

Doctors in society

Medical professionalism in a changing world

Report of a Working Party, December 2005



Royal College
of Physicians

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Foreword

Why was this Working Party necessary? Until quite recently the role of doctors in people's lives, in the community and in national life, and the responsibilities that went with professional standing, were well understood. That is no longer the case. Social and political factors, together with the achievement and promise of medical science, have reshaped attitudes and expectations both of the public and of doctors.

The relationship between doctors and society, the doctor–patient relationship, and the environments in which doctors undertake their training and their practice, have all changed. Events that have undermined public trust in medicine, and a questioning of traditional values and behaviour have also greatly influenced the life and work of doctors. They have challenged characteristics that were once seen as hallmarks of medicine.

Undoubtedly these changes have brought progress, with benefit for patients and for the public good. But there have been insidious consequences too. There is mounting evidence that in different ways these consequences can jeopardise the quality of patient care, and the fulfilment of doctors, whose prime goal is to serve patients well. The trust that patients have in their doctor is critical to their successful care.

This Working Party, whose membership extended far beyond the Royal College of Physicians, began its task with the assumption that at the heart of good medical care is a set of values, attitudes and behaviours called medical professionalism. Our aims have been to discover what is understood by the concept of medical professionalism today, to formulate a description that can command wide recognition and support, and to make recommendations that we believe will help shape a new medical professionalism as a valued and welcome force in the life of our society.

We have made recommendations for a new, strengthened form of medical professionalism, valid for our time, to maintain trust and confidence in doctors and their part in our system of healthcare. We give renewed emphasis to qualities that must endure, discard those that have become outdated, and bring in new aspects that recognise the extended responsibilities of doctors today.

The report is not for the profession and its institutions alone. Our recommendations call for responsible engagement that draws in a well informed public

alongside the medical profession, together with the national agencies that have an essential part to play in influencing the steps we believe are necessary.

December 2005

Baroness Cumberlege
Chair, Working Party on Medical Professionalism

Professor Dame Carol Black
President, Royal College of Physicians

Acknowledgements

The thinking of this Working Party has been greatly enriched by a series of formal oral evidence-gathering sessions (see Appendix), together with more informal meetings with representatives of organisations, lay and medical, which have a strong interest in medical professionalism. The Working Party wishes to thank all those who have given their time in providing oral and written evidence. A seminar and series of workshops, held in Cambridge in June 2005, provided a further important opportunity for the Working Party to test its emerging ideas. The outputs of that meeting have helped to shape this report.

We are grateful to the Frances and Augustus Newman Foundation and the Kohn Foundation for their financial support.

Working Party members are grateful to Baroness Cumberlege for her skilful and insightful chairmanship. Without her indefatigable leadership the Working Party would not have achieved its aims within the allotted time.

We also wish to thank Dr Declan Chard, Chairman of the Royal College of Physicians Trainees Committee, for organising a comprehensive survey of trainees' views concerning medical professionalism.

The Working Party owes a particular debt of gratitude to the following individuals: Dr Susan Shepherd, for her energy and skills in coordinating and documenting the activities of the Working Party, without which little would have been accomplished; Hodie Shepherd for her help during the early stages of the project, including setting up databases and sending out hundreds of consultation letters.

A technical supplement of written evidence will be published separately from this report.

This report was written by Dr Richard Horton, and revised by him after discussion with Working Party members. The final document is an agreed consensus of the Working Party.

Gathering the evidence

In order to gather material to write this report, the Working Party adopted an innovative and comprehensive method of consultation, beginning in October 2004 and finishing in June 2005. During this time the Working Party took oral evidence from 20 witnesses, received over 100 written responses to a set of questions about medical professionalism, commissioned a questionnaire and focus groups, drew on peer reviewed literature, and took additional soundings from a broad range of medical and lay opinion. A large amount of this material – in full or in summary form – can be found in the report’s Technical Supplement, published separately.*

Throughout the text of this report, the Working Party has selected quotations from its witnesses, and from focus group participants, to illustrate and amplify the points made and conclusions drawn. The Working Party believes, therefore, that this report is truly informed by evidence.

* Royal College of Physicians. *Doctors in Society: Medical professionalism in a changing world*. Technical supplement to a Working Party Report by the Royal College of Physicians of London. London: RCP, 2005.

Terms of reference of the Working Party

Aim

To define the nature and role of medical professionalism in modern society.

Tasks

To obtain and consider written and oral evidence on key tenets and behaviours of professionalism, particularly in medicine.

To obtain and consider written and oral evidence on how professional values in medicine are changing.

To consider the underlying reasons for these changes.

To consider ways of defining medical professionalism relevant for the twenty-first century.

To consider ways in which it might be developed, strengthened, and promoted in the service of patients and the public.

Summary

Medicine bridges the gap between science and society. Indeed, the application of scientific knowledge to human health is a crucial aspect of clinical practice. Doctors are one important agent through which that scientific understanding is expressed. But medicine is more than the sum of our knowledge about disease. Medicine concerns the experiences, feelings, and interpretations of human beings in often extraordinary moments of fear, anxiety, and doubt. In this extremely vulnerable position, it is medical professionalism that underpins the trust the public has in doctors.

This Working Party was established to define the nature and role of medical professionalism in modern society. Britain's health system is undergoing enormous change. The entry of multiple health providers, the wish for more equal engagement between patients and professionals, and the ever-greater contribution of science to advances in clinical practice all demand a clear statement of medicine's unifying purpose and doctors' common values.

What is medical professionalism and does it matter to patients? Although evidence is lacking that more robust professionalism will inevitably lead to better health outcomes, patients certainly understand the meaning of poor professionalism and associate it with poor medical care. The public is well aware that an absence of professionalism is harmful to their interests. The Working Party's view, based on the evidence it has received, is that medical professionalism lies at the heart of being a good doctor. The values that doctors embrace set a standard for what patients expect from their medical practitioners.

The practice of medicine is distinguished by the need for judgement in the face of uncertainty. Doctors take responsibility for these judgements and their consequences. A doctor's up-to-date knowledge and skill provide the explicit scientific and often tacit experiential basis for such judgements. But because so much of medicine's unpredictability calls for wisdom as well as technical ability, doctors are vulnerable to the charge that their decisions are neither transparent nor accountable. In an age where deference is dead and league tables are the norm, doctors must be clearer about what they do, and how and why they do it.

We define medical professionalism as a set of values, behaviours, and relationships that underpin the trust the public has in doctors. We go on to describe what those values, behaviours, and relationships are, how they are changing, and why they matter. This is the core of our work. We have also identified six themes

where our definition has further implications: leadership, teams, education, appraisal, careers, and research. The Working Party's definition and description of medical professionalism, and the recommendations arising from them, can be found in Section 5 of this report. If our recommendations are acted upon, we believe that professionalism could flourish and prosper to the benefit of patients and doctors alike.

However, the exercise of medical professionalism is hampered by the political and cultural environment of health, which many doctors consider disabling. The conditions of medical practice are critical determinants for the future of professionalism. We argue that doctors have a responsibility to act according to the values we set out in this report. Equally, other members of the healthcare team – notably managers – have a reciprocal duty to help create an organisational infrastructure to support doctors in the exercise of their professional responsibilities. Just as the patient–doctor partnership is a pivotal therapeutic relationship in medicine, so the interaction between doctor and manager is central to the delivery of professional care. High-quality care depends on both effective health teams and efficient health organisations. Professionalism therefore implies multiple commitments – to the patient, to fellow professionals, and to the institution or system within which healthcare is provided, to the extent that the system supports patients collectively. A doctor's corporate responsibility, shared as it is with managers and others, is a frequently neglected aspect of modern practice.

The audience for this report is, first and foremost, doctors. But we believe it should be of equal interest to patients, policy-makers, members of other health professions, and the media. All these groups have a vital part to play in discussing and advancing medical professionalism. This report is only the beginning of an effort by the Royal College of Physicians, together with others, to initiate a public dialogue about the role of the doctor in creating a healthier and fairer society.

Medical professionalism has roots in almost every aspect of modern healthcare. This Working Party could not hope to solve all the issues and conflicts surrounding professionalism in practice today. But our collective and abiding wish is to put medical professionalism back onto the political map of health in the UK.

1 | Introduction

1.1 The medical profession in the UK, as well as in much of the industrialised world, is at a turning point in its history. Medicine's ability to alleviate suffering, prevent disease, and treat illness has never been greater than it is today. Yet that success has not always been guaranteed. It has been and remains founded upon a covenant between the medical profession and society. In return for certain privileges – of self-governance, for example – doctors are rightly expected to fulfil the highest possible standards of professional practice. The terms of that covenant will change as the relationship between doctors and society changes. In the foothills of a new century, there is evidence that the pace of this social change is accelerating. Doctors must keep ahead of these shifts in society's expectations.

New forces

1.2 Information about health and disease, which was once almost exclusively the preserve of doctors, is now available to every member of the public who has access to a computer. This sea change in the availability of knowledge offers a tremendous opportunity for the health professions to engage the public in taking an interest in and responsibility for their own health. But for some medical practitioners, and indeed for some members of other health professions, this democracy in information access can pose troubling questions. How does one negotiate differences in the interpretation of medical evidence between doctor and patient? How does one signal which evidence is reliable and which is not?

... control is breaking down rapidly with consumerism, State intervention, and the web. Increasingly there will not be a unified place where you get your healthcare ...

We are moving to a much more dispersed world of medical knowledge where patients will have access to information and so will many others.

