Everyone is entitled to a good doctor*

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ABSTRACT

- All patients want good doctors they can trust. Good doctors are competent, respectful, honest, and able to form good relationships with their patients and colleagues.
- Medical practice is inherently risky. The public, recognising this, believes that in a modern health service the competence and professionalism of all doctors should be a given, not an additional avoidable hazard. Some doctors find this expectation reasonable, others threatening.
- Good medical practice may be best achieved by professional regulation based on explicit, patient-centred professional standards embedded in medical education, registration and licensure, specialist certification and doctors' contracts. Effective professional regulation and professionalism should be an integral part of wider quality improvement and quality assurance.
- The advantages for patients are self-evident, but the trustworthiness, influence and good name of individual doctors and the medical profession collectively would be enhanced if together they were able to show that the house of medicine is being maintained in good order.

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When patients and their relatives say they have a "good doctor", they mean a doctor whom they feel they can trust without having to think about it. They equate "goodness" with integrity, safety, up-to-date medical knowledge and diagnostic skill, and the ability to form a good relationship with them. For them, good doctors are clinically expert and at the same time are interested in them, kind, courteous, empathetic and caring. All these attributes matter to them because they know that their doctors' decisions can affect the outcome of their illness — even make the difference between life and death, or between enjoying a speedy recovery and suffering serious disability.

In his lifetime, William Osler epitomised the good doctor. He was at the leading edge of medicine — his classic textbook of medicine, his skill as a clinical diagnostician and his charismatic bedside teaching all stand testimony to that.[1,2] But, to an exceptional degree, he matched his scientific and clinical prowess with a love of people, a powerful sense of ethical conviction and a passion for his profession which set him apart from his contemporaries.[3]

Today, we would call Osler an outlier, one who stood at the very top of his profession. Beneath him and a few others like him were — and still are today — the vast majority of good doctors who are competent, conscientious and trustworthy. The large size of this group constitutes a critical mass of what Avedis Donabedian called "goodness", of which the profession can be justly proud.[4] It has been fundamental to sustaining considerable public confidence in doctors.

Beneath this group is another layer of doctors whose practice is in some way not good enough. Some are clinically inadequate, others cannot communicate, or relate appropriately to patients. Some cannot do any of these things well. Currently, this group is impossible to quantify, but we all know that these are doctors we try to avoid if possible. We know about them from our friends, from local gossip — "the word on the street" — and from our own experience. Doctors themselves, with their insider knowledge, are careful to steer clear of them when their own families are ill.

Beyond this band of substandard practice there is another group of outliers: potentially dangerous doctors who are unfit to practise unsupervised. An indication of the size of this group may be gained from the United Kingdom's National Clinical Assessment Service (NCAS), which has shown recently that the 1-year rate of referral to NCAS is 0.5% for all doctors, rising to 1% if doctors in training are excluded.[5] These doctors were tolerated until very recently — the past 10 years or so — by what the public would say was an excessively self-protective profession.

This bell-curve pattern of practice has been with us since the modern medical profession emerged in the middle of the 19th century. The profession has long accepted it as normal. For over a century, the public thought the same. However, recently that mutual understanding between profession and public has been under increasing strain as respective expectations started to diverge. While doctors' attitudes have remained substantially unchanged, the health care expectations of an increasingly well educated and informed consumer society have been changing quickly.

The result is that many more people today have their own ideas about what they want from the doctor–patient relationship.[6,7] For them, it is the patient who defines the basis of the relationship, not the doctor. Equally, now that they have become more aware, this section of society is making it clear that they are no longer prepared to put up with a profession and a system of professional regulation that continues to tolerate what they consider to be inadequate or bad practice. Their appreciation of good doctoring is as strong as ever: they are not anti-doctor. However, they think that, in a modern health service with effective professional regulation, quality assurance and risk management, all doctors should be good doctors. There should be no element of chance about it. Some doctors find this expectation threatening, others perfectly reasonable.

Captives of history

The modern medical profession began to take shape in the second half of the 19th century — Osler's time. This was the age of small, single-handed general practice, with the emerging specialties largely confined to the newly developing university teaching hospitals. The leading physicians of the day concentrated on achieving a better understanding of the body, and on describing and diagnosing disease. Despite these advances, medicine was essentially harmless because, at that time, treatments were largely ineffective. Good relationships with patients were important because doctors' incomes depended on it, and they had little else to offer.

