Commentary

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Organizational Professionalism: Role of Medical Council in Public Trust in the Profession

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Abstract

As an ideology for managing healthcare relying on internal professional oversight, medical professionalism entrusts the responsibility of regulation to the members of the profession themselves. This allows them to demonstrate to the public that the necessary measures are in place to ensure the competency of individuals practicing medicine and to oversee their performance according to professional standards. This commentary explores how medical councils maintain professionalism through self-regulation and their critical role in sustaining public trust.

The medical council plays five key roles in fulfilling its self-regulatory function: A. Setting medical education standards and accrediting medical schools, B. Granting licenses to practice medicine, C. Establishing continuous education standards to maintain professional competency, D. Defining professional performance regulations, and E. Handling disciplinary matters related to professional conduct.

The strengths and weaknesses of their execution in our country's medical council will be analyzed by introducing and providing examples of successful implementations of each of these roles in various countries. Finally, three solutions are recommended to maintain public trust and enhance these functions through conflict-of-interest management: separating the professional advocacy section from the self-regulation section, including non-medical professionals in the Medical Council and its various commissions, and ensuring transparency in policies, member information, and disciplinary rulings.

Keywords: Professionalism, Medical council, Self-regulation

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Introduction

Professionalism in healthcare encompasses a set of behaviors and beliefs aiming at effective service delivery, fostering an intimate doctor-patient relationship that builds societal trust (1-3). This trust underpins the self-regulation of the medical profession, which is essential for maintaining public confidence (4).

Regulating healthcare services involves free-market and socialist systems, each presenting distinct challenges. Successful regulation hinges on internal professional self-regulation—medical professionalism (4). With its specialized knowledge, the Medical Council plays a crucial role in this framework, ensuring high-quality service delivery through its independence and autonomy (5, 6).

The Medical Council is responsible for establishing a self-regulating framework vital for public trust (7) and goes beyond typical associations by overseeing continuing education, evaluating qualifications, setting performance standards, and monitoring conduct. It also advocates for medical professionals' rights

and engages with lawmakers and the media to promote optimal service delivery conditions (6).

Key responsibilities of the Medical Council include:

1. Establishing standards for medical education and accrediting medical schools
2. Licensing medical practitioners
3. Setting continuous education standards to maintain competency
4. Developing code of ethics
5. Overseeing disciplinary actions related to professional conduct

This article will explore the responsibilities of medical councils in various countries, analyze the strengths and weaknesses of local councils, and propose strategies for enhancing their effectiveness.

1. Establishing Standards for Medical Education and Accrediting Medical Schools

The medical council should ensure medical education quality by establishing and overseeing standards. The UK's General Medical Council (GMC) exemplifies this by setting and enforcing educational standards for medical training (8, 9). The GMC requires medical schools to conduct annual evaluations of their educational quality, create action plans for improvement, and submit a comprehensive report every four years to maintain accreditation (10).

In our country, while the Medical Council's policy documents lack a clear definition of medical education standards, they highlight the council's role in significant reforms in medical education, specifically in revising objectives, content, and teaching methods to align with national needs (11). Article 43 of the Charter of Medical Community Rights mandates the Medical Council to continuously review educational programs, assess quality, and address deficiencies in medical education (12).

The Medical Council is disengaged from medical universities, lacks established education standards, and does not effectively collaborate with medical schools or evaluate necessary competencies for practice. Consequently, the Ministry of Health's Educational Deputy oversees medical education, limiting the Council's influence on policy.

2. Licensing Medical Practitioners

The Medical Council assesses the minimum competencies of medical graduates before issuing a practice license, focusing on their physical and mental capabilities, along with essential knowledge and skills. This is particularly important for international graduates. Starting in the 2024-2025 academic year, all UK medical school graduates must pass the MLA (Medical Licensing Assessment) to obtain a license, a requirement previously limited to international graduates via the PLAB (Professional and Linguistic Assessments Board) exam (13).

In the United States, state medical boards assess an individual's medical knowledge and skills through the USMLE exams and evaluate their ethical, physical, and mental qualifications before granting a medical license in a specific state (14).

Iran has introduced a public system for registering medical professionals' credentials and educational records. However, the Medical Council only verifies graduation from approved medical schools and does not conduct an independent assessment for issuing medical practice licenses. There is currently no structured evaluation framework in place.

