New medical professionalism

*A scoping report for the
Health Foundation*

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Introduction

The role of doctors has always evolved in response to changes in society, demand, the structure of healthcare services and, of course, the changing state of medicine itself. This trend continues, with various factors driving important changes in the roles played by doctors and others working in healthcare. The motivation exists among doctors and others to rise to both the challenges and opportunities these changes create. However, recent history has left many working in healthcare feeling battered, exhausted and cynical about further change.

This situation creates significant risks for patients and public. These risks include the possibility that doctors do not play the role they could and should in shaping the future; that motivation in the NHS is eroded even further; that expertise is lost; that quality declines; that the argument that we cannot afford the NHS gains in strength; and that the founding principles of the NHS themselves become unsustainable. There is a great deal at stake.

The Health Foundation wants to play an active and constructive role in addressing these risks. The first step is to conduct a genuine dialogue involving truly diverse participants. This report seeks to provide a starting point for that dialogue, and in particular to address three questions:

– What questions are worth discussing?

– Who needs to be involved in the discussion?

– How can we make sure the discussion is constructive?

The report does not set out to define 'medical professionalism'. Instead, we review the ways in which doctors' relationships with evidence, society, patients, teams, regulators and employers have changed, are changing or may need to change, and the implications for medical professionalism.

A number of those interviewed expressed concerns about the proposed focus on medical professionalism and, by implication, on doctors. The same question was already a live one at the Health Foundation. The decision to focus this report on the topic of medical professionalism was made first pragmatically and second contingently. The Discussion section returns to the question: Is medical professionalism the right topic for dialogue?

Definition and dialogue

There has been no shortage of recent attempts to define medical professionalism, and no obvious increase in clarity as a result. The problem lies in part in phrases such as 'new medical professionalism', which reify the concept and lift it clear of the history and relationships within which its meaning lies. The practical impact of definitions is also questionable.

Much more can be achieved by dialogue, provided it is rooted in real practical problems, drawing in theoretical perspectives when these are helpful, and making full use of narrative and story to bring problems and solutions to life. A good conversation can open up a space for exploration, while reflection can change our ways of thinking, feeling and acting – even though those we are talking to may have no specific 'change objectives' in mind.

However, dialogue is not a miracle cure. In particular, given the amount of discussion about medical professionalism that has taken place over recent years, one must wonder why things have not already changed. A future dialogue must never lose sight of a critical question: What can we do differently this time to avoid the same outcome?

Tradition

Traditionally, professionalism has been seen as a quality of the individual doctor – as opposed to the relationship-based approach we have taken in this report. Typically, it is seen as a combination of values, knowledge and skill, integrity and good judgement in an individual. The doctor–patient relationship is seen as pivotal, but traditionally has been understood paternalistically. Other key concepts in traditional accounts of professionalism include character, vocation, autonomy (a term with multiple meanings) and self-regulation.

Tradition has no special claim on the truth, but neither is it necessarily wrong or outdated. Criticism of one element of the traditional view of professionalism should not be taken to imply that all its other parts are wrong.

Tradition is also something with which people, including doctors, have a complex relationship. For some, that relationship will be one of antagonism and frustration; for others, respect and nostalgia. One can show empathy for these feelings while at the same time disagreeing with the beliefs that underpin them. Evidence strongly shows that a sense of some continuity can be crucial to people's willingness to embrace change.

Doctors

The world has changed fast around doctors. But the population of doctors has also changed, and the profile of personal values and motivations that doctors bring to their role is not the same as it was 10, 20 or 50 years ago. Reasons for this include generational change; the increasing number of women in medicine; social mobility; and the large number of doctors with different cultural roots.

We should reject the construct of a 'typical doctor'. Consideration of the functional diversity of the profession alone suggests such an idea is out of place even before other factors are taken into consideration. Understanding the diversity of doctors will be an important task to be taken into the Health Foundation's dialogue.

Healthcare and medicine

Evidence

The growth of evidence-based medicine, and the growing accessibility of that evidence, have both had profound effects on medical professionalism.

To the extent that evidence determines the right thing to do, it erodes the scope for individual judgement. However, it can be argued that judgement and experience remain critical in the application of evidence to specific situations; in managing uncertainty; in weighing ethical questions; in managing the human side of care; or even in improving the efficiency of interactions. Psychology is starting to shed light on the real mental processes involved in judgement, enabling us to assess the strengths and limitations of judgement in an evidence-based way.

The combination of evidence-based medicine and the information technology revolution has transformed medical knowledge from something **possessed by doctors** to something that can be **accessed by anyone**. As a result, patients, journalists, governments and others are all able to draw on evidence for their own ends. Doctors are having to adjust to a world in which second opinions do not have to come from another doctor to carry weight.

The pace of change in medical evidence is transforming the model of what it takes to become and remain a professional in medicine, from an apprenticeship model (once demonstrated, mastery is not questioned) to a lifelong learning model in which knowledge and skills need to be updated and confirmed continuously.

The very idea of being 'up to date' is becoming obsolete. No individual can now keep abreast of the fast changing and vast field of medical knowledge. This has driven a trend to specialisation, and fatally undermined the idea that 'expertise means knowledge-in-the-mind'.

Constructionists have questioned medical claims to knowledge on more radical grounds, arguing that what we call 'truth' or 'knowledge' are in fact

constructs of the operation of power. On this view, the concept of medical professionalism is not a quality of individuals but a kind of rhetorical tactic to perpetuate power. Constructionism forces us to look closely at the dynamics of power in medicine, and the way ideas like 'knowledge' and 'evidence' can serve those dynamics.

Society

Wider changes in society have had important consequences for the roles doctors are expected to fulfil and the associated conceptions of medical professionalism.

Modern doctors are increasingly able to do something that was for the most part beyond them a hundred years ago: cure their patients. As a result, curing has moved to the fore in society's understanding of the doctor's role and risks crowding out the broader project of healing, which is focused on helping the patient to make sense of what is happening to them. Increasing specialisation makes it even harder for doctors to take account of a whole person and their experiences, even though evidence is emerging that these things matter to health outcomes.

The successes of modern medicine in keeping people alive who would once have died, combined with broader social changes (eg around lifestyle and diet), mean we simply cannot afford to do everything we are now capable of doing. Many have argued that these challenges require fundamental shifts in the role of the doctor:

– from treating people when they get ill to keeping them healthy in the first place

– from doing something to people to persuading and enabling them to do things for themselves

– from meeting the needs of an individual patient to meeting the needs of a whole community.

The question of how to handle the tension between responsibilities to the patient in front of one and responsibilities to the wider community is emerging as one of the critical challenges for modern medical professionalism.

This challenge needs to be addressed, moreover, in the context of the rise of consumerism. Arising from the definition of paternalism as 'a concern for what experts believe is **good** for people, irrespective of what those people **want** or think', are two distinct senses of consumerism.

– The first is 'a concern for what people want, irrespective of whether or not it is good for them'. Far from being required to become more responsive to consumerism in the first sense, doctors are in fact being asked to hold the line against it in their role as stewards of resources.

