

## THE GEOFFREY KAYE ORATION 2004

### “OUR PROFESSIONALISM AND OUR VULNERABILITIES.....”

The Geoffrey Kaye Oration is delivered biennially by the retiring President of the Society.

It was my pleasure and privilege to present the 2004 Oration at the Darling Harbour Convention Centre on 21 September 2004. An abridged version of this paper was published in the April 2004 ASA Newsletter.

Geoffrey Kaye was this Society's first and longest serving secretary and he has been honoured since his death by this Oration. My predecessors have studied Kaye and his works and have addressed certain aspects of his character as themes of these orations. Much is known about him and much has been said. Gwen Wilson's work "50 Years" is the source of much of what I will say.

Kaye was born in 1903, graduated in Medicine from University of Melbourne in 1926, attained an MD (Melbourne) in 1929, DA (Eng) in 1939, Fellowship of the English Faculty in 1949, Foundation Fellowship of the Australasian Faculty in 1952, and Life Membership of the ASA in 1964.

As a "resident anaesthetist" at the Alfred in 1927, Kaye was already handling private anaesthesia cases a year after graduating "to earn pocket money" whilst working for his MD. He aspired to an MRCP and to be a physician which he felt was a "dignified calling, but perhaps.....(sic) a somewhat futile one".

His thoughts turned to *anaesthetics*. He was impressed by the *technical* aspects of practice (unsurprisingly, as was his wont), and also by "the doyens of the day" noting them to be "*self trained specialists*" ...where (sic) conditions of Australian medicine at that time, especially in rural areas, required that they be *resourceful*. Fine qualities, he felt.

We have heard in previous Orations of "Kaye the communicator", "Kaye the visionary" and "Kaye the organiser", but not specifically I believe of "Kaye who was impressed by *technical* aspects" (or "*Kaye the gadget man*", as I suggest he might subsequently have been called).

There was no doubt that Kaye *was* a gadget man. One of his great passions was *anaesthetic apparatus*. Engineering techniques fascinated Kaye and he maintained from that time an engineering workshop in his home. This was the basis of the collection now housed within the College in Melbourne, and it had begun with a visit to the USA in 1930 and an association with McKesson. Kaye though had a fascination with the *contemporary* – worth remembering in the context of the "historical collection" at Ulimaroa.

*Kaye the gadget man* was though what I believe John Ashton, in the 1990 Geoffrey Kaye Oration, would describe as a “gauge watcher” and a “dial fiddler”.

Kay was also known for his martinis – no doubt an interest acquired during his American visit - and later for his *military career*, and there was no doubt he was an *internationalist*. Any of these might well be themes for future Geoffrey Kaye Orations.

### **Our professionalism.....**

Our specialty has enjoyed wonderful times over the last seventy years. I say seventy, because to me, *Anaesthesia* became a specialty in this country in 1934 with the establishment of the Society, spawning a Faculty, a College and two subdisciplines (Intensive Care and Pain Medicine) along the way. We, as anaesthetists, are all proud *professionals* – and we use that term to describe what we do and who we think we are as medical practitioners expert in *anaesthesia*.

“*Specialists*” and “*resourceful*”, and “*technical*”.....these words impressed Kaye, and no doubt to him connoted *professionalism*.

The dictionaries are consistent: the *professional person* is typified as skilled, proficient, expert, masterly, experienced, trained, qualified *and paid*.

John Hains (President from (1992 - 1994), writing in “Anaesthesia and Intensive Care” in 1987, described the development of the Society’s current symbol, or more correctly, badge. In heraldry, a badge is a “distinctive symbol”. In replacing the Society’s former badge, which contained a kangaroo jumping over a stylised Australia (certainly itself a “distinctive symbol”), certain features were felt to be important. These included elements of the original design (some *history*), the need for a reference to some element of anaesthesia (*our science*), a linking of the identity of the (then) Faculty and the Society (*collegiality*), and “uniqueness” (lending perhaps some *special authority*?) Various designs were proposed, some including the serpent seen so often in the “caduceus”, which was in one design “embowed” such that the serpent appeared to be eating its tail. This circular serpent lead ultimately to our circular symbol. The colours selected were black and gold: these were the colours used in the Faculty (and now College) gown (providing for the linking of identities), with the pot and wavy lines indicating vapour (the element of anaesthesia), and the hand (used in the UNESCO badge) suggesting “compassion sought and given by the touch of a hand”. The final product, our current badge, was felt to be “a distinctive symbol, clear and bold, which depicts *the ideals of the care, control, compassion and skill inherent in the practice of anaesthesia*”.

