

# Doctors in society: medical professionalism in a changing world

Valerie Wass

*We mean business. This report is not about 'motherhood and apple pie'. It must be acted on to ensure medical professionalism flourishes to the benefit of both doctors and patients.*

(Dr Richard Horton)

## Background

The decision made by the Royal College of Physicians to form a working party to define the 'nature and role of medical professionalism in modern society' was undoubtedly bold. Its report, *Doctors in society: professionalism in a changing world*,<sup>1</sup> and evidence from which the conclusions were drawn<sup>2</sup> are now published. The overwhelming opinion of the working party was that the recommendations must be viewed as the springboard for further work, not as an end in themselves. The issues identified are significant and must be further developed and shared with other health professions.

The report was aimed primarily at doctors but it was anticipated that patients, policy makers, other health professionals and the media would all engage with the findings and contribute their views. A wide range of health professionals and stake holders in the NHS were invited to the conference.

The quotations below that have no accompanying reference number are taken from speakers at the conference.

## Medical professionalism: values and behaviours

*Deference is dead. In the modern world, patients want a more equal relationship with their doctor. The Internet supplies a wealth of information, not always accurate; science provides new technologies, sometimes potentially dangerous; management monitors and expects results in productivity, on occasions engendering unavoidable conflict.*

(Baroness Julia Cumberlege)

Every patient is entitled to a good doctor, and medical professionalism lies at the heart of this compact. Yet tensions undoubtedly exist between the doctors and societal needs. Although it can be argued professionalism is still alive and reasonably well, it is at a critical juncture. The profession is adapting to advances in scientific technology, changing con-

sumer expectations and increasing demands on resources. Patients bring information which professionals must now appraise against their own professional knowledge. Doctors face uncertainty yet patients want certainty. Treatment was once relatively cheap, ineffective and safe; it can now be expensive, effective but also potentially dangerous.

The College, led by Professor Dame Carol Black, acknowledged that doctors needed support in order to value and develop their professionalism. The medical profession is in jeopardy and faced with spreading demoralisation through neglect and a lack of coherent vision. Complacency should be challenged. There is a need to review medical education

## Valerie Wass

BSc MRCP MRCP, Professor of Community Based Medical Education, Division of Primary Care, University of Manchester

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## Conference programme

### ■ Medical professionalism: values and behaviours

Richard Horton, Editor-in-Chief, *The Lancet*

### ■ Leadership

Professor Dame Carol Black, President, Royal College of Physicians

### ■ Teams

Professor David Scott, Consultant Rheumatologist, Norfolk and Norwich University Hospital

### ■ Education

Professor Trudie Roberts, Professor of Medical Education, University of Leeds

### ■ Careers and appraisal

Dr Ahmed Elsharkawy, Wellcome Trust Clinical Research Fellow, University of Southampton

### ■ Research

Professor Valerie Wass, Professor of Community Based Medical Education, University of Manchester

### ■ Employers, managers and multi-professional teams

Mr Bob Nicholls, NHS Appointments Commissioner, and ex-lay member of the General Medical Council

### ■ Patients, public and the media

Ms Claire Walmsley, Executive Coach and Mentor, Patient and Carers Involvement Steering Group, Royal College of Physicians

### ■ The medical profession

Professor Sean Hilton, Vice-Principal, St George's, University of London; General Practitioner

### ■ Summing up and close

Mr Niall Dickson, Chief Executive, The King's Fund

and develop a motivated committed workforce with values and behaviours appropriate to the changing societal needs.