– The second is 'an insistence that what is good for someone cannot be defined without the participation (in so far as possible) of that person'. It is well captured by the phrase 'No decision about me without me'.

Patients

The relationship between doctor and patient has changed in many different ways. At least five distinct reasons for the decline of paternalism can be identified.

– An essentially moral rejection of paternalism, in line with the principle 'No decision about me without me'.

– The transformation of medical knowledge from something possessed by the doctor to something which can be accessed by anyone.

– Growing evidence that the subjective meanings and experiences of the patient have a substantive impact on health outcomes. In this case, the relationship to paternalism is complex, in that some patients may crave precisely the kind of parent–child relationship that paternalism implies.

– A growing emphasis on the patient's role as an active partner in the maintenance of their own health, driven both by evidence of improved outcomes and the need to manage resources.

– A greater awareness that doctors in general are not perfect and that individual doctors may be very bad – leading to a greater willingness to question doctors.

At the same time, doctors are being expected to take on what might be described as a 'new paternalism', and to say 'no' to the patient, not because of their own expert opinion about what is good for that patient, but because of expert opinions (often not their own) about what is good for the community as a whole. There are significant risks here for the trust patients place in their doctors.

A recurrent theme in both the literature and our interviews is that doctors need new skills and capabilities to deal with the changing relationship between doctor and patient.

In general, it is easier to reject paternalism than to say exactly what goes in its place. The lack of a word to replace the (obviously paternalist) 'patient' is one obvious symptom of this difficulty. Perhaps the real change is that a single paternalist relationship between doctor and patient has been replaced by a multiplicity of relationships which vary with situation, need and the specific role being taken by both patient and doctor. If true, this has significant consequences for the concept of medical professionalism. No longer would professionalism be simply about fulfilling a pre-defined role; it would also be about recognising which role any given situation calls for. This is an area in which judgement has a clear role to play.

Teams and other collective endeavours

The model of the heroic doctor single-handedly treating their patient has little or no relevance to the modern realities of healthcare. The quality of the care received by a modern patient depends on a collective endeavour, one that spans professional boundaries, organisations and traditional policy divides such as that between health and social care.

In the context of teams and other collective endeavours, doctors need to develop their skills in areas that have not been traditional strengths. These include the skills of influencing and, just as important, being influenced. There are disparities between different settings and specialisms regarding the extent to which these skills are currently in evidence.

Teams also provide a new context for judgement and decision making. The potential for collaborative judgement, however, needs to be balanced against the need for one individual to take accountability – and implies a need to rethink the way in which responsibility is attributed when things go wrong.

Finally, teams provide a new context in which to think about how to tackle the many and sometimes conflicting requirements of 'new medical professionalism'. If we insist that every individual doctor does everything, then we are merely replicating the model of the heroic doctor from which we are trying to move away. In the team context, professionalism may be more about recognising one's own areas of weakness and taking responsibility for ensuring they are matched by strengths in colleagues. Such an approach would also free up individual doctors to make their own unique contributions in line with their particular aptitudes and motivations.

However, the collaborative nature of modern healthcare also raises serious questions about the idea that there is a single, distinct medical professionalism which both unites and distinguishes **all** doctors across many different contexts. Instead, the term 'doctor' may now describe a network of 'family resemblances' between roles in different contexts.

This is not about disbanding the idea of professionalism, junking shared values and standards or dismissing people's very real vocations. But the project of trying to establish the defining and distinguishing features of 'a doctor' across extremely diverse contexts may be becoming an unhelpful distraction.

Profession and state

Regulators

Recent years have seen the intervention of the state in regulation following a series of failures in existing self-regulation mechanisms. Some aspects of the way this process has unfolded have created a negative emotional context for future dialogue around professionalism. This is especially true of those actions which have been perceived as questioning doctors' motives; seeking to eliminate risk entirely and in so doing creating new risks; or replacing trust with rules, surveillance and control.

There are, however, some positives. On the one hand, the attachment of individual doctors to the idea of self-regulation may reflect a laudable desire to take responsibility for the shortcomings of others – a desire which, if transplanted into the context of teams, exactly reflects what is now required of doctors. On the other hand, recent writing about regulation clearly positions regulators as participants in the collective endeavour of healthcare with a role to play alongside, not above, professionals.

Employers

The **fact** of management has implications for the 'Traditional Perspective'. There is evidence that most doctors now recognise the need for management, and accept these implications. The **how** of management, however, remains an area of debate.

Aspects of the way in which management was attempted during a significant recent period have left an emotional legacy in this area. These include:

– A failure to involve doctors adequately in the creation of targets, policies and protocols. The result was that doctors were **made accountable** for things for which they did not **feel responsible**. In many cases, it also led to doctors feeling mistrusted.

– A lack of adequate scope for judgement in the implementation of targets, policies and protocols, often as a result of focusing on process rather than outcomes. The result was that doctors felt deprofessionalised and undervalued.

– Policies and interventions based on the evidence-free assumption that human motivation can be explained entirely in terms of calculations of gains and losses, which therefore disregard much of what doctors actually care about – and leave no room for the idea that a rewarding job can be a motivation in itself.

– The withdrawal of key elements of the old compact between doctors and the NHS. In particular, erosion of the freedom to do what you really want to do in life (the key intrinsic reward of being a doctor under the old compact) by various requirements to do what someone else wants you to do, in return for things that someone else believes you want.

– The failure to establish a new compact better suited to the realities of modern healthcare.

In the future, doctors' compact will be, increasingly, not with society or the state but with organisations: the trust, the consortium, the practice. Increasingly, it is organisations such as these that will both shape the practice and determine the *quid pro quo* of medical professionalism.

Many doctors face challenges in organisations, being ill-equipped with the skills and capabilities needed to thrive in an organisational setting. On the positive side, the scale of organisations is far better suited to the re-evaluation of the compact than the entire NHS. Moreover, practical and documented approaches to 'compacting' already exist and we are confident that examples will be found in practice of refreshed compacts between organisations and doctors delivering a 'new medical professionalism'.

Discussion

The proposed focus on medical professionalism has some clear pragmatic benefits, but also clear risks associated with it. We suggest the dialogue be structured instead around foci which communicate in a more accurate and direct way the new contexts in which the professionalism of doctors **and** others needs to be put into practice:

– professionalism with (individual) patients

– professionalism in clinical/healthcare teams

– professionalism across care pathways

– professionalism in healthcare organisations.

If a single overarching term is required, we suggest that this might be: professionalism in modern healthcare.

Within each of these contexts, three types of question need to be addressed:

– practical dilemmas and challenges on the ground

– reflective questions, rooted in these dilemmas and challenges

– skill requirements.

Examples of each type of question in each of the four contexts are offered, along with examples of the ways in which a range of different types of dialogue (eg action learning groups, dialogue events, online discussion groups, a national panel) might be used to achieve a balance across all the different types of question. The offered framework also provides a structure for thinking about which audiences need to be engaged.

