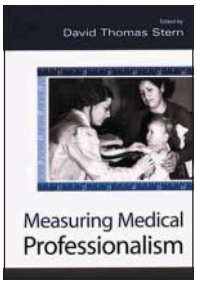
reviews

BOOKS • CD ROMS • ART • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS

Measuring Medical Professionalism

Ed David Thomas Stern

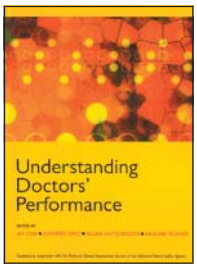


Oxford University Press, £29.99/$49.50, pp 311
ISBN 0 19 517226 4

Rating: ★★★★

Understanding Doctors' Performance

Eds Jim Cox, Jennifer King, Allen Hutchinson, Pauline McAvoy



Radcliffe, £27.95/$52, pp 184
ISBN 1 85775 766 1

Rating: ★★★☆

The past 20 years have seen a resurgence of interest among doctors in the concept and practice of "professionalism." The Royal College of Physicians of London recently defined medical professionalism as "a set of values, behaviours, and relationships that underpins the public trust in doctors." In his elegant introduction to *Measuring Medical Professionalism*, Jordan Cohen, president of the Association of American Medical Colleges, said that a physician imbued with professionalism offers patients by far the best chance of a good outcome in our increasingly sophisticated and risky healthcare system. For patients nothing can substitute for having a trustworthy doctor, "not laws, not regulations, not a patients' bill of rights, not watchdog federal agencies . . . nothing."

So where did this new interest come from? After all, professionalism in medicine has deep historical roots. Until the 1980s it was the undisputed keystone of the regulatory bargain between the state and doctors in which doctors promised to put the interests of the public and patients first, ensuring a good standard of competent, ethical practice, in exchange for the freedoms and social status inherent in self regulation. What actually happened is that a culture of professionalism that was originally appropriate for the relatively uncomplicated practice characteristic of medicine in first half of the 20th century failed to evolve. This failure occurred because the international medical profession did not adjust for the effect that burgeoning scientific discoveries were having on the organisation and delivery of medical and health care. Nor did it respond quickly enough to the rapidly changing expectations of an emergent educated middle class society in the information age. The result, unnoticed by many doctors, was that the "old style" professionalism passed its sell-by date. Thus the hole that doctors left in the regulation of medical work began to be filled from outside by the new managerialism and market forces.

> "Organised medicine is going to have to say, 'There's a new sheriff in town,'—and mean it"

Then came the renaissance. It began with thoughtful doctors, sociologists, and lay people seeing that unrestrained consumerism, commercialism, and managerialism could easily strip the profession of medicine of its ethical core: of its conscience, its identity, its very being, of what the medical sociologist Eliot Freidson calls its soul. That could have disastrous results for patients, the public, and doctors alike, for despite modern science medicine is still a judgment based profession in which trust is fundamental to effective clinical practice.

Three early initiatives to address the problem stand out. In the late 1980s the American Board of Internal Medicine launched an ambitious programme to develop a physicians' charter that sought to align professional core values with public expectations. In Canada the medical school at McGill University was giving new meaning to its Oslerian legacy of professionalism. And in the United Kingdom in the early 1990s the General Medical Council began a fresh, patient centred approach to professionalism, embodied in the 1995 "Good medical practice" statement. Today this consensus statement between public and profession is being embedded into all aspects of UK medical practice, education, regulation, and doctors' contracts of employment.

Which takes us to *Measuring Medical Professionalism*. The book focuses on the difficult territory of assessing professionalism in the various stages of the medical curriculum. By common consent the development of assessment methods is still at an early stage, so this well produced critical review is timely. The excellent introduction by the editor, David Stern, provides a working framework. The main body of the book comprises chapters, all by US authors, which together represent an authoritative overview of the current state of the art and, incidentally, show just how seriously the Americans are taking the conceptual and methodological challenges. If the book has a weakness it is that the direct assessment of patients' experiences gets too little attention. The book ends with a well argued commentary by Fred Hafferty from Minnesota. Hafferty leads the reader through difficult terrain with engaging frankness and clarity—socialisation, authenticity, altruism, professional standards, and the hidden curriculum are examples. All good stuff.