### The basket of qualities

*Medical practice requires neither humility nor altruism. Good medical practice, however, requires both.* (Junior Hospital Doctor)<sup>2</sup>

*Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.* (Working party definition)

Dame Janet Smith inspired the working party to view professionalism as ‘a basket’ of values and behaviours which enabled the public to trust their doctors. All the collated evidence confirmed that patients valued medical professionalism. The challenge was to overcome any current culture of suspicion to ensure that this trust was not undermined. There was much debate about which values should stay in the basket, which ones failed to stand up to twenty-first century expectations, and what new ones should be added (Fig 1). The original values in the basket were taken from an adapted version of the Oxford English Dictionary definition of professionalism. Mastery, autonomy, privilege and self regulation were discarded. Judgement replaced art, and moral contract was substituted for morality and social contract. Excellence was added, in unanimous acknowledgement that professionalism was much more than competence alone. Altruism was the one value where there was significant disagreement within the consultations but it remained in the basket.

### The six themes

The working party made recommendations under six headings and identified key organisations across all stages of professional medical development to address these issues.<sup>1</sup>

#### Leadership

*The fragmented professional structure of practice hampers efforts to engage constructively with the public and politicians, and even stifles communication among doctors themselves. While there are many*

*leaders within medicine, there is little leadership of medicine as a whole.* (Professor Dame Carol Black)

Leadership in medicine implies multiple commitments to the patient, fellow professionals, the institution or system within which healthcare is provided, and at a national level. A doctor’s corporate responsibility, shared with managers and others, is a frequently neglected aspect of modern practice. Medicine needs stronger leadership to have greater impact on the development of healthcare policy and clinical practice. At the same time, individual leadership skills and the doctor’s commitment to patients and peers must be fostered. Leadership skills need to be rooted in training at medical school.

#### Teams

*The most notorious professional failures we have seen over recent years have been as much about systems as individuals.* (Sir Nigel Crisp)<sup>2</sup>

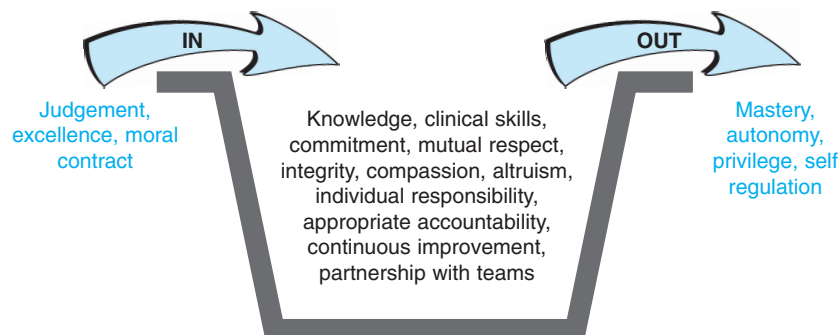
It has been recognised for a long time that healthcare is best delivered by multi-professional teams yet significant tensions exist within many inter-professional aspects of healthcare. Some see health partnerships and the leadership it should create as the necessary driver of change and improvement. However, the doctor’s role, as other health professionals take on more of their work, is becoming less well understood, and the impact of European Working Directives has led to increasingly unstable teams. The Working Party recommends more postgraduate support and training to maximise doctors’ contributions to teams and a stronger evidence base to optimise delivery of inter-professional learning.

#### Education

*The RCP report calls for root and branch reform of the way professionalism is nurtured and sustained from medical school to the workplace.* (Dr Richard Horton)

The need to foster professional values in doctors throughout their careers through appropriate selection into medical school, training and assessment, is a common thread throughout the report which resulted in six recommendations on education. These embrace:

Fig 1. The basket of professional qualities.



- lay representation on medical student selection panels
- developing appropriate professional behaviour beginning at a student's arrival at medical school
- more undergraduate training in management and leadership, and
- improved mentorship during postgraduate training.