Any dialogue about professionalism will take place in the context of a very difficult emotional legacy. Individuals on all sides have felt mistrusted, let down and undervalued. In our conversations, people have described what is needed from a dialogue using metaphors such as 'marriage guidance' and 'truth and reconciliation'. The expression of emotions is often considered unprofessional. However, emotions are facts and expressions of emotion are therefore a kind of evidence. To ignore this evidence or pretend it does not exist is equally unprofessional.

We suggest that dialogue should be guided by a commitment to explicitly stated values which enable the constructive expression of emotion and difference. We suggest that these values might include empathy, respect, curiosity, honesty, pluralism and reflexivity.

The Health Foundation will need to be honest about its own feelings, beliefs and intentions as a participant in the dialogue, in line with these values.

The last of these will be of particular importance. We must always ask ourselves: Are we using the rhetoric of 'evidence' to maintain power in the dialogue and exclude those whose evidence lies in stories? Are we pushing for a consensus to avoid acknowledging the depth of disagreement? Are we falling into the traps that we have fallen into before?

Part 1: Introduction

1. About this report

Key messages

- Medical professionalism has always evolved and changed.

- There are significant risks in the current situation.

- In this report, medical professionalism is explored in the context of relationships between doctors and others.

- The question 'Is **medical** professionalism the right focus?' is addressed in the conclusions.

1.1 Context

Medicine as a profession has always had to move with the times, and will continue to need to do so.[1]

This is a piece of work that needs doing. We are in interesting times. It's vital that we don't stagnate, and that there is fresh look at professionalism.

(David Haslam)

There's a part of me that thinks: 'I just want to be a doctor.'

(Maria-Teresa Claridge)

The role of doctors has always evolved in response to changes in society, demand, the structure of healthcare services and, of course, the changing state of medicine itself. There is a growing consensus that the current mix of factors may require fundamental changes in the roles played by doctors and others working in healthcare.

This is timely and relevant. We're going to have to change, and we have got to think about how to change.

(Maria-Teresa Claridge)

We've got to change the very construct of what it means to be a doctor.

(Peter Lachman)

There is every reason to believe that the motivation exists among doctors and others working in healthcare to rise to both challenges and opportunities.

Broadly speaking people go into medical school because they want to do a good job. They still want to do a good job now and if that energy could somehow be unleashed we'd have no problems in the NHS.

(Alf Collins)

There are a lot of clinicians who are passionate about taking opportunities to do things differently. They're not always the usual suspects. I've been surprised on more than one occasion by people saying things and wanting to take opportunities that I wouldn't expect. Most people in NHS do it for all the right reasons. That's still there.

(Susan Went)

On the other hand, recent history has left many doctors and others working in healthcare feeling battered, exhausted and cynical about further change.

An awful lot of doctors feel very deprofessionalised at the moment. I think some of that is nonsense and I will challenge it. But at other times I think they have a point.

(Oliver Warren)

Very few doctors see the opportunities. We've got ourselves into a rut where change is not a good thing – or not what we want. It's the ostrich mentality – and unfortunately, if you stick your head in the sand, all too often things do go away. I don't see many who would see changes as opportunities – except when it comes to new medical advances.

(Claire Lemer)

This situation creates significant risks for patients and public. These risks include the possibility that doctors don't play the role they could and should in shaping the future; that motivation in the NHS is eroded even further; that expertise is lost; that quality declines; that the argument that we cannot afford the NHS gains in strength; and that the founding principles of the NHS themselves become unsustainable. There is a great deal at stake.

The Health Foundation wants to play an active and constructive role in addressing these risks. In the longer term, this will mean having a clear impact among ordinary doctors on the frontline. Evidence of that impact will come from the things those doctors:

– **Think**: eg 'Five years ago, there were all sorts of different strands of thought around my role as a doctor. Now I feel it's come together and made sense for me in what I do.'

– **Feel**: eg 'I don't feel threatened by the way my role is changing. I want to take on these new challenges.'

– **Do**: eg 'I'm doing things differently as a result of being involved in the Health Foundation's work or other work prompted/inspired by that work.'

The Health Foundation is setting out with neither a preconceived view of what doctors should be doing differently, nor a plan for how to persuade them do it. Instead, it believes that the first step is a genuine dialogue, involving truly diverse participants and focused on solving real practical problems.

Medics and other professionals are tired of being exhorted to be better people. You cannot roll things out from a lofty ivory tower. You have to focus on solving practical problems, and put the issues in a real context. You have to start from the question: 'How can this help me with the practical problems I face on a daily basis?'

(Mary Dixon-Woods)

The Health Foundation's aims in that dialogue are to:

– understand better what the key questions around the role of the doctor are, where people stand on these questions, and how their positions evolve in response to challenge and discussion with others

– have a clear view of the next steps the Foundation can best take, including other kinds of intervention if appropriate

– engage a wide range of participants, including many individual doctors, who want to stay involved with future activity

– inspire others to take action.

Other participants will have their own valid aspirations, which the dialogue will need to accommodate.

1.2 The aim of this report

In light of the above, the aim of this report is not to define medical professionalism, nor to lay out a series of interventions. It is instead to provide a starting point for dialogue, and in particular to address three questions:

– What questions are worth discussing?

– Who needs to be involved in the discussion?

– How can we make sure the discussion is constructive?

While we have made an effort to be comprehensive and balanced in this report, we are human beings, citizens and sometime patients with our own personal perspective. Our aim in putting forward opinions has been to prompt conversation, not pre-empt it.

The report draws on a review of recent literature, together with a series of interviews with doctors and others who are listed in the Acknowledgements. Most of the content of this report has been shaped by these interviews, but of course the report as a whole does not reflect the views of any one of the interviewees. We have done our best to represent the diversity of views expressed, and not to present some false consensus: these are topics on which people do not agree.

1.3 Why *medical professionalism*?

By focusing on medical professionalism, you risk colluding with the power agenda of doctors in relation to the healthcare system. You have to make it about all professionals, and especially those working at the front line of care – which is more often than not a nurse or the equivalent. Vast areas of care are also delivered by lay people.

(Debra Humphris)

My heart sank very slightly when I got the note from you. Why medical professionalism? It's doctors, nurses, all the other people. You cannot treat the professionalism of doctors separately.

(Harry Cayton)

A number of those we interviewed in preparing this report expressed concerns, some of them severe, about the focus on doctors in this work. In fact, the same question was already a live one at the Health Foundation. The decision to focus this early report on the topic of medical professionalism was made first pragmatically and second contingently.

In light of this, we have stuck to our brief in writing the report, but also remained alive to the possibility that medical professionalism may not in fact be the best focus for the proposed dialogue. To the three questions identified in section 1.2 above, may be added a fourth, which is also addressed in the Discussion section: Is medical professionalism the right topic for dialogue?

In embarking on this project, we were also aware that different views exist about the relationship between medical professionalism and the risks to healthcare described in the last section. To simplify considerably:

– Those who associate professionalism strongly with the vocation and motivation of individual doctors tend to see it as a potential **motor for change**.

– Those who understand professionalism as an objective definition of what is required of doctors, to be implemented through training, revalidation and regulation, tend to see professionalism as a **mechanism to achieve change**.

