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John P. McGovern Award Lectureship

PATIENTS, THEIR DOCTORS AND THE POLITICS OF MEDICAL PROFESSIONALISM

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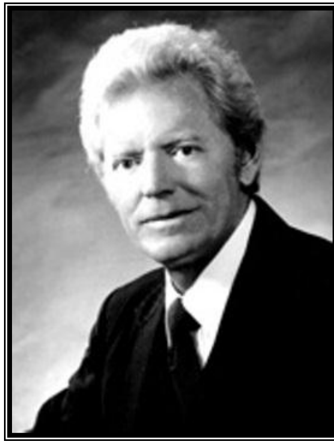

John P. McGovern, M.D.

Through the generosity of the John P. McGovern Foundation to the American Osler Society, the John P. McGovern Award Lectureship was established in 1986. The lectureship makes possible an annual presentation of a paper dedicated to the general areas of Sir William Osler's interests in the interface between the humanities and the sciences-in particular, medicine, literature, philosophy, and history. The lectureship is awarded to a leader of wide reputation who is selected by a special committee of the Society and is especially significant in that it also stands as a commemoration of Doctor McGovern's own long-standing interest in and contributions to Osleriana.

On the cover - The John P. McGovern Award Lectureship commemorative medal which is presented to each annual lecturer.

The 29th John P. McGovern Award Lecture

PATIENTS, THEIR DOCTORS AND THE POLITICS OF MEDICAL PROFESSIONALISM

by

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Although retired from practice, Sir Donald is Honorary Professor, School of Health in the University of Durham, a Vice President of the U.K. Patients Association, Patron of Picker Institute Europe and President of Age U.K. Northumbria.

For most of his professional life, he was a partner in Lintonville Medical Group, one of the first multi-disciplinary teaching family practices in the U.K. He was one of the founders of medical education for family medicine and through the Royal College of General Practitioners had a leading role in developing practice-based quality assurance through standard setting and medical audit based on peer review.

Sir Donald chaired the Professional Standards Committee of the General Medical Council before his election as President in 1995. Fostering a culture of patient-centred professionalism in medicine and modernising professional regulation were central themes of his six year Presidency. He led the development of *Good Medical Practice*, the national code of practice for the U.K. medical profession today, and of re-licensure for British doctors through the process of revalidation.

Among his honours, Sir Donald was appointed CBE in 1986 and Knighted in 1994 for his services to medicine and medical ethics.

Introduction

Jay Iselin, the distinguished U.S. television journalist and editor, died in a hospital in New York on May 6, 2008. His wife Lea felt compelled to write about his struggles with the increasingly complex medical condition that finally brought him down.[1] Sometimes Lea said his doctors in various U.S. hospitals, all very prestigious institutions, helped him, sometimes he was left to coordinate his various medical problems on his own, sometimes neglected at crucial moments and at others subject to actively negligent care. Throughout, Jay considered each of his doctors a personal friend in whom he continued to place his utmost trust. In his wife's view, this trust was frequently misplaced, at times in fact acting as a negative factor in his medical care, for it tended to distract the doctors from focusing their attention on Jay's serious problems. I met Lea two years ago. Her memories of her husband's experience were still raw. Lack of consistent clinical quality and coordination had been recurring, serious problems.

Here in Britain, we have recently seen the tragic consequences of some persistently poor medical and especially nursing care affecting nearly 1200 patients at the National Health Service's (NHS) Stafford Hospital. Robert Francis QC, who chaired the Stafford Hospital Public Inquiry, said such poor care would not have happened if all doctors and nurses had conscientiously observed their codes of professional practice.[2] I very much agree. His observation is echoed in several other reports on British medical failures[3-5]and other countries have experienced similar problems too. Francis saw the underlying problem as essentially one of culture, which he explored both in individual professions and in the organizations – hospitals, clinics and offices - where doctors and nurses practice. Like others before him he showed how difficult it is to change professional cultures, particularly where they may be self-protective, perhaps because trying to change them can get so very personal.

Today we honour the memory of William Osler, the great doctor who epitomized professionalism at its finest. In his textbook of medicine, his up-to-date knowledge was there for all to see. He obsessed about the need for early diagnosis. He had a huge respect

for patients and colleagues alike. He had a strong sense of the rights and wrongs of professional conduct. He was an inspiring bedside teacher. Osler knew all about variations in professional practice, which in his day ranged from the excellent to the execrable. Were he here now, he might well wonder why such a successful profession, which in the last half century has helped so many patients in ways that he could scarcely have dreamed of, could still find itself unable to insist on a decent standard of practice from all its members, not just the conscientious majority. He would see Jay Iselin's story and the calamitous practice at Stafford Hospital as examples of the problem.

Today, every country is wrestling with the ever-increasing complexities, costs and risks involved in modern health care. These pressures are increasing inexorably. Achieving consistently good quality care at the lowest reasonable cost has become an imperative for everyone.

