Medical professionalism: the trainees' views

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ABSTRACT – Medical professionalism is deeply embedded in medical practice in the UK but, with changes in the modern healthcare climate, its nature and role have been increasingly challenged. The Royal College of Physicians (RCP) therefore convened a working party to consider the concept of medical professionalism, to clarify its value and purpose, and to define it. As part of this project, the RCP Trainees Committee was commissioned to survey trainees to obtain their views on the matter. A questionnaire was sent to 19,190 medical and surgical trainees, and 4,576 medical students; 2,175 responses were received. The results were clear. Junior doctors and medical students see medicine as a profession which is learnt through apprenticeship and defined by responsibility towards patients, and which requires qualities such as altruism and humility. 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. Furthermore, the overwhelming majority think that a reduction in medical professionalism would lead to people leaving the profession.

KEY WORDS: junior doctors, medical professionalism, medical students, survey, training grade doctors

Introduction

Professionalism has for a long time been considered an intrinsic part of the practice of 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 been increasingly questioned. Self-doubt has not been restricted to the profession of medicine; evidence points to the erosion of trust in all professions.[1] The other traditional professions, of 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 included much discussion of the subject since the 1970s, when there were particularly savage attacks on the concepts of professionalism.[3] Professionals were seen as elitist, class biased and keen 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 potential 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 exclusive knowledge. The second characteristic is dedication to public service. This demands that the profession put the good of society before its own. This has looked increasingly uncertain with the portrayal of doctors as arrogant and bent on maximising 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, as well as the scandals at the Bristol Royal Infirmary and Alder Hey Hospital, have eroded the public's confidence in the ability of the profession to regulate itself; with this in mind, the Chief Medical Officer is currently looking at the role of revalidation for the profession.

In this changing climate, the profession has sought over the last 10–15 years to address the issue of professionalism. Numerous articles were written in the late 1990s in the UK around this subject (see references 6–9 for examples). Other countries were involved in similar debates and in 2002 a collaboration between the European Federation of Internal Medicine, the American College of Physicians and American Society of Medicine in addition to the American Board of Internal Medicine led to the Medical Professionalism Project, launched in 1999.[10]

Within UK medicine, there are many unique additional challenges to medical professionalism. The introduction by Modernising Medical Careers of a new career pathway, the establishment of the Postgraduate Medical Education and Training Board, 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 doctors are working. The Royal College of Physicians (RCP) therefore convened a 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.

Key Points

A questionnaire on medical professionalism was sent to 19,190 medical and surgical trainees, and 4,576 medical students; 2,175 responses were received

Junior doctors and medical students believe medicine to be a profession which is learnt through apprenticeship and defined by responsibility towards patients

Junior doctors and medical students think that standards of care should be defined and regulated by the profession, and that training should be directed by the profession

The majority of junior doctors and medical students believe that a reduction in medical professionalism would lead to people leaving medicine

Methods

A questionnaire was designed with the following aims in mind:

1 To excite a response from trainees
2 To obtain trainees' opinions on key aspects of professionalism without imposing a rigidly preconceived definition
3 To encourage additional free text responses on all aspects of professionalism.

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, 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 Working Party on Medical Professionalism. Responses were collated and two main recommendations were 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, and a link to the questionnaire webpage, along with a letter inviting them to complete it, was circulated electronically to all those on the list. 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 database, was 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 represented.

Results

The questionnaire was launched on the 24 March 2005, and closed to responses on the 14 April 2005. Via the BMA, it was sent to 19,190 medical and surgical trainees, and 4,576 medical students. In all, 2,175 responses were received. Of these, 34% stated that they were aged between 30 and 34 years, 30% between 25 and 29 years, 17% under 24 years, and 15% between 35 and 39 years; 49% that they were male, 47% female; 50% that they were specialist registrars, 22% senior house officers and 20% medical students; 43% that they were in a medical specialty, 22% gave no response, 18% that they were in a surgical specialty, and a total of 16% that they were either general practice, anaesthetic, psychiatric or paediatric trainees; 40% that they were single, 35% with a partner, 23% with a partner and children; 31% that they were working a full shift rota, 30% gave no response, 27% were working an on-call rota, and 13% a partial shift rota. Please note that the preceding figures omit results for response rates below 10%; the complete results of the questionnaire may be found in a technical supplement[17] to the Working Party report. [18]

Table 1 provides condensed results to four of the main questions. 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.

Ninety-seven per cent of respondents thought that the purpose of medical professionalism was to maintain or improve patient care; 89% thought that its purpose was to maintain or improve medical education and training; 58% to maintain or improve clinicians' morale, and 56% to maintain or improve the quality of their working lives.

Over 80% of respondents thought that increases in public expectations of access to and outcomes of medical care challenged medical professionalism; over 70% thought that limited financial resources, changes in working patterns and increases in protocol-driven patient care were challenges; while about 60% thought that changes in under- and post-graduate education and training, changes in the roles of non-medically qualified practitioners, and expectation of clinicians' quality of life at home and work were challenges.

Seven hundred and seventy-six free text comments were received. Of these, themes not already addressed in the questionnaire included: targets (8% of comments), particularly 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; and the European Working Time Directive (3%). The RCP Medical Professionalism Working Party had access to all the comments submitted by trainees in an unedited form. A selection of these may be found in a technical supplement to the Working Party report.[17]

Discussion

Although the response rate to the survey is not as high as hoped, the results are clear. Junior doctors and medical students see medicine as a profession learnt through apprenticeship and defined by responsibility towards patients, requiring qualities such as altruism and humility. 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 over the past five years there has been an increase in clinicians' responsibilities and a concurrent decrease in their autonomy. Eighty per cent of trainees agreed that autonomy formed part of their concept of medical professionalism, and 83% thought that autonomy had decreased. Of great concern is the potential for this view to translate to career decisions: 80% of trainees thought that a

Table 1. Responses to the four main questions in the questionnaire sent to medical trainees and medical students.

(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

(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' responsibilities to patients	98	1	0 (0.2)	1
Clinicians' responsibilities to their employers	42	33	24	1
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 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' responsibilities to patients	47	42	8	3
Clinicians' responsibilities to their employers	66	27	4	3
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) Do you think an actual *decrease* in the degree of professionalism in medicine would affect the following?

	Definitely or probably increase (%)	*No change (%)*	*Definitely or probably decrease (%)*	*No response (%)*
Applications for medical school	4	32	61	3
Applications for hospital consultant posts	4	30	62	4
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 non-medical posts outside the NHS	80	10	5	5

decrease in professionalism would increase the number of medical practitioners leaving the profession entirely. As one trainee put it:

> *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.*

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 members of other specialties. There may also have been 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.

The survey results show that trainees believe medical professionalism to be beneficial to patient care, putting the patient at the heart of a therapeutic relationship, above other concerns; it was considered 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, it 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. Perhaps most importantly, as one respondent to our questionnaire told us:

> *Medical professionalism is not optional. It is an essential part of being a doctor, no matter how many challenges face us.*

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