A lack of professionalism leads ineluctably to poor performance. *Understanding Doctors' Performance* is edited by a UK group who are experienced assessors of poorly performing doctors. In their multi-author presentation they have brought together existing knowledge about the factors influencing a doctor's performance. They succeed well in their aim of providing practical, evidence based guidance to help individuals, employers, and regulatory, educational, and professional agencies charged with the task of managing concerns about doctors' performance. The essays cover all aspects of impaired performance and are nicely written and of good quality. They provide a sound, basic guide for those having to handle performance problems for the first time.

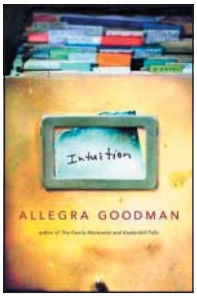
However, one must sound a cautionary note about such positive movement. Today the public expects that everyone must have a good doctor—that there should no longer be any element of chance about it. Public trust in the medical profession will therefore be sustained only if doctors are serious about being re-energised by the new professionalism. To achieve this, the institutions of medicine must act together decisively, putting the public interest first. Principled, courageous professional leadership will be at a premium. In Hafferty's colourful words, "Organised medicine is going to have to say, 'There's a new sheriff in town,'—and mean it."

Donald Irvine *chairman, Picker Institute Europe, and former president, General Medical Council*
donald@donaldirvine.demon.co.uk

Items reviewed are rated on a 4 star scale (4=excellent)

Intuition

Allegra Goodman



The Dial Press, $25, pp 344
ISBN 0 385 33612 8
Also available as an ebook, $17.95
www.randomhouse.com/bantamdell/dialpress.html

Rating: ★☆☆☆

This is a novel about research institutes, the precariousness of their funding, and the vulnerability and vanity of the human characters that inhabit them. It also claims to be about the nature of scientific discovery.

A gawky, brilliant, and highly strung postdoctoral researcher, Cliff, has spent seven years working obsessively on the task assigned him by his professors on his first day in post—to find a cure for cancer by injecting variants of a virus into nude mice—with spectacularly negative results. One day, while making routine measurements, he notices that the tumours are regressing in half his sample. Within a month they have melted away.

Cliff's contemporary at the lab and erstwhile girlfriend, Robin, already miffed that his attention has shifted from her to the contents of the cages, and knowing that at his recent appraisal he was told his grant was coming to an end, suspects fraud and embarks on a one woman mission to expose him. But the professors use their contacts to fast track a paper into *Nature* and outgun the competition for a much needed grant that will save everyone's jobs and buy gleaming new equipment all round. Crucially, the findings have yet to be replicated, so much of the plot hangs on uncertainty. Even we, the readers, never find out if Cliff's scribbled and barely coherent lab notes came from honest and timely observation or from a desperate attempt to cover his tracks.

You will have to read the book to see whether Cliff ever gets back under the sheets with Robin. But you have probably heard enough to consider this book (widely acclaimed by literary critics) as an example of how high stakes science is portrayed to the lay public. In Goodman's universe, science is 100% inspiration. There is nothing between an absence of findings and the prime slot in *Nature*; nothing between "incurable" and "curable" cancer; and precious little for the mid-career scientist between unemployment and a Nobel prize. The literary tropes of suspense, surprise, irony, and twists in the plot lend themselves to dramatic and unexpected discoveries by the laboratory underdog, whereas a story about dogged puzzle solving by middle ranking scientists with an average amount of ability and integrity is not much of a story.

I've been mean with the stars because I'd like to see quality writers be more responsible when portraying scientific issues. Goodman should read Ian McEwan's *Saturday* (see review *BMJ* 2005;330:368) to see what can emerge when a talented writer does his homework before grappling with a specialist subject matter.

Trisha Greenhalgh *professor of primary health care, University College London*
p.greenhalgh@pcps.ucl.ac.uk

TV

Is Gordon Ramsay good for our health?

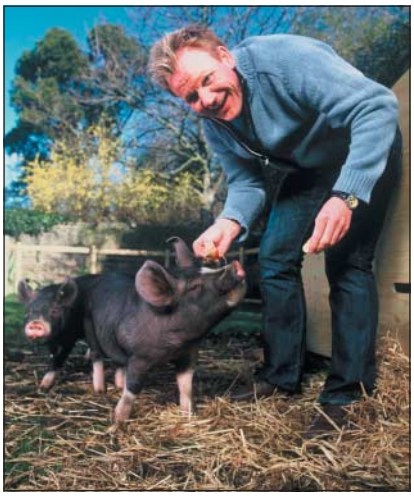
Gordon Ramsay's F word, Channel 4, Wednesdays at 9 pm

Rating: ★★★★

Despite the millions of unopened boxes of health promotion leaflets rotting in landfill sites and the deafening whine of chainsaws felling forests to produce ever more, health promotion makes an F word of a difference to people's lifestyles. Television and celebrity chefs, however, directly affect our diet and attitudes towards food. Remember the beaming faces of Jamie Oliver and Tony Blair as they shook hands in 10 Downing St after Jamie's series on school dinners (see review *BMJ* 2005;330:678)?

