Editorial

THE MEDICAL PROFESSION IN THE UK CLOSE TO THE EDGE - 'QUO VADIS?'

It is axiomatic in any discussion about the unwritten contractual relationship which exists between every medical doctor and any one of their patients that a duty of care is owed by the doctor to his patient. The patient has an unalienable right to expect that a doctor will deal with all his medical problems to the best of his training, experience and ability. It also goes without saying that this delicate relationship is based on mutual trust and confidence between the doctor and his patient; anything at all that whittles away at this professional bond, and depletes such basic tenets of this doctor-patient interaction, will mar and flaw in a fundamental manner this co-operative and carefully poised interaction.

Prior consent to any proposed treatment and investigation has to be obtained, and this only after an open and unhurried discussion with the patient - or his immediate carers, if for some reason his competency and mental understanding has become diminished. Such consent should be soundly based on an exchange and imparting of information, in plain language, in the context of a truthful, honest, accurate and complete response to any questions asked by the patient of his doctor, no matter how banal or irrelevant they may appear. There is no scope for holding-back information, fuding or prevarication: the process has to be taken seriously and be seen to be totally unassailable on scrutiny. The approach has to be non-paternalistic and there is certainly no scope for the I-know-best-trust-me attitude. This obligation should transcend any legal impositions or implications; it is simply an integral and intrinsic part of professional 'best practice'.

If one picks up any of the popular newspapers in Britain over the last few months, it seems that not a month has passed by without yet another news item being reported at length by the media in which a fundamental attack is mounted against doctors. Open and widespread criticism of doctors is now common-place and, more worryingly, a significant proportion of it appears to be well justified. There can be no doubt that this is seriously eroding and damaging the mutual doctor-patient trust. This is at a time that the health services in general seem unable to cope with the demands which are being increasingly made of them by the population at large, and by the politicians in particular, who spend considerable amounts of their time heckling and castigating each other about alleged deficiencies in the general medical services being provided; particularly about administration, prioritisation, general financing, the unattainable, non-realistic and irrelevant targets that have been set, and the 'league tables' of performances that are being regularly compiled and published.

One can guarantee that on anyone's personal agenda, no matter what their age and socio-economic background, health of mind and body, of oneself and one's family, over-rides many other basic considerations and demands. This should be reflected (and often is) in the manifestos of political parties seeking the public mandate to rule: the party that can provide the most effective and efficient health and welfare services must surely be the one to be elected.

If a person feels unwell he wants to get better as soon as possible. He would wish to have his condition or medical complaint looked at by a doctor at an early date, and any investigations and second opinions which are required to be carried out promptly. Effective curative or palliative treatment should be instituted as early as possible. A thriving and reasonably wealthy nation should be able to provide all of this to all of its citizens, 'from the cradle to the grave'. A failure to do so, for whatever reason, requires careful scrutiny and perhaps a re-think of political priorities and agendas.

The litany of high-profile public medical scandals seems to be never-ending and continues to expand:

- An inordinate number of deaths occurred in Bristol in young babies requiring open-heart surgery to correct congenital malformations. The situation only came to the fore when an anaesthetist eventually broke ranks and managed to voice his disquiet about his colleagues.
- The notorious, hardly imaginable, exploits of the former GP from Hyde, Harold Shipman, exposed other deficiencies in the system of recording and investigating sudden deaths, dispensing of controlled drugs, rehabilitation and re-registration of doctors convicted of drug offences and personal addiction; it revealed a tissue of other problems.
- In Liverpool and elsewhere, parents of children who died years previously had to attempt to come to terms with the discovery that the formalin-fixed organs of their children removed at autopsy were still being retained in large numbers within pathological stores without their knowledge and certainly without their informed consent.
- In North Staffordshire, a clinical trial of treatment of continuous negative intra-thoracic pressure in premature babies and in children suffering from bronchiolitis went ahead with little apparent parental knowledge or at least without their directly obtained and informed consent, yet with the apparent full ethical approval and *imprimatur* of the local hospital ethics committee.
- A consultant gynaecologist, known to be incompetent, was allowed to continue to practice for many years without his colleagues intimating to anyone in authority that there was a major and blatant problem concerning his expertise and competence; the patients were sacrificed on the altar of maintained respectability and tight colleague-to-colleague spurious solidarity. Another similar case is being scrutinised at present.
- Results of pre-natal tests were erroneously churned out in considerable numbers from a biochemistry departmental computer, and mothers who had been happily re-assured of an absence of problems had to be recalled with delayed 'bad news' when their pregnancy had moved on considerably.