All this changed rapidly after the Second World War, when specialisation in high-tech medicine really took off.[8,9] Armed with new science and technology, specialists were able to do more and

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more wonderful things. They were nearly all men, and they were glamorous, powerful role models. Paternalism dominated relationships with patients, who were expected to do as they were told — "doctor knows best", as the saying goes. Communication was a one-way street. And things like consent to treatment were mere formalities, if sought at all.

The downside of this medical success story was the tolerance of poor practice.[10] In English-speaking countries, the process of self-regulation was supposed to ensure that doctors were properly trained and that their practice was safe. However, history shows that this was never as effective as its promise because of the intrinsically self-protective nature of the medical culture. Turning a Nelsonian blind eye was the easiest thing to do. Elsewhere, regulation run directly by the state was no more effective, for the same reason.

This self-protective, "take-it-on-our-terms" attitude persisted through the century right up to the 1980s. The public was content because the heady successes of medicine seemed so reassuring. People trusted the profession to do all that was necessary to protect them.

This trust was misplaced. British general practice is a good example of a prolonged struggle to deal with a substantial tail of poor practice.[11-13] Doctors like my father formed the College of General Practitioners in 1952 to try to establish some basic standards, but professional resistance was strong. Furthermore, successive governments colluded over the years with the powerfully protective medical trade union — the British Medical Association (BMA) — when it suited them to do so. "There is no such thing as a bad general practitioner", said a BMA general practitioner leader in the 1970s.[14] Poor practice was less prevalent in the hospital specialties because the specialties had more robust entry standards, and working in a team offered some informal oversight of practice by peers — but it was there just the same.

The obvious question is why a profession with so many conscientious people could act so defensively. How does this behaviour fit with a profession committed to putting patients' interests first? One explanation lies in the 19th century cultural mindset of unfettered professional autonomy that, deep down in the profession's collective psyche, lingers on even today. This assumes that, once doctors are fully trained, for the rest of their professional lives they are then entitled to exercise wide discretion as to how they practise medicine, how thoroughly they keep themselves up-to-date, how they relate to patients and colleagues, and what standard of practice they personally consider acceptable. It's all their call. Patients' views don't come into it. Think, for example, of the difficulty there is even today in getting new knowledge adopted quickly into practice through evidence-based medicine.[15]

Another reason stems from that strong sense of brotherhood and pride in belonging to an honourable profession, which is instilled in doctors through medical education. It is one of the great strengths of the medical culture. However, until very recently the culture was strongly self-protective, which made doctors reluctant to report poor practice. In his day, Osler, an enthusiastic advocate of professional solidarity, publicly urged doctors not to criticise colleagues: "Never let your tongue say a slighting word of your colleague".[16] Britain's General Medical Council (GMC) reinforced this attitude until the late 1980s by advising doctors not to "disparage" a colleague.[17] To do so was considered unprofessional, and could precipitate disciplinary action, not against the doctor who gave cause for concern but against the doctor who was sounding the alert!

This inward-looking view of professional responsibility could not last. In the 1980s, the public mood in the Western world was changing as the consumer revolution took hold. People became more questioning about services in all walks of life. In Britain, consumer organisations became far more critical of too many doctors' poor communication skills and the continuing tolerance of poor clinical practice: poor practice was the public's main concern.[18-20] So, the gap between the public and the profession was growing wider.

The Bristol effect

Things came to a head in the early 1990s with reports of high mortality rates among children undergoing complex cardiac surgery at the Bristol Royal Infirmary.[21] Besides questions about the surgery itself, it became clear at a GMC hearing in 1997–1998 that many people had known about this situation for years.[22] An anaesthetist had disclosed audit data about the results of the two surgeons involved. His colleagues pilloried him for whistleblowing and he was forced to emigrate to Australia.

The importance of "the Bristol case" was that it happened in a major teaching hospital with doctors who were not "bad" in the conventional sense. The case involved personal professional failure and institutional systems failure. It involved a closed, medical "club culture" in that hospital, which was highly protective and secretive, and intolerant of criticism.[21]

When the full details were disclosed at the GMC hearing, they had a profound effect on the public. People were angry and bitter. The principal emotional reaction was of trust betrayed. The press focused that anger on the profession and self-regulation.[14]

Bristol shocked the medical profession. Richard Smith, then Editor of the *British Medical Journal*, said it all when he chose Yeats' words, "All changed, changed utterly", to head his leading article after the Bristol scandal broke.[23] And so it was. Both the government and the GMC brought forward comprehensive plans to modernise medical regulation, including far more public involvement, workplace clinical governance, revalidation and strengthened GMC powers for assessing fitness to practise. The need for radical change was reinforced by further bad, high-profile cases that followed in quick succession.