### Appraisal and careers

*Just because we are caring, we should not be taken advantage of. We should be nurtured and supported in our career to enable us to do the same for our patients on a daily basis.* (Junior Hospital Doctor)<sup>2</sup>

Almost all of over 2,000 medical students and junior doctors acknowledged a strong personal commitment to their patients (98.5%), and to maintaining ethical standards (96%). Junior doctors' values have not changed. Seventy-five per cent of the respondents felt altruism was intrinsic to medical practice and valued their work. Yet a sense of not being valued by others, feeling like 'cogs in a wheel', and of occasional bullying emerged from the survey.<sup>2</sup> The tensions lie in the need for more supportive career management, mentorship and eradication of poor senior professional role modelling.<sup>2</sup>

### Research

*Unless professionalism can be quantified in some way, it is hard to know what precise contributions notions of professionalism make to patient care or how patient care is threatened when professionalism is compromised.*<sup>1</sup>

Despite a large international literature on professionalism, much of the work is descriptive. The report encourages funding organisations to support research to strengthen the scientific basis for understanding professional values and the contribution they make to healthcare outcomes. Research to understand how the description of professionalism given by the Working Party applies both to the needs of our ethnically diverse patients and to our workforce recruited from overseas is urgently needed. At the same time, we need medical education research to decide the best method of enabling doctors to learn about professional behaviour. Without solid assessment tools to measure the 'qualities in the basket', questions about the efficacy and impact of medical professionalism cannot be answered effectively.

### Discussion

*This is an important product of the times we are in.*

*This is not just a basket of values. The sum is greater than the parts.* (Audience members)

The report was well received; the work was described as 'proactive' and 'more important than we know'. There was a repeated call for the work to be extended to embrace other professions not involved in healthcare in order to address a more widely perceived loss of professional identity and a need to improve morale.

There was no feeling of exclusion from consultation and it was agreed that the project should now draw in other professionals.

There were a few reservations. The content was at risk of being too conceptual. The 'global' use of terms had in a sense 'fudged' some of the specifics. The report had a good focus on professional duty to society, but the impact of professionalism on clinical expectations and patient outcomes was less well addressed. The international research dimension<sup>2</sup> had not been sufficiently highlighted, and the work could be better advanced through international collaboration.

*Where does the buck stop?* (Audience members)

The subject of medical leadership within a multi-professional healthcare team stimulated much debate. Leaders need to have followers to be effective. The roles are complementary, not fixed. But what is the relationship between leadership and follower-ship? Doctors sometimes do not wish to lead but, at same time, do not want to be led! Leadership can involve significant conflicts between clinical patient care and management. Every doctor has the potential to be a role model in both the clinical encounter and within inter-professional healthcare teams. They should therefore be aware of and display the qualities and behaviours that comprise this aspect of medical professionalism.

But when should they agree to be led? Within integrated care pathways, it is not always clear who is ultimately accountable for clinical decisions. A repeated question was, 'Where does the buck stop?' The integration of competencies across changing professional teams needs to be maximised. Doctors make decisions with significant resource implications and in areas of uncertainty, yet other health professionals also have natural leadership skills. Does it show complacency to acknowledge follower-ship sometimes or should doctors insist on retaining a lead in decision making?

*We need exemplars of the 'doctor in society'. If gold rusts what will the iron do?* (Audience member)

Educationalists in the audience were positive, but asked whether the report was proactive enough. Perhaps we should aim to identify appropriate medical professional behaviours at sixth form level? There was concern that universities might not rise to the challenge of implementing the report's recommendations in their medical schools: 'If the faculty don't think it is important then it isn't important'. Key educational questions centred on 'How do we measure and assess this basket of qualities?' The difficulties facing the universities in addressing fitness to practise issues were highlighted. 'When we find unprofessional values, what do we do?' 'How do we rectify them?'

Concerns centred on fostering professionalism in medical schools and avoiding attrition of values through inappropriate role modelling.<sup>3</sup> Support for juniors in overcoming problems intrinsic to addressing poor professionalism in senior doctors is needed. Patients should also be encouraged to challenge unacceptable behaviour. Overall, the importance of learning appropriate professionalism, supported by mentorship and reflective portfolios, in medical school followed by improved appraisal during training was felt to be crucial.