Combine all these – can we define anaesthesia professionalism?: *care, control, compassion and (technical) skill*. “*Specialists*”, and “*resourceful*”!

But is this definition enough in contemporary times ?

William Sullivan (a prominent American medical sociologist whose writings feature prominently in the recent literature addressing professionalism) gives an expanded view:

*“the professions have been granted a monopoly over the use of a body of knowledge..... as well as considerable autonomy, prestige, and financial rewards.....on the understanding that they will guarantee competence.....provide altruistic service.....conduct their affairs with morality and integrity”.*

Sylvia Cruess (a Canadian medical sociologist) whose writings also are well known in this area also addresses broader attributes of professionals, in a recent paper in the MJA (Med J Aust 2002; 177: 208-211):

*“core element is work.....based on the mastery of a complex body of knowledge and skills.....a vocation founded on knowledge of science or learning..... the practice is used in the service of others.....a commitment to competence, integrity, morality, altruism and the promotion of the public good within their domain..... these commitments form the basis of a social contract between a profession and society.....society in return grants the profession autonomy in practice and the privilege of self-regulation.....professions and their members are accountable to those served and to society”.*

Other commentators such as Irvine (an Englishman) have had similar things to say.

And there are other definitions of professionalism which others (be they patients, colleagues or others in the broader community) use to describe how *they* understand who we are and what we do.

**..... and our vulnerabilities?**

I do see an increasing challenge to “our professionalism” as we understand it. We are I believe vulnerable, and this is the theme of this oration.

Our professionalism is being challenged in a number of ways:

Firstly, there is a challenge to us as *medical practitioners*, and secondly, a challenge to us as *medical practitioner anaesthetists*. There are a number of challengers, all of whom have different concepts of what “our professionalism” is.

Our professionalism (as *medical practitioners*) has been under challenge for certainly a decade, perhaps two or three, *popularly* with the rise of complementary and alternative medicine and the expression of a belief that orthodox medicine is not the sole possessor of knowledge in health care, and more *philosophically*, by postmodernism and post structuralism. This recent challenge is not a feature of third world countries, where health resources are short and health outcomes as we expect them uncommon. It is though a phenomenon that is well observed in western society, where “consumer” and “green” movements are well established. Other professions have also of course been subjected to similar scrutiny, and the rise of secularism continues unabated.

I will address this first challenge initially. Our professionalism as *medical practitioner anaesthetists* is under challenge for different reasons and I will come back to this later.

In many ways, these challenges (as we would view them) to “our professionalism” remain hard to understand, but I would advocate that we do indeed need to try to understand them – and the modern sociological theories that underwrite them - if we wish to maintain control of “*our* professionalism”.

### **the Sociologists’ view.....**

Firstly, Sociologists – and medical sociologists – now emphasize a “contract between professions and society”.

The “contract” gives rise to their preferred definition of *professionalism*.

Sullivan (writing with particular reference to Canada and the United States) states that *the “contract” is..... relatively simple: the contract is the social basis of the extraordinary grant of occupational authority and independence to professionalized occupations [such as medicine and law].... a social contract between the profession and the public.*

*Professionalism is (then) the moral understanding among professionals that gives concrete reality to this social contract.*

He adds:

*“Professionalism is based on mutual trust.....in exchange for a grant of authority to control key aspects of their market and working conditions through licensing and credentialling, professionals are expected to maintain high standards of competence and moral responsibility.....the work of the traditional learned professions has long been understood to require a significant domain of discretion in individual practice.....it has therefore been thought to require a stronger sense of moral dedication than most occupations..... a professional is not required to ignore material considerations but is expected to subordinate financial gain to the higher values of responsibility to clients and to the public interest”.*