– Those who draw attention to the structures of power and authority associated with change tend to see the concept as at best a distraction, at worst a **source of resistance to change**.

The Health Foundation's own theory of change allies it most closely to the first of these views. Our own prejudices will be amply apparent in the report that follows. We have, however, done our best to represent all three perspectives.

1.4 How this report is structured

The idea that underpins our approach to structuring this document is outlined in a paper shared with us by Harry Cayton:

A new professionalism could be defined not in terms of autonomy but in terms of relationships. […] The qualities of professionalism would then derive not from what a doctor is, from being, but from how they behave in relation to others. A professionalism based not on individuality but on mutuality.[2]

In the main chapters of the document, we review how doctors' relationships with evidence, society, patients, teams, regulators and employers have changed, are changing or may need to change, and the possible implications for medical professionalism. Many of these relationships interact with one another, meaning that themes introduced in one chapter are often continued in a later chapter. We have indicated these connections with cross-references.

We have divided this discussion into two parts: the first broadly focusing on changes in the nature of healthcare and medicine, the second focusing on the changing compact between the profession and the state. This division is far from perfect.

In the rest of this introduction we cover some important preliminaries.

Chapter 2 discusses the challenges of defining professionalism and the importance of ensuring that dialogue is focused on what professionalism means in practice, not on paper.

Chapter 3 sets out what we call a Traditional Perspective on professionalism, to provide a fixed point for subsequent discussion. We may note at once one fundamental way in which the report diverges from this Traditional Perspective; rather than defining professionalism as a quality of an individual doctor, we approach professionalism in the context of doctors' relationships with others.

Of course, this does not mean that individual doctors do not make a difference. At the same time as reviewing the ways in which relationships have changed, we should remember that the population which partakes in all of those relationships has also been changing. These changes are very briefly reviewed in chapter 4.

2. Definition and dialogue

Key messages

- Another attempt to define new medical professionalism would be of limited practical value.

- Dialogue focused on current practical problems around medical professionalism can catalyse change.

- There has been much discussion of medical professionalism in the last decade: what can we do differently this time to ensure dialogue leads to real change?

This chapter discusses the challenges of defining professionalism, and the importance of ensuring that dialogue is focused on what professionalism means in practice, not on paper.

2.1 Doing without definitions

The whole concept of professionalism means different things to different people. Before this interview I was wondering: which tack will he take me down?

(Hugh Reeve)

As far back as 2006, a paper from the Picker Institute noted wryly that, 'Defining the "new medical professionalism" is a growth industry'.[3] Five years on, there has been no discernible let-up in production and no discernible increase in clarity about what the term means.

A recent systematic review on the topic of developing medical professionalism in future doctors, for instance, found that 'there is currently no commonly accepted theoretical model being used for the integration of professionalism into the undergraduate curriculum' and offered a useful summary of the state of play:

There still remains uncertainty about what professionalism actually is, and although medical educators primarily frame professionalism as a list of characteristics or behaviours, many sociologists favour theories that incorporate political, economic and social dimensions into the understanding of the nature and function of professionalism. In addition, moralists will argue that professionalism should be seen clearly as an aspect of personal identity and character which develops over time.[4]

It is in this context that Lemer and Stanton[5] remark that 'the words "medical professionalism" have come to encompass the identity crisis that doctors find themselves in'.

Why is it so difficult to define 'new medical professionalism'? Part of the answer lies in the term itself. After all, to talk about a 'new medical professionalism' is to imply that there is an 'old medical professionalism' which is no longer fit for purpose. The mere application of two adjectives ('old' and 'new') to an abstraction ('medical professionalism') creates the illusion that we are talking about two things. In the process, medical professionalism is lifted clear of the history and relationships within which its meaning lies. Moreover, by reifying in this way, we risk emphasising contrasts between old and new at the expense of continuities.

In chapter 3, we are knowingly guilty of exactly this kind of reification when we set out what we call a Traditional Perspective on professionalism. The value of setting out that perspective is that it provides a reference point for the discussion in subsequent chapters of forces that are driving the continued evolution of medical professionalism. The Traditional Perspective serves, that is, as a fixed point in our exposition. But it is absolutely not intended to represent a mythical fixed point in history.

Clarity on this point is important, as there is an appealing account of the history of medical professionalism which runs as follows. Once upon a time there was consensus about how society operated. Everyone 'knew their place' and accepted a common model of social roles and the authority, responsibilities and privileges associated with them. Medical professionalism was part of a social order that has, in the 20th century, been replaced by a fractured society in which social roles are no longer clear.

The problem with this account is that even if such a social consensus did once exist, and medical professionalism did find a home in it, it was no more than a temporary equilibrium state in a dynamic system. For instance, one could see the challenges to doctors' authority in the 20th century as the latest chapter in a trend that stretches back to the Enlightenment (challenge to political authority) and Reformation (challenge to priestly authority).[6] Scepticism about doctors' authority too has a long prehistory, as the plethora of comic caricatures and parodies of doctors from earlier centuries attests. The idea that the pre-war years saw the last days of a dark/golden age (depending on one's perspective) of paternalistic stability is at best a simplification, at worst (probably) false.

Worse still, the myth of a stable, monolithic 'old medical professionalism' does great injustice to those individual doctors who were themselves at the forefront of transforming the profession. The constant evolution of medical professionalism has been driven from within the profession as well as from the outside.

Even when I was a student, there were people who practised in this way.
(Tony Giddings)

Finally, even if it were meaningful to talk about an 'old medical professionalism', that would not necessarily justify the reification of 'new medical professionalism'. As we shall see in subsequent chapters, nearly every aspect of the Traditional Perspective has been challenged in some way. But there is not one single argument against it, rather a whole range of overlapping and sometimes conflicting challenges. Different people will accept different arguments while rejecting others, leading not to a single debate between 'new' and 'old', but a cacophony of micro-debates between bits of each. Sometimes the debate is between different parts of the 'new'. Plenty of live arguments remain.

Of course it makes sense to talk about 'change', and therefore what is 'older' and what is 'newer', in connection with medical professionalism.

Professional practice is always changing. I think of what was commonplace when I started my career in terms of what a doctor would do in a hospital or in their community; so much has changed.
(Hugh Reeve)

But we should be very mindful of the distortions that follow when we start treating abstractions from history and relationships as if they were real things-in-themselves.

Professionalism as I look at it has always been developing. It's a mistake to think that there is one fixed version of what professionalism is. It's set in the context of our relationship with society, with each other, and with our organisations (whether as employees or owners). It always has moved on. There is this quaint belief that professionalism has this autonomous existence – but it's a relationship. Anyone who thinks professionalism isn't changing is missing one

of the fundamental pieces of being a doctor: that we only have our position in society by the gift of patients. There are other societies where doctors don't have that position.

(Jonathan Fielden)

Everything we do in this area needs constant renewal. We're not going to create a perfect world, but we can improve it. Our model of the work situation that we're trying to improve is based on us having in our mind's eye a Utopia – but that's never a helpful model. The reality is that we're all fumbling around doing the best job we can of something intrinsically difficult, but with an open mind we can be better.

