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"Professional Ethics in Medicine; its History and its Future"

PRESENTED BY: Professor Russell Gruen

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"Professional Ethics in Medicine; its History and its Future"

DR FRENCH: I would just like to welcome everyone here on behalf of the Medico-Legal Society and, in particular, welcome our speaker tonight Professor Russell Gruen and his wife Dr Theresa Yee.

Professor Gruen is a professor of surgery in public health at Monash University, Director of the National Trauma Research Institute and a surgeon and head of trauma quality assurance at the Alfred Hospital. He graduated in medicine from the University of Melbourne, trained in general surgery at St Vincent's Hospital in Melbourne and then in trauma surgery and surgical critical care at Harbourview Medical Centre in Seattle. From 2006 to 2009 he was associate professor of surgery at the University of Melbourne and the Royal Melbourne Hospital.

Russell aims to support the integration of higher quality research, clinical practice and policy decision making and has a variety of research and policy experiences. He received a PhD for his study of the delivery of surgical services to remote and disadvantaged Aboriginal communities in Northern Australia. In 2002 and 2003 he was a Harkness Fellow in healthcare policy and a Fellow in Medical Ethics at Harvard University in Boston studying medical professionalism and the public roles of doctors.

The focus of his recent research has been clinical quality improvement, optimising systems of surgical and trauma care and improving the use of evidence in clinical and health policy decision making. He is editor of the effective practice and organisation of Care Group in the Cochrane Collaboration, an international organisation

dedicated to making up to date accurate information about the effects of healthcare readily available. He also established the global evidence mapping initiative to bring together a network of people and organisations to develop innovative methods of characterising and texturalising and increasing the accessibility of research in broad clinical areas and he leads a program of translational research in traumatic brain injury.

He has received research funding totalling more than $5m and holds an NH & MRC career development award and has authored over 55 publications in peer review journals. He has also been awarded an RACSGJ Royal Medal, a general surgeon Australia medal and a travelling fellowship of the James IV Association of Surgeons.

I must say when I was reading Professor Gruen's CV I felt like I waste my time a lot. He really has done an enormous amount in a relatively short period.

His topic tonight is "Professional Ethics in Medicine; its History and its Future". Let us welcome Professor Gruen.

PROFESSOR GRUEN: Thank you very much, Rebecca, and as a Melburnian I thank you very much for this generous invitation and the opportunity to come to this fine venue with such an important crowd to talk about a topic that I think is important now and important in the past and I think it will be important in the future.

When Steve Bolsin, a 43 year old anaesthetist blew the whistle on the Bristol Royal Infirmary's high death rates for children's cardiac surgery; the hospital's unwillingness to investigate the surgeons responsible, medicine would be - as Richard Smith, British Medical

Journal's editor, put it - all changed - changed utterly.

I am sure the events of that are well known to many of you. Bolsin had worked for over six years to reduce the number who died on his operating table from one in three to one in 20. What was probably the most important single handed clinical outcomes improvement initiative ever brought about in the National Health Service.

It was his decision to go to the media in 1995, however, with catalysed changes of global significance, such as public reporting of performance, public interest disclosure act and the now well entrenched concept of clinical governments. It was also a decision that sacrificed his job, national popularity and ultimately his young family's life in Britain. Being unable to obtain work in the UK after the ensuing scandal, Bolsin took up a senior appointment in exile at Geelong Hospital, Victoria.

Important as the legal and clinical governance ramifications were, Bolsin's story also focuses the spotlight squarely on professional ethics. On the face of it, Bolsin was a good doctor who in his own words "just couldn't go on putting those children to sleep with their parents present in the anaesthetic room knowing it was almost certain to be the last time they would see their sons or daughters alive". The medical establishment closed ranks denying there was a problem, resisted any change until they were forced to do so by an angry public.

Of course there were many complexities in the Bristol case that were brought out in the Kennedy report and opinions about right and wrong were deeply divided within the profession. It was obvious though that at the end of the 20th Century on both sides of the Atlantic

organised medicine was under siege. While people desperately wanted to trust their own doctor when they were sick, it seemed they had a deep mistrust of the profession when they were well.