David Armstrong (13 January 2005)

How does one offer advice in the face of lack of evidence? How does one find the time in a pressured consultation schedule to discuss fully the ramifications of information found by a patient on the Internet?

1.3 As information has become more available to the public, so the incredible contribution of science to medical practice has been more widely revealed. Science – in the laboratory and in the clinic – and its influence on clinical medicine and the health of the population is one of the great success stories of our modern era. The applications of research have reduced disability and prolonged lives.¹ But with these advances have come new risks. No drug is entirely free of potential adverse effects. Every surgical procedure carries with it the chance of a complication. Science has justifiably raised the expectations of the public about what medicine can offer. But doctors now have a parallel challenge to embed these expectations in a realistic appraisal of what can and cannot be achieved by medical science. Doctors have the difficult task of explaining the nature of uncertainty and risk in the practice of today's scientific medicine.²

1.4 The political and media environment within which this kind of modern medical practice takes place has the virtue of making the reality of medicine more transparent and understandable. A tougher issue for doctors to address is that when there is a new question or uncertainty raised about a particular aspect of medicine – eg the safety of a drug – the ensuing debate is often held in the full glare of the media, with little opportunity for calm and rational thought. This public spotlight can make it hard for a doctor to explain the basis or, indeed, the limits of the science underpinning that uncertainty (eg the risks associated with hormone replacement therapy). Politicians and managers, too, can be put under extreme pressure to react to events before time has passed for more considered reflection. Again, doctors can be at the sharp end of these rapidly changing political circumstances, amplified by a 24/7 news media.

1.5 Amid the major social forces that affect doctors in their professional practice, they themselves may have different expectations of their evolving careers compared with a generation ago. Younger medical practitioners now expect a more balanced approach to their professional lives. Twenty years ago doctors were willing to accept punishing on-call schedules and the sacrifice of their personal lives for a rewarding professional vocation. Newly qualified doctors today remain intensely committed to medicine. But, like many other groups in society, they wish for a better balance between work and personal time. They want to be able to enjoy life with their own families. And they want far more flexible working environments.

Patients accept that medicine is getting more and more complex and that doctors need balanced lives.

Margaret Goose (12 November 2004)

1.6 This shift in expectations has come at a moment when there is an ever stronger consumerist ethos in society. The public expects, entirely correctly, that they should have rapid access to high-quality medical care as and when they need it. This has been the aspiration of the National Health Service (NHS) since its inception in 1948. In 2005 it is now expected to be a reality. Politicians, concerned as they are by the views of citizens, have endorsed this attitude. But converting that aspiration into reality has placed unprecedented strains on a health service that for decades has suffered repeated changes in structure as well as chronic underinvestment. While funding for healthcare in the UK has been dramatically boosted in recent years, steering the health system to meet the expectations of patients and doctors alike has created new and unanticipated problems. To take one example: while it has been entirely appropriate for government to tackle unacceptably long waiting times, many doctors, who naturally tend to place the interests of the sickest patients first, worry that treatment priorities have been distorted as a result.³

I do not think there is necessarily a clash between good doctoring and targets. The point is about getting the targets right.

Sir Nigel Crisp (20 May 2005)

1.7 More disturbingly still, the medical profession has been slow to adapt to changing societal expectations. High-profile cases highlighting poor professional practice have been enormously damaging to the reputation of the profession. These cases have helped to construct a convincing political argument for stronger regulation of medicine. This argument became even more urgent with the results of Dame Janet Smith's inquiry into the general practitioner and serial killer, Harold Shipman. She concluded that the medical profession had failed to take reform of its

The presumption that professions will always know best is, I think, problematic. Particularly the presumption that professions will know best with only a sketchy understanding of the full range of context.

Dr Gordon Kuhrt (8 April 2005)

regulatory procedures seriously.⁴ She suggested to the Working Party that the profession and its systems of professional regulation had not kept up with the changing demands of the public.

Wider contexts

I have been for some years perturbed and distressed about the situation of many of the great professions in our country.

Dr Gordon Kuhrt (8 April 2005)

1.8 It would be wrong to think that these challenges to professionalism are confined to medicine. They are not. Many systems of professional self-regulation bequeathed by the Victorian era have undergone reform and upheaval since the 1970s. Michael Moran, in his persuasive analysis of the British regulatory state, has called this ‘the crisis of club government’.⁵ Moran points to the ways in which governments have responded to changing social mores, as well as to institutional failings, by extending the reach of their surveillance and control of the public sector. Professional autonomy gave way to accountability; informal mechanisms of standard setting became more formal; tacit knowledge available to only a few gave way to measurable information available to all. In medicine, Moran argues that, having secured the privileges of the medical profession with the Medical Act of 1858, the state withdrew from the regulation of doctors for a century. But as professional competence became the subject of public scrutiny, thanks to several notorious failures of professionalism, Moran observes that:

One of the most striking features of these scandalous cases is the gap they revealed between the conception of professional standards ... and what an increasingly assertive lay public thought were appropriate standards ... Here was a particularly stark instance of the encounter between the nineteenth-century club system and modern democratic society. There has, consequently, been increasing legislative intervention in the regulatory affairs of the profession, including intervention to reshape the composition of the regulatory institution itself.

1.9 Some doctors are only too aware of these tensions. Many are conscious of the fact that they are often portrayed as poor communicators, arrogant, defensive, too quick to use jargon, resistant to change, self-interested, and operating in an exclusive, highly paid club culture. Not surprisingly, doctors see themselves in a different light. They believe that they are now much better at

The profession is often regarded as being arrogant ... actually it is its diffidence and the fact that it does not sell particularly well [what it is doing] that is equally a problem.

Sir Graeme Catto (18 March 2005)

communicating with patients. Communication skills are taught routinely during the course of a medical career. And they emphasise the value of a doctor's expertise, responsibility, commitment, and independence.

1.10 But the greater critical and manifestly public pressure that doctors now face has led to new challenges that are hard to side-step. The trust that an individual patient has in his or her doctor remains high. Polling by the British Medical Association (BMA) indicates that nine out of ten members of the public trust doctors to tell the truth.⁶ That figure is well above the perceived honesty of television news readers (62%), civil servants (43%), and journalists (20%). But to rely on this statistic alone will give doctors a false sense of reassurance about how their work is perceived by the public.

1.11 For example, the Picker Institute Europe, an organisation that promotes the understanding of patients' needs at all levels of healthcare policy and practice, found that almost half of hospital inpatients and a third of patients consulting their general practitioners would have liked more involvement in decisions about their care.⁷ The Healthcare Commission confirmed these findings. About a third of patients they surveyed received conflicting information from health professionals; sometimes the information given about diagnostic tests, possible treatment side-effects, and discharge medications was confused or non-existent.⁸

1.12 There is clearly room for improvement in a doctor's everyday professional practice. But there is also an understandable fear among doctors that continually adverse media coverage about individual episodes of poor professional practice might seriously erode trust in a largely highly performing medical profession. The issue of trust and how to protect it has become an important and welcome subject of mainstream debate in society since Onora O'Neill's timely 2002 Reith Lectures.⁹

1.13 Medicine shares these challenges with several other traditional professions, of course. The Church of England, for example, has been accused of being patriarchal, hierarchical, inappropriately privileged, and authoritarian. In response, some Church leaders are urgently trying to renew their social contract with society. Lawyers have seen a rapid commercialisation of their professional skills. They face the loss of self-regulation. The evidence suggests, therefore, that professionalism is

Medicine, like the law, has lost a lot of confidence. It is losing its sense of leadership.

Lord Phillips of Sudbury (18 March 2005)

under broad attack. Professionals and professional organisations are increasingly mistrusted.

1.14 Regulation is being offered as the solution to this pervasive social anxiety about the reliability of professionalism. Indeed, some critics claim that regulation is based on the implicit assumption of mistrust in the professions. The logic is that recent very public displays of medical error, for example, have led politicians to the view that doctors will not act properly without an enhanced threat of sanction. More optimistic observers believe that professionalism can coexist with greater regulation – that the two cultures are complementary rather than antagonistic. This more hopeful view is reflected in the General Medical Council’s (GMC) recent change of strap line from ‘Protecting patients, guiding doctors’ to ‘Regulating doctors, ensuring good medical practice.’

Recent responses

1.15 During this period of rapid social change and public reflection about the role of the professions in society, medicine has invested considerable energy in looking again at its own fundamental values. One example is the Medical Professionalism Project, launched in 1999. This project was coordinated between the European Federation of Internal Medicine, the American College of Physicians, the American Society of Internal Medicine, and the American Board of Internal Medicine. The result was a new charter on medical professionalism, which set out three principles (on patients’ welfare and autonomy, and on social justice), together with a set of professional responsibilities.¹⁰ These responsibilities were expressed as ten commitments – to competence, honesty, confidentiality, maintaining appropriate relationships, improving quality of care, improving access to care, the just distribution of finite resources, scientific knowledge, maintaining trust, and professional duties. The charter simultaneously argued for balancing rights and responsibilities on both sides of the patient–doctor partnership.

1.16 In the UK, the King’s Fund produced a report aiming to redefine the meaning of medical professionalism for better patient care.¹¹ Its premise was that the traditional image of the professional was outdated. Doctors could no longer

rely on the notion of a professional as ‘a selfless clinician, motivated by a strong ethos of service, equipped with unique skills and knowledge, in control of their work and practising all hours to restore full health to “his” or “her” patients’. The King’s Fund recommended that doctors change tack. They had to do more to put patient interests at the heart of their practice. They had to define a new ‘compact’ between themselves, government, the public, health-service managers, and patient groups. They had to strengthen medical leadership. And they had to define more clearly the roles of doctors and managers.

