Doctors in society: medical professionalism in a changing world

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Opinion polls suggest that doctors are among the most trusted people in society. My own observation is that leaders of medical colleges and organisations are resolutely and seriously self-critical in a way that no other group of employers, experts, workers or advisors has shown itself to be.

(Harry Cayton, National Director for Patients and the Public, Department of Health)[1]

Background

One would have to have been living on Mars to be unaware that the medical profession in the UK, and indeed worldwide, is suffering from a crisis of confidence. At first sight, this may seem paradoxical. After all, medicine is delivering what patients want to a degree that would have exceeded the wildest dreams of even a few decades ago. The staggering, and staggeringly rapid, increase in life expectancy in the UK and the improvements in quality of life, testify to the effectiveness of modern medical care. There have been impressive improvements in processes as well as outcomes, with increasing attention being paid to providing more friendly methods of healthcare delivery. 'The patient's experience' has moved to centre stage. And yet there are frequent reports of dissatisfaction with what doctors are and what they do or fail to do.

It is difficult to know how widespread this reported dissatisfaction really is. Much to the chagrin of its critics, successive MORI polls have shown that the public trusts and appreciates the medical profession more than it does those journalists, lawyers, politicians and others who sometimes highlight doctors' shortcomings. If, however, one looks deeper than snapshot surveys of public opinion, it is difficult to shake off the suspicion that the traditional relationship between doctors and society is being called into question. The sometimes grotesque misrepresentation of the profession in the media, so that errors and misdemeanours are given a lavish coverage that ever-improving routine good practice will never attract; the interminable and often ill-judged, always expensive and frequently evidence-free policy initiatives by successive governments; and the increasing encroachment of the law and the legal profession on medical practice – these all suggest a more critical attitude towards doctors.

Some of the reasons for this lie within the profession and may indeed be connected more with its virtues than its shortcomings. For example, as clinical practice becomes more effective, so its habit of self-criticism becomes more institutionalised: the ethos of evidence-based medicine has exposed the gaps in evidence. Doctors acknowledge uncertainty as never before. And there are other trends internal to medicine. Compared with a generation ago, doctors have different expectations of their evolving careers: the phrase 'work–life balance', almost unheard of until recently, surfaces at every moment, in part as a result of a very welcome widening of the intake of the medical workforce.

Other reasons lie outside the profession. Advances in technology have made medical information, once the exclusive province of the doctor, available to any member of the public who has access to a computer. What is frequently described as 'the decline in deference' has encouraged patients to challenge medical expertise – and indeed professional expertise of all kinds. Intensifying consumerism has resulted in rising patient expectation – for care that is not only technically competent but also delivered conveniently; and for explanations of illnesses and their treatments that are both comprehensive and comprehensible. In a health service driven by political imperatives which insist on ever-increasing throughput, these demands cannot always be met. This mismatch between rising expectations and what can be delivered in routine practice has resulted in much dissatisfaction and increasingly intrusive policies that prescribe medical practice ever more closely, without narrowing the apparent gap between what some patients want and what they get.

Doctors have sometimes failed to keep up with changing societal expectations. This has been highlighted by the responses to high-profile cases of poor, or even criminal, practice. There is a perception that the profession has not taken seriously enough the reform of its regulatory procedures.

The Working Party: aim, methods and membership

It is obvious, then, that the time is ripe for a re-examination of the ethos, the values, that have underpinned the astonishing achievements of scientific

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medicine. These values, after all, have created the humane institutions in which medical care is provided and therapeutic partnerships are forged between patients and doctors.

The Working Party on Medical Professionalism was established with the overall purpose of defining 'the nature and role of medical professionalism in modern society'. Within this broad aim, the Working Party tried to define professionalism as traditionally understood, and to determine which aspects of professionalism were no longer relevant or even desirable, and identify those aspects which should be supported and nurtured. Our overriding preoccupation was to identify those conditions in which individual doctors and the profession as a whole could flourish to the benefit of patients – in short:

> *To consider ways in which* [medical professionalism] *might be developed, strengthened, and promoted in the service of patients and the public.*[1]