The new professionalism

In 1995, the GMC sought to unify the profession around new, explicit, patient-centred professional duties and standards that reflected public understanding as well as doctors' understanding of what constitutes good medical practice.[24] In 1998, in the aftermath of Bristol, it decided that compliance with these standards would be best achieved by embedding them in medical education, licensure, specialist certification, revalidation and contracts of employment.[25,26] These fundamental changes were intended to signal a decisive break with the doctor-centric professionalism of the past, to put patients' interests unequivocally first.

There has been real progress towards redefining the relationship between the public and the profession around the twin principles of patient autonomy and transparent physician accountability. Nevertheless, opinion in the profession is still divided. Some doctors are fulsome and enthusiastic about renewing their professionalism and profession regulation around patient-centred principles. Others, deeply conservative, want to make the least change

1 Important features of a professional code of practice[28,30]

A code of practice should:

- Provide clear and, where possible, assessable standards closely related to everyday practice;
- Embody patients' expectations;
- Show doctors what is expected of them;
- Give patients a benchmark against which to judge their experiences. ◆

consistent with keeping up good appearances. Revalidation gives focus to these different views.

The divisions were fully exposed in 2004 during the Shipman Inquiry into the case of Dr Harold Shipman. The Inquiry was conducted by Dame Janet Smith, a High Court judge.[27] She was strongly critical of the GMC for having just emasculated its own originally coherent proposals for revalidation and fitness to practise that it had launched soon after Bristol. It seemed that the GMC, when faced with continuing resistance from some in the profession to a form of revalidation robust enough to give the public proper protection, altered course to accommodate these doctors' interests, to the detriment of patient safety. Dame Janet exposed this policy reversal with devastating precision. Consequently, as a result of her criticisms, the government asked the Chief Medical Officer for England, Sir Liam Donaldson, to make proposals that would get the reform program, particularly revalidation, back on track.

In an outstanding report, *Good doctors, safer patients*, Sir Liam builds on the standards-based model.[28] He places the regulation of doctors within the wider set of institutional systems for improving and quality-assuring medical practice. He recommends a common standard of entry to the profession that would be assured through a new standardised national examination. He restores rigour to the process of revalidation. In the management of concerns about a doctor's practice, he emphasises the importance of a supportive rather than an adversarial approach, with proper retraining and rehabilitation for doctors, where appropriate.

Professional standards

The Royal College of Physicians of London has recently defined medical professionalism as signifying a set of values, behaviours and relationships that underpins the trust the public has in doctors.[29] As standards are the crux of the matter, it is worth looking at them more closely.

A professional code of practice for doctors should consist of a set of clear, unambiguous and, where possible, assessable set of standards that relate closely to the work of a doctor.[28,30] It should be the visible expression of a doctor's professionalism and provide the vehicle for making sure that doctors know what, in practical terms, is and is not expected of them. It should provide a benchmark by which patients can set their expectations and judge their experiences, and should ensure that all those who contract with doctors have a shared understanding. It should also provide greater transparency for the public, patients and employers. Box 1 summarises the important features of a code of practice.

In fact, a new generation of professional codes began to appear in the early 1990s. For example, a consortium led by the American Board of Internal Medicine Foundation began work on the Physicians' Charter, to provide a basis for strengthening professionalism.[31] The GMC started work on *Good medical practice*.[24] The Royal College of Physicians and Surgeons of Canada designed their CanMEDS document[32] around the competencies needed for training in patient-centred practice. In Quebec, the Collège des Médecins du Québec began to develop a code of ethics of physicians, which became statutory in 2002.[33] Recently, the Picker Institute has shown that CanMEDS and *Good medical practice* are the most patient-centred.[34]

In 2005, the United States Federation of State Medical Boards initiated an informal Alliance for Physician Competence to promote effective medical regulation. It has taken up the work begun by the American Board of Medical Examiners and other organisations to create an American version of *Good medical practice*. The Alliance believes that a unified code can provide a new foundation for education, licensure and certification for American medicine. The draft code will be complete and available for review by interested organisations early in 2007. The Alliance also plans to develop a consensus on the data needed to provide evidence of meeting the standards of "Good medical practice USA" throughout the career of a doctor.