He continues:

*“the root of the public's trust is the confidence that physicians will put patients' welfare ahead of all other considerations, even the patients' momentary wishes or the physicians' monetary gain”.*

### **The three Sociological theories of “professionalisation**

Secondly, Sullivan has proposed three divergent theories of professionalisation - that is, the processes leading to professionalism – that have held sway throughout the twentieth century:

- 1) the “*collective mobility*” theory of professionalisation emphasises the *economically strategic* side of professionalism - the use of claims of *superior knowledge* and *special moral integrity* as devices which secure *some control* over the *economic* market for services [i.e. a struggle between economic interests]

The *economic dimensions* of professionalisation within “the liberal capitalist order” are stressed, noting important variations in other parts of the world viz. the USA was perhaps quite ‘laissez faire’ in this context, the “British world” much less so.

I would call this the “robber baron” theory.

[The potential for conflict is apparent. In this construct, a rise of “*managed care*” would be seen as *a loss of guild monopoly* in the face of more powerful market players (especially insurers and providers) (legitimated as an advance of consumer sovereignty). This would be the interpretation in the USA with insurers and providers aggressively engaging “suppliers” and patients. (In Australia, if you have a public appointment, you could read “State Health Departments” , DVA and Workcover insurers for “more powerful market players”).

- 2) The “*rationalisation*” theory of professionalisation emphasises *cultural and social authority* arguing that the “market success” of medicine has been the consequence of an ability to exercise authority over a specific area of *scientific* and *technical* expertise [i.e. an agent of the spread of scientific and technological rationalisation].

These interpretations of professionalisation emphasize the role that *expert knowledge (especially scientific knowledge)* has played in establishing professional autonomy in work and prestige in society.

I believe this is best called the “traditional theory of medical professionalism”, and it is I contend the prevailing view within the profession in this country.

[Again, conflict could arise from the advent of “*managed care*” which from the point of view of this theory would represent a serious loss of legitimacy from a *scientific elite* to an *economic elite*. This I suggest would be the view taken by Australian medical professionals].

- 3) The “*cultural and political development*” theory of professionalisation, by focusing on the professionalisers' social criticisms and their formulation of new social goals, sees the emergence of professionalism as *an ideology of social reform*.

Professionalisation is thus a cultural and political development which could infuse social responsibility into what had been perhaps a more industrial context, rather than a *struggle among economic interests* or as *an agent of the spread of scientific and technological rationalisation*.

From this viewpoint, professionalisation is seen as an expression of occupational self-interest and a movement with broader appeal to the middle classes, and the catalyst for a distinctive "social ideal" that has been crucial to (relatively recent) developments like “the welfare state”.

I would call this “the social reformist” theory.

[Conflict could again arise where proponents of this theory promote their particular interests].

The scene is set for the proponents of all three theories to come into conflict as we will now see!

**The challenges to us as *medical practitioners* .....**

- **from “the social reformists”.....**

I believe that the traditional relationship between the doctor and the individual patient underwrites the traditional definition of medical professionalism. I believe that our profession itself has always codified this relationship through oaths and codes which are in more legal parlance forms of “contract” and that these continually evolve. The preamble to the current AMA Code notes that changes in society, science and the law constantly raise new ethical issues and may challenge existing ethical perspectives. However, the AMA Code *says first*: Consider first the well-being of your patient *and secondly*: Approach health care as a collaboration between doctor and patient; treat your patient with compassion and respect.

The 2004 version of the Code in “the Doctor and Society” asks: “Endeavour to improve the standards and quality of, and access to, medical services in the community. Accept a share of the profession’s responsibility to society in matters relating to the health and safety of the public, health education and legislation affecting the health of the community. Make available your special knowledge and skills to assist those responsible for allocating healthcare resources. Use your special knowledge and skills to minimise wastage of resources, *but remember that your primary duty is to provide your patient with the best available care* (my italics)”.

Duty then to “Society” is only a part of the AMA Code of Ethics, with the overwhelming emphasis given to the contract with *the patient*.

