Doctors in society

Medical professionalism in a changing world

Technical supplement to a report of a Working Party of the Royal College of Physicians of London

December 2005

Royal College of Physicians

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Introduction

In the period between October 2004 and June 2005, a Working Party of the Royal College of Physicians of London (RCP) looked extensively into the topic of 'medical professionalism'. During the course of its investigation the Working Party gathered evidence widely, including:

- written submissions and oral evidence from 20 witnesses
- written responses from 109 individuals and organisations following an invitation to respond to the Working Party's 'four questions'
- 2,175 responses to an online questionnaire to junior doctors and medical students
- the views of College Fellows and Members
- a series of focus groups with nurses, professionals allied to medicine and the public
- a seminar at Trinity College Cambridge in June 2005 designed to test the themes emerging up to that point
- a core bundle of references and source documents on 'professionalism'.

The results of the Working Party's consultations and deliberations are contained in the RCP's publication, *Doctors in society: medical professionalism in a changing world.* This document is a supplement to that report, and is a compilation of much of the material considered by the Working Party in coming to its conclusions. It is a statement of current views on the nature and state of medical professionalism at the start of the twenty-first century and provides a rich source of additional material for those who wish to examine the topic in greater depth, or who wish to read in full the views of those who contributed to the consultation process.

Acknowledgements

Members of the Royal College of Physicians Working Party on Medical Professionalism wish to thank all those people and organisations who generously contributed their time, and their individual and collective wisdom to this project.

This technical supplement to the Working Party report is a compendium of these contributions, without which little would have been achieved.

1 Written submissions of those who gave oral evidence to the Working Party

During the course of its meetings, the Working Party received oral evidence from 20 witnesses. Before giving evidence, each witness was invited to consider the Working Party's four questions and to provide a written submission on the questions posed, and on anything else relevant to the topic. Most did this, and their contributions follow in the order in which they appeared before the Working Party. Some witnesses presented research findings rather than speaking to the four questions; these contributions are also set out. The Working Party's four questions are set out on page 13 of the Working Party report and again on page 68 of this supplement.

The following witnesses provided oral evidence without a written submission:

- Mrs Claire Rayner, President, Patients' Association
- Dr David Armstrong, Reader in Sociology as applied to Medicine, King's College, London. Dr Armstrong gave oral evidence on the sociology of the professions.
- Julian Le Grand, Professor of Social Policy, London School of Economics. Professor Le Grand gave oral evidence, referring, in particular, to his publication, *Motivation, agency and public policy: of knights and knaves, pawns and queens.*[1]
- Sir Derek Wanless, author of *Securing our future health: taking a long-term view*[2] and *Securing good health for the whole population.*[3]

A list of those who gave oral evidence is given in the Appendix to the Working Party report.

References

1 Le Grand J. *Motivation, agency and public policy: of knights and knaves, pawns and queens.* Oxford: Oxford University Press, 2003.

2 Wanless D. *Securing our future health: taking a long-term view*, April 2002. www.hm-treasury.gov.uk/media/A99/D2/letter_to_chex.pdf

3 Wanless D. *Securing good health for the whole population*, February 2004. www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm

Friday 12 November 2004

The submission of **Miss Margaret Goose** OBE
Chair, Royal College of Physicians Patient and Carer Involvement Steering Group

Expectations of competency and trust underpin the patient's perspective on medical professionalism, but doctors' attitudes and behaviours are also key, as they will either enhance or undermine expectations. More detailed observations are set out below. These are personal views, but are informed by long-standing links with patient organisations and input from the RCP Patient and Carer Network.

Competency

This covers knowledge, skills and experience. It is not just passing examinations, but keeping up to date. Patients recognise that knowledge is now extremely complex and this complexity will increase. Individually, patients have different expectations on how this should be handled.

Concepts of competency are key to the current debates concerning revalidation and accountability. If a doctor has an inappropriate attitude or cannot communicate effectively, patients are likely to consider them lacking in competence.

Patients and the public are increasingly sceptical about self-regulation following Bristol, Alder Hey, and Shipman. If self-regulation is to continue, the profession must demonstrate that it is successfully dealing with those who are objectively shown to have demonstrated poor performance and thus restore public confidence.

Trust

The research underpinning Onora O'Neill's BBC Reith lectures in 2002[1] and the Samuel Gee lecture indicates that the public, when asked, generally are more distrustful of the medical profession, but that their personal, individual action indicates they still have confidence in individual clinicians. There is a generational difference, with younger people more likely to challenge professionals.

The relationship between the doctor and the patient in private practice is more personal, but also contractual.

The scepticism mentioned in *Competency*, above, will continue unless the apparent 'closed-shop' approach is replaced by a more transparent and robust system of accountability.

Values

Patients still expect doctors to give a service, and the concept of vocation and altruism are generally assumed, although it is recognised that hours of duty have been reduced.

An individual patient's values and reaction to what is being discussed will be influenced by personal experience and that of family and friends, which may differ from the views ascribed to the general public, particularly as portrayed in the media. In some situations, concern has been expressed that personal financial gain to the doctor could be influencing decisions about individual patient care.

Judgement

Patients recognise that situations are not always clear-cut and that judgement is required. In exercising judgement, more patients now expect the doctor to take account of the issues which are important to the patient, and could be broader than those covered by scientific evidence.

Behaviour

The behaviour demonstrated by the doctor will determine the patient's perspective on the four areas listed above – for example, appearance, hygiene, punctuality, introductions and willingness to find out more are examples of 'behaviour'. Self-confidence can be mistaken for arrogance.

Communication is still a major issue. Every patient is unique and may change their expectations at different stages of their illness/treatment/care. Listening and having respect for patients' views and time, and explaining any delay are points frequently mentioned by patients.

Issues relating to leadership, and teamwork with other medical colleagues (hospital and primary care) and with other healthcare (and social services) colleagues, have a major impact on the care provided to patients. Patients regard continuity of care as extremely important. If a doctor is the leader they must accept responsibility for this.

Doctors' supreme role has now been challenged and there is no going back

Patients now have access to more information, but still need an interpreter. The following categories of patients were described by Margaret Mythen and Tom Coffey: 'Mrs Internet, Miss Alternative Therapy, Mrs Doctor Knows Best, Mr Socially Vulnerable, Mr and Mrs Busy, and Mrs Empowered'.[2]

Increasingly, consumerism and the move towards a patient-centred NHS stemming from the 1992 Patient's Charter are now recognised as underpinning policy.

Other professions have developed their own expertise and have become more autonomous in service delivery.

Overall, there is a change in the relationship between doctor and patient, moving from paternalism to partnership. This is reflected in changing language – for example, 'concordance' rather than 'compliance' in medicines management.

In this context, the RCP Patient and Carer Involvement Steering Group has embarked on a project on the explanation of risk and shared decision-making.

Systems and facilities

Patients do not necessarily recognise that the effectiveness of an organisation and its systems can have a major impact – for example, medical records not being available, physical facilities and environment. On the other hand, patients can sometimes excuse doctors' poor performance because of the pressure they perceive they are under.

Other health professions

Many of the above issues apply, but because doctors were previously on a pedestal they had further to fall.

Other professions

The Church: more a question of society changes. Other professions, for example, the legal profession: generally services are paid for, thus there has always been a different relationship and the issues involved are not a question of literally 'life and death'.

References

1 O'Neill O. *A question of trust.* The BBC Reith Lectures 2002. Cambridge: Cambridge University Press, 2002. www.bbc.co.uk/radio4/reith2002/

2 Mythen M, Coffey T. Choice ideas. Fighting shy. *Health Serv J* 2004;**114**:18–9.

The submission of **Mr Harry Cayton**
National Director for Patients and the Public, Department of Health, London

Let me start by saying that I believe that doctors and other health workers continue to be held in high regard by patients and the public. Opinion polls suggest that doctors are amongst the most trusted people in society, and my own observation is that the leaders of medical colleges and organisations are resolutely and seriously self-critical in a way that no other group of employers, experts, workers or advisers has shown itself to be. Compare doctors with accountants, non-executive directors of companies, lawyers, religious leaders and charities, and you will struggle to find self-criticism and professional reform, despite evidence of massive failure in all these groups, at anything like the level it is taking place amongst doctors.

But you may have noticed that I avoided using the word 'professional' to describe any group of workers in that introduction. It is because it does not feel to me that 'professional', in the sense of having consistently high standards of conduct as a class of people, is any longer very convincing.

I find myself particularly put off by the wonderfully pompous, self-regarding definition provided by the Working Party.[1] It just has to have been written by a self-defined 'professional' redolent with moral superiority.

You will not be surprised that, being a citizen advocate, I prefer Shaw's definition in *A doctor's dilemma*: 'All professions are a conspiracy against the laity'.

For these reasons, I find myself struggling to give evidence in the format required by your structured questionnaire, since the questionnaire is based on a definition which I wish to challenge. I hope, nevertheless, that I will be helpful, as well as possibly provocative.

I asked myself: how does medical professionalism feel to a contemporary citizen or patient? The first thing is, it feels differently to each group and differently according to experience to each individual. There are two levels of trust required: trust that the person I see is who they say they are and can do what they say they can do; and trust in the institutions that train, accredit and regulate him or her.

The first thing I must trust is *competency*. Having confidence in *expertise*, that is clearly central, as is trust in *confidentiality*. But I think that modern patients are increasingly concerned about the *manner* in which they are treated, wanting respect and courtesy as well as kindness, good *communication* and the understanding of options, and with *informed consent*.

Patient trust in, and respect for, individual clinicians is greater than public trust in regulatory bodies. Self-regulation is easily mistrusted as professions

'looking after their own'. The police investigating the police proved to be unsatisfactory and, of course, the GMC has already gone through significant reform. In a sense it has already moved from self-regulation to shared regulation. I think this is a concept that could be developed further as part of the social contract. On 14 November 2004, Lord Warner announced changes to move the Committee on Safety of Medicines and the Medicines and Healthcare Regulatory Agency towards a shared regulation model with a great deal more patient and public involvement. Regulatory bodies are also portrayed as slow, timid and secretive. Some of this may be deserved; much of it is a failure in communication and a lack of public understanding of their powers and role.

You ask which of the characteristics of professionalism are no longer useful or true. I am going to suggest three:

- I am not sure that *altruism* is any longer a significant professional marker. I see no reason to think that lawyers, for instance, or accountants are altruistic professions, and while there are, of course, many, many people who work in healthcare who are motivated by altruism, such motivation is neither restricted to medical professionals (as distinct from care assistants or porters), nor necessary to their practice. A private doctor carrying out cosmetic surgery is a businessman selling a product and no more altruistic than, say, Georgio Armani or Estée Lauder. It is the claim of altruism that allows the medical profession to claim moral superiority: 'I am a doctor, therefore, I am good'. Certainty of goodness leads to complacency and worse.
- Second, I think *mastery* is an archaic concept. Indeed it comes from late Middle English and is linked to the mysteries of the Guilds: the idea that members were in possession of secret knowledge withheld from others. So, while a body of knowledge is clearly essential, it is the interpretation of knowledge, the engagement with new knowledge, the acknowledgement of uncertainty about knowledge, the sharing of knowledge, not the holding of knowledge, that are characteristics of modern medicine.
- Third, *autonomy*. I think professional autonomy has already gone. And I think the medical profession is finding that the most painful loss of all. It is gone because of the very complexity of applying knowledge; people cannot do it well if they try to do it alone. It is going because of standards, guidelines, revalidation, regulation, contracts, decision-support and team work.

What different qualities might there be? Where could we find new characteristics from which self-respect and pride in profession could come? I suggest the following:

- *Empathy* – a concentration on the individual other – through communication, partnership, consent, courtesy, respect, supported self-management and choice.

- *Expertise* in the application of knowledge, rather than the mastery of a body of knowledge.
- *Mutuality*, rather than autonomy. A new professionalism could be defined not in terms of autonomy, but in terms of relationships: relationships with knowledge; with colleagues; with patients; and with society.

The qualities of professionalism would then derive not from what a doctor is, from self, but from how he/she behaves in relation to others; a professionalism based not on individuality but on mutuality.

An afterthought

In our discussion, I was asked to what extent a doctor's private behaviour should affect their professional competence. Could a man who looked at pornography be a fit person to be a gynaecologist? In effect, I was being asked, 'Do you need to be a good person to be a good doctor?'

Since my argument seeks to uncouple *being* a doctor from *behaving* as a doctor my immediate response was to say that I did not think private actions should affect a doctor's status unless they directly affected his or her competence, such as excessive drinking or lack of cleanliness. This does not seem to be an adequate response and I have thought about it further.

We can use this question to test my suggestion that modern professionalism can be derived from how people conduct relationships.

It is possible to construct a framework in which criminal behaviour is in breech of appropriate relationships *with society*; inappropriate sexual behaviour towards a patient in breech of relationships *with patients*; rudeness or bad timekeeping a breech of relationships *with colleagues*, and so on.

The question, 'Does looking at pornography make you unfit to be a doctor?' could therefore be considered in terms of what does this private behaviour say about that doctor's relationship with others? Does it tell us about his attitude to women in particular? If so might it help us to make a judgement about his suitability to be a gynaecologist.

I don't think this question is easily answered but I do think my mutuality model allows us to address it, not by saying a doctor must be good, but by allowing private conduct to be taken into account when it affects public (professional) relationships.

Reference

1 Cruess SR, Johnston S, Cruess RL. Professionalism for medicine: opportunities and obligations. *MJA* 2002;**177**:208–11.

Friday 10 December 2004

The presentation of **Dr Vikram Jha**
Lecturer in Obstetrics and Gynaecology, University of Leeds

Documents from the General Medical Council (*Tomorrow's doctors* and *Good Medical Practice*) and from the Medical Professionalism Project (Physician Charter) [see Appendix 1: Reading List] emphasise the importance of appropriate professional attitudes and behaviour amongst medical students. There are three main problems with existing knowledge on the subject:

- Professionalism is defined in terms of attributes and behaviour such as empathy, integrity and altruism. These terms are nebulous and represent ideals that are difficult to operationalise.
- Terms such as attitudes, behaviour, values and, indeed, skills are often used interchangeably. In reality they are different concepts and should be treated so.
- There are very few validated methods of measuring professional attitudes in medicine.

The overall aim of the project is to develop a reliable and valid tool for measuring attitudes to professionalism in medicine.

Systematic review

I am in the process of carrying out a systematic review on measures of professionalism in medicine. Only studies that have data are to be included in the study. A number of reports in the medical education literature – on programmes to promote or methods to measure professionalism – are anecdotal and inadequately evaluated. A number of these represent views of educationalists on how or why these interventions work. The systematic review will provide quality evidence on validated methods of promoting or assessing medical professionalism.

Interview study

I have completed a qualitative interview study aimed at describing attitudes that underpin professional attributes and behaviour in medicine. The objectives of the study included investigating individuals' views and beliefs on the subject, identifying themes emerging from these views, identifying associations between

data-derived themes and concepts of professionalism, and generating items for use in the development of the final tool to measure professional attitudes. The reason for doing a qualitative study was to generate quotes from the interviews that could be used as statements or vignettes in the final tool, rather than use material thought up by the researcher as is often reported in the literature.

The study was a cross-sectional survey employing qualitative methods. In-depth semi-structured, face-to-face interviews were used to elicit data. In order to generate a wide range of responses, a purposive sample consisting of 23 individuals from four groups were selected: those in training (medical students), those already trained (clinical practitioners), those trained and training others (educationalists) and lay professionals. The interviews were transcribed and analysed using thematic analysis with NUD*IST software.

Results so far

The background theory was that whilst global attitudes do not necessarily predict specific behaviour, they predict aggregates of behaviour (aggregation principle). The results of the study are presented in the form of the final seven themes, together with the attributes and behaviour categories. These categories are either derived from the interviews or from the literature. Textual examples are provided as illustrations of the categories, some of which are clear examples whereas others represent the more grey areas of professionalism that are difficult to define. A number of the attributes and behaviours mirror those found in the literature.

Themes derived from interview study

Theme 1 Compliance to values

	Positive	Negative
ATTRIBUTE	Integrity Professionally ethical Honourable	Hypocritical Irresponsible Impropriety
BEHAVIOUR	Behave responsibly Report colleagues Maintain confidentiality	Behave irresponsibly Cross boundaries

Theme 2 Patient access

	Positive	Negative
ATTRIBUTE	Available	Inaccessible
BEHAVIOUR	Provide continuity of care Be part of community	Not respond to calls

Theme 3 **Physician-patient relationship**

	Positive	Negative
ATTRIBUTE	Empathetic	Unsympathetic
BEHAVIOUR	Collaborate with patient over care Enhance physician-patient relationship Treat patients with respect as individuals	Negatively affect physician-patient relationship (poor communication)

Theme 4 **Demeanour**

	Positive	Negative
ATTRIBUTE	Appropriate manner	Rude Arrogant
BEHAVIOUR	Project appropriate image	Dress inappropriately

Theme 5 **Professional management**

	Positive	Negative
ATTRIBUTE	Disciplined Leadership People management	Careless
BEHAVIOUR	Work in team	Not work in team

Theme 6 **Personal awareness**

	Positive	Negative
ATTRIBUTE	Awareness of being a reflective practitioner Awareness of differences Awareness of physician privileges Self awareness	Dogmatic
BEHAVIOUR	Audit own practice appropriately using own knowledge and skills	Gender behaviour Prejudiced behaviour

Theme 7 **Motivation**

	Positive	Negative
ATTRIBUTE	Altruistic Caring	Self-driven
BEHAVIOUR	Protecting patients' interest	Refuse to treat patients

Conclusion and future

The themes derived from the interview study represent professional attitudes underpinning aggregates of professional attributes and behaviour in medicine. The results of the study will form the basis of the material for the tool to measure these attitudes initially in medical students. The results of the systematic review will form the basis of future work on developing valid methods of assessment of attitudes in medicine.

The submission of **Professor Dame Margaret Turner-Warwick**
Former President of the Royal College of Physicians

These notes were prepared as a basis for a brief oral presentation and discussion at the RCP Working Party on 'Defining and maintaining professional values in medicine'. They are intended as no more than notes to highlight some of the key issues relating to the problems being faced by many doctors in the care of patients. No attempt has been made to write a fully argued or referenced text.

Abbreviated generalisations can easily be misleading and the context is important. For example, a distinction has to be made between the problems faced by the medical profession in general in today's society and the more specific problems of organisation. The experiences of different doctors in different specialties and in different parts of the country will vary. Nevertheless, there is now considerable evidence that, for a variety of reasons, patients do not always get the care they need, and these reasons must be addressed. I have been asked by the College to share these brief discussions and read the published literature, remembering that there are always two sides to any problem. They are intended to be constructive rather than critical and are written with a full awareness of the huge challenges faced by all of those trying to improve healthcare for both the public and patients in a changing world. I would be happy to hear your views, both supportive and otherwise. These will help the College in its deliberations.

In the time available, I wish to focus on seven topics all relating primarily to professional doctors' care of patients (the broader issues of healthcare in the UK are outside the current remit):

- What defines a professional person as opposed to an artisan (artificer) or tradesman?
- Why I believe that professional doctors are still required in modern medicine.
- Do patients want and need professional doctors?
- Since this is a report from the RCP, do Fellows and Members of the College believe that professionalism (as defined below) is crucial for medicine? It is essential that we get their views on this.
- What is the evidence that professional standards in the care of patients have been eroded in recent years? How has this occurred?
- How much responsibility for this must be taken by doctors themselves and how much by government and management? As Professor Chris Ham has pointed out, a fundamental gap has developed between *policy intent* as set by

governments as an overall plan to improve healthcare to the nation, and *delivery of patient care* at the coalface as a service to individuals by health professionals. Delivering services to populations and their delivery to individual patients create distinctive agendas.

- What should now be done to restore and maintain those standards?

What distinguishes a professional person from an artisan or tradesman?

A *professional* person not only has particular knowledge and skills, acquired through training and refined by experience, but also agrees to conform to certain standards of personal behaviour and codes of practice.

Because of their responsibilities to patients, professional doctors must also adhere to codes of behaviour that include honesty, ethical integrity, humility to recognise their personal limitations, compassion and empathy. It is essential to the notion of professional codes of practice that they include standards of training and practices set by the corporate body of the profession itself. Inherent in this – and it applies to any profession – is self-regulation. This reflects trust placed in professional doctors to serve the best interest of patients and the public and not themselves. This is not an exclusive responsibility; it must be coupled with 'intelligent accountability based on good governance, independent inspection and careful reporting'.[1] Self-regulation and intelligent rigorous accountability amount to 'shared regulation' in modern terminology.

These personal standards and codes of practice are essentially independent of politics and government, but professional people must conform to the laws of the land. There may be very exceptional circumstances where a professional medical doctor finds his/her own professional ethical position incompatible with the law (eg where the state demands doctors' participation in torture, or other forms of harm to people). Under such circumstance he/she has to take responsibility for making a judgement, either to comply with the law or declare his/her position, recognising the consequences.

Because of the incompleteness of our knowledge in medicine, personal professional qualities also include the capacity to make judgements, the ability to extend and develop knowledge through innovation and, because of the complexities of modern medicine, the skills of leadership. Professionalism requires all of these.

The medical profession is the corporate body that, working through the General Medical Council (GMC) – which now also includes many lay people – and the medical Royal Colleges, is responsible for setting the values, standards

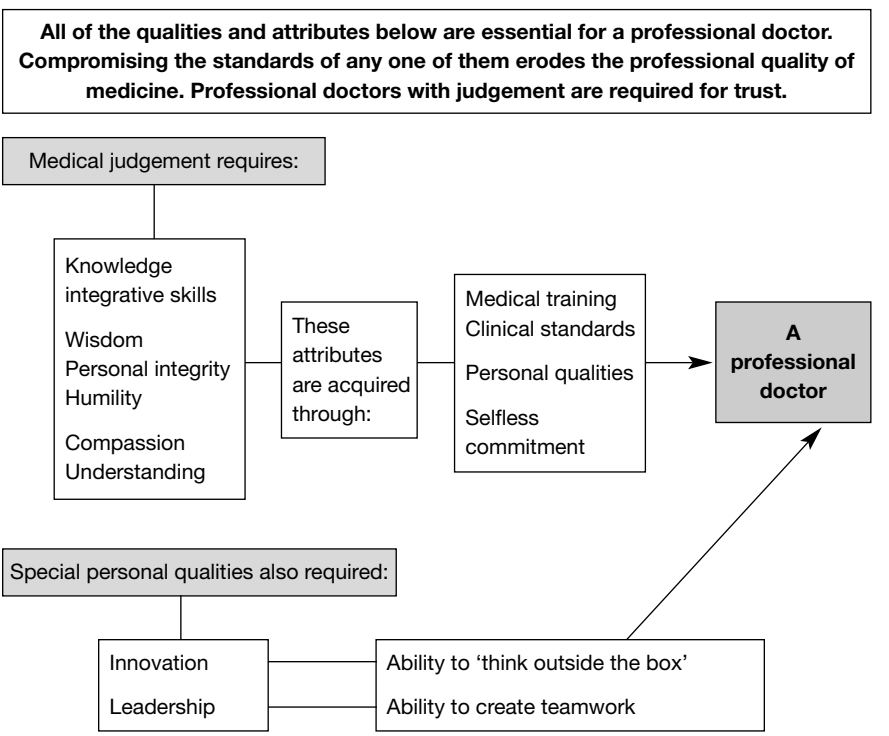
and codes of practice which medical doctors must attain and with which they must comply.

Thus, doctors have a triple responsibility in the NHS, which may sometimes be in conflict: responsibility for care to their patients; responsibility for personal codes of conduct and clinical standards to their corporate professional body; and accountability for their performance to their employers. There is a need for everyone working in the NHS to understand more clearly the implications of this three-way accountability.

By contrast, artisans (artificers) may have great skills but are primarily accountable to their employer, complying with whatever standards and conditions the employer may set. Artisans do not necessarily have the same formal independent accountability, as do professions, to their corporate professional body.

Why are professional doctors needed in medicine?

Where clinical information is incomplete and/or there are alternatives and choices, judgement is required.