1.17 Meanwhile, the Picker Institute Europe, under the chairmanship of Sir Donald Irvine, launched an initiative on patient-centred professionalism. The aim of this project will be to look at how health professionals can adapt their behaviours and services to accommodate patients’ increasing desire for more involvement in their care. The Picker project plans to review concepts of professionalism and patient-centredness. It will examine professional standards in the regulation and accreditation of doctors, and review public perceptions on professionalism. Additionally, Picker researchers will study evidence on health illiteracy, shared decision-making, self-management of chronic disease, and team working. The GMC is currently consulting widely on a revised version of its influential *Good medical practice*. And the Chief Medical Officer of England is reviewing clinical performance and medical regulation, a crucial part of which relates to what the public should expect of a modern medical professional.

1.18 Beyond these formal institutional responses to questions surrounding medical professionalism, a research agenda has also been emerging. Measuring aspects of professionalism has become an important task in health research. Unless professionalism can be quantified in some way, it is hard to know what precise contribution notions of professionalism make to patient care or how patient care is threatened when professionalism is compromised. And without valid measurement, evaluating a clinician’s professionalism will be impossible. One recent American review of the instruments used to measure medical professionalism, for example, found that there were few well-documented studies available from which one could draw reliable information about a concept that is so central to clinical practice and the delivery of high-quality care.¹² Research into professionalism is in its infancy and needs to grow.

1.19 One motivation behind this Working Party was a sense that doctors have been far too reactive in contemporary public debates about medical practice. They have frequently responded defensively to the critical statements and policies of other bodies influencing the healthcare community, both inside and outside government. As a result, some doctors have come to feel that their vision

for medicine as a positive and vital service to society is drowned out by critics who have little direct experience of delivering care to patients.¹³ That feeling of isolation from debates about what kind of medicine doctors should be delivering to the public is bad for patients.

Opinion polls suggest that doctors are amongst 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 (12 November 2004)

The medical profession undersells itself.

Sir Nigel Crisp (20 May 2005)

1.20 The purpose of medicine is clear. It is to care for the sick always and to cure patients where possible; it is to prevent ill health and to treat disease; it is to promote well-being and to create healing environments. Professionalism lies at the heart of being a good doctor. It sets a standard for what patients should expect from their medical practitioners. In this sense, professionalism is indeed ‘an ideal to be sustained’.¹⁴

Medicine now

1.21 In the UK, professionalism has provided the framework of values that has shaped the patient–doctor consultation for close to five hundred years. It was an appreciation of the importance of professionalism in medicine that was one of the founding forces behind the creation of the Company of Physicians in London (the forerunner of the Royal College of Physicians) in 1518. Thomas Linacre, together with five colleagues, established the Company of Physicians to regulate and license doctors in the practice of medicine. While it was the responsibility of the universities to educate doctors, it rested with the Company of Physicians to set and maintain professional standards. It did so with extraordinary stringency. By 1538, there were still only 18 members!¹⁵

1.22 Today, our health system is typified by astonishing complexity. This complexity has to be managed with great skill to ensure that the large but finite resources invested in healthcare are spent cost-effectively. Sometimes, disputes about resource allocation become major points of public debate. Access to testing for and treatment with the breast cancer drug, Herceptin[®], is merely one example of how politics, science, and medicine co-exist in an uneasy nexus. As the

Chairman of the National Institute of Health and Clinical Excellence, Professor Sir Michael Rawlins, wrote, 'to pretend that we can bury our heads in the sand and assume that the resources available to the NHS are infinite, stands logic on its head'.¹⁶

1.23 Individual patients and society as a whole therefore need to be sure that they are getting value for money. The relationship between health managers, who are the stewards of these precious resources, and doctors, who set the standards of practice to which these resources must be directed, is one of the most important of all relationships in any advanced health system. Managers and doctors share many attributes, not least the desire to create a superlative health system. But their perspectives can sometimes clash. Resource constraints may threaten what the doctor will see as the proper discharge of his or her professional duties. Yet doctors must be conscious of the need for prudent management of limited resources across an entire health service. They have an important part to play in leading discussions about resource use. Their dual participation in clinical and managerial roles is an important aspect of their professionalism and should be encouraged. Indeed, the spheres of health management and clinical practice are, in some ways, the central territory for debate (and conflict) about the meaning of professionalism in medicine today.

In our education and training ... medical students learn very little ... about the NHS. They ... are going into a large organisation that has to make resource decisions and has to move people about [and they learn] nothing.

Sir Ian Kennedy (20 May 2005)

1.24 Doctors occasionally see managers as obstacles to good professional practice, especially when those managers are viewed as proxies for unpopular government policies. Managers may think that doctors are blocking change by appealing to vague and outdated notions of professionalism. Neither attitude is helpful for patients. And such disputes can fuel systemic discontent among the medical workforce, a discontent that the health system cannot bear if the service is to be improved.¹⁷ Only by creating the right organisational environment for health professionals can the purpose of medicine be properly realised. Doctors have a duty to engage in health management just as managers have an obligation to understand and facilitate good professional practice. This duty for doctors is one of the most difficult challenges they face in the modern era.

1.25 Professionalism matters as much in the twenty-first century as it did in the sixteenth century because it codifies the idea that a doctor's responsibilities

go beyond a mere contract of employment. Professionalism acts as the continuity and counterweight to changes in policies concerning healthcare delivery, policies that can sometimes strain services and introduce new uncertainties into patient care. A particular recent anxiety, for instance, has been the consequences of the European Working Time Directive.¹⁸ This Directive stipulated that, by August 2004, doctors in training should be working on average no more than 58 hours a week. By August 2009, this number has to be reduced to 48 hours a week. There are also specific provisions for rest periods.

1.26 The switch to shift-working among doctors has the laudable aim of reducing the number of continuous hours that doctors work on the front lines of acute medicine. Some evidence suggests that reducing working hours in this way may improve quality of life.¹⁹ But one possible effect of a switch to shifts has been to increase the likelihood of sleep deprivation and clinical error.²⁰ As one trainee respondent to our call for evidence underlined:

Changes in working hours have resulted in a lack of continuity of care for patients. This has a direct effect on learning and morale. More importantly, it means that junior doctors lack a sense of responsibility for the care of individual patients – eg an ‘I’ll just hand it over to the next shift’ attitude.

It is also estimated that the UK will need well over 12,000 more doctors to implement the Directive fully and safely.¹⁸

1.27 This report aims to make the case for a new concept of medical professionalism, one that recognises the complexity and uncertainties within clinical practice and which is based on an indissoluble partnership between patient and doctor in a radically new social context. We wish to initiate a national dialogue about the future of medical professionalism as a public good, and to enlarge the scope of the debate about the role of doctors in society. We also believe that our new definition and description of medical professionalism (Paras 2.5 and 2.6) will help doctors to articulate a renewed vision for medicine – a clear purpose for the profession – at a time of continued political and social change.

1.28 The debate about the future of medicine and medical professionalism will intensify in coming years. And so the audience for this report is broad – patients, the wider public, policy makers, health service managers, healthcare employers, educators, doctors, and other healthcare professionals. We have tried to set out how notions of professionalism need to change and why. We point to the implications of this new professionalism for doctors and the health system as a whole.

1.29 Our goal has been to produce a concise, compelling, and passionate argument about the value of medical professionalism for patients. We want this

report to be inspiring and motivating to all who read it, reflecting, we hope, the inspiration and motivation that we felt as we drew our final ideas together. In sum, we want others to share our enthusiasm for a profession, and its values of professionalism, which together make such a substantial and beneficial contribution to society.

2 | Professionalism as partnership

2.1 The Working Party and the witnesses we took evidence from considered four questions:

- 1 Do you think that professionalism has any meaning today? Say why you think this is so.
- 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 ten to fifteen years?
- 3 What can be done to strengthen those aspects of professionalism that you care about? How would you propose to go about doing this?
- 4 Are there aspects of professionalism that are currently defended but which ought to be abandoned?

2.2 There was general agreement in the one hundred plus written submissions received that professionalism in medicine has meaning today. In addition, the evidence we received from over two thousand medical trainees indicated that over 98% believed medicine to be a profession and that the purpose of professionalism was to maintain or improve patient care. A sense of professionalism is clearly seen as a powerful force for supporting good medical practice.

Definition

2.3 We asked our questions with a definition of professionalism already in mind. We were aware that definitions of professionalism were many and varied. All were open to challenge, most did not apply to doctors, and some were plainly out of date. As a starting point, we chose a modified *Oxford English Dictionary* definition of a profession:

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.^{20a}

2.4 Many attempts have been made to define medical professionalism,^{10,21-28} but the idea defies any magic formula. Instead, professionalism refers, at a minimum, to a collection of attitudes and actions. It also suggests knowledge and technical skill. A clear statement about what doctors mean by professionalism matters, as medical trainees indicate. When we considered the totality of evidence we received, we concluded that there was a case for a brief definition and a longer description of medical professionalism.

2.5 Here is, first, our **definition** of medical professionalism:

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

The professional is the person who is able to put into practice what the professional values are.

Sir Kenneth Calman (6 May 2005)

I think the public ought not to even have to think about whether they trust their doctors – it should be something that they are able to take completely for granted.