Medicine faced an identity crisis. What did it mean to be a good doctor? Who dictated the terms? Such questions are at the heart of what has become known as professionalism, defined by 20th Century sociologists as "the cognitive, moral and collegial attributes of professionals".

I want to discuss what happened to the medical professionalism from this point onwards and ask particularly whether or not the response is sufficient to carry us well into the 21st Century. But first we need a bit more history. The Hippocratic Oath in the 5th Century BC is widely regarded as the beginning of professional ethics in medicine. It required of a new physician "to swear upon the healing Gods that he will uphold a number of professional ethical standards ascribing for the good, never doing harm, keeping away from seduction, keeping secrets" and so on.

In reality though, right up to the 19th Century, doctors found professional distinction pretty difficult to attain largely because the scientific basis of medical practice was rudimentary and the treatments were often harmful. Many doctors resorted to achieving status and authority through public health initiatives rather than clinical practice. This changed rapidly early in the 20th Century as scientific and clinical evidence evolved. By mastering this body of evidence, doctors became valuable to the public. Bacteriology, germ theory, specific

disease-based treatments ushered in the biomedical model of disease for doctors and scientists.

The new medical schools rode this wave that offered cures instead of imprecise tinkerings of public health and by the 1950s income, professional status and authority of doctors far exceeded that of public health professionals. These were the halcyon days of the medical profession.

Then things started to change again. In the latter half of the 20th Century the science of epidemiology demonstrated that most major illnesses were not random occurrences and that people's overall health status depended not only on their treatments but also on a whole range of social and environmental factors. Business and government became the principal purchasers of healthcare, especially in North America. Disparities in health status, unequal access to treatment, bearable quality of care became apparent. Managed care designed principally to control costs failed dismally to do so and by the late 1990s insurance premiums were rising at more than ten per cent per year, 114 million Americans had medical debt problems, 40 million were uninsured.

While Bristol happened on one side of the Atlantic, on the other side there were plenty of high profile cases of poor quality care. There were also some very public examples of professional self interest, such as when the cash strapped American Medical Association decided to solve some of its woes by endorsing for a fee Sunbeam healthcare products. By this time the public had grown increasingly cynical about the medical profession's ability to put aside its own interests and to self regulate standards of importance.

Here is a slide showing the 35-year trend in the proportion of respondents who expressed a great deal of confidence in the health system and its leaders taken from three large long running surveys. Bob Blendon, a Harvard public opinion analyst said to me in 2002 over 30 years American medicine had gone from being one of the most trusted to being one of the least trusted social institutions.

Any 20th Century sociologists such as Talcott Parsons, All Star Terence Johnson took a keen interest in the rise and fall of the American medical profession. But the greatest impact on the profession itself was made by the son of an immigrant Russian shoe salesman, Chicago-based Eliot Freidson whose 1970 study "Profession of Medicine" revealed how the medical profession tended to be blind to its own shortcomings and who spent the next 30 years working to save and nourish professionalism. Freidson distinguished professional work from other work by the fact that it was complex, esoteric and discretionary, requiring theoretical knowledge, skills and judgment that ordinary people do not possess, might not understand and can't readily evaluate.

Furthermore, he argued professional work is especially important for the wellbeing of individuals or society, having a value so special that money can't be its only measure. For Freidson the character of professional work underpinned two fundamental elements of professionalism. The first relates to professional identity. It arises because a relatively demanding period of training is required to learn how to do complex and esoteric work well. Training, he said, tends to create

commitment to knowledge and skill so that the professional's work becomes essential life interest.

Professionals also develop intellectual interest in their work where they are concerned with extending and refining it. They believe in its value to society. They do not merely exercise a complex skill and identify themselves with it. Essentially, what professionals do is not labour only for the income but for the pleasure of something more.

The second element relates to professional duty, in particular a fiduciary relationship with clients, because although professional work is highly valued it is too complex for clients to evaluate it accurately, therefore they have no choice but to place more trust in professionals than they do in others. Freidson argues that professionals are expected to honour that trust therefore the client's needs must take precedence over the professional's needs to make a living.

