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Yann Joly, Bartha Maria Knoppers

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Nola M. Ries

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Health professionals and the organization of healthcare

Current trends

Nola M. Ries

10.1 Introduction

This chapter addresses contemporary challenges facing modern healthcare systems and the ways in which the regulation and practices of health professionals must adapt and change to meet such demands. In many countries around the world, health systems are facing enormous, inter-related pressures. Escalating healthcare costs are a pressing concern. The increase in healthcare expenditures exceeds GDP growth in many nations (Pammolli *et al.* 2012) and is being driven by multiple factors, including aging populations and the growing burden of chronic diseases such as cardiovascular diseases, metabolic disorders, cancers and mental health conditions (Organization for Economic Cooperation and Development (OECD) 2011; Rechel *et al.* 2013). The Lancet's 'Global Burden of Disease Study,' published in 2012, underscored the major social and personal impacts of chronic, non-communicable diseases, pointing out that people are living more years with disability and disease. According to the World Economic Forum, the global financial costs of the non-communicable disease burden will exceed US$30 trillion over the next twenty years (Bloom *et al.* 2011).

The shift in the global disease burden demands new approaches to the organization of health-care, including shifts away from acute, episodic care delivered in hospitals, to community and home-based care (World Health Organization (WHO) 2006: xix). Hospitals themselves must be transformed to deliver care in ways that prioritize the patient, value their experience of care, overcome professional 'silos,' and involve collaboration with health and community services beyond the hospital walls (Future Hospital Commission 2013). Effective collaboration among health professional groups is also key. As will be discussed, broadening the scopes of professional practice and reforming laws to enable expanded practice roles may also be key to meeting contemporary health service needs. Yet new approaches to healthcare delivery have implications for the professional relationship, including the relationship between care providers and their patients and the relationships among different health profession disciplines.

This chapter commences with an overview of professionalism in healthcare and the core elements of the professional relationship. The obligation to meet legal and ethical duties is discussed as a feature of professional status. Current debates over challenges to the professional identity are noted, especially a perceived diminution in professional autonomy for some, as governments

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demand more stringent regulatory oversight and promote more efficient models of healthcare delivery. The growing trend towards inter-professional, team-based collaboration is discussed. A short case study in Canada is presented to illustrate examples of law reform that enable broader scopes of professional practice and inter-professional collaboration. The final section of this chapter discusses three linked issues impinging on the delivery and organization of healthcare: the push to evidence-based practice; greater community-based and patient-managed models of care; and the continuing emphasis on improving the safety and quality of care. This section notes legal and ethical issues that arise in these topics, and also identifies areas for further research. Last, the conclusion briefly comments on the notion of a 'new professionalism' in healthcare.

10.2 Legal theory and ethical theory

10.2.1 Key features of professionalism

Members of professions typically enjoy a claim to specialized expertise, social status, and financial security. Members also argue that their work, including entry into the profession, qualifications, practice standards, and discipline, should be controlled by the professional body itself (Plochg *et al.* 2009). Professional bodies thus typically have self-regulatory authority to restrict membership to those with prescribed credentials and to superintend the conduct of practitioners. For example, in 2009, the World Medical Association (WMA) adopted its 'Declaration of Madrid on Professionally-led Regulation,' which emphasizes the importance of professional self-regulation and also underscores the responsibilities that accompany it, including a duty to ensure the competence of members, enforce compliance with codes of ethics, deliver high-quality care for patients, and provide transparent regulation that fosters public trust and confidence (2009).

Indeed, power and autonomy are conferred on professions in exchange for an expectation – a social contract – that members of the profession will use their expert knowledge and skills to advance the interests of their patients and the public (Sullivan 2000). Members are generally expected to adhere to an ethical code of conduct and to meet standards typically enforced internally by the profession and externally through processes such as negligence litigation or other dispute resolution mechanisms (Southon and Braithwaite 2000).

