The Ethics of Medical Performance

On February 6th 2013 Robert Francis QC (1) published the second part of his report into a seriously failing hospital Trust.

This traumatic revelation of the truth is an opportunity for us as a profession to seriously question some basic professional values around patient care and performance. Trying to respond and reason with the enormity of this report has encouraged me to reflect on the concept of the ethics of medical performance. The reality is that the level of performance is very high in most Consultant units but there are some areas where women are being disadvantaged by poor individual or team care.

You will forgive me for a few personal observations but anecdotes can be powerful and in this case one individual was to have a significant impact on me and the subsequent regulation of medicine. In 1983, I was very proud to receive a DM from the University of Nottingham. Beside me at the ceremony was a more senior trainee also receiving the same degree. This doctor was to have a profound effect on medicine as a whole but in particular to women’s health, but not the legacy you would want. He was publically disgraced because of his disregard to patient safety. In the 90s and the early part of the 21st century there were a few infamous cases of doctors practising medicine with an ethical framework that was unimaginable. The Bristol paediatric cardiac scandal, the issue concerning retained specimens at Alder Hay Hospital, the various catastrophes around cervical cytology and the blatant murdering exploits of Harold Shipman. The Kennedy report (2), written in response to the Bristol tragedies, aimed to improve clinical performance and patient outcomes. It has taken too long for us as a profession to get to grips with poor
performance. I am not and have never been an arrogant or brilliant doctor—I am an ordinary, conscientious doctor who makes mistakes but I have always striven to practise to the same standards that you all practice to in this room, but there has been an unacceptable complacency about poor performance.

So I will start with the four fundamental principles and values that underpin medical ethics (3):

- a doctor’s appreciation of the integrity of the patient as an individual
- a doctor’s commitment to acting in the best interests of the patient
- a doctor’s obligation to do no harm
- A doctor’s obligation to see the fair distribution of scarce health resources.

So what other criteria influence us as individuals, as a profession, as global citizens in delivering ethical standards and benchmarks of clinical care and governance of behaviour? I would suggest that family values, religious teaching, cultural norms, even history through the Hippocratic Oath will impact on our core beliefs and influence behaviour.

Similarly medical and clinical performance embraces four elements:

Individual motor skills of manual dexterity

The cognitive intellectual skills and analytical skills

Most importantly the empathic and communication skills, all vital to the delivery of good care.

Again underpinning these principles is the strong driver of professionalism—the core value that defines Good Medical Practice (4).
I believe strongly that this Royal College defines an agenda embracing performance and ethics around the concepts of care, quality, improving outcomes, improving training and assessment and defining professionalism, which is strongly endorsed by the membership. However, in the current climate there are huge pressures that threaten these principles which I will return to later.

Ethical controversy abounds in our discipline at the clinical interface between science, investigation, treatment and humanity. The boundaries of assisted conception, genetic screening, gynaecological cosmetic surgery, cloning, abortion, post menopausal conception, withdrawal of active care, assisted dying and so on, I could go on but my thesis is different. We struggle with these clinically based ethical issues outlined on a daily basis, but always try and do our best for our patients and their families. Indeed examine the agenda of any reproductive ethics committee and it will be packed with theses controversial issues. However, are we not missing the most fundamental challenge of all- ensuring that these same people- the patients- receive the best possible care at all times day or night? Is not our greatest ethical challenge to insure that care is equal to all our citizens and for the greater good? So what are the pressures that can distort these honourable objectives that I alluded to above?

Financial pressures, employment contracts and hours of work, workforce challenges, legal issues, political pressures and public expectation to name but a few.

The failure and instability in global economics, together with the Nicholson challenge has created huge tensions in our publically run NHS. What we hold so dear in this country-Our mantra of health care free at the point of access
does not pose us with the ethical conflicts evident in other countries. However, the financial and target pressures create their own challenges for doctors. How do you prioritise clinical need, comparing maternity care with gynaecological surgical waiting lists? Who should provide the clinical need- consultant or other healthcare provider and where should your own priorities be? Should additional waiting list initiative work compromise your ability to perform your routine commitments?

Hours of work and on call and the recurring pressure of the dreaded European working directive may improve performance due to lack of fatigue but lessen continuity of care with impacts on patient care and training experience. Personal factors including time of day, affective state, domestic distractions, health, alcohol and drugs will all impact on performance.

