“Trust me ,I’m a Physician”

Dilemmas for the College and

the Professional Qualities Curriculum

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For discussion

- Professionalism
  - Discussion yesterday regarding performance
- Challenges of the new health care – a new professionalism?
- What's happening elsewhere?
- Challenges and dilemmas for RACP PQC

Professionalism

- The medical profession holds a rare position of respect and trust which is tied to significant professional and personal responsibility. This position is founded in the concept of professionalism, wherein society grants a profession monopoly over the use of a specific body of knowledge and skills and allows autonomy through the privilege of self-regulation, for which the profession guarantees competence, integrity and altruism.

Cruess S, Johnston S, Cruess R. Professionalism for medicine: opportunities and

- Professionalism is thus a set of values, behaviours and relationships that underpin the trust of the public

- **Is it more than that?**

It’s been largely about the way we behave as autonomous individuals…

Maybe society expects more?

Professionalism as a competency

<table>
<tr><th>CanMEDS roles</th><th>RACP Professional Qualities Domains</th></tr>
<tr><td>Medical expert</td><td rowspan="2">Clinical Decision making
Leadership and Management</td></tr>
<tr><td>Manager</td></tr>
<tr><td>Communicator</td><td rowspan="4">Communication
Quality & Safety
Cultural Competency

Ethics

Health Advocacy
Broader Context of Health</td></tr>
<tr><td>Collaborator</td></tr>
<tr><td>Professional</td></tr>
<tr><td>Health advocate</td></tr>
<tr><td>Scholar</td><td>Teaching and Learning</td></tr>
</table>

Why the push to change?

Economy
Impact of health on budget
Increasing costs
shrinking tax base
Competing economic priorities
Quality = reduced cost

Technology
new technologies – cost & quality
With technology comes 'accountability' and standardisation e.g. EHR

Government
Short termism
Reactive – efficiency based
Concern about well known quality gap
Demanding accountability / transparency
"Clinical Governance"

The health care industry

The Natural environment
Increasing Green movement
Climate change
Water
Impact on funding base

Demographics
Ageing / growing population
Burden of chronic disease

Social Structure
Rise in consumerism
greater awareness / demand for quality

Critical issues for Australian health care

- *Safety remains disgraceful by industry standards*
- *Unsustainable cost increases*
- *Inexorable demand, limited supply*
- *Terrible clinical support systems*
- *Lack of evidence*
- *Lack of application of available evidence*
- *Variability in care*
- *Regulatory processes don't guarantee quality*
  - *e.g. Accreditation - divert resources*
- *Remains a political football*

A vision of the future?

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My School provides an important opportunity for everyone to learn more about Australian schools, and for Australian schools to learn more from each other.