Many such as Dick Crews, the former Dean of Medicine at McGill, embraced the concept of a social contract. Dick argued forcefully in his leadership of the American Board of Internal Medicine's professionalism project that the privileges physicians enjoy including monopoly, use of knowledge, considerably autonomy in practice and being allowed to self regulate, not to mention awards and social standing. Consequent upon their commitment to competence, integrity and morality the altruistic tend to promote the public good. If professions fail to live up to expectations, he argued, society will withdraw its trust and the privilege it bestows.

In fact the social contract was not a new idea. The

last line of the Hippocratic Oath reads "If I keep this oath faithfully may I enjoy my life and practise my art, respected by all men and in all times but if I swerve from it or violate it may the reverse be my lot". In the year 2000 this proposed contract had a new veracity, plenty of examples where the profession was caught falling short of its part of the deal.

The last decade has seen a spectacular and sustained response to the medical profession. The catalyst was the publication in February 2002 of a charter of medical professionalism. It was a bold restatement of the responsibilities of doctors as professionals, casually referred to as "a modern Hippocratic Oath". The charter had its critics, it reflected a particularly North American view and arose mostly out of the discipline of internal medicine. Nonetheless, it was given teeth by the American Council of Graduate Medical Education and the American Board of Medical Specialties Requirement that as of July 2003 all American medical and specialist training programs had to teach and assess professionalism as a core competency.

The concept of professionalism rapidly gained traction. The charter provided a roadmap. It defined three fundamental principles: primacy of patient welfare, patient autonomy and social justice. The first two were uncontroversial. Social justice, however, and its implied responsibilities for public roles that redress social inequalities was greeted with some ambivalence and much confusion; teasing this out became the topic of my Harvard Fellowship year in 2002 and 2003. The charter described end commitment: professional competence, honesty,

confidentiality, appropriate relationships, managing conflicts of interest, improving care quality, improving care access, to adjust distribution of resources, increasing scientific knowledge and to maintain the profession itself.

A plethora of codes of practice and professional conduct emerged, many of which built upon the charter. I am not in any way dismissive of their importance, it is just that there is a lot of them. I have personally been involved in drafting the codes of professional conduct of both the American College of Surgeons and the Royal Australasian College of Surgeons. Each has been a very enjoyable gathering of experienced and thoughtful people wanting to advance the cause of the profession, the wellbeing of patients and to do something important that will positively influence future generations and largely they have succeeded. The codes have spawned teaching materials, assessment tools, public statements and are the topic of many worthwhile formal and informal discussions. In a decade across the world doctors in training are better versed about the non-technical aspects of their work than ever before.

Yet in all of this activity I think there is something missing, something not quite right. We reflect on Freidson's fundamental elements: professional identity and professional duty. The charter's principles and commitments and those of all the codes that have followed are very much concerned with the duty and little to do with professional identity. It is not that different to the Hippocratic Oath some 2500 years ago. They are rules lauded down from all high, social contract just like the

last line of the Hippocratic Oath, it is the carrot and stick assuring compliance.

I believe there are two problems with this in the 21st Century. The social contract is no longer and may never have been a robust concept. The carrot and stick is not the best way to motivate desired behaviour. The first problem was with the social contract. It is not the individual principles and commitments in the charter itself that are the problem. Although they tend to be abstract and devoid of context there is almost no one who would disagree with any of them. We know this because we have surveyed 1600 physicians across North America and have over 94 per cent strong support for each of them.

The problem lies with the contractual arrangement between society and the doctor. If there ever was a direct quid pro quo between good behaviour and the public's bestowing of privilege it has been diluted and separated by multiple degrees through increased complexity of clinical care, increased numbers and types of stakeholders in the process, commercialisation of the healthcare endeavour, government regulation and control.

While the old-fashioned notion of the trusted doctor and his patient still holds true, in the intimate environment of the consulting room or the focused environment of the operating theatre it breaks down as soon as the patient goes out the door. Others become responsible for parts of the care, multiple intermediaries involved in service provision, patient obtains a deluge of information with the media or the internet. More than ever before patients have access to information about their condition and what to expect from their care. They

are not all as well informed but they don't know that. No longer can we assume that a fiduciary relationship must exist because patients can't evaluate the quality of care accurately.