We used a variety of methods. A very large body of literature was made available to the members of the Working Party, so that we could obtain a clearer idea of the true nature of present concerns and place them in historical perspective. We received written submissions and oral evidence from a wide range of individuals, from within and beyond medicine, who could give us some insight into professionalism. Our witnesses included the President of the General Medical Council (GMC), the Chairman of the Shipman Inquiry, the Chief Executive of the NHS, senior representatives from other professions such as the Church and the law, the Chief Medical Officer, a former Director of the McKinsey consultancy, key figures in medical charities and patient representative groups, a Professor of Social Policy at the London School of Economics and a sociologist. There was crucial input from trainees, including a comprehensive survey on their attitudes to professionalism. A series of dinners – a popular research tool – with various representative bodies was used to gather more facts and assess reactions to preliminary ideas. A meeting in Cambridge, with over a hundred invited delegates, was convened to test out some of our provisional conclusions.

The members of the Working Party came from disparate backgrounds. Although the work was carried out under the aegis of the Royal College of Physicians, there were representatives from other Royal Colleges, from academic medicine and medical education, from nursing, from the British Medical Association (BMA) and the King's Fund, and the NHS Confederation. There were lay members, including a lay representative from the GMC.

Main conclusions and recommendations

Professionalism

So what did we conclude? The first was that 'professionalism' matters as much in the twenty-first century as it did in the sixteenth when the College was founded. This was the overwhelming consensus evident in the 100-plus written submissions we received and the view of 97% of over 2,000 trainees surveyed. Professionalism 'codifies the idea that a doctor's responsibilities go beyond a mere contract of employment'. It 'acts as the continuity and counterweight to changes in policies concerning health care delivery that can sometimes strain services and sometimes introduce new uncertainties into patient care'.[1] (Among these latter, we particularly noted the impact of the European Working Time Directive and the move towards care being delivered by ever-widening teams.) Professionalism also reflects something that is central to the practice of medicine: the need to employ judgement and to cope with uncertainty. Good medical practice can never consist of automated journeys down algorithms and standardised care pathways.

An easy definition of 'professionalism' eluded us. This was hardly surprising, given that the word has a complex history and multiple connotations. We concluded that the term 'signifies a set of values, behaviours and relationships that underpins the trust the public has in doctors'.[1] Knowledge, clinical skills, and judgement have to be combined with values such as integrity and the commitment to continuous improvement of one's practice. Central to the new professionalism was the notion of a partnership between patient and doctor, 'based on mutual respect, individual responsibility, and appropriate accountability'. The new equality between patient and doctor means that not only the medical profession but also patients through their representative bodies have 'a duty to work to strengthen the system of healthcare'. It also means that we have to look at more intelligent ways of holding doctors to account for their actions – one that is not merely informed by a culture of suspicion, unfairly extrapolating from the bad behaviour or poor practice of the minority, and does not result in endless, pointless documentation. Some of our witnesses were suspicious of the notion of 'altruism': its implicit claim to moral superiority might lead to complacency or worse. We were impressed, however, by the trainee who argued that while medical practice 'requires neither humility or altruism ... good medical practice ... requires both'.

The discussion of professionalism comprises the longest single section of the Report, though we were always conscious of the danger of navel-gazing, and equally of producing a description that was made up of 'hooray' words that no one would either disagree with or find informative. Our challenge to the traditional notions of 'self-regulation' and 'autonomy' as traditionally conceived should be sufficient to provoke some readers. Our first recommendation, that 'each doctor reflects on [the] definition and description of medical professionalism' and see how it is expressed in their daily practice may therefore be the most important. All our other recommendations flow from our sense of what professionalism is and how it needs to be fostered in a world that is not always favourable to it.

Our other recommendations (see box; see also the full Report published as a Supplement to the previous issue of *Clinical Medicine*),[2] are grouped under different themes: leadership; teams; education; appraisal; career pathways; and areas for research.

Leadership

We focused first on leadership because many of our witnesses testified to the feeling that the profession had lost influence and in some areas, for example health policy, the medical voice had

Recommendations of *Doctors in society: medical professionalism in a changing world*

The Working Party defines medical professionalism as follows:

> ***Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.***

In order to set out in more detail the meaning of these values, behaviours, and relationships, the Working Party describes medical professionalism in the following way:

> ***Medicine is a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability.***
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> ***In their day-to-day practice, doctors are committed to:***
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> - ***integrity***
> - ***compassion***
> - ***altruism***
> - ***continuous improvement***
> - ***excellence***
> - ***working in partnership with members of the wider healthcare team.***
>
> ***These values, which underpin the science and practice of medicine, form the basis for a moral contract between the medical profession and society. Each party has a duty to work to strengthen the system of healthcare on which our collective human dignity depends.***

1 The Working Party **recommends** that:

- Each doctor reflects on the Working Party's definition and description of medical professionalism, recognising that he or she is a role model for doctors and other health professionals.

