

2012 Gerry Lynch Memorial Scholarship

Self-regulation: The challenge of maintaining public trust in an environment of increased scrutiny and criticism.

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Class of 2012

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The medical profession possesses an expansive and unique body of knowledge with which we serve the healthcare needs of the public. In exchange for our service we have been granted the privilege of self-regulation. As a professional body, we are responsible for choosing those individuals with whom our body of knowledge is shared, defining the scope and standards of practice for members and disciplining those practitioners that do not meet professional expectations. Central to the privilege of self-regulation is the responsibility to act in the best interest of the general public. In the past the public trust has been unwavering. Such was the power of the separation created between doctor and patient by a monopoly on medical knowledge and upward social mobility granted by access to the profession. This is no longer the case. In the 21st century, deference to medical authority is being challenged by an increasingly assertive and well-informed public. Aggressive media scrutiny has thrust those matters once managed internally into the public realm. Social media and the internet have ensured that such criticism is widely disseminated while, at the same time, consolidating the collective public outcry. The consequence has been an erosion of the public trust and growing suspicion that self-regulation places the interests of doctors above those of their patients. In Canada the medical profession has reached a cross-road. The choice is to meet the challenge of maintaining the public trust in an environment of increasing scrutiny and criticism or to relinquish regulatory control to government oversight. Self-regulation in its present form is clearly no longer sustainable.

Canadian medical professionals are not alone in the challenges of maintaining self-regulation in the contemporary social environment. The previous decade has seen unprecedented changes leading to the fall of self-regulation of the medical profession in the United Kingdom. The

catalyst for this change was Harold Shipman, a physician estimated to have murdered approximately 250 people between 1975 and 1998 via opiate overdose¹. The intense media scrutiny surrounding the trial and subsequent hearings of colleagues who failed to detect the patterns of suspicious deaths surrounding his practice spectacularly eroded public trust in the medical profession. The Shipman scandal ultimately resulted in a series of recommendations outlined in the White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*². This document led to broad reform of the General Medical Council (GMC), the regulatory body responsible for overseeing the medical profession in the UK. Following the advice of the white paper, the composition of the council was changed to an equal number of lay and physician members. As well, the GMC was made more accountable to Parliament, increasing government oversight. The concept of revalidation was introduced to provide periodic reassessment of physician competency to practice. A body separate from the GMC was also created to adjudicate fitness to practice and disciplinary cases involving medical professionals.

The result of UK medical regulation reforms was a new paradigm with increased government oversight, enhanced cooperation between medical professionals and the public they serve and mechanisms built in to ensure impartiality in fitness to practice decisions. While these reforms address growing public scrutiny of the medical profession, government intervention was necessary to spark the change. The changes outlined in the UK model are all but inevitable in Canadian medical regulation. There have already been attempts by provincial governments to institute regulatory oversight. In 2007 in Alberta, Bill 41 was passed, allowing the government to seize control of the College of Physicians and Surgeons in an emergency³. Similar legislation,

Bill 179, has been introduced in Ontario⁴. The reaction of the medical community has been outrage and the laws referred to as “draconian”. These government inroads into medical regulation represent a slow attrition against professional autonomy and are the first steps towards a UK-like model. The difference in Canada is that we have the opportunity to save face and further build public trust by pre-emptively proposing similar reforms as a professional body. This avoids government paternalism that threatens to instead polarize the medical profession and the public they serve. Instead of headlines like *“Government wrests control of professional regulation from doctors for public good”*, physician-led reform could result in *“Doctors seek partnership with public in modernization of professional regulation”*.

While a complete discussion of potential reforms is beyond the scope of this text, some simple proposals can be put forward. A quick census reveals that 3 of 12 (25%) of the board members of the College of Physicians and Surgeons of Newfoundland and Labrador and 1 of 10 (10%) members of the College of Family Physicians are lay representatives^{5, 6}. The remainder of the provincial Colleges of Physician and Surgeons have varying degrees of minority representation of the public on their councils, with the highest proportion in Ontario at 14 of 32 (44%) members⁷. These numbers are far too low and give the public only a weak voice with which to influence council affairs. Increasing the number of lay members of provincial college councils would create an equal partnership between the profession and the public and remove much of the potential for councils to put the interests of the medical profession above those of the patients they serve.