'Without the intervention of conscience, the law cannot govern. There must be a moral basis of trust.'(Reverend Gordon Dunstan)[2]

A note on judgement

- Our state of medical knowledge on diagnosis, therapy and management of patients is almost always incomplete and/or there is more than one option for care.
- Under these circumstances, judgement is always needed for good patient care.
- Judgement of several distinct types is required: judgement on the strength of evidence, judgement on appropriateness of treatment for the individual patient etc.
- The development of judgement is also crucial to advance medical knowledge and for leadership in modern medicine.
- Each of these requires standards of distinctive training, development and fostering of personal attributes.

Thus, these multiple and diverse attributes of professionalism must be taught and fostered at all levels of medical education: undergraduate, postgraduate and continuing medical education, if professional medicine is to survive.

The profession has a responsibility to do more through its corporate bodies and the General Medical Council to ensure that systems are in place to identify and deal with doctors who fail to adhere to the values and codes of practice it sets. Remembering again Rev Gordon Dunstan, 'The Law cannot regulate all human behaviour which also needs professional and social 'conventions' to prevent anarchy and tyranny'.[2]

Do patients want and need professional doctors?

I believe patients expect care from professional doctors who they can trust to help them make judgements on the appropriate care for them as individuals. They value a personal patient-doctor relationship where doctors can respond to their needs when they need help. They value continuity of care. Where multidisciplinary or rotating teams are necessary they value an identifiable team leader who can coordinate management and retain overall responsibility.

Do Fellows and Members of the RCP believe that professionalism is crucial for medicine?

It is imperative to get their views.

Where and how have professional standards been eroded, making professional values affecting patient care difficult to maintain?

Frequently, it is not the professional values themselves which change. The following list provides some examples where changes in the NHS, while often well intended and sometimes regarded as inevitable, have, as a matter of fact, made the maintenance of professional care of patients more difficult.

At a national level

- However justified the reasons, the profession was marginalised in the radical 1990 reforms, in spite of constructive suggestions proposed by the Conference of the Academy of the Royal Colleges and their Faculties. It was therefore unable to influence the proposals, many of which have now been reversed.
- Many of the national advisory committees in which the profession and the Department of Health worked together – each contributing their complementary expertise and knowledge – have been disbanded or are in abeyance, eg Clinical Standards Advisory Group (CSAG), Joint Planning Advisory Committee (JPAC), Specialist Workforce Advisory Group (SWAG), some Joint Committee on Higher Medical Training (JCHMT) functions, Specialist Training Authority (STA) and Standing Medical Advisory Committee (SMAC). They have been replaced by committees with much greater direct government control. It is fully recognised that in the past these committees had many problems and needed reform. However, the principle of high-level joint advisory committees bringing together government and the profession, with representatives appointed by the profession working on equal terms, was a sound one, because it was able to build bridges between those responsible for policy on the one hand and delivery of care on the other.

At a more local level

Examples based on good evidence from major surveys or substantial reports have been included here. In these, it is important to remember that adverse concerns only represent a percentage of replies (ie they are not universal), but they are sufficiently common to warrant inclusion here. Sources include the following:

- Royal College of Physicians surveys
- Commonwealth Foundation Survey
- Healthcare Commission Survey
- British Medical Association Survey (published by *Hospital Doctor*)

- *Committed but critical: an examination of young doctors' views of their core values* by Isobel Allen, Health Policy and Economic Research Institute, British Medical Association, 1997.
- *The quest for quality in the NHS* by S Leatherman and K Sutherland, published by the Nuffield Trust, 2003.
- *Medical morale.* Standing Medical Advisory Committee advice (Department of Health). **www.advisorybodies.doh.gov.uk/smac/moraleadvice.htm**
- *Hippocratic oaths* by Ray Tallis, published by Atlantic Books, 2005.

The policy intentions to improve healthcare and, at the same time, to meet the challenges arising from changes in society have often been entirely understandable and sometimes inevitable. However, the knock-on consequences in some instances have had adverse effects on professional care of patients. These now have to be noted, tackled and resolved if possible, if professionalism in medicine is to survive. Some of these examples may be uncomfortable both for doctors and management, but they are worth facing robustly because the rewards for patients are very great. It is worth noting that the compounding effect of several changes operating together has caused more damage to professionalism and patient care than the damage caused by any single change.

Some practical illustrative examples of where professional standards are being eroded

- Overall, many professional doctors have reported that the service they are able to give to patients has deteriorated in the last five years. Patients also believe the service they want has deteriorated.
- Authority for clinical decisions has been eroded often due to priority being given to targets and costs at the expense of individual patients. In consequence, doctors feel disenfranchised and this, in turn, has lowered morale. As morale deteriorates, performance often falls.
- Authority for quality of training for the profession has been shifted towards control by government, potentially undermining standards set by the profession, who are necessarily the trainers. The recent difficulties experienced in the setting up of the Postgraduate Medical Education and Training Board (PMETB) endorses the justification for questioning the wisdom of this shift.
- The principles of clinical governance to enhance accountability of doctors is now generally accepted, but the increasing prescriptive regulation of clinical activities of doctors by management (who often have no clinical training) has

undermined the professional authority of doctors in the care of their patients, and thereby the patient-doctor relationship so valued by patients.

- Many changes, especially shift systems, have led to deterioration of continuity of care of patients. This has caused concern for patients and doctors alike.
- Large rotating and multidisciplinary teams, which may be necessary for many reasons, have often meant that no one takes ultimate responsibility for the overall care plan of individual patients (which is what patients want).
- Lack of a clear team leader also often causes junior doctors to feel isolated, and has militated against their acquiring professional skills.
- Increased pressure of work has resulted in concerns that there is inadequate time for doctors to build trust with patients and communicate with them. Patients, too, call for more time with their doctor.
- Maintaining quality of care in spite of increasing workloads – often due to staff shortages – when compounded by simultaneous central pressures to meet new targets (eg A&E waiting times) has put even greater pressures on staff.
- GP numbers have fallen dramatically due to many factors, including over-regulation and bureaucracy. While intelligent accountability which recognises quality care must be welcomed, overprescriptive income-dependent diktats such as 'quality points' crudely reduce professional authority and judgement, and are likely to act as a further deterrent to good doctors entering this highly valued area of UK medicine.
- The new contracts allowing GPs to opt out of out-of-hours work altogether has seriously undermined the principle of professional commitment. Clearly, the professional must not be exploited and sensible working hours are crucial; however, professionalism in medicine requires a commitment (probably through sensible rotas) to care for patients who require help at unsociable hours. This is the stuff of medicine.
- An increasing number of doctors wish to work part-time. This inevitably means that delivery of medical care has to be adapted around workforce requirements rather than the provision of a workforce to meet the needs of patients. This challenges the profession to ensure that the needs of all patients are met.
- EU directives on working hours are seriously eroding training time for juniors. Clearly, excessive hours of work are unacceptable, but the long-term consequences of the current ruling have to be faced.
- Shortened training programmes are causing concern amongst some newly appointed consultants who fear that they have inadequate experience to meet their new responsibilities.

- There are recurring complaints of over-regulated bureaucratic systems imposed on community and hospital practice, which can redirect resources away from clinical care.
- The flexibility to participate in clinical research, needed to improve the NHS, has been made more difficult by the rigid timetabling of professional activities in the new consultant contracts.
- Tertiary care for patients with complex and less common problems, linked crucially with substantial clinical research (lab and patients) and specialist postgraduate training, has contributed particularly to the international standing of British medicine. Current trends in regionalisation, referral patterns and tariffs are all conspiring against such innovation in medicine.

The compound effect of all these factors is eroding professional standards. In consequence, doctors are voting with their feet. Senior doctors are retiring early, leading to shortages and loss of those with valuable clinical and teaching experience. Recruitment is falling and some junior doctors are leaving. Urgent and radical steps have to be taken to correct the situation. Otherwise, the NHS will deteriorate. Some of this erosion has, of course, been driven by external factors such as EU regulations, doctor and nurse manpower shortages, the demand for part-time work and many others. The challenge is to find solutions without eroding professional values and standards.

What should be done?

- Doctors have to decide now, for the sake of their patients, whether they wish to continue as professionals as defined or whether they wish to transfer to the role of an artificer. Since this is a RCP report, the Working Party should get data on this, at least from its own constituents.
- If continuing as 'professionals', doctors must accept the commitment, in the fullest sense, to the profession (and its reward), which inevitably entails a compromise in certain ways to their personal lifestyle. This has to be understood and accepted. It is necessary to ensure that all their actions are for patients, not themselves. Clearly, doctors must not be exploited, but a commitment has to be made.
- Their self-regulation must be rigorous and they must accept 'intelligent' accountability to retain the trust of their patients.[1]
- For this reason, as recommended by Donald Irvine, it is sensible for the Colleges to represent the profession on values and standards and stand apart from the British Medical Association, allowing the latter to represent doctors

on trades union issues. The profession can then be seen to act without self-interest. The profession must, however, concern itself with the interests of doctors in so far as it affects their patients.

- Government must recognise the importance of the survey data and set up collaborative systems to correct these serious problems quickly (see below for suggestions).
- Government must be persuaded that the quality of the NHS depends on a professional medical workforce, and respect what the profession can do to improve clinical standards, care of patients, training standards and training of future doctors. This does not preclude using non-medically qualified individuals much more extensively for specific tasks for which they are appropriately trained.
- The profession must recognise the efforts of government to improve the management of the NHS and have the opportunity of helping them to define and achieve this in such a way that it does not have adverse effects on patients.

Doctors working in the NHS have two responsibilities, which may sometimes be in conflict. First and foremost, they have responsibility for their patients. Second, if they work in the NHS they must work with management and government, remembering always that: 'If we want a culture of public service, professionals and public servants must in the end be free to serve the public rather than their paymasters.'[1]

Essentially there must be a new mutually respecting and equal partnership between government, management and the profession. This can be done in many practical ways often using modified existing structures. No revolutionary change is needed; it is a mutual recognition of responsibilities that is required. These partnerships must operate at the highest levels of the NHS as well as at local levels.

The government and the profession

- Functions should be defined where government must lead, eg strategy, policy, finance, recognising the need for improved mechanisms for consultation where important suggestions from the profession can be incorporated.
- Functions should be defined where the profession must lead, eg clinical standards of patient care and professional training, recognising the need for a balance between self-regulation and intelligent accountability amounting to 'shared regulation'.
- There should be adequate meeting points at the highest levels where the profession (with representatives appointed by them) and government can meet on mutually respecting terms.

- The Joint Consultants Committee should be reviewed so that professional issues in the interests of patients can be separated from trades union matters, and work in a less confrontational way.
- Better use should be made of SMAC for specific issues. (The evidence on morale is a good example of its use.) Its recommendations must be implemented.

The profession and management at a local level

- Management should be freed from directive-overload from the centre and the financial penalties of targets so that they can focus on standards of care in partnership with the profession. Performance should still be rigorously measured. Together they should develop better and validated ways to monitor 'care' to increase patient and public confidence.
- The partnership between managers and the clinical directors is crucial. Although increasingly they are working well together, where problems arise these have to be resolved by mutual agreement.
- To ensure that the professional clinicians have confidence in their clinical director he/she must have the authority to stand firm on clinical matters if these are compromised by policy directives.
- Functions should be defined where management must lead (organisational issues) but with intelligent accountability.
- Areas should be defined where the profession should lead (clinical issues) but with intelligent accountability.
- Managers understanding of medicine and what professional care is about should be improved. This would do much to enhance the respect for managers from the medical profession.

Conclusion

- Doctors must decide whether medicine should continue as a profession; if they decide it should they must demonstrate their commitment and insist that this is not compromised.
- All professional doctors must act in the interest of patients and not themselves. To demonstrate this, professional representation to government should be separated from those acting as trades unions.
- The survey data on how professionalism has been eroded recently is substantial and must be taken seriously by government, and corrected. The workforce is currently voting with its feet and this trend must be reversed,

not by pay scales, but by recognising their proper professional responsibilities.

Suggestions to restore professionalism

- A change of culture is needed so that the authority for strategic and policy matters by government and the authority for clinical standards by the profession are mutually respected because their expertise is complementary. As in all professions, and for reasons discussed, self-regulation is a practical necessity but this must be linked and augmented by clear accountability that together constitutes 'shared regulation'.
- The potential conflict between political and patient-care agendas should be recognised. This can only be resolved by working together in a new mutually respecting partnership. Many will say that this is already happening, but the survey data suggests otherwise.
- The profession and managers at a local level should be freed from central pressures as far as possible so that they can work together in the care of patients without the risk of penalties.

Doctors need to better understand managerial issues, and managers need to understand the uncertainties, complexity and limitations of medical practice. There are simple practical ways that this could be achieved. This could do much to improve collaboration between management and the profession in the NHS.

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Thursday 16 December 2004

The submission of **Sir Donald Irvine**
Chair, Picker Institute Europe and Former President of the General Medical Council

It is a pleasure to give evidence to the Working Party, the timing of which is most appropriate. My contribution is embodied in the two papers accompanying this note and the leaflet from Picker Institute Europe.[1–3] Both papers are published this week in the *Annals of the Academy of Medicine of Singapore*. By way of introducing my evidence I wish to make three general points and then several particular ones.

- First, today there is abundant evidence from the public and patients about what they regard as essential characteristics of a good doctor. These characteristics include medical knowledge and clinical skill, being up to date, being empathetic, a good listener and a good communicator, being honest, and being an effective team player. Today, people regard having a good doctor as an entitlement rather than as a hope or aspiration. The public today is far more assertive in expecting 'the system' to make sure that this happens for all patients, especially where their doctors are unsupervised. Equally, they expect 'the system' to protect them from sub-optimal or poor practice as well as from those who are actually unfit to practise.
- Secondly, public and patient trust is, therefore, critically dependent on two things. First, there needs to be a strong consensus between the public and the profession about what, at any time, constitutes good medical practice and a good doctor. Only then will the public and the profession be at ease with each other about the nature of the medical culture and, therefore, our professionalism. The second point is that medical regulation must be effective for patients as well as supportive of doctors. In today's society, if the profession is not strongly proactive in making sure that the practice of all doctors licensed to practise can be regarded as 'good', it will never enjoy full public trust, even though the majority of practitioners are highly regarded by their patients on their own merits.
- My third general point is that doctors' professionalism cannot be separated from the practising environment. Generally, good practice is most likely to follow in a supportive environment. There are, of course, exceptions. Outstanding practice may be seen in the most unfavourable conditions, and poor practice can happen where the conditions are excellent. It is in the

interests of both patients and doctors that they work together to secure optimum conditions. In this, the profession's hand will be immeasurably strengthened if it has first made sure that it is fulfilling its half of the regulatory bargain between itself and the public.

The following are particular points I want to raise:

- The medical profession today commonly uses the term 'professionalism' in a fairly narrow sense to describe doctors' attitudes and behaviours that exclude scientific knowledge and technical clinical performance. The public and patients, on the other hand, think it encompasses both. I agree with the latter view. The dichotomy needs to be resolved.
- Professionalism is about the practice of individuals and of the profession as a group. Self-regulation (modified nowadays as professionally led regulation) is the underlying principle. Ineffective self-regulation negates the principle and is therefore a denial of professionalism.
- Professionalism rests on the three pillars: expert knowledge and skill, ethicality and service to patients. Medicine today is in transition from a 'doctor-centred' to a 'patient-centred' culture of professional behaviour, largely as a response to changing public expectations of doctors and of professions generally.
- If the medical profession is to enjoy the full trust of the public in future then it has to put patient-centred professionalism at the heart of its vision for the future. The realisation of that vision must become the first and overriding priority for individual practitioners and professional institutions, including our medical schools.
- The UK has adopted a model of medical professionalism that is based on generic professional standards linked directly to licensure, specialist certification, medical education and contracts of employment to ensure compliance. The standards published by the General Medical Council (GMC) and the medical Royal Colleges are already substantially patient-centred, but they do need continuous updating with, from now on, more robust evidence of patient experience and expectation, and doctors' expectations. The Picker Institute can help with this.
- From the public's point of view, the main challenge to the medical profession is to implement that patient-centred culture in the everyday practice of every doctor licensed to practise. As said earlier, people today believe that every citizen is entitled to good medical care – not care that in a minority of cases may be a cause for concern or only barely acceptable. That is a perfectly

reasonable and realisable expectation. It is one shared by doctors when they or their families become ill.

- The responsibility for achieving that rests, whilst we still have self-regulation, with the professional regulatory, standard-setting and educational bodies. I believe that the obligation on them to achieve a consistent standard of good care for all patients is a moral one.
- The track record of the regulators is not good. Despite so much good practice by so many highly conscientious doctors, there is still a long and damaging history of the profession collectively protecting the weakest links rather than putting the safety and well-being of all patients unequivocally first. Anyone who doubts this should read Dame Janet Smith's report on Shipman.[4] I recommend a full reading of Chapter 26 on revalidation, in which Dame Janet details the recent retreat by the GMC from a model that had the potential for improving practice generally and protecting patients from poor practice, to one which, in her judgement (and mine), cannot. And all this on the basis not of principle, but of expediency (Dame Janet's words). These are self-inflicted wounds the profession simply cannot afford. They undermine self-regulation and the good name and general trustworthiness of the profession as a whole.
- So it is crunch time. Fine talk of professionalism and worthy codes of practice will all come to nothing unless the profession shows the will and determination and leadership needed to put principles into practice systematically, for the benefit of all patients. Most doctors are still idealistic about being a doctor, care passionately about their patients, and care equally about their self-respect and the good name of their profession. I feel sure that they would be supportive of robust professionally led regulation that really did protect all patients, provided that it is fair to good doctors and to doctors in need of help. Enlightened self-interest can be a powerful motivator.
- The best contribution that the Royal Colleges can make to the common cause would be to take direct responsibility for the goodness of the professionalism of their own members through 'membership of good standing' or similar device.

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4 *The Shipman Inquiry*, January 2005. www.the-shipman-inquiry.org.uk/home.asp

Friday 11 February 2005

The submission of **Sir Liam Donaldson**
Chief Medical Officer, Department of Health

Comments on the Working Party's four questions

Question 1: Do you think that professionalism has any meaning today? Say why you think this is so

'You are in this profession as a calling, not a business; as a calling which exacts from you at every turn self-sacrifice, devotion and tenderness to your fellow human beings.' (William Osler, 1907)

Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?

'Physicians as a rule have less appreciation of the value of organisations than members of other professions.' (William Osler, 1897)

Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?

'The hardest conviction to set into mind of a beginner is that the education upon which he is engaged is not a college course but a life course, not a medical course but a life course for which the work of a few years under teachers is but a preparation.' (William Osler, 1932)

Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

'One patient is a good witness and another poor. Some seem quite unable to give any precise account of what they feel to be wrong. This may be due to stupidity or the effects of the disease on their mental faculties. It is important to recognise the reason for evasiveness of such patients and not to allow oneself to become annoyed with them.' (*Hutchinson's clinical methods*, 14th Edition, 1963.)

Friday 25 February 2005

The submission of **Dame Janet Smith** DBE
Lady Justice of Appeal and formerly Chair of the Shipman Inquiry

Your questionnaire provided a definition of a profession as follows:

> *An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members profess a commitment to competence, integrity and 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, which in return grants the profession the right to autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.*[1]

I have found the definition most helpful and will outline what I want to say by reference to that.

Mastery of complex knowledge and acquisition of skills

Primarily this is to do with education, about which I have very little knowledge. However, it is generally agreed that acquired knowledge and skills are of limited use unless kept up to date. In my view, it is important for doctors not only to keep their knowledge base up to date, but to demonstrate that they have done so. Also, there is a need to ensure that their practical skills are being exercised in a way that is acceptable today. In this I include (for physicians and GPs especially) consultation 'style' and practice. Standards and patient expectations have changed and there is a need to ensure that all doctors conduct consultations appropriately. My views on revalidation are set out extensively in my Fifth Report.[2]

Vocation

I do think that a sense of vocation is important, although I do not think it necessarily needs to be associated with altruism. No professional should be expected to provide services without proper remuneration; nor in this day and age should a professional lack the support systems necessary to enable him/her to

live a normal family and social life. However, what matters is the doctor's underlying attitude to patients and his/her willingness, when push comes to shove, to put the patient first. It concerns me that there has, at least in the past, been so little effort to investigate the underlying attitudes of applicants and students. I think that psychological aptitude testing may have a role to play. Incidentally, I think that such testing would have shown Shipman to have some very strange attitudes.

Commitment to competence, integrity and morality, altruism and the promotion of the public good

These requirements ask a very great deal of ordinary mortals – too much in my view. They are unrealistic. Competence? Yes. Integrity and morality? Are we to say that a man is unfit to be a doctor if he is found to be cheating on his wife? Plainly not. However, integrity within the professional context is vital. To expect altruism is to ask too much. We are all entitled to promote our self-interest. And doctors rightly have a vigorous trade union. That said, there is a need to strike the right balance and to insist on an individual doctor's willingness to put the individual patient first when appropriate.

A commitment to the promotion of the public good is vital. In the Fifth Report, I have said that the GMC is still operating too much for the protection of doctors and too little in the public interest. On an individual level, it is not easy for professionals to act in the public interest where this conflicts with personal and 'tribal' loyalties. Doctors find it very difficult to report incompetent colleagues. I do not underestimate the difficulty of this. Willingness to admit mistakes is another very difficult area. A culture change is needed in both areas and this will not be achieved quickly.

The social contract

This is a splendid notion if it is intended to suggest the profession and society contracting voluntarily on equal terms, the one being accountable to the other and a dissatisfied party having some remedy for the breach of obligations of the other. But things do not work like that. Self-regulation has not worked in the public interest and 'society' has had no remedy for its dissatisfaction. Until quite recently, Parliament has left the doctors to run their own show. The economic reality is that society cannot manage without the doctors and there is no alternative source of supply. The notion of contract simply does not work.

This leads into the next aspect of the definition: accountability. In the past few years there has been a move towards modification of the self-regulatory model.

We now have 'professionally led' regulation. As I have explained in my Fifth Report, my view is that this is not yet working satisfactorily in the public interest and requires considerable modification. My recommendations on these issues are set out in the Fifth Report.

Comments on the Working Party's four questions

Question 1: Do you think that professionalism has any meaning today? Say why you think this is so

Professionalism *ought* to have meaning and, in my view, is of vital importance. It is the basket of qualities that enables us to trust our advisers, whether on medical, legal, financial or educational matters. We have to strive for the position where the public/customer/patient can place unquestioning trust in the professional. The maintenance of professionalism should be the responsibility of the regulator and other bodies such as, within the medical profession, the Royal Colleges. If we abandon professionalism, commerciality will rule. What a nightmare that would be.

Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?

There are several problems and challenges. One is the maintenance of professional attitudes throughout all levels of the profession, including the young and the middling successful. I do not know much about the attitudes of these doctors today although I have the impression from the medical press that they are fed up. Disillusionment and professionalism are not comfortable partners. In the Inquiry, I heard only from established professionals, mainly leaders of the profession. As you would expect, they were deeply committed to professionalism. However, I do have some knowledge of attitudes among the young at the Bar. I think that they remain committed to professionalism (in the sense of ensuring competence), but that there is a more commercial and less altruistic attitude than when I was young. However, I do not imply criticism by saying this. The 'pay and conditions' in the public sector are much worse than they used to be. The balance is wrong at the present time. I do not know enough about doctors' pay to draw any parallels. But, in general, you cannot expect people to maintain high professional standards unless they can be proud of their profession, proud to get into it, and not disillusioned on arrival by poor pay and prospects, and overwork.

Another problem is that the rate of change today is far greater than it was when I was young. This is true of medicine as of law. Far greater effort is required

to keep oneself up to date and fit to practise than used to be the case. The public expects more of its professionals than in the past and satisfying the public requirement for confidence in the competence of doctors is a major task.

Another issue that concerns me is that insufficient attention is paid to the suitability of candidates to be admitted to a profession. People now think it is their 'human right' to be admitted to a profession if they have passed the examinations. The requirement of being a 'fit and proper person' is very difficult to impose. I say this from my experience of admitting aspiring barristers to one of the Inns of Court. There is great pressure to admit people who have past convictions. I dare say the same thing applies in medicine. I think the professions need to be tough about who they will admit.

Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?

In my Fifth Report, I have expounded at length on the subject of revalidation, which could, I believe, go a very long way towards ensuring continuing competence and giving the public confidence in doctors. But the GMC proposals would achieve neither.

I have already said that we should be tougher on admitting people who cannot show 'fitness' in all its aspects.