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	Table 1. Health care safety and quality indicators by quality domain	Safe	Appropriate	Effective	Continuous	Responsive
	Healthy start					
1	Birth trauma – injury to neonate	◆				
2	Low birth weight infants		◆	◆		
3	Decayed, Missing and Filled Teeth among primary school children		◆	◆		
	Staying healthy					
4	Oral health in residential aged care		◆	◆	◆	
5	Eye testing for target population		◆			
6	Failure to diagnose	◆	◆			◆
7	Potentially preventable hospitalisations		◆	◆		
	Getting better					
8	Assessment for risk of venous thromboembolism		◆			
9	Appropriate prophylaxis for venous thromboembolism		◆	◆		
10	Appropriate use of antibiotics in General Practice for Upper Respiratory Tract Infection		◆			
11	Survival from out-of-hospital cardiac arrest following ambulance service intervention	◆	◆	◆		◆
12	Pain management in the Emergency Department		◆			◆
13	Thrombolysis for Acute Myocardial Infarction		◆			
14	Thrombolysis for stroke		◆			
15	Stroke patients treated in a stroke unit		◆			
16	Management of Acute Myocardial Infarction		◆			
17	Management of Chronic Heart Failure		◆			
18	Mental health inpatients having seclusion	◆	◆			◆
19	Health Care Associated Infections (HCAI) acquired in hospital	◆				
20	Staphylococcus aureus (including MRSA) bacteraemia in acute care hospitals	◆				
21	Adverse drug events	◆	◆		◆	
22	Pressure ulcers in care settings		◆	◆		
23	Falls resulting in patient harm (in a health or aged care setting)	◆				
24	Intentional self-harm in hospitals	◆	◆	◆		
25	Complications of anaesthesia	◆				
26	Accidental puncture/laceration (technical difficulty with procedure)	◆				
27	Obstetric trauma – third and fourth degree perineal tears acquired during childbirth	◆	◆			
28	Postoperative respiratory failure	◆		◆		
29	Postoperative haemorrhage	◆	◆			
30	Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT)	◆	◆	◆		
31	Unplanned return to operating theatre in the same admission	◆	◆	◆		
32	Unplanned re-admission to an Intensive Care Unit	◆	◆	◆		
33	Unplanned hospital re-admissions	◆	◆	◆	◆	
34	Failure to prevent a clinically important deterioration (Failure to rescue)	◆	◆	◆		
35	Risk-adjusted in-hospital Mortality	◆	◆	◆		
36	Death in low mortality DRGs	◆		◆		
37	Independent peer review of surgical deaths	◆		◆		
38	Presence of appropriate incident monitoring arrangements, including sentinel events monitoring			◆		
39	Knee and hip replacement revision within 5 years	◆		◆		
40	Cancer Survival		◆	◆	◆	◆
	Living with illness/disability					
41	Continuity of care – discharge planning		◆	◆	◆	
42	Post-discharge community care for mental health patients		◆		◆	
43	Functional gain achieved in rehabilitation		◆		◆	
44	Enhanced primary care services in general practice		◆		◆	
45	General practices with a register and recall system for patients with chronic disease		◆		◆	
46	People with asthma with a written asthma action plan		◆		◆	
47	Management of hypertension in general practice		◆	◆		
48	Management of chronic pain in arthritis and musculoskeletal conditions		◆	◆	◆	◆
49	Annual cycle of care within general practice for people with diabetes		◆		◆	
50	End stage kidney disease in people with diabetes			◆	◆	
51	Lower-extremity amputation in people with diabetes			◆	◆	
52	Treatment of depression in primary care		◆		◆	
53	Inappropriate co-prescribing of medicines	◆	◆			
54	People receiving a home medicine review	◆	◆			
	Coping with end of life					
55	Quality of Palliative care		◆	◆		
	Indicators that span all health needs domains					

So expectations are changing…
So are Doctors…

- Altered autonomy and hierarchies because of greater demands for accountability & access to information
- Leadership roles critical but inadequate attention paid to them

Bruce Dowton MJA 2004

- Increasingly “technicians”
- Professions losing influence

Accountability – professionals failing the community

If the profession fails to self regulate……….

Accountability? Is it just the system?

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Balancing "No Blame" with Accountability in Patient Safety

Robert M. Wachter, M.D., and Peter J. Pronovost, M.D., Ph.D.

Since this article has no abstract, we have provided an extract of the first 100 words of the full text and any section headings.

This year marks the 10th anniversary of the Institute of Medicine's report *To Err Is Human*,[1] the document that launched the modern patient-safety movement. Although the movement has spawned myriad initiatives, its main theme, drawn from studies of other high-risk industries that have impressive safety records, boils down to this: Most errors are committed by good, hardworking

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Purpose of medicine as a profession

- A vocation in which a physician's knowledge, clinical skills, and judgement are put to the service of protecting and restoring human health and wellbeing.
- Purpose realised through respect, individual responsibility and appropriate accountability
- Professionalism is at the heart of being a good doctor

Professionalism and Performance are intimately linke

RCPL 2005

Implicit in this view of the future

- Shift to patient from provider
- Accountability – individual and system
- Individual and collective autonomy vs true accountability
- Recognition of need for continual improvement
- Need for new physician skill sets
- Opportunity is “demonstrable professionalism”

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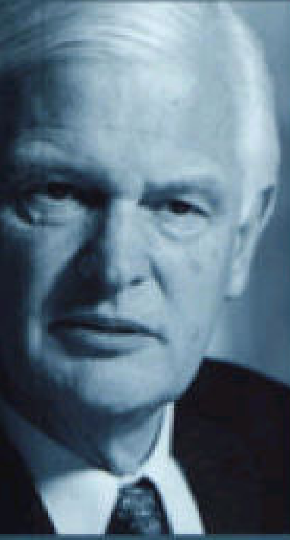


The Doctors' Tale

Professionalism and Public Trust

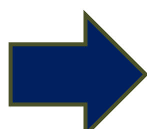
Why doctors need to respond

- Patients need to be confident that doctors are not only competent and practice safely but that they aspire to excellence
- Operationalising professionalism
  - can no longer be about individual autonomy and professional behaviour
- Building trust through observance and demonstration of the tenets of professionalism including care delivery.
  - “demonstrable professionalism”

Are we preparing doctors for the new health care?