Contractual Issues. Prior to the advent of job planning conflicts of interest were common for doctors who worked across the NHS and independent sectors. I believe that such conflicts are less frequent today and the structure of hospital medical staffing excludes such flexibility. There is no longer a Senior Registrar to backfill while the consultant attends to other responsibilities in alternative providers.

Legal Issues and accountability: - Increasingly medical litigation will help to shape the process of performance both in a contractual responsibility through to a defined legal definition of acceptable or unacceptable practice. For most of us today failing to rise to the challenge of perceived standards in the eyes of the law, the Bolam principle (5), will create further redress and enquiries. Competition between private and commercially-driven providers and established networks can potentially cause harm. In the current political
landscape this is likely to increase, with a growth in any qualified provider, but
as doctors we have to hold onto quality of care as the ultimate determinant.
Remember that you may have a conflict of interest as an AQP.

Political ambition and public expectation fanned by political expediency are
very challenging, as exemplified by the desire of Trusts to achieve Foundation
Trust status. All of these elements are capable of seriously pushing a Trust or
Department off course with detriments in terms of performance issues for
clinicians.

So where do we currently stand in terms of, doctor’s performance,
accountability and medical regulation.

The Medical Act 1858 (6) marks the start of the modern period of medical
regulation in the UK.
The roles and responsibilities of the regulator have always played a pivotal
position but are now significantly increased from merely maintaining the
register and include defining some ethical standards. The General Medical
Council, now the regulator of doctors’ total education and general
performance defines basic ethical concepts and behaviour through ‘Good
Medical Practice, updated in March 2013’. This document lays out very clearly
the defined expectations of professionalism. Serious failure to follow these
principles will result in disciplinary measures through the Fitness to Practise
channels.

The guidance, Good Medical Practice, is addressed to doctors,
but it is also intended to let the public know what they can
expect from doctors. Patients need good doctors. Good doctors
make the care of their patients their first concern: they are
competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity. These concepts resonate with the fundamental ethical principles that I covered earlier.

When I became a consultant in 1986, I believed that I was only accountable to one person, Janet my secretary and possibly to my employer and the regulator. This rather naive stance displayed a lack of understanding of the principle of accountability. Quite clearly our principle accountability is to the patient, for whom we are caring, but what rights does that patient have and what powers of jurisdiction can they invoke if the accountability fails? I suggest that your employer to whom you are ultimately accountable has that role by proxy, but this is where the process has been wanting. The current structures of clinical governance and measurement of care are designed to safeguard such interests, but the quality and influence of these systems have not been sensitive enough in all but the most extreme cases.

The recent conflict of interests between delivering the politically motivated targets in Mid Staff, trying to achieve Foundation Trust status and delivering quality care demonstrate how complex ‘ethically acceptable’ accountability can be. Indeed, it is obvious that the ethical line was breached by the preoccupation by the Board of process targets. Does a Royal College have a duty of care to make a stand and oppose the political institution of the day if they disagree with such policy? We had a flavour of this with the passing of the Health and Social Care Bill/Act (7). These are complex processes but as doctors we have a clear demarcation of responsibility to protect quality- the challenge is to know when the line in the sand has been crossed. The conscience of the
institution or profession can be difficult to define, particularly when dealing with the political ambition of Government and the opposition parties within our democracy. In addition the institution has a desire for recognition and influence to alter policy. Leaders have to adapt to leading an institution in a particular direction but it is incumbent on the RCOG to stick to its core beliefs of quality of patient care and if necessary vocalise clearly this passion on a constant basis.

We are now entering a new part of medical history with a welcome emphasis on assessment, accountability and regulation of clinical performance, both of individual doctors and Trusts. Over the last few years there has been exciting developments in assessment processes for those in training, including work based assessment, a new MRCOG (8), OSATS (9) and more recently NOTTS (10). Many of these processes were unavailable for those who are deemed to be trained but this is changing. For testing memory substitute assessing competence.

The NHS introduced the process of revalidation of all doctors in December 2012(11), with the expressed intent of raising standards and helping doctors but also alerting individual doctors and employers of problems of performance difficulties. To maintain a license to practice medicine you must be revalidated every 5 years, which includes an annual appraisal, including feedback from colleagues and patients, outcome data where available, audit information, CPD, reflective learning, SUIs, handling of complaints and compliments and issues of health and probity.