I have already spoken about the threat to professionalism (disillusionment) in my own (former) profession, which is associated with poorly paid publicly funded work. So far as the medical profession is concerned, I have little to contribute. I read that the profession is disillusioned. I have some difficulty in understanding why and cannot therefore suggest how this might be alleviated.

Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

I cannot think of any.

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Friday 11 March 2005

The submission of **Mr Paul Coombes**
Former Director, McKinsey and Company Inc

I welcome this opportunity to share my views on professionalism and to suggest how they may relate to the agenda of the Working Party.

In these remarks I want to emphasise one single thought: professionalism in any domain is not only about values, credentials and the adequacy of disciplinary procedures. The critical extra dimension is the set of what I would call core enabling processes through which values and technical mastery are demonstrated day to day and week to week in a given organisational context. Unless these core enabling processes are working well, the noblest values will be undermined, technical excellence will be eroded, and individual professionals will become progressively more cynical and demotivated. These are generic observations that apply across different private sector professions. My strong hypothesis is that the same will hold true in the medical world.

Core enabling processes

Let me explain what I mean by core enabling processes.

Client/patient service

In essence, there are four different sets of managerial processes through which professionals carry out their work. The first of these is what one might generically term the client service process (or in your context might be better described as the patient service process). This encompasses the sequential set of steps through which professionals identify the clients (or patients) they seek to serve, agree the service proposition, diagnose the specific requirements, decide what to do, carry out the appropriate actions and ensure the required follow-up.

Knowledge development and dissemination

The second core enabling process in a professional environment is the knowledge development and dissemination process. This covers the whole sequence of steps from the identification of promising avenues for fundamental research right through to the development of practical applications and the effective distribution of new knowledge across a professional environment. In this process, the complex interaction between tacit and explicit or codifiable

knowledge is of the utmost importance, and managing this whole area skillfully is at the cutting edge of contemporary organisational theory.

Talent management

The third core enabling process is talent management. By this I mean the whole sequence of attracting, training and qualifying candidates for a profession and then the further steps of assigning, coaching, motivating, evaluating, rewarding, promoting and mentoring. Throughout this process, the creative structuring of 'incentives' – in the economists' broadly defined sense of the term – is the central and subtle challenge. This is because the conditions under which professionals perform at their best are hard to get right.

Self-governance

The fourth and final core enabling process through which professionals carry out their work is the self-governance process. Here I am thinking not so much of the overarching arrangements for a whole profession, such as in your own case the role played by the Royal Colleges. Rather, I am thinking of the governance processes as they function within the context of an individual firm, or in your case, of course, predominantly the NHS. The governance process in this sense therefore includes the steps of establishing a legitimate framework of decision rights, defining objectives, setting priorities, assigning responsibilities and driving and monitoring performance.

In a high performing professional environment, all these core processes are well aligned and interact in a complementary, mutually re-enforcing manner. When they are working well, the individual professional is not acting as an autonomous loner. Instead, he or she is working in a demanding team environment where management processes, applied with a light touch and freely endorsed, self-evidently contribute to the personal growth and development of the individual practitioner as well as to the success of the organisation in fulfilling its fundamental purpose.

How far does this situation reflect the world of medical professionalism in the UK?

It is not for me to make a judgement. However, I would like to comment on what I see as four managerialist dogmas, or half-truths, that appear to the outside observer to be quite strongly entrenched within the NHS. This matters because, in my view, these dogmas reflect seriously outdated management thinking that handicaps the professionalism you naturally want to encourage.

Four managerialist dogmas

- *Targets and strategic planning* The first dogma is the profound commitment to targets and strategic planning as the route to outstanding performance. The fundamental error here is that targets imposed by an external authority which is not perceived as legitimate or informed simply lead to game-playing behaviour, with individuals managing to the target rather than to their own professional assessment of what is needed.

  As for strategic planning, it had its heyday in private sector management during the 1970s but then became widely discredited as naïve and hyper-rationalist. Jack Welch, the former head of General Electric and probably the most admired leader of a commercial organisation during the last 20 years, completely dismantled a team of over 200 central planners and described graphically where the excessively bureaucratic process was going wrong: 'The books got thicker, the printing got more sophisticated, the covers got harder and the drawings got better…'[1] but it was all becoming an empty process.
- *Best practice* The second managerialist dogma is the belief in best practice as core to effective knowledge dissemination. 'What could be wrong with this?' one might ask. 'Isn't this the way to raise standards?' The problem, however, is that while in some arenas this is clearly justified, as a general principle the rigid application of so-called best practice stultifies innovation. If 'best practice' has been settled, then individuals who were once professionals, trusted to make their own nuanced judgements, become technicians, obliged to adhere to a rigid standard.

  The problem is that by eliminating the scope for judgement, professional accountability gets drained away. The attraction of the best practice dogma is, of course, that in a low-trust environment it offers a risk-averse mode of surviving without being exposed to criticism or even litigation. True professionals accept, however, that good practices may co-exist, and that the widespread elimination of personal judgement undermines a profession's very raison d'etre.
- *Command and control* The third component of this managerialist litany is 'command and control'. As applied to the talent management process, this mode of leadership and guidance tends to create a heavily adversarial context for professionals who typically find the partnership format the most appropriate model for effective governance. Command and control goes hand in hand of course with top-down strategic planning, target setting and the imposition of best practice rules. But applied to professionals it provides a discouraging framework of incentives which all too easily degenerates into a blame culture and an environment of atomised accountability.

- *The blank slate* The fourth and final aspect of managerialism that I want to comment on is the dogma of the blank slate. This is the belief that organisations can be freely and easily redesigned to meet the latest set of strategic goals and performance targets and that this is essentially a matter of reconfiguring lines and boxes on an organisation chart. This view stands sharply in contrast with enlightened management thinking today which sees organisations as path-dependent entities where history and context matter hugely, and where the existence of subtle complementarities means that piecemeal change initiatives often have quite counter-productive effects.

Summary Taken together, these four elements of managerialism are deeply inimical to the role of the professional. They are essentially dirigiste in nature and predicated on a lack of trust in individual initiative and professional judgement. Yet such an approach is not inevitable, even in large complex organisations where a concentrated group of professionals are working together. Instead, the central task in such conditions is designing an enlightened framework of incentives that embodies the spirit of true professionalism and instills this across the core enabling processes of the organisation. Within your own context of the quest to strengthen medical professionalism, this task of redesign is likely to be an essential practical counterpart to the re-affirmation of professional values and the tightening of qualification and disciplinary procedures. The challenge you face, I suspect, is how to dedicate enough time and expertise from within the profession to carrying out this work.

Comments on the Working Party's four questions

Question 1: Do you think that professionalism has any meaning today? Say why you think this is so

Yes, for two reasons. First, from the perspective of a user, there continues to be certain domains of work of critical importance to society where information asymmetries between service providers and clients/users will always remain high and where the normal market pressures of competitive intensity will be insufficient to prevent the possibility of exploitative behaviour. In such arenas, the *caveat emptor* principle is inadequate and clients/users need the protection of additional safeguards.

Providing such protection has traditionally been the role of the professions, which, in exchange for certain privileges of status and access, can set and enforce standards. The underlying question is whether this distinctive professional role can be progressively replaced by regulation. Perhaps at the margin this is possible.

But the essence of a profession is its ability to ensure that the individual practitioner not only possesses appropriate technical qualifications, but also that the practitioner has given a wholehearted commitment to a set of values shared with fellow practitioners that commit such an individual to acting in the best interests of the client/user/patient. The task of a profession is to inculcate such values so that they are willingly embraced and adopted by the practitioner.

Regulation, by contrast, works typically through control and inspection and is predicated on a degree of implicit mistrust of the willingness of the average practitioner to do 'the right thing' without the threat of coercion. Regulation will therefore always have a tendency to become over-prescriptive. Yet in the fields covered by the traditional professions the very nature of the work tends to defy such detailed prescriptiveness. At some point, you have to trust individuals, and the governance mechanism of a professional body provides, when it is working well, a subtler set of checks and balances than the blunt instrument of regulation.

The second reason for believing that professionalism has a meaning today is that, from the perspective of the practitioner, the twin elements of technical mastery and commitment to a set of compelling values normally represent a concept of professionalism; it is these elements that have the potential to provide a hugely important dimension of personal motivation, fulfillment and identity. Even when, for an individual, such elements may have waned, it is the role and challenge for a profession to renew and re-awaken that individual's commitment to such a concept. This is a task that regulation can never achieve, hence the importance of sustaining a vibrant professional environment.

Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?

Three common forces are putting pressure on professions such as law, medicine, teaching, accounting and actuarial work. These are:

- The pace of technological change, which affects the character of 'client service'. Sometimes it commoditises traditional professional skills and eliminates the need for future professional involvement. Sometimes, by contrast, it makes client service still more complex and renders it still more challenging for the individual professional to maintain continued mastery of his or her field.
- The demand for ever greater economic efficiency and higher productivity in the provision of professional services, either to ensure continued competitive performance in private sector professional settings, or to contain budgets in public sector contexts where demand is typically open-ended.

- Rapidly changing – and sometimes divergent – societal expectations that make an agreed and stable definition of 'good professional work' more problematic than in the past.

Looking ahead, these common forces can be expected to continue with the evident risk that individual professions will be compelled to respond by imposing more and more inappropriate managerialist approaches that risk further eroding true professionalism. The concern here is that in the effort to contain costs and enforce common performance standards, good professionals will feel that they are losing so much autonomy that they exit their profession. In a number of professional fields we see this happening already, with the evident risk that the chain of mentorship from one generation to the next will be irretrievably weakened. Alternatively, and in a way just as serious, the risk is that practitioners lose faith in a distinctive professional ethos and come to see their work as just another job.

Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?

An effective response will need to take place at two levels. At the level of the individual practitioner, the challenge across the professions is to establish modes of management guidance that are each effective and fulfilled in his or her own work. So, for example, areas for improvement are likely to include:

- the willingness of professionals to accept regular tough-minded and thorough peer evaluation
- the need to ensure that severe underperformance is systematically identified and rigorously dealt with
- the commitment to remain intellectually curious and questioning throughout a professional career and to engage wholeheartedly in continuous professional development
- the readiness to be open about one's work and wise enough to call on others when appropriate
- the willingness to engage in management and governance issues (rather than feeling frustrated or victimised) on the basis that contributing wherever possible to the self-governing mechanisms of a profession is not a distraction from the true professional's work, but an integral component.

The second level at which the status of an individual profession can be strengthened concerns the whole design of the regulatory and operating context within which it is embedded. The underlying problems differ somewhat between

the individual professions in the UK. But it is clear that the current ownership and management structure of the NHS gives rise to major, complex problems of 'incentives' (in the economists' sense of the word). It follows that the quest to devise creative new governance arrangements, within which professionals can work more effectively, is likely to be an essential component in strengthening professional values in the years ahead and rebuilding practitioners' confidence in their vocation.

Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

The most common temptation facing any long-established profession is to cling on too long to practices, privileges and traditional craft skills that have simply become outmoded. This can happen for many reasons including changes in demand or technology. It is an uncomfortable experience for a professional when technical mastery is commoditised and overtaken by some creative innovation. But the wise professional should not feel threatened by the impact of, for example, paralegals or paramedics, or simply computers. It is the task of the true professional to remain intellectually curious and to continue acquiring new skills. That said, knowing when to let go and to delegate responsibilities hitherto reserved to the profession is a task not just for the individual practitioner to face alone, but for the profession as a whole to confront.

Reference

1 Wilson I. The seven deadly sins of planning. In: Mintzberg H, Ahlstrand B, Lampel J (eds), *Strategy bites back*. London: FT Prentice Hall, 2005.

Friday 18 March 2005

The submission of **Professor Sir Graeme Catto**
President, General Medical Council

Hippocrates wrote:

> *First of all I would define medicine as the complete removal of the distress of the sick, the alleviation of the more violent diseases and the refusal to undertake to cure cases in which the disease has already won the mastery, knowing that everything is not possible.*

The first duty of a doctor contained in the General Medical Council (GMC) guidance to the profession, *Good medical practice* [see Appendix 1: Reading List], is to 'make the care of your patient your first concern'. Our first and overriding duty is still to care for and about our patients. So, in one sense at least, the service ethic at the heart of medical professionalism has changed very little over the last two-and-a-half thousand years. In other respects, almost everything has changed.

If we look at the other elements that are traditionally attached to our understanding of professionalism – things like mastery over a complex body of knowledge and skills, autonomy, the social contract between society and the profession based on trust – they have all been subject to challenge in recent years. And quite right too.

This is not to say that medicine does not require doctors to possess and demonstrate an extremely high level of knowledge and skills. Clearly, the opposite is true. But the field is now so vast, and changing so rapidly, that what students learn today will almost certainly be out of date within a few years. Nor is it easy to describe a single body of knowledge and skills that meaningfully defines the profession. The expertise of a public health specialist has little in common with that needed by, say, a neurosurgeon. Certainly at the level of technical knowledge and skills we are not one profession, but many.

Increasingly, too, the exclusivity of medical knowledge and skill is being broken down. Interprofessional learning is now commonplace in medical education and seems likely to increase. Professional boundaries are being blurred as more and more of the things that were once the sole domain of doctors are being undertaken by other healthcare professionals. None of us works alone any longer, but in multidisciplinary teams in which we depend upon the expertise of others. This is not a diminution of medicine, but a strengthening of healthcare. We must also acknowledge that, more than ever before, knowledge is available to

patients and the public, and that patients need the opportunity to be involved in decisions about their care. So, it is hard to argue that our professionalism resides solely in what we know or in the skills that we alone possess.

This democratisation of healthcare roles, and blurring of boundaries, raises the question of what, if anything, distinguishes doctors from other health professionals, and whether such a distinction actually matters. I think that it does matter because, even within teams, ultimate accountability for patient care must reside with someone. That person will usually (though not always) be the doctor and, for the moment at least, that is how it is perceived by patients. And, whilst it is important to recognise the degree to which the lines of demarcation between areas of professional knowledge are shifting, there is an additional expectation of doctors. In an era when care is increasingly driven by protocols, what we expect of doctors is to be able to see the broader picture and to identify those cases when the protocol no longer applies. The risk, of course, is that in defining the distinctive contribution of doctors in this way we head down the path of exclusivity and medical dominance that has distorted our contribution in the past. That must not happen.

The next question is whether we can continue to insist upon our individual or collective autonomy. On the one hand we must continue to hold firm to the principle of the profession determining clear professional standards independent of government, the NHS or any of the other heathcare providers and employers. On the other, the reality is that, both individually and collectively, we are part of a complex and interdependent regulatory network. Healthcare must be one of the most extensively regulated sectors in the country. NHS performance management, clinical governance and appraisal, National Institute for Clinical Excellence (NICE) guidelines, the standards set by the Healthcare Commission (and its equivalents in the devolved administrations), the Royal Colleges, the PMETB, the GMC and, increasingly, Europe, all play a role in regulating the way we practise as individuals and as a profession. There is a tension here, but it needs to be a tension that helps to support the provision of high quality healthcare, and does not get in the way of it.

That leaves us with the social contract based on trust. One might consider that the rash of regulation to which I have referred proves that trust, too, has gone. It is undoubtedly the case that the succession of medical scandals in recent years, coupled with a less deferential and more sceptical society, have contributed to a loss of trust in the institutions of medicine and calls for greater accountability and transparency. In the face of this, we cannot continue to assert our professionalism as an unassailable fact. Yet, at the same time, we are repeatedly told that doctors are more trusted than any other professional group. Patients continue to trust their

doctors when most burdened by illness and worry because they must trust that their doctors will make the care of their patient their first concern.

This takes us back to the values and standards underpinning doctors' professionalism. Those values and standards must be owned by the profession if they are to have any force. They cannot be bolted on as an afterthought in a climate of suspicion and alienation. They must be determined independent of government and the exigencies of NHS management. That internalisation of values was well expressed by Lord Andrew Phillips when he wrote:

> *It seems self-evident to me that the essence of professionalism is to be able to call upon the honour, probity and principled judgement of the practitioner. A self-respecting, fully functioning profession would surely profess just that, and deal with the inevitable failures.*[1]

Referring to observations made by social economist Fred Hirsch, Lord Phillips noted that the alternative to this internalisation of values was a dependence on external regulation. That leads inevitably to 'a rising mass of codified petty regulation, swollen by the need for rules to enforce rules and to counter their avoidance'.[1] The effect of such regulation is to drive out self-policing and the force of individual conscience.

But if the values that define professionalism have to be owned rather than imposed on the practitioner, it is equally true that they cannot be imposed on the public in whose interest they are to be exercised. That is why, in a speech to the Social Market Foundation last year, I said that I do not believe in professional self-regulation. Self-regulation without public involvement is a flawed model, which can lead to professions becoming isolated and out of touch with society. It can lead to arrogance, paternalism and lack of accountability on the one side, and to mistrust on the other. Instead, the development, maintenance and enforcement of the values that define medical professionalism must be shared with the wider society in whose interests the profession is regulated. The challenge for us as a profession, individually and collectively, is to establish a more mature relationship with patients and with the public, based on partnership and mutual respect.

The introductory papers provided by the Working Party asked me to reflect on what aspects of professionalism are under threat, what should be preserved and what discarded. As I have indicated, the key element is professional ownership of the values and standards that we must apply in making the care of the patient our first concern. In the wake of a succession of high profile medical scandals, the recommendations of the Shipman Inquiry and the review by the Chief Medical Officer intended to strengthen procedures for assuring patient

safety, it would be false to pretend that trust in professionalism has not been profoundly shaken and that professionally led regulation (which is founded on the principle of professional ownership of values) is not under threat. This only goes to emphasise the primary importance of those values being held in partnership with the public if we are to achieve the mature relationship between profession and society to which I have referred. I believe that we now have a better opportunity to realise this than ever before.

Comments on the Working Party's four questions

Question 1: Do you think that professionalism has any meaning today? Say why you think this is so

Yes. Medical professionalism is defined by our individual and collective ownership of a set of principles that reflect our duty to make the care of our patients our first concern. They are the principles of good medical practice and the standards of competence, care and conduct that patients have a right to expect of doctors in all aspects of their professional work. These values are not exclusive to doctors. Many, if not all, are common to other healthcare workers and professionals in other sectors. For example, the GMC's expression of these values in *Good medical practice* is mirrored in the guidance issued by many of the UK's other healthcare regulators.

Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?

In one sense, the threat is less to professionalism itself than to society's trust in the medical profession and its professionalism. In my introductory statement I have suggested the reasons for this and the steps we must take to restore confidence in professionalism.

I have referred to the need for a mature relationship between the profession and the public. This requires a more open, patient-centred approach to healthcare; a willingness on the part of the profession to participate, not just in shared decision making at the individual doctor/patient level, but in partnership with the public in shaping and enforcing professional values. But it needs to be coupled with a new maturity within society as a whole in its attitude towards health and healthcare provision. This means balancing recognition of patients' rights with realistic expectations; replacing blind trust in professionals with an acknowledgement of risk and the limitations of resources. It also requires what is now a growing consensus regarding our personal responsibility for our own health.

Challenges also come from managerialism and the delivery of care through contractual obligation. I have argued for professional ownership of values and for standards to be developed independent of the demands of government and employers. This tension between these sometimes-conflicting forces seems unlikely to decrease in the next 10–15 years.

The third challenge comes from the changing demographic of the medical profession, in particular the feminisation of the workforce. We need to be able to welcome diversity and acknowledge that it will mean rethinking our attitudes on issues such as career patterns and the work-life balance.

The final point to make in relation to the challenges facing us is that we must not imagine that they are exclusive to the UK. The drivers for change that we are experiencing exist throughout the developed world. We must, therefore, be prepared to look beyond our own shores in seeking solutions.

Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?

The purpose of the GMC is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Our job, therefore, is to uphold and strengthen professionalism. We must continue to do this by ensuring that the values of good medical practice are inculcated in doctors from the time that they become students, and that those values continue to inform their practice throughout their careers. Our emphasis must be on education and the maintenance of standards, rather than just catching miscreants. To this end, we have expended considerable effort in overseeing and quality-assuring basic medical education and developing and disseminating guidance for the profession on a wide range of issues.

Perhaps one of our most interesting areas of current activity is our Futures Project. This is an ongoing piece of work aimed at identifying the sorts of changes that will take place in medical practice over the coming decades, so that we can ensure that doctors in the future are equipped with the skills and attitudes necessary to work in a constantly changing environment. It takes account of many of the issues I have touched on elsewhere in this submission: blurring professional boundaries, specialisation, changing public expectations, patient-centredness, accountability, resource management and technological change, to name but a few. Perhaps, in the end, it is this need to keep up with constant change that is the greatest challenge facing our professionalism.

The introduction of revalidation, supported by effective local systems, will help to reinforce professionalism by encouraging all doctors to reflect meaningfully upon their practice and demonstrate, on a regular basis, that they

remain up to date and fit to practise. Of course, the details of our revalidation proposals have themselves come under challenge and they are currently the subject of a review by the Chief Medical Officer for England. But the principles upon which these proposals are founded are not contested.

Throughout this submission I have commented on the need for the values of good medical practice to be developed and maintained in partnership with patients so as to enhance public trust in our professionalism. At its simplest level, the GMC has shown its commitment to this by increasing the lay membership on our Council from 25% to 40%. Meaningful representation from outside the medical profession is embedded in all aspects of our business. In January 2005, we amended our corporate strategy so as to express our commitment to involving patients and the public in our work and to continually seeking ways to widen and deepen that involvement. We will shortly be unveiling our strategy for delivering on this commitment.

One area I have not touched on so far is how we deal with doctors whose fitness to practise may be impaired, although it is this with which we are most usually associated in the minds of the public and the profession. The activation of our fitness-to-practise procedures signifies professionalism gone wrong. That is why so much of our emphasis is now upon prevention through education and maintenance of professional standards. What is also needed is the ability to identify, at an early stage, potentially dysfunctional doctors. We need to know the warning signs of emerging dysfunction, and the indicators of actual dysfunction, with a view to developing a more risk-based approach to identifying those individuals who may put patients at risk.

Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

No doubt notions of paternalism and exclusivity (perversions of true professionalism) continue to linger in some corners of the profession, but could not be defended.

Reference

1 Phillips A. Are the liberal professions dead, and if so, does it matter? *Clin Med* 2004;**4**:7–9.

The submission of
Andrew Phillips (Lord Phillips of Sudbury)

Real professionalism, as I think of it, is of fast declining significance on all fronts. This is mainly because we live in an increasingly materialist age, decreasingly communalised, where issues of public esteem, 'give and take', and a broad sense of moral obligation are also in retreat. Today, I suspect professionalism is used as a synonym for high competence. That meaning, of course, is but part of the full meaning.

I would be exceedingly gloomy if I did not believe that our history goes in cycles, and that the pendulum may start to swing back before too long. I am not sure whether that depends upon a religious revival, but I am a long-term optimist, albeit a short- to mid-term pessimist. One also has to face growing globalisation, which has a tendency to even greater moral minimalism.

The medical profession could take a real lead. It has an intrinsically moral ground to build on and a reputation that has not been as blasted as that of, for example, lawyers. The proposed report of the Working Party is a good start, so long as it does not pull its punches and is not afraid to use the unfashionable language of duty and altruism.

Professionalism in medicine (and the law) must surely address unmet need – hence cannot confine its concern just to paying patients. Some hard thinking, I would suggest, needs to go on around the nature of private hospitals, many of which are charities but with little outward sign of response to what I and many would take to be the essence of charity or, indeed, of real professionalism.

Friday 8 April 2005

The submission of **The Venerable Dr Gordon Kuhrt**
Director of Ministry for the Church of England

The Church of England clergy have traditionally been regarded as one of the professions. Through the late nineteenth century and first half of the twentieth century, selection, training and remuneration became more standardised. Formal entry has always been by episcopal ordination and licensing.

During the last 30 years (in common with other professions) there has been a proliferation of 'subprofessions', for example, non-stipendiary clergy, ministers in secular employment, lay preachers (readers) and pastoral assistants. In addition, women have been admitted as readers (1969), deacons (1987) and priests (1994). Women are now in all senior positions except bishop (concerning which, debate is now well underway).