10.2.1.1 Professionalism in healthcare practice

Several key elements of professionalism in healthcare practice have been identified (Wilkinson *et al.* 2009). First and foremost, health professionals are expected to comply with core ethical principles, including a duty to safeguard an effective therapeutic relationship with patients based on trust and integrity (Stirrat *et al.* 2010). Professionals should also be reliable, capable of effective communication and working relationships with others involved in the provision of care, and dedicated to maintaining and improving their own competence and that of the healthcare system. Other professional and ethical obligations include a commitment to non-discrimination (except permissible exercises of conscientious objection), acting within their scope of practice boundaries, and identifying and avoiding conflicts of interest. Such obligations are articulated in codes of ethics at international and domestic levels, and also in jurisdiction-specific legislation and case law (see, for example, the WMA's *International Code of Medical Ethics*, updated in 2006).

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10.2.1.2 Challenges to professionalism

In recent years, some health professional groups, most notably physicians, have expressed concerns about the erosion of professionalism in healthcare (Davidson 2002; Cohen 2006). Describing 'threats' to professionalism, Sullivan writes:

> The professions have never been more important to the well-being of society. Professional knowledge and expertise are at the core of contemporary society. How such professional expertise is developed, how it is deployed, by whom it is deployed and for what ends are among the most pressing issues facing all modern nations. At the same time, many of the most distinctive features of the professions, especially their privileges of self-regulation and self-policing, are being curtailed.
>
> *(2000: 674)*

The current organization of healthcare – with the rise of healthcare managerialism, increasing bureaucratization, and commercial and budgetary pressures – is alleged to diminish professionalism. Sullivan contends that healthcare systems now 'substitute questions of cost and benefit for traditional relations of care and trust' (2000: 674). Discussing the practice of medicine, Jotterand similarly argues:

> Contemporary medicine is predominantly dependent on socio-economic criteria external to the traditional set of norms and values internal to medical professionalism. The dependence of physicians on social institutions for the delivery of healthcare has created a new paradigm in which physicians have a social obligation to respect cost containment policies, which sometimes affect the welfare of patients.
>
> *(2005: 118)*

Other healthcare trends, such as the increasing use of information technology and a growing prevalence of shift and part-time work, may alter the traditional professional relationship between care provider and patient. A 2013 commentary in the *British Medical Journal* asserts that today's doctors 'are simply less available for their patients' (Roland and Paddison 2013). The authors suggest that shift work during hospital training means 'a generation of young doctors is emerging with limited experience of taking personal responsibility for a defined group of patients. The idea that problems can always be passed on to someone else at the end of a shift is difficult to reconcile with the ethos fundamental to relational continuity' (Roland and Paddison 2013: 22). A recent US study reported that interns spend only 12 per cent of their time with patients compared to 40 per cent of their time on computer use (Block *et al.* 2013).

In addition to changes to the individual relationship between care provider and patient, macro-level reforms also impact professionalism. More stringent governmental oversight of health professions arguably impinges on their independence. Governments have moved to circumscribe self-regulation where professions fail to supervise their members adequately, and where care quality and patient safety issues have come to light. For example, as of December 2012, doctors in the UK must comply with a new process to demonstrate their fitness to practice. The so-called 'revalidation' process involves an annual appraisal and submission of documentation to the General Medical Council (GMC) every five years to demonstrate continuing fitness to practice. This change, which the GMC describes as 'the biggest shake up in medical regulation for more than 150 years' (2013) was spurred by high-profile cases of physician misconduct and serious patient harm (Smith 2004; Chief Medical Officer 2006).