It follows that we doctors have a strong moral obligation to make sure that, however our healthcare systems evolve in the future, the individual members of our profession - every single one- consistently gives optimal medical care. By optimal care, I mean the best medical care achievable under normal operational circumstances. Patients expect this standard to be a given. Doctors on the whole support the idea of optimal practice – good doctoring. However some see it as an aspiration without commitment, something to aim for, rather than an obligation to deliver. Hence the powerful, unresolved tension between aspiration and obligation seen in the longstanding toleration of widely variable standards of practice. It is the process of trying to eliminate this tension by moving the profession to where the public today wants it to be – something I call the politics of medical professionalism – which is the challenge and the subject of my lecture this morning.

Since I started practising in 1958, I have had a ringside seat, and indeed considerable personal involvement, as the process of cultural transition has unfolded in Britain. The experience has taught me just how difficult it is for the profession to change from a traditional doctor – centered professional culture to a patient-centered

professional culture in tune with public expectations now. However, it can be done, as I will show you later. Nurses, incidentally, face the same challenge in their professional practice, but that is a story for another day.

What patients want

So what do patients want? It is pointless to think about medical professionalism unless we can see it through patients' eyes. It is the patient who has the illness and who is - or should be - the final arbiter of what is right for them. It is their body, their mind, their illness and their life. We are in the era of patient autonomy.[6] A political environment in which patients expect, and are expected, to be in relatively autonomous doctor-patient relationships is replacing the historical model of passive patient trust.

Unlike doctors, patients do not talk about professionalism as an entity. Instead, they equate professionalism with consistently good doctoring. For them 'good doctors' are up-to-date, competent, respectful, courteous, kind, empathetic and honest; people who will listen to them, relate to them, do their best to find out promptly what is wrong with them, prescribe the right treatment and care for them in a manner which makes them feel that their interests come first.[eg7] Patients want their doctors to be good team players when teamwork is needed. All these qualities are essential elements of a trusting doctor-patient relationship, as Osler understood perfectly. They have not changed with time.

My wife and I can attest to this picture from first-hand experience. Nearing eighty, we both have long-term conditions and so see more than we would wish of the NHS in action. We have an excellent family doctor, Dr. Andy Bell. However, in our encounters with NHS services we have seen it all – the good, the bad and, in between, the many shades of grey mediocrity which evoke grudging acceptance from patients rather than fulsome praise. The factor distinguishing between the exceptional, the good, the grey and poor medical practice comes down mainly to the attitude and ability of individual clinicians. Such is the lack of consistency that we have asked two

daughters to watch out for us, to protect us from poor NHS medical and nursing care if we become incapable of doing this ourselves.

Patients now have more information than ever about the results of care given by individual clinical teams and clinicians. With such knowledge comes power. Yet even today the NHS too often expects patients to be the unquestioning, grateful recipients of state beneficence rather than discriminating users who have paid their taxes to help fund the Service and who can decide for themselves which providers and choices of treatment are best for them.

Freely available and easily accessible information about the quality of outcomes, clinical performance and patients' experience of care given by individual clinical teams and clinicians is the foundation of patient autonomy. Our new digital world of social networking, when combined with complete transparency about clinicians' performance and outcomes, enhances the power in patients' hands and therefore the choices patients can make based on evidence of quality. For example, today anyone can access the knowledge base of medicine directly without mediation by a doctor. Similarly, thanks to the late Harvey Picker, distinguished American manufacturer of x-ray machines and philanthropist, the methodology now exists to give the public accurate information about the experiences that patients and relatives have had with individual doctors and nurses and whether that experience accords with published professional standards.[8]

If knowledge is power, all these developments will transform the relationship between patients and doctors in future. Rather than regard these developments as a threat, doctors should see here opportunities to rethink the conditions for continuing patient trust. Even today patients want to be able to trust their doctor without having to think about it. For that to happen, the basis for such trust must be absolutely sound.

It follows that patients want to know that doctors they are consulting today are practising to a standard that is 'as good as it gets' - their way of describing optimal care. Naturally patients expect continuous improvement as medical science advances, but for them generic improvement is not the same as, or a substitute for, a guarantee of

their doctor's overall professionalism at the time of a consultation. That's where the obligation comes in. Patients know that there is an unquantified tail of grey or frankly suboptimal practice visible in the doctors they try to avoid if they can.

So, as I said at the beginning, the critical question now is how to change the medical culture so that suboptimal practice becomes unacceptable - unprofessional - to doctors as well as patients. It is primarily a cultural issue rather than a regulatory one. To succeed, we first need to know why the medical culture came to be as it is.

Why is the medical culture as it is?