2 The Working Party **further recommends** that:

- Doctors assess their values, behaviours, and relationships against the Working Party's description, and that they take personal responsibility for ensuring that this aspirational standard of modern professionalism is met in their daily practice.

The Working Party's definition and description have implications for the issues of leadership, teams, education, appraisal, careers, and research.

3 **On leadership, the Working Party recommends that**:

- The General Medical Council revises its important document, *Tomorrow's doctors,* to strengthen leadership and managerial skills as key competencies of professional practice.
- Royal Colleges and Faculties identify the standards required of their Membership and Fellowship to satisfy the qualities of professionalism in a modern team-based environment.
- Royal Colleges and Faculties, medical schools, the British Medical Association, and other healthcare organisations, take on the responsibility to develop a cadre of clinical leaders. These bodies need to define the skills of leadership that they seek, and implement education and training programmes to develop doctors with those skills.
- Royal Colleges and Faculties, together with others, seek ways to strengthen and unify medicine's national leadership and voice.
- The Royal College of Physicians, working with others, creates an implementation group to define the requirements for a common forum, the purpose of which would be to speak on behalf of medicine with a unified voice.

4 **On teams, the Working Party recommends that**:

- The Academy of Medical Royal Colleges initiates a review of how doctors can best be supported – for example, through training – in their contributions to multi-professional teams.
- The General Medical Council, other regulatory bodies, and medical schools explore ways of strengthening common learning to enable better interprofessional education and training.

5 **On education, the Working Party recommends that**:

- Medical schools review their student selection criteria to identify students with developed, or the potential to develop, qualities of medical professionalism.
- Consideration be given to the contribution lay members of medical school selection panels might make to assessing whether students have the necessary professional aptitudes to study medicine.
- Medical schools consider introducing professional values early into the undergraduate medical course by means of a ceremony at which students would pledge their commitment to those values publicly. This event would be akin to the 'white coat ceremony' practised by many American medical schools.
- The General Medical Council strengthens its guidance on undergraduate medical education to ensure that time is set aside in teaching and training for a period of professional engagement with students, including raising managerial and organisational awareness. Each student's professional values should be assessed throughout their training to ensure their fitness to practice.
- The General Medical Council, in collaboration with other bodies, reviews the implications of the UK's increasingly ethnically and culturally diverse population and medical workforce for medical education, training, and professional development. Consideration of this should extend to overseas doctors entering UK practice.
- The Academy of Medical Royal Colleges considers the issue of mentorship in a doctor's training and, building on existing programmes, reviews the potential value of a national mentorship programme to provide a means for the sustainable transmission of professional values.

6 **On appraisal, the Working Party recommends that**:

- The Department of Health, in conjunction with the Academy of Medical Royal Colleges, the General Medical Council, and the British Medical Association, begins a review of the professional content of appraisal, with a view to incorporating professional values as key components in evaluating a doctor's performance and development.

7 **On careers, the Working Party recommends that**:

- The British Medical Association, the Academy of Medical Royal Colleges, and the Department of Health establish a mechanism to examine how best to improve the management of medical careers. The goal would be to create career pathways and journeys that best meet the present and future needs of patients, reflecting demographic changes in both society and medicine.
- Each doctor's career should have embedded within it, by employers and doctors themselves, a commitment to sustain professionalism.

8 **On research, the Working Party recommends that**:

- The funders of research – in particular, the NHS Research and Development Programme, the Medical Research Council, the General Medical Council, and the Economic and Social Research Council – establish a forum to call for and consider research proposals into how medical professionalism might best be studied as part of an overall goal to improve health outcomes. Patients should have an active and substantive input into this research agenda.

been virtually silenced. This was in part because much of what the profession had achieved in the past had been forgotten or taken for granted. The focus on poorly functioning doctors had distracted from the fact 'that medicine and the professionalism of doctors have been vital and creative forces for individual and societal well-being'.[1] The scientific discipline that underpins medical practice is a powerful critical force supporting the drive to a high-quality patient-centred health service and a corrective to the panic or rhetoric that has informed many changes in the organisation of healthcare.