- Doctors unknown to their employers to be suffering from hepatitis C and untreated tuberculosis were allowed to carry out surgical procedures and to treat children.
- An anaesthetist whose basic qualifications were suspect and whose general competency was a cause of major concern to several hospitals in which he had already worked was allowed to continue to practice apparently unhampered until a child died because of his incompetence; even then his registration was maintained.
- 'Do-not-resuscitate' decisions - perhaps for the correct reasons - were taken unilaterally in hospitals without the certain knowledge of the patient and their immediate family.
- Erroneous anti-malarial prophylaxis was handed out to soldiers on active duty in Sierra Leone resulting in about a score of them contracting malaria.
- A retired (75-year-old) non-registered histopathologist allegedly wrongly reported on about 200 biopsy specimens of breast.
- And so on and so on...!

The whole matter revolves around the question of the medical profession's public accountability. In the ascerbic preface to his play *The Doctor's Dilemma,* George Bernard Shaw wrote that all professions are a conspiracy against the laity. The law as it stands currently entrusts most of this scrutiny and accountability squarely into the hands of the General Medical Council (GMC), and thus the medical profession - as are many other professions - is largely self-regulating. The system is to a large extent reactive rather than proactive in that the GMC only responds to complaints made to it. A. J. Dunning, Professor of Cardiology in Amsterdam, states that 'the profession's sole legitimacy is the interest of its patients'. Given what has taken place so far, as the lawyers would say, *res ipsa loquitur* – the facts speak for themselves!

Patients nowadays are by and large much better informed about their medical complaints. Many 'surf the net' and download reels of information which they will read and then come armed with to confront their medical advisers. Physicians may often be faced with the additional task of leading their patients through this maze of information, thus enabling them to pan out the nuggets of useful information from the muddy waters of surfeit data.

The concepts of clinical governance and revalidation of doctors which have been mooted by central government have been embraced and to some extent implemented by the GMC; when they are fully implemented the profession will have gone a long way to ensuring that the future will be better than the present. The consensus suggestion likely to be put forward in terms of subsequent assessment of performance in a medical career position will be based on a portfolio of evidence relating to performance in post, annual appraisal and a record of continuing professional education and development - possibly at five year intervals.

There is an emerging popular imperative that a sound and binding confidence in the medical profession has to be re-established; this has fuelled central government further in its intention to ensure that this does take place. The legitimate demands which every citizen is looking for from the health services can perhaps be précised as follows:

- A reasonably prompt access to competent and caring medical practitioners, as and when this is required, both in primary care and in hospitals.
- A balanced but close co-operation between primary care and hospital care, with a seamless continuity and communication between the two.
- An integrated medically-led, regularly updated health care system that caters for all the medical and social needs of all patients from the cradle to the grave, with close interaction between medical, nursing and paramedical professionals.
- Access to specialised investigation and treatment options without the intervention of tiers of bureaucracy which, to most, appear wasteful of time and resources.
- An inpatient hospital system in which all the needs of the patient, including their nursing and basic social needs such as assistance with eating, bathing and phoning home are carefully and individually considered and catered for.
- A proper balance between prophylactic and preventative medicine, and between palliative and curative treatments.
- An integrated scheme enabling full and supervised convalescence and recuperation before discharge from hospital to the home environment, and the availability of comprehensive community-based medical and nursing services thereafter.
- A dialogue and exchange of information between those who have to attend hospitals and general practice surgeries, and those who manage and work in these hospitals and surgeries.
- The issue of consensus guidelines of 'best practice' which are evidence-based, financially achievable and affordable, that enable a uniformly sound and competent attention to illnesses nationwide and that have the approval of both those in primary care and hospital practice.
- An unashamedly uniquely patient-directed approach, unfettered by administrative hindrance and other considerations.

A frequent ploy of industry is for managers to seek to assess their own schemes of operation by putting themselves anonymously through the systems that they have devised, planned and manage. I am convinced that it would be quite salutary and revealing for persons in medical and hospital administration, doctors and lay administrators alike, to find out directly and anonymously for themselves, and not through surveys, about the procedures that are in place in each individual hospital; for example, in terms of arranging an outpatient appointment or an endoscopy, or attending for a repeat appointment to an outpatient clinic, or perhaps spending a couple of days as a patient on a day ward. They may be unpleasantly surprised that procedures that seem to be so streamlined on paper do not actually work in practice. And that there are genuine grievances that should be considered and rectified.

The medical profession has to look carefully at the path that it is currently charting for itself, at those who are leading it down this path, and indeed ask the question, whither hence? Could it ensure that at least some of these reasonable grounds for such 'doctor-bashing' cease to exist? Should not doctors be able to sort their own profession, and indeed, if there are grounds for improvement, should it not be the profession, rather than an external agency or (perhaps even worse) central government, imposing safeguards and standards? The sands of time are running out on doctors – and indeed may have already run out completely: it is time to act, and to act decisively.