Medical Profession’s Autonomy Challenge
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Any problem?

Sanctity of life & human body
Hamurabi
• 215. If a physician make a large incision with an operating
knife and cure it, or if he open a tumor (over the eye) with an
operating knife, and saves the eye, he shall receive ten shekels
in money.
• 218. If a physician make a large incision with the operating
knife, and kill him, or open a tumor with the operating knife,
and cut out the eye, his hands shall be cut off.
• 219. If a physician make a large incision in the slave of a freed
man, and kill him, he shall replace the slave with another
slave.

Regulating Behavior
• What
  – Intrinsic vs extrinsic factors
  – Self “interests” vs External “controls”
• Who
  – Self -> Morality
  – Guild -> Profession
  – Society -> Law

Professionalism
• Professionalism is the conduct, aims or qualities that characterize a profession or a
  professional person (Merriam Webster Dictionary)
• A moral code is often the basis of professionalism
• It involves “professing” [VOWING] openly that you are that type of person, usually by taking
  an oath
Internal regulation – autonomy

- Medical Professional codes
  - Imhotep
  - Hippocrates
  - Ibn Maymoun
  - Geneva oath

Abu Imran Musa ibn Maymun ibn 'Ubayd Allah
(Maimonides)

The eternal providence has appointed me to watch over the life and health of Thy creatures.
May the love for my art actuate me at all times;
May neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.
May I never see in the patient anything but a fellow creature in pain.
Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements.
Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today.
Oh, God, Thou has appointed me to watch over the life and death of Thy creatures; here am I ready for my vocation and now I turn onto my calling.

Self-regulation held by an oath

- The "Oath" is a personal individual commitment and does not entail any external regulation or control.

- Medicine continued as an unregulated market with the entrepreneurial attitudes and practices dominating medical practice for centuries

- The tension that existed in the Hippocratic text between a life of service to patients and entrepreneurial self-interest was resolved in practice usually in favor of self-interest.

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Threats to autonomy

- Gregory’s problem list - 1700
  - Abuse of Power
  - Arrogance
  - Greed
  - Misrepresentation
  - Impairment
  - Lack of conscientiousness
  - Conflict of interest
Public image

Ils savent, mon frère, ce que je vous ai dit, qui ne guérit pas de grand'chose: et toute l'excellence de leur art consiste en un pompeux galimatias, en un spécieux babil, qui vous donne des mots pour des raisons, et des promesses pour des effets.

Thomas Percival - 1803

Gregory & Percival Code

Physicians should commit to:
1. Maintain scientific and clinical competence
2. Primacy of patient welfare
3. Maintain and pass on medicine as a public trust
   (not a private guild, that is, group self-interest should be kept systematically secondary in the care of patients)

Health Professionals are Fiduciaries

• A fiduciary is one who:
  – holds a specialized knowledge or expertise
  – holds the trust of others
  – is held to high standards of conduct
  – avoids conflicts of interest
  – does not seek personal gain
  – is objective
  – is accountable or obligated (ethically and legally)

Managed Care: Techniques

• Managing demand
  – Capitation
  – Gate keeping
  – Consumer education
• Managing delivery of care
  – Non-physician use
  – Home care
  – Telemedicine

Threats to autonomy

• Technology – 1970s
• Managed Care – 1980s
• Variations in practice – 1990s
Variations in practice

- RAND reports: more than a third of medical care may be unnecessary or of little benefit

“System” Causes of Unwarranted Variation

- Under-use of effective care.
- Misuse of preference-sensitive care
- Overuse of supply-sensitive care

Regulating the Profession 1950 - 1980

- Oaths are good but also medical codes should be adhered to and rules placed to define
- Specialties
- Privileges
- Licensing
- Continuing education

Doubts about Quality of Care

- Became an issue in the US in 1990s
- Consumer distrust of health providers
  - Institute of Medicine Reports
    - To Err is Human: IOM report in 1999
    - Crossing the quality chasm: IOM report in 2002
  - Managed Care Organizations excessive control
    - Referrals to specialists, Utilization management
  - Employers activism
    - Reacting to rising health care costs (10% a year), employers shifted costs to patients and educated them about how to chose “better” care (consumerism)

Estimated Deaths Due to Medical Error

- National Institute of Medicine report 1999

- Estimated Deaths: 10,000 people die each year as a result of medical errors. In every state, medical errors are the third leading cause of death behind heart disease and cancer. Of all the deaths, 98,000 people die each year in U.S. hospitals as a result of medical errors. This is more deaths than are caused by car crashes, plane crashes, handguns and handguns combined.