In fact the courts in the United States upheld this view. Goldfarb v. Virginia State Bar in 1975 even, the court unanimously ruled that the professions of law and medicine were subject to the rules of the marketplace and were not exempt from anti-trust regulation. They were considered ordinary purveyors of commerce - no different from any other business.

In Pegram v. Herdrich in 2000, the Supreme Court ruled that under the Employee Retirement Security Act of 1974 physicians do not have a fiduciary relationship with their patients. According to common law, a fiduciary relationship is the highest duty owed by a professional to a client. The court issued a new definition of the physician/patient relationship wherein physicians act not only on behalf of patients but also on behalf of health maintenance organisations. If it ever existed, the social contract is no longer what it used to be. However, it also leads me to the other problem, that is about the lack of attention to professional identity, the best means of motivating doctors to behave professionally.

It is here that I think we turn to another type of sociology. It is the sociology portrayed in the latest blockbuster film "The Social Network". For those of you who have seen it, I am sure you will agree it is a wonderful film. It chronicles the evolution of Facebook, an idea at Harvard College that dawns in 2003, the year that I was at Harvard blissfully studied professionalism

in health policy, to become an entity that is now valued at over 60 billion dollars. Facebook's success is based on its ability to capitalise on two fundamental human desires: the need to be part of a community; the need to be personally successful.

On Facebook the community was the "in" crowd, the markers of success of scoring with the most attractive of the opposite sex, but the message is the same for anything: if your enterprise hooks into motivators that are deeply situated you can get lasting success. Medicine and I am sure law still attracts the best and brightest and they are generally motivated by high ideals. I see this in plenty of our residents and students.

But as Haile Debas, Dean of Medicine at UCSF said to me "If we take the most idealistic creatures on the planet in four years we can turn them into ordinary folks with ordinary motives". We have not found through all the exhortation of principles in carrots and sticks a way to reliably sustain their ideals through all the other things that happen in their lives and influence their behaviour.

Of course this is also Generation Y. We all know them. As a group they have been characterised as being unwilling to sacrifice personal life to succeed in their work. They tend not to value title status or experience and, importantly, they demand flexible environments and benefits. Their adult life has been characterised by an expanding job market and a shrinking workforce and this has significantly impacted on their view of the world and their career outlook. They are ambitious, confident, demanding and impatient. They are highly educated, debt ridden, digitally and internet immersed. Often they are

described as narcissistic, little understanding or regard for corporate behaviour.

A 2007 questionnaire conducted by the Association of American Medical Colleges more than half of the graduating medical students agreed that a physician's work interferes too much with family relations and other interesting pursuits. This generation are less likely rather than more likely to be influenced by principles exulted from the high altar of professional society who they are just as likely to regard as old-fashioned.

A neat little book titled "Drive - Surprising Truth about what Motivates us" Daniel Pink offers an alternative. He reveals that while carrots and sticks may be useful for mundane tasks they are ineffective in many situations and can stifle high level creative exceptional abilities, rush intrinsic motivation, diminish performance and foster short-term thinking. Complex or creative pursuits in medicine must fall into that category. Pink argues the secret to high performance is not our reward and punishment drive, it is our deep-seated desire to direct our own lives, to extend and expand our abilities to live a life of purpose.

This sounds to me quite unlike principles and commitments of professionalism. Just as it sounds unlike principle-based ethics of beneficence, non-maleficence, autonomy and justice. I personally do not think those principles speak to our deeply held values.

Miles Little, a surgeon and founder of the Centre for Ethics, Values in the Law and Medicine at the University of Sydney made similar observations about surgical ethics. As Miles Little said, principle-based

ethics failed to capture the extreme nature of the surgical experience, the vulnerability that it entails and what that means for the way the surgeon understands himself and the surgeon/patient relationship.