(Tony Giddings)

2.2 Focusing on the practical

Even if it were possible to define new medical professionalism, it is far from clear what practical difference doing so would make.

I don't think the definition of professionalism enters into the everyday medic's life except when something happens – something infringes on the day-to-day reality, something goes wrong.

(Claire Lemer)

Defining what should happen is not a way to make it happen.

(Susan Went)

In line with this, our interviewees were unanimous in the view that any dialogue around medical professionalism or similar topics should be clearly rooted in the practical, with implications for the types of questions addressed, the discussion formats adopted, and the language used.

There is a very interesting issue around: what does it mean to be a modern professional in practice? So let's say we can even agree on what those behaviours that demonstrate professionalism are, but how does a modern professional put those into practice in real life, in real dilemmas, in both the clinical and moral context of a changing health system and changing moral systems. For instance, a GP I know is concerned that GPs are going to face a dilemma between the duty of care and their duty as guardians of the public purse. How do modern professionals deal with that dilemma?

(Harry Cayton)

If you start from the idea that professionalism is a dynamic process, you could almost link it to the various stages of a doctor's development. Are we ensuring at medical school that people are qualifying to enter a profession that will be fundamentally different? Are we doing the professional refreshing bit? And then there's almost a remedial piece – how to cope with the new professionalism – something for people of my generation and above, to explain that there is this new skill set and that this isn't a threat, there is a way through this.

(Jonathan Fielden)

I like the idea of active learning sets, people trying to find solutions together.

(Iona Heath)

Local teams need an opportunity to be creative. The slogan 'We work with the best' is all very well, but you also need to make it easy for 'problematic' teams to come forward and seek support with managing their practical problems.

(Mary Dixon-Woods)

We don't need ivory tower stuff, people pronouncing from on high – stuff that doesn't reflect what really goes on on the ground.

(Maria-Teresa Claridge)

It needs to be something that people working with patients would recognise and say, that's important.

(Oliver Warren)

If you were to set the value of debating the concept of professionalism against the question of whether patients are being seen by the right people, the latter seems to be the more important question.

(Tony Giddings)

Unsurprisingly, a number of our interviewees identified the introduction of clinical commissioning as an area which created both an opportunity and need for dialogue around professionalism.

There's obviously work to be done in this area: how to have effective conversations, how to facilitate the process, what will make an integrated approach more likely? It's an area that's ripe for pragmatic work – and it would be real world work, rather than something done in an abstract way, action research and action learning. You would be going through the process, but have the mechanisms and permission and time to reflect and learn, and learn from what's happening elsewhere.

(Hugh Reeve)

None of this is to say that such dialogue should not also draw on theoretical or academic perspectives, only that such perspectives need to be made real by linking them to practical contexts.

I would find it fascinating to spend a decent amount of protected time talking through these issues with other clinicians for other specialties and patients. And indeed philosophers, ethicists.

(David Haslam)

We need to hear ways of thinking from other disciplines – importing things from anthropology, ethnography, psychology, and not just from a reductive management science stance.

(Iona Heath)

One excellent way of achieving this practical focus is to build dialogue around narratives which bring to life either problems or solutions, including stories of where people are already getting things right – if possible, presented by those people themselves.

We need something that says: 'Look, this is where it's being done; this is what people are doing out there now.'

(Alf Collins)

It's a joy to share ideas. But there's also something about how the information is given. Not publishing in some journal, but something much more human. We should go back to human storytelling, hear it from people who are motivated and interested. There is something around the honesty of a story – the integrity of where it's coming from and the person that's delivering it. A story that's delivered with humility, humour and honesty: these resonate, but also make things feel significant and important.

(Maria-Teresa Claridge)

There is also a clear need to look out, not inwards: there is surely much to be learned from looking at other areas which have faced, and sometimes resolved, similar challenges.

> *Why reinvent the wheel? We should be learning the lessons from social care and other professions, rather than starting all over again. Professionalism is not exclusive to medics.*
>
> *(Debra Humphris)*

In this document, we have done our utmost to delineate questions about medical professionalism that will have real practical relevance. But the task of linking those questions to practical realities and identifying the stories that bring the problem to life – as well as the solutions that people have already found – is a task for the dialogue that follows. Not every chapter or every question will resonate with every reader, of course. But we hope that in our effort to be comprehensive and address the varied interests of a potentially diverse audience, we have not fallen into the trap of delivering what one interviewee described as an 'erudite tome, to add to the other erudite tomes'.

2.3 Beyond dialogue

If rooted in the practical, dialogue is itself a kind of intervention. A good conversation that opens up a space for exploration and reflection can change our ways of thinking, feeling and acting – even though those we are talking to may have no specific 'change objectives' in mind.

> *The development of professionalism evolves over time by a process of exploration and reflection.[7]*

> *We're never going to change things by writing books. But if we gave every professional team the opportunity to engage in self-discovery, using scientifically proven approaches and then letting them work out how to use them, that self-learning mode can fertilise many minds.*
>
> *(Tony Giddings)*

But we should also exercise some caution here. Dialogue can be powerful, but it is not a miracle cure.

Consider, for instance, the following quotation from a report written nearly 10 years ago with the title *Rethinking Professionalism: the first step for patient-focused care?*

> *Every successful project begins by enabling its stakeholders to dream – and produce a shared vision of where they would like to end up. People not in jobs that regularly encourage them to be visionary find this very difficult, bogged down as they usually are in the daily grind and its apparently insoluble problems. Health professionals feel that they have too often been on the receiving end of reform rather than in the driving seat, expected to welcome it without being given the means to achieve it or the rewards for doing it.[8]*

There is little to disagree with in this statement. The question we must ask is: why does it still feel necessary to say the same things 10 years later? Why, when has there been so much discussion and definition of medical professionalism in the intervening period, is there still a need for dialogue?

There are lots of possible answers to these questions. Maybe earlier discussions asked the wrong questions. Maybe they involved the wrong people. Maybe they were conducted in the wrong way. Or maybe things have moved on so fast that they are already out of date.

In this report, of course, we will offer some thoughts on what might be the right questions, the right people and the right way to conduct a dialogue. For anyone to think that we have settled these questions for good, however, would be naive, if very flattering to us. The one thing we will say with conviction is that the dialogue the Health Foundation launches should never lose sight of one critical question: what can we do differently this time to avoid the same outcome?

3. Tradition

Key messages

- Professionalism has traditionally been seen as a quality of an individual doctor, combining values, knowledge, skill, integrity and judgement.

- The doctor–patient relationship has traditionally been understood paternalistically.

- Much of the traditional model has been criticised, but that does not mean it should be rejected wholesale.

- Establishing continuity with the past can be crucial to people's willingness to embrace change.

In this chapter we set out what we shall call a Traditional Perspective on medical professionalism. This provides a reference point for the discussion in subsequent chapters of forces that are driving the continued evolution of medical professionalism. The caveats set out in section 2.1 should be borne in mind.

The Traditional Perspective is defined as much by the question it seeks to answer as by the answer that it gives. That question is: 'What does the professionalism of an individual doctor consist of?' As already noted in section 1.4, this report takes a different approach, seeking to understand medical professionalism in the context of doctors' relationships with others.