- Source: Philadelphia Inquirer
1999: The 1st IOM Report

To Err is Human

- The challenge
  - reduce medical errors by 50% in five years
- The call to action
  - non-punitive error reporting systems
  - legislation for peer review protections
  - performance standards for safety assurance
  - visible commitments to safety improvement
  - attention to medication safety

2001: The 2nd IOM Report

Crossing the Quality Chasm

- Safety is a key dimension of quality
- Systems approach to safety improvement
  - simply trying harder will not work
  - stepwise correction of problems in the system is the key to success
  - overcome the culture of blame and shame:
    - Human error is to be expected!

A Few Simple Rules for Health Care in the 21st Century

<table>
<thead>
<tr>
<th>Current Approach</th>
<th>New Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do no harm is an individual responsibility</td>
<td>Safety is a system property</td>
</tr>
<tr>
<td>Information is a record</td>
<td>Knowledge is shared and information flows freely</td>
</tr>
<tr>
<td>Secrecy is necessary</td>
<td>Transparency is necessary</td>
</tr>
<tr>
<td>The system reacts to needs</td>
<td>Needs are anticipated</td>
</tr>
<tr>
<td>Professional autonomy drives variability</td>
<td>Decision-making is evidence-based</td>
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Quality

- Three faces of quality
  - Process of care
    - CQI, TQM, Process Improvement
  - Outcome of care
    - Outcomes management, disease management, profiling
  - Standardization of care
    - Clinical guidelines, EBM, protocols, case management

Regulating the Profession

1980 – 2000...

- Guidelines / standards of care based on epidemiologically sound evidence
- Patient Safety as a core value
  - The reduction and mitigation of unsafe acts within the health-care system, as well as through the use of best practices shown to lead to optimal patient outcomes.
- Error disclosure
- Just culture
**Safety Culture Components**

- **INFORMED CULTURE**
  Those who manage and operate the system have current knowledge about the human, technical, organizational, and environmental factors that influence the safety of the system as a whole.

- **REPORTING CULTURE**
  An environment in which people are prepared to report their concerns and near misses.

- **JUST CULTURE**
  An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior.

- **LEARNING-CULTURE**
  An organization that possesses the willingness and the competence to draw the right conclusion from its safety information system and the skill to implement major reforms.

- **FLEXIBLE CULTURE**
  A culture in which an organization is able to investigate themselves in the face of high-stakes operations or certain kinds of danger—often shifting from the conventional, hierarchical mode to a flatter mode.


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**Culture of Blame**

The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes.”

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on Health Care Quality Improvement

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**A Just Culture**

Reconcile the public interest of reducing errors with sanctity of life and human body

**A Set of Beliefs**

- A recognition that professionals will make mistakes
- A recognition that even professionals will develop unhealthy norms
- A fierce intolerance for reckless conduct

**A Set of Duties**

- To raise your hand and say “I’ve made a mistake”
- To raise your hand when you see risk
- To resist the growth of at-risk behavior
- To participate in the learning culture
- To absolutely avoid reckless conduct

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**Just culture Issues**

1. Who in the society gets to draw the line between acceptable and unacceptable behavior?
2. What and where should the role of domain expertise be in judging whether behavior is acceptable or unacceptable?
3. How protected against judicial interference are safety and quality improvement data?

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**Summary**

- **Medical profession** has particularities leading to unique responsibilities for physicians:
  - Sanctity of life and human body
  - Privileged Information
  - Privileged scientific knowledge
  - Inexact science
- The “fiduciary” nature of the patient-physician relationship requires physicians to act according to **high standards of conduct**.
  - Implicit individual contractual relationship related to performance and not outcome
- The consequences of unprofessional behavior are destruction of public trust and worse outcomes for people with illness
- A **culture of safety** is imperative to maintain professional autonomy
Responsibility and Accountability

- Ethical – Accountable to self
  - Maximize good
  - Do what is “right”
- Professional – Accountable to “Guild”
  - Standards
  - Cohesion
- Legal – Accountable to Society
  - Civil
  - Penal

“We can’t change the human condition, but we can change the conditions under which humans work”

James Reason

Any Problem?