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The growth of other health practitioner groups, including those allied to medicine and nursing, as well as alternative practitioners, and successful lobbying in some jurisdictions to expand their scopes of practice, also challenge traditional relationships and hierarchies in healthcare (Welsh *et al.* 2004; Dower *et al.* 2013). As a clear and simple statement to guide professional conduct, healthcare practitioners ought to 'behave towards colleagues as he/she would have them behave towards him/her' (WMA 2006). This dictate may be compromised, however, by inter-professional conflicts over regulatory issues, including scopes of practice and roles within healthcare delivery. The ability to exert 'autonomy and dominance over other groups' (Southon and Braithwaite, 2000) has been described as a characteristic of professions and, in healthcare, the medical profession has traditionally emphasized and protected its dominant status over other health professional groups. Indeed, in its 2008 'Consensus Statement on the Role of the Doctor,' the UK Medical Schools Council asserted that '[d]octors alone amongst healthcare professionals must be capable of regularly taking ultimate responsibility' in clinical situations (Medical Schools Council 2008).

Yet the organization of healthcare is shifting dramatically to emphasize team-based practice and inter-professional collaboration. Baxter and Brumfitt observe that '[i]nterprofessional working clearly presents considerable challenges to practices dominated by power and status considerations' (2008: 240). Others underscore the imperative of moving beyond traditional power hierarchies to establish new ways of working. Sheridan explains that '[a]lthough competition between professions … has been inherent to the professionalisation process, there are interdependent relationships that must be built and maintained if good care is to be delivered over time and in different settings' (2013: 75). Health practitioner groups cannot 'afford the impression that narrow professional interests are guiding their responses' (Blumenthal and Abrams 2013: 1933) to health system reforms that ultimately aim to improve quality of care for patients. Moreover, the contemporary focus on person-centered care and shared decision-making seeks to empower patients and, in doing so, erode the paternalistic foundation on which health professional practice was built (Hodgkin and Taylor 2013).

The next section presents a case study of trends in the regulation of health professions in Canada, focusing on legislative reforms that aim to broaden practice boundaries and foster inter-professional collaboration among a wider range of health practitioners.

10.2.2 Country case study: legal trends regarding health professions in Canada

Effective and efficient healthcare delivery requires that all professionals work to the full scope of their knowledge and skills (Fairman *et al.* 2011). It has been noted, however, that '[t]eam-based care is seen as a wave of the future, but progress has been slow because inter-professional educational opportunities are few (though increasing), training silos are many, and cultural change is difficult' (Iglehart 2013). Governments in some jurisdictions, including Canada, have embarked on legal reform to enable an expanded scope of practice of some professionals, for example broadening the scope of nurses to provide more primary care services and giving certain prescribing rights to pharmacists (Tannenbaum and Tsuyuki 2013). Reforming practice restrictions to enable a wider scope of activities increases patient access to those regulated health professions (Kuo *et al.* 2013). Differing scopes of practice across jurisdictions in one country, such as different regulations at the state or province level in the US or Canada, pose unnecessary regulatory barriers to some health professionals' practice (Fairman *et al.* 2011; Elwood 2013) and create 'mismatches between professional competence and legal scope-of-practice law' (Dower *et al.* 2013: 1971).

An important regulatory trend in Canada is the move toward a common legislative framework for health professions in each province or territory, often referred to as 'umbrella legislation'. Umbrella legislation involves enactment of an overarching statute that provides a uniform regulatory framework for all professions governed by the legislation. Profession-specific laws or regulations are then developed in accordance with the umbrella act. This is in contrast to the traditional approach where separate statutes regulate each health profession and allow certain exclusive scopes of practice that prohibit anyone other than a member of the profession from providing specific services.

These reforms in several of the more populous Canadian provinces, including British Columbia, Alberta and Ontario, have sought to lay a foundation for enhanced inter-professional collaboration, and to enable regulated professionals to practise to a full scope of practice that includes shared activities with other professions. Umbrella regulation typically provides non-exclusive and non-exhaustive descriptions of professional activities. The scopes of practice for regulated professions may have overlapping or shared activities. Restricted or controlled practices are narrowly defined and detail higher-risk activities that may only be performed by members of specific regulated health professions. The same restricted activities may be granted to more than one profession; however, not all professions will be granted restricted activities. Umbrella legislation with non-exclusive scopes of practice provides a possible foundation for inter-professional collaboration. Indeed, it is argued that the regulatory frameworks, and the practice cultures they influence, are 'determinants of the shift to a culture of inter-professional regulation' (Lahey and Currie 2005: 198).