3.1 The Traditional Perspective

What does the professionalism of an individual doctor consist of?

The answer offered by the Traditional Perspective begins with the **values** of the doctor in question: the things that they are personally committed to and motivated by.

These values cover both conduct (the manner in which they discharge their role) **and** capability (the knowledge and skills to which they aspire) – one of the most important values of a doctor being their commitment to what a recent definition of medical professionalism called 'excellence'. Traditionally, however, capability has played a special role in distinguishing professionals. To use a more modern phrase, the possession of arcane **knowledge and skills** is, according to the Traditional Perspective, the USP of the medical professional (or indeed any other kind of professional). Values might be shared by others, but knowledge and skills set the doctor apart.

In respect of both conduct and capability, of course, it is possible to identify certain **minimum standards**: someone who fails against these is not fit to take on the role of a doctor. While meeting minimum standards is a necessary condition of professionalism, however, it is not a sufficient one for the Traditional Perspective. Professionalism is about commitment, not mere compliance (compliance with minimum standards being just one expression of this commitment).

Of course, it is not enough simply to say or believe, however sincerely, that one is committed to certain things. A claimed commitment to excellence, for instance, is meaningless if one has not in fact acquired a satisfactory level of knowledge and skill, or if one does not take adequate steps to ensure that one keeps both up to date. Unfortunately, gaps can all too easily open up between what people say and what they do. There is a well established distinction to be drawn between an individual's espoused theory (the values they claim to subscribe to) and their theory in use (the values that are actually demonstrated by their behaviour). Professionals are expected to keep these two things aligned by reflecting on their practice and, where necessary, adjusting their behaviour to match the values to which they subscribe. The word **integrity** is often used to describe this critical project of maintaining consistency in word, thought and deed.

Even for a doctor with integrity, however, there may be room for doubt about what the right course of action is in a particular situation. The doctor asking 'What should I do?' will often find that their values, knowledge and skills underdetermine the answer, especially in situations characterised by considerable uncertainty. In these situations, the individual doctor has to use their own professional **judgement** to make good the gap. In this, they are distinct from a 'technician' who works to rules, procedures and algorithms.

For clarity, it is worth stating at once that it is perfectly possible to exercise judgement in a collaborative context, involving and consulting with others (see section 8.2). In the Traditional Perspective, however, a doctor's professional judgement was not thought of in this way. Yes, a doctor might seek a second opinion from another doctor; but not from anyone else. The Traditional Perspective is essentially **paternalistic**.

Overall, then, the Traditional Perspective sees professionalism as a combination of values, knowledge and skills, integrity and good judgement in a single individual. This combination is in turn underpinned by that individual's:

– **character** – the source of an individual's values and guarantee of their integrity

– **experience** – through which knowledge, skill and, most importantly, judgement is acquired.

According to the Traditional Perspective, professionalism is very much a quality of the individual doctor. Indeed – in line with the emphasis placed on character – medicine is typically seen by this perspective as a **vocation**. In this, it aligns with what many doctors would themselves say about their choice of role: that they chose to become a doctor because the role reflects their personal values, rather than choosing their values to suit their role. They don't just **do** 'doctoring': they **are** doctors.

This emphasis on vocation is also apparent in what many doctors have to say about the rewards associated with the role. Historically, doctors have been well rewarded, not just by having their 'mouths stuffed with gold', but also with social status and organisational power. Individual doctors, however, are as likely to talk, often with some passion, about the **intrinsic rewards** that come from the job itself – using language such as 'making a difference' or 'helping people'. The opportunity to fulfil one's vocation is in itself a reward, which is why we talk about a job being a 'rewarding' one. The ways society enables doctors to pursue their vocation may be just as important in the mix of give-and-get as the more traditional **extrinsic** rewards listed above.

The Traditional Perspective sees professionalism as a quality of the individual doctor, but the importance of professionalism lies in the role it plays in relationships with others. Foremost among these for the Traditional Perspective is the **doctor–patient relationship**, and the **trust** on which it is founded. According to the Traditional Perspective, that trust is underwritten by the professionalism of the doctor.

There is an obvious problem here, however. Most patients are not in a position to estimate the character or experience of their doctor, meaning that they must take professionalism, which supposedly underwrites trust, on trust.

It was to solve this problem, according to a Traditional Perspective reading of history, that **professional bodies** developed. On this reading, the principle behind these bodies is that it is only other doctors who are able to assess the character and experience of their fellows (because only they have the necessary values, knowledge, skills and judgement) – hence the importance of **self-regulation** to this perspective. Other doctors also have a clear interest in doing so, as the unprofessionalism of a fellow doctor could undermine trust in the profession as a whole. Professionalism, according to the Traditional Perspective, is not just about a doctor meeting their responsibilities to their patients; it is also about meeting their responsibilities to other doctors. The unprofessional doctor has let the side down.

There is one further word commonly associated with the Traditional Perspective: **autonomy**. A little surprisingly, perhaps, we will not be using the word in most of this report. Our opinion is that the word is used with a number of different meanings, each associated with a different part of the perspective outlined above. Uses include:

– the fact that judgement is, by definition, not governed by algorithmic rules

– the idea that a doctor takes individual responsibility for a decision which, in the end, they alone must make

– the idea that a doctor is answerable to their own professional values and not to external requirements (such as organisational objectives)

– the idea that a doctor should be given flexibility in their working practices

– the idea that the profession should be autonomous, ie self-regulating.

Using a single word in all these contexts can create the impression that these ideas stand or fall as a set. Clearly there are connections but we believe they are more complex than this. There may be value in further discussion of the different meanings of autonomy and their relationship to one another – a point we return to in our conclusions.

3.2 Doctors' relationship with tradition

Before concluding this chapter, we should note that tradition is itself something with which people, including doctors, may have a complex relationship. For some, that relationship will be one of antagonism and frustration; for others, respect and nostalgia. Often the same person will move from one position to the other during the course of their lives. Very often, the stance that a doctor takes to tradition and history will be integrally tied up with their professional identity, their sense of who they are as a doctor. The stories we tell about the past serve as the ground against which we delineate ourselves.

The idea that the traditional has some special claim on the truth is clearly absurd. We need to be prepared to challenge even those things that we hold most dear.

It would be worth asking what people mean by professionalism, and might it be that some of the nostalgic feeling for what were taken for core values was not very much helping our open-mindedness.

(Tony Giddings)

On the other hand, the idea that the traditional is necessarily wrong or outdated is clearly just as absurd. As one interviewee noted, one of the reasons why the traditional model of professionalism is hard to dislodge is that 'it stands for some very good things, like personal responsibility, experience, and courage in making judgements'. Nor should the manifest failings of some parts of that perspective be seen as a failure of all the other parts: bathwater should be differentiated from babies.

Most importantly, when one does reject elements of the Traditional Perspective, one has to remember that the things rejected remain precious to other people. It is possible to have empathy with someone, and to demonstrate it in one's own behaviour and language, while at the same time disagreeing with their beliefs and holding that their behaviour is unacceptable. That, after all, is what we expect doctors to do all the time with their patients.