To answer to this question, we must go back to the modern profession's roots in the mid-19th century. The original driving force for state recognition of medicine as a profession, through licensure, was the desire of allopathic practitioners to be recognized as people who were uniquely knowledgeable about the human body, its diseases and how best to treat them. Allopaths, therefore, believed that they were very different from, and self-evidently much better than, all the other 'quack' healers of the time.[9] There was a strong element of self-interest in this claim of distinctiveness because of its implications for power, status and income.

Abraham Flexner got to the heart of the matter in his 1910 landmark report on medical education in the United States and Canada.[10] He described how, in the previous century, allopaths had simply assumed themselves to be a profession and how medicine's unfolding status and self-image as a profession have influenced its behavior ever since. Practitioners who had undergone the necessary training in medicine and secured registration/licensure granted by the state were presumed to be professionals by both the medical community and the public. From that point on in doctors' careers, the particulars of their future practising styles, their competence, their attitude to patients and colleagues, their ethical principles and ethos of service were deemed to be largely a matter for the individuals themselves to decide because - well, they were professionals. This was personal professional autonomy in action.

Doctors joining the profession absorbed this inward-looking, doctor-centered culture. They brought their culture to the running of healthcare as they assumed leadership roles. Of course there were 'club' rules - expressed as professional etiquette - made by the members for the members about things that mattered to them. Clinical competence was a no-go area unless it appeared so bad as to constitute 'serious professional misconduct'. Hence the ban on criticizing a colleague's clinical practice, known in Britain as disparagement.[11] Many doctors felt themselves entitled to, as opposed to deserving of, respect from the public and patients because of their 'professional' status, carrying with it the assurance of income, their standing in the community and freedom from overt accountability.

It is therefore easy to see why any sense of collective self-discipline was difficult to sustain given the many ways in which the public interest could collide with this kind of professional self-interest. For example, in 1912 the American College of Surgeons decided to overhaul American surgical practice. The transformation was to be guided by Ernest Codman's ideas about clinical end results (today's clinical outcomes). Codman was a quality-minded surgeon at Massachusetts General Hospital. The College rejected Codman's data-based, end result approach as too contentious after it found that only 89 out of 692 hospitals examined could meet the standards. Shocked, the Regents of the College burnt the original survey data and draft report in the furnace of the Waldorf Astoria Hotel in New York.[12]

The College decided instead to go for 'minimum standards' for hospitals covering such non-threatening matters as the organization of staff, the rules of professional conduct and the maintenance of medical records. These measures were to form the basis for future specialty accreditation in the U.S.

We had a similar self-protective attitude in Britain. For example, the General Medical Council (GMC) was established in 1858 by parliament - at the profession's urging - as its new self-regulator. In 1889, the President of the GMC said that the Council "should not seem over-anxious to be at work"… since …"the spreading abroad

of the shortcomings of any erring members of our honourable profession is a proceeding to be carefully restrained within precise limits."[13] George Bernard Shaw soon rumbled this self-protective nonsense. In 1933, in a postscript to his play The Doctor's Dilemma, he said, "the condition of the (British) medical profession is now so scandalous that unregistered practitioners are more popular with patients than registered ones."[14]

Medicine's self-protective attitude helps to explain why Flexner was convinced that any movement by the profession towards meeting societal rather than self needs would be driven mainly by the pressure of public opinion rather than by motivations arising from within medicine itself.[15] But in the first half of the twentieth century such pressures barely existed. It did not matter. Medical treatment at that time was largely ineffective – nature would take its course despite anything doctors could do.

After World War II, the standing of the profession really took off. There were great advances in medical science and practice, which the public loved. The American sociologist Eliot Freidson called the period between 1945 and 1965 "the Golden Age" of U.S. (and British) medicine for it gave individual doctors almost complete control over their work. However the downside, he noted, was that "only the most grossly incompetent or negligent behavior led to disciplinary action."[16]

The effect of this professional dominance was to reinforce a concept of professionalism and professional self-regulation in the minds of generations of doctors wherein their own values, priorities and special interests should naturally predominate. One result was the reinforcement of a strong paternalism in the medical culture. Another was that the profession seemed unable to grasp the significance of the changes beginning to happen in the 1970s and 1980s as Western governments introduced more managerialism and external regulation in pursuit of greater accountability and consistency in the quality of healthcare.

The first serious challenge to the power of the British medical profession came in 1984 with the famous case of Alfie Winn.[17] Alfie,

age eight, had become ill with vomiting and a high temperature. His parents called their family doctor, Dr. Arthur Archer, who arrived three hours later. Archer asked Alfie to open his mouth. The boy seemed comatose and his mother said, "He can't hear you." The doctor said, "If he can't be bothered to open his bloody mouth, I shall not bloody well look at him." He prescribed an antibiotic. Two hours later the distraught family took Alfie to a hospital where he died four days later of meningitis. Appearing before the Professional Conduct Committee of the GMC the doctor was found not guilty of serious professional misconduct.