Dame Janet Smith (25 February 2005)

Description

2.6 Our **description** of medical professionalism sets out these values, behaviours, and relationships in clearer terms:

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.

In their day-to-day practice, doctors are committed to:

- *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.

2.7 Our justifications for these statements – a summary of answers to questions 3 and 4 on page 13 – follows. The words we have selected aim to map out a substantially new conceptual geography (a collection of qualities or dimensions) for medical professionalism – one that lays out the values that inform the behaviours and relationships of doctors. These values create the basis for a modern healthcare system.²⁹

Professionalism is a basket of qualities that enables us to trust our advisors.

Dame Janet Smith (25 February 2005)

2.8 Securing trust is the most important purpose of medical professionalism. Trust – and so professionalism – operates at two levels:

- in the doctor providing care (individual professionalism)
- in the system where that care is given (institutional professionalism).

Both aspects of professionalism matter if a patient's trust is to be won and deserved. The behaviours that strengthen trust are recognisable to everybody. They include courtesy, kindness, understanding, humility, honesty, and confidentiality. These behaviours create an environment of safety around the patient. A deficit in these behaviours will undermine trust. They are essential to being a good doctor.

[Professionalism] is based around standards, and the starting point is that it is not just about standards that the individual acquires, but they are [also] in the context of the institution. By standards we are talking not just about clinical standards, but about behaviour and values.

Sir Nigel Crisp (20 May 2005)

The peak of professionalism is somebody who absolutely understands and knows how to relate to people, who shares values with everyone else and is operating in a system where the institution shares all those values.

Sir Nigel Crisp (20 May 2005)

What aspects of professionalism should be abandoned?

2.9 We have discarded notions of mastery, autonomy, privilege, and self-regulation.

2.10 *Mastery*, in the context of professionalism, suggests the skilful use of a body of knowledge. But the idea is also ambiguous and open to misunderstanding. Mastery can suggest control, authority, power, and superiority – ideals that are not compatible with our view of the patient–doctor partnership as the fundamental unit of clinical practice. If the concept of mastery is open to such multiple readings, it is better abandoned than retained.

2.11 *Autonomy* is also open to misinterpretation. On the credit side, autonomy suggests independence and freedom from external control. Patients should be confident that when they consult a doctor, the advice they receive is governed only by their interests and needs alone. In that sense, independence is an asset to medical professionalism. But autonomy also suggests the right to self-governance, an appeal to personal authority – that is, the right to pursue a practice that is entirely self-generated. Clearly, that is not a value we wish to recommend. The doctor should tailor his or her care to the expressed needs of the patient in the light of a body of reliable scientific evidence. Clinical autonomy might suggest that a doctor has the authority to act independently of both the wishes of the patient and the preponderance of medical evidence. Neither attitude can be supported, especially in an era of team-based care.

2.12 *Privilege* – in the sense of a special freedom or immunity from, for example, some liability – is also outdated in today's properly more egalitarian world. *Self-regulation*, while a principle that many doctors would defend as a sensible and practical way to govern the profession, is irrelevant to the essential values and behaviours that underpin professional practice.

Professionals only have duties – they do not have privileges. They have duties over and above the duties of being a citizen.

Sir Ian Kennedy (20 May 2005)

Inappropriate privilege is when it is simply claimed *a priori*.

Dr Gordon Kuhrt (8 April 2005)

2.13 We have also exchanged three concepts for more modern and, we hope, meaningful alternatives. *Competence* means the ability or capacity to do something. We wanted to set a higher standard than mere capability. Instead, *excellence* stresses the possession of abilities to an eminent or meritorious degree. A good doctor should not only have a skill. He or she should be able to demonstrate the exercise of that skill in an especially worthwhile way, a concept better served, we believe, by the idea of working towards excellence.

2.14 The *art* of medicine has a long history, going back at least as far as Galen.³⁰ In the sense of the application of knowledge or a technical skill, art is a useful idea. But the Working Party received much evidence arguing that a defining feature of medical professionalism was *judgement* – the application of critical reasoning to a problem presented by a patient in order to arrive at an opinion about how to solve or ameliorate that problem. Doctors are increasingly going to act as interpreters and prescribers of information. They need to be well positioned to assist patients in understanding their illness and the risks they face. The special nature of the very personal patient–doctor partnership is exactly this: a shared concern with finding a path through the ‘indeterminacies’ that disease can bring – in life choices as well as in clinical decisions. We felt that judgement, in place of art, better caught this more modern concept.

I think technical competence is important in doctors, but I think there is a distinction between professionalism and the honour and the probity and the principled judgement of practitioners.

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 the characteristics of modern medicine.

Harry Cayton (12 November 2004)

2.15 We also exchanged, or rather subsumed, *social contract* and *morality* into a single term, *moral contract*. It seemed to us that the idea of a moral dimension to medicine was important. It indicated something right and good in relation to the behaviours and actions of a doctor. The ultimate expression of those behaviours and actions is perhaps best summed up in the idea of a contract between the public

and the profession – a moral contract. A social contract, while a correct description of the mutual agreement that exists between the public and profession, seemed too neutral a term. We wanted to emphasise an ethical edge to that mutual agreement.

Elements of the historic social contract [need to be] modified in the light of contemporary circumstances.

Dr Gordon Kuhrt (8 April 2005)

2.16 Finally, there was a group of ideas in the generic definition of a profession which seemed redundant. *Occupation* is implied already in the idea of a profession at work in the service of patients. *Complex* is implied in the notion of judgement. *Public good* is an accurate description of professionalism in a purely technical sense (professionalism is non-rival – that is, once available, everybody can benefit from it – and non-excludable – that is, once created, it is impossible to prevent people from gaining access to it). But the idea of professionalism as a public good has no practical value to either the patient or the doctor at the bedside or in the clinic.

What aspects of professionalism should be retained?

2.17 We believe that there are strong and self-evident grounds for keeping notions of *knowledge, skills, science, practice, profession, society, service, commitment, and integrity*.

2.18 More justification is needed for the idea of *vocation*. Some of those who gave evidence to us were uncomfortable with this concept. For example, one definition of vocation is ‘a divine call to do certain work’. It need hardly be said that doctors shed any claim – if they ever had one – to God-like status long ago. Some witnesses to the Working Party believed that vocation struck the wrong note for another reason: medicine is a job, not a vocation, they said. We disagree. The notion of a calling – choosing a career for strong personal reasons, a career that requires particular dedication to other human beings – seemed to us worth preserving. Being a good doctor does require a unique set of human and scientific interests and skills that, ideally, attract people who are enthusiastic about what can at times seem a hybrid discipline. It is this very multi-disciplinarity that helps to make a good doctor. A sense of passion and ethical commitment about a career in medicine is an attitude we want to foster, not destroy. In support of this view, we noted that 78% of over two thousand trainees agreed or strongly agreed with the statement that ‘medicine is a vocation.’

2.19 We also want to stress the value of *appropriate accountability*. Accountability implies a responsibility to somebody else. Doctors certainly are accountable for their decisions. But there is a danger that accountability – an unthinking accountability, unchecked, and fuelled by extravagant media stories about medical ‘scares’ – could shade into a culture of suspicion, whereby a doctor’s behaviour is presumed to be somehow against the interests of patients. To avoid such a damaging environment of blame, it is essential that we devise mechanisms of appropriate accountability for doctors. By appropriate we mean fit for the purpose of enabling doctors to work in the best interests of patients without the fear of unfair penalty if an error is made unintentionally and in good faith. Ezekiel and Linda Emanuel have explored the meaning of accountability in medicine.³¹ They caution that the idea of being accountable is not easily reduced to a single or simple definition. Accountability applies to individuals and teams. It applies to multiple sets of activities. And it refers to procedures. No one model of accountability can be applied to medicine alone. Onora O’Neill has also questioned the over-simplistic reliance on accountability as a means to bolster trust.³² She writes of ‘intelligent accountability’. She argues that much of what passes for managerial accountability today actually destroys trust.

The multiplicity of organisations with a remit has confused the issue of where accountability lies.

Claire Rayner (12 November 2004)

The whole essence of professionalism is that you are serving the public. Whether you are a nurse or a doctor, it is around public confidence that there is a system in place and a framework that people are measured by and can be called to account on.

Ms Denise Chaffer (6 May 2005)

2.20 The issue of *altruism* caused the most discussion and dissent among Working Party members. We have retained the concept in our description, but we do so with caveats. A narrow definition of altruism suggests unselfishness or having a regard for others. That view would seem utterly uncontroversial. Altruism should not be about sacrificing oneself entirely for one’s profession, at least in terms of enduring poor working conditions or a withered family life. But we received evidence warning us that altruism carried risks. To claim that doctors should be altruistic might imply that doctors are somehow morally better than other healthcare professionals. Doctors, we were told, should not suggest that they have an exclusive right to call themselves altruistic. As one witness put it to us,

A private doctor carrying out cosmetic surgery is a businessman selling a product and no more altruistic than, say, Giorgio 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.

2.21 Some members of the Working Party found this view very persuasive. However, others believed that doctors should practise unselfishly and with a regard for others: this principle as applied to their daily work, one that is shared by other health professions, remained valuable and it should not be discarded lightly. We have noted that altruism is not new to controversy in the analysis of professionalism.³³ Physicians still seem to value this concept,³⁴ as does the Department of Health.²⁹ Also, our survey of trainees revealed that over 70% agreed or strongly agreed with the statement that 'medical practice requires altruism'. Seventy-five per cent of Fellows or Members of the Royal College of Physicians felt the same. On balance, therefore, we found sufficient justification to keep this concept alive in our description of medical professionalism. Our view was perhaps best summed up by the trainee who told us that: 'Medical practice requires neither humility nor altruism. Good medical practice, however, requires both.'