If we are to make inroads into improving public trust we must be willing to ensure our patients that physicians objectively meet basic standards for practice. The current continuing medical education (CME) model, requiring physicians to accumulate points, lacks rigorous evidence of efficacy. A 2009 review by the American College of Chest Physicians acknowledge that the evidence that CME improves clinical outcomes was only 2C (weak, low quality evidence)⁸. Criticisms levied against CME include inflexibility with respect to physician learning style, questionable physician compliance and the ease with which one can “cheat” the system. At the end of the day CME, while noble in theory, offers no guarantee that physicians meet basic competency standards. Further eroding public trust is the degree to which CME is industry funded and susceptible to both intentional and unintentional bias⁹. In their recent reforms, the GMC in the UK has proposed moving towards a periodic revalidation process². This involves providing evidence of professional education, a portfolio of clinical practice performance, peer review and, perhaps most importantly, patient feedback questionnaires. While reaction has been negative from those comfortable with the status quo, few people, physician or patient, could argue that formal review of physician competence is not potentially beneficial to patient care. Canadian physicians would do well to incorporate such a comprehensive review process. Not only are we professionally bound to ensure basic practice standards, but the message such reforms would send to the public is that we are willing to accept the burden of revalidation in the patient interest.

A commitment to formal revalidation must come with a caveat. The profession is not acknowledging that there is a need to hunt for bad apples amongst its members. This is a much-perpetuated myth that fails to acknowledge the systemic nature of medical error¹⁰. Canada has

had its share of bad apples. In 2007, Sean Buckingham, a Newfoundland physician, was found guilty of trafficking prescription narcotics in exchange for sex¹¹. In 2010 in Ontario, child forensic pathologist Charles Smith was found to “lack basic expertise” in pathology, despite having conducted almost 1000 child autopsies, and was implicated in a number of wrongful convictions after “actively misleading” investigators¹². A witch hunt is unlikely to be successful as these individuals have already managed to circumvent several mechanisms for discovery including acceptance to and graduation from medical school, acceptance to and graduation from a residency program and initial licensing from a provincial college. Additional layers of regulation are unlikely to succeed in this circumstance. However, as the Canadian cases and the Shipman case in the UK demonstrate, the media is fond of focusing on these bad apples when their stories surface. The public is thus presented with a biased view of a minority of exceptional cases. The benefit of revalidation arises from identifying systemic shortcomings in the competency of the professional community and instituting mechanisms for improvement. Going a step further, the profession would do well to promote the fact that the majority of physicians excel in patient care. Lamentably, media coverage of physician excellence is lacking but not absent. Few members of the public have heard of Nigel Rusted or Patrick Parfrey, both local physicians and Members of the Order of Canada^{13,14}. Recent coverage of the Broken Earth group’s work in Haiti highlight these exceptional medical professionals and do much to foster public trust, but more is required¹⁵.

The overarching theme of the aforementioned proposals for changes in Canadian medical self-regulation is partnering with the public in a relationship characterized by transparency, accountability and honesty. The very connectedness that has increased public scrutiny of the

medical profession can also be our greatest asset. An example of such innovation recently took place in Montreal. Hacking Health was a coming-together of healthcare professionals and information technology gurus for 24 hours of intense brain-storming. Doctors, nurses, pharmacists and other front-line workers presented what they perceived as barriers to providing quality medical care and so-called “hackers” came up with solutions in real time¹⁶. Already some fruits of this exercise have been realized, including a system for tracking the use of Factor VIII in hemophiliacs that has the potential to save millions of dollars. Such are the benefits of public engagement by the medical profession.

As physicians we practice at the cutting edge of medical science, continuously evolving with new evidence and technology. Unfortunately, the institution of medical self-regulation has lagged behind, failing to meet the demands of the modern patient population. The result has been increased scrutiny and a slow, but steady, attrition of public trust. Sullivan, in his article *Medicine Under Threat*¹⁷, states:

The root of the public's trust is the confidence that physicians will put patients' welfare ahead of all other considerations. It is the function of medicine as a profession to safeguard and promote this trust in the society at large. In the present climate, which works against this trust in several ways, physicians will find themselves unable to sustain their important role as guardians of these values unless they can find ways to re-engage the public over the nature and value of their work for the society at large.

The best way to re-engage the public is to directly address their concerns. This paper has suggested several ways in which this may be accomplished, but the overall theme is openness,

accountability and an increased role of public partnership within the regulatory framework. Complacency in this regard will inevitably lead to government intervention as has recently taken place in the UK. Our best course of action is to act preemptively of our own accord, demonstrating that we are willing to put aside the relative comfort of the status quo and engage the public in an effort to build trust. This new paradigm of patient-directed regulation, while sacrificing some of the autonomy of true physician self-regulation, carries the spirit of acting in the best interest of the public and, properly implemented, has the potential to benefit all parties involved. With the strength of a profession, great strides have been made in medicine. With the strength of a nation, anything is possible.

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