The public was shocked by this outcome. Alfie's case had attracted much publicity because he was the mascot of the Sheffield United Football Club. Alfie's Member of Parliament took up the case. There was an unsuccessful attempt in parliament to make the GMC lower the threshold before which it would take action on a doctor's registration. Nevertheless, through Alfie's case the way was now open for rising public pressure, supported by concerned doctors, to try to force the profession to take issues of clinical competence seriously in future.

In 1998, Mrs. Jean Robinson, a patient advocate, got to the nub of the profession's general indifference to competence questions when she said, "no medical profession in the developed world could have had a body of patients who are more docile and grateful than the British since the formation of the NHS…Only when a sufficiently large number of patients and their relatives had been radicalized did we begin to see change and a discussion of (competence) problems in the media."[18]

Flexner's prediction at the beginning of the century, that only consumer power would stir the profession to act, was beginning to ring true.

The start of cultural change: adopting a national code of medical practice

So what was to be done about changing the professional culture? From the 1970s the GMC in Britain advised on professional

behaviors that could constitute serious professional misconduct.[11] Doctors generally ignored this negatively expressed advice.

However by the early 1990s, things were changing. For example, in Britain young men with AIDS, facing almost certain death, were redefining patient autonomy. They wanted medical care on their terms. There was growing public pressure for more openness about medical practice. New, very persuasive lay (public) members of the GMC were steering their medical colleagues towards greater patient-centeredness. And I have mentioned the public concern about the tolerance of poorly performing doctors. These were some of the factors that led the GMC to decide that it must publish a positive statement setting out the professional duties and responsibilities of all doctors registered with it. Virtually unrestricted personal professional autonomy, particularly on clinical matters, was no longer an option. Doctors needed to know what was expected of them and patients needed to have a yardstick against which to judge their doctor's practice.

The result was Good Medical Practice (GMP), launched in 1995.[19,20] This was the moment when the GMC signaled to the public and the British medical profession that it intended to replace the traditional doctor-centric culture with a more overtly patient-centered culture of professionalism. The advice was called 'good' medical practice because it told everyone about the generic standards of practice expected of every registered British doctor. It was written in plain English. The emphasis was on professional obligation, not simply aspiration without commitment. It was made absolutely clear that it applied to every individual.
Whilst GMP was being prepared it became obvious to those of us closely involved that motivating levers would have to be used to get the profession to take it seriously. This is why the GMC began to use GMP in its fitness to practice committees. Charges against erring doctors started to be framed as alleged breaches of the generic standards of GMP. At the same time, GMP became the foundation of the new guidance on basic medical education – Tomorrow's Doctors.[21] Thus the medical schools, the medical royal colleges and the postgraduate training organizations knew that they had to make GMP the foundation for all British medical education.

Good Medical Practice was the first national code of practice for the medical profession in the world. It has since been adopted as the national standard in Australia[22] and New Zealand.[23] Elsewhere there have been several specialty-specific initiatives. For example, in 1999 the U.S. Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) jointly began the Outcomes Project to define competencies that would be used in accrediting graduate medical education programs and in framing requirements for the ABMS Maintenance of Certification program (MOC).[24] This project identified the six general competencies widely used in the U.S. today. In 1996, the Royal College of Physicians and Surgeons of Canada adopted the CanMEDS Physician Competency Framework describing the core knowledge, skills and abilities of specialist physicians.[25]

In 2005 the US Federation of State Medical Boards (FSMB) started informal consultations with other interested organizations to promote effective medical regulation. One result was the creation of the informal National Alliance for Physician Competence, charged with producing a US version of Good Medical Practice. The various entities responsible for educating, licensing, certifying and credentialing U.S. doctors all recognized that they had no common language or framework for fulfilling their responsibilities in a consistent way, and needed one. GMP-USA was intended to present a common view of professional responsibility for U.S. and Canadian doctors.

The GMP-USA was published online in 2009[26] but it was never adopted by any of the constituting bodies. The main opposition came from the American Medical Association. The AMA's objections were set out in the December 2008 letter to the authors from Dr. Heyman, chairman of the AMA Board of Trustees.[27] Words like "demonstrate" and "take personal responsibility" and so on were unwelcome. The AMA wanted a document that would be aspirational, for improvement, not for setting standards against which doctors could be held to account. The tension between obligation and aspiration without commitment, which I mentioned earlier, was revealed for all to see.

Jim Guest, President and CEO of Consumer Union, was a member of the GMP-USA group. He and other public members wrote a wonderfully clear preface summarizing patient expectations of doctors. However, it proved to be too challenging. As a result of external pressure the preface was demoted to an appendix attached to the final report.

Today the U.S. and Canada still have no national code of professional practice for their doctors. I hope that another attempt will be made because, without national codes, I cannot see how the profession in North America will be able to meet public expectations of consistency in future.

