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Professionalism in medical practice

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The concept of professionalism for doctors has been present since antiquity.[1] The range of definitions in the published literature reflects the challenges in defining this part of medical practice.[2] In Singapore, it is codified by the Singapore Medical Council (SMC) Ethical Code and Ethical Guidelines, which was last updated in 2016 and is currently undergoing revision.[3] The SMC guideline goes beyond the matter of doctor-patient interaction. It covers domains that include good clinical care, good medical practice, relationships with patients, relationships with colleagues, maintaining health and fitness to practice, probity, advertising, finances in medical practice, and business relationships. Medical professionalism is also legislated through the Medical Registration Act.[4] The SMC is empowered to regulate the ethical behaviour and professional conduct of registered doctors. When there is a formal complaint made to SMC, a Complaints Committee (CC) is set up to evaluate the complaint and determine whether a formal inquiry is needed. A disciplinary tribunal (DT) is established for such formal inquiries. Defendant doctors and witnesses can be cross-examined at DT hearings. The DT will judge the case and pronounce a decision on whether the doctor is guilty of professional misconduct. An appeal against the decision of the DT can be made to the Court of Three Judges, which consists of three High Court judges. The accounts of DT proceedings are published. Such data was analysed as part of a case series that examined the nature and outcomes of sanctioned medical misconduct in six international jurisdictions.[5] However, there is a lack of studies that systematically examine the outcomes of SMC DTs in general, and those specifically focused on junior doctors, in particular.

In this issue of the *Singapore Medical Journal*, Norman et al performed a retrospective analysis of the outcomes of cases handled by SMC DTs regarding unprofessional behaviour of junior doctors.[6] A total of 317 DT cases were identified, of which 13 (4.1%) involved junior doctors: 4 (30.8%) cases involved professional misconduct, 4 (30.8%) cases involved fraud and dishonesty, 3 (23.1%) cases saw an acquittal, and one case involved defect in character and another disrepute to the profession. This study is important because this issue has not previously been addressed locally. It highlighted that only a small proportion of DT cases involved junior doctors, as well as the need to differentiate medical errors due to systems factors from those due to individual culpability. However, as the study was retrospective and only evaluated cases that required a DT, the results probably only represented the tip of the iceberg. Conceivably, some cases of lack of professionalism that were of lesser severity did not progress to the stage of requiring a DT.

Awareness of what constitutes medical professionalism is crucial and needs to be addressed during the formative years, starting from medical school and continuing throughout postgraduate training.[7,8] Junior doctors in public healthcare institutions in Singapore practise under close supervision, and many are in formal training programmes. Such supervised practice provides an opportunity to detect less than ideal behaviour and facilitates targeted interventions. In a retrospective case control study, Teherani et al extracted negative comments from student files for 68 case (disciplined) and 196 matched control (non-disciplined) physicians. Three domains of unprofessional behaviour were significantly related to later disciplinary outcome: (a) poor reliability and responsibility; (b) lack of self-improvement and adaptability; and (c) poor initiative and motivation.[9] Bad habits, once ingrained, may be difficult to change and will not simply disappear when the junior doctor becomes more senior.[10] It is crucial that the system is robust enough to identify unprofessional behaviours early, to facilitate timely intervention and behavioural change.[11] Not all professional misbehaviours are equal in severity.[12] The hope is to change behaviour and prevent progression to a severity that warrants formal disciplinary actions. An important concept towards such efforts in coaching and remediation is that of a just culture, as opposed to a blame culture; the latter is unfortunately more instinctive and has been suggested as a major source of an unacceptably high number of medical errors.[13,14] A just culture advocates balancing the accountability of healthcare workers and improving innate systems errors as an approach to improving patient safety.[13] A blame culture is more likely to occur in healthcare organisations that rely predominantly on hierarchical, compliance-based functional management systems, while a just or learning culture is more likely to occur in organisations that encourage greater employee involvement in decision-making. Active organisational management is important for the transformation from a blame culture to a just culture.[14] A just culture does not mean absence of individual accountability. Intentional, reckless and malicious acts are still punished, whereas unintentional and systems errors are managed with coaching and remediation. Team strategies and tools to enhance performance and patient safety in healthcare institutions have been developed. These skills are essential to the delivery of quality healthcare and in preventing and mitigating medical errors.[15]

The issue of what constitutes professionalism in medicine is complex. There are factors at the individual level, at the systems level and even at the regulatory level. It is crucial to consider the entire ecosystem, in terms of the medical community as a whole,

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and the interaction with regulatory authorities. Much attention has been focused on the individual. It is also crucial that systematic gaps are identified and remedied; otherwise, the individual is set up for potential failure. As for the regulatory perspective, there was recently disquiet on the ground regarding the appropriateness of regulatory punishment that was meted out in specific cases. In a recent case, a DT conviction for failure to take proper informed consent was set aside on appeal to the Court of Three Judges.[16,17] Since then, the SMC disciplinary process has undergone further review and reform. This is crucial for building trust and confidence in the system. Structural improvements, and improvements to processes and procedures, have been implemented. The role of mediation in the disciplinary process is emphasised, and there is a focus on enhancing training for CC and DT members.[18] Doctors need to be actively engaged in matters related to professionalism. On a macro level, there must be awareness of systemic gaps and concerted efforts to address these gaps. On a micro level, this involves role modelling, coaching and engagement in remediation efforts. One must also be prepared to step forward to serve, be it as trained independent expert witnesses or as members of the CC and DT, and help to make the system more robust.

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