Based on his ethnographic research in cancer survivors he defined five characteristics of a surgical ethic. Patients perceive the need for rescue from something so serious that it warrants surgery; proximity of the surgeon to parts of the patient that not even the patient knows about; an operation and its aftermath as ordeals to be endured and the reassurance provided by the surgeon's presence in the course of surgery and during recovery.

Instead, I think Pink's message echoes the flavour of Freidson's first element of professionalism: the importance of a robust professional identity. Secrets to motivating professional behaviour may now be to have a clear view of what constitutes professional behaviour and to bolster professional identity. We must have good role models. Build on the long history of thoughtful work that I have described to show us what service to patients, integrity and accountability, pursuit of excellence and fairness.

We must celebrate our autonomy, to make important decisions within the clinical relationship. We can foster mastery of our craft in the pursuit of excellence. I see this in the sheer joy that colleagues get when they discover how to do something better. We can recognise and embrace without carrots and sticks the fundamental purpose for which we strive. Steve Bolsin showed us there could be nothing more important to justice and wellbeing.

DR FRENCH: Professor Gruen said he is happy to take some questions, so we have got a microphone if anyone wants to start.

QUESTION: Thank you, Russell. One of the privileges of being a professional, as you mentioned, is autonomy, the privilege of making decisions about your patient. If you look at it ethically the highest level is to make a decision which is in the patient's best interest. Are you concerned by the fact that hospital administrators are taking these sorts of decisions to the courts: decisions such as removing nasogastric tubes, pegs and tracheostomies and that this is in fact undermining professional autonomy.

PROFESSOR GRUEN: Thanks for the question. I am going to answer it a little bit obliquely in that I am often dealing with slightly tricky decisions: conflicts between clinicians, obvious cases of quality failures, a quality improvement committee where we really have to deal with problem cases. Sometimes there are differences of opinion between management and patients and sometimes patients have gone to the courts and are confronting to us with legal representation.

Fundamentally, the way to handle those situations and those dilemmas are in the patient's interests, the moral compass where true north is always what is best for the patient. It does not need to dismiss the importance of all the other drivers of the billion dollar healthcare endeavour that we are all part of, but it does remind everybody that fundamentally you are on strong ground if you are arguing what is in the best interests of the patients and people have a much weaker argument and if

they are arguing for something else they need to be able to very much substantiate and argue forcefully in a way that can overcome the importance and significance of what is in the patient's best interests.

So, keeping that as true north on the compass is a tool that I and my colleagues use for resolution of difficult situations.

QUESTION: Thank you for your informative talk. I just wonder whether you can comment on the fact that in the past year or so there has been a lot happening from a parliamentary position where legislation has come in to regulate health professions and there is obviously now a lot that has been discussed to do with the way that this is operating, particularly to do with the operations of APRA. Do you believe that the new regulations and the way that it has been handled will improve the sorts of things that you have been talking about?

PROFESSOR GRUEN: I am an optimist. I think we are still seeing the way that is evolving and what APRA's mandate will really be and how it is going to change (if anything) the way we all work. I think there is going to be substantial money behind it and it is probably going to therefore be able to offer plenty of carrots and have a number of sticks up its sleeve to change things and we are going to have to wait and see how that pans out. I still fall back to the position that I think most of us in this room and most of the people who I work with are innately good people who wanted to do well and do the right thing and there have been a lot of insults and assaults over the last century through which doctors and lawyers have endured, have adapted and have continued to promote the

fundamental cause for which they work. So, I do not think that any, say, transient Federal Government legislation about regulation is going to fundamentally change what we do but it might make it a little uncomfortable at the edges.

MS CUE: My name is Kerry Cue, I am not a doctor or a lawyer, I am a journalist and therefore I am free and I think this is a good forum to ask this question. If doctors are forced by fear of litigation to adopt check box or tick box diagnoses or performance, how can they exercise their complex skills that you were talking about?

PROFESSOR GRUEN: You started that question - - -

MS CUE: Do you want me to say it again?

PROFESSOR GRUEN: No, you started the question with "if".

MS CUE: Yes, I did, I started with "if". I would say they are being forced to follow tick box diagnoses and performance.