Making the code stick: achieving consistency of practice through re-licensure

Having a code of practice is one thing; making sure that all doctors observe it conscientiously is quite another.[28] We come hard up against the boundary between obligation and aspiration without commitment. In 1998, the GMC began to confront the issue by deciding that licensure, hitherto granted on completion of basic medical education, would cease to be a once and for all indicator of professional competence. Instead it would become a continuously updated, evidence-based statement of all doctors' current fitness to practise in their chosen field, renewed every five years.[29] It was the definitive lever needed to bring Good Medical Practice into the daily lives of every British doctor.

The process, called revalidation, came into effect in December 2012. Revalidation is based on a portfolio of evidence, gathered continuously in the interim years, showing that a doctor meets the generic standards set out in Good Medical Practice and specific specialty standards determined by the relevant medical royal college or specialist society. Every year the evidence of performance is reviewed in an annual workplace-based appraisal. Think of it as a form of Maintenance of Certification (MOC) that the State licensing authorities might require in future of every U.S. doctor, not only those who volunteer.

Why did the GMC take this step? After all, no other country had done so. The trigger was the fallout from the crisis in pediatric cardiac surgery at the Bristol Royal Infirmary.[4,30] In June 1998 the GMC found two consultant surgeons and the medically qualified CEO of the hospital guilty of serious professional misconduct. The doctors had allowed heart surgery on infants to continue knowing that the death rate was twice the average in the U.K. Parents - and the nation - were furious.

But behind Bristol was more general public unrest. As I said earlier, this had surfaced with Alfie Winn and been reinforced by several more recent high profile failures in clinical practice. Despite the warning signs the professional bodies and the NHS were still not protecting patients properly. Clearly a reactive system of licensure, which required a complaint or a disaster to trigger action and a high bar of 'serious professional misconduct' to be overcome, was unfit for purpose in late 20th century healthcare. Consistency nationwide would be better achieved through a renewable license to practise that every doctor would be expected to honour conscientiously, every day.

At the same time, government introduced sweeping changes to the NHS in the form of the National Institute for Clinical Excellence, a national institutional regulator - currently called the Care Quality Commission - and the process of clinical governance operated by employers in the workplace. It was intended that the managerial and professional measures for assuring quality and safety would be mutually supportive but the process has been painfully slow because of foot dragging by some NHS managers and elements of the medical profession.

The revalidation decision in 1998 divided the profession. I was President of the GMC at the time. In the frantic process of achieving agreement for implementation between 1998 and 2012, the loose coalition of reformers held together by the GMC was the key driver.[31,32] The profession split between reformers - the GMC, royal colleges and patients' organizations - who wanted a robust, evidence-based, national process with public participation and external scrutiny, and the conservatives - led by the BMA -who objected to

the linkage of individual performance review to licensure because of the implications for the continuing right to practise of doctors whose performance was an issue. The government stood slightly to one side hoping, as one senior civil servant told me, that "the good guys would win." Over the years, and after I had left the GMC, the battle swayed this way and that with a dramatic intervention in 2004 by a High Court judge, Dame Janet Smith, in her inquiry into the practice of a killer family doctor, Harold Shipman. Dame Janet said in no uncertain terms that the adoption of watered down assessment proposals favored by the conservatives would not comply with the evaluation of practice required by the recently amended Medical Act governing British medical practice, which the profession itself had asked for.[33] As a result of her intervention the plan finally adopted does comply, just.

Nonetheless, three big questions remain unanswered today. Will the GMC actually adopt optimal standards for re-licensure, as patients instinctively expect, or will it settle for something less? Will the evidence of performance offered by doctors be sufficiently robust to demonstrate the achievement of such standards? And will the processes for assessing and judging the evidence be equally robust in demonstrating continuing compliance? The answer to these questions should come from the evaluation of revalidation to be done over the current revalidation cycle by the GMC.

The U.S. has taken a parallel course. In 2000, the American Board of Medical Specialties introduced the Maintenance of Physician Competence (MOC) to ensure a board-certified physician's commitment to continuous lifelong learning and competency. The program is methodologically very well founded and continuously evolving. However, it is still controversial amongst U.S. doctors even though it is voluntary.

The Federation of State Medical Boards (FSMB) has recently adopted the Maintenance of Licensure concept (MOL). This would be the U.S. equivalent of revalidation. At the moment there is a substantial bolus of over 100,000 U.S. doctors - a quarter of the medical workforce at least - who are either not board certified or are board certified but have chosen not to do MOC. Dr. Chaudry, President of the FSMB, said in 2013, that the first components of MOL at the

state level are several years away. Why so long? Because, as we found in Britain, the unresolved tension amongst U.S. doctors between professional obligation to the public and professional aspiration without commitment is a difficult nut to crack. The failure to reach agreement on GMP-USA was, I suggest, symptomatic of the problem.