20th Century

- Provider centred
- clinicians as technicians - disengaged
- Price driven
- Knowledge disconnect
- Slow to innovate
- Reactive, episodic care – illness based
- Paper based
- Outcomes ignored
- Cost increases
- Safety static or worsening



21st Century

- Patient centred, team based,
- Clinicians truly engaged
- Driven by value to consumer
- Knowledge management
- Rapid innovation
- Health oriented
- Data in electronic form
- Outcomes measured
- Cost declines
- Safety improves

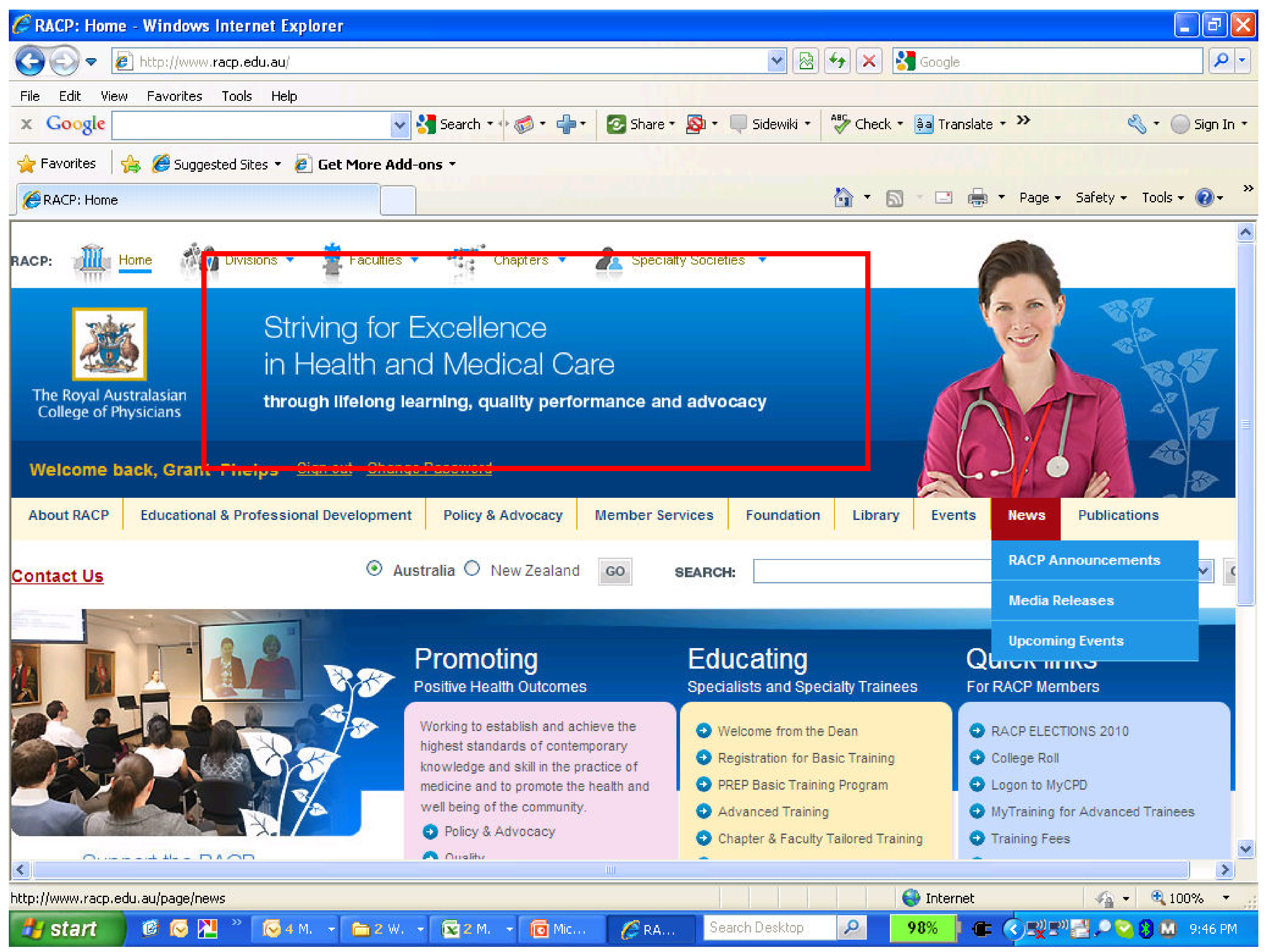
Elements of new professionalism – working with and supporting the system