What qualities should be added?

2.22 The new dimensions of professionalism that we have included in our description are grouped into four domains, set out below.

The patient

2.23 A definition of medical professionalism without the presence of the *patient* is inconceivable today. And it is obviously important to emphasise the *partnership* that the patient enters into with the medical practitioner. We also cite two outcomes of the patient experience with his or her doctor – *well-being* and *human dignity*. Well-being indicates the holistic notion of achieving a state of health, comfort, and happiness. It encompasses the physical, mental, and social aspects of a patient's life, aspects that the doctor seeks to heal or repair.

Modern patients are increasingly concerned about the manner in which they are treated, wanting respect and courtesy as well as kindness, with good communication and the understanding of options and with informed consent.

Harry Cayton (12 November 2004)

Dignity emphasises something more dynamic: the intrinsic moral worth of a human being and also the freedom and capacity – physical and mental – of the individual to live a life that they desire.³⁵ Doctors aim to restore and strengthen both well-being and a patient's dignity.

The doctor

2.24 The *doctor* is the essential complement of the patient in their interactive partnership. The doctor and patient both have *duties* and *responsibilities* to one another and to society. Furthermore, doctors must have a perpetual commitment to the *continuous improvement* of their practice through continuous professional development. For doctors to claim to be acting professionally, they must be able to demonstrate a commitment to inquire into and review the clinical outcomes of their work – and to have those audits scrutinised by their peers. They must also display *compassion* in their daily work. And they must be able to *work in partnership* with the wider healthcare team. The idea that a profession is a bounded group – bounded by a discrete body of knowledge, a monopoly of service, autonomy over conditions of work, and a unique code of ethics – is outdated. Groups of health workers now share many values and attributes. Those ties of interprofessionalism should be more widely acknowledged by doctors.

Professionalism based on a set of relationships with the elements required to be a good doctor, including the social contract relationship, personal relationship with your patient, the very important relationships with colleagues – those seem to be areas that would be interesting to explore.

Harry Cayton (12 November 2004)

The patient–doctor interaction

2.25 The exercise of professionalism depends on effective interactions with others. For doctors, those interactions extend from their own colleagues to wider society. The most important interaction, however, is the *partnership* between patient and doctor, one based on *mutual respect*. That partnership has to be at the centre of any definition of medical professionalism. Such partnerships are changing rapidly. An increasingly well-informed and confident public wishes to have fuller and richer exchanges with doctors. The profession has to meet that expectation.

The qualities of professionalism ... derive not from what a doctor is – from self – but from how they behave in relation to others. A professionalism based not on individuality, but on mutuality.

Harry Cayton (12 November 2004)

The profession

2.26 Any statement of professional *values* must also clearly put those values in the service of a *purpose*: to protect, restore, and strengthen human well-being and dignity. That purpose needs to be clearly stated, even if it seems obvious common sense. Without a statement of purpose, the practice of medicine can erode into a purely technical exercise of pathological description and disease management, devoid of human empathy and compassion. But that purpose goes beyond the individual patient. It also exists in the context of a *healthcare system*. When medical trainees were asked about what defines medical professionalism, over 60% agreed or strongly agreed with the proposition that, along with setting ethical standards, having responsibilities to patients, and setting standards of care, clinicians should be able to direct resource allocation. Doctors plainly see a role for themselves in shaping the system within which their work is conducted. But management responsibility is still insufficiently recognised by many doctors. While medical practitioners should certainly influence resource use, they must also accept their share of accountability for how those resources are deployed and for the difficult choices that inevitably follow when resources are constrained.

The doctor – and any other healthcare professional – has a responsibility to use resources appropriately.

Sir Kenneth Calman (6 May 2005)

2.27 The values set out here resonate with the duties of a doctor as described by the GMC.³⁶ These converging codes of professional behaviour should, nevertheless, carry a health warning. The concept of patient-centredness is now axiomatic in modern medicine. But there are dangers. Patient-centredness can be used as a rhetorical device to preserve the autonomy of the doctor against a prevailing set of practice standards (evidence-based medicine) and managerial imperatives.³⁷ We believe that if professionalism is to be retained as an idea with practical meaning for patient care, it must be implemented through a truly balanced patient–doctor partnership – a partnership in which a doctor’s

values, behaviours, and relationships engender trust and are appropriately accountable.

2.28 The Working Party recommends that each doctor reflects on the above definition and description of medical professionalism, recognising that he or she is a role model for doctors and other health professionals.

2.29 The Working Party further recommends that doctors assess their values, behaviours, and relationships against its description, and that they take personal responsibility for ensuring that the aspirational standard of modern professionalism is met in their daily practice.

2.30 We wish to add a further comment about the GMC's important statement concerning the duties and responsibilities of doctors.³⁶ There is some overlap between the findings of this Working Party and the GMC's *Good medical practice*. In its list of duties, for example, the GMC describes 14 attributes that a doctor must adhere to, including respect, politeness and honesty. They are treated as rules that are linked to the threat of punishment if they are breached. In the GMC's words: 'serious or persistent failures to meet the standards ... may put your registration at risk'.

2.31 While *Good medical practice*, which was first published in 1995 and revised in 1998 and 2001, occasionally uses the word 'professional' to describe, for example, 'work' and 'competence', the GMC does not set doctors' duties in the overall context of medical professionalism. The GMC seems not to have found the idea of professionalism useful in its statement of the principles and standards necessary to ensure good medical practice.

2.32 The GMC is currently revising *Good medical practice*. We believe that there is an opportunity for the Council to draw on a large body of published evidence about professionalism, much of which this Working Party has found so valuable. We hope that the GMC will be able to use this evidence to strengthen its vision for what constitutes the necessary standards of competence, care and conduct of doctors. But we also hope that the GMC will go further and surround that vision with an enabling framework of ideas to create a positive and not merely punitive environment for doctors – an environment in which the GMC's standards can be attained and sustained throughout a medical career.

3 | Implications and recommendations

3.1 Both our definition and description of medical professionalism have implications across the whole spectrum of medicine. Six major themes emerged from the evidence we received: leadership, teams, education, appraisal, careers and research. We do not pretend to have explored every aspect of these large domains, let alone to have solved some of the problems posed within each area. All we can do here is to point to avenues for further debate and investigation. The intention of the Royal College of Physicians is to explore these themes in greater detail in its future work on professionalism.

Leadership

3.2 A common view presented to us was that leadership in medicine today is seriously failing. The profession is underselling itself. Too often, doctors are regarded as negative, defensive and self-serving. Doctors' leaders have struggled to convey the positive attributes of the profession and the contributions that the profession makes to society. 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. The Royal Colleges and Faculties set the highest possible standards for medical professionalism and practice, but there is almost no coherence of vision on many important issues facing patient care across the Royal Colleges and Faculties. That uncertainty only widens when the views of the BMA, GMC, and specialist societies are taken into account. How can better coordination be achieved? How can the inherent tribalism of medicine be turned into a more positive force for public good?

It appears that increasingly medicine requires leadership skills.

Dame Margaret Turner-Warwick (10 December 2004)

We have hit an era where the visibility of medical leadership outside statutory health service roles has been very low.

Sir Liam Donaldson (11 February 2005)

[I think] there has been a loss of medical involvement in policy making, and that has been to the detriment of the quality of policy.

Sir Liam Donaldson (11 February 2005)

Tribalism has a profound impact on the profession – we are a dysfunctional profession at that level right through the system, and it is hurting us.

Sir Donald Irvine (16 December 2004)

Tribalism causes doctors as a group to protect themselves, rather than acting collectively.

Dame Janet Smith (25 February 2005)

3.3 We considered leadership in medicine to exist at four distinct levels: the individual doctor, the front-line clinical team, the local service entity (NHS or primary care trust, or others), and the national policy stage.

Leadership is as much individual as collective. We spend too much time on the collective. I would say that more doctors [should] exercise leadership in their own lives.

Lord Phillips of Sudbury (18 March 2005)

3.4 Each doctor has the potential to be a role model for other doctors and for colleagues in a broader inter-professional healthcare team. Given this position, we believe that every doctor should be aware of the qualities that make up professionalism, together with what those qualities mean for one's own personal behaviour and practice. These behaviours and practices indicate a leadership role, no matter how small, for every medical practitioner. As one of our witnesses put it to us:

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.

3.5 Recent public debates about the individual doctor's professional standards of practice have tended to centre on knowing the limitations of one's knowledge, skill, behaviour and actions. This issue has raised, for example, the question of how doctors should report poorly functioning or impaired colleagues.³⁸ These perspectives are valid, but overly negative. They fail to balance an appropriate consideration of the limits of medical practice with another, more positive, view

– namely, that medicine and the professionalism of doctors have been vital and creative forces for individual and societal well-being, and will continue to be so.³⁹ In particular, the scientific underpinning of medicine, together with the rigorous professionalism that science helps to inculcate, are critical forces to achieving a high-quality patient-centred health service.