We considered leadership at several levels: the individual doctor and the front-line clinical team; the local service or institution; and the national level of healthcare policy.

At the level of the individual doctor, we emphasised the centrality of managerial and leadership skills as key competencies of professional practice and urged the GMC and Royal Colleges to consider this. Nevertheless, given that doctors are members of teams, we also acknowledged that medical leadership has to be complemented by 'followership'.

The urgent need to reinstate medical leadership at the heart of local health service planning was underlined by the fact that managerial decisions, often informed by out-of-date dogma, expressed in target setting, and strategic planning reflecting a naïve hyperrationalism, sometimes had an adverse effect on patient care, and curtailed creativity and innovation. We acknowledged that medical leaders, acting as advocates for quality, might sometimes find themselves in opposition to management. Nevertheless, working with managers to drive forward policies that would benefit patient care was equally a manifestation of good leadership.

We identified the crucial role of the Royal Colleges and other bodies in restoring medical leadership at the national, and even the international, level. It was vital that such bodies should work more closely and more effectively together to develop a unified voice on matters of common and fundamental importance. They should take responsibility for developing a cadre of medical leaders, by defining the necessary skills and implementing education and training programmes. In this way, the profession could be proactive in shaping healthcare strategies, and in influencing the wider debate, rather than merely reacting to sometimes ill-advised strategies upon which they had not been consulted. It was suggested that there should be a new national forum – with a significant input from patients and other professionals – 'to debate, explore, think about, study, and develop policies across the many different institutions of medicine'.[1]

Teams

Medicine is teamwork and, while some tensions between different members of the team are inescapable, they have the same ultimate goals. Some of these tensions arise from the fact that doctors do not have sufficient time for team building, and sometimes have an unclear idea of the scope and limits of the responsibilities of different members of the team. There may be different views as to what counts as a successful team. We therefore argued that the Academy of Medical Royal Colleges should consider how doctors could be best supported, for example in their training, in optimising their contributions to multi-professional teams; and that the GMC, other regulatory bodies, and medical schools, should explore ways of strengthening common learning through the interprofessional education already being pioneered in some medical schools.

Education

We felt that professionalism would be valued and fostered only if proper attention were paid to it in medical education. In this, we were strongly supported by trainees who felt that building a professional ethos and identity was a key role of education. An educative approach was far preferable to a punitive approach. We suggested measures such as setting aside time within medical training for reflecting on professional values and establishing a system of mentoring, not only to help students to learn from positive role models but also to minimise the impact of negative role models and unsupportive work conditions. Explicitly prioritising professional values would have implications for student selection criteria and procedures, and for curriculum design and content, as well as for postgraduate training. The Working Party felt that the Academy of Medical Royal Colleges should review current mentorship programmes and consider a national mentorship programme 'to provide a means for sustainable professional values'.

Appraisal

The use of the word 'sustainable' is important here. A medical career may extend over 30 to 40 years during which a doctor may see several hundred thousand patients. We therefore gave much thought to what would ensure against waning commitment in 'the long haul'.

Appraisal may be the key to maintaining commitment and enthusiasm and, along with them, professional values. Unfortunately, as it is conducted at present, appraisal rarely serves this function. This is in part because it is largely a clerical exercise in which boxes are ticked against measurable activity and in part because of a tendency to confuse performance management with professional development. Many, perhaps most, doctors feel that current appraisal processes have little to do with either assessing or fostering the qualities that make one a good doctor. It was obvious to us that there was much work to be done to make appraisal an instrument for supporting doctors in their wish to provide good care. We therefore recommended that key institutions – the Colleges, the Department of Health, the BMA etc – should begin a review of the professional content of appraisal.

Career pathways

Another way of sustaining professionalism in 'the long haul' is to acknowledge that doctors are as unique as patients and that individual fulfilment is the key to sustainable professionalism. 'To produce happy patients, we need happy doctors.'[1] The current level of unhappiness in the profession may be gauged by the

fact that in 2004 three-quarters of physicians planned to take early retirement.[3] This professional disaffection must be addressed urgently. We were impressed by the need for more flexible and varied career pathways, guided by meaningful appraisal. We were equally impressed by the need for genuinely protected time for self-development – to keep up-to-date, to retrain, or to reflect on one's practice in a systematic way. This would help to create a more favourable context for professionalism to flourish in the long term. The acquisition of management skills and responsibilities would enable those who have spent many years delivering services to be able to influence the way those services develop – a key to the satisfaction many doctors have derived from their professional lives in the past. Improved – and active – management of careers is therefore essential to maintaining values and the good practice that flows from them.