PROFESSOR GRUEN: I think there are a number of complex aspects to that question. One is yes, we live in an era of evidence-based medicine where it is probably much clearer what many standards of care are and there is an agreement both within the profession and in the broader medico-scientific community on what they are.

Secondly, there is increased ability to understand and know what doctors are doing through tracking their prescribing habits, through understanding their operation that they perform, through measuring their outcomes, through monitoring hospital discharge/readmission rates, unplanned returns to theatre, surgical side infections, all those sorts of standards of care.

Thirdly, as I mentioned in the presentation, there is an increasingly demanding public who is more informed

about what they expect out of their healthcare who often come brandishing the printout from the internet that says "I want you to do this because this is what I read on mybowelproblem.com. Within all of that we still have an individual's autonomy to make some decisions. We need to do with that with the patient who comes brandishing the report in the context and within the boundaries defined by the administrator who runs our hospital within a society that is measuring and monitoring what we do and in Australia that is far less than what it is in the United States or the UK, mind you. We have only had kind of the threat of public reporting of performance made by the prime minister last year. We have not seen any moves towards that actually happening, whereas in the UK your name is there on a league table of your complication rate from cardiac surgery or bowel surgery or whatever and your hospital is there amongst the other hospitals on a league table and the public can see exactly what your rate is and compare it to the others. There is a serious threat to individual sort of autonomy in that, but it has not translated in the UK to be the complete dismantling of professional practice nor is it thought to be in the future. So, I am an optimist. These are real world constraints. Medicine is an expensive business. It is an important business. It should not be allowed to just shoot blindly with the treatments that we have at our disposal.

DR PRAGA: Shirley Praga. Thank you for your lecture. I notice you were talking a fair bit about the USA and about health maintenance organisations and over the last I guess 30 years in various organisations such as the AMA and the

Australian Doctors' Fund, I have been involved with many others in fighting the introduction of US style managed care into Australia and to some extent successfully in the private sector. I wondered what you thought about the importance of these organisations in maintaining the ethical practice of medicine and the law.

PROFESSOR GRUEN: First I want to congratulate you for a successful defence of our shores. Dr Lilian Kow, who is a guest of ours from University of Texas and incoming President of the Academy of Academic Surgeons, and I were talking today about the problems of the managed care environment. Managed care as of the sort of '70s/80s/90s was an ogre and has been widely perceived to be the cause of many ills.

In reality, it was just the marketplace operating in a system that allowed it to operate. It did not have a fundamental platform of universal access to healthcare, a society that said everybody is going to get a basic level of healthcare regardless of market forces and it did not really offer any protection therefore managed care flourished.

As I said, it was designed to control costs. It failed dismally in part because of profit, managed care organisations as well as not for profit managed care organisations, a duplication of the administrative function was far more inefficient than Medicare or Medicade (as the national organisation is in the US) and of course our Medicare system. And for a variety of reasons, including the fact that healthcare rights are being attached to work privileges was a consequence of post-war America where one of the ways that employers had

of attracting a scarce workforce in the mid '40s was to say "We will give you free healthcare if you come and work for us".

This idea took off and all of a sudden you have got a very large section of the population who have healthcare while they are full-time employees of big companies and as soon as they get self-employed, casual or stop to have babies or anything of those things they lose their healthcare. It takes a whole system reform which Hilary Clinton failed to bring in, which Obama has not yet successfully brought in and which seems to be able to be torpedoed by rockets of conservative elements of the American medical marketplace and very successfully. So, congratulations to you. I think it has been a fight well worth fighting and Australia is certainly the better for it. Thank you.

DR FRENCH: Thank you very much, Professor Gruen, and some good questions and I would just like to ask Dr Raphael Kuhn our medical secretary to give a vote of thanks.

DR KUHN: Professor Gruen, on behalf of the Society I would really like to thank you for a truly illuminating and insightful presentation on medical professionalism on ethical professionalism in medicine. It has been very thought provoking and makes the medical profession realise just how many challenges we have to face especially the one of professional identity. I would like you to accept a small token of our appreciation for an absolutely superb presentation.

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