The implied social contract between professions and society has come under major pressures in recent years and, in my judgement, needs radical treatment to prevent total breakdown. Some clergy are included in the sorry catalogue of failure. Contributory factors are:

- examples of incompetence
- abuse, fraud, other criminal behaviour
- suspicions of self-seeking, protectionism, autonomy and self regulation
- scepticism about genuine accountability to those serviced and to society.

The wider cultural epistemological context includes a postmodern suspicion of metanarratives as instruments of oppression. Particularly suspect are institutions and/or procedures that are, or appear to be:

- patriarchal
- hierarchic
- authoritarian
- monologic.

The Church of England has recently been addressing some of these issues, and has approved and executed a major programme of reforms. These include:

- disciplinary legislation
- child protection rules
- guidelines for the professional conduct of the clergy

- grievance procedures
- data protection procedures.

Partly in the light of the Employment Relations Act 1999 (especially Section 23), we have produced two major reports on clergy terms of service, which are now to be turned into legislation and guidelines. These include:

- appointments procedures that are demonstrably fair
- job description/profiles that are clear
- written terms and conditions of service that are just and reasonable
- annual review and accountability procedures that are genuine
- continuing professional development of competence which is embraced.

At the parish level we have had church councils with elected lay people since 1919. At deanery, diocesan and national level, we have had full Synodical Government since 1970. This means the laity has a full voice in every aspect of church government.

Comments on the Working Party's four questions

Question 1: Do you think that professionalism has any meaning today? Say why you think this is so

I do believe professionalism continues to have meaning in terms of boundaries (entry and licence to practise), expertise and service, but we must beware of inappropriate privilege.

Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?

The threats and challenges are treated in my opening statement. They cluster around (perceived) lack of discipline and altruism, and concern for privilege and protection.

Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?

The strengthening of key aspects is also addressed in my statement. See especially my list of issues included in the reports on clergy terms of service.

Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

The protection of inappropriate privilege and self-regulation.

The submission of **Professor Sir Alan Craft**
Chair, Academy of Medical Royal Colleges
President, Royal College of Paediatrics and Child Health

This is a personal view based around the questions asked in the annex to the 'invitation to respond' letter. I write in my capacity as a paediatrician, President of the RCPCH and Chair of the Academy of Medical Royal Colleges, but mine is not necessarily the view of the College or Academy.

Comments on the Working Party's four questions

Question 1: Do you think that professionalism has any meaning today? Say why you think this is so

In 1949 my illustrious predecessor, Sir James Spence, wrote, 'The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it.'[1] Professionalism is all about trust and this is at the heart of Spence's statement. In the days when we could do little to help sick people, trust was important. It was unlikely that we doctors would do them much harm. Now there is a huge amount that can be done with a real potential for harm. It is, therefore, even more important that the doctor is trusted. Today's doctors make great play of the MORI polls, which show that trust in doctors is as high as ever, with politicians and journalists at the bottom of the scale. We take comfort in this but I do believe it is much more important than it seems. It is not surprising that we are trusted. When the 'chips are down' patients put implicit faith in doctors and it therefore puts a huge burden on us to retain our professionalism. Patients expect it and we must deliver it.

The growth of consumerism has meant that patients are much more questioning and demanding. My family bought its first car in 1964 – a Ford Anglia. It had to be taken back after 600 miles to have its faults corrected and to be 'run in' for the first 1,000 miles. My current car, acquired two years ago, has been returned to the garage only twice for an annual service. I expect what I buy to be of this standard and patients expect nothing less from their healthcare.

It is said that the ease of access to medical knowledge through the media and internet has made professionalism less important. Nothing could be further from the truth. 'Information without perspective is just a higher form of ignorance'. Professionals provide this perspective.

I have no doubt that professionalism is as important as it was 50 years ago. It is, however, now transparent and needs to be more explicit. As Onora O'Neill said, 'Professional autonomy has to be earned.'[2]

Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?

Now It is said that the modern generation of doctors do not have the same sense of vocation as 50 years ago, ie they lack professionalism. Because generations 'X' and 'Y' wish to have a work/life balance, does that mean they are necessarily less professional? I do not think so. Today's medical students and young doctors are every bit as committed as we were when young. But they are working in a different environment. Society has changed and public expectations have increased. The European Working Time Directive, the new consultant and GP contracts, the feminisation of our workforce and the internationalisation of medicine are all challenges which have to be addressed, but there is no fundamental reason why professionalism should not transcend these changes.

I see one of the biggest threats to be politicians, either directly by their interventions or by their giving the public unrealistic expectations of the services that are provided. There is little doubt that the ministerial response to Alder Hey and, to a lesser extent, Bristol did a huge amount of damage to professional morale. It sent professionals into a defensive and suspicious mode and helped to create a climate of distrust of politicians as well as the GMC. There is no doubt that reacting to the worst undermines the good.

In 10–15 years Medical advances, changes in society and the influence of politics are not going to go away. This makes it even more important that doctors understand what medical professionalism is, and retain their integrity.

Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?

The reforms to medial education, both at an undergraduate and postgraduate level, should be laying the foundation in which professionalism can flourish. We are now seeing a different breed of doctor qualifying who understands not only the basics of medicine but also professional values. They expect to work in an environment that generates mutual trust and where team working is the norm. I believe professionalism would be strengthened if we could genuinely move to a no blame culture. However, this will mean ensuring that annual appraisal is a

formative process in which difficulties can be shared and where threats of GMC referral do not pervade. It took British Airways five years to move to such a no blame culture. I think it will take a generation in medicine but we have a good start, and with the right support from the top we could see a very different profession in 30 years where professionalism is as important as it was 30 years ago.

Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

Professionalism should be defended but, like everything in life, it needs to be fit for purpose and adapted to our changing society.

Other thoughts

The importance of academic and scientific progress must not be overlooked when we think about professionalism. The way that doctors respond to potentially new treatments – from their research origins to their introduction and evaluation in clinical practice, not forgetting the ethical aspects – is a reflection of professionalism.

References

1 Spence J. The need for understanding the individual. In: *The purpose and practice of medicine*. Oxford: Oxford University Press, 1960.

2 O'Neill O. *A question of trust*. The BBC Reith Lectures 2002. Cambridge: Cambridge University Press, 2002. www.bbc.co.uk./radio4/reith2002

Friday 6 May 2005

The submission of **Ms Denise Chaffer**
Director of Nursing, Worthing and Southlands Hospitals NHS Trust

Thank you for giving me the opportunity to submit my views on medical professionalism. My views are shaped from working for over twenty years in the health service, being a registered nurse, registered midwife, registered tutor and currently Executive Director of Nursing in an acute district general hospital. In my current role I am actively involved in clinical governance, which includes risk management and the management of serious untoward clinical incidents. I have developed a number of clinical leadership programmes more recently for medical consultants who are clinical directors. I believe the quality of clinical leadership to be key to the delivery of high quality care to patients.

Overall, I believe we have a medical profession to be very proud of, which serves the public and the NHS to a very high standard. The public still continues to hold the medical profession in high regard, but this has been recently compromised by a number of serious high profile cases that has led to demands to more closely manage the 'professionals'. I believe that all health professionals should practise within a consistent and well-publicised clinical governance framework, and that robust mechanisms must exist to ensure early detection of misconduct and malpractice, and that they are exposed and rapidly dealt with.

Comments on the Working Party's four questions

Question 1: Do you think that professionalism has any meaning today? Say why you think this is so

Professionalism is important today to ensure that the public and any individual has the confidence that a member of a profession from whom they seek advice is, as far as possible, governed by an agreed set of rules and standard of conduct, drawn up by the public and the profession in the public interest. It is important that the public and government understand this. However, it is also important that the professionals do not interpret professionalism as a licence to serve the interests of the profession itself, rather than the population that they are there to serve. It is also important that professionals maintain standards which are independent of politicians but remain accountable to the public they serve.

Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?

Threats to the concept of professionalism appear to come from a number of sources. Firstly, threat from public confidence, which has been seriously undermined by issues such as Shipman, the Bristol Inquiry, the organ retention scandal and the Laming report.[1–4] These seriously undermine public confidence and lead to demands and pressure on the government of the day to ensure that the professionals involved are 'called to account', and questions of whether the current regulatory bodies are fit for purpose. In addition to this, the public question the behaviour of some professionals, in particular a perception of 'arrogance' or use of 'position power' in which only other professionals can question the views of the professionals, and the views and opinions of the 'consumer' are not seen as relevant or credible.

Medical professionals in particular are seen by the public as gatekeepers of services, which, as such, means that they are perceived as very powerful. This has the potential to seriously disempower patients and their relatives. They can also be viewed as commonly 'closing ranks'; thus, the perception is that if mistakes are made, the professionals will cover up for each other.

The other challenges come from government itself, who see professionals (doctors in particular) as spending large amounts of the health resource on areas such as drugs, surgical innovations and using the clinical judgements/professionalism to justify expenditure on the basis of best practice and evidence-based medicine. Hence the action from government to the professionals comes in the form of some controls (eg NICE guidelines, consultant contract, General Medical Services contract, patient choice), to apply some consistency and restrictions on expensive practices. The Healthcare Commission and some other bodies such as the Clinical Negligence Scheme for Trusts, the Patient Safety Agency, Cancer Peer Reviews and the confidential enquiries into various patient group deaths, use a form of peer review – ie other health professionals look for benchmarking standards to compare and ensure consistency between professional practice.

Other threats and challenges arise where there may be conflict between political targets and clinical priorities, some of which may lead to resources being redirected. Greater dialogue with the health professionals would help address some of these conflicts, as health policy can sometimes be viewed as more about winning votes than acting in the best interests of patients. The influence the government has over areas such as future medical training, EWTD etc, again

needs greater balance. The establishment of more forums for greater dialogue and less polarization could help to balance the conflicts between best safe clinical practice and effective use of resources.

Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?

I think that all aspects of professionalism should be preserved but an accountability and clinical governance framework should be applied to all professionals, and monitored. No health professional should ever be permitted to be solely independent, all must report in some form, and be accountable to someone senior. This could be a manager, supervisor, peer board or mentor, but all should ensure that their professional practice is conducted within a prescribed clinical framework similar to that provided for the recent Commission for Health Improvement (CHI) reviews. These include monitoring of patient outcomes, clinical risk, evidence-based practice, patient involvement and response to patient feedback, education, research etc. This does not oppose the concept of the 'single-handed general practitioner', but seeks to ensure that they practise within a recognised supervisory structure. Independent midwifery is one example of where this is already in place. These governance arrangements must be free from political control and remain consistent and robust, regardless of which political party is in power. These arrangements should be regularly reviewed and not 'knee-jerk reformed' by government intervention when incidents occur. These governance arrangements must stand up to public scrutiny and thus reassure the public that individual complaints and issues will be dealt with in a fair and transparent manner. This should also protect the medical profession from trivial or malicious complaints, and serve to increase public confidence that professionals can be called to account for their practice and conduct.

Part of professionalism should include greater development of team working and the development of learning organisation principles, such as openness, fair blame culture, and mutual trust for team members. One important aspect of health professional teamwork is the team's collective responsibility to the public it serves. It must always be prepared to act in the public interest. For example, if a health professional has concerns about another, there must be a clear 'whistle-blowing' or 'raising serious concerns' process. Perhaps a 'helpline' for professionals linked to the GMC could be part of this process.

Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

No, but the public need to be better informed about the components of professionalism and be reassured by what this means.

The components of professionalism should be preserved, but it needs to be made explicit that professionals have to work within a framework and will be called to account.

The professional bodies should urgently establish what professional behaviour should be for all professions, and agree a framework of how it should be challenged when clinician behaviour falls short of this.

References

1 *The Shipman Inquiry*, January 2005. www.the-shipman-inquiry.org.uk/home.asp
2 *The Bristol Royal Infirmary Inquiry*, July 2001. www.bristol-inquiry.org.uk/index.htm
3 *The report of the Royal Liverpool Children's Inquiry*, January 2001. www.rlcinquiry.org.uk/
4 *The Victoria Climbié Inquiry*, January 2003. www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm

The submission of **Professor Sir Kenneth Calman**
Vice Chancellor and Warden, University of Durham;
Former Chief Medical Officer for England

This statement is based on a book, currently in progress, on the history of medical education. The first part of the book reviews the changes from Chinese medicine in the third millennium BCE through to Britain in the twenty-first century CE. The second part draws out the main themes identified and tries to analyse them further. The five major themes are:

- The roles and boundaries of medicine. This includes a discussion on the aims of medicine, professionalism, boundaries between other knowledge bases and professional groups. It includes a discussion on the role of the doctor in society.
- The quest for competence: the search for the good doctor. This includes how to assess the doctor and links to the aim.
- Who should become a doctor? Selection for medicine.
- Handing on learning: the learning environment, the curriculum, methods of assessment etc.
- Beyond learning; dealing with new knowledge. This covers research, discovery, innovation and the concept of the medical magnet, an individual or group which attracts other doctors to go and study and learn with them. This has been a feature of medical education for 3,000 years and is still relevant today.

Each of these themes is relevant to the Inquiry of the College, though this statement will deal only with the first of these points. Further information can be provided as required.

Defining the aim of medicine and its roles is a fundamental task which needs to be done before considering what kind of education is required to produce a medical practitioner or specialist; it is essential that there is a clear view of the role of medicine and of the doctor. Without such a vision of the aim of medicine, it becomes impossible to plan an educational programme and to assess whether or not it has been effective.

Poynter, in a chapter on medical education since 1600, makes the interesting point that this has never really been clear.

> *Medical education reflects the organisation of the profession and its institutions and just as vestigial features are very prominent in the profession in England, so*

> *they may be clearly seen in the system in education. This has never been designed and planned as a whole for its purpose. Indeed, nobody is agreed on its purpose, that is, what type of doctor the system is intended to produce. To take an industrial analogy, it is rather as if a great variety of machine tools were assembled from a number of different car factories and linked together in the belief that the ultimate product would be a motor car of some kind, though nobody was at all sure what it would look like or how it would perform. The product does indeed work and does indeed pass the different kinds of inspectors, each of whom is supplied with a different blue print for his tests.*[1]

The historical review in this volume suggests that it is possible to define the aims and roles of medicine and of the doctor on which most doctors are likely to agree. Crucially, however, it also requires the agreement of patients and the public. In achieving the role and purpose of medicine, the doctor is seen as the primary mechanism through which these are realised. Such definitions raise issues around the concept of a professional and what we mean by a professional.

The roles and the aims also begin to define the boundaries of medicine. Where does it begin and where does it end? How is the knowledge base of medicine related to other disciplines and branches of knowledge? What role do the arts and social sciences play in the education of the doctor? How does the doctor interact with other professional groups? These are important questions, and, like the definition of the aim of medicine, lay the groundwork for the subsequent questions in this section of the book: the quest for competence, selection for medicine and the learning environment. Without such a debate, the comment by Poynter at the start of this chapter will continue to remain true.

The aim of medicine

Following the review of the history of medical education it is possible to set out aims for medicine and the roles of the doctor. It is suggested that the *aim* of medicine is to assist in the process of healing. This is the primary function of the doctor. Doctors do this by providing care, relieving suffering, promoting health, preventing illness and disease. This aim is grounded in the understanding of health and the mechanisms of illness and disease, and, from this, to provide effective and appropriate treatment. Finally, doctors must do this in full cooperation with the patient, public and other providers of healthcare.

Put another way, the *purpose* of medicine is to serve the community by continually improving health, healthcare, and quality of life for the individual and the population, by health promotion, prevention of illness, treatment and care, and the effective use of resources, all within the context of a team approach.

The roles of the doctor

Three roles thus follow from the aim set out above:

- To be a healer, understand the processes of care and to intervene when appropriate. To wish to help others and see medicine as a vocation.
- To understand people, and use this to provide better care, with cooperation and involvement of patient and the public. To communicate as effectively as possible. To be an advocate for health.
- To understand the reasons for illness and disease and to use this knowledge to improve health, healthcare and improved quality of life and well-being.

The kind of doctor required is one whose qualities fit these roles; that of healer, people centred and curious about health and illness. By defining the qualities required, not the type of doctor, it becomes easier to see a way forward. There is not a single 'type' of doctor, there may be several 'types', but they should all have the qualities listed above.

It should be obvious, for example, that not all doctors will spend an equal amount of time, nor will they have specific expertise, in each of these roles, but all will have some part in them, and all will ensure that their work is directed towards the aim as set out above. For example, pathologists will spend much of their time examining the process of disease, but will have an interest in how this is applied to the process of care. The research scientist will operate in the same way. The psychiatrist may have a greater emphasis on understanding people, as may the doctor interested in changing the public health. The general practitioner will have a more even spread, while some specialist clinical colleagues will spend more time on care processes such as treatment. Trying to find the 'ideal' doctor may be an illusion. What we may need is a range of doctors with a series of qualities that are expressed in different degrees in different individuals.

Defining a profession: a summary

One way of defining a profession is to set out the characteristics that seem to be most appropriate. Using the work cited in the review and the paper by Calman (1994) [see Appendix 1: Reading List] these characteristics might include:

- A vocation or calling and implies service to others. This remains an important part of being a doctor. The wish to be a doctor and to help others may seem old fashioned in a time of increasing commercialisation of medicine but it remains central. When we consider how best to select medical students and young doctors for particular specialties this will be an important factor to consider.

- Trust and respect. Two key aspects of a profession: the patient and the public must trust the doctor, and there should be mutual respect. These two factors can be difficult to establish and require considerable care and hard work. They can be easily lost, and, in the words of the proverb, 'Trust comes on foot and goes on horseback'.
- Respecting the value of human life. This is an important value. Doctors are in such a privileged position, which could allow them to take advantage of those who are vulnerable.
- Maintaining privacy and confidentiality. Those who consult a doctor expect to have their privacy protected and their health information to remain confidential.
- Acting as an advocate for the patient and the public in health-related matters; recognising that the doctor has a role as advocate, supporter, agent for change and educator.
- A distinctive knowledge base, which is kept up to date. The knowledge base comes from the sciences, arts and social sciences. It is broad and constantly changing. This requires that the doctor must continue to learn and keep up to date.
- A special relationship with those it serves – patients or clients, including the importance of trust. This is not just a client or customer relationship. It is deeper and grounded in values, and based on trust.
- Particular ethical principles – the ethical base. This is of fundamental importance, and has been central to clinical practice for generations. These are set out in various ways through codes, oaths and sets of principles.
- Setting standards and examinations. This has been a part of professional practice for centuries – set by the profession, assessed by the profession. Slowly this will change as the public have a hand in the standards set.
- Self-regulating and accountable to patients, clients and the profession itself. This is perhaps the most contentious at the present time. How far can the profession continue to be accountable to itself, and how much can it relinquish this to those not part of the profession? The view of this author is that involvement of patients and the public in a tangible way will only strengthen the profession. There is nothing to hide or be afraid of.
- Open and available for evaluation. This is the corollary to the discussion on self-regulation. The need to be open and transparent in relation to outcomes of care and public health practice.
- Works closely with other professional groups. The important of teamwork

and of recognising the skills and expertise of others is very much part of being a profession

- Able to lead and determine direction of the clinical team. This must be earned by the demonstration of many of the qualities listed above.

These then are some of the characteristics of a profession, though there are some who would argue that in the twenty-first century medicine is no more than a trade – a series of skills which can be easily mastered and bought at a price. This is not what a profession should be. It has at its core the commitment to people and has a strong vocational aspect without which it would just be another job. It follows from this that respect for the value of human life is a given, as is privacy and confidentiality. Acting as an advocate may seem again to be out of place, but, as will be discussed in another section, it is increasingly important. Perhaps the most contentious is that the profession should sets its own standards and be self-regulating. In the twenty-first century, the public should expect to be part of this. Self-regulation could be seen to perpetuate an inward-looking club with no responsibility to the public. But these views are not incompatible, and there is no need for contention. The public involvement in such bodies as the General Medical Council (GMC) and, increasingly, in the Royal Colleges provides a way in which such an input can occur. The profession of medicine should not be afraid of such ventures as it can only strengthen the profession when those outside see the effort involved. As Freidson (1994) noted [see Appendix 1: Reading List], medicine should not be 'free of lay evaluation'.

The list above attempts to define some characteristics and qualities of the profession, but what about professionals? Clearly, they should subscribe to the list of characteristics above, but this then needs to be translated into personal values. These might include the ability to demonstrate:

- the wish to be a doctor and to see it as a vocation; to be committed
- respect for human life and an interest in people
- care, compassion and concern for patients and the public; empathy
- ethical consideration of all issues
- interest in health as well as illness.
- communication and advocacy skills
- ability to act as an educator and advocate of change
- courage to take difficult decisions
- equanimity in the face of difficult issues and stressful circumstances
- a wish to continue to learn and undertake continuing professional development

- confidentiality and privacy in their work
- an understanding of teams and the value of colleagues in other disciplines
- ability to analyse and solve complex problems
- teaching ability, for patients and the public
- accountability to patients, the public and the profession
- curiosity and an interest in research and development
- humility and the ability to recognise when things could have been done better
- that they can be advocate for health
- that they can be a leader in promoting health.

Such a list can of course be debated, discussed and refined. Its potential value lies in the selection of those who wish to study medicine or who wish to proceed up the career ladder. Such a set of characteristics might be useful in this process.

Reference

1 Poynter FNL. Medical Education in England since 1600. In: O'Malley, 1970:235–249.

Friday 20 May 2005

The submission of **Professor Sir Ian Kennedy**
Chair, Healthcare Commission

Thank you for the opportunity to comment on your questions about the role of professionalism in today's health service.

If professionalism refers to the notion of a group of people working to common standards and a common code of ethics, this must remain an important underpinning for the behaviour of members of professions who may be in a position of power or influence over potentially vulnerable individuals receiving the services of those professionals. Historically, the idea of professionalism has gone hand-in-hand with the concept of self-regulation, ie professionals themselves have agreed the standards which guide their conduct, regulate entry to the profession in line with those standards, judge members of the profession who are alleged to have breached those standards, and remove from the profession or otherwise sanction those found to have failed to adhere to those standards.

Traditionally, it has been the professionalism of clinical professionals (in particular the medical profession) that has been the sole means whereby the quality and standards of clinical care have been set and performance assessed. The (reasonable) judgement of a clinician, made in the light of the prevailing standard of the time has been the guiding principle by which the quality and acceptability of care have been judged, not least by the courts.

However the growth in 'consumerism', easier access to information, and a better educated, more demanding, less deferential public has led to the questioning of professionalism as an acceptable means on its own of safeguarding standards and reflecting the interests of those served by the professionals.

Against this background, and in a managed and increasingly complex system of healthcare in which considerable public money is invested, the government has recognised the need for a more objective, independent means of setting standards and judging the extent to which they have been met. While informed by, the system must not be 'captured' by, professionals' interests, but rather be also informed by the needs and wishes of patients and the public.

The Healthcare Commission, as one of the current guardians of the regulation of healthcare, would not see regulation as meaning an end to the relevance of professionalism. Regulation (or independent assessment) and professionalism can instead be complementary: defining, assessing and delivering care of high quality within parameters which have been described by a broader group than simply professionals themselves.

Such an approach has important implications for the future of professionalism. These include the need to recognise the multidisciplinary nature of the delivery of healthcare; the need to recognise the role of patients as partners in their care, and patients and the public as having legitimate views on the delivery of healthcare; and the need for reflective care (ie learning and improving throughout a professional's career). This approach also calls for effective clinical/professional leadership so as to develop and support the skills and attitudes required. This, in turn, necessarily has implications for the training of professionals but there are also significant changes in culture and attitude that are needed in much of the established workforce. The professions will need to recognise and demonstrate that they are both willing and able to address these issues if professionalism is to be seen as having a legitimate role in the setting and monitoring of standards.

Investigations and discipline when things go wrong will also need to become more in tune with the expectations of a new professionalism, and demonstrably more sensitive to the views of patients and the public. The professions can no longer be seen to be judge and jury in their own cause. The 'club culture' referred to in the Bristol Inquiry report; 'doctors looking after their own'; failure to adopt properly reflective practice; failure to highlight concerns and ensure that remedial action is taken when necessary; the propensity to value the individual professional over working in teams: all of these must be addressed as part of a new approach to professionalism. The Healthcare Commission's investigations of potentially serious service failures, in common with Inquiries that have gone before, have all highlighted these issues as being at the root of poor (and often unsafe) care of patients.