Looking ahead, the biggest danger in both the U.S. and Britain with a regulatory approach unsupported by cultural change is that, on its own, it can too easily result in a minimalist, tick-box mentality. Doctors without a genuine sense of ownership of the medical standards may satisfy regulators without commitment to observe such standards conscientiously in their everyday work – the very antithesis of patient-centered professionalism.

Making change happen: examples of patient-centered professionalism

The sustained resistance of some doctors to modern professional accountability in Canada, Australia and New Zealand, as well as the U.S. and U.K., is hardly the signal that the public want to hear of the profession's determination to put the needs of patients first. Professional regulation is only the underpinning step. It is the conscientious commitment of individual doctors to the daily observance of optimal standards that will ultimately decide the degree of trust patients and the public invest in doctors in future. So I offer you now three examples showing what can be achieved when doctors themselves decide to change their professional culture against prevailing forces.

1. British Family Practice

My first example is from family practice. In 1950, Joseph Collings, a researcher at Harvard, examined British general practice to see how well equipped it was for its role in the new NHS.[34] He described a staggeringly wide variation in standards. There was no public reaction and the new NHS had neither the will nor the means to act.

But a small group of embarrassed but dedicated family doctors did act. They formed the College of General Practitioners in 1952 to set professional standards where none existed, to introduce proper training and to modernize practice as the main provider of British primary care. As a young family doctor, I found their leadership amazing and inspiring.

Those were heady early days, which I remember as one of the most satisfying periods of my career. There was a huge release of creative energy by doctors who wanted to be part of the new practice world and who saw it as a matter of professional honour and pride that they open up their practice to close scrutiny by their peers. They welcomed help from patients, social scientists and others outside medicine. They professionalized medical teaching and introduced clinical audit to British medicine. Bright new young doctors flocked to join the College, keen to share in the action. Here was an old specialty renewing itself, attempting to pull itself up by its own bootstraps by force of collective will and personal self-discipline.

The key mechanism for facilitating culture change was the development of a national network of well-led, small groups of highly motivated clinical teachers who used these for spreading their form of patient-centered professionalism through learning, teaching and peer review.

2. Mayo/Cleveland Clinics

For my second example, I have chosen the Mayo and Cleveland Clinics. The founders of these two famous practices went against the traditions of the day by creating multi-specialty not-for-profit groups of salaried doctors who have no financial incentives for patient volume or number of procedures. Mayo Clinic evolved from the late 19th century family practice of William Worrall Mayo (an immigrant from Eccles, England) and his sons William and Charles in Rochester, Minnesota. Cleveland Clinic was founded in 1921 by doctors who wanted to build on their experience of team-based care gained on the battlefields of France in World War I. Fittingly, the founders of Cleveland Clinic invited Will Mayo to give the keynote address at their Clinic's opening. Doctors lead both Clinics, from the

President and CEO across the whole organization. Today, each Clinic employs some 3,000 doctors on campuses spread across the nation.

Why have I chosen Mayo and Cleveland Clinics? Because these practices have sustained a worldwide reputation for clinical excellence and outstanding patient care at reasonable cost for nearly 100 years - a remarkable achievement. So what is it about their culture that has made such care possible?

The most striking thing about Mayo is the impact everywhere of its primary value, namely that "the needs of the patient come first." This is no fly-by-night mission statement. On the contrary it is the single point of focus in everything Mayo does, pursued from the Clinic's earliest days with almost religious fervor. You see it in clinical practice, the attitude of staff, the management ethos, the design of buildings, the patient-centered focus in medical education and research, even in the dress code for staff. Patients feel it for themselves. That simple primary value epitomizes the culture. It is at the heart of the Mayo Clinic Model of Care.

The founders' credo of the Cleveland Clinic, "To Act as a Unit" in the service of patients, is still the focus of clinical practice, education and research today. Great care is taken to nurture professionalism across the complete spectrum of practice and education. For example, the Clinic's Professionalism Council deals with challenges that affect patient care and collegial relations. It sponsors a leadership development program as part of the annual performance review of medical staff. It provides mentorship to support doctors to allow them to do their best work. All of these and related efforts are designed to put patients first; to promote a culture of teamwork, collegiality and professionalism leading to very good care for patients and a healthier and more productive workplace.

At both Clinics success depends heavily on the care taken to choose consultants, trainees and students with the desired qualities. If you are positively motivated, equally great care will be taken with your further professional development. However, if you feel that you cannot work with these two Clinics' particular approaches to

professionalism, or if your performance falls short, you leave. You exclude yourself.

The governing bodies of both Clinics are ultimately responsible for the optimal standards of practice and care on which the prized reputation of these institutions rests. A collegial management style, clinical governance, operational standards, protocols, record systems and data are all seen as aids; to help doctors and nurses give optimal care, not as ends in themselves.