3.6 Multidisciplinary healthcare teams are the indivisible units of delivery for high-quality health services. We consider teams in more detail later in this report (Paras 3.18–3.26). From a leadership point-of-view, flexible team-working is as much about recognising when to follow as it is about knowing when and how to lead. The complementary skills of leadership and ‘followership’ need to be carefully documented and incorporated into a doctor’s training to support professionalism. These skills argue strongly for managerial competence among doctors. An individual doctor’s decisions have both clinical and managerial elements. A decision to spend time with one patient and not another, for example, reflects a judgement about resource allocation. There are signs that management skills will gradually become incorporated into fitness-to-practise requirements.⁴⁰

3.7 We recommend that the General Medical Council revises its important document, *Tomorrow’s doctors*, to strengthen leadership and managerial skills as key competencies of professional practice.

3.8 The GMC is shortly to publish important revised guidance on *Management for doctors*, setting out its view of good management practices, together with their maintenance, teaching, and assessment. These managerial skills need to be set in the context of the available evidence concerning team working. It should be made clear who will take responsibility for defining these skills. Documenting success stories is important. And a clear understanding of how appropriate mechanisms of accountability can be laid down should be explained. We stress that while a doctor may not be the team leader in all circumstances, a patient will want to know who their doctor is and who is responsible for their clinical care. In any team setting, there must be a lead clinician. A doctor will therefore almost always have to display skills of leadership *and* followership. The way a doctor acts in the team will create positive or negative incentives among others to act in a more or less professional manner.

3.9 We recommend that all 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.

3.10 Within the local organisation responsible for managing and delivering services, doctors have an additional and critical part to play. This role can

sometimes be seen as adversarial. We received a great deal of evidence, for example, about the clash of cultures between medicine and management. As one respondent to our survey of trainees told us, ‘Hospital managers rather than clinicians making some vital decisions, such as [on] waiting lists, reduces medical professionalism’. Troyen Brennan has reformulated this often-repeated concern into a more positive and eloquent mission for the profession:⁴¹

Physicians are the stewards for quality, and they must aggressively develop an agenda for improvement ... we are at a critical cusp of time in which we have a last chance to retain our professional role, and to do so we must become protectors of quality. Activism must persist and grow if we are to promote the professional/quality link at the level of patient care. This responsibility reaches to every physician.

3.11 Sometimes that responsibility means doctors should oppose poor management thinking. The Working Party received strong evidence indicating that some of what passes for modern management theory is, at best, unproven or, at worst, outdated and erroneous. Management dogma, uncritically applied, can harm professional behaviours. The rigid application of target setting can produce perverse game-playing. Strategic planning can evolve into naïve hyper-rationalism. And the notion of ‘best practice’ may curtail creativity and innovation. Doctors should be prepared, when necessary, to argue against these orthodoxies. Doctors currently have a neglected role in health-service management and leadership.

In recent years, in large corporations, people have had to come to terms with the fact that the litany of [management] dogmas just do not work.

Paul Coombes (11 March 2005)

3.12 We recommend that the 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.

3.13 Finally, we wish to offer some comments about medical leadership at a national (and even international) level. Some of the evidence we received was especially harsh about this aspect of the profession. As one trainee put it to us,

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 and seniors.*

3.14 The sharpness of this criticism is understandable but not entirely fair. The Federation of Royal Colleges of Physicians of the UK has, for example, made strenuous efforts to set standards for the duties of a physician, good clinical care, and maintaining good medical practice.⁴² This effort had the clear goal not only of strengthening the confidence and standing of doctors in society, but also of assuring patients about the standards they should expect from their physicians. Nevertheless, the public role of the doctor – in advocacy and community participation – has been neglected.⁴³

3.15 We recommend, therefore, that the Royal Colleges and Faculties, together with others, seek ways to strengthen and unify medicine's national leadership and voice.

3.16 We also recommend that the Royal College of Physicians, working with others, create 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.

I think the most important thing that any of us can do is to make sure that the fragmentation ends ... where there is common ground we should be speaking with one voice.

Sir Graeme Catto (18 March 2005)

The message I have heard ... is that to be legitimate you have to come with solutions and take a leadership responsibility in shaping rather than just telling us why things are bad.

Professor Julian Le Grand (11 March 2005)

3.17 No single institution across medicine presently exists to define an overall vision for health from the profession. If doctors wish to be active participants in shaping the landscape of health, and not simply passive responders to prevailing circumstances largely outside their influence, they need to create the best and most effective institutional framework for doing so. We believe that there is a case to be considered for a new national forum – with substantial input from patients and other professionals – to debate, explore, think about, study, and develop policies across the many different institutions of medicine. That forum, which must not simply become another talking shop, would have the additional role of talent-spotting and nurturing medical leadership. It would bring the best

minds of medicine to bear on matters of national importance. It would be able to speak with authority on behalf of UK medicine on issues of common interest, and without suppressing legitimate other voices. Common interests, which reflect common values, include national health strategies; the services and resources required to meet the future health needs of the population; ethical issues; horizon scanning; public-health advocacy; and the structural organisation of the health system.

Teams

3.18 Most discussions of contemporary medical practice are plagued by manufactured and often false conflicts: between doctors and managers, specialists and general practitioners, and employers and employees. It would be foolish to argue that tensions do not exist between professional groups in healthcare. But an emphasis on differences between those who make up the healthcare team damages collective efforts to create a continually improving healthcare system.

It is not impossible to build a really trusting relationship where the management side and the medical side try and take responsibility as leaders in their own fields.
 Dame Margaret Turner-Warwick (10 December 2004)

3.19 The keys to strong clinical teams are recognition, mutual respect, and an appreciation of the constant redefinition of boundaries among the team. Recognition of the importance of interprofessional issues in medicine is not new.⁴⁴ But, overall, doctors have not spent sufficient time learning from other members of the healthcare team (eg ward-based patient handovers by nurses). The truth is that, in practice, doctors have insufficient time for effective team-building. They are often confused about their roles. And the vertical management of separate professional groupings tends to undermine the goals and work of a cross-disciplinary team.

A good leader is someone that works with the team rather than working above it, and respects everyone's input.

Focus group participant

[Professionalism] should be a proper partnership between the various players, not only doctors, but nurses and social workers, so that you maximise the contribution that each could make whilst respecting the autonomy of each of those.

Sir Ian Kennedy (20 May 2005)

The most important bit in team working is that people respect each other's roles within those teams and understand where accountability begins and ends and what they are accountable for.

Ms Denise Chaffer (6 May 2005)

3.20 There is relatively little knowledge about how teams of health professionals operate in practice. What evidence there is suggests that teams are not even close to fulfilling their real potential. Ethnographic research in hospital settings, for example, shows that collaboration between professional groups is usually short-lived, unstructured, opportunistic, fragmented, and rushed.⁴⁵ The number of professionals associated with one ward is large and diverse – doctors, nurses, therapists, social workers, pharmacists, care coordinators, and others. The idea of a clearly defined healthcare team is a myth in search of a manager.

We have to be flexible and we have to operate in teams in the best interests of patients and not hang on to this tribalistic view.

Ms Denise Chaffer (6 May 2005)

3.21 However, we do know that the nurse–doctor relationship remains central to the team, at least in hospital settings.⁴⁵ Although many professional interactions are initiated by doctors, doctors themselves tend to be highly task oriented in their collaborations and communications with other professionals. They often have very different perspectives on the performance of the team compared with their colleagues. If tasks are completed efficiently, for example, doctors may regard interprofessional collaboration as good. Professional colleagues, who put greater store on the value of stronger and closer social relationships among the team, might take a different view. As Scott Reeves and Simon Lewin concluded,⁴⁵

different professionals construct collaboration in very different ways and have competing notions of what constitutes collaborative work... policies aimed to promote [teamwork] need to recognise these different understandings of collaboration.

3.22 Teams in many healthcare settings, notably acute care, are inherently unstable. They are provisional, forever changing, forming and reforming with every new shift. Many teams in medicine only come together and exist for a brief time. The challenge is therefore how to make teams as effective as possible given

their inherent fluidity. Effective teams have shared goals, clear roles and responsibilities, a work plan, rules for how members of the team work together, and methods of monitoring their success. For doctors, as for other health professionals, it is vital that they are clear about their specific areas of responsibility. They need to understand the value of what they are adding to the team, a contribution that will vary according to time and place. Doctors also need to design robust mechanisms to ensure continuity of care despite discontinuity of personnel. As Cyril Chantler has written, ‘At all times patients need to know who is directly responsible for their care; each of us still needs a personal doctor who cares for and about us when we are ill’.⁴⁶

You do not have to be a doctor or a nurse to act as a professional and demonstrate aspects of professionalism.

Ms Denise Chaffer (6 May 2005)

3.23 Professionalism matters here because the qualities of a professional are about making sure that teams work effectively despite the difficulties they face. A good healthcare system should have the machinery to support doctors in their professional role as members of a team. That need is assuming even greater urgency with the training of nurse and medical care practitioners.

3.24 We recommend, therefore, 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.

3.25 The idea of working with other healthcare professionals in a team needs to be introduced early in every doctor’s career, ideally at medical school, so that an appreciation of the value and roles of other professionals can be developed and reinforced.

3.26 We recommend, therefore, that the General Medical Council, other regulatory bodies, and medical schools explore ways of strengthening common learning to enable better interprofessional education and training.

Education

3.27 The Working Party faced two major challenges. First, to define what medical professionalism meant for a modern health service. And second, to consider the conditions that would help that vision for professionalism to flourish. Professionalism will only be valued and fostered by proper attention to

its place in medical education, systems of appraisal, and the evolution of the medical career. Each of these areas is addressed separately in our report.