## Taking the work forward

*The working party's recommendations have far-reaching implications for medical institutions in Britain today – the GMC, the Academy of Medical Royal Colleges, the Department of Health, the British Medical Association, medical schools, and research funding bodies. Britain's health system needs mechanisms to incentivise policy makers, employers, and managers to value professionalism as an important lever for improving the quality of services to patients.<sup>4</sup>*

Three working party member perspectives were presented.

### Lay member

For medical professionalism to flourish, we need enabling processes. A real partnership between management and doctors in a sympathetic and reflective environment is required. All managers should be accredited with specific training in medical management to facilitate their understanding of the NHS. Doctors must learn to be followers as well as leaders and learn to be managed. Legitimate frameworks of decision making involving all members of the team are required with appropriate self governance.

Doctors also have a duty to engage in national frameworks. We need a better understanding of externally imposed targets. Are these driving out judgement in the interest of the unique patient and challenging professional values? Recognition of the increasing tendency for other professions to take on the tasks traditionally performed only by doctors and the fear engendered by these shifting professional boundaries must be addressed.

### Patient member

Patients have responsibilities too; we are facing this moral dilemma together. Given the demands made on society through longer life expectancy, increased consumer demands and resource restraints, there should be a shared professional partnership, eg an obligation to attend for appointments. Patients need to be engaged in medical education in order to influence and facilitate change. All concerned with these issues must 'stand up and put their heads above the parapet'. They should find and cultivate relationships with 'people who matter' and use these links to bring about gradual change.

### Doctor member

The essence of this report focuses on everyday work with patients. Doctors must reflect on their personal ethical codes of practice, relationships with others and social responsibilities and respond constructively to the recommendations. We need to build methods of dissemination and ensure wide access to the report. It is a natural companion to *Good medical practice*, which is currently under revision by the General Medical Council. The recommendations for undergraduate education challenge our universities to engage openly. Partnership with all medical organisations is essential.

## Discussion

*Leadership must be top of the wish list.* (Audience member)

We must distinguish leadership from management. There is an urgent need to engage with society to encourage more mutual understanding across both a pan medical forum and public forum. This requires passion, commitment, road shows and unashamed demands on other sectors.

Various organisational representatives offered their views. The NHS Confederation applauded the document as a significant way forward, proposing joint work to link with employers and form better clinical leadership. The British Medical Association viewed the report as significant and reported having internal processes in place to address issues of career management, appraisal and leadership. The need to engage with the universities, the Postgraduate Medical Education Training Board (PMETB) and Modernising Medical Careers (MMC) to emphasise professionalism and develop appropriate role models at all levels of training was repeatedly highlighted. Leadership is needed from the GMC to ensure that professionalism and leadership are properly covered in the revised version of *Good medical practice*.<sup>4</sup>

## Summing up

*Being a good doctor touches every aspect of medical life.*  
(Niall Dickson)

There is an urgent need for doctors to feel good about themselves and better valued. This report recognises uncertainty, judgement and discretion as enduring qualities of medical practice. Values matter but they must be explicit values and represent those of today's doctors as well as those of the previous generation. We need to reinvigorate the professional values that underpin team work and corporate responsibility, and review leadership, engagement and accountability within the profession. The Working Party has been challenged to be more practical as well as conceptual. The basket of qualities must not become 'cloned' and we face unanswered questions (Box 1).

The conference identified a need for doctors to lead and make clear compacts with patients, fellow professionals, managers and society. There is a thirst for a new professionalism. Now is the time to be more specific and move on to create these new partnerships.

### Box 1. Unanswered questions.

- How should we select medical students?
- How do professional behaviours differ from competencies?
- How do we measure the 'basket of qualities' that comprise professionalism?
- How do we avoid selecting students with inappropriate professional behaviour?
- Where does the buck stop in integrated healthcare?
- How do we support trainees?
- How do we find time for reflection?

