

George A. O. Alleyne
Chancellor
University of the West Indies
June 11, 2010

**The highest standards
Kingston, Jamaica***

First, let me thank the Medical Association of Jamaica for the invitation to address you after dinner. I spoke to you for the first time about 20 years ago and it was so late in the evening and there were so few present and even fewer awake and attentive that I abandoned my prepared text. I recall vividly being berated because I spent much of the short time advising the young physicians to devote more time to their families and recounting the kinds of discourse one could enjoy with children who often say the most amazing things. I also recall telling some rather benign stories about the young which according to one of the guests, who was a man of the cloth, were rather “close to the bone”.

But I appreciate your asking me to speak again, although I do confess to being a bit concerned at being asked to speak so often after dinner recently. I wonder if it is because the perception is that after you reach a certain age what you say does not require much concentration to understand it and is therefore best said after a meal. Post prandially there is increase in splanchnic blood flow; heightened parasympathetic activity with a shift in autonomic balance that results in that intense desire to be at rest.

But this evening I will not tell stories about children. I wish to reflect on the extent to which practice here and in similar places is being shaped by forces which in many cases are outside our control. The theme of your symposium is “**Challenges in Health Care Delivery in the Caribbean**” and it must be obvious that one of the keys to overcoming those challenges will be the quality of the human resources involved in health care. As I prepared to speak to you and reflected on the theme, I read the address made by your President on assuming office. I am sure his words, though directed to this Association, would find echo throughout the Caribbean. Dr. de la Haye said:

“How the public perceives us is critical. We cannot allow the weak links to damage our image. I urge you to put our patients’ needs first and to uphold the highest standards of clinical practice at all times.”

I was intrigued by his use of imagery to convey the interdependence within the medical profession. Individual practitioners are links in a chain and therefore have responsibilities to each other. I also asked myself, “What are the highest standards of clinical practice?” Have they

* Presented at the Banquet of the 2010 Medical Association of Jamaica Symposium, Kingston, Jamaica, 11 June 2010

changed over the years, or are there some immutable core standards which are altered but only at the periphery by modern contextual factors?” It is obvious to affirm that doctors are but human and their actions are therefore by definition imperfect. But I was struck by a quote by a friend of mine, Professor Srinath Reddy, who said, ‘If the perfect is impossible, then we must perfect the possible’. I believe that this applies to all of our actions and through the ages there have been attempts to perfect the possible in terms of medical practice. There are two fundamental approaches. There is the effort to establish what a good doctor is and in addition how what that doctor does can be improved or enhanced by the ever changing technology. How does one continue to be a good doctor throughout the lifetime of practice and to whom or what should the responsibility devolve to ensure that goodness persists and those highest standards are maintained as your President enjoined you?

Let us go back in history to see what has been the thinking about the attributes and responsibilities of the good doctor, noting the admixture between what the doctor should be and what should be done.

The Charaka Samhita is among the oldest Sanskrit medical manuals, and I found in a lecture by a Dr. Valiathan an extract from the instructions given to those entering medical training. This gives an idea of the ethics of Indian medical practice 2000 years ago.

“You should remain a celibate, speak truth, adhere to non-violence and use substances that enhance intellectual power. You should sport a beard and a moustache, avoid meat. You should strive by every means to get your patients well and never entertain evil thoughts about them even at risk to your life. Your words should be pleasing, truthful, well chosen, brief and matter-of-fact; you should never lose sight of place and time, the constant pursuit of knowledge and the improvement of equipment and skills. You should not parade your knowledge because pedantry-even on the part of experts is always tedious”

The Hippocratic Oath which most of you know also dates back just over 2000 years and the relevant parts say:

“I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone, but I will preserve the purity of my life and my arts. All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.”

Perhaps the other well known physician’s oath is that of Maimonides –the famous Jewish physician/ philosopher of the Middle Ages and here is an extract.

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 time; 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 unto my calling."

Let us fast forward to 2009 and look at what the General Medical Council of Great Britain says about good medical practice and the duties of a doctor registered with them. The duties fall under six headings, four of which emphasize and stress the primacy of attention to the patient. One speaks to providing a good standard of practice and care which must involve keeping professional knowledge and skills up to date, recognizing and working within the limits of your competence and working with colleagues in the ways that best serve patients' interest. The last one enjoins doctors to be honest and act with integrity.

It is interesting that over the course of the ages, there has been so much similarity in the perception of what a good doctor should be and should do. There is emphasis on the personal characteristics of the doctor, the primacy of the well being of the patient, the need for modesty and the responsibility to keep knowledge and skills up to date. I suppose nowadays there would be some queries about the chastity and purity aspects, but I suppose one could adhere to the dictum of Saint Augustine and pray "Give me chastity and continence-but not yet".

Over the course of these almost two centuries human nature has not changed and one must ask what has taken place to render the task of maintaining these highest standards more difficult. The main influence has been the vertiginous growth of technology which has allowed man to alter the course of nature and life and perhaps to create life itself. I was impressed to note in your website an elegant treatise on the impact of technology on practice and you emphasized the information technology. There is no doubt that doctors now can be more effective and efficient in caring for the patients. The technology of prevention, diagnosis, cure and care including that given at the end of life is truly impressive.