The submission of **Sir Nigel Crisp**
Chief Executive, Department of Health and NHS

Professionalism is a much used and misused word today. To some, it might simply be the pedantic opposite of 'amateur' – the professional is someone who can earn their living at an occupation because they have reached a certain standard. To others, 'professional' simply denotes a high standard.

There is a grain of truth in both these rather vague definitions that we can apply to the medical profession. And I must emphasise straight away that while I am here to talk about medicine my theme relates to all health professions.

That grain of truth is around the term 'standard'. A professional – of whatever kind – is someone who works against a standard and in many cases, like medicine, the standard is highly defined and demanding. Though, the fact that it is highly defined does not in my experience mean that it is not subject to much debate and indeed can be misunderstood.

In medicine, professionalism means that a patient can expect a high standard of care from individuals and teams even in the most difficult circumstances. This implies professionalism of two kinds, for example from the NHS:

- individual professionalism through which individuals and teams care for patients as well as relating to their families and their carers
- institutional professionalism whereby systems are in place to encourage and support individuals and teams and (I will come on to this later) to assure standards.

I am building a picture of professionalism that goes wider than treating patients effectively. I am thinking in terms of building and maintaining relationships, trust, understanding, honesty, confidentiality and, in fact, humanity.

You could say that these standards – or values – are time-honoured, and I would agree to an extent, but things are changing. In particular, the relationship between doctors and patients is, I believe, more demanding than ever. Our culture is more demotic and democratic than ever, patients have more information (for example, through the internet) than ever and expect a more equal relationship.

The government's own policies reflect this change – the accent on a patient-centred approach and on patient choice are two instances. These policies are not accidental, they stem from a clear need to engage with patients. In an ageing population, the management of long-term conditions can also put more responsibility on patients and carers.

The picture I have then is of some fundamental values and standards set in

new contexts and perhaps expressed in a new way. The challenge is that values and standards not only have to be held, they have to be apparent and they have to be related; to patients, yes, but also more widely to the world at large.

The job in hand is, I suggest, fourfold. How do we:

- instill professionalism?
- maintain it?
- measure and assure it?
- explain it in a way that engages the public and makes it comprehensible and usable?

Instilling professionalism looks the most straightforward. Clearly, the grounding for this is in medical school where two things are going on:

- students are led towards a positive engagement in a professional, value-based ethos
- those who cannot or will not attain this ethos are weeded out.

I know that there is a debate at the moment on how far fitness to practise and its attendant regulatory requirements should be applied to students. I shall not rush to conclusions but the debate is, I feel, necessary and valuable.

We are launching this year our new Foundation Programmes for newly qualified doctors. Much of what might be considered innovative in the new programme reflects the contextual changes I have spoken of. For example, broadly based competences not only covering essential knowledge but communications and relationships. 'Foundation' means what it says and we need to go on from there to build new specialty and GP training programmes with the same patient-focus.

But of course, doctors spend most of their careers not as trainees (though it sometimes feels like it) but as fully fledged independent practitioners. There are two issues here.

The first issue is the ability of doctors to work in teams of other professionals – to lead and to be led. We are beginning to turn aspirations about inter-professional learning and working into something more concrete. Learning from others, learning about others and sometimes learning with others provide the framework here. How far can we expect interprofessionalism to translate itself from the organisational wish list into tangible professional standards and values? I pose this in the knowledge that the most notorious professional failures we have seen over recent years have been as much about systems as individuals.

Second, we must revisit the whole question of continuing professional development (CPD). In recent years, professional and personal development for

doctors has been underpinned by appraisal. Evidence-based CPD you may call it. Now, post-Shipman, we have to look again at the role of appraisal, its links to clinical governance, and, of course, the whole question of revalidation is under review. At bottom, CPD has to be owned as much by organisations as individuals, and in view of the changes likely over the course of any doctor's career we have to think hard about how systems support doctors in fundamental career changes – not once but perhaps more.

I asked earlier about how we could measure and assure professional standards. This poses for me a profound question: is professionalism something to be imposed or is it to be expected? By this I mean, should we impose systems to catch out all forms of unprofessional behaviour? Or do we believe the highest form of professionalism comes from those who wholeheartedly subscribe to their professional values. I admire the latter position but I do not believe we can rely on its universality without systemic safeguards. What do we lose by relying on systems? What do we gain by relying on individuals? Where is the balance?

Having said that, I do ask what role doctors themselves have in shaping the systems that quality-assure them? It is clear patients are no longer passive recipients, so why should doctors take on that role?

You know that, following the Fifth Shipman Report, Liam Donaldson is currently undertaking a review that touches on much of this from appraisal through revalidation to clinical governance. A number of doctors are involved already and I hope many more have taken up his call for ideas. One thing I will say at this stage is that whatever arrangements are proposed following the review it will be difficult to secure their effectiveness unless they draw commitment from doctors themselves.

I would like finally to talk about patient and public expectations of professionalism. I started by thinking about misconceptions, but thinking about the broader context it is important to engage patients and the public in using professionalism properly. It is not very helpful if only the experts in the regulatory bodies or Royal Colleges understand how a professional ethos works. Or when standards are applied in a way that is not understood.

Patient-centredness and patient choice mean that patients have to know how to get the best out of their doctor, how to work with them and what to expect from them. What are the minimum standards they can expect and, indeed, how far can they expect standardisation, particularly standardisation of health provision when the sources of that provision are more varied than ever? Perhaps the ethos of the health professional produced through common experiences set against common standards is what will bind healthcare together in the NHS of the coming century.

2 Written responses to the Working Party's four questions

The Working Party was aware that definitions of professionalism were many and varied and did not take a definitive view on them. Many definitions contained elements that were open to challenge, did not apply to doctors, or were out of date. However, a definition of a profession based on the *Oxford English Dictionary* and modified by Cruess, Johnston and Cruess[1] had merit. At the start of its work, therefore, the Working Party adopted the modified *OED* text as its working definition and devised four questions designed to elicit views on professionalism.

> *An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members profess a commitment to competence, integrity and 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, which in return grants the profession the right to autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.*[1]

The Working Party's four questions

- Question 1: Do you think that professionalism has any meaning today? Say why you think this is so
- Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?
- Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?
- Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

The four questions, together with the Working Party's working definition, were circulated to over 400 key organisations in the UK, including all of the medical Royal Colleges and specialist societies, and to individuals with special expertise or who had shown an interest in the topic. The questions were also available on the Royal College of Physicians website. Recipients were invited to contribute to the debate by sharing their views on all or some of the four questions and adding any further thoughts of their own.

The Working Party received over 100 responses to the questions. These responses were analysed and are summarised in this section. A list of those who contributed to this part of the consultation process are listed at Appendix 2.

Question 1: Do you think that professionalism has any meaning today? Say why you think it is so

There was general agreement in the submissions that professionalism does have meaning today, and that the concept of professionalism is 'fundamental to the delivery of excellence in healthcare'.

However, writers commented on two things. Firstly, the meaning of professionalism may have become devalued. This is probably due to its multiple and uncritical use as a descriptive term, applied to almost anyone claiming skills and providing a consumerist-type service: in the minds of many the distinction between a true professional and a skilled artisan may not be clear. It is important to get to grips with what it means to be a professional – the term should not be used lightly, even though it is commonplace to equate professionalism simply with 'doing a job well'.

Secondly, the continuing ability of doctors to lay claim to aspects of professionalism without a genuine understanding of, and a dialogue about, what these components mean, and how they might be demonstrated (realistically) in practice, is called into question. For example, the legitimacy of holding fast to the principle of autonomy and the privileges of self-regulation, without obvious and outward signals that the medical profession is able to make good the perceived deficiencies of the past, is unsustainable.

The reasons why professionalism has meaning were also generally agreed: it is all to do with standards. Patient welfare is a strong motivator. Without the 'attitudes, customs, and skills' associated traditionally with professionalism, medicine will become just another tradable commodity.

Behaviours and characteristics that have formed the basis of medical practice for a number of years are as relevant today as they were at almost any time in the past. It appears that 'goodness' is not out of fashion. When it was mentioned, there was support for the notion of altruism as a key component of professionalism. The importance of skills and knowledge was a key priority in many submissions.

At a time when medical professionalism is apparently under threat, the principles contained in the OED definition become even more important to preserve: 'it would be regrettable if it were only in its absence that its importance came to be widely realised and respected'. Writers commented that, should professionalism cease to have meaning and a prominent place in the working lives of doctors, their whole *raison d'etre* would be severely called in to question. 'The practice of medicine is an expression of care for ones' fellow men'. Medicine is special; we need to make it special and keep it special.

Many submissions offered examples from writings and publications (most of which were contained in the Working Party reading list, see Appendix 1) offering definitions of professionalism and supporting the concept. Some writers described what professionalism means to them personally and how they strive to maintain its principles in their daily practice.

Question 2: If you believe that professionalism is a relevant concept, what threats and challenges do you think it faces today? What threats and challenges do you foresee in the next 10–15 years?

This question provoked the largest volume of responses. Respondents did not always distinguish between threats and challenges, or between threats and challenges faced today and those faced in the future. Once identified, most 'threats' can be turned into challenges. It was widely agreed that the solutions are in the hands of doctors – if they wish to take up the challenge of devising and applying them.

Four major themes emerged. They are summarised here to illustrate major views rather than attempting to reflect the nuances contained in individual responses. Overlap between points is acknowledged.

Doctors and the public: social trends and public expectations

- Rising public expectations, fuelled by knowledge of technological advances and information freely available on the internet; public knowledge that is not always matched by public realism; doctors failing to communicate adequately the limitations of modern medicine.
- An increasingly litigious society more willing to 'take on' the establishment; a social redefinition of what is legitimate authority, resulting in professionals becoming defensive about their practice.
- Failures which result in widespread criticism of the profession, rarely countered by praise and promotion of the profession as a whole (despite public expectations of improved transparency in decision-making in patient management being met increasingly); disengagement of many doctors and negative attitudes fostered both within the public and within the profession.
- A growing culture of anti-professionalism on the grounds that it somehow equates with privilege, which finds expression in continuing attempts to discredit professionals.
- A hostile media: 'bad news' is given more weight than 'good news' and the profession has not countered this.
- A perception that the profession has fallen short in the application of internally determined standards, leading to a threat to the ability to self-regulate.
- An increase in 'single issue activism' – issues such as anti-abortion, stem cell research and anti-immunisation campaigns – putting additional pressures on medical professionalism; people will use human rights legislation to demand medical care which doctors might consider unprofessional.

Government, legislature, regulation and management

- An inexorable march towards an increase in private healthcare.
- The EWTD making the profession seem less vocational; the EWTD and the consultant contract encouraging a different ethos of working; the EWTD, consultant contract and politically motivated 'targets' undermining professionalism; the distinctly anti-professional notion of 'restricted' hours embodied in these pieces of legislation.

- Emphasis on programmed activities, which is the antithesis of altruism; emphasis on targets at the expense of quality of care.
- The potential of treatment centres to restrict training opportunities.
- The move towards regulation and accountability, resulting in an approach to medicine that leaves little room for imagination and the wholehearted devotion that many doctors have applied to their working lives in the past; the potential of the EWTD to reduce opportunities for doctors to organise their own workloads and to impair job satisfaction (although it was designed to improve the quality of work and to ease the burden of open-ended commitment).
- Restriction in doctors' hours leading to a less experienced workforce (careful assessment of competency and a structure for ongoing training needed).
- Loss of continuity of care as an important and unwanted by-product of recent changes to doctors' working hours and practice (as identified by patient groups and representatives), leading to a diminution of opportunities to develop a 'relationship' with one's doctor.
- Loss of the apprenticeship model of training; decline in the ability of seniors to educate junior colleagues due to pressures of time and changing expectations for work-life balance.
- A loss of identity through working in large organisations: conveyor belt medicine.
- Guidelines and protocol-based medicine which suggest that individual practice or autonomy is unacceptable.
- Tension between care of the individual patient and public health expenditure due to resource limitations; financial influences on clinical decision-making.
- Technological developments which may persuade doctors that basic clinical skills are of less value.
- Limited opportunities for doctors to influence the macro-management of the NHS in the UK; changes in how healthcare is delivered, as well as the pace of change in the delivery of these services; introduction of initiatives without appropriate consultation (which would enable the profession to give advice and help shape the future of new services).
- Issues around relating to an organisational perspective while retaining an independent perspective.
- Government desires to eradicate medical power base: the 'creep' towards uniformity.
- Increased pressure on doctors to perform according to protocols that are driven from the centre and designed partly to ensure a proper uniformity of

quality and practice, but also to regulate expenditure. (There is a sense that doctors are at their best when they have a degree of freedom of action. A balance will have to be struck between the use of guidelines and protocols and the desire of all members of the profession to practise both the science and the art of medicine.)

- Tension between autonomy and self-regulation versus government control.
- Over-regulation of medical research.

Changes in the nature and constitution of the healthcare workforce

- The breakdown of professional barriers by encouraging the attitude that anyone can do anything provided they have been trained – aggravated by crises in workforce capacity.
- Gender shift and work-life balance. (However, the notion that the 'feminisation' of the medical workforce equates with a diminution of professionalism was strongly rejected – women have all the right qualities 'in spades'. Practising differently does not mean that people do not espouse the same values.)
- Erosion of the role of the consultant; the development of non-medical practitioners who undertake areas of work previously done only by doctors. (This is appropriate in many aspects, and it is important that we recognise the value of working in teams. However, taken to its full extent doctors could be reduced to one of a team of technicians. It is important to continue to promote the notion that the consultant is an expert, drawing on a wide breadth of knowledge and experience which enables him or her to deal with the complex, non-standard situations.)
- 'Dumbing-down' of specialist care by a proliferation of 'other grades'.
- Increasing difficulties with identifying exactly what makes the practice of a doctor unique – particularly when one examines what constitutes a 'body of knowledge and skills' (although by and large the principles of professionalism remain universally relevant and applicable); 'encroachment' of other healthcare professionals into the medical domain, meaning that this aspect of professionalism needs constant appraisal; confusion about precisely what a doctor 'is' and 'does'.
- Increasing encroachment of other healthcare professionals' jurisdiction into functions traditionally executed by doctors.
- Uncertainty that undergraduate and postgraduate training programmes will deliver the number and quality of doctors to meet demands; uncertainty of being able to deliver lifelong education and training within modern working

practice. (Medical education must be embedded as core business of the NHS, supported by high quality commissioning so that adequate resources and quality assurance can be built in.)

The contribution of the medical profession itself

- Increasing fragmentation of medical and surgical practice into specialties and subspecialties, threatening overall identity and cohesion.
- The need to empower the Academy of Medical Royal Colleges to present an interdisciplinary collegiate view. (The biggest threat is the profession itself – too seldom do we speak with one voice. The profession must find a way to work together as a collegiate body that has not been managed thus far. Only by speaking as a profession, rather than as individual groups of specialists, can medical professionalism, on which all of our specialist practices are built, be defended and developed further.)
- Weakness from the profession in its responses to adverse events (quoting Shipman) – or giving the impression that it is weak.
- Individual professionals themselves: insensitivity to patient needs, lack of personal commitment, lack of awareness of public attitudes, and lack of ability to change.
- Lack of medical leadership.

Question 3: What can be done to strengthen those aspects of professionalism that you care about? How would you propose going about this?

Suggestions put forward included:

- Steps to reinforce professionalism should also seek to redefine it so that professionalism prepares students and staff to face future challenges, rather than defend past privilege.

Aspects of professionalism can be strengthened by:

- convening the Working Party and raising the issues
- providing overt and credible medical leadership
- medical professionals speaking with a unified voice
- strengthening the professional voice within health reform; doctors participating more fully in health policy debate
- introducing robust methods of self-regulation

- setting standards and monitoring these in the workplace (includes dealing with complaints); having enough of the right sort of information to be able to sensibly monitor and appraise (removing the subjective)
- keeping up to date and maintaining high standards of personal competence and integrity
- selecting the right candidates for medicine
- inculcating the professional values during education and training; not neglecting the science base of medicine – skills and competences are highly valued
- restoring models of apprenticeship
- clarifying the basis of the relationship between doctors and the organisations in which they work
- working with patients to strengthen the doctor-patient relationship
- effective team-working.

Additional comments put forward about these aspects follow.

Leadership

- Credible spokespersons should be established to talk to the media and the public in order that messages can be readily understood. It is clear that the medical profession needs to speak with one voice – strengthening the Academy of Medical Royal Colleges might be a way to do this. Doing this might be regarded as a relative 'disempowerment' of its constituent parts, but we must find a way to work together as a collegiate body – something that has not been achieved before. Our leaders should speak more loudly about our successes.
- Short-term initiatives that lack an integrated approach should be eradicated.
- Medical leaders should continue the dialogue that has taken place within the confines of the Working Party and the consultation process.

Education and training

- Aspects of professionalism must be written into medical curricula. Educators and trainers must know how to teach these aspects. Consultants must be aware of the importance of the traits and behaviours we aim to foster, and act as 'appropriate and inspirational role models'. Senior members of the profession must lead by example.

- Medical students and other healthcare workers need to be trained explicitly in the ethics of medical professionalism and interprofessional ethics.
- Medical education and training does not appear to have as high a priority in the health service – this needs to be redressed.

Doctors and health policy: doctors and the public

- There should be explicit debate about what care can and cannot be provided. The processes whereby doctors and the public reach agreement on the nature of professionalism and resource allocation etc need to be enhanced. Greater emphasis should be placed on public education about the roles and expertise of 'professionals'; for example, the introduction of new technology could be debated with the public.

Standards

- The Royal Colleges should continue to work towards maintaining high standards, and do this in an open way so that the medical profession is not seen as self-serving.
- The titles of consultant, doctor, surgeon etc should be preserved for those who are suitably qualified and experienced to hold them.

Regulation

- Whilst tightening the 'regulation screw' will not prevent another Shipman, appraisal, revalidation and accountability must be welcomed. Regulation needs to take place with a sense of partnership (notably with the public); overt and readily understood regulatory processes must be established.
- Core professional values should be included in contracts of employment.

Teamwork

- Teamwork has innate advantages: it enables us to capitalise on strengths and abilities whilst allowing us to ameliorate individual and collective weaknesses. We must show respect for those who comprise the team (medical colleagues, other healthcare professionals, patients and carers, and managers). Teamwork encourages a spirit of professionalism and reduces the number of 'loners' (those more like to 'stray).
- Within multidisciplinary teams, medicine must play a leading role in establishing clinical standards and clinical protocols (thus another facet of medical leadership).

Question 4: Are there aspects of professionalism that are currently defended that ought to be abandoned?

Practically no aspect of professionalism was recommended for abandonment, apart from the more overbearing and paternalistic components of the definition that need refining and bringing within a modern context. Any 'aura of elitism' should be expelled, as should the view of the profession as a 'rigid body, resistant to change'.

A refinement of principles and a redefinition of values are required, rather than wholesale revision: a rebalancing rather than outright rejection. For example, no one rejected altruism, but many contributors understood that this was not 'at any price'. A preservation of the '24-hour medical career culture' (and all that this embodies) is probably unsustainable (and unlawful). Methods should be found to satisfy the desire of doctors to 'do a good job', to enable them to express their desire to demonstrate the best characteristics of professionalism in practical and productive ways. The provision of high quality healthcare needs to embody professionalism; it needs to demonstrate those qualities that have traditionally set doctors apart.

There was a very clear view from the responses that the many components that will comprise the regulatory process (CPD/CME, appraisal, dealing with non-performers etc) must be strengthened considerably, or the privilege of self-regulation will be lost – 'a satisfactory method of self-regulation is not yet in place'. A few respondents advocated handing over self-regulation completely, with the view that placing it solely within the remit of the medical establishment is no longer tenable. Regulation needs a strong lay voice. However, it was noted that 'the nature of the work is so complex that it would not be possible or fair for it to be judged by a majority of non-professionals'.

It is inconceivable to make progress on any front without the full participation and support of the public (our strongest allies). Medical partnerships with the public, healthcare colleagues, management, and with each other are absolutely critical.

Strong medical leadership is overdue – a reformed and strengthened Academy of Medical Royal Colleges (that includes lay representatives) might be a way forward.

Reference

1 Cruess SR, Johnston S, Cruess RL. Professionalism for medicine: opportunities and obligations. *MJA* 2002;**177**:208–11.

3 Medical professionalism in 2005: the trainees' view

Dr Declan Chard, Chair, Trainees Committee, Royal College of Physicians;
Ahmed Elsharkawy, Wellcome Trust Clinical Research Fellow, Southampton University and member of the Working Party on Medical Professionalism;
Nina Newbery, Medical Workforce Unit, Royal College of Physicians

Professionalism has, for a long time, been considered a given in medicine, but with changes in the doctor-patient relationship and, more globally, in the way medical care is delivered, the nature and role of medical professionalism has come to be increasingly questioned. Self-doubt has not been restricted to the profession of medicine; increasing evidence points to the erosion of trust in all professions.[1] The other traditional professions of the law and the church have also increasingly questioned their role in society.[2]

The debate about professionalism is not a new one; sociology literature has been full of these sorts of discussions since the 1970s when there were particularly savage attacks on the concepts of professionalism.[3] Professionals were seen as elitist, class-biased and out to maximise their personal profits. Indeed, these were some of the accusations levelled against clinical psychologists when they sought to achieve professional status in the 1950s.[4] Perhaps the mood was best summed up by George Bernard Shaw's statement that, 'Every profession is a conspiracy against the laity.'

It was sociologists who first attempted to define the characteristics of a profession.[5] By examining these, the threats that face all the professions in the twenty-first century can be put into context. The first characteristic is the possession of a specialised body of knowledge. With the information technology revolution and the increasing influence of the internet on people's lives, the medical profession in particular can no longer claim to have exclusivity of knowledge. The second characteristic is dedication to public service. This demands that the profession puts the good of society before its own. This has come under increasing threat with the portrayal of doctors as arrogant and out to maximise their profits

from private practice at the expense of NHS work. Finally, and perhaps most controversially in the current climate, professions are characterised by self-governance. The case of the serial killer Harold Shipman and the scandals at the Bristol Royal Infirmary and Alder Hey Hospital have eroded the public's confidence in the ability of the profession to self-regulate. With this in mind, the Chief Medical Officer is currently looking at the role of revalidation for the profession.

Within this changing climate, the profession has sought within the last 10–15 years to address the subject of professionalism. Numerous articles were written in the late 1990s in the UK around this subject.[6–9] However, other countries were actively involved in similar debates. In 2002, a collaboration of the European Federation of Internal Medicine, the American College of Physicians, American Society of Medicine and the American Board of Internal Medicine led to the setting up of the Medical Professionalism Project.[10]

Within UK medicine, there are many unique additional challenges to medical professionalism. The introduction of a new career pathway with Modernising Medical Careers, the establishment of the Postgraduate Medical Education and Training Board (PMETB), the increasing provision of healthcare in the private sector as exemplified by independent sector treatment centres, and the service reconfiguration that has accompanied the implementation of the European Working Time Directive have all changed the climate in which medical professionals are working. With current uncertainties in mind, the Royal College of Physicians (RCP) convened the Working Party to consider the concept of medical professionalism, to clarify its value and purpose and, if possible, to define it. As part of this project, the RCP Trainees Committee was commissioned to survey trainees to obtain their views on the matter, and undertook this with the help of the British Medical Association (BMA) Junior Doctors Committee.

Online questionnaire to trainee doctors and medical students

A questionnaire was designed with the following goals in mind:

- to excite a response from trainees
- to efficiently obtain trainees' opinions on key aspects of professionalism without imposing a rigidly preconceived definition
- to encourage additional free text responses on all aspects of professionalism.

A review of relevant literature identified a number of key issues and themes to address, and a long-list of questions was drawn up.[5,9,11–16] This draft questionnaire was then circulated for comment to members of the RCP Trainees Committee, the Academy of Medical Royal Colleges (AMRC) Trainees Group (the chairs or deputy chairs of all the Medical Royal Colleges' trainees committees), the BMA Junior Doctors Committee and Medical Students Committee, and the RCP Medical Professionalism Working Party. Responses were collated and two main recommendations taken forward: keep it short and make responses anonymous.