It is within what I see as this difference in emphasis (between the traditional view of the medical profession, and the view of sociologists who may be devotees of the social reformist script for *professionalism*) that I see some of the vulnerability of “our professionalism”. The scene is set for a second contract: what Society requires of medical professionalism. I believe we can consider many of the conflicts we perceive in our practice as medical practitioners and as “medical practitioners in anaesthesia” in terms of friction between the proponents of the three theories, and I will explore further examples of this friction later before offering some possible strategies that might assist the preservation of “our” professionalism .

From the USA, a NEJM article has noted “.. ..considerable interest in reinvigorating medical professionalism..... reflects a profound unease with the seeming primacy of economic factors among those currently affecting medical practice..... general agreement that patients' interests must take precedence over physicians' financial self-interest ..... professionalism also entails service to vulnerable populations and civic engagement.

This is US based, and more a challenge to the “*collective mobility*” theory though again introduces a duty to “Society”.

From the UK, the Lancet reported “the new professionalism evolving in UK medicine is fundamentally different from the past.....an explicit statement of professional duties, responsibilities, values, and standards for doctors, developed and agreed on by the public and the profession.....compliance is being secured by linking it directly with medical registration..... doctors will have their abilities assessed regularly by peers and by members of the public..... to ensure that they remain up-to-date and fit to practise.....disciplinary action will follow if they are not”.

This challenges the “traditional theory of medical professionalism” and introduces “assessment...by the public”.

The “Medical Professionalism Project” has become the trans-Atlantic and major flag carrier for these sentiments. It is “internist” driven. It asserts ownership of the “professionalism” highground. Its “Charter” was published simultaneously in “the Lancet” and “Annals of Internal Medicine” in early 2002. The “Project” arose out of “concerns” that changes in “Healthcare Delivery Systems” in North America and Europe were threatening “the very nature and values of medical professionalism”. Theory ‘3’ issues a challenge!

The Charter was published in the Medical Journal of Australia in late 2002 and keenly promoted by its Editor, Martin van der Weyden. Cruess and Irvine themselves, writing on “Medical Professionalism”, have been recent contributors to the pages of the MJA.

The Charter is to support the efforts of practitioners to ensure that both physicians and healthcare systems are committed to *patient welfare and to social justice* and that this commitment would be *applicable to different cultures and political systems*. It was said that ninety professional associations, Colleges, Societies and certifying boards had endorsed the Charter by the middle of 2003,. These included the American Board of Anesthesiology, the American Board of Medical Specialties, The American Society of Anesthesiologists and the Royal Australasian College of Physicians and Surgeons (sic).

Practitioners are exhorted to commit to “the three fundamental principles” with the (professional) responsibility for doing so laid “squarely on our shoulders”.

The “three fundamental principles of the Charter” are *the primacy of patient welfare* (“self apparent, central to the trust at the heart of the physician–patient relationship, not be compromised by external factors”), the *autonomy* of patients (“must be respected”) and *the promotion (sic) of ‘justice’ in the healthcare system by the profession*.

Accompanying the principles was the suite of *professional responsibilities*: these are commitments to professional competence, honesty with patients, confidentiality, the maintenance of appropriate relationships with patients, continuous improvement in quality of care, improving of access to care, facilitation of a just distribution of finite resources, the upholding and promoting of scientific knowledge and research, limitation of conflicts of interest, and the respect of additional responsibilities which include education, standards, regulation and discipline.

The Project is now to review the impact of the Charter and “within that context, explore the opportunity to define the health rights and responsibilities of patients, physicians, and society”.

Two of “the three fundamental principles” with most of the (professional) responsibilities are of course recognisable from most Codes of Ethics (including that of the AMA) and indeed from Hippocrates. What is novel is the *improving of access to care, facilitation of a just distribution of finite resources, and the limitation of conflicts of interest*. These are new concepts which have been introduced by sociologists and their allies, and not necessarily ones that the profession would not support.

I am delighted to say that my Presidential predecessors had mentioned “professionalism” before the Charter was published, though everyone is talking about it now, and orations dealing with professionalism are hardly novel.