3.28 There is an intimate relation between education and professionalism. In our survey of trainees, for example, over 90% agreed or strongly agreed that one purpose of medical professionalism was to maintain or improve education or training. Over 80% also agreed that one effect of medical professionalism was to do the same. Education builds an ethos and identity for the doctor. The entire ethos of professionalism is, for most doctors, closely bound up not only with what they do but also with how they view themselves as an individual person. As one trainee put it to us,

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 ... it is the responsibility of every medical practitioner to promote professionalism throughout all aspects of their lives.

3.29 Education and training have critical but neglected roles in strengthening this ethos of professionalism. They provide a far better way to improve the standard of patient care than any punitive regulatory regime. Many of the qualities that we have defined as making up professionalism are not taught or reflected on systematically in the undergraduate medical curriculum or in postgraduate training. Professionalism is not a perk or a luxury in a modern health service. It is a central component of the covenant of trust between patient and doctor. The sustainable transmission of professional values should be an urgent imperative of all those concerned with delivering high-quality clinical care.

Communication is at the root of everything; you need to be able to communicate in this profession, otherwise the system falls apart.

Focus group participant

We know quite a lot about communication and skills and how to teach them. But there is not much about the attitudes that have to underpin this.

Sir Donald Irvine (16 December 2004)

3.30 An understanding of the value of these professional qualities should be sought in applicants at the point of entry into medical school. Every potential doctor should be able to demonstrate an awareness of generic professional attributes. Those attributes should be assessed at interview, in an applicant's personal statement, and in the teacher's report about the student. The appointment of lay members to medical school selection panels might be one way to promote these qualities at interview.

3.31 During a student's undergraduate years, time must be allocated so that these values can be reflected upon and specifically developed through learning a set of personal behaviours in clinical settings. The teaching of medical humanities may have an especially important part to play here. The successful nurturing of professional values will also depend greatly on the richness of the apprenticeship and mentoring experience that each student receives. Role models have a critical part to play in this acculturation process. The importance placed on these values must be transmitted and sustained in the postgraduate years. Again, mentorship is the key. As undergraduate medical training and assessment moves closer towards a national licensing process,⁴⁷ now is a good moment for medical schools to consider how professional values, behaviours, and relationships can be incorporated into their curricula locally, and into examinations nationally. One specific issue worth further thought is the potential to introduce professional values at the beginning of the undergraduate medical course with a ceremonial induction into the professional culture of medicine, an event somewhat akin to the 'white-coat ceremony' practised at many American medical schools.

In addition to all the formal tools and techniques and training ... the best private sector professional firms achieve [talent management] through mentorship; through apprenticeship; through not being afraid of that. It is time-consuming, but ultimately that is the chain of knowledge and how values get handed down from one generation to the next. The time taken on that in all sorts of ways conveys not only knowledge, but values and specific skills. The more that can be encouraged the better.

Paul Coombes (11 March 2005)

3.32 Sean Hilton and Henry Slotnick have set out six domains in which professionalism is manifested: an ethical practice, reflection and self-awareness, responsibility for actions, respect for patients, teamwork, and social responsibility.⁴⁸ Professionalism across these six domains is acquired during a period of intense experience and reflection on that experience, in parallel with a growing knowledge and skill base in medicine. This interval of professional development is the crucial gestation period for a set of values and behaviours that will inform a doctor's practice for much of his or her career. These values and behaviours can be attained (through curriculum design and the clinical environment), but they can also be subject to attrition (through hostile influences, including negative role models and unsupportive work conditions).

3.33 There is a widespread suspicion that medical cultures are somehow inimical to these kinds of modern professional values. The existing institutions

of medicine must work harder to link notions of professionalism to quality improvement – to embed professionalism into the routine work environment. This change in medical culture must also take account of the greater ethnic diversity of the population and the fact that much of medical training today takes place in a management vacuum. As Christine Jorm and Peter Kam have written, drawing on their experiences in Australia,⁴⁹

While bad doctors are rare, rusty and archaic ones are common. A systematic approach is needed to the maintenance of personal professional standards and the establishment of objective evidence-based guidelines for medical practice. These approaches need to be patient-oriented and not defend doctors or institutions.

3.34 We recommend that medical schools review their student selection criteria to identify students with developed, or the potential to develop, qualities of medical professionalism.

3.35 We recommend that 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.

3.36 We recommend that 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.

3.37 We recommend that 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 practise.

3.38 We recommend that 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.

3.39 We recommend that 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.

Appraisal

3.40 Good systems of appraisal are one of the foundation stones for sustainable medical professionalism. In the UK, there is also an ongoing discussion about revalidation – ensuring that doctors are fit to practise through a regular review of their work by peers and members of the public.⁵⁰ Our Working Party did not investigate the details of the regulatory or proposed revalidation processes. We merely note here that those discussions are continuing and we support the concept of linking the demonstration of fitness to practise with a doctor's registration through a system of independent, professionally led, publicly accountable regulation. These debates are not confined to the UK. Proof of ongoing competence and its linkage to certification to practise is a subject of concern in many industrialised nations.⁵¹

3.41 Appraisal is different from revalidation. Appraisal is not linked to a doctor's licensed status to practise. Its primary aim is not to assess performance. Appraisal is, instead, part of the career development process for every doctor. It aims to identify personal and professional development needs, career paths, and goals; to agree plans for those to be met; to consider a doctor's contribution to the quality and improvement of local health services; to optimise the use of their skills in achieving the delivery of high-quality care; and to offer doctors the opportunity to discuss and seek support for their work. According to the Department of Health,⁵²

Appraisal should include data on clinical performance, training and education, audit, concerns raised and serious clinical complaints, application of relevant clinical guidelines, relationships with patients and colleagues, teaching and research activities, and personal and organisational effectiveness.

3.42 The Department of Health does not mention professionalism and professional values. We view this omission as a serious failure in the current appraisal process. There is an understandable tendency in government to focus on measurable targets and tasks. But as one doctor put it to us in evidence: 'The erosion of medical professionalism has led to healthcare aimed at achieving targets rather than being based on patient needs.' And the reverse might also be said to be true: an unrelenting focus on targets damages the broad range of values – values that are not easy to quantify – that make up professionalism. The result will surely be a diminished overall patient experience within the health service.

3.43 Reflecting on professional values and the ongoing threats to those values (eg financial inducements or commercial conflicts of interest) should be at the heart of

any appraisal process for doctors. These values form the very ethos of medical practice and they are the crucial orienting coordinates of professional development. The Working Party discovered huge variation in views about the existing arrangements for appraisal in the NHS. Some doctors find the process positive and rewarding. More found it counterproductive and unhelpful in meeting the goals set out by the Department of Health. What is clear is that the system of appraisal now in place has not delivered on its expectations. We believe that part of the reason for that failure is the lack of attention given to professionalism in the appraisal process.

What we need to do is to work towards a system where doctors recognise that they need to, on a regular basis, reflect on their practice, attitudes, everything that they do. They need to do that on a personal basis, but with someone else to get an external perception on it.

Sir Alan Craft (8 April 2005)

3.44 Indeed, the evidence that the Working Party received suggested that there is considerable confusion about the purpose of appraisal. Many doctors believe that appraisal is a component of performance management rather than professional development. This confusion threatens the legitimacy of the whole appraisal process. Part of the current dissatisfaction with appraisal lies in the fact that many doctors think it has little to do with developing the qualities that make one a good doctor. This view is only worsened by the lack of resources available, in many cases, to deliver improvements in professional development. Without these resources, appraisal is meaningless.

The appraisal system has not got to be a performance management system.

Sir Alan Craft (8 April 2005)

3.45 We recommend 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.

3.46 Two further issues arose in the evidence presented to the Working Party, both of which impinge more on questions about revalidation than appraisal. First, should the Royal College of Physicians be prepared to withdraw its Fellowship in the face of consistently poor professional practice? Although the College

does not exist as a medical regulator, it does have a continuing responsibility for the integrity and reputation of its Fellowship. We hope that the College will study this question in its follow-up work on medical professionalism. Second, how should professionalism be included in a trainee's Record of In-Training Assessment (RITA)? RITA reviews take place annually to examine the evidence documenting a trainee's progress and performance. RITAs consider competencies, skills, knowledge, experience, and attitudes and beliefs. Professionalism is not a specific end-point of the RITA review. Perhaps it should be.

Careers

3.47 High-quality patient care depends upon a highly motivated and committed medical workforce. The Working Party heard evidence from several sources describing the present low morale among many working in front-line clinical services today. As one trainee commented,

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.

3.48 If we assume for the moment that our previous recommendations are fully implemented, we could envisage a medical undergraduate experience that was critically formative in developing professional values. In the postgraduate years, we could imagine a system of mentoring and career development that would establish these professional values in a doctor's life still further. But what then happens to the doctor during the 30-40 years of independent medical practice? Inevitably, as Hilton and Slotnick point out, there will be a degree of natural decay in professional values.⁴⁸ Certain personal or 'system-wide' events may take place to blunt those values still further, perhaps creating fertile ground for scepticism or even cynicism about the relevance of professionalism to practice.

3.49 These individual influences co-exist with wider social fluxes. The greater numbers of women in the medical workforce are creating welcome pressures for more flexible career paths to manage interruptions in working lives.⁵³ The greater social, cultural, and ethnic diversity of medicine means that professional values must be rooted in a culture of respect for difference. And the changing needs and expectations of patients mean that the profession has to be more prepared to adapt careers in new and often unusual ways – eg cross-disciplinary training schemes.