Research

Most of our recommendations arose out of the best information available to us. Whilst some of this was little more than 'clinical impressions' of individuals or strongly held opinions, it will be evident from the huge amount of material – in full or in summary form – to be found in the Report's Technical Supplement[4] that our work was based on an extensive review of current knowledge. It became clear to us, however, that there was an urgent need for more evidence about the nature of professionalism, about the influence it has on delivering what patients want, and about how it can be fostered.

We identified several interesting areas for possible future study. First, it would be important to determine what we knew already by creating a programme of research synthesis, akin to the Cochrane Collaboration. Specific research themes included investigating: the evolving partnership between patients and professionals – as individuals and in teams – and its influence on the landscape of healthcare; whether an emphasis on professionalism produces better health outcomes for patients; the best methods to teach and assess medical professionalism; the means by which medical professionalism could be quantified; the impact of the social and cultural diversity among doctors on medical professionalism; those aspects of professionalism especially important for clinical leadership; and the way that ongoing health-sector reforms (including the European Working Time Directive) have affected professional values.

We recommended that research funders should establish a forum to call for and consider research proposals into medical professionalism.

Concluding thoughts

Although the impetus for the Working Party came from worries about the profession, the Report also acknowledges and celebrates its huge achievements. Indeed, if the values and commitment that have made modern medicine possible, creating both the powerfully effective technologies and forging the therapeutic partnership with patients, are lost, then medicine will very quickly run into serious difficulties. Populist hostility to a profession perceived as merely 'paternalistic' would not only be unfair. It might also make way for something much worse: purely marketing-based medical practice.

We were conscious, at the end of our deliberations, that there was much work yet to be done. The present Report should be seen as a framework document. While it makes many concrete recommendations, it also points the way for more work in numerous areas, so that many specific, more closely evidence-based recommendations can be made. This is work in which perhaps other colleges, or other institutions within and without the profession, might take the lead.

A Report is only a piece of paper. We hope very much that it will speak to those who deliver front-line medical care year in and year out, and will prompt them to start a discussion with others as to how the conditions in which high-quality medical care is practised can be created and sustained. Others have a key part in advancing medical professionalism. Successful interprofessional working requires other professionals to play their part. Managers should listen to clinicians and vice versa. Policymakers should be cautious about the potential effects of incessant change and the unforeseen consequences of seemingly desirable initiatives. Above all, if patients are to be true partners, new responsibilities will need to be shared.

If this Report has the effect we hope – and promotes a debate on the nature and future of professionalism that goes beyond sound-bites and monosynaptic responses – then it will perhaps have been one of the most important documents the College has published in its 500-year history.

Acknowledgements

Those of us who were on, or involved with, the Working Party felt profoundly indebted to four people. To the President who had the vision to establish the Working Party in the first place. To Baroness Cumberlege who chaired the Working Party brilliantly: she fostered an atmosphere of free and open inquiry and was brave enough not to restrict the range and scope of our inquiries and discussions in advance, but was wise enough to see when it was necessary to move towards closure. To Dr Susan Shepherd, who not only oversaw the entire process but also acted as our information broker, ensuring that, while nothing important was lost, the signal was not drowned in the noise. And to Dr Richard Horton, Editor-in-Chief of the *Lancet*, who wrote successive drafts of the Report, using his immense literary skills and wide understanding of medicine to distil and organise the outcome of our deliberations on the rich material presented to us. The result was a Report that 19 people from diverse backgrounds and with widely different starting views could sign up to and feel proud to own.

References

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Editor's note

In the published report, *Doctors in society: medical professionalism in a changing world*, the definition of a profession given on pp 13–14 was cited as being taken from the Oxford English Dictionary. In fact, the definition was based on that of the Oxford English Dictionary but developed by Richard and Sylvia Cruess and Sharon Johnston in a paper entitled 'Professionalism for medicine: opportunities and obligations'. *MJA* 2002;**177**:208–11.