Legislative changes in some provinces aim to facilitate inter-professional collaboration (Lahey 2012). Statutes in some provinces state explicitly that a health profession regulatory college has a duty to collaborate with other professions and to promote collaborative practice among members of the profession. For example, Ontario's *Regulated Health Professions Act* 1991 states that one of the objects of a health profession College is '[t]o develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance inter-professional collaboration, while respecting the unique character of individual health professions and their members' (Schedule 2, section 3(1)(4.1)). Similarly, British Columbia's *Health Professions Act* 1996 describes the role of a College in promoting and enhancing 'inter-professional collaborative practice between its registrants and persons practising another health profession' (section 16(2)(k)(i–ii)). Taking a different approach to encouraging voluntary collaboration, in 2012, the Nova Scotia Legislature passed the *Regulated Health Professions Network Act* to establish a Regulated Health Professions Network. Its mandate is 'to foster and enable collaboration among regulated health professions in a manner that upholds and protects the public interest' (*Regulated Health Professions Network Act,* section 5).

While legislative reform enables broader or more flexible scopes of practice for many professional groups (and, indeed, gives self-regulating power to a wider range of health professions) and urges inter-professional collaboration, changes to statutory instruments alone will not transform the traditional hierarchies and silos of healthcare practice. Changes to the law are arguably a necessary, but not sufficient, condition for changes to the culture and practice of healthcare. Legislation sets out broad principles but general statutory language is interpreted 'on the ground' by health organizations and professionals who may have vested and conflicting interests. As a consequence, existing policies and practices based on traditional models of power and expertise may be slow to change. Disputes over 'professional turf' are significant barriers to change, particularly if leaders focus on '[scope of] practice disputes and turf protection rather than the exploration of collaborative and interdisciplinary approaches' (Jansen 2008: 222).

Expanding on the topic of inter-professional collaboration, the following section discusses several broad and connected trends in healthcare practice, and considers the legal/ethical issues they raise for health professionals. This section also highlights areas for further research.

10.3 Current and emerging legal/ethical issues

10.3.1 Evidence-based practice

Evidence-based practice may be considered part of the trend toward a 'new professionalism' in healthcare. Paternalistic, intuitive judgments about patient care are now replaced by evidence-based practice, patient-centered care, and regular evaluation of health professionals' performance (Roland and Paddison 2013: 22). Similarly, scopes of practice limited by traditional professional hierarchies are giving way to new patterns of collaborative practice based on evidence that team approaches improve quality of care and patient outcomes. In the United States, for instance, a 2010 report from the Institute of Medicine advocated for more training opportunities and an expanded scope of practice for nurses to enable them to work as 'full partners' with doctors and other health professionals. The report criticized unduly restrictive state regulations that limit nurses' scope, despite evidence demonstrating that nurses with expanded qualifications and experience, including nurse practitioners, advanced practice registered nurses, and certified nurse-midwives, deliver safe and quality care to patients. Evidence about the competence of health practitioners to expand their practices safely and effectively provides an impetus for law reform with legal recognition of broader domains of practice and, as a result, enhanced professional status.

More research is needed on the role of different healthcare professionals in delivering care to patients with chronic diseases. A 2013 editorial in the *New England Journal of Medicine* – aptly titled, 'Putting Aside Preconceptions' – argued there is insufficient evidence to determine if the different practice cultures and areas of competence of primary care doctors and nurse practitioners 'affect their comparative ability to manage complicated diagnostic problems or treat patients with multiple, interacting chronic illnesses' (Blumenthal and Abrams 2013: 1933). Research examining the perspectives and experiences of practitioners and patients, and the impact of legal-regulatory structures on practice, is also a key component.