3.50 The solution to this array of forces, which needs to be accommodated in considering ways to strengthen professional cultures, rests on a simple but largely forgotten idea. It is that the doctor is as unique as the patient. Individual fulfilment for the doctor in medicine is an essential adjunct to the individual satisfaction that the doctor, as part of a multi-professional team, aims to bring to the patient. The idea that a doctor's needs and expectations, beyond their contractual status, should merit more serious consideration in healthcare debates is not to make special pleading on behalf of an already, some might say, privileged profession. It is to assert only that an effective health system requires a committed and motivated medical workforce. To produce happy patients, we need happy doctors. Many doctors are not presently in such a happy place. A large part of that unhappiness is due to a failure in the management of their medical careers. Improved career planning will need action at the individual and organisational level.

Medicine is not an homogeneous entity ... we should ask the question, 'Are there mechanisms in place whereby those who want to provide leadership are enabled to do so and are there career structures in place whereby those who want to move from medicine to some form of management and back and forth – are they in place?'

Sir Ian Kennedy (20 May 2005)

3.51 A report published by the Royal College of Physicians in 2005 demonstrates how serious this issue has become for the future of UK medical practice.⁵⁴ In 2004, over three-quarters of consultant physicians planned to take early retirement – a loss of 6,189 person-years of experienced work from the health service. Much of the blame for this precipitous loss of human capacity from healthcare delivery falls on the inflexible patterns of work endured by doctors over a long career.

3.52 The sustainability of a positive, patient-centred, and life-enhancing professional culture throughout a medical career will depend on several influences. Consistently good appraisal would be a valuable start. More flexible career pathways is another important goal. Protected time to keep up-to-date, to retrain, or simply to use structured periods to reflect on one's practice in a systematic way would provide a richer environment for professional development. And the acquisition of management skills and responsibilities would enable those who have devoted a good part of their career to delivering services to move into positions of policy influence over those services.

I think it is very important that we get more doctors into management positions and that actually is another way of exercising professional influence.

Sir Nigel Crisp (20 May 2005)

3.53 We recommend, therefore, 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.

3.54 We recommend that each doctor's career should have embedded within it, by employers and doctors themselves, a commitment to sustain professionalism.

3.55 Two further ideas deserve consideration. First, that there should be a periodic reaffirmation of professional values during the course of a medical career. Could the Royal Colleges and Faculties take on this responsibility? Second, that lay involvement in medical appointment panels might restore professional values as an important element for career development. Would employers find value in such a rebalancing of selection priorities?

Research

3.56 The Working Party has tried hard to base its analysis and recommendations on published evidence or on new findings – from witnesses and its own commissioned survey research – brought before its members. However, we have been struck by how weak the research base is on the effects of medical professionalism. We see a great opportunity here to test assumptions and to strengthen the scientific basis for understanding the contribution that professional values can make to modern healthcare. All we can do at this stage is to point to several interesting areas for possible future study.

- (a) What do we already know? It would be helpful to create a programme of research synthesis, akin to the Cochrane Collaboration, to identify and collate existing knowledge about medical professionalism.
- (b) How is the evolving partnership between patients and professionals – as individuals and in teams – influencing the landscape of healthcare? Mike Bury has identified three especially important aspects of patient–professional interactions that deserve further study:⁵⁵ first, the role of the active or expert patient; second, the whole concept of partnership itself; and third, the changing relationships between professionals in a team.

- (c) Does an emphasis on professionalism and professional values produce better health outcomes for patients?
- (d) What are the best methods to teach and assess medical professionalism? What is the best curriculum design to encourage professional values in young doctors?
- (e) How can medical professionalism be quantified through a set of multidimensional measures that can be incorporated into a range of instruments for assessing performance (individual appraisals, team assessments, hospital league tables)?⁵⁶ This is an urgent area for the UK's health system today. As Louise Arnold has noted,⁵⁷
Without solid assessment tools, questions about the efficacy of approaches to educating learners about professional behaviour will not be effectively answered.
- (f) What is the impact of the social and cultural diversity among doctors on medical professionalism?
- (g) What aspects of professionalism are especially important for clinical leadership? How can these aspects be linked to the training of a new cadre of clinical leaders in UK healthcare?
- (h) How have ongoing health-sector reforms (eg the European Working Time Directive) affected professional values? There has already been interesting work on the effects of efforts to strengthen professional values among doctors, especially in the context of changes at the GMC.^{58,59} These investigations deserve to be extended.
- (i) How robust is our description of professionalism across different clinical contexts, health systems, and cultures?⁶⁰

3.57 We recommend that research funders – 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.

4 | The future of medical professionalism

4.1 The state of medical professionalism is a major and controversial subject of public and professional debate in today's health service.⁶¹⁻⁶⁵ This debate is taking place against a background of enormous change in the delivery of healthcare.⁶⁶ There is an unprecedented level of new financial investment in the NHS and a commitment to make it more responsive to patient needs and expectations. Services are being delivered by an ever-broadening range of providers.⁶⁷

the [medical] profession ... needs to get involved in debates about how change will happen.

Sir Derek Wanless (8 April 2005)

4.2 While doctors are adapting to these changes, many feel unsettled not only by the pace at which these changes are taking place but also by the unanticipated effects they are having on their ability to deliver the best possible care to patients most in need.⁶⁸ The values that guide doctors through this evolving environment are best summed up in a single word – professionalism. Professional values constitute the social capital of medicine. The organisational culture of health – the shared attitudes and norms that govern patterns of behaviour in health settings – remains a neglected determinant of quality in the UK's health system.⁶⁹ Indeed, at its best, professionalism is deeply and constructively challenging to those who wield political power. Professionals, because of their covenant of trust with patients and their moral contract with society, are advocates for those they serve. The health professions make the case for high-quality health services based on reliable evidence. They are informed by a duty to put the patient first before all other interests. The trust that the public puts in doctors rests on this practical realisation of medical professionalism.

4.3 The future for professionalism in medicine depends on creating an enabling environment for professional values to flourish. That environment extends – at a minimum – into the areas of leadership, teams, education, appraisal, careers, and research. We also need mechanisms to motivate policy-

makers, employers, managers, and regulators to value professionalism not only for itself but also because it is an important lever for improving the quality of services to patients. Doctors must lead this debate. They must show that they own their profession's values and that they are prepared to be measured against them. Professionalism cannot be imposed by governments or by a regulatory culture. It must emerge from and be sustained by doctors themselves.

4.4 This report is an attempt to usher in a major philosophical shift in attitudes to medical practice. The social and political tide in many spheres of public life is currently being driven towards ever more rule-based regulatory regimes. Medicine is at the leading edge of this cultural shift. According to the prevailing orthodoxy, good standards of medical practice are a matter of rigorously enforced dutiful conduct. By contrast, our view is that the regulatory pendulum has swung too far in this direction. It needs to be brought back to a more balanced position where there is an understanding that an environment which encourages a doctor's 'goodness' is one that will promote positive patient outcomes. This 'goodness' is what we mean by professionalism. Instead of focusing on doctors' weaknesses, we prefer to begin with their virtues. The challenge is to find ways to understand how these virtues can be nurtured, reproduced, and sustained across the health system over time.

4.5 The Royal College of Physicians plans to continue the investigations started by this Working Party. The College especially wants to open up a wider dialogue with patients and public. The Working Party sees professionalism as a decisive factor in creating a high-quality health service. Our view was well summed up in the words of one trainee doctor, someone who will be part of the future of health and healthcare in the UK:

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

4.6 That is a view this Working Party agrees with wholeheartedly. Our abiding wish is to put medical professionalism back onto the political map of health in the UK.

5 | Definition, description and recommendations

Definition

1 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.

Description

2 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.

In their day-to-day practice, doctors are committed to:

- *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.

Recommendations

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.

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 practise.
- 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.

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Appendix: Those who gave oral evidence to the Working Party

Friday 12 November 2004

Mrs Claire Rayner *President, The Patients' Association*

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

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

Friday 10 December 2004

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

Dr Declan Chard *Chair, Trainees Committee, Royal College of Physicians*

Professor Dame Margaret Turner-Warwick *Past President of the Royal College of Physicians*

Thursday 16 December 2004

Sir Donald Irvine *Chairman, Picker Institute Europe*

Thursday 13 January 2005

Dr David Armstrong *Reader in Sociology as applied to Medicine, King's College London*

Friday 11 February 2005

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

Friday 25 February 2005

Dame Janet Smith DBE *Lady Justice of Appeal and formerly Chairman of the Shipman Inquiry*

Friday 11 March 2005

Julian Le Grand *Professor of Social Policy, London School of Economics*

Mr Paul Coombes *Former Director, McKinsey and Company*

Friday 18 March 2005

Professor Sir Graeme Catto *President, General Medical Council*

Andrew Phillips (Lord Phillips of Sudbury)

Friday 8 April 2005

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

Professor Sir Alan Craft *Chairman, Academy of Medical Royal Colleges; President, Royal College of Paediatrics and Child Health*

Sir Derek Wanless *Author: Securing our future health: taking a long-term view (2002); Securing good health for the whole population (2004)*

Friday 6 May 2005

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

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

Friday 20 May 2005

Professor Sir Ian Kennedy *Chairman, Healthcare Commission*

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