In his new series of the *F word* prolific swearer Gordon Ramsay is campaigning for families to sit down and eat. He shows a family who ditched their dinner table, as they never used it. Surely it can't be worth upsetting the kids by going retro at meal times? Remember sitting at dinner upsetting your parents with your radical views and the blazing arguments? The excoriating silences and stilted conversation when your girlfriend or boyfriend came to tea, and how you laughed afterwards? Peeling the vegetables and washing-up rotas? Cooking and eating are an expression of family identify, communication, and social norms—a microcosm of society and life. Today eating has been reduced to little more than a bodily function, and "quality family time" is eating off our laps while watching someone being evicted on *Big Brother*. Good luck, Gordon.

Gordon Ramsay rages on. This time it is those beloved middle class takeaways, the readymade meal. An English family living in France is profiled, so addicted to this homogenised slop that they ship in readymade meals from England. A generation of families has been lost, apparently without even the most rudimentary of cooking skills. France may have many flaws, but at least its citizens seem to value the importance of food, family, and farming. Our schools teach "food technology" rather than cooking, no doubt done in the name of risk reduction and the fear of the Health and Safety Executive. It is clear that we have lost our way with food.



Back to basics: Gordon Ramsay

Likewise society has become uncoupled from farming. Our children are suspicious of anything that doesn't come wrapped in cellophane or cardboard. Animals have become "Disneyfied"—cute, clothed, and talkative. The reality is the forgotten, factory farmed animals abused in the name of cheap meat. Animals, no longer respected in a symbiotic relationship that can be traced back to when humans first became farmers, are just another disposable product. To counter this, the celebrity chef Hugh Fearnley-Whittingstall persuades Gordon Ramsay to fatten some pigs in his back garden. These beautiful animals churn his lawn in an instant, and whether he will eat them in the end only time will tell. Involving his four children in rearing these animals is laudable.

There is much to commend in Gordon Ramsay's *F word*, for he has unwittingly touched on the issue of our time: affluence and convenience. The domestic monotony of previous generations has been replaced by something far more tedious: leisure and celebrity. I doubt Gordon Ramsay will enjoy a good swear with Tony Blair off the back of these programmes, but he is watchable none the less. Will we see families sitting together for meals and the demise of the ready meal? I doubt it. As any chef or parent knows, the most popular dish is the course of least resistance. Anything for an easy life.

Des Spence *general practitioner, Glasgow*
destwo@yahoo.co.uk

PERSONAL VIEW

Thinking the unthinkable: selling kidneys

The call by two US renal specialists for active consideration of "the controlled initiation and study of potential regimens that may increase donor kidney supply in the future in a scientifically and ethically responsible manner" through cash payments is an uncomfortable challenge (*Kidney International* 2006;69:960-2). However, it is not one that necessarily requires us to venture far into new territory. We already have well regulated tariffs for the valuing of various body parts, including kidneys. And the valuation that the two specialists suggest—$40 000 (£22 000; €32 000), which is based on calculations by a Nobel prize winning economist—is compatible with these tariffs.

Several "incentive models" (*American Journal of Transplantation* 2005;5:15-20) already operate for the involvement of people in medical activities that do not benefit themselves directly. In the United Kingdom and the United States living donors currently have their expenses related to the operation and recovery reimbursed by the NHS, Medicare, or insurance companies (or in the state of Wisconsin by tax rebates to the value of $10 000). Private sector employers and the US federal government provide several weeks of leave for organ donation. This reimbursement model is closer to a "service" model of compensation for income lost than a "market" model of sale of a commodity.