## References

- 1 Royal College of Physicians. Doctors in society: medical professionalism in a changing world. *Clin Med* 2005;5: Suppl 1. [www.rcplondon.ac.uk/pubs/books/docinsoc/](http://www.rcplondon.ac.uk/pubs/books/docinsoc/)
- 2 Royal College of Physicians. *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. London: RCP, 2005. [www.rcplondon.ac.uk/pubs/books/docinsoc/](http://www.rcplondon.ac.uk/pubs/books/docinsoc/)
- 3 Hilton SR, Slotnick HB. Proto-professionalism: how professionalisation occurs across the continuum of medical education. *Med Educ* 2005; 39:58–65.
- 4 Horton R. Medicine: The prosperity of virtue. *Lancet* 2005;366:1985–7.

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# book reviews

## Living medicine: recollections and reflections

By Margaret Turner-Warwick. Royal College of Physicians, London 2005. 326pp. Hardback £25, paperback £15.

Dame Margaret Turner-Warwick tells us in the introduction that her book was written for her family. We can be grateful to them for providing her with the stimulus to write for it helps us to understand the past and is also an intelligent guide to how medicine can retain its position of trust in society in the future.

Dame Margaret witnessed and participated in a remarkable period of medical advance during the third quarter of the twentieth century. For a practising doctor the introduction of antibiotics and corticosteroids and, in the UK, the creation of the National Health Service, transformed the ability to provide effective treatment. The concurrent development of clinical science provided the evidence on which these developments were based.

She had qualified in 1950, the first year in which the number of cases of lung cancer in the UK exceeded those of tuberculosis and the year Austin Bradford Hill published two seminal papers. These were the results of the first clinical trial demonstrating the long-term efficacy of combination treatment for tuberculosis with streptomycin and para-aminosalicylic acid (PAS) and, with Richard Doll, the case-control study which first suggested cigarette smoking as a causal link to the progressive increase in the incidence of lung cancer during the 1930s and 1940s.

Aneurin Bevan believed that the NHS, by improving the health of the population, would eventually pay for itself. However, the increasing cost of healthcare and the most effective means of providing it had been a constant theme of the past 40 years and had led to sharp disagreement, and on occasions conflict, between government and doctors. This period also witnessed an increasing expectation among patients and the public of both the quality of clinical care

and the behaviour of doctors. In our time widely reported scandals, such as those at Bristol and Alder Hey, have led not only to highly publicised reports and increased government regulation but also to questions about whether doctors can be trusted and, by extension, deserve self-regulation.

The book is in two parts: in the first Dame Margaret describes her life from childhood, to becoming a doctor in a male-dominated profession. In the second part she reflects on the problems currently facing the profession. She brings knowledge and experience gained as a hospital physician, a professor of medicine, the dean of the National Heart and Lung Institute, the president of the Royal College of Physicians and a chairman of a hospital trust. She also brings an understanding gleaned from her experiences as a patient, with ear infections during early childhood, tuberculosis as an undergraduate and breast cancer while a practising physician.

She was the third of four daughters born into a professional family with a strong culture of education and intellectual achievement; a family in which the children were told to 'expect no dowries' but who received family and financial support to pursue a professional career. Her undergraduate career as a scholar at Lady Margaret Hall, Oxford, was an extremely happy and intellectually stimulating period. She recounts her clinical career from medical training to consultant posts, initially as a general physician with an interest in rheumatology at Elizabeth Garrett Anderson Hospital, later as a Senior Lecturer with Guy Scadding at the Institute of Diseases of the Chest before succeeding him as the Chair of Thoracic Medicine.

Her personal and professional encounter with tuberculosis, which she developed in her final year at Oxford in 1946, is particularly instructive. It was treated, because of family concerns about the effects of food rationing in UK, in a sanatorium in Switzerland. This was before the advent of chemotherapy, and artificial pneumothorax