My reflections, having been very involved in the introduction of the process focus on two areas. Firstly, are we sensitive enough to the views of patients? Patients are very generous in feedback and most will assess doctors
performance in this domain as outstanding or good so how robust are the metrics and these need to be more robust

Secondly, the central pillar of this process will be the appraisal and objective assessment will be fundamental by the appraiser. The cosy process that occurred when appraisal commenced, when close colleagues appraised one another is no longer acceptable, and a significant shift in undertaking a robust professional process is vital. A greater rigour and objectivity is required if we are to regain the confidence of the public that the process is meaningful. This is a very serious issue as adverse outcomes for individual doctors could be challenged legally, since the potential implications are not just reputational but will include a number of alternatives including remediation, retraining or at worse referral to fitness to practise panels. There is also the possibility of ‘unhappy’ patients challenging outcomes if untoward processes happen to them, which the process has failed to detect. So there is a pressure on the Responsible Officer to guarantee quality assurance on the totality of the process at Trust level. Our ethical responsibility is to ensure quality for the patient.

The RCOG has an increasing role in the area of quality assurance, management and leadership. We continue to have a major responsibility in the maintenance of standards of performance of trainees through defining the curriculum for knowledge and professionalism, signing off competencies, defining examination standards, standards and outcomes, orchestrating the process of revalidation and evaluation of services and individuals in trouble. The importance of developing professionalism within the curriculum in parallel with theoretical knowledge was clearly stated in *Tomorrow’s Specialist* (12)
where a clear commitment was made to give equal weight to both components.

New metrics are evolving. OSATS are now well defined markers of technical skill and competence. NOTTS/OSATS: The development of objective structured assessment tools for surgery and non technical skills for surgeons attempt to develop and incorporate a wide spectrum of manual and interactive skills into a more quantifiable way. The incorporation of situational awareness, decision making, communication and team working and leadership are all fundamental principles of professionalism which are tools used in the most pressurised environment-the theatre or the labour ward. By quantifying these elements one can monitor performance and change of performance. Such tools may be incorporated into revalidation with time.

Indeed, Royal Colleges have a conflict of interest in some of these areas. On the one hand they define the standards across the piste but they are not the final regulator, and secondarily, they are organisations who are responsible to their members who are in effect their sponsors. In other words, they may be the guardian of standards but they have no regulatory responsibilities.

I will use an anecdote as an exemplar. In December 2012 there was a media story about a tragic stillborn infant delivered in a hospital in England where national guidelines for certain conditions were not in use in this Trust when this death occurred. This behaviour is obviously at variance with what we would recommend. A major responsibility of the RCOG is the writing and reviewing of national guidelines. From an ethical viewpoint we need strategies that insure that these elements of our contribution to standards and quality are incorporated in standard clinical practice.
So what happens when things go wrong? Within the current structure major concerns about performance from the employer, patients or colleagues are reported to the GMC, the National Clinical Assessment service or a Medical Royal College. The annual report rate to the GMC is a 1:70 annual risk (13), for NCAS the risk is 180(14), with 6% of enquiries being based on our discipline.

These review processes have a different perspective and output in assessing performance. RCOG Individual and service reviews may focus on performance and competence whereas the GMC and NCAS are likely to be involved in conduct problems. The GMC and NCAS may already be involved but if not where does the responsibility of the RCOG lie in detecting and managing serious issues of performance? Currently if an implementation plan, recommended to a trust following a review has been ignored within a time frame the RCOG will report to the regulator or CQC.

So how do we as a specialty fare in the area of performance compared to other specialties or with other countries? Comparators of outcome with other countries are available—eg stillbirth rates, but these data are complex and do not reflect the totality of performance.

The risk profiling of our discipline is well described. The data from the NHS Litigation Authority(15) demonstrated that over a ten year period, there were 5,087 maternity claims costing a total of £3.1bn from a cohort of approximately 5.5 million births which constitutes less than 1 in a 1000 births resulting in litigation. The causation was generally within four areas which come as no surprise to you: antenatal ultrasound investigations, cardiotocograph interpretation in labour, perineal trauma and uterine rupture.
The concept of whistle blowing for both individuals and organisations is real. Again, the recent experience of Mid Staffordshire brings this embarrassment home to roost. Within the recommendations of *Good Medical Practice* you are required to act when you are aware of poor performance. This is not to support the introduction of a police state in which all innovation and risk on behalf of patient benefit is stultified. Quite the opposite, it is an attempt to identify and improve performance before it is too late and also it is to safeguard the interests of patients, staff and the institution. This also applies to trainees- in Francis terminology the eyes and the ears of the organisation, so what are your additional duties of care. What should you do if you are suspicious of falling standards of an individual or the trust? We have to facilitate a culture that allows you to report on poor performance.