3. Setting Standards for Continuous Education to Maintain Professional Competency

Medical knowledge is rapidly advancing, with significant changes in treatment protocols over the years, for instance, the approach to peptic ulcers transitioned from surgery and antacids in 1973 to treating it as an infectious disease with antibiotics targeting Helicobacter pylori and proton pump inhibitors by 2013 (15). The volume of medical literature is expanding at a logarithmic rate, doubling the time for medical knowledge, decreasing to approximately 73 days by 2020 (16).

The limitations of human memory and infrequent engagement can lead to information fading, prompting the Medical Council to establish oversight, as research indicates physicians often misjudge their educational needs (17, 18).

In the UK, the General Medical Council (GMC) mandates strict revalidation standards for doctors every five years, which involves compiling documentation related to care quality, peer reviews, and identifying areas for improvement. This includes reports of serious incidents, patient feedback, and assessments (19, 20). The Continuing Professional Development (CPD) program requires physicians to assess their knowledge in key areas and reflect annually on CPD outcomes. GMC representatives review their performance to facilitate license renewal.

In the US, revalidation is overseen by specialty boards coordinated by the Federation of State Medical Boards (FSMB). Physicians must take board examinations every 6 to 10 years and maintain an active state medical license. They must perform annual self-assessments and earn

CME credits through educational participation, documenting practice outcomes and action plans for improvement, and demonstrating progress on quality objectives (21, 22).

In Iran, the Medical Council emphasizes continuous education, revising regulations based on the community's needs. Article 44 of the Iranian Medical Rights Charter mandates high quality in-service training with ongoing quality evaluations (11, 12). The Ministry of Health CME regulations require physicians to earn a specific number of CME credits every five years, but there are no examination requirements or needs assessments for program selection, and training program effectiveness remains unmeasured (23). The Ministry is responsible for implementing these laws, but the Iranian Medical Council lacks a systematic method for monitoring competency maintenance.

4. Developing a Code of Ethics

Medical councils define professional conduct for physicians, replacing traditional oaths like the Hippocratic Oath. The American Medical Association (AMA) established the first U.S. regulations in 1847, with updates to address ongoing healthcare challenges (24). In the UK, the General Medical Council (GMC) developed self-regulation guidelines in the 1970s, leading to the first edition of Good Medical Practice in 1995, which has been revised multiple times (25). In Iran, the Iranian Medical Council issued the Professional Conduct Guide for Physicians in 2018 (1397 in the Iranian calendar) to outline physician behavior standards. However, many professionals remain unaware of this guide, and efforts to promote or enforce its implementation have been insufficient (26).

5. Overseeing and Disciplinary Actions Concerning Professional Conduct

The Medical Council's enforcement of self-regulation in Iran's medical profession relies on effective oversight of conduct and proactive measures against violations, as outlined in the 2004 Medical Council Law. This law assigns the Disciplinary Prosecutor's Office to investigate ethical violations though it restricts peer reporting to cases with personal grievances, limiting insight from fellow professionals. Moreover, complaints from scientific associations require a private complainant for investigation, leading to inconsistencies in penalties and inadequate focus on ethical violations. While a Professional Conduct Guide exists, disciplinary boards often only reference 27 clauses from the 2004 Disciplinary Code. Additionally, claims for blood money (diya) are treated criminally, outside the Medical Council's jurisdiction (11).

In military contexts, the 1978 Executive Regulation places competency reviews under military jurisdiction (27, 28). In contrast, the UK's General Medical Council (GMC) has established a comprehensive misconduct reporting process initiated by incidents like Dr. Shipman's killings (29) and the Bristol Royal Infirmary scandal (30). The GMC allows public attendance at hearings and publishes disciplinary outcomes online, varying by case (31). In the US, state medical boards oversee investigations into allegations against certified physicians while maintaining records in the Federation of State Medical Boards (FSMB) database (32). The emphasis on self-regulation includes support for those with illness or substance use disorders, highlighting the need for reporting systems and rehabilitation to preserve competency.

Recent studies indicate that alcohol and substance use disorders among US physicians reflect general population rates. In response, state medical boards have established assessment and rehabilitation centers, mandating healthcare providers to report concerns about physicians' ability to practice due to psychiatric or substance issues. Research shows that 75% to 85% of impaired physicians can resume practice after treatment (33), while non-compliant individuals may face license revocation (34).