- Integrity, compassion, altruism
- Continuous improvement
- Leadership and followership
- Working in partnership / teamwork
- Responsibility to institution and system – corporate responsibility
- i.e. new professionalism must recognise physicians role in the healthcare system (new skills / new thinking)

Existing challenges to professionalism

- Competing priorities- rising cost of health care vs drivers of cost of health care
- Perverse incentives – are we really in the healthcare business?
- Policy for policy's sake – top down control
- Lack of respect / trust – terrible cultures
- Lack of respect for professional stewardship of safety and quality – "clinical governance"
- Lack of clinical leadership and professional support for clinical leadership

Responding to these challenges is not easy….



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RACP and ongoing practice

"MyCPD is designed to:

ensure that all participants are involved in a range of continuing educational activities directed at enhancing clinical standards throughout their professional careers so that clinical practice and patient care of the highest quality will continue to be provided"

We work in a broader context

- "Graduates from this training program will be equipped to function *effectively* within the current and emerging professional, medical and societal contexts…"

Good Medical Practice: A Code of Conduct for Doctors in Australia

Developed by a working party
of the Australian Medical Council
on behalf of the medical boards of the
Australian states and territories

A GUIDE BY
THE ROYAL AUSTRALASIAN
COLLEGE OF SURGEONS

SURGICAL COMPETENCE AND PERFORMANCE

RACS Competence & RACS Performance

Surgical Competence and Performance

Medical Expertise

Integrating and applying surgical knowledge, clinical skills and professional attitudes in the provision of patient care.

Demonstrating medical skills and expertise

Consistently demonstrating the highest standards of medical knowledge, surgical skill and professional behaviour.

Good behaviours

- Provides a consistently high standard of pre-operative, intra-operative and post-operative care
- Ensures appropriate pain management is instituted in a timely manner
- Consistently considers the impact of co-morbidities on presentation of surgical disease or recovery from surgical intervention
- Ensures the development, implementation and evaluation of a plan of fluid and electrolyte management

Poor behaviours

- Orders inappropriate or unnecessary investigations
- Denies that surgical underperformance will directly impact on patient safety and health outcomes
- Is unresponsive to concerns regarding post-operative issues
- Fails to ensure that a clear post-operative plan is available

Monitoring and evaluating care

Regularly reviewing and evaluating clinical practice, surgical outcomes, complications, morbidity and mortality.

Good behaviours

- Participates in surgical audit and peer review
- Compares own results with: departmental peers; other surgeons in the community; and the published material
- Reviews and discusses 'problem' cases
- Participates in root cause analyses or other reviews of adverse events

Poor behaviours

- Fails to regularly attend audit meetings or audit own results
- When clearly at fault, blames others for poor outcomes
- Makes no comparisons of their work to others' results or agreed standards
- Employs new technique without an appropriate appraisal process