What can be done becomes more mind-boggling every day. In the window of the Wellcome Trust in London I saw a sign which read "What if one could explore the genetic potential of one's lovers". I invite you to let your mind wander at the possibilities of this. I am sure that some of you will interpret this as meaning that some of us are genetically programmed to be better lovers than others, which is really not the intent of the rhetorical question.

But soon the question of the urge to make love will not be something influenced by gifts, entreaties and affirmations of undying love. A recent article in the Washington Post explored a question which is one that has bedeviled poets, philosophers and generations of frustrated men: What do women want! The subject of the article was the first pill designed to do for women what Viagra did for men: boost their sex lives. Apparently a German pharmaceutical firm has developed a drug “flibanserin” which stimulates women’s sexual desire. The article pointed out that soon there will be no need for chocolates and flowers. The only thing gentleman will need is a little pink pill. The article was written by a man, perhaps a very young one, or he would have known that chocolates and flowers have nothing to do with possibility of sexual favors!

But more seriously, the impact of technology on medicine goes much beyond a female Viagra. The technological imperative sometimes drives us to face the dilemma that has engaged us from the beginning of medicine. Does the fact that it can be done make it imperative that it should be done? We must recall that initially medicine or the practice of the art of healing and philosophy or the search for the knowledge or the truth were not as divorced as they are today. It is from the branch of philosophy that much of the thinking and practice of ethics is derived.

Many of the great physicians of old were also well known as philosophers. Maimonides was a philosopher. Galen whose influence on medical practice has been never surpassed is said to have asserted that the best physician is also a philosopher. Wikipedia described Galen as “grounding medical practice in theoretically sound knowledge or philosophy as it was called in his time”. But post Galen, it is said that medicine stalled as an aspect of philosophy. Those who practiced became divorced from those explored what should be done and the latter have become ethicists.

Has technology in general not altered the possibility of establishing that bond or relationship between the doctor and the patient? I have had personal experience of a relative entering a medical institution for an acute problem and having the emphasis placed immediately on the application of the various diagnostic technologies before there was even any attempt to interact with the patient as a human who was in need of reassurance as a first step. The patient was an object-a problem-a medical Rubik’s cube for which a technological solution had to be found.

In recent years, in many places in which I have these conversations, there is concern about the ethics of medicine, the ethical aspects of the influence of technology in medicine and the extent to which it is altering the fundamentals of the doctor-patient relationship. I do not believe that this angst is solely a reflection of the age-old phenomenon of the old believing that the young are somehow not quite as upright as they are. Is it technology that is contributing to the conversion of medical practice into something more like a market? In such a market the doctor because of his or her possession of the technology and because of the inherent asymmetry of information, takes advantage of a superior position in a relationship that has the patient as a client in a transaction that sometimes leads to unethical behavior. I would like to believe that this is not frequent in your Association. But if it does occur at all, then it weakens the chain to which your President referred implicitly as he spoke of the damage done by the weak links.

Another injunction common to considerations of medical practice throughout the ages has been the responsibility of maintaining competence. I have spoken about this here before and continue to stress the need for a formal system of ensuring that doctors are subject to some form of periodic recertification. This is a complex issue as there can be no recertification without certification and there also has to be a formal system of registration of specialists before there is a process for their recertification or validation to use the term employed in the UK.

At present, with one exception, a Caribbean medical graduate can establish an independent medical practice immediately post internship. The exception is the Bahamas where the Medical Council as a matter of policy-not of law- insists on a period of two years post internship before being able to practice independently. Their proposed new act seeks to make it law that this two year period in which there will be intermediary registration, will be mandatory before the doctor is given full registration and allowed to practice independently. There was a time when the University of the West Indies insisted on a two year internship. At that time I favored this, but was conscious that the University was taking unto itself a function that pertained to the state. It is for the state or one of its competent organs to determine when after a period of basic training under supervision, a doctor is fit to practice independently and the mechanism for ensuring that professional competence is maintained as befits a good doctor.

There is considerable debate about the method of ensuring the maintenance of such competence, but I think there is general agreement that the system of continuing medical education credits is inefficient if not worse. Surely it is time for the Caribbean Medical Councils to address this issue seriously! There will always be vested interests in resisting a system that forces professionals to maintain competence, but in the case of medicine, any affirmation on the commitment to the best standards of practice and the welfare of the patient is less than convincing without a system that enforces compliance with some system of certification, recertification and specialist registration.

Mr. Chairman, let me thank you again for the opportunity to be with you. When the parent of this Association, the British Medical Association was founded in 1832, it had as one of its objectives:

“Maintenance of the honour and respectability of the profession generally, in the provinces, by promoting friendly intercourse and free communication of its members and by establishing among them the harmony and good feeling which ought to characterize a liberal profession”.

Mr. President, I hear echo of those sentiments in your own words as you seek to stimulate the profession to renew a sense of pride and professionalism and maintain honor and respectability. There is a noble tradition of such qualities in the Jamaican medical profession which through the years has always prided itself on the highest standards of clinical practice

Long may that tradition continue! You have my best wishes!