Article 34 of the Disciplinary Code in Iran mandates a five-member commission to evaluate medical professionals' conditions affecting care provision (27). This commission includes representatives from the Medical Council and relevant medical experts. However, the Iranian Medical Council has yet to establish guidelines for assessing mental and physical disabilities or substance use disorders, resulting in an unstructured approach to these issues.

Managing Conflict of Interest as a Key Measure for Improving Performance and Maintaining Public Trust

The Medical Council aims to maintain public trust in the medical profession but faces challenges due to inadequate mechanisms for managing conflicts of interest. There are concerns about self-regulation, as professionals elected by their peers may prioritize the profession's interests over impartial oversight, raising issues of fairness in addressing professional misconduct. This creates a conflicted self-regulatory framework that struggles to enforce strict and transparent disciplinary measures while advocating for members. Implementing key measures is essential

to preserve public trust and manage conflicts of interest effectively. The following sections will provide a detailed exploration of these critical measures.

1) Separation of Professional Advocacy from Self-Regulation

A professional union plays a crucial role in advocating for its members by promoting professional autonomy, protecting their rights, and enhancing conditions for service delivery. Members benefit from essential services such as financial consultation, legal advice, and training for managing medical practices although integrating these services with self-regulatory roles may raise concerns about self-regulation responsibilities.

In the UK, the General Medical Council (GMC) is responsible for self-regulation by overseeing physicians' performance (35), while the British Medical Association (BMA) advocates for them (36). In the US, the American Medical Association (AMA) manages professional advocacy (37), and self-regulation is handled by state boards in various medical specialties, coordinated by the Federation of State Medical Boards (FSMB) (32, 38).

Countries like South Africa, the UK, Ireland, New Zealand, Hong Kong, Singapore, Malaysia, Bermuda, and the Caribbean provide physicians with support services through the Medical Protection Society (MPS), which operates on a membership fee model. Each country also has its own Medical Council responsible for overseeing self-regulation in the medical profession (39).

2) Inclusion of Public Members in Medical Councils and their Committees

In many countries, Medical Councils are composed of professionals elected through traditional means and representatives from various sectors, such as universities, medical associations, the Ministry of Health, and the general public. For example, about 24% of council members in the United States are from the general population.

The following table shows the proportion of public members in Medical Councils across selected countries (Table 1).

The election-based composition of the Medical Council raises concerns about conflicts of interest, as elected members might prioritize professional agendas over self-regulation responsibilities. This could decrease participation in council elections or lead to the replacement of current members. To enhance effectiveness and accountability, it's essential to include public representatives, ensuring that public perspectives and needs are addressed for balanced decision-making.

3) Transparency of Policies, Member Information, and Disciplinary Rulings

Easy access to information about licensed medical practitioners is essential, including their qualifications and specialties, which the Medical Council should verify. Policies and decisions of the Medical Council must also be transparently available to the public, helping individuals understand the complaint process and building confidence in the review system. Many countries promote transparency in disciplinary rulings to maintain public trust. For example, physician review websites in the United Kingdom, various Canadian provinces, and several U.S. states provide accessible information on the outcomes of disciplinary actions against doctors (31, 40, 41). This practice ensures accountability and reassures the public about the integrity of the medical profession.

Conclusion

Maintaining public trust in the medical profession relies heavily on the Medical Council. To enhance this trust, the Council should practice self-regulation, ensure transparency, and avoid conflicts of interest. Key policies include: 1. Separating professional advocacy from self-regulation; 2. Including public representatives on the council; and 3. Ensuring transparency in policies and disciplinary decisions. By implementing these steps, the Council can effectively fulfill its self-regulatory responsibilities while remaining accountable to the public.

Authors' Contribution

All authors contributed to the discussion, read and approved the manuscript, and agreed

Table 1. Proportion of public members in the Medical Council of selected countries

Country	Total Members in the Medical Council	Public Members in the Medical Council
United Kingdom	10	5
New Zealand	13	5
Hong Kong	32	8
South Africa	32	9
Canada	12	3
Iran	29	0

to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflict of interest

The author has no conflict of interest in this paper.

Declaration on the use of AI

The authors of this manuscript declare that no artificial intelligence (AI) was used during the writing process.

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