How you frame the discussion around professionalism is crucial. If you want to empower doctors, you need to avoid approaches which are akin to dropping bombs on them. If you talk about 'changing medical professionalism', that implies rolling something out regardless of what people feel. Instead of the language of 'change', you could use the language of 'evolve'. Or talk about 'expanding the definition of medical professionalism', and then explore with doctors how traditional views of professionalism limit them.

(Mary Jane Kornacki)

Evidence strongly shows that continuity perceptions are crucial to embracing change. Disruptions to continuity in all domains of life can be profoundly disturbing to people, affecting their wellbeing and mental health. When the change threatens people's sense of identity, then the risk of defensiveness is increased. Moreover, there is a big difference between actual and perceived continuity: sometimes it is difficult for people to recognise continuity even where it does exist. However, when people do see a continuity thread from past to future – despite the change, or perhaps even because of the change (without which even more would be lost) – then they can begin to open up to the possibility of changing themselves.

An excellent example of empathy for tradition mixed with a clearly stated case for change is provided by a recent address by Donald Berwick to the Royal College of General Practitioners. In it, he imagines how his own father – also a doctor – might have reacted to changes in medical professionalism, and asks: 'is this the epitaph of profession, or the reconsideration of profession? In the former lies grief. In the latter possibility':

This is a time of loss, I know, but it is also a time of great discovery. I cannot promise you comfort; it was a glorious time when our privilege as physicians, earned through expertise, altruism, and self-regulation, sufficed for our communities and our tasks. We need now to find the joy and pride – we can find the joy and pride – that lie in slightly different places; the warmth of teamwork, the excitement of the expedition together into the vast terrain of modern knowledge, the humour and vivid ambition of the millennial generation, the benefits to our patients from the miracles of technologies, with their risks tamed by humility and infinite caution. But, still, we are fortunate. Still, it is our privilege to enter into the dark and tender places of people's lives, where, still, trust abounds when human beings turn to us in their pain. Still, there will come the middle of the night, and, with it, we still have our duty to meet and our quiet promise to keep: to bring comfort. And, in the morning, still, there will be thanks.[9]

4. Doctors

Key messages

- Doctors are themselves a varied and changing population.

- We should be very careful not to stereotype doctors.

The content of the rest of this document could crudely be summarised thus: the world has changed fast around doctors. But what of doctors themselves? Not the role, but the human beings that occupy it.

There are very good reasons to believe that the profile of personal values and motivations that doctors bring to their role may also have changed over time. Some striking examples include:

- **Generational change.** Culture in the UK has become generationally stratified, with younger and older generations holding different values and norms. Medicine cannot be immune from this. One simple example, often noted, concerns the expectations of today's junior doctors regarding working hours. But there are likely to be other differences: for instance, if younger people are more consumerist in their thinking, they are more likely to expect consumerist thinking in their patients.

- **Gender.** Whether or not we believe men and women come from different planets, there are clear statistical differences between the genders at a population level, across a wide range of psychological and behavioural variables. The mere fact that doctors were once all men, and now are not, implies a fundamental change in the profile of doctors.

- **Social mobility.** Just as doctors were once all men, so too they were once drawn from a very narrow social and cultural pool. The post-war period saw a growth in social mobility, and a slow opening up of what were once exclusive social clubs to broader sections of the population. The process is far from complete, however, and as one interviewee noted, may even be thrown into reverse by factors such as tuition fees.

- **Different cultural roots.** Many of those working in healthcare in the UK grew up either in other parts of the world or in families that preserved strong cultural connections to other parts of the world. Doctors are a culturally diverse group and cultures vary greatly in the sense they make of such fundamental human experiences as disease, illness and death.

In preparing this report, we have had the opportunity to talk to a small number of doctors. These conversations have done much to stimulate and shape our thinking. Our interviewees would, however, be the first to remind us that their views are not typical of doctors as a collective. Indeed, it is hard to imagine what a 'typical doctor' would be like. Consideration of the functional diversity of the profession alone suggests such an idea may be out of place even before other factors are taken into consideration.

What do doctors think about the issues discussed in this report? Which parts would they agree and disagree with? Which of the questions raised would they consider important, and how would they answer them? We have relatively little information on which to base an answer to these questions: they are for the most part open questions to be taken into a dialogue, not questions we can settle in advance.

Part 2: Healthcare and medicine

5. Evidence

Key messages

- To the extent that evidence determines the right thing to do, it erodes the scope for individual judgement.

- Medical knowledge has been transformed from something possessed by doctors to something that can be accessed by anyone.

- The rate at which new evidence is generated means the idea of being 'up to date' is becoming obsolete, unless one specialises in a narrow field.

- The status of medical knowledge has been challenged on more radical grounds by constructionist analyses of medical power.

The world is changing dramatically. It's particularly driven by the information revolution, the availability of all the knowledge in the world – this fundamentally changes the relationship between professionals and the people they serve or work with. There's a tremendous risk of both professionals and people feeling that something has gone wrong with the relationship, that it is out of date, that it is breaking down.

(David Haslam)

The growth of evidence-based medicine, and the growing accessibility of that evidence, have both had profound effects on medical professionalism. In this chapter, we consider how doctors' evolving relationship with evidence has been shaped by three basic characteristics of evidence. We then turn, in the final section, to a more radical set of questions about the status of medical knowledge.

The term 'evidence' is used in this chapter as shorthand for **empirically validated generalisations**, which is roughly the meaning it has in the expression 'evidence-based medicine'. This is in fact rather an unusual usage: evidence more commonly refers to the facts of specific cases, not to generalisations from many such cases (think about a detective mystery). That usage would imply, however, that medicine has always been evidence-based.

5.1 Evidence versus judgement

The first key characteristic of evidence is that it reduces the need for judgement based on experience. When real evidence was thin on the ground, clinical experience and judgement were central to decision making and essential elements of medical professionalism. But, to the extent that evidence determines the right thing to do, so too an individual doctor's experience and judgement become irrelevant. The rise of evidence-based medicine has therefore marked a steady erosion of the scope of medical judgement.

On the other hand, evidence-based medicine is precisely that: evidence-**based**, not evidence-**determined**. Scope for judgement remains, therefore, in the application of evidence in specific situations.

We have all these things like checklists and protocols, often quite rightly, because human beings aren't perfect, so if you have systems that make them less likely to make errors, that's a good thing. But in so doing, if you're not careful, you can take it too far and stop appreciating what professionals

bring to the table, which is the ability to marry experience and knowledge together to suit the unique circumstances of the patient.

(Oliver Warren)

One of the key marks of professionalism is to know when to ignore guidelines, and to recognise when the primacy of the individual in front of you and their needs are not covered in a simple way that a guideline might indicate. I like the concept of phronesis – the nicest definition I have heard is: the art of knowing what to do when you don't know what to do. It's incredibly profound: all professionals run into situations when they don't know what to do. It's a key mark of professionalism – as opposed to whatever the opposite is, trudging along following instructions.