In Britain, the fourth edition of *Good medical practice*, just published, provides some 60 generic standards.[35] It describes the essence of the good doctor (Box 2). Research by the Picker Institute has shown that it contains everything patients think is necessary for patient-centred care.[36] *Good medical practice* is addressed to every doctor, and it makes it clear that serious or persistent failure to follow its guidance will have consequences for the doctor's licence to practise. Work is now underway to define the necessary criteria, thresholds, competencies and sources of evidence needed to make it fully operational for revalidation.

It is quite likely that, within the next 10 years, further co-operative development between countries will result in a convergence on what one might call "International good medical practice". This common generic framework could be adapted to the differing health care systems in each country and serve as the basis for unifying technical and clinical standards in the same specialty in several countries. Such a framework would have huge potential in helping to draw together what is fast becoming a truly global profession.

Doctors worry that explicit standards could result in rule-based, tick-box practice. In fact, there is a delicate balance to be struck between having clear principles of practice that doctors must observe, and preserving the degree of discretion needed for competent clinical judgement. Many people outside the profession do not appreciate that medicine is not an exact science. In fact, it is prone to error, and inherently risky, because doctors regularly have to make decisions about diagnosis, treatment and patient management on less than perfect information. Such information comes from the nature of illness, and patients' responses to it, which are hardly ever neatly packaged. Consequently, decisions are based on clinical judgement which, of necessity, is partly intuitive and partly

2 Good medical practice[35]

Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity. ◆

dependent on the application of knowledge and skills in areas where personal interpretation is essential.

Doctors must retain the right to make these judgements as conscientiously as they can. Patients depend on it. That makes it all the more important to be sure that doctors' competence is not itself an avoidable risk. Hence the necessity for revalidation.

Four strategic issues

Securing universal coverage — revalidation

Revalidation is the process through which doctors demonstrate regularly that they are fit to practise in their chosen field. In the UK, Donaldson has proposed a two-strand model embracing relicensure by the GMC and complementary recertification by the Royal colleges.[28] Assessment will be against generic and specialty standards set by the GMC and the colleges and the specialist societies within the template of *Good medical practice*.

Relicensure will be every 5 years and will involve satisfactory participation in annual National Health Service appraisal at the workplace, informed by standardised multisource feedback, and the resolution of any issues known to a GMC affiliate in the local area.

Recertification by the relevant Royal college will involve everyone on a specialist or general practitioner register held by the GMC. Each specialty is to design standards and assessment tools to assess performance against the specialty-specific standards. The recertification period could vary between specialties, but would not exceed 5 years.

American experience with recertification provides us with the most robust working model. The American Board of Medical Specialties has agreed on a common format and framework for assessment.[37] Some 85% of US physicians are now recertificated. A recent meta-analysis has shown that doctors' knowledge does indeed decline with years in practice if not constantly refreshed.[38] America is facing up to the knowledge challenge.[39] Other countries will have to do so sooner rather than later.