There were no readily accessible lists of all medical students, medical or surgical trainees in the UK. The largest available list was held by the BMA; all those on the list were invited by email to complete an online questionnaire, and given a link to a webpage. In addition, a link to the questionnaire webpage was circulated electronically to all specialist registrars whose details were held on the Joint Committee on Higher Medical Training (JCHMT) database, posted on the Association of Surgeons in Training website, and sent to members of the AMRC Trainees Group, with a request that this be forwarded to the trainees they represent.

Results

The questionnaire was launched on 24 March 2005, and closed to responses on 14 April 2005. Via the BMA, it was sent to 19,190 medical and surgical trainees, and 4,576 medical students. We received 2,175 responses; demographic details of these respondents are provided in Table 1. Table 2 provides a summary of the results of the questionnaire. Percentages have been rounded to integers. Where the rounded value is 0 but the actual value was greater, a result to one decimal place is also provided.

We received 776 free-text comments. Of these, themes not already addressed in the questionnaire included:

- targets (8% of comments), in particular waiting times (3%)

- managers (5%), mostly concerns about clinical decisions being taken or inappropriately influenced by managers, and pressure on clinicians to meet targets regardless of clinical priorities
- the media (4%), and a perceived negative portrayal of doctors
- European Working Time Directive (3%).

A selection of these comments are presented later in this section, and have been edited to correct spelling and punctuation where this would not alter the intended meaning. The Working Party had access to all the comments submitted by trainees in an unedited form.

Discussion

Whilst the response rate to the survey is not as high as would be desired, the results are clear. Junior doctors and medical students see medicine as a profession, requiring qualities such as altruism and humility that are learnt through apprenticeship and defined by responsibility towards patients. They believe that professionalism maintains and improves patient care; that standards of care should be defined and regulated by the profession; and that training should be directed by the profession. However, trainees believe that there has been an increase in clinicians' responsibilities and a concurrent decrease in their autonomy over the past five years. Eighty percent of trainees agreed that autonomy formed part of their concept of medical professionalism; 83% thought that autonomy had decreased. Of great concern is the potential for this view to translate in career decisions; 80% of trainees thought that a decrease in professionalism would increase the number of medical practitioners leaving the profession entirely. The perceived main challenges to professionalism were the expectations of the public and politicians set in the context of limited financial resources, changes in working patterns, protocol-driven care and changes in medical education.

This survey was not perfect; the questionnaire represented a compromise between several competing factors. To encourage responses, it had to be both brief and excite interest; it also had to address key issues, while avoiding a rigidly preconceived definition of professionalism. Further, given that survey responses were anonymous, there may be bias towards those who hold relatively strong opinions, and towards physicians rather than surgeons or other specialties. It is also to be expected that there were some duplicate submissions, although the survey system was set up to allow only a single entry for a given internet protocol address which should have limited this.

This survey shows that trainees believe medical professionalism to be beneficial to patient care, in placing the patient at the heart of a therapeutic relationship above other concerns. They believe it is a sustaining component of medical careers,

instilling values that are rewarded by good clinical care rather than rigid compliance with working patterns or targets, and that as such it should be valued. Furthermore, the survey demonstrates vibrant opinions around the concept of medical professionalism from those of the profession's members who will have the greatest influence over its future.

Acknowledgements

We would like to thank all those who responded to our questionnaire; Susan Shepherd for her encouragement and support; the RCP Medical Workforce Unit for technical advice and support; members of the RCP Trainees Committee, Academy of Medical Royal Colleges Trainees Group, the British Medical Association Junior Doctors Committee and Medical Students Committee; and members of the RCP Medical Professionalism Working Party for their valuable comments on the draft questionnaire.

Tables of questionnaire results

Table 3.1 Demographic details

Age	No response (%)	24 and under (%)	25–29 (%)	30–34 (%)	35–39 (%)	40 and above (%)
	1	17	30	34	15	4
Gender	No response (%)		Male (%)		Female (%)	
	3		49		47	
Grade	No response (%)	Medical student (%)	House officer (%)	Senior house officer (%)	Specialist registrar (%)	General practice registrar (%)
	2	20	3	22	50	2

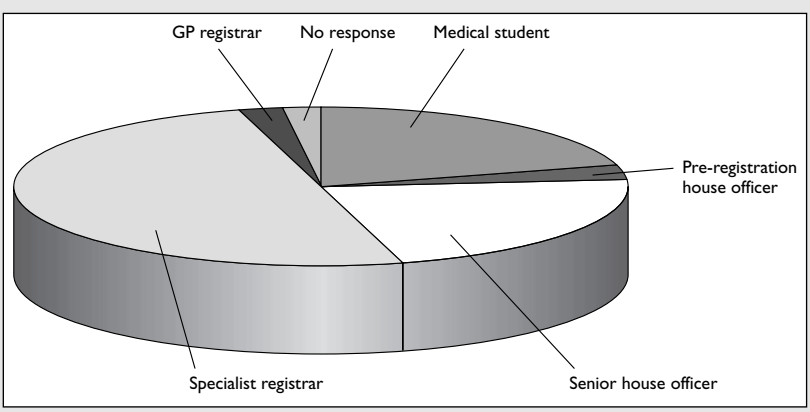

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Table 3.1 Demographic details – *continued*

Specialty	No response or not specified (%)	Paraclinical (%)	Medical (%)		Surgical (%)
	22	0 (0.5)	43		18
	General Practice	Anaesthetics	Psychiatry		Paediatrics
	3	5	4		4
Working pattern	No response	On-call rota	Full-shift rota		Partial-shift rota
	30%	27%	31%		13%
Domestic circumstances	No response	Single	Single with children	With partner	With partner and children
	1%	40%	1%	35%	23%

Table 3.2 Responses to questions

(a) What is medicine in the UK?

	Strongly agree or agree (%)	Neither agree nor disagree (%)	Strongly disagree or disagree (%)	No response (%)
Medicine is a profession	97	1	1	1
Medicine is a vocation	78	13	8	2
Medicine is an art	72	18	9	1
Medicine is a science	92	5	1	1
Medical practice requires altruism	69	23	6	3
Medical practice requires humility	84	11	4	1
Medicine is learnt through apprenticeship	92	5	1	2

Fig 1 Percentage respondents who strongly agreed or agreed with statements about medicine

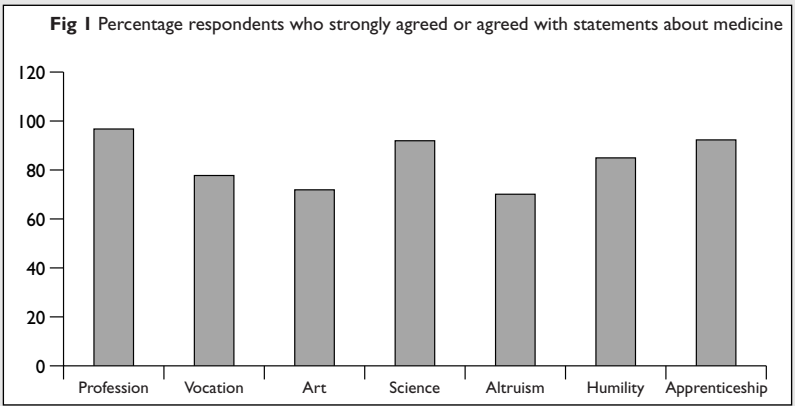

Table 3.2 Responses to questions – *continued*

(b) What defines medical professionalism?

	Strongly agree or agree (%)	Neither agree nor disagree (%)	Strongly disagree or disagree (%)	No response (%)
Clinicians' ethical standards	96	3	0 (0.5)	1
Clinicians' autonomy	80	13	6	1
Clinicians' ability to direct resource allocation	61	25	12	2
Clinicians' responsibilities to patients	98	1	0 (0.2)	1
Clinicians' responsibilities to colleagues	89	8	1	1
Clinicians' responsibilities to their employers	42	33	24	1
Clinicians' politeness	71	19	9	1
Standards of clinical care defined by the profession	94	4	1	1
Standards of clinical care defined outside the profession	35	29	35	2
Undergraduate medical education and training directed by the profession	85	10	3	1
Postgraduate medical education and training directed by the profession	90	6	2	2
Regulation of clinical standards by the profession	90	6	2	2
Regulation of clinical standards outside the profession	33	30	35	2

(c) Do you think any of the following have changed over the past five years?

	Definitely or probably increased (%)	No change (%)	Definitely or probably decreased (%)	No response (%)
Clinicians' ethical standards	51	39	7	3
Clinicians' autonomy	6	8	83	3
Clinicians' ability to direct resource allocation	10	12	75	4
Clinicians' responsibilities to patients	47	42	8	3
Clinicians' responsibilities to colleagues	35	51	11	3

continued over

Table 3.2 Responses to questions – *continued*

(c) Do you think any of the following have changed over the past five years? – *continued*

	Definitely or probably increased (%)	No change (%)	Definitely or probably decreased (%)	No response (%)
Clinicians' responsibilities to their employers	66	27	4	3
Clinicians' politeness	32	54	11	3
Standards of clinical care defined by the profession	65	20	12	3
Standards of clinical care defined outside the profession	75	15	7	4
Undergraduate medical education and training directed by the profession	39	25	32	4
Postgraduate medical education and training directed by the profession	44	27	25	4
Regulation of clinical standards by the profession	64	15	17	4
Regulation of clinical standards outside the profession	83	10	2	4

(d) What is the *purpose* of medical professionalism?

	Strongly agree or agree (%)	Neither agree nor disagree (%)	Strongly disagree or disagree (%)	No response (%)
To maintain or improve patients' care	97	1	0 (0.1)	2
To maintain or improve the quality of clinicians' working lives	56	25	16	2
To maintain or improve clinicians' morale	58	27	14	2
To maintain or improve medical education and training	89	7	2	2

Table 3.2 Responses to questions – *continued*

(e) What are the *effects* of medical professionalism?

	Strongly agree or agree (%)	Neither agree nor disagree (%)	Strongly disagree or disagree (%)	No response (%)
It maintains or improves patients' care	92	4	0 (0.4)	4
It maintains or improves the quality of clinicians' working lives	56	27	13	4
It maintains or improves clinicians' morale	61	25	10	4
It maintains or improves medical education and training	79	14	3	4

(f) Do you think an actual *decrease* in the degree of professionalism in medicine would affect the following?

	Definitely or probably increased (%)	No change (%)	Definitely or probably decreased (%)	No response (%)
Applications for medical school	4	32	61	3
Applications for hospital training posts	4	33	60	4
Applications for hospital consultant posts	4	30	62	4
Applications for general practice training posts	26	32	37	5
Applications for general practice salaried or partnership posts	29	32	33	6
Retirement age of clinicians	15	14	66	5
Number of medical practitioners seeking management roles within the NHS	46	29	19	6
Number of medical practitioners seeking non-medical posts outside the NHS	80	10	5	5

continued over

Table 3.2 Responses to questions – *continued*

(g) What are the main challenges to medical professionalism?

	Strongly agree or agree (%)	Neither agree nor disagree (%)	Strongly disagree or disagree (%)	No response (%)
There is none	1	7	82	10
Increases in the public's expectations of *access to* clinical care	82	7	7	5
Increases in the public's expectations of the *outcomes* of clinical care	83	6	6	5
Increases in party political expectations of *patients' access to* clinical care	86	6	3	5
Increases in party political expectations of the *outcomes* of clinical care	84	7	3	5
Increases in clinicians' expectations of quality of life *at work*	56	21	18	5
Increases in clinicians' expectations of quality of life *at home*	58	19	18	5
Increases in private sector provision of healthcare	39	32	23	5
Increases in protocol or guideline-driven patient care	71	12	11	6
Advances in medical technology and pharmacology	37	22	35	7
Limited financial resources	77	9	8	6
Changing roles of non-medically qualified practitioners	63	16	15	7
Changes in clinicians' working patterns	75	12	7	6
Changes in undergraduate medical education and training	59	23	12	7
Changes in postgraduate medical education and training	63	20	10	7

Selection of free-text comments submitted supplementary to the questionnaire responses

What is medicine in the UK?

- 'Medicine is a profession in which human error is an intrinsic part of the work – expectations that any mistake needs to result in compensation has changed my attitude. Altruism and vocation should not be applicable when faced with management and a public who are ever-ready to point out the duties, but then reluctant to reward good work.'
- 'Medical practice requires neither humility nor altruism. Good medical practice, however, requires both.'
- 'Medicine is being transformed by the present government into an army of target-driven conveyor-belt medical automatons with no autonomy or independent thought.'

If you do not believe medicine is a profession, please comment further

- 'Doctors are increasingly becoming glorified clerks and robots following protocols to satisfy centrally created Stalinist targets within the NHS. Furthermore, their professionalism is becoming increasingly undermined by nurse specialists assuming titles that lead patients to believe they are medically qualified, and carrying out activities appropriate to doctors, while junior doctors continue to have their time used inefficiently performing administrative and nursing roles, when their time could be better spent in training and more appropriate activities.'
- 'I clock-in in the morning, clock-off when I leave and get paid for hours worked. I have little real say anymore in the development of services, and little influence in the big decisions. Politicians tell me which patients will receive treatment through their current policies. Medicine is now a job, not a profession.'
- 'Medicine is a career. It is also a vocation but that doesn't mean that we should be expected to repeatedly work overtime without being paid for it, or that we should have to take abuse from patients. Just because we are caring, we should not be taken advantage of, and we should be nurtured and supported in our careers to enable us to do the same for our patients on a daily basis.'

- 'Medicine is a profession, but is currently evolving as an 'industry' in the UK. Patients are being referred as clients, and that dissolves the 'emotional bond' that has existed in the past. I fully agree that sweeping reforms were required in the way medicine was being practised, but the so-called reforms are now degenerating into 'management overdose'. I hope that the patient is not the loser at the end of the day.'

What would be affected as a result of a decrease in the degree of professionalism?

- 'Already, students in medical schools are discussing the impact of a target-led, deprofessionalised NHS career on their desire to practise medicine within the NHS, or at all. Coming at a time when the costs of training for the individual are increasing, pay and conditions are in a state of flux with new contract negotiations in virtually [all] sectors, and the impact of EWTD still to be determined, more students are looking at alternative applications for their medical degree. I fear that making medicine more of a 'job' and less of a 'profession' is likely to reduce recruitment and retention, as well as reducing the high standards we desire in our future medical practitioners.'
- 'I have recently left NHS clinical medicine because of these changes. I felt like I was being worked for a government that did not really have the patients' best interests at heart. I was treated like some kind of technician and not allowed to make decisions based on the clinical needs of my patients. I was severely undervalued. I now work in the pharma[ceutical] industry where I am appreciated and treated like a professional. I am trusted and have earned the respect of those that I work with. It is wonderful to feel appreciated for a change.'
- 'There will always be people who wish to do the job. Medicine will, however, fail to attract high quality candidates, and will turn out graduates of poorer quality, with poorer decision-making and analytical qualities.'

What are the main challenges to medical professionalism in the UK?

- 'As medicine becomes feminised, it is undermined by managers, government and the increasingly professionalised and masculinised allied professions. This is 'concretely' evident in our pay scales and I believe the weakness of our union and the strength of the other unions perpetuates this trend.'
- 'Doctors [are] being treated like factory workers, and being expected to perform like saints!'

- 'I think that the government and NHS managers treat junior medical staff with contempt.'
- 'The main challenge is the inability of politicians to realise the difference between political direction and political control. They should be content to say what they want done and allow the profession to work out how to do it. I don't tell a mechanic how to repair my car (although maybe I should??!). Unfortunately, because all political parties use health as a rod to hit each other with they are continually fiddling and distorting priorities. Why can't they take the same approach to health as they did to the Bank of England and relinquish some control?'
- 'The media-driven claim-and-blame culture, tacitly encouraged to a greater or lesser extent by politicians, adversely affects 'old-fashioned' standards of professionalism. If everything is to be reduced to targets, and financial and legal considerations, factors such as altruism, politeness and trust (which are the bases of medical professionalism) will be eroded by the thought 'how can I stay out of court, within budget and not upset the head pharmacist?'
- 'The Working Time Directive has improved quality of life for doctors but has cost us in terms of continuity of care. The effect of this is to foster an atmosphere where no one feels responsible for the patients' interests.'
- 'There seems to be this myth amongst some of my colleagues that working flexibly or fewer hours (so that your entire life is not sacrificed to your profession) means an end to medical professionalism. Yet my experience is that healthier working hours and conditions have helped me retain my enthusiasm for my work, my patient empathy, my commitment to providing the best care I can – all things that I struggled to maintain working 80 hours a week. I feel I am more professional when I am not burnt out!'

Do you have any other comments or thoughts on medical professionalism? Please describe any instances where you believe medical professionalism has positively or negatively affected patient care?

- 'I believe that being a professional underpins everything that I do both at work and socially. It is essential that it is maintained and strengthened. Media have an important role in this; however, it is the responsibility of every medical practitioner to promote professionalism throughout all aspects of their lives.'
- 'I believe that doctors are no longer respected as professionals by patients, managers or government. Increasing pressures on doctors to meet targets,

perform better with poor resources and avoid litigation have caused widespread disillusionment and discontent. Instead of improving standards in the healthcare profession, it has reduced them. If I were a 6th form student contemplating studying medicine now as compared to 15 years ago, then I would be choosing to follow another profession other than medicine.'

- 'I feel that our profession has been sold up the road by our superiors over the years for a few pieces of silver, for their own selfish interests. That has eventually placed us, both present and future doctors, in very difficult positions, undermined our morale, confidence and standing in society. We lack leadership and foresight in our present day peers/seniors.'
- 'I feel that professionalism is respecting your patients and striving to do your best for them. This will sometimes mean working beyond the hours on your rota. If the EWTD leads to us becoming 'clock watchers' who finish when our shift does, without adequate handover at shift change, then I feel both medical professionalism and ultimately patient care will suffer.'
- 'I haven't seen any instances where medical professionalism has negatively affected patient care. Only the opposite. However, I've seen [and] heard of plenty of instances where nurses rigidly sticking to protocols, and being backed up by managers who don't understand medicine, has led to ridiculous scenarios where patient care has been affected, excess money spent unnecessarily, and morale damaged, all in one go! I think doctors should have power to override managers when their decisions affect patient care for the worse.'
- 'I personally feel that the immaturity of younger graduates is detracting greatly from the profession. I also feel that the lack of dress code on hospital wards (with the loss in general of the white coat) has led to younger doctors dressing as if they are in attendance at a nightclub. I feel that this sort of behaviour is destroying professionalism. Finally, I feel that as the numbers of women with children in the profession increases, and the inability of the system to deal with their particular flexible needs continues, then they will have no choice but to put family in front of career. This change in demographics of the profession, I think, will have the greatest single impact.'
- 'In society as a whole we see declining ethical standards. For example, the importance of the truth, and lying to gain compensation. Medicine is no different. We cannot pretend that doctors don't want better lives, more money and to find more satisfaction from their careers. If we carry on pretending that, then doctors will continue to leave the profession and go where they get better pay, better respect and are more valued (as several of my medical friends have done already).'

- 'It is important that we continue to regulate and assess ourselves as a profession. The introduction of 360-degree appraisal at the SpR stage where we are forced to canvas the opinions of ancillary staff as to our probity and trustworthiness is frankly insulting (and is an exercise in futility as it would never identify another Shipman or similar).'
- 'Just an observation as a fourth year medical student. My degree has been concerned with many of the challenges to medical professionalism – indeed, the information covered in five years in order to prepare us scientifically for all the medical advances that are surely to be made, along with an exhaustive module on medico-legal and ethical affairs has taken up a significant proportion of this course. However, I am worried that in the process, fewer of us are appreciating that medicine is an art as well as a science and that if we were to go back to an apprenticeship style of learning, I would feel a lot more confident about clinical skills and how to talk to and understand my future patients.'
- 'Medical professionalism has always been of benefit in patient care – it is what keeps this hospital going. Losing the goodwill of the medics is now likely, and the consequences (in terms of working to contract, doing the bare minimum) will be considerable. I believe the RCP with the other Colleges and BMA must take a stand – healthcare is too important to be a politicians' football, and the changes in contracts and pensions have only been to our detriment. I do not believe a work-to-contract, or even a strike, would be unreasonable to achieve better terms and conditions of service, in order to deliver a better standard of care for our patients, out of the politicians' hands.'
- 'Medical professionalism is not optional. It is an essential part of being a doctor, no matter how many challenges face us.'
- 'Most instances of lack of professionalism that I have witnessed have involved the poor treatment of a junior doctor by someone more senior, either consultant or SpR. Bullying juniors is neither professional nor acceptable yet still persists, especially among male colleagues in surgical specialties. It is difficult to say whether the clocking-off culture engendered by the EWTD is resulting in less professionalism and willingness to go the extra mile, or whether it is failure of the system to cope with the very realistic expectation of junior doctors to get home on time.'
- 'My perception of professionalism has probably been eroded by what feels like ever-increasing expectations from patients and, more particularly, their families of what can be achieved for patients, and how quickly this can be achieved, whilst resources do not appear able to keep up with these expectations. This has

been fuelled to a fair extent by adverse media coverage of the medical profession and, on occasions, positive coverage of advances in medicine.'

- 'On a daily basis, medical professionalism is what saves people's lives and function. In our hospital, the dedication of the medical staff to their patients means they do not go blind, and they frequently give over and above what is expected of them or what they are paid for. Unlike non-medical staff who work by the hour or to protocol or to rules. The erosion of the profession is apparent in the waiting times for casualty where resources are diverted from sight-threatening diseases to treating patients who cannot be bothered to go to their GPs for trivial eye problems. Our regulatory bodies need to be more resolute and supportive of our clinicians when they make a stand.'
- 'Professionalism entails more than technical competence at specific tasks. We are in danger of extinguishing a legacy of skills in our pursuit of goal-directed activity. An effort to inculcate a sense of pride and duty to patients as part of our training is regarded as ridiculously old fashioned. Instead, we continue to reduce hours in line with shift workers, whilst complaining that our salaries are not commensurate with university colleagues who work in the law or other professions. It should perhaps be remembered that many lawyers are motivated by altruism and a desire to improve society: qualities that make good judges and law lords. Perhaps we need to relearn simple lessons from our bewigged and befrocked colleagues?'
- 'Shift working, EWTD and new consultant contract all lead to hour counting and diary filling – steps away from professional. Unfortunately for HMG, "professional" has been synonymous with "works for free", and now "works for free" is synonymous with "idiot".'
- 'The more that junior doctors are treated as factory workers who clock on and clock off, the more they will start to behave like factory workers, and altruism, goodwill, and ultimately professionalism will diminish.'
- 'The present lack of support and care by senior 'professionals' in medicine has driven me out – after two years out I am beginning to feel human again – those feelings of self-worth and self-esteem would be a lot to give up to return to work in medicine again although I do miss the patient interaction.'
- 'To me, professionalism is about your personal standards in how you work, and not about the influence of the medical profession, which has sometimes been more concerned with looking after itself rather than acting as a force for good.'
- 'Virtually all patients will thank you when they realise how hard one works for their benefit. The sooner the NHS is taken away from politicians only

keen on serving themselves for short-term gain the better. Control (if it must rest within Whitehall) has to be under a non-politically aligned steering group with five-, 10- and 20-year goals. The NHS is far too inelastic to change significantly over short periods of time – it merely creates waste and stresses out the staff too much. They are the most important resource and should be cared for better.'

- 'We are in a difficult transition, as traditional professionalism is overtaken by whatever the replacement is we are in danger of exposing our patients to the worst of both. To pretend the old days were without problems is no more realistic than pretending that all change is for the good.'
- 'We have lost the power to regulate ourselves according to what we believe is right. We have lost the power to educate ourselves in the way that we feel is right. We have lost the power to have working patterns that are best for patient care. We have lost the right to give the treatment we feel is best for our patients. Our opinion is not sought and our advice is ignored. We are a profession in name only, in that the politicians control our regulation, our training, our treatments, our working patterns, our terms of employment. Our sole purpose seems to be to carry the burden of responsibility when things go wrong, without any power to alter the factors that cause them. We have responsibility without authority. We have become answerable to people who have no knowledge or understanding of medicine either as an art or science. Our profession is truly in decline and I despair for the future.'
- 'Whilst public and government expectations of professionalism have increased, the benefits of such a status have decreased. Pay, conditions and respect all seem to be declining in comparison with our other 'professional equivalents'. The media and public are only too quick to magnify any situation in which they believe a doctor did not behave in a professional manner and neglect the millions of situations in which doctors do make sacrifices for their profession. I fully believe that we should maintain and even improve professional standards, but this should go hand-in-hand with the rewards if we are going to retain quality staff.'
- 'Professionalism and autonomy appear to be disappearing from medicine. I feel undermined and not valued at work and I have seen how this flagging morale among colleagues has caused more than ever to leave the profession. It is a hard job that takes dedication and stamina to continue, but as we are criticised and treated as 'cogs in a wheel' rather than as individual professionals I think we will see ever-increasing numbers of people leaving this profession.'