The Mayo and Cleveland Clinics exemplify a professionally-led, patient-centered culture of professionalism, based on optimal standards, which has been sustained across these big organizations for a long time.[35] They show that it can be done.

3. British Adult Cardiac Surgery

My third example is about British adult cardiac surgery. This small specialty has transformed itself in a very short space of time into a model of outstanding clinical practice and patient care[36] using optimal standards as the foundation.

Following the revelation of the disaster in pediatric cardiac surgery at Bristol in 1998, the adult British cardiac surgeons through their Society for Cardiothoracic Surgery (SCTS), have taken a decisive stance on professional standards led initially by the then Honorary Secretary of the Society, Professor (now Sir) Bruce Keogh. They have decided that it is their responsibility, their duty, to ensure an optimal standard of surgical outcome for all patients under the care of any NHS cardiac surgeon because they - not the managers or politicians - know more about cardiac surgery than anybody else.

The National Adult Cardiac Surgery Audit describes the patient mortality rates of every NHS cardiac surgeon and surgical team carrying out individual operations on almost every patient undergoing heart surgery in the NHS. The exceptions are the less than five percent of emergency and salvage cases which cannot be accommodated by the current risk model. The surgeons have found that a surgeon-specific degree of data granularity is essential. They

have embraced transparency through the regular publication of their results. More recently the SCTS, led by Professor Ben Bridgewater, has developed a sophisticated method for continuously monitoring the results so that unexpected departures from the prevailing standard can be quickly spotted, investigated and attended to before patients or surgeons themselves are exposed to further risk. The SCTS has managed to do this whilst still making it possible for surgeons to carry out risky operations on patients who have chosen surgery because they would have no chance of life without it.

And what do the results tell us? First, the overall results of British cardiac surgery are significantly better than elsewhere in Europe. Second, they show continuous improvement because frequent feedback results in the fine-tuning of surgical performance. And third, because the recent advances in surgery have reduced time spent in hospital, a comparison with international benchmarks shows that the money saved appears to have more than covered the costs of the monitoring system.
Even today, the journey is still not easy, not least because so much of what these surgeons have been doing involves exposing their own personal practice and indeed their own personalities. The exceptional leadership of several individuals was and still is critical. However, the overall result is excellent; everybody wins – patients, surgeons, the NHS and taxpayers.

Here is a model for other interventionist specialties now to adapt for their own use. I hope that British cardiologists will be next through the British Cardiovascular Society.[37]

Completing the change: the essentials

So how do we move forward? I do not believe that top down regulatory or managerial actions alone can ever force deep-seated change in a professional culture. They rob people of personal responsibility. Moreover, the resentment they may cause could have the opposite effect. This is why the main driving force must surely come from within, from the hearts and minds of professionals themselves, as the British cardiac surgeons and the doctors at the Mayo and Cleveland Clinics have shown.

The key thing is that doctors working together take full responsibility for their clinical and professional standards, individually and collectively. They must show that they have the will and the means to discharge this responsibility consistently. Quality-minded medical colleges, professional societies and individual hospitals and practices on both sides of the Atlantic need to act now to take the initiative themselves, to set an example and create the momentum for wider change.

For patients, the professional obligation to deliver always trumps the wishful thinking of aspiration without commitment. In my experience politicians, policy makers, healthcare managers and the public all want the profession to take this responsibility because the alternatives are just too difficult. It is only when the profession engages half-heartedly, or not at all, that they start to talk about imposed alternatives.

Given a clear direction of travel, the detail of working out 'the how' is the next step, but is beyond the scope of my talk today. However, the following are the essentials:

1. Prime focus on the needs of the patient, as seen through patients' eyes.
2. A holistic culture of professionalism embracing medical practice, medical education and medical regulation.
3. Inspired medical leadership willing to challenge the orthodoxy of the status quo.
4. Optimal standards - the best we can do today - to become the norm.
5. Specialist colleges and societies to take full responsibility for setting and monitoring optimal clinical standards in their respective fields.
6. The absolute necessity for high quality data capable of showing regularly whether clinical and care standards are being met.
7. Linking aspiration, the pursuit of excellence and personal responsibility through continuous professional development.
8. Every clinician to have regular, expert, evidence-based, formative and summative appraisal against generic professional and specialty-specific standards.

9. Evidence demonstrating individual doctor performance to be published regularly by professional societies, employers and regulators.
10. Use of the power of role modelling to the full in transmitting professional values and standards to the young by example, through practice and education.

Last word

In 1885, William Osler said, "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."[38]

In this lecture, I have tried to put the spirit of Osler's words into the practice of early 21st century medicine. I am optimistic about the future strength of the relationship between doctors and their patients for two reasons. First, a growing number of leaders in the medical profession and in healthcare have accepted the need for truly patient-centered medical care and are working out how best to achieve this at the level of the individual doctor-patient relationship. Second, the public in the future will know more about the overall trustworthiness of doctors they may see because it will become usual for evidence to be published telling patients how good individual doctors are at their job. The change needed to realign the medical culture of professionalism with today's public expectations is already under way. Indeed future generations of patients and doctors may wonder why the transition was so difficult and took so long. After all, they may say, wasn't it obvious? Patients everywhere want to be *sure* that they have a good doctor.

