaps as these can identify the systemic defects, leading in turn to systemic improvements.

The culture of safety sees "patient safety" as a positive thing, to be continuously improved beyond present day standards, and evolving to prevent bad outcomes not presently identified as problematic. On the other hand, the culture of blame is perceived as being negative, seeking to sanction by professional discipline and liability, conduct deemed to be substandard. Professional discipline and individual liability seek to change behaviour that exceeds the threshold of culpability.

Professional discipline focuses on specific "providers" who have already (possibly even years previously) caused injury and are therefore deemed likely to cause more in the future, classically the "bad apples". Similarly, liability focuses on discrete episodes of poor care; the disciplinary tribunal's inquiry into a charge brought to it is relatively narrow, being confined to the subject matter of the complaint. The opportunity to identify systemic errors is limited, as is the Tribunal's ability to deal with recidivists who commit relatively "low level" (sequential) breaches of professional standards.

In contrast, the culture of safety approach, like healthcare quality improvement in general, succeeds by improving practice throughout the system, often by making just small and incremental improvements throughout the system.

A key difference between the two approaches is that professional sanctions must look backward for blame while the patient-safety approach looks forward to prevent like-injuries reoccurring. The professional sanction/tort liability system does not inquire how recurrence of the injury or event can best be prevented – it asks which, if any, of the defendants should be sanctioned, or pay damages. Almost as a by-product, the sanctions approach also offers

the hope of deterrence, and, in part, the professional disciplinary process is also educative. The professional disciplinary process is also, in large part, rehabilitative. But this process also is individualized, rather than systemic. For example, the disciplinary tribunal may impose conditions on practice and/or require a practitioner to undertake re-education or upskilling.

In contrast, culture of safety advocates hold that the most productive approach to preventing injuries is not to fix blame for a single event, but to fix problems for next time. Liability and discipline are grounded in adversarial fact finding, process and sanctions; the culture of safety movement strives to reduce fear among practitioners, fostering cooperation in finding, understanding and fixing problematic systems. Relevant systems for improvement include both the various processes within which and through which an individual practitioner works, and the organizational context within which individuals and processes function.

However the question I wish to pose is, in grasping so readily at the mantra of "the culture of safety", do we risk throwing the baby out with the bath water? Is it true that the "culture of safety" movement offers theoretical strengths not present in the professional sanctions approach. These strengths flow from seeking ongoing systems improvement, rather than one-off resolutions of specific cases. A culture of safety systematically seeks to generate useful information (what to do about problems), knowledge (how to do it), and modes of implementation (changing clinical and other processes involved in patient care), as well as methods to continually assess the effectiveness of changes made. In theory, the culture of safety approach seems a more powerful tool than discipline or liability alone.

Where it is weakest however, is where sanctions are meant to be strongest – providing external motivation to set up and productively operate safe patient care systems; setting standards – an important function of the professional disciplinary process is to ensure that professional standards are consistent with the community's expectations and values; providing transparency, and assuring accountability. The allocation of blame to culpable acts also has social efficacy. For example, in the context of providing an opportunity for "therapeutic jurisprudence" – the theory of law as a social force that produces behaviours and consequences; compensation, or even the legal process itself, can affect a person's healing or well-being quite independently of the process, or its legal and theoretical purposes.

Developing a culture of safety in healthcare requires more than simply looking to other high risk industries, such as aviation, and transposing processes and practices into the healthcare environment. Each has quite specific motivations, mores and values. Most obviously, pilots have far stronger incentives to take care than doctors; there is no stronger deterrent-incentive than one's own personal safety. But even this ultimate incentive has never been enough to prevent crashes.

In terms of regulating for patient safety, the health sector has its own special considerations. These include the role of professional self-regulation and the need to control risk while allowing for innovative care and treatment, and a professional environment in which the practitioners are committed to the exercise of judgment and the application of discretion on a regular basis. These are factors that have a significant impact on a regulator's ability to secure compliance with rules and regulations. Other factors include:

- the professional's propensity to comply willingly with rules and regulations;
- the strength of enforcement powers in sanctions available;
- the seriousness of the risks at issue;
- the visibility of breaches of the rules;
- the frequency of contacts between regulators and those regulated and political influences.

The inclination to comply may also be influenced by costs, self interest (or self preservation), the profitability of breaking the rules and running risks, good citizenship and reputation factors, the perceived likelihood of detection, the level of knowledge about the risks, intra-organisation pressures, and competing organisational objectives.

Areas of professional judgment present special problems of risk management, and for command or rule-based regimes of control. Professionals generally make decisions and operate in accordance with policies that are of high importance, low visibility and high discretion. Practitioners moreover tend to cherish their domains of clinical judgment and will resist control devices. For example, there is research to suggest that doctors are more tolerant of rule-breaking than nurses and that doctors, trained in use of clinical judgment, are more tolerant of protocol breaches than others, such as nurses who have been trained in the regulation of behaviour by rules and guidelines.

All of this suggests that a very prescriptive regulatory system involving rules and regulations will give rise to compliance issues. Practitioners may side-step rules or standards of care by "creative compliance" strategies and defeat the polity objectives of rule makers. This is especially the case if the rules and regulations are perceived to duplicate existing rules or standards, or to be ill-targeted and over or under inclusive.

Self-regulation therefore may need to be combined with external regulation to achieve strong accountability, an operational environment which is perceived as "safe" for both practitioners and patients and an independent complaints resolution process.