> We already permit the sale of body parts and fluids on the market model

The service model is well established in the payment of research subjects for their time and loss of earnings (on a wage payment model that references the national minimum wage) and the risk factor and unpleasantness of the procedures they are subjecting themselves to. A US study found that payments to participants in medical research ranged from $5 to $2000 (*Contemporary Clinical Trials* 2005:26;365-75), and UK drug testing companies commonly offer £2000 to £3000 for unpleasant regimes requiring residence in a testing unit. Another US study found that although monetary payment had positive effects on respondents' willingness to participate in research, regardless of the level of risk, higher payments did not seem to blind respondents to the risks of a study (*Journal of Medical Ethics* 2004;30:293-8). Many research organisations pay completion bonuses.

We already permit the sale of body parts and fluids on the market model. Blood and gametes are distributed and redistributed for a monetary value. The UK is one of the minority of countries that still rely on predominantly voluntary donations of blood. Although sperm and ova have the awesome power of creating new human life, we do not seem to worry too much about their "fungibility"—the fact that in these transactions they are being traded and provided as exchangeable things. Which is to say that we have gone a long way towards commodifying body parts, tissues, and fluids and accepting their fungibility in the process of enhancing their use in both curative and preventive medicine—and indeed in elective procedures such as abortion, fetal reduction, and selection.

We have also already determined "tariffs" for the value of certain body parts in compensation models for workers' accidents, criminal injury, or injury incurred during military service. The UK Criminal Injuries Compensation Authority pays £2500 for a fractured coccyx, £3800 for a hernia, and £22 000 for loss of one kidney. The UK Veterans Agency has just issued a 15 level list of tariffs that is compatible with the Judicial Studies Board's guidelines for the assessment of general damages in personal injury cases. More than a billion dollars has been paid out under the US radiation exposure compensation systems and the Marshall Islands nuclear claims tribunal (which pays $75 000 for cancer of the kidney).

If we are not shy about reaching these values why do we shrink from constructing a regulated exchange system for body parts that would undercut the existing illegal trade, which is so hazardous for the vendors? The average wage in the UK in 2004 was £26 151, which is close to the national average wage index of $35 000 in the US. Both values are close to the $40 000 recommended by the Nobel prize winner Becker and his colleague. If such a sum were part of a package that involved the highest level of clinical care and follow-up, would it be any more reprehensible than the "vending" that is currently permitted for other body materials?

> We have gone a long way towards commodifying body parts, tissues, and fluids

Sue Rabbitt Roff *senior research fellow, Centre for Medical Education, Dundee University Medical School*
s.l.roff@dundee.ac.uk

Competing interests: SRR is a lay member of the Unrelated Live Transplant Regulatory Authority (soon to be decommissioned). She is also a lay member of the Postgraduate Medical Education and Training Board, the fitness to practise panel of the General Medical Council, and a deputy non-clinical scientist member of Tayside Local Research Ethics Committee.

SOUNDINGS

Giving up on getting better

The stillbirth rate in the United Kingdom has fallen steadily during my lifetime. This was not a by-product of prosperity: cars and foreign holidays do not save babies' lives. Things got better because we wanted them to. There was a consensus among professionals, politicians, and the public that we should work together to make pregnancy safer.

In 1998, however, the graph levelled off, and in 2002 the stillbirth rate increased for the first time in 50 years. Recent figures show the rise has been maintained. What is interesting is that we are pretending not to notice this historic change, let alone trying to understand what lies behind it.

Official statistics still say most stillbirths are "unexplained," but this is an old fashioned fudge. We know that over 50% of the deaths are associated with intrauterine growth restriction. The small babies who are at risk may be identified by ultrasound scans and timely intervention can deliver them alive.

We could try to save some of them but we choose not to. The reasons are not economic but political. Lay campaigners have managed to persuade us that pregnancy should be demedicalised. The NHS, intent on keeping people out of hospital, has been happy to agree. My antenatal clinic today is almost empty.

Pregnant women are now classified on arbitrary criteria as high risk or low risk. The former are carefully monitored. For the latter, the abdomen is checked by palpation, a technique unsupported by evidence. As a result, corrected singleton perinatal mortality is now higher among "low risk" than "high risk" women.

We do not mention this when women choose their antenatal care. Although we know that a hospital's stillbirth rate is inversely proportional to intervention and consultant availability, NHS patients are not allowed to book directly with an obstetrician. Instead, community midwifery is being overstretched.

Is it just that when figures are good, people give up on making them better? Not necessarily. When the risk of cot death was 1 in 500 a media campaign reduced it to 1 in 2000. Our current stillbirth rate of 1 in 200 could be tackled and the first step would be to give women the facts. But that would mean disturbing the new politically convenient consensus. Easier to keep quiet and let some babies die.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*