I would though ask: to what extent are the “principles” threatened in this country, and to what extent might we be committed to all the “responsibilities”? Further, where might our innate professional values (i.e. our ethics) have failed our patients or our society to the extent that we – as an Australian profession or specialty - should also commit to the Charter and its principles and responsibilities, as have the ninety bodies alluded to above? Does theory ‘2’ yield to theory ‘3’?

Australia has a unique healthcare delivery system that has evolved over half a century, that probably by now well reflects its political and societal values. There have been watershed changes and there has been gradualism. But it is only in the last few years that we have seen the beginning of a real debate about healthcare and its costs and proposals for a reappraisal of the distribution of resources (the “principal of *social justice*”).

- **from the Ethicists.....**

“The internists” have been active even more recently with the “Medicine as a Profession Managed Care Ethics Working Group”, established by a number of “concerned organisations” including once more the American College of Physicians. The “working group of stakeholders” included patients, medical practitioners, “managed care representatives” and ethicists. The language of the document includes “health plans” and “purchasers”. These terms are largely unfamiliar to Australians and are not easily translated: it refers to the common American practice of employers providing (private) healthcare as an employee right, and deals with some of the concerning aspects of “managed care”. This is I think theory ‘3’ confronting theory ‘1’. And we do have “managed care” in Australia already, and it does not (as yet) involve private health insurance funds. It involves State Governments! The Medicare agreements, through the funding arrangements between Commonwealth and State Governments, provide for the “purchase” of healthcare on behalf of Australians who obtain their healthcare in “public hospitals”. It is here that the profession and the specialty can take heed of the principals espoused by this group: “that the delivery of health services should be characterised by respect, truthfulness, consistency, fairness and compassion.....(with) a shared responsibility for the appropriate stewardship of healthcare resources.....all parties should foster an ethical environment for the delivery of effective and efficient quality healthcare”.

This is the language that we would hear if there is a change of Federal Government at the end of 2004, with the establishment of a Commission that would see PBS and NBS



expenditures “cashed out” and extended to the lower levels of the health system. This has been canvassed last year through the national health summit, espoused by the national health reform allowance.

- **from regional political forces.....**

Most of us are now familiar with New Zealand’s Health Practitioners Competence Assurance Act (the HPCA Act). Trisha Briscoe, then President of the NZMA, has recently published a superb critique of this legislation and it is seminal reading.

The stated purpose of the Act was “to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice their professions”. The Act was initially widely supported. It was to be “an omnibus piece of legislation” designed to bring a large number of health practitioner groups regulated by numerous statutes into line with the registration, competency and discipline provisions of the Medical Practitioners Act, which was felt to be a modern, effective piece of legislation. She noted that this whilst laudable was ambitious and conceptually flawed.

During its gestation, that the initial concept became “lost under the onslaught of multiple competing agendas” resulting in a complicated piece of legislation which “undermines professional functioning.....its effect may be exactly the opposite of its intention”.

Briscoe also reports “a political perception that more political and external controls on the professions are what Society wants”. Theory ‘3’ in action! This though is said to be counter to “the growing body of international opinion that competence, quality and safety are better assured through models structured on professionalism rather than State control”.

The Act as passed also provides for additional and great ministerial powers over the “scopes of practice” of all health practitioners. Theory ‘3’ again. Sixteen health practitioner groups now also have the ability to define their own “scopes of practice”. This may see the New Zealand Nursing Council determine that nurses would practice independent anaesthesia. Theory ‘3’ confronts theory ‘2’!

Briscoe’s summary was that health legislation can actively promote professionalism or it can discourage it. The NZMA believes that the HPCA Act is a backward step for the promotion of professionalism in medicine. She finishes by quoting Sullivan “neither economic concepts nor technology nor administrative control has proved an effective surrogate for the commitment to integrity evoked in the ideal of professionalism”. Theory ‘2’ rules!

Should Australian anaesthetists be concerned with the HPCA? For a number of reasons, I believe “yes”. Firstly, the geographic and cultural proximity of our two countries is obvious, and almost close enough for osmosis. Secondly, and more specifically, the New Zealand Health Minister meets with the Federal and State Ministers of this country on a regular basis. The HPCA Act is in my view a prototypical example of the clashing of theories of professionalism, and their respective supporters. We are unlikely to change the mind of the zealots, be they other professionals, sociological supporters of theory ‘3’ or politicians with an electorate to play to.