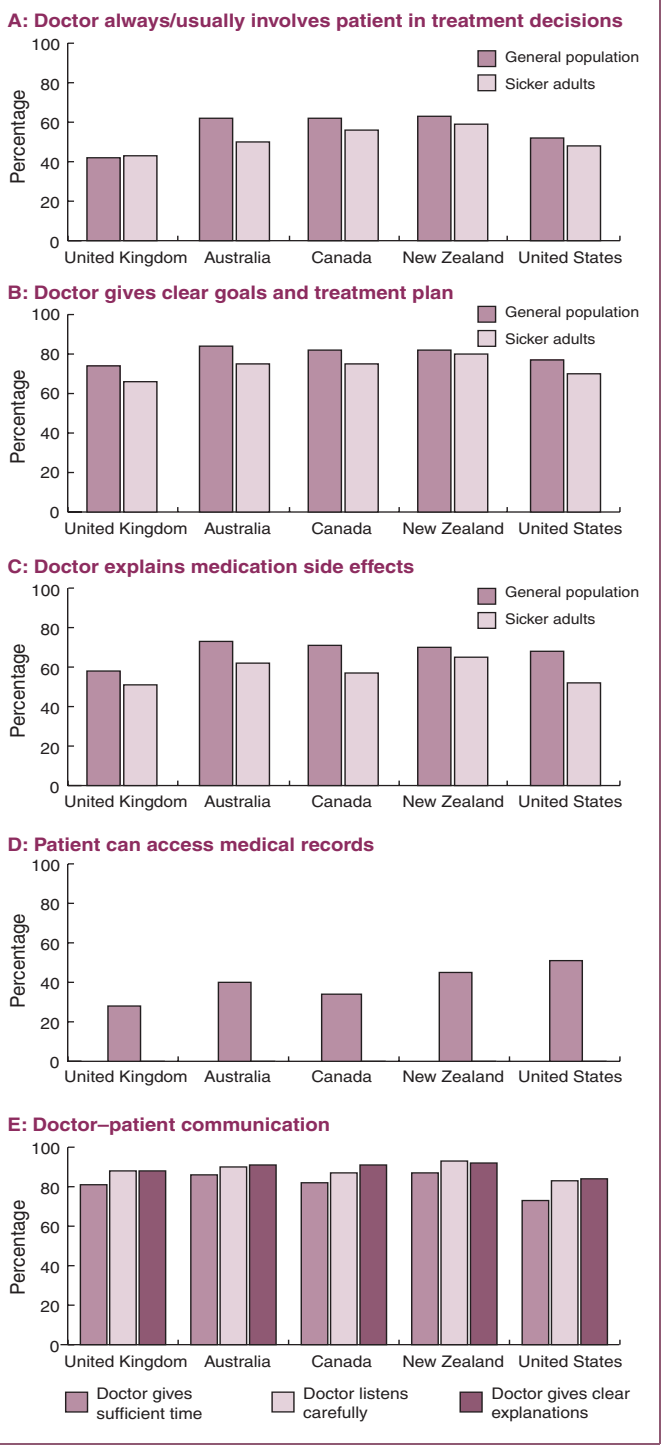
The public has strong views on revalidation. In Britain, a 2005 Mori Social Research Institute survey showed that nine in 10 members of the public thought it important that doctors' competence be checked every few years.[40] Nearly half the sample thought these assessments already happen, and that they should be every year. The public view is in sharp contrast to that of those who think that revalidation should be a "light-touch" process. The public is most concerned about the doctor being up-to-date, having high success rates with treatments, getting high ratings from patients, and having good communication skills.[28]

Closing the gap between patients' expectations and experience

We know that patients tend to judge medical and health care by things they think are important and on which they are able to form their own opinions. Patient satisfaction provides one measure. A complementary and more accurate measure is patients' actual experience of care.

In Box 3, I have selected five examples of a cluster of doctors' behaviours, which come under the general heading of professionalism[41] (doctor–patient communication, involving patients in treatment decisions, giving clear goals and a treatment plan, explaining medication side effects and giving patients access to their records). Experience was compared in five countries — the UK, Australia, Canada, New Zealand, and the US. Box 3 shows that most patients are well served by their doctors, who deliver on what is promised in their professional codes. However, a sizeable minority of patients — significant in terms of the proportion of the total population who may be affected — do not experience such care. The size of this minority may help to explain the background buzz of discontent one often hears about doctors' attitudes and communication skills. My point is that if so many patients get what they

3 Patients' experiences of five measures of doctor's professionalism in five countries[41]



expect from most doctors, and are well content with that, it should be possible to close the outstanding gap. Data on patients' experiences, fed back regularly into doctors' appraisals for employment and revalidation, offer the most promising way of achieving this.

The threshold of goodness

Another sensitive issue is the "threshold of goodness": the boundary between acceptable and unacceptable practice. Traditional professional regulation, based on implicit standards, aims to foster excellence and protect the public from bad doctors. But what does this mean? Excellence, goodness and badness are not defined. Furthermore, the threshold for action by the regulator on a doctor's registration lies between "not good enough" and "bad". Consequently, everything is regarded as at least "good" unless the regulator can prove "badness" on a case-by-case basis after a complaint about a doctor. If one combines this reactive model with the instinctively protective professional culture, and no regular revalidation, it is easy to see why the band of poor practice highlighted by the Bristol case could have been seen as part of normal professional life.

In the new, proactive model of professional regulation, professional standards are explicit. Excellence is still there as an aspiration. Everyone should be encouraged to aim high. But "goodness" is described in some detail in codes like *Good medical practice*. Goodness is intended to be the optimal standard of practice capable of being achieved by every conscientious doctor. That is easy to agree, and is what patients expect. It is the consequence that doctors find difficult, because it means that the threshold of regulatory acceptability must be raised to lie between "good" and "not good enough", not as it does now between "not good enough" and "bad". Securing acceptance of that higher threshold, and defining it in operational terms, is one of today's most urgent tasks.

