



Title	Medical professionalism in a changing SAR
Author(s)	Kumana, CR; Kay, R
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Medical professionalism in a changing SAR

Harold Shipman was a British general practitioner who committed suicide while serving a life sentence for killing around 250 of his patients, mostly elderly women who lived alone. Alder Hey was the children's hospital where thousands of body parts, including whole heads, were stockpiled without the families' consent. Bristol was the city where two cardiac surgeons were found guilty of serious professional misconduct for being responsible for between 30 and 35 "excess deaths". Together, these three names shocked the nation and have vastly reshaped the medical landscape of Britain in the new millennium. In the words of Baroness Julia Cumberlege, Chair of the Working Party of the Royal College of Physicians (RCP) on Medical Professionalism, "Deference is dead".

"In the modern world", Baroness Cumberlege continued, "patients want a more equal relationship with their doctor.... management monitors and expects results". For 15 months in 2004-5, her working party drew on a sea of opinions to produce a report entitled *Doctors in society: medical professionalism in a changing world*.¹

Billed as the most far-reaching College report of recent years, *Doctors in society* defines medical professionalism as "a set of values, behaviours, and relationships that underpins the trust the public has in doctors". It discards the notions of mastery, autonomy, privilege and self-regulation as incompatible with today's world. Six main 'themes' (leadership, teams, education, appraisal, careers, and research) are proposed, attention to which, the report promises, will lead to both improvements in patient care and 'fulfilling lives' for doctors.

Leadership in the medical profession, the report surmises, is often "negative, defensive and self-serving". Individual doctors need to strengthen their skills of leadership on the one hand and of 'followership' on the other. *Teams* in the hospital setting are usually "short-lived, unstructured, opportunistic, fragmented and rushed". They need better interprofessional collaboration and communication. Professional values, behaviours, and relationships should be nurtured early in one's medical *education*, and sustained through mentorship during the postgraduate years. The aim of *appraisal*, the report reassures, is not to assess performance. It is part of the *career* development of a doctor, which should also include protected time to keep up-to-date, to retrain, or simply to reflect. Finally, more *research* is needed, particularly on how robust the concept of medical professionalism is across different health systems and cultures.

We have some of the answers to the last question by contrasting the RCP report with the one released 4 years earlier by the American Board of Internal Medicine (ABIM)

and others.² While the RCP report struggles with the semantics behind "values, behaviours, and relationships", the ABIM version rests neatly on its three principles—primacy of patient welfare, patient autonomy, and social justice. While the RCP sets six main 'themes' for doctors and their institutions to debate and explore, the ABIM places 10 commitments—to competence, honesty, confidentiality, maintaining appropriate relations with patients, improving quality of care, improving access to care, a just distribution of finite resources, scientific knowledge, maintaining trust by managing conflicts of interest, and professional responsibilities—squarely on the shoulders of the individual doctor. The RCP report is arguably a product of a state-driven health system, while the ABIM version is that of a market-driven system where consumer satisfaction has always been a necessary goal.

Whilst the issues raised by both reports are undoubtedly important and interesting, they do not tackle just how any necessary changes are to be implemented. Several pertinent concepts were not discussed (eg the abuse of knowledge and professional jealousy), and many that were dealt with abstract generalisations rather than genuine dilemmas (such as the ethics of human experimentation or relationships with the drug industry). Moreover, they failed to consider some well-established and relevant tenets.³ Thus, the mere avoidance of unprofessional behaviour does not constitute professionalism (a healthier aspiration). Similarly, the quest to achieve professionalism should not be likened to a destination (it is a life-long journey). There was also no mention of every doctor's obligation to learn from mistakes (one's own and those of others).

Does the Hong Kong Special Administrative Region (SAR) need its own set of statements regarding medical professionalism? Both the British and the American projects were born out of being challenged by forces of change within their societies. Such forces—from technical progress, the information explosion, rising public expectations, and a 24/7 news media—are universal. Far from being immune from them, our SAR, with its global exposure, should have been feeling the heat for some time. Why is it, then, that medical professionalism has not crossed our minds yet?

Professor Sir David Todd, in the first Halnan Lecture in 1998,⁴ raised the question "In general, vocational training has been a success, but has there been enough emphasis on 'professionalism'?" He went on to ask, "Role models among teachers and senior doctors should help, but do we have a sufficient number of such leaders?" His parting shot was to quote the late President John F Kennedy who said "It is time for a new generation of leadership, to cope with a

new problem and new opportunities. For there is a new world to be won.”

In his address titled “Present and Past Tense” at the Hong Kong Academy of Medicine’s 10th Anniversary Congress in 2003, Professor Todd went on to consolidate and expand on these ideas.⁵ He stressed that the essence of something as intangible and complex as medical professionalism might well be more effectively communicated by suitable role models, rather than didactic statements. He saw Continuous Medical Education (CME) and its more humanistic cousin, Continuous Professional Development (CPD), as having an impact on *education* and *careers* as well as professionalism. As CME/CPD was becoming compulsory, he thought it was crucial to monitor its quality, content and timing, and that it should be appropriate for its targeted audience without unnecessary repetition. He also noted that personal interactions (written or e-mail correspondence; direct or telephone conversations) doctors have with specialists or other opinion leaders also constitute effective forms of genuine learning, but remain unrecognised for the purposes of CME/CPD. Finally, Professor Todd cautioned that in future, doctors would need training to deal sensitively with patients displaying ‘cyberchondria’ (anxiety generated by the plethora of information available on the Internet).

In whatever health system these challenges are to be met, the steps taken will only succeed if they can be seen

to improve health outcomes and public trust. To achieve these goals, new skills and attitudes have to be inculcated. More than ever in these rapidly changing times, we need inspiring role models as teachers and leaders, and not just a few, but a whole new generation of them. Rather than creating more platitudes about what is ‘medical professionalism’, we would do better by finding, nurturing, and retaining these individuals.

CR Kumana, FRCP, FHKAM (Medicine)
(e-mail: cyrus@hkam.org.hk)

Executive Editor

R Kay, MD, FHKAM (Medicine)

Editor-in-Chief

Hong Kong Medical Journal

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