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John P. McGovern Award Lectureships

1. *Our Lords, The Sick* presented by Albert R. Jonsen, Ph.D., April 12, 1986, in San Francisco, California.

2. *To Humane Medicine: Back Door or Front Door?* presented by Edward J. Huth, M.D., April 29, 1987, in Philadelphia, Pennsylvania.

3. *Medicine and the Comic Spirit* presented by Joanne Trautmann Banks, May 3, 1988, in New Orleans, Louisiana.

4. *The 'Open Arms' Reviving: Can We Rekindle the Osler Flame?* presented by Lord Walton, April 26, 1989, in Birmingham, Alabama.

5. *Rx: Hope* presented by E. A. Vastyan, May 8, 1990, in Baltimore, Maryland.

6. *Osler's Gamble and Ours: The Meanings of Contemporary History* presented by Daniel M. Fox, April 10, 1991, in New Orleans, Louisiana.

7. *From Doctor to Nurse with Love In a Molecular Age* presented by William C. Beck, March 26, 1992, in San Diego, California.

8. *The Heroic Physician In Literature: Can The Tradition Continue?* presented by Anne Hudson Jones, May 12, 1993, in Louisville, Kentucky.

9. "*The Leaven of Science": Osler and Medical Research* presented by David Hamilton, May 10, 1994, in London, England.

10. *A Body of Knowledge: Knowledge of the Body* presented by Sherwin B. Nuland, May 10, 1995, in Pittsburgh, Pennsylvania.

11. *Other People's Bodies: Human Experimentation on the 50th Anniversary of the Nuremberg Code* presented by David J. Rothman, April 25, 1996, in San Francisco, California.

12. *The Coming of Compassion* presented by Roger J. Bulger, April 3, 1997, in Williamsburg, Virginia.

13. *Why We Go Back to Hippocrates* presented by Paul Potter, May 6, 1998, in Toronto, Ontario.

14. *Health Care in the Next Millennium* presented by John D. Stobo, M.D., May 5, 1999, in Montreal, Canada.

15. "*Writ Large": Medical History, Medical Anthropology, and Medicine and Literature* presented by Gert H. Brieger, M.D., Ph.D., May 17, 2000, in Bethesda, Maryland.

16. *Reflections on American Medical Education* presented by Kenneth M. Ludmerer, M.D., April 18, 2001, in Charleston, South Carolina.

17. *John Shaw Billings as a Historian* presented by James H. Cassedy, Ph.D., April 24, 2002, in Kansas City, Kansas.

18. *The Evolution of the Controlled Trial* presented by Sir Richard Doll, May 23, 2003, in Edinburgh, Scotland.

19. *Practising on Principles: Medical Textbooks in 19th Century Britain* presented by W.F. Bynum, M.D., Ph.D., FRCP, April 20, 2004, in Houston, Texas.

20. *Just Call Us Children: The Impact of Tsunamis, AIDS and Conflict on Children* presented by Karen Hein, M.D., April 11, 2005, in Pasadena, California.

21. *A Leg to Stand On: Sir William Osler & Wilder Penfield's Neuroethics* presented by Joseph J. Fins M.D., F.A.C.P., May 2, 2006 in Halifax, Nova Scotia.

22. *Touching Where It Hurts: The Role of Bedside Examination* presented by Abraham Verghese M.D., M.A.C.P DSc (Hon), May 1, 2007, in Montreal Quebec.

23. *Managed Fear: Contemplating Sickness in an Era of Bureaucracy and Chronic Disease* presented by Charles Rosenberg, May 5, 2008, in Boston, Massachusetts.

24. *Is Scholarship Declining in Medical Education?* presented by Patrick A. McKee, M.D., April 21, 2009, in Cleveland, Ohio.

25. *Selling Our Souls: The Commercialization of Medicine and Commodification of Care as Challenges to Professionalism* presented by Nuala P. Kenny, M.D., April 27, 2010, in Rochester, Minnesota.

26. *"The Back Forty":* American Medicine and the Public Interest *Revisited* presented by Rosemary A. Stevens, Ph.D., May 2, 2011, in Philadelphia, Pennsylvania.

27. *"Osler and the Enduring Narrative of Clinical Medicine"* presented by C. David Naylor, M.D., April 23, 2012, in Chapel Hill, North Carolina.

28. *"Louis Pasteur: Exploring His Life in Art"* presented by Bert Hansen, Ph.D., April 8, 2013, in Tucson, Arizona.