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4 Questionnaire responses: College Fellows and Members

In her bulletin of April 2005 the President invited College Fellows and Members to respond to the same trainees' questionnaire [see Section 3] electronically via the RCP's website. In addition, the President wrote to a small number of senior Fellows inviting them to complete the questionnaire in hard copy form. The results of this part of the consultation are presented in tabulated form.

Fellows and Members' online responses to questionnaire

- 238 forms received
- 67% male, 31% female (2% no answer)
- 62% aged between 40 and 59 years.

Table 4.1 Fellows and Members' responses

(a) What is medicine in the UK?

	Agree (%)
Medicine is a profession	97
Medicine is a vocation	78
Medicine is an art	76
Medicine is a science	93
Medical practice requires altruism	75
Medical practice requires humility	85
Medicine is learnt through apprenticeship	90

(b) What defines medical professionalism?

	Agree (%)
Clinicians' ethical standards	96
Clinicians' autonomy	74
Clinicians' ability to direct resource allocation	51
Clinicians' responsibilities to patients	96
Clinicians' responsibilities to colleagues	85
Clinicians' responsibilities to their employees their employers	40
Clinicians' politeness	68
Standards of clinical care defined by the profession	96
Standards of clinical care defined outside the profession	27
Undergraduate medical education and training directed by the profession	88
Postgraduate medical education and training directed by the profession	92
Regulation of clinical standards by the profession	92
Regulation of clinical standards outside the profession	26

Table 4.1 Fellows and Members' responses – *continued*

(c) Do you think any of the following have changed over the past five years?

	No change (%)	Increase (%)	Decrease (%)
Clinicians' ethical standards	43	40	13
Clinicians' autonomy	4	2	92
Clinicians' ability to direct resource allocation	10	4	81
Clinicians' responsibilities to patients	38	44	13
Clinicians' responsibilities to colleagues	50	30	13
Clinicians' responsibilities to their employers	18	75	3
Clinicians' politeness	55	29	11
Standards of clinical care defined by the profession	20	16	15
Standards of clinical care defined outside the profession	17	70	8
Undergraduate medical education and training directed by the profession	27	30	38
Postgraduate medical education and training directed by the profession	23	45	27
Regulation of clinical standards by the profession	16	50	30
Regulation of clinical standards outside the profession	9	82	4

(d) What is the *purpose* of medical professionalism?

	Agree (%)
To maintain or improve patients' care	95
To maintain or improve the quality of clinicians' working lives	38
To maintain or improve clinicians' morale	45
To maintain or improve medical education and training	88

continued over

Table 4.1 Fellows and Members' responses – *continued*

(e) What are the *effects* of medical professionalism?

	Agree (%)
It maintains or improves patients' care	95
It maintains or improves the quality of clinicians' working lives	60
It maintains or improves clinicians' morale	71
It maintains or improves medical education and training	86

(f) Do you think an actual *decrease* in the degree of professionalism in medicine would affect the following?

	No change (%)	Increase (%)	Decrease (%)
Applications for medical school	33	2	60
Applications for hospital training posts	32	3	60
Applications for hospital consultant posts	25	3	68
Applications for general practice training posts	37	12	45
Applications for general practice salaried or partnership posts	36	20	35
Retirement age of clinicians	9	9	75
Number of medical practitioners seeking management roles within the NHS	35	39	18
Number of medical practitioners seeking non-medical posts outside the NHS	12	76	4

Table 4.1 Fellows and Members' responses – *continued*

(g) What are the main challenges to medical professionalism?

	Agree (%)	Disagree (%)
There is none	1	88
Increases in the public's expectations of *access to* clinical care	75	10
Increases in the public's expectations of the *outcomes* of clinical care	75	11
Increases in party political expectations of *patients' access to* clinical care	90	2
Increases in party political expectations of the *outcomes* of clinical care	88	2
Increases in clinicians' expectations of quality of life *at work*	48	22
Increases in clinicians' expectations of quality of life *at home*	55	20
Increases in private sector provision of healthcare	31	25
Increases in protocol or guideline-driven patient care	59	19
Advances in medical technology and pharmacology	28	40
Limited financial resources	68	11
Changing roles of non-medically qualified practitioners	49	20
Changes in clinicians' working patterns	75	5
Changes in undergraduate medical education and training	51	16
Changes in postgraduate medical education and training	53	15

Senior Fellows' responses to questionnaire

- 49 forms received
- 92% male
- 77% aged 71 years and over.

Table 4.2 Senior Fellows' responses

(a) What is medicine in the UK?	
	Agree (%)
Medicine is a profession	98
Medicine is a vocation	88
Medicine is an art	75
Medicine is a science	90
Medical practice requires altruism	87
Medical practice requires humility	85
Medicine is learnt through apprenticeship	77
(b) What defines medical professionalism?	
	Agree (%)
Clinicians' ethical standards	96
Clinicians' autonomy	63
Clinicians' ability to direct resource allocation	67
Clinicians' responsibilities to patients	98
Clinicians' responsibilities to colleagues	85
Clinicians' responsibilities to their employees their employers	57
Clinicians' politeness	87
Standards of clinical care defined by the profession	92
Standards of clinical care defined outside the profession	26
Undergraduate medical education and training directed by the profession	92
Postgraduate medical education and training directed by the profession	94
Regulation of clinical standards by the profession	94
Regulation of clinical standards outside the profession	43

Table 4.2 Senior Fellows' responses – *continued*

(c) Do you think any of the following have changed over the past five years?

	No change (%)	Increase (%)	Decrease (%)
Clinicians' ethical standards	51	24	14
Clinicians' autonomy			81
Clinicians' ability to direct resource allocation			75
Clinicians' responsibilities to patients	53	22	14
Clinicians' responsibilities to colleagues	57	22	6
Clinicians' responsibilities to their employers	32	47	8
Clinicians' politeness	51	26	12
Standards of clinical care defined by the profession	26	47	16
Standards of clinical care defined outside the profession	32	44	12
Undergraduate medical education and training directed by the profession	30	24	32
Postgraduate medical education and training directed by the profession	22	38	26
Regulation of clinical standards by the profession	26	40	22
Regulation of clinical standards outside the profession	28	40	4

(d) What is the *purpose* of medical professionalism?

	Agree (%)
To maintain or improve patients' care	93
To maintain or improve the quality of clinicians' working lives	47
To maintain or improve clinicians' morale	60
To maintain or improve medical education and training	93

continued over

Table 4.2 Senior Fellows' responses – *continued*

(e) What are the *effects* of medical professionalism?

	Agree (%)
It maintains or improves patients' care	97
It maintains or improves the quality of clinicians' working lives	73
It maintains or improves clinicians' morale	82
It maintains or improves medical education and training	92

(f) Do you think an actual *decrease* in the degree of professionalism in medicine would affect the following?

	No change (%)	Increase (%)	Decrease (%)
Applications for medical school	18	6	71
Applications for hospital training posts	16	2	75
Applications for hospital consultant posts	20	2	71
Applications for general practice training posts	16	8	70
Applications for general practice salaried or partnership posts	20	8	63
Retirement age of clinicians	18	6	71
Number of medical practitioners seeking management roles within the NHS	26	38	26
Number of medical practitioners seeking non-medical posts outside the NHS	8	82	4

Table 4.2 Senior Fellows' responses – *continued*

(g) What are the main challenges to medical professionalism?

	Agree (%)	Disagree (%)
There is none		60
Increases in the public's expectations of *access to* clinical care	77	6
Increases in the public's expectations of the *outcomes* of clinical care	83	8
Increases in party political expectations of *patients' access to* clinical care	87	6
Increases in party political expectations of the *outcomes* of clinical care	83	4
Increases in clinicians' expectations of quality of life *at work*	55	12
Increases in clinicians' expectations of quality of life *at home*	71	10
Increases in private sector provision of healthcare	36	22
Increases in protocol or guideline-driven patient care	75	4
Advances in medical technology and pharmacology	42	40
Limited financial resources	67	14
Changing roles of non-medically qualified practitioners	53	20
Changes in clinicians' working patterns	81	6
Changes in undergraduate medical education and training	60	10
Changes in postgraduate medical education and training	65	8

5 International aspects of professionalism

Professor Sean Hilton, Vice-Principal, St George's, University of London; General Practitioner; and member of the Working Party on Medical Professionalism

The Working Party's remit was to consider redefinition and maintenance of medical professionalism in response to societal change. More traditional notions of the medical profession's dominance in healthcare systems have been challenged: by scarcity of resources despite increasing investment; by increasing accountability in the light of medical scandals; by managerialism; and, perhaps most importantly, by consumerism.

The challenges facing medical professionalism are global, but are most pronounced in developed countries with sophisticated healthcare systems. The majority of the international literature arises from North America, but the references include examples from around the world, including Europe, South Africa,[1] Singapore,[2,3] Australia,[4] New Zealand,[5] and Japan.[6]

Note: * Indicates an organisation or association for which a website is listed at the end of the section.

United States of America

During January 2005, the USA was visited on behalf of the Working Party and discussions were held with a number of key and influential colleagues [listed in the Acknowledgements on page 116]. The Working Party is grateful to all of them for their time, advice and insights that they provided for our project, particularly in considering the education and training implications.

In Dartmouth, Massachusetts, Dr Paul Batalden's unit at the Center for the Evaluation of Clinical Sciences* provides a striking example of how quality improvement and reductions in medical error are on the other side of the same coin as medical professionalism. Dr Batalden and Professor Sheila Ryan (in Omaha, Nebraska) are both prominent members of the Institute for Healthcare Improvement*. Initiatives there – including the Academic Chronic Care Collaborative (ACCC)* and Transforming Care at the Bedside* (TCAB) – offer potential models for the UK of quality improvement achieved by professionalism and teamwork in action.

In San Francisco, Dr Steven Miller, President of the American Board of Medical Studies (ABMS)*, presented Maintenance of Certification (MoC) as part of the process of 'rebuilding trust' between the US medical profession and the public. Maintenance of Certification is comparable to revalidation in the UK, and there is much that we can share with them.

In Chicago, a meeting was held with Professor David Leach, Chief Executive of the American Council for Graduate Medical Education (ACGME)*, and architect of the six competencies that now form the educational outcomes for residency training across the USA. These are of relevance to the outcomes likely to be assessed through Modernising Medical Careers.

At the American College of Surgeons (ACS) in Chicago, Dr Ajit Sachdeva, a surgeon on the ACS Professionalism Task Force*, described how strongly they had been influenced by the 1999 Institute of Medicine report, *To err is human*, which reported on 98,000 deaths per annum resulting from medical error. Postgraduate training for surgeons in the USA is now focused on patient safety, patient outcomes and the six ACGME competencies.[7,8]

Finally, a visit was made to Stritch Medical School at Loyola University, Chicago*, and Rochester Medical School in New York State,* which are exemplars of the incorporation of professional values and peer assessment into undergraduate curricula.

The message from the RCP's links with individuals and organisations in the USA is that professionalism offers much more than a fading discussion point for sociologists; it is the vehicle for delivering enhanced patient care and reduced medical error.

The widest ranging project relating to medical professionalism is the Physician's Charter – a joint European and North American initiative in internal medicine.[9] A section on the history and current status of the Physician's Charter is also included in this supplement.

The place of medical professionalism in society

In developing countries with limited healthcare resources there is less evidence of debate about the place of medical professionalism; in some developed countries such as Spain and Japan, there appears to be little evidence of change to the traditional autonomy of the doctor in relationships with patients. Nevertheless, there is substantial international literature documenting the changing nature of the relationships between doctors, patients, healthcare systems and the societies they serve. Consistent themes in the debates are:

- changing relationships with patients
- conflicts of interest for physicians
- equity of access in an era of rising demand and healthcare costs.

There has been enormous interest and activity regarding professionalism in the UK in the last twenty years. The literature is dominated by work from the USA, but there is also ample evidence of concerned activity in Canada and Australia. Much of it has been prompted by the perceived politicisation of healthcare; conflicts of interest regarding commercialism and its influence on medical practice; and anxieties arising from medical litigation, with the defensiveness and cynicism that this engenders in clinical practice. All of this threatens to compromise the fiduciary relationship between doctor and patient. Pellegrino argues for a strongly ethical dimension to 'profession' within professionalism.[10]

Swick published a highly influential paper arguing for a normative definition of medical professionalism based on observable physician behaviours.[11] These behaviours were adopted by the Academy of American Medical Colleges (AAMC) in its projects on incorporation of professionalism into medical student outcomes, accreditation and re-accreditation processes.[12]

Wynia *et al* from the American Medical Association argued for a definition of medical professionalism that is more focused on the societal responsibilities of physicians.[13] Their model of professionalism has three components:

- devotion
- profession
- negotiation.

Both Swick and Wynia *et al* make the point that erosion of definition of professionalism merely to equivalence with self-regulation, has been highly detrimental. Importantly, 'loss of moral base' (Wynia *et al*[13]) and (non-) 'adherence to high ethical and moral values' (Swick[11]) has occurred as a result. At the extremes, they cite examples of horrifying falls from professional standards that occurred amongst complicit physicians within regimes in South Africa (apartheid), Germany (Nazism) and USSR (communism). More generally, however, the vagueness and implicitness of the notion of professionalism can lead to an insidious decline in moral and ethical standards in dealing with complex decisions and conflicts of interest.

Richard Cruess and Sylvia Cruess from Magill University, Montreal, have written extensively about recent challenges to the profession of medicine.[14–19] They distinguish between the ancient role of physician as healer – dating back at least to Hippocratic times – and the more recent development of professionalism in medicine, mainly since the industrial revolution. They argue that physicians as a profession have held an implicit social contract with society, and that, in recent years, as professional self interest has been seen to predominate over altruism, society has sought to redefine and make more explicit the contract. The results, seen by physicians as loss of autonomy and respect, have led to widespread loss of morale, and a need for physicians to reassert their professionalism in a renewed social contract with society.

Kucsewski from Loyola University, Chicago, views professionalism in medicine as the embodiment of several issues: medical etiquette; interpersonal communication; medical ethics (both those relating to personal practice of the physician, and treatment decision making); cultural competence and sensitivity; and service to society. He defines medical professionalism as 'The norms of the relationships in which physicians engage in the care of patients', recognising the centrality (although not exclusivity) of the relationship between physician and patient, and also indicating that changing societal norms influence that relationship.[20]

Cruess *et al*, Swick and others emphasise the individual responsibilities placed on the physician, and espoused within their views of professionalism. Others, including Rothman,[21] Ginsberg,[22] Hoff[23] and Frankford,[24] give equal prominence to the setting, context or system of healthcare in which professionals work: 'institutionalising reflective practice/communities of practice'. Epstein[25] develops this theme, and uses the term 'mindfulness' as the logical development of reflective practice.

The American Board of Internal Medicine (ABIM)* is one of the largest constituent organisations of the ABMS and, in the mid 1990s, commissioned

Project Professionalism, which sought to define the components of medical professionalism.[26] It defined the core of professionalism as 'constituting those attitudes and behaviour that serve to maintain patient interest above physician self-interest'. Accordingly, professionalism, as ABIM has defined it, aspires to:

- altruism
- accountability
- excellence
- duty
- honour and integrity
- respect for others.

The project report added that although their focus had been on the patient, they recognised the unique importance of professionalism within the context of relationships between physicians and other health professionals, and between professional organisations.

The bibliography within this supplement contains references, publications and websites covering these themes.

Medical education and training

Undergraduate

Prominent themes occur in the literature concerning undergraduate medical education in North America and elsewhere:

- instilling professional values
- humanism and ethical practice
- encouraging the development of reflective judgment
- addressing the damaging effects of the hidden curriculum.

Aspects of professionalism may be taught in the classroom or in the medical school environment, but, essentially, professionalism can only be learnt by the individual. There is a good deal of evidence and opinion to suggest that professionalism in context is what will make a positive impact on patient care. Adverse effects of informal, hidden curriculum, unacceptable changes in working environment are all working against this. Solutions are to be found in small communities working in a context of mutual respect and a wish to improve patient care.

In 1998, Swick *et al* surveyed 125 US medical schools about the inclusion of professionalism issues in their curricula.[27] Ninety percent responded that they included some formal instruction related to professionalism, although only just

over half had explicit approaches to assessing it, and only around one third conducted staff development activities in this area. Commenting on this, Ludmerer argues for professionalism to be incorporated formally throughout stages of medical education,[28] a point also made with authority by Cruess and Cruess.[29]

At the University of Rochester, New York, Epstein and Hundert have described a process of continuous curriculum development, in which professionalism is fostered by integration of seven dimensions of professional competence with ongoing assessments.[30,31]

At Loyola, Chicago, curriculum reform involved a radical review of how best to foster professionalism. Three principles: integration, leadership and justice, underlie the reforms and have led to a range of developments.[32]

In earlier published work, the University of New Mexico has used seven basic professional traits and their observable non-cognitive behaviours in the evaluation of their students.[33]

Wear and Castellani have argued for a broadening of the undergraduate curriculum that 'better prepares graduates' to deal:

- scientifically – with the pathophysiology of illness
- astutely – with language and communication issues
- knowledgeably – with biases in decision making (their own, plus that of colleagues and patients)
- politically – with how services are organised and accessed
- ethically – with moral ambiguities in medicine
- empathically – with the experience of illness across differences in race, gender and class. [34]

Hemmer *et al* from Maryland evaluated three different methods of assessing professional behaviours of medical students in hospital and ambulatory care settings.[35] Deficiencies in professionalism requiring remediation were best uncovered by the individual evaluation.

Papadakis *et al* in California have highlighted a strong correlation between unsatisfactory behaviours on record at medical school and subsequent disciplinary actions by state medical boards. They also have reported on four years experience with a system of 'academic probation' for students receiving two or more adverse clerkship reports.[36–38]

Ginsburg *et al* conducted a meticulous literature review regarding assessment of professionalism.[22] They argue that describing physicians and students as 'unprofessional' is less helpful than identifying missing or unsatisfactory 'professional behaviours' that may be addressed individually. Assessment of professionalism should incorporate three components:

- consideration of the contexts/environments in which lapses occur
- conflicts that leads to such lapses
- reasons that students/residents make the choices they make to resolve conflicts.

Ginsburg *et al* report on further work to evaluate attempts by final year medical students to describe how they resolved personal conflicts stemming from lapses in professional behaviours by colleagues or teachers.[39]

In 1997, Gordon wrote about Sydney University's intentions to include personal and professional development as a key component of their new graduate entry curriculum for medicine.[40] Subsequently, she has published a positive evaluation of the assessment approach to PPD in the first year of the Sydney course. This is based on portfolio assessment and interviews,[41] and proposed a new framework for the facilitation of students' personal and professional development.[42]

Gordon's framework is based on the impact of several factors on the cognitive, affective and metacognitive processes in learning:

- education
- feedback
- rewards and incentives
- disincentives and penalties
- participation.

There is much interest in the use of portfolios as an assessment and/or developmental tool to foster professionalism. Driessen *et al* reported on use of portfolios in the early undergraduate years at Maastricht.[43] The rationale for their curriculum is that the combination of 'authentic learning' with theoretical instruction should better enable students to relate theory to practice. The express purpose of using portfolios in the early years of their course is to develop the students' reflective ability.

Albanese has commented on the decline and fall of humanism in medical education, reinforcing the point that, in general, medical students set out with a high degree of compassion for patients, and a concern to relate effectively to them.[44] However, the medical school and healthcare environments are largely responsible for decreasing humanism.[45]

Hafferty has written extensively on the 'hidden curriculum, and its (usually) negative effects on the development of professionalism in previously committed, idealistic students.[46–49] Loss of empathy and humanism on progressing through the medical course has been described elsewhere.[45]

The Arnold P Gold Foundation* is a public foundation in the USA, founded by neurologist Arnold Gold to create innovative medical education programmes

that foster humanism in medicine. Gold states, 'the house of medicine stands on two pillars – science and humanism.' Three schools offer the Foundation awards, and promote useful discussions centred around modes of assessing humanism.

Postgraduate

In many countries, the approach to postgraduate training has moved from specified time spent in specialist accredited training posts allied with specialist knowledge base, to a system of high-level competencies and educational outcomes. In the USA, the six competencies project of the ACGME has led the way. In 1997, the ACGME moved towards an educational outcomes approach to accreditation, preferred over summative assessments. Six outcomes have been described by the project, which are now accepted by all boards falling within the ABMS membership:

- patient care
- medical knowledge
- practice-based learning and improvement
- interpersonal and communication skills
- professionalism
- systems-based practice.

Measures for assessment of professionalism in residents need to be developed at three levels: individual, programme and institutional. Measures for individual assessment are encouraged to be longitudinal, and predominantly formative, requiring regular feedback from supervisors and mentors. Instruments preferred are 360^0 evaluation and portfolios.

Markakis *et al* from Rochester, New York, discuss the underlying philosophy of their primary care internal residency program in which the development of professionalism and humanism is an explicit educational goal.[50]

The Canadian Medical Education Directions for Specialists project (CANMeds) of the Royal College of Physicians and Surgeons of Canada delineates a competency framework for successful completion of specialist training and continuing accreditation. It specifies seven roles expected of the competent specialist:[51]

- medical expert/clinical decision-maker
- communicator
- collaborator
- manager

- health advocate
- scholar
- professional.

Within the professional role, they define specific objectives for professionalism.

In Europe, Denmark has adopted the educational competencies, defining the roles described by the CanMEDS project.

Continuing professional development

In the USA, recertification of specialists is being transformed through the MoC process – described as the mechanism for 'rebuilding of trust' between physicians and patients.[52] There are four components of MoC:

- professional standing (licensure)
- lifelong learning and self-assessment
- cognitive expertise (by examination)
- practice-based learning and improvement (practice performance assessment).

Lifelong learning comprises short-term goals (credit based on sustainable achievement, eg knowledge) and long-term goals (improved patient outcomes).

A Canadian example of professionalism within CPD is the Physician Achievement Review (PAR)* – an initiative from the Alberta College of Physicians and Surgeons.[53,54] It is designed to provide doctors with information about their medical practice through the eyes of those they work with and serve.

In Holland, van der Kamp *et al* have developed an instrument to assess professionalism in general practice CPD.[55]

Patient involvement

Patient and lay involvement is increasingly seen as an essential part of professional accountability. What are the appropriate areas for this focus? One seems to be patient safety, as a means to improving the patient experience. In certain states of the USA, the courts have agreed that data from open discussions about learning from medical error will be excluded from litigation for negligence. Loyola University, Chicago, has moved patient safety from risk management to quality improvement.

The American Academy on Physician and Patient (AAPP)* is a society with over 20 years of dedication to research, education, and professional standards in patient-doctor communication. Its goal is no less than to change the practice of medicine

by helping clinicians and patients, and learners and teachers, to relate more effectively. The AAPP had its roots in the Task Force on the Medical Interview, which was formed in 1978, and was officially organised in 1993 by the leadership of the task force. Their regular publication, *Medical encounter,* and their website act as vehicles to give prominence to the doctor-patient relationship aspects of professionalism.

The Picker Institute* is a not-for-profit entity dedicated solely to developing a patient-centred research approach to performance measurement. It was founded in 1987 and has been providing patient experience measurement services to the healthcare industry for more than ten years. The more recently established counterpart Picker Institute Europe* is prominent in the UK and Europe.

The Centre for Patient and Physician Advocacy (CPPA)* is based at Vanderbilt University, Nashville. The CPPA's mission is to promote patient and professional satisfaction with healthcare experiences, improve patient safety, and restrain escalating costs associated with patient dissatisfaction. The inter-related functions of research, teaching, and evaluation/intervention services can be viewed on the website.

Assessing professionalism

There is considerable interest in the assessment of professionalism across the medical education continuum. Authoritative reviews have been carried out by Arnold, Lynch and Veloski *et al.*[56–58]

The National Board of Medical Examiners (NBME)* has reviewed and published a list of 60 behaviours that form the basis of any assessment programme for professionalism.