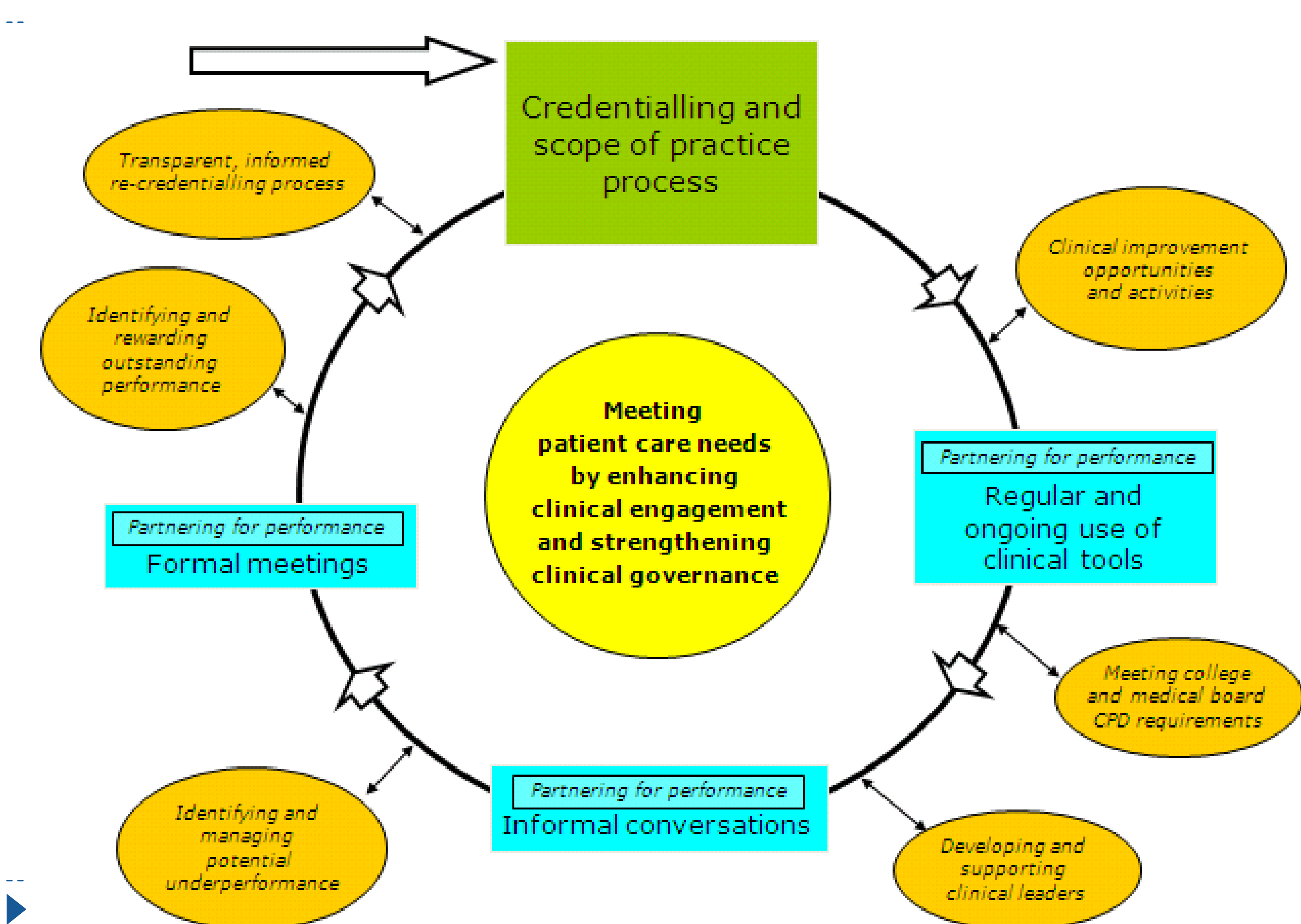
AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE

Standard for Credentialling and Defining the Scope of Clinical Practice

A National Standard for credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals

July 2004

The Victorian Performance Model



The UK - Revalidation

- Aims to ensure patient safety and improve quality of care
- Positive affirmation of a physician's practice
- Encourage ongoing improvement
- Identify underperformance

- Physicians have confidence that their work will withstand external scrutiny
- "demonstrable professionalism"

Revalidation – judging professionalism

Domain 1 – Knowledge, Skills and Performance

Attribute	Standard	Supporting Information - including specialty specific examples of best practice
1.1 Maintain your professional performance	**All doctors** ■ Maintain knowledge of the law and other regulation relevant to practice (13) ■ Keep knowledge and skills up to date (13) ■ Participate in professional development and educational activities (12) ■ Take part in regular and systematic audit (14)	**Peer Feedback**[1] • Validated Colleague MSF (at least once per five year revalidation period) • *Evidence of involvement in other assessments of individual or team practice if undertaken by subspecialty eg Peer Review or Service Accreditation where applicable.* **Patient Feedback**[2] • Validated Patient Questionnaire (at least once per five year revalidation period) • Reflection and learning from substantiated complaints • *Evidence of quality of advice given to patients (eg anonymised patient records and outpatient clinic letters) and information/educational material given to patients* **Education, Training and Development**