Conclusions

If we are to build a safer healthcare system it is essential that a "systems approach" to safety is developed but the design of any patient-safety system must adequately take into account the cultural, sociological, and physiological qualities of the professional/healthcare environment.

The commitment to safety cannot be a discrete, autonomous, self-contained policy. It must be embedded in professional vales, education and training, the design of buildings and equipment, protocols and guidelines for treatment care and the administration of drugs, and the systems for responding when things go wrong. Effectiveness also requires that the system is flexible and responsive to new information and changing circumstances, but that it does not lose sight of underlying philosophies and values, including sanctions.

In relation to institutions, particularly in the healthcare sector, self-regulation and fully independent regulation both have strengths and weaknesses as mechanisms for securing compliance, and enforcement. In the health care context, any successful patient safety system has to take into account the nature of health professionals' decisions, and the decision-making environment. In such an environment, professionals tend to be resistant to control devices such as formal rules, regulations and standards and the risk is that simply insulating practitioners from discovery in terms of self-reporting of errors or other mishaps that lead to injury or might have done so, may, in the absence of a strong professional culture, simply remove disincentives to report. There is no evidence that it would provide any positive incentive to promote patient safety. Such a system must rely on practitioners' internal motivations to improve i.e. on professionalism and a strong adherence to professional values and standards.

It is therefore crucial to maintain external pressures and/or incentives to improve, recognizing that professional sanctions alone are probably insufficient and, in many ways, counterproductive. What is required is an approach that combines both professionalism, professional sanctions and systems-safety motivations and responsibilities for keeping patients safe. We ought to be able to do this better than we have done to date in the context of a no-fault compensation system and a history of strong professional organisations and structures.

In terms of the implications of the proposed new legislation for the profession, I suggest that what we are seeing is a steady erosion of professionalism or, as suggested in the most recent editorial in the British Medical Journal, the de-professionalising of doctors. There are a number of factors which currently inhibit the ability of the (NZ-model) professional disciplinary system to contribute the meaningful way to systemic change; a focus on professional standards and professional disciplinary sanctions is, in my view, not among them.

Rather, the two most significant factors preventing the professional disciplinary process from being more effective in preventing patient injuries are delay (i.e. the delay between the occurrence of an event, investigation and sanction if warranted) and the multiplicity of agencies involved in the process. On the basis of what has been published to date about the proposed statutory amendments, they do nothing to address either of these key factors.

The proposed changes do however complete the transformation of medicine from an independent, professional practice to a controlled and highly politicized service industry, and move the professional disciplinary process, with the increased participation (effectively dominance) of laypersons, even closer to a quasi-tort liability system.

It seems to me that if we are to promote a culture of safety we need to tap into the "professional social ideal" and the notion of a profession constructed around loyalties to purposes deeper than the pursuit of immediate advantage. The idea of a doctor-patient relationship framed in terms of a partnership and expectations of "professional conduct" also become more distant if professionalism is devalued – it should also be noted that the new legislation started out as the Health Professionals Competency Assurance Bill and, in the latest version, has become the Health Practitioners Competence Assurance Bill.

It is therefore my view that the most effective way to improve patient safety and reduce the incident of errors and patient injuries is to demonstrate, as a community, a strong commitment to, and understanding of, the practice of medicine as a profession, and the community is entitled to, and should, require adherence to professional values and standards will most effectively be achieved (and sustained) in the context of strong professional institutions, organisations and systems.

In the context of an existing no-fault compensation system, we do have the ability to develop a less adversarial system for dealing with injuries resulting from errors or other mishaps. Other options include simply identifying the flaws in the present system and redressing them to provide for the reporting, investigating and resolving adverse events within strict time limits and with the involvement of a limited number of agencies.

This process may, in fact, involve some internal inconsistencies. For example, the Director of Proceedings, and individual complainants, are currently permitted (under the provisions of the Health & Disability Commissioner Act) to make claims for compensation and damages. Such claims being heard and determined by the Human Rights Tribunal (formerly the CRT).

This involves a hearing which is virtually identical (in terms of evidence and procedure) to that conducted by the MPDT in the context of a professional disciplinary charge brought to it. If a complainant is to obtain any compensation or establish an entitlement to damages then they, and the respondent doctor, must participate in (at least) two separate hearings processes.

If the jurisdiction to award compensation and/or damages is to be retained for medical injuries, then it is my view that it should be transferred to the disciplinary tribunal. At first glance, this sits uneasily with the argument that the professional disciplinary processes should not function as a quasi-tort jurisdiction, and that discipline has nothing to do with providing compensation or redress. However, the debate needs to focus on the issue of whether or not, in the context of no-fault compensation, such compensation and/or damages should be available to persons harmed by medical accidents, and not to other, equally deserving, citizens who suffer a personal injury, or similar insult.

If it is to be available, the fact that it is currently available under human rights legislation in the procedural circumstances such as apply at present, that is, requiring the parties to go

through two separate but similar hearings, both often years after the event is, I believe, inhumane to both of the injured party, and the health professional.

On the basis of my experience over the past six years, I have come to the view that substantial improvements could quite readily be made to the existing system both to improve its effectiveness, and also to incorporate a systems approach to patient safety. For patient safety to be assured, it must be implemented in harmony with the most positive aspects of existing structures, while the aspects of those structures that inhibit or prevent the introduction of more systemic safety approaches must be address.

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