The Physicians' Charter

The Physicians' Charter was developed by the Medical Professionalism Project – a joint initiative by the ABIM, the American College of Physicians (ACP) and the European Federation of Internal Medicine (EFIM). The Charter was published simultaneously by the *Lancet* and the *Annals of Internal Medicine* in 2002.[9,59] It has subsequently been translated into ten languages and endorsed by over 120 medical organisations, including the RCP.[60]

The Charter describes principles and responsibilities for medical professionals that are applicable internationally, despite the great variations in organisation and provision of healthcare around the world. The three fundamental principles of primacy of patient welfare, patient autonomy, and social justice are linked to ten professional responsibilities of all physicians. These are commitment to:

- professional competence
- honesty with patients
- patient confidentiality
- maintaining appropriate relationships with patients
- improving quality of care
- improving access to care
- just distribution of finite resources
- scientific knowledge
- maintaining trust by managing conflicts of interest
- professional responsibilities.

The EFIM Annual Congress in Paris 2005 included a joint ABIM/EFIM session on the progress with the Charter. The process of the RCP's Working Party to date was outlined at a round table discussion. There were two notable developments from the session:

- From the European perspective, there seems to be some pressure from internists for future revisions of the Charter to balance the responsibilities of physicians with statements about rights, eg patient responsibilities within partnerships, and responsibilities of healthcare systems to support physicians.
- Jordan Cohen from the AAMC presented a paper for discussion entitled 'Alliance between society and medicine: the public's interest in medical professionalism'. This arose from a meeting of the Project Professionalism group in Philadelphia in November, and takes forward the agenda of the Charter on a broader front. The following synopsis is taken from the discussion paper, and will be discussed further by the various membership groups:

  The alliance agenda comprises a set of duties and responsibilities for the public that parallels those for physicians laid out in the Physician Charter. The overarching principles from which these duties and responsibilities derive also parallel those articulated in the Charter.

  Fundamental principles:

- primacy of public welfare
- public accountability
- social justice.

These are accompanied by a set of conjoined public and professional responsibilities:

- to align the payment system with professional values and performance

- to foster improvement in the quality and safety of healthcare services
- to construct and maintain a medical liability system that fairly compensates individuals injured during the delivery of medical care
- to provide universal health insurance for a basic set of preventative and medical services
- to provide adequate support for the education and training of physicians
- to provide adequate support for medical and health sciences research
- to recognise and minimise opportunities for conflicts of interest
- to create and maintain an effective forum for ensuring accountability in fulfilling the duties and obligations called for by the social contract.

Conclusion

Society has much to gain from fostering adherence by its physicians to the principles and responsibilities of medical professionalism. In an era of increasingly complex and costly health services, no alternative can serve the public's interest as well as physicians' commitment to professionalism. No laws, no regulations, no patient bill of rights, no watchdog government agency, no fine print in an insurance contract can substitute for a caring physician dedicated to the welfare of patients.

It is noteworthy that a Charter with three years of maturity can simultaneously argue for balancing rights and responsibilities on both sides of the partnership, and be issuing such a clarion call for medical professionalism.

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Dr Ajit Sachdeva, Professionalism Task Force, American College of Surgeons

Professor Henry Slotnick, Emeritus Professor Medical Education, University of North Dakota

Websites of organisations featured in this section

(Indicated with a * in the text)

Academic Chronic Care Collaborative (ACCC)
www.aamc.org/patientcare/iicc/initiatives.htm
Accreditation Council for Graduate Medical Education (ACGME)
www.acgme.org/Outcome/
American Academy on Physician and Patient (AAPP)
www.physicianpatient.org
American Board of Internal Medicine (ABIM)
www.abim.org/
American Board of Medical Studies (ABMS)
www.abms.org
American College of Surgeons (ACS) Professionalism Task Force
www.facs.org/education/tfprofessionalism.html
Arnold P Gold Foundation
www.humanism-in-medicine.org
Centre for Evaluative Clinical Sciences (Dr Paul Batalden)
www.dartmouth.edu/~cecs/hcild/hcild.html
Centre for Patient and Physician Advocacy (CPPA)
www.mc.vanderbilt.edu/root/vumc.php?site=CPPA&doc=2022
Institute for Healthcare Improvement
www.ihi.org
National Board of Examiners (NBE)
www.nbme.org
www.nbme.org/PDF/NBME_AAMC_ProfessReport.pdf
Physician Achievement Review, Alberta
www.par-program.org
Picker Institute
www.pickerinstitute.org
Picker Institute Europe
www.pickereurope.org
Stritch School of Medicine, Loyola University Chicago
www.meddean.luc.edu
Transforming Care at the Bedside (TCAB)
www.ihi.org/IHI/Topics/MedicalSurgicalCare/TransformingCare
University of Rochester School of Medicine
www.urmc.rochester.edu/smd/education/medical/index.cfm

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6 Focus groups

The Working Party commissioned a series of focus groups consisting of nurses, professionals allied to medicine and some health service managers, and patients, carers and the public. The purpose of this was to obtain a perspective of professionalism from those who work closely with doctors as colleagues and from those who are the recipients of medical care and services.

The Working Party commissioned two sets of researchers. Root Research UK consulted with primary and secondary care nurses and with occupational therapists, speech and language therapists, and physiotherapists. Professor Janet Grant and staff from the Open University Centre for Medical Education consulted with patients, carers, the public and health service managers.

Although the views of focus group respondents do not necessarily reflect those of the Working Party, all the material gathered during this phase of the consultation was carefully considered when drawing up the final report.

Summary of findings from the focus groups

Root Research UK (Root)

Nurses and therapists were asked to build profiles of 'good' and 'bad' doctors. The characteristics provided the framework for Root's further exploration of the topic and description of the key qualities required of a professional person. These are as follows:

- the ability to communicate well with patients, carers and healthcare professionals
- respect for other professionals – regarded as integral to delivering improved care for patients
- the ability to work collaboratively and share knowledge
- the ability to take responsibility and to be accountable for decisions taken – to demonstrate the characteristics of leadership
- confidence in decision making; to challenge and accept challenge from others
- to be competent and knowledgeable in one's field of expertise, combined with an ability to be aware of one's limitations.

A strong multidisciplinary team environment where support is provided and views are respected was considered highly important and something which all healthcare professionals should be working towards. Communication throughout the entire team is essential to maintain good working relationships and to gain the best from individuals. This ties in strongly with the need to work collaboratively, including decision-making. Understanding of, and respect for, the role that each healthcare professional plays within the team is essential if a collaborative approach is to be established – one that benefits from all relevant knowledge and experience, working effectively and professionally.

Effective leadership is crucial. A good leader is someone who takes ultimate responsibility and accountability for shared decisions and is able to manage a team appropriately. Respondents believed that a team that is headed by a competent leader works together more effectively because the team will share experiences and knowledge and hence will deliver a better standard of care. Good leaders are consultants that combine technical ability and experience with strong people skills, such as approachability and ability to listen, and who respect others.

Being confident in one's own ability to make appropriate and correct decisions was considered an essential component of being professional. Awareness that others may have different views, and listening to and respecting these views, is also important. A professional should be open to challenge from others in their teams. Nurses and therapists who participated in the focus groups felt that an

essential part of being professional is having the confidence to challenge decisions made by other team members, especially (medical) consultants.

A professional needs to be competent and knowledgeable in their field of experience. In combination with this, it is essential they possess integrity and honesty and are aware of their limitations, realising when they may need to call upon others to help. Nurse respondents especially felt over-regulated in comparison to doctors, and over-penalised for errors that may not be their fault. They believe that all professionals should be accountable for their actions. Nurses and therapists believed that professionals should be monitored and their performance rewarded where appropriate, as praising good work encourages professionalism.

The goal of any professional should be to provide the best patient care possible. However, because of cost containment respondents felt that there is a move towards employing people without the necessary skills or pushing greater responsibility onto others without providing adequate training (this point was put forward mainly by nurse respondents). The concern of respondents was that professionalism will become compromised as budgets are tightened, with a consequential detrimental effect on patient care.

It was hoped that, in the future, all professionals in the health service will work towards the same goal: improved patient care, both physical and emotional. By working more closely together in multidisciplinary teams, communicating effectively, understanding and appreciating each other's roles and learning from other's knowledge and expertise, this goal will be achieved. By striving to increase competency levels through continually improving technical skills, medical knowledge and people skills, medical professionalism can be improved throughout the whole of the healthcare environment.

The Open University

The Open University's report for the Working Party presents the findings of nominal group work conducted with 11 focus groups, a questionnaire survey, a comparison of required professional characteristics of hospital doctors and GPs, and a literature review. The aim of this part of the Working Party's consultation process was to identify the range of characteristics (behaviours, values, knowledge, skills and attributes) that make a doctor valued by patients, carers and the public.

All parts of their study, for all groups in the sample, showed the same set of characteristics required of a doctor to demonstrate professionalism. These fell into five themes or categories:

- Technical skills and knowledge (the most important)
- Communication skills

- Advice-giving
- Presentation of self and personal qualities
- Approach to the patient.

Nominal group process results

The nominal group process revealed a large degree of agreement between different groups of people. All are agreed that doctors primarily must have good technical skills and up-to-date knowledge. For most, doctors must be good communicators, active listeners, able to explain matters at the right level for the patient, and to check, understand and allay fears. They must have the time to do so and speak comprehensible English. The correct diagnosis, honest, objective advice and a management plan are important.

Personal qualities are valued as part of the professional role: polite behaviour, smart appearance, confidence, honesty, organisation and high standards seem to describe a doctor who behaves in a professional manner. And that behaviour should indicate an approach to the patient that shows knowledge of that person and his or her history, respect, empathy, confidentiality and a concern for the patient's welfare based on his or her social context and needs.

Questionnaire study

The picture emerging from this part of the study generally matched and enhanced the picture emerging from the nominal group process. The questionnaire study showed that all groups are in agreement that:

- doctors are there to serve society but are held in high regard
- doctors' status is declining
- doctors, overall, are trusted and respected
- interpersonal skills and communication are very important
- regulation is not of major concern but the majority feel that doctors should have their competency and performance checked and should keep up to date.

There are some differences in what the groups wanted of their GP and of hospital doctors, with the latter being expected to be more technically able. Both groups were expected to have good communication and interpersonal skills.

7 Opinion surveys

Professor Janet Grant and staff from the Open University Centre for Medical Education reviewed the findings of seven national polls designed to test people's views about their healthcare and treatment by doctors.

Reports of people's views about their healthcare and treatment by doctors fall into three main groups:

- The annual opinion polls of the general public and patient satisfaction studies carried out by MORI.
- A series of surveys by the Department of Health that form the National NHS Patients' Survey Programme.
- A number of surveys undertaken by the Commission for Healthcare Improvement (CHI), later the Healthcare Commission.

An overview of the findings of these last two groups was recently published by the Picker Institute Europe,[1] drawing together data from 15 separate reports between 1998 and 2005 and including the views of over 918,000 consumers of healthcare provided by the NHS in England. A selection of these reports is referred to in this review of surveys.

While percentages give a picture of a survey group's views overall, MORI (2004)[2] strikes a note of caution that 'performance' as measured by people's perceptions is quite strongly linked to the characteristics of the local population. Ethnic diversity has been shown to be a key driver in their patient satisfaction surveys, as is age, with older people tending to be more satisfied with health services than those who are younger. There are also variations in the experience of patients with different diagnoses.

Findings from the opinion surveys

Data on what people expect from their doctor can be divided into the three broad headings of knowledge and skills, personal qualities, and accessibility.

Knowledge and skills

Survey data of people's opinions of doctors' knowledge has focused on two areas: the doctor's knowledge of their patient's presenting condition and their knowledge of the patient's medical history.

Knowledge of the patient's condition

In the CHI 2003 survey of local patient services,[3] most respondents (85%) felt that the person they saw (who in 86% of cases was a GP) knew enough about their condition or treatment. A further 12% said the healthcare professional knew something, but not enough, and 3% thought they knew little or nothing about their condition or treatment.

Of those completing the young patient survey,[4] 60% said that all or most of the doctors who treated them knew enough about their condition, while 26% said most of the doctors knew enough, 11% that only some knew enough, and 3% that none of the doctors knew enough.

Awareness of the patient's medical history

Patients expect doctors to be aware of their medical history in order to see the 'full picture' and thereby give the patient confidence that they will take the right course of action.

While most of those (82%) in the 2003 CHI outpatient survey,[5] for example, felt that the doctor they saw was aware of their medical history, 13% said the doctor knew something, but not enough, and 5% believed that they knew little or nothing about their history.

Ability to provide effective treatment

The majority of surveys have also asked participants to say how far they trusted those responsible to provide them with effective care. Of those who took part in the 1999/2000 Cancer National Overview,[6] 86% said they had confidence and trust in all doctors responsible for their treatment.

More recently, in 2004, 76% of primary care patients said they definitely had confidence and trust in their GP, while 80% of inpatients[7] and 81% of outpatients

had confidence and trust in the hospital doctors they saw. However, only 59% of mental health patients said they definitely had trust and confidence in their psychiatrist.[1]

The Picker report also concluded that while most patients trust their doctors, a significant minority feel that doctors could do more to ease their pain. The 2004 surveys, for example, report that 15% of cancer patients, 27% of inpatients, 44% of those in A&E, and 31% of younger patients felt that staff could have done more to help.

Involving the patient in decision-making

Most people nowadays expect to be treated as partners in their care and participate in clinical decision-making. When patients expect to be involved more than a doctor allows for, this can cause dissatisfaction in their overall view of their care. Evidence from the various surveys suggests that this is an area where there is room for improvement, with many patients not involved as much as they would like to be in decisions about their care and treatment.

In the 2004 inpatient survey, for example, nearly half of those who took part reported that they would have liked to be more involved in decisions about their care and treatment, while in the outpatient survey the figure was 30%. In the young patient survey, just under a third of the parents said they were not involved as much as they wanted to be in decisions about their child's care and treatment, while 47% of the young patients themselves said they would have liked to have been more involved in the decision-making.

Other communication skills

The majority of surveys have looked at other issues of communication such as listening to the patient and communicating information in a way that can be understood.

In the CHI 2003 survey of local patient services:

- 84% of patients said that the healthcare professional they saw (who in 86% of cases was a GP) had definitely listened to them; 15% that they had only listened to some extent; and 1% that they had not listened to what they had to say. The respective figures for the outpatients survey were 79%, 19%, and 2%.
- Of those who needed an explanation of the reasons for any treatment or action, 76% said that they could understand this completely; 20% said they could understand it to some extent; and 3% that they could not understand

the explanation at all. Similar percentages were found in the outpatient survey with 76%, 22% and 3% respectively.

- Of those who had questions to ask, 79% said they definitely got answers they could understand; 19% got answers they could understand to some extent; while 2% could not understand the answers they were given, and 1% said they did not have an opportunity to ask any questions. The figures from the outpatient survey were lower at 69%, 26%, 3% and 2%. Data from the inpatient survey reported that 65% got an answer that they could understand from a doctor 'always', and 29% 'sometimes'.
- The purpose of tests had been explained in a way that could be understood fully by 82% of patients; to some extent by 15%; and not in a way that could be understood by 3%. For outpatients, the figures were lower, with 72% understanding the purpose fully; 18% to some extent; and 9% not at all.

The majority of respondents in the inpatient survey felt they were given the right amount of information, although 20% thought they had been given too little, and 1% too much.

Language difficulties were also mentioned in the outpatient survey, where 2% of respondents reported that they needed help with understanding English, of whom just over a quarter (27%) did not receive any. As only a small proportion of the respondents to this survey came from minority ethnic groups, language difficulties could well be a much larger problem in the patient population as a whole.

The patient satisfaction study carried out by MORI in winter 2003[8] reported that 77% of respondents were satisfied with explanations given by staff about their illness and treatment and 75% with how well informed they felt about decisions made about their treatment.

When asked to select the two aspects they felt were most important, three issues were key: quality of care was the most important (48%), explanation by staff was second (29%), and information about decisions affecting treatment (22%) was third.

Personal qualities

While knowledge and skills are important, there is evidence that these are not enough on their own, and that personal qualities contribute to a doctor's professionalism in the eyes of their patients. As Vetter says, 'In addition to competence in their field, medical professionals need to retain those humanistic qualities; integrity, respect and compassion, that constitute the essence of professionalism.'[9]

Trustworthiness and honesty

Doctors have consistently topped the list of the most trusted professions in the last 22 years of MORI's annual poll conducted for the BMA, above other professionals such as teachers, judges, clergymen and police officers.

The percentage of the public who trust doctors to tell them the truth rose from 82% in 1983 to 91% in 1999 and has remained between 89% and 92% since then despite the potential of high profile cases to damage people's trust in the profession as a whole.

However, while the majority think that doctors tell the truth, a proportion of the public also believes doctors to be guilty of withholding information at times. In the outpatient survey, 9% thought that the doctor was deliberately not telling them certain things they wanted to know, either 'definitely' (2%) or 'to some extent' (7%).

Treating patients with respect and dignity

The MORI studies show that, in ratings of overall satisfaction with inpatient care, being treated with respect and dignity was the aspect that mattered most to those surveyed.

In the CHI 2003 survey of local patient services, most patients (93%) felt that the person they saw (in 86% of cases a GP) had treated them with respect and dignity all of the time; 6% felt they were treated with dignity and respect some of the time; and 1% felt they had not been treated with respect and dignity at all. The figures in the outpatient survey were 87%, 12% and 1% for this aspect of care; for the inpatient survey they were 79%, 18% and 3%, suggesting room for improvement particularly in hospital care. This is backed up by the view of 31% of inpatients that they were not always given enough privacy when discussing their condition or treatment.

In the 2004 inpatient survey, 6% of respondents said doctors 'often' talked in front of them as if they were not there; a further 22% said they 'sometimes' did so; the figures from the outpatient survey of 2003 were 3% and 9% respectively. A similar proportion (5%) of those in the young patient study reported that doctors 'often' talked in front of them as if they were not there, with a further 18% saying this happened 'sometimes'.

Accessibility

Rosen and Dewar's work for the King's Fund led them to conclude that, 'There is an increasing expectation among the public for timely and convenient access to an ever-wider range of services, provided with greater openness and accountability.' [10]

Getting to see the doctor

Data from the MORI polls of 2003 on the percentage of respondents who were satisfied with access to hospital services highlights several areas where patients felt improvements were needed (Table 1).

Table 1 Percentage of patients who were satisfied with access to hospital services

	Winter 2002 (%)	Spring 2003 (%)	Winter 2003 (%)
Amount of time waiting for an appointment/treatment	46	57	57
Amount of choice given about hospital treatment received	51	61	53
Amount of choice about when/where treated in hospital	36	52	52

Source: MORI

Satisfaction with access to GP services was higher, but still an area of concern to many (Table 2).

Table 2 Percentage of patients satisfied with access to GP services

	Spring 2003 (%)	Winter 2003 (%)
Length of time to get a GP appointment	62	72
Amount of choice for date and time of GP appointment	53	64

Source: MORI

Consultation time

Consultation time is another factor that may be outside the individual doctor's control, but which may affect the patient's view of their care overall, particularly if they are not able to discuss as much as they would like with the doctor in the time available.

While 78% of those who took part in the winter 2003 MORI survey said they were satisfied with the length of time staff spent with them and 74% of the outpatients surveyed by CHI in the same year felt they definitely had enough time to discuss their health or medical problem with the doctor, this left 22% and 26% respectively who would have liked more time with a doctor.

The Picker report summarises the findings of the 15 national surveys as follows:

> *Hospital waiting times are getting shorter, but access times have not improved in primary care since 2003. Patients are less satisfied with consultation length in*

general practice than they were in earlier surveys, but Accident and Emergency patients reported some improvement in the length of time with the doctor. While most patients said they had sufficient time to explain their symptoms or monitor their treatment, a significant minority would have liked more.[1]

Conclusion

The findings of recent opinion surveys show the majority of patients to be broadly satisfied with the quality of care they received from doctors, and to have confidence in their ability to provide effective care. However, studies have also highlighted areas where there is room for improvement, such as the explanations given by doctors on the patient's condition and involving patients in their own care. Knowledge and skills are not enough on their own and there is evidence that people's satisfaction with their doctor reflects their expectations of the doctor's personal qualities and behaviour to a large extent. Despite the high profile given to individual 'bad' doctors, patients continue to trust doctors to tell them the truth – more so than any other professionals. Access to, and consultation time with, doctors are areas that still cause dissatisfaction to patients, with a significant minority wanting more time to discuss their symptoms or treatment with their doctor.

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Appendix 1 Reading list

As background reading, Working Party members were provided with a core bundle of documents related to medical professionalism. These are set out below, listed in alphabetical order.

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Appendix 2 Individuals and organisations responding to the Working Party's four questions

Association for the Study of Medical Education
Association of Anaesthetists of Great Britain and Ireland
Association of Clinical Pathologists
Association of Forensic Physicians
Association of Surgeons of Great Britain and Ireland

Stuart Blackwell
David Bourne
British Association of Emergency Medicine
British Association of Medical Managers
British Association of Oral and Maxillofacial Surgeons
British Association of Perinatal Medicine
British Geriatrics Society
British Homoeopathic Association and Faculty of Homeopathy
British Hypertension Society
British Institute of Learning Disabilities
British Medical Association
British Orthodontic Society
British Orthopaedic Association
British Thoracic Society
British Thyroid Foundation

College of Optometrists
College of Pharmacy Practice
Critical Care Committee of the Royal College of Physicians, London
Maurice Conlon

Dr Jim Appleyard
Dr Andrew Bamji
Dr C B Brown
Dr Susan Burge
Dr Timothy Chambers
Dr Robert Delamont
Dr Finlayson
Dr Duncan Forsyth
Dr Jean Lawrie
Dr Bernard Norton
Dr L J Patterson
Dr John M S Pearce
Dr Sarah Pearce
Dr Sheila Peskett
Dr Dermot Power
Dr Lesley Rees
Dr Peter Skew
Dr S Bertel Squire
Dr Peter Stride
Dr Gail Thomson

English Community Care Association
Eyecare UK

Faculty of Accident and Emergency Medicine
Faculty of Pharmaceutical Medicine, Royal College of Physicians
Forum for Associate Specialists and Staff Grades in Emergency Medicine

Rod Hughes

Guild of Catholic Doctors

Institute of Chiropodists and Podiatrists

Joint Specialty Committee for Rheumatology, Royal College of Physicians, London
Joint Specialty Committee for Gastroenterology and Hepatology, Royal College of Physicians, London

Keele University

Macmillan Cancer Relief
Medical Women's Federation
Mencap
Mr I M Caldwell
Mr John Marriott
Mr M C T Morrison
Mr Jim Platts
Medical Research Council
Medicines and Healthcare Products Regulatory Agency
Members of the Patient and Carer Network of the Royal College of Physicians, London

National Association of Clinical Tutors
National Counselling Service for Sick Doctors
National Institute for Clinical Excellence
NHS University
Nursing and Midwifery Council

Open University

Geoff Packe
Picker Institute Europe
Professor P D Howdle
Professor Gillian Mann
Professor Martin Marshall
Professor Chris McManus
Professor John Saunders
Professor C D Ward
Professor Sir David Weatherall
Professor Roger Williams
Professor C B S Wood

Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Nursing
Royal College of Nursing, Rheumatology Forum
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians of Edinburgh
Royal College of Physicians and Surgeons of Glasgow
Royal College of Radiologists
Royal Society of Medicine
Royal Society of Tropical Medicine and Hygiene

Society of Apothecaries of London
Society of Clinical Psychiatrists Suspended Doctors' Group
Specialist Advisory Committee in Cardiology, Royal College of Physicians, London
Standing Committee of General Practitioners, Royal College of Physicians

The Chartered Society of Physiotherapy
The Institute of Sports Medicine
The Medical Protection Society
The Medical Defence Union
The Nuffield Trust
The Royal Society

University of Central Lancashire
University of Luton

Whitelaw Frater
Martin Wilkinson
Peter Williams

The following contributed to the consultation process by attending a small group discussion on the topic of medical professionalism.

British Medical Association
NHS Confederation
Picker Institute Europe
Royal College of Nursing
Royal College of Surgeons of England
The King's Fund