- **through the “Quality debate” and “the medical indemnity crisis”.....**

Further challenges to our *professionalism as medical practitioners* have been observed at “close range”: that is, in Australia.

These I believe have been the “quality and safety in healthcare” movement which in its initial delivery (almost ten years ago) directly affronted our professionalism and was unashamedly misused by a devotee of theory ‘3’, and the “medical indemnity crisis” (which in its genesis was I believe influenced by the former). It also was perceived as an assault on our professionalism.

The message of the “Quality Study” was so sensational that the study’s deficiencies were largely missed. Certainly, retrospective chart review is in my mind no way to define standards of national practice, though no one else has produced an alternative study. The authors of this work certainly though had a demonstrated commitment to the primacy of patient welfare (one of the principles of the Charter) and a commitment to the improving of quality of care. Measures have been progressively adopted by the specialty in Australia and New Zealand and this shows in my view how our professionalism enables us to react rapidly. More ponderously, other bodies in and outside the specialty, aided by substantial Federal and State monies, are also pursuing safety and quality initiatives though in some cases with the measured zeal of the “social reformers”.

With the “medical indemnity crisis”, an adventurous interpretation of the common law by judges and its exploitation by lawyers (all “social change” agents) encouraged claims which were quite often of little or modest virtue. Negligence was infrequently central to the action. We witnessed the largest medical professional indemnifier in Australia taken to the point of bankruptcy (though it was not entirely blameless).

Doctors were concerned that their livelihood and assets would not survive this assault. It seems that we have had a reprieve, perhaps (optimistically) a victory, but the medium and long-term outcome remains quite uncertain. The plaintiff lawyers continue to take every opportunity to remind the public that the profession practises negligently. The feeling that this continuous farrago has engendered in us is indeed an affront and a challenge to our professionalism.

We have had to learn how to practise in an era of increasing regulation and overview by traditional and new “players” – not just Federal and State Governments through the DHA, the HIC, State Health Departments and Medical Registration Boards, but also AMC, AHMAC, AMWAC, ACSQHC and Standards Australia, not to mention APRA, ACECC, the NCC and probably now the medical indemnity organisations. We debate MOPS and “CDC / CPD”, and have seen what may become a new national CPD paradigm. There is the threat of “new trainers”.

The actions of all of these other parties should be viewed within the context of the divergent theories of professionalisation.

**The challenges to us as “*medical practitioner anaesthetists*”.....**

A number of the challenges and issues mentioned above have strong connections with and implications for anaesthesia and for how we practice it.

What gallery do we play to? To our patients, to our colleagues (medical and nursing), to “the public” (including “government”). “Task substitution” is an expression we’ve heard. Apropos our specialty, we’re told “task substitution” may be necessary because of workforce shortages.

We are affronted daily by what seem challenges to our professionalism at worst: the achieving of “proper” consent, “DOSA”, “IFC”, “Gapcover”, “production pressure”, all of which impinge the “doctor - patient relationship”.

These again are manifestations of the divergent theories of professionalisation in action.

- **“Gauge watchers”, “dial fiddlers” and “numbers men”**

John Ashton [ASA President, 1988-1990] had much to say in his Geoffrey Kaye Oration in 1990 about *professionalism* in its older context, as have some other Presidents at other times, for example, Peter Brine at the NSC in Perth in 2000. John noted that the ASA had realized (in the 1940’s) that “the same high standards for qualification” as for physicians and surgeons would be needed: this was seen with the inauguration of the Faculty. John, in 1990, was though more concerned with the relationship between the surgeon and the anaesthetist.

He was concerned with an (over)emphasis on technology and he foresaw what I feel has become a “trap”: if we were to become “gauge watchers”, “dial fiddlers” and “numbers men”, “we will surely be relegated to the status of technicians”. His concerns were with having us seen..... as “good doctors”.