[1] The raters in the MSF should reflect the range of those with whom physicians work in their daily practice, whether this is clinical, academic, managerial or a combination of these. Raters should come from all relevant groups, not just consultant colleagues.
[2] For the subspecialty of Palliative Medicine, and possibly other situations, patient feedback relevant to the individual physician may be difficult to obtain. Frequently Palliative Medicine specialists act in an advisory role to consultants in a number of other specialties, and many of the patients being cared for are inappropriate to be given questionnaires. There are also concerns about recently bereaved relatives being asked to complete questionnaires. Further work may be required to identify a suitable tool for this subspecialty.

		• Record of "open book" knowledge assessments related to e-learning or other knowledge assessments. • Evidence of any specific training, assessment or re-assessment of practical and other skills • CPD record - specific learning needs identified and met – signed off as related to individual professional practice **Audit and Quality Improvement** • Participate in, or carry out, one full audit cycle or other approved Quality Improvement exercise in relation to professional practice within each five-year revalidation period with evidence of any practice change • Participation in national or other multi-centre (eg regional) and local audit, where present, with evidence of any practice change demonstrated by re-audit **Practice** • For most physicians, this will be covered by audit and MSF (above). • *Observed clinical practice may be recommended, or agreed at appraisal* • *Logbook of clinical cases encountered and discussed, with reflection and practice change* • *Record relevance of legislation to clinical cases or other situations encountered in practice in log-book or e-portfolio* • *Results of clinical outcomes compared to College or specialty recommendations, where available and validated*
1.2 Apply knowledge and	**All doctors** ■ Recognise and work within the limits of your competence (3a)	**Peer Feedback** • Validated Colleague MSF (at least once per five year revalidation period)

All elements of a doctor’s work?

Good Medical Practice

STOP
BROWN'S
NHS
CUTS!

Gordon Brown on clinical leadership

"Lasting change can only come from clinicians and staff. We need to do much more to empower staff, to give them the time with patients that they need to improve patient care, to put them in the lead in developing ideas on improving patient-care, and to respect their professionalism."

"Understanding Doctors: harnessing professionalism" King's Fund/ RCP 2008

Leadership as a competency

"The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served. Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence".

Ara Darzi "Our NHS, our future: NHS next Stage Review" 2007

Clinician leaders

– experts of balance

Clinical Leadership is a competency

- "… it is putting clinicians at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and populations, not as a one-off task or project, but as a core part of clinician's professional identity"
  - Building Clinical Leadership across London NHS London 2008

For leadership to matter…

Must link with organisational purpose

An evolving PQC

CanMEDS roles	RACP Professional Qualities Curriculum Domains	"New" competencies
Medical expert Manager	Clinical Decision making Leadership and Management	•Management •Leading people and teamwork •Leading change •Understanding value •Managing Improvement
Communicator Collaborator Professional Health advocate	Communication Quality & Safety Cultural Competency Ethics Health Advocacy Broader Context of Health	•Health care context & industry awareness •Health care transformation through policy •Patient engagement & advocacy •Career development and management •Lifelong professional •**Followership**
Scholar	Teaching and Learning	•Meaningful CPD – measuring impact •Health care delivery improvement research •Learning from outside healthcare

Does the College in future….

- Expect these competencies?
  - Yep!
- Encourage and support them?
  - Management / Leadership / Followership interest groups?
  - Leadership mentors?
- Teach them?
  - Outsource it?
  - Link with other colleges?
  - Masters in Medical Leadership
- Assess against them?
  - OMG….. How?!
- Expect them as part of ongoing demonstration of professionalism?
  - In which case CPD needs to evolve – Performance based framework
  - How link with recertification?

A new professionalism. No longer a matter of "if", but "when"

Clinical Performance Framework

- Assisting fellows to understand and manage clinical performance
- Bolstering professionalism through accountability
  - Reflecting a range of professional domains
  - “I know I’m a professional because I can prove it”

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