Indeed, I continue to be distressed with our own cases of poor performance by the delay in initially identification of a problem through to satisfactory resolution.

So what are our strategies to reduce the problem of poor performance? The RCOG suggests that the following elements are central to the issue of improving performance, including clear leadership, outstanding metrics, a clear evidence base, quality training and assessment, lifelong learning, embracing new patterns of care and close team working with professional colleagues.

Clarity of a vision in which the needs of women is first and foremost has been a central component of the strategy, *High Quality Women’s Healthcare* (16) and *Tomorrow’s Specialist*. Putting the individual needs of patients first and foremost is a fundamental principle from the Francis report. The challenges of developing and training outstanding clinical leaders are being developed on a number of fronts. Professional national leadership has been hugely
encouraged by the appointment of a national clinical director in women’s health.

The introduction of good information systems and strong clinical governance, introduced into NHS practice by the last CMO Sir Liam Donaldson and Gabriel Scalley, is part of this challenge (17). The reputation of cardiac surgery and the outcomes for patients has been transformed by the production of risk assessment and modification for outcomes in surgery (18). Sudden alterations in medical and surgical performance can lead to corrective measures if required. Such processes are being developed and implemented for obstetrics and gynaecology. Why you might ask are 30% of elective LSCS for reasons other than placenta praevia performed before 39 completed weeks? (19)

Within the maternity provision it seems likely that outcome data will reflect the performance of the multidisciplinary team rather than individuals. In contrast, in a surgical discipline it is likely that the outcomes will be much more focused on the individual surgeon. However, such data has problems- one needs to understand what lies behind the figures- in other words the indications and the wisdom of the individual decision may be lost. In my own area of gynaecological oncology the decision and conflict between radical therapy and supportive non interventional care may be fine; in the former you may be criticised and so you may in the latter. This exemplifies the complexities of this area and the challenges to quality assure the meaning of the data.

The Specialist Career Development Working Party, which has started its brief recently will begin to examine concepts and vehicles of lifelong training for those after CCT, in line with the new ways of delivering clinical care. The
emphasis on close team working is likely to be a strong element of all our work.

For the future remediation will become more common at an earlier stage. Current data suggests that following serious events 60% of doctors can return to meaningful work following remediation.

And what of the ethical challenges surrounding our service structures? The RCOG has for some time supported the concept of senior, 24 hour consultant presence on labour ward. This can only be achieved realistically by reconfiguration in the current economic climate. The behaviour of many people can be severely tested in such a climate as exemplified in Leeds around paediatric cardiac surgery. Indeed does 24 hour consultant cover outweigh the needs of appropriate number of midwives - the ethics of resource utilisation is complex. Should one wear blinkers to protect one’s own fiefdom? The reality is that new configurations of care will evolve rapidly. The subspecialties which account for fewer than 20% of our specialists will continue at the sharp end together with academics and innovators, but it is likely that much care will pass to community stings and we need to embrace such change to provide the most cost effective safe and quality driven service.

At the beginning I alluded to the concept of institutional ethics and conscience and the effect on performance. Much has been said and incorporated in the Mid Staffs report about the impact of targets and bullying on performance. As a specialty we have to address this challenge internally, as it can be detrimental to performance.
Mr Chairman - the challenges of performance have always been with us but never under such a spotlight. After 40 years in medicine, I have been heartened by the desire of all doctors, experienced and in the training grades, - to give the patient the best care possible, but we are all human and performance can vary from day to day, indeed within a clinic one can make completely different decisions for a very similar problem or there are days when operating seems so difficult and a struggle. But the openness and desire to deliver safe, high quality care, based on evidence that is acceptable to the patient, the three principles described by Lord Ara Darsi (20) have improved the quality of performance. I hope and believe that the leadership of our discipline and our Royal College will continue to strive to improve the quality of care for all women both in the UK and indeed globally, but it can only do this with full cognisance of the ethical values that are so fundamental to us. These elements are enshrined in our recently released Manifesto, containing our commitments to patient care as a result of the Francis report. Please embrace the current opportunities to raise the quality of our performance for the women we serve.

Thank you
References:

5. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582