- **“we will surely be relegated to the status of technicians.....”**

A perception that we are practitioners of a technical specialty with a first class safety record presents particular problems. Anaesthesia seems in many ways to be a “mature speciality” with a perception that much of the “hard work” in research has already been done. Certainly, the firm establishment of the scientific basis of the speciality was seen in the 60’s and 70’s, with dramatic improvements in our application of new knowledge and physiology and pharmacology leading to a dramatic reduction in certainly mortality, and probably also morbidity. The scientific ‘action’ in our part of medicine is now more in Intensive Care and Pain Medicine.

Could ‘anaesthesia’ be seen now as “too easy”?

Could perhaps our efforts, both intended and unintended, be our undoing as *medical practitioner anaesthetists*?

Perhaps our Mortality Reports and our claims of “world’s safest anaesthesia” make our specialty look safer than it really might be.

*Sullivan queries whether “a profession (can) secure public recognition of its claims to traditional professional prerogatives on the basis of its technical skills alone...”.*

In a purely Australasian context, and using mainly hindsight, the excision of the two subdisciplines (Intensive Care and Pain Medicine) could be seen as having been a degrading of our core professional body of knowledge and expertise. With the “time pressures” of contemporary practice confining us to operating theatres, we might perhaps be seen by some others as perhaps technicians tied to machines and monitors, not doctors who get out into wards and consulting rooms to consult. What would we think of surgeons or other proceduralists who operated on patients with whom it seemed they had not had consultations? These others may be tempted to think that they too can dispense our drugs – and perhaps they can - but of course [we would assert] without what we know is our *professionalism*. Herein lies a particular component of our *vulnerability* as “medical practitioners in anaesthesia”.

**Answers.....?**

What do I think we should do to address our concerns about *professionalism*, .....  
*and our vulnerabilities?*

Is it worth fighting for?

In an Australian and very local context, Southon [as a Social Scientist, writing from the School of Health Services Management at UNSW (Soc Sci Med. 1998 Jan;46(1):23-8)] observed that:

“increasingly questions are being raised about the ability of.....current health reforms to address the challenges..... facing health systems. We investigate this situation by exploring the role of *professionalism* in the delivery of health services.

In contrast to the dominant approach of considering professionalism as a social phenomenon, professionalism is considered as primarily a task-related phenomenon” – that is, theory ‘2’ perhaps, but not theory ‘3’.

- the characteristics of the task are high levels of uncertainty and complexity.
- high levels of uncertainty and complexity lead naturally to the key social features that typify professionalism.

“However, health reforms threaten professionalism”:

- health reforms have been based on .....dissatisfaction with the performance of professionals.....[theory ‘3’]
- the reforms have been developed without.....consideration of the.....role that professionalism has played.
- the reformers have adopted a simplified view of the task.
- this simplification is (sic) inconsistent with the realities and complexities of health service provision.
- the centrality of professionalism has thus intrinsically been downgraded.
- the downgrading .... is.... unwarranted.
- this.....generates many of the conflicts and contradictions being reported.

In sum, “the future of health service reform depends on an effective understanding of the nature of the task, recognition of the central role of professionalism and the development of professional and organisational structures that support each other”.

A sociologist gives heart to theory ‘2’!

I hope that you now know that “others” have differing expectations of “our professionalism” and what they think it should be offering them and society.

Cruess says we “must understand the origins and nature of professional status, and the obligations necessary to sustain it..... Professionalism must be taught explicitly”. I agree. But we need to be quite clear about the parameters of the debate.

The Charter is said to help in this regard, but is it so different from the Codes – with the exception of social justice concepts? I think is a diversion!

[Our Society and College both espouse the principles of the primacy of patient welfare and patient autonomy. Further, the commitments to professional competence and honesty with patients, quality of care, scientific knowledge and “professional responsibilities” hardly need to be restated].

Should we address the fair distribution of resources and possible discrimination in healthcare? How well do we do in this area, and how well might we do? Commitment to improving access to care and to the distribution of finite resources is complex. We are beginning to see the start of a wider community debate in these areas.