The push to evidence-based practice also reveals, regrettably, that many healthcare services may not actually improve health, and some interventions may make patients worse off. A 2009 commentary in the *Journal of the American Medical Association* observed that 'the aggregate effect of [healthcare spending and services] on health may be smaller than generally assumed' (Kilo 2009: 89). Many practices adopted into routine healthcare practice may lack evidence that they are any better than past practices. In a 2013 analysis of research published in the *New England Journal of Medicine* over a decade, Prasad and colleagues found 146 practices or interventions that were 'reversed' by a study, that is found to be inferior to past practices or practices that did not include the intervention (Prasad *et al.* 2013) The lead author underscored the lack of research to substantiate many commonly used practices and interventions: '[a] large proportion of current medical practice is unproven in the sense there are no good studies that really justify the practices' (McCarthy 2013: 1). Another commentator asserted that the pace of new medical developments means 'ineffective, harmful, expensive medical practices are being introduced more frequently now than at any other time in the history of medicine' (Ioannidis 2013: 780). These findings have legal and ethical implications in that practices, which become the 'standard of care' in clinical and therefore legal terms may, in fact, have little evidence to support their use.

10.3.1.1 Campaigns against too much medicine

Related to the push to evidence-based practice is a growing criticism – from inside and outside health professions – of excessive 'medicalisation.' As more medico-technological interventions are developed and promoted, conditions previously understood as normal variation in human function or behavior shift to being characterized as diseases that must be detected and treated (Moynihan *et al.* 2008). Professional associations in various countries have recently launched initiatives to identify practices that promote 'appropriate' healthcare, meaning 'the right care, provided by the right providers, to the right patient, in the right place, at the right time, resulting in optimal quality care' (Kermode-Scott 2013). For example, the Choosing Wisely initiative involves approximately 50 medical organizations in the United States and 24 in Canada that will develop evidence-based recommendations for practices or procedures that should be reconsidered or discontinued because they fail to benefit, and may even harm, patients (American Board of Internal Medicine Foundation 2014; Levinson and Huynh 2014). In the UK, the *British Medical Journal*'s Too Much Medicine project (2014) focuses on the harms of over-diagnosis and unnecessary healthcare interventions.

Some analysts have argued that liability fears drive healthcare professionals, especially physicians, to engage in 'defensive practice' by ordering tests, prescribing drugs, making specialist referrals, and providing other interventions that do little to help diagnose or treat conditions. Research in the United States, the United Kingdom and other jurisdictions has found that defensive practice is indeed common, especially among certain medical specialists groups (Studdert *et al.* 2005; Nahed *et al.* 2012; Ortashi *et al.* 2013). And worryingly, some medical students and residents report their clinical training encourages defensive behavior (O'Leary *et al.* 2012). The current emphasis on evidence-based practice may dissuade a culture of over-servicing patients, particularly if a legal standard of care shifts to support less rather than more intervention in cases where a common practice is shown to be non-beneficial. Some commentators caution, however, that judicial reliance on evidence-based sources such as clinical practice guidelines is not a panacea. Mehlman (2012) asserts, for example, that such guidelines amount to an unwarranted expansion of the self-regulatory power of health professions that develop the guidelines. A more damning criticism is that the perceived expert impartiality of such guidelines is an illusion and that powerful interest groups, including pharmaceutical companies, unduly influence the development of such standards (Spence 2014). Moreover, some health professional groups object to governmental agencies producing practice guidelines without adequate consultation with the health practitioner groups to which the rules apply. For example, the World Medical Association adopted a resolution in 2013 criticizing non-medical agencies for producing standards to be implemented in clinical practice without 'the necessary professional ethical and technical competencies,' most notably in the European Union.