The public's view is that they want the same threshold that doctors accept for themselves and their families. Doctors instinctively go for the higher threshold. After all, given the choice, no one in their right mind would go to a doctor who is "not good enough".

But I sound a cautionary note. Not all doctors whose patients or colleagues think they are "not good enough" are inevitably flawed. The category includes good doctors who simply have a blind spot that they would willingly attend to if they knew about it. We have all been there if we are honest with ourselves. With regular feedback informing regular appraisal, the problem can be identified, investigated and corrected promptly. No stigma should attach. It is doctors who won't respond who are the problem.

The hidden curriculum

Medical education offers the best way of internalising the values and standards of the new professionalism.

I assume that revalidation will fuel new learning methods and technologies for continuing professional development. We are good at that. The big strategic issue is with the hidden curriculum and with the institutional culture in our teaching establishments.[42] It can have such a huge impact on doctors' attitudes.

If I had to choose one thing in helping to bring about change, it would be to concentrate on the qualities of clinicians with teaching responsibilities as role models of everyday good medical practice. William Osler was keenly aware of this in his day.[3] What we need now are individual medicals schools to take responsibility, and to be sure, at least, that their teaching faculty members are all exemplars of good doctoring. We know from experience that where that can be achieved successfully, the result is high morale all round as well as high patient and student satisfaction — a win for everyone.

Mindset changes summarised

Drawing the threads together, the developments I have described involve at least four serious mindset changes for doctors. Doctors are being asked, first, to accept that in future they must conscientiously follow explicit professional standards of good medical practice (hitherto, these have been, at best, optional); second, to accept through revalidation that they are to become personally responsible for showing that they are maintaining their fitness to practise. Third, systematic continuing professional development will become the normal way through which standards are continuously internalised. And fourth, doctors will have to accept that if, for whatever reason, their practice falls below the threshold of goodness, they will have to put it right promptly or their right to unsupervised practice will have to be limited or stopped until the cause of the problem has been identified and appropriate action taken. That can only be done successfully if regulators and employers adopt a supportive and developmental rather than a punitive approach to managing practice that is "not good enough".

Winning hearts and minds

Obviously, we are most likely to achieve a good doctor for all if the medical profession can see patient-centred practice in a positive light, as the right thing to do for the public and individual patients, and the hallmark of their modern professionalism. The good news is that more and more doctors are not only thinking this way, but also giving practical leadership in their own practices.

In making this difficult cultural transition, I cannot overstate how important it is that, for optimum results, professional standards of practice have to be internalised across the profession. This can only be done by having medical leaders and teachers who are prepared to lead by example, as Osler did, by putting their own clinical practice publicly on the line. They also need to know how to engage hearts and minds, and to be prepared to make the effort to win the argument with as many individual colleagues as possible. It means leaders among the regulators and within the colleges and specialist societies and medical schools, who know how to change institutional cultures. And it means leaders who will not sacrifice the best interests of patients or the longer-term interests of their profession on the altar of short-term political expediency.

It helps enormously if people can see the direction of travel clearly and also the good things that can flow from it. For individual doctors, there should be the greater peace of mind and self-confidence that comes from knowing, and being able to show others, that they are really on top of the job, and therefore known to be absolutely reliable and trustworthy. Doctors who are self-confident and self-aware are more able to take control of their own professional lives, and not to feel that they are being driven by the system as so many do today. Self-confidence, self-respect and self-control beget high morale.

For the profession, there would be gains in being seen to be firmly patient-oriented, and in being able to demonstrate to the public with conviction that the house of medicine is indeed in good order. The result could be a measure of trust and respect in wider society that the collective profession today can only dream

of. That trustworthiness would be an immense strength for the profession and a civic force for good. It could provide the basis for the profession to join with the public, together to play a much more assertive role in helping to shape public policy on the science, ethics and delivery of health and health care as economic pressures make this more and more difficult.

I have no doubt that this cultural revolution in medicine will result in much stronger patient-centred professionalism and professional self-regulation. It will be immensely reassuring to the public and patients, and appeal to the huge majority of conscientious doctors who take pride in the standing of their profession. It makes me wish that I were starting all over again!

William Osler, who epitomised everything that patients want in a doctor, might have wondered what on earth all the fuss was about. He thought that: "In a well-arranged community, a citizen should feel that he can at any time command the services of a man who has received a fair training in the science and art of medicine, into whose hands he may commit with safety the lives of those near and dear to him."[43] For him it was obvious — everyone is entitled to a good doctor.

Competing interests

None identified.

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