A commitment to maintaining trust by managing conflicts of interest that might compromise professional responsibility through the pursuit of private gain or personal advantage exists. We back this up through our IFC Position Statement. The Charter says that “physicians have an obligation to recognize, disclose .... and deal with conflicts of interest”, and in this country, we have lawyers and courts to back it up!

The Charter notes that the profession is “confronted by an explosion of technology, changing market forces, problems in healthcare delivery, [bio-terrorism] and globalization”. It does not mention government! We are familiar with expression “managed care”, and believe that this connotes problems in the appropriate delivery of patient care to the patient’s detriment, particularly when financial resources are finite and allocation is difficult. State Governments practise “managed care” in this country!

How should NZ anaesthetists deal with the HPCA? How would *we* view others who might aspire to our professional activity? Further, how could we rest with governmental control of professional ethical standards? The HPCA is as mentioned above a prime example of the clashing of theories of professionalism and their supporters.

Cruess says that Medicine's professional associations must be extremely wise in how they negotiate for their members. “Any hint that the public good is being ignored during ..... negotiations can be damaging to the credibility of the profession and result in loss of the trust, which is so essential to the healing process”.

The privilege of self-regulation outlined in “the contract” entails an absolute obligation to guarantee the competence of members. The setting and maintenance of standards is

of overriding importance, and issues such as recertification and revalidation are, without question, now regarded as professional obligations. The disciplining of unethical or incompetent practitioners must be rigorous, open, and have the support of every practising physician. A heavy price has already been paid for failures in this domain. eg Bristol, perhaps Camden and Campbelltown.

Even if the medical profession itself carries out the above actions, it is unlikely that the values cherished by physicians for centuries can be preserved unless their preservation is encouraged and supported by society through the structure of the healthcare system. Healthcare systems can actively promote desirable behaviour or they can encourage physicians to place their own interest first. If undue competition among physicians is promoted by the system, one should not be surprised if competitive physician-entrepreneurs emerge. If medical manpower policies coupled with payment methods actively encourage physicians to see large numbers of patients to maintain an adequate income, they will do so. Physicians will maintain professional values, but not at any price. Thus, the support of policy makers in preserving a value-based healthcare system becomes critical. For this to occur, the issue must be considered to be important by those negotiating on behalf of the profession.

In this country, anaesthesia is represented by two organisations which have distinct areas of particular interest and responsibility, but also areas where their interests overlap. We accept that the ASA represents the professional, economic and industrial interests of anaesthetists. ANZCA is responsible for the training and examination of anaesthetists, the associated aspects of teaching hospital purview, and professional standards. Both bodies address continuing education and welfare. The observation of this dichotomy has been a mantra of this Council. It has been a feature of GKO's that the Society / College relationship is addressed. In my view, this dichotomy is beneficial to both organisations, though it is counter to a view expressed by a number of my predecessors in the early 90's. The prestige of our College as an independent training and examining body is I believe underwritten by the dichotomy.

We are seeing encroachment on the traditional independence of the profession, in particular I believe through engagement of the Colleges over trainee selection and OTD matters, in a way that I believe could ultimately risk their independence. I believe that the maintenance of Collegiate independence requires the support of strong member based organisations like the AMA and ASA. This is ultimately essential for the future vitality of our profession and the maintenance of our professionalism.

We need to work on our professionalism.

We must as anaesthetists get out of the operating theatres more often – and in a shirt and tie or equivalent. Most of our patients will appreciate it. We need to 'look professional'!

We need to be seen to care for our patients. They will appreciate it – more so when awake than when comatose. *Whose idea was it to let others do our preoperative consultations?* John Ashton was in my view rightly concerned with what he saw as an overemphasis on technology. His concern was in having us seen as *good doctors* – not just good technicians. This safeguards *our professionalism*.

*The promotion, protection and support of our craft; and the maintenance of our professional status, interests and independence are key objectives of the ASA.*

These further objectives are central to the preservation of *our professionalism* in a time of challenge.

I think Geoffrey Kaye would approve of this approach even if *professionalism* in his time was best expressed as a facility with gauges, dials and numbers.

**Dr J P Bradley**  
**Immediate Past President**  
**20 February 2005**