10.3.2 *Shifting paradigms of healthcare delivery*

The growing, global burden of chronic conditions demands changes in the delivery of healthcare, with a shift 'to community-based and patient-centered paradigms of care for the treatment of chronic diseases' (World Health Organization 2006: 19). Health systems in many countries must contend with the challenge of establishing an optimal distribution of health workers, with some regions concerned about an over-supply of hospital-based physicians and a concurrent shortage of community-based workers, mental health specialists, and skilled care assistants (Imison and Bohmer 2013). Legal issues concerning the regulation of professionals and their scopes of practice are again key considerations. The World Health Organization noted

'[t]he shift from hospital-based to community-based care, and the new emphasis on multidisci-plinary and intersectoral approaches, means changing roles for staff … Scope-of-practice regula-tions, designed to establish minimum standards and protect patients, can become impediments to the pursuit of change' (2006: 26). Analysts studying approaches to care coordination in the UK stress that commitment and support are required 'across the political, regulatory, organiza-tional and professional spectrum towards the goal of coordinated care' for persons with complex, long-term health conditions (Goodwin *et al.* 2013: v).

Emphasis on patient self-management is another important component in the shifting para-digm of healthcare delivery. Patient self-management is described as 'an individual's ability to detect and manage symptoms, treatment, physical and psychological consequences and lifestyle changes inherent in living with a chronic condition' (Redman 2010). From a legal and ethical perspective, the adult patient with mental capacity has long been recognized as an autonomous agent, with the right to consent to or refuse healthcare interventions. While it should stand to reason that the patient is also viewed as the manager of their own health condition, the notion of patient-centered care and patient self-management is still viewed as a revolution waiting to happen (Hodgkin and Taylor 2014).

The interest in patient self-management is spurred by several developments. Importantly, patients and their advocates seek more autonomy and control in managing their condition. This is driven, in part, by a gradual destigmatization of certain illnesses where individuals are now seen as capable of managing their conditions at home and increasingly independent from insti-tutionalized care. Technological innovations help support self-management. Many patients have vast access to online information and peer support groups. Additionally, a range of technologies is available for patient use to monitor and treat their conditions, such as devices to measure blood pressure and blood sugar and self-administered catheters for chemotherapy patients. The advent of personally controlled health records also helps facilitate greater patient autonomy concern-ing their health information and conditions. From the perspective of administrators who are concerned with scarce resources and controlling healthcare budgets, patient self-management offers the potential for cost savings insofar as it appropriately keeps people away from expensive hospital stays and other healthcare interventions.

10.3.2.1 Challenges of patient self-management

As currently organized, many healthcare systems – and thus the professionals who work within them – have deficiencies in the delivery of patient-self management programs. Scholars have identified several critical ethical and policy concerns (Redman 2007, 2010). First, there are worries about shifting responsibility to individual patients who may lack personal and other necessary resources to manage their conditions adequately. Examples include health literacy, an understanding of how to navigate the healthcare system, self-advocacy skills, and education on their specific condition and strategies for self-management. At the professional and institu-tional health system levels, failure to ensure appropriate implementation and support for patient self-management may have the undesired effect of worsening patient outcomes. For example, Redman observes that many hospital readmissions for patients with heart failure result from inadequate discharge counseling to help patients understand how to monitor and manage their condition at home (2007). Such adverse outcomes may represent failures to meet legal and ethical obligations to patients. Likewise, a shift to patient self-management poses the risk of exacerbating inequalities between patients who have the resources to be successful self-managers and those who do not.

A lack of adequate resources and training for health professionals also compromises the potential effectiveness of patient self-management initiatives. Self-management programs must be integrated into complex healthcare systems. In this regard, funding issues are key. For example, are activities related to patient self-management insured or reimbursable through public or private health insurance funds? Longer appointment times to educate and counsel patients, as well as coverage for devices that patients may use for at-home monitoring and treatment, are among some of the pressing financial implications of investing in patient self-management tools. Returning to the issue of evidence-based practice, more research is needed on the longer-term effects of patient self-management, both in terms of biomedical and psychosocial outcomes for patients and broader health system impacts.

10.3.3 Patient safety

The issue of patient safety has attracted much attention from health and legal scholars in recent years, and the growing prevalence of chronic diseases exacerbates these concerns. The World Health Organization (WHO) explains, '[a]s health services for chronic conditions have evolved, so too has their complexity. Although much has improved, the volume of information, the number of medications, and the myriad of providers has led to a number of unintended [patient safety] consequences' (WHO 2006: 28). A push to greater patient self-management may also create new safety risks, particularly as patients take more responsibility to monitor and treat their conditions independently.

Legal systems and rules have a significant influence on how health professionals deal with patient safety issues, including principles, processes, and procedures governing disclosure of adverse events, findings of liability, and compensation for harm. It has been argued that:

> A medical-societal alliance is needed to advocate a medical liability system without perverse incentives and to protect the right of injured patients to fair compensation. At the same time, the liability system must foster frank discussion of medical errors and wide dissemination of lessons learned so that proper steps can be taken to prevent recurrences.
>
> *(Cohen* et al. *2007: 671)*

Emerging comparative research explores different countries' approaches to malpractice, legal liability, and related patient safety issues (Oliphant and Wright 2012). It provides a foundation for further scholarship and gives practitioners and policy-makers insight into the experiences of other jurisdictions.

Enabling patients to be more actively involved in their own care decisions and disease management requires 'a whole-system approach' (Coulter *et al.* 2008) and, as a 2013 editorial argues, 'the growing population of people with multiple long-term conditions, disabilities, and frailty will demand a different model of care and support – a primarily social not medical model' (Hodgkin and Taylor 2013: 7). Moreover, such system-level changes can be facilitated by legal-regulatory reforms and innovations, such as: patient charters or bills of rights; statutory requirements for healthcare organizations; and professional regulatory bodies that can engage with patients in meaningful ways to collect, report, and act on feedback about patient experiences and quality of care. Patient charters or bills of rights have been adopted in various jurisdictions, including a number of European countries, Australia, Hong Kong, Israel, New Zealand, and South Africa (Flood and May 2012). Health law scholars point out that patient charters are most effective when they articulate clear rights, can be interpreted and applied coherently with other sources of law, including professional discipline procedures, and have affordable and efficient

means of complaint resolution and enforcement (Flood and May 2012). Healthcare laws in certain jurisdictions create organizations to provide oversight, to report on quality of care issues, and to receive and investigate patient complaints, including Canada (for example, Health Quality Ontario and British Columbia's Patient Care and Quality Review Board), the United Kingdom (Care Quality Commission), and Australia (Commission on Safety and Quality in Health Care). Comparative analyses of the activities and impacts of such bodies is an important area for future health law research, including analysis of different statutory models and identification of best practices.

10.4 Conclusion

This chapter has considered a number of important trends in contemporary healthcare, relating these issues to professionalism in healthcare, the regulation of health professions, and legal and ethical implications. As the organization of healthcare is facing multiple pressures, some argue that a new model of professionalism in healthcare is required. A 'new professionalism,' which ties together many of the themes in this chapter, is described:

> It places a stronger emphasis on accountability, recognizing the benefits of creating a different dynamic between patients and professionals, and assuming a stronger sense of responsibility for the ways in which the wider health system works and for all dimensions of quality. It promotes a desire constantly to improve what clinicians do, accepting change as an asset rather than a threat. It commits to using a range of different approaches to developing and mobilizing knowledge about how to improve care and to building the formal evidence base underpinning improvement. Finally, it emphasizes the importance of clinicians working in multidisciplinary teams across organizational boundaries. Most fundamentally, no longer is a commitment to improving the quality of patient care an 'add-on.' It is a central part of the role of a clinician and a core value of the new model of professionalism.
>
> *(Stanton* et al. *2011: 48)*

We are thus in an era of changing approaches to healthcare organization and in the regulation of healthcare practitioners. Fortunately, common interests and shared goals exist among all stakeholders in health systems, including patients, practitioners, policy-makers and regulatory authorities. A fundamental aim of healthcare is to produce safe and beneficial outcomes for patients in a cost-effective manner. Patients ought also to be recognized and supported as meaningful managers of their care, both at the personal level in their interactions with health professionals, and at the socio-political level in how health systems are structured and practitioners regulated.

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