(David Haslam)

Judgement, on this account, takes over only at the point at which the evidence gives out and genuine uncertainty sets in:

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.[10]

It has to be noted that is not entirely clear what the practice of medicine is distinguished **from** by this need for judgement. Certainly not other clinical professions: for instance, one of only three eligibility criteria for groups seeking regulation by the Health Professions Council is the 'exercise of judgement by unsupervised professionals which can substantially impact on patient health or welfare'.[11] Come to that, one might very well argue that the 'practice of being a patient' is distinguished by a need for judgement

in the face of uncertainty. The question of what distinguishes the role of the doctor is discussed further in section 8.4.

There has been a revival in recent years of academic interest in the concept of judgement and its relationship to experience. This is thanks to the resurgence in philosophy (and, more specifically, in medical ethics) of a tradition now called 'virtue ethics'. This tradition, which can be traced back to Aristotle, sees the source of moral excellence (of which medical professionalism would be one type) in the **character** of the agent – broadly stable dispositions which lead them to do the right thing – and in their judgement or 'practical wisdom' (the usual translation of Aristotle's term 'phronesis'). According to this tradition both character and judgement can be developed by training and education – and in particular by the exploration of case studies or emulation of role models. While it is possible to point at examples of good judgement, however, judgement cannot be reduced to an algorithm or procedure.

Philosophical elaboration of these concepts is of great value, especially in the area of ethics; but the wider claims of experience and judgement must themselves answer to the evidence. More than one of our interviewees mentioned a recent study in which GPs requested information about scenarios (as they might of a patient) as the basis for diagnoses. The researchers report not only that 'the correct diagnosis was given 42% of the time and the appropriate management decision 52% of the time', but also that:

No significant effect of experience was detected on diagnostic accuracy, in accordance with other studies. Experience had an effect on information gathering, with GP registrars requesting more information overall, and more non-critical information. […] With practice, a lot of this non-critical information gathering is bypassed and clinicians become more efficient in their search.[12]

Findings such as these represent a fairly clear challenge to models of judgement based on experience, at least in their application to the core task of diagnosis.

Of course, that does not mean that experience-based judgement may not be relevant in other respects: in weighing ethical questions, in engaging with patients as human beings, or even (as the above findings suggest) in improving the efficiency of consultations.

An experienced doctor can do a lot in 10 or 15 minutes compared to a junior doctor or nurse practitioner. What have they got that lets them do this? Better consultation skills, the experience of comorbidity and of handling this kind of condition, defining boundaries, prioritising, having a clear management plan, not getting bamboozled but working out what to do and in what order.

(Maria-Teresa Claridge)

Detailed investigation of the real processes of reasoning – as opposed to idealised models of 'reason' and judgement – is an important area of contemporary experimental psychology, and one that is likely to transform our understanding of the proper role of judgement in medical professionalism. (Consider for instance the growing literature on the mental heuristics and shortcuts which characterise, and sometimes render faulty, real human thought processes.) It will do so, of course, on the basis of evidence.

5.2 Access to evidence

Judgement based on experience is usually seen as an attribute of an individual. One cannot acquire judgement without building up a comparable body of experience. By contrast, evidence is in principle accessible to anyone (though, as is sometimes pointed out, accessing the knowledge may not be the same thing as understanding it).

This is the second key characteristic of evidence: that it is in principle accessible to anyone. The rise of evidence-based medicine has had a profound effect

on the nature of medical knowledge, which has long been a key source of medical claims to authority. To put it simply, medical knowledge has been transformed from something a person **possesses** to something a person **accesses**. (The same argument does not apply so obviously to medical skill: surgeons, for example, can still make a claim to **possession** of something that differentiates them.)

At the same time as medical knowledge has become something that is in principle accessible to anyone, so too the information technology revolution has made it accessible in practice. One no longer needs a library card. Medical knowledge has been more fundamentally transformed from something that **doctors possess** to something that **everyone can access**.

As a result, patients, journalists, government and others are all able to draw on evidence for their own ends. Sometimes the consequences are inspiring, as when patients with long-term conditions become expert partners in their own care or set up support networks. Sometimes the consequences are depressing, as when journalists make selective use of reported findings to create national panics or feed conspiracy theories. (For more on the uses made by government, see section 10.1.)

In either case, doctors are having to adjust to a world in which second opinions do not have to come from another doctor to carry weight.

There's a tension here. One of the fundamental parts of the social contract, what people understand by 'professionalism' is that you are an expert. This applies not just to medicine but to other areas too. The reason you train to be a professional, and the reason people ask for your advice, is that you have an expert opinion in that field. You have a level of enhanced knowledge and understanding that credibly allows you to advise others on a course of action and act as a source of expertise.

(Susan Went)

Professionalism has elevated us to an almost unsustainable place in society. We have to bring ourselves down from that pedestal if we're to maintain this trust. Our patients' ability to find information is now as quick as ours.

(Jonathan Fielden)

Things have changed, but often the perception is that we are still trained to be 'gods'.

(Peter Lachman)

If your internal definition of what you are no longer holds true, you feel you're failing. You got good A levels, you're a clever bugger, you got into medical school, you were told you were the crème de la crème, you thought you were taking this knowledge out into the world – and now everyone's got it. What does that mean you are? There are some interesting differences in the craft specialties, like surgery, but even they are being questioned and challenged in ways that they find uncomfortable. It's not the deal they were originally promised. It's all very similar to the translation of the bible out of Latin – priests used to have exclusive access, then everyone had access. Defining what the doctor does in terms of knowledge isn't appropriate any more.

(David Haslam)

As is frequently noted, this has had a transformational effect on the relationship between doctor and patient (see section 7.1).

5.3 Changing evidence

Within the medical profession – or indeed any domain of human activity – an increasing emphasis on evidence as opposed to experience tends to undermine the equation between age (implying greater experience) and ability. Where evidence changes fast a reverse equation may be established. In research conducted by one of the authors of this report, for instance, some members of the public expressed a preference for a doctor who was experienced enough to be competent, but not so experienced as to be out of date.

A quick review of Victorian novels, full of idealistic young doctors seeking to bring in new approaches to medicine based on the latest science but facing opposition from elders who have always done things the same way, reminds us that this particular tension is not new. What has changed is the speed at which new evidence is generated. Those young doctors in Victorian novels would now find they were as out of date as their older peers within a few months of setting up in practice. And this is the third key characteristic of evidence: that the medical evidence base is changing and expanding so rapidly.

In fact, the pace of change in medical evidence is transforming the prevailing model of what it takes to become and remain a professional in medicine. In the 'old world', doctors demonstrated their knowledge and skills by completing arduous training after which their professionalism was unlikely to be questioned.

Our attitude was wrongly cultivated at medical school. We were told in simple terms that if we worked hard and learned all we needed to learn, we would then possess the skills to work in a productive way without much risk of being wrong. It's clear from a lot of different studies that that is not a helpful way to regard medicine.

(Tony Giddings)

In the 'new world', by contrast, doctors' knowledge and skills need to be updated (eg through CPD) and confirmed (eg through revalidation) on a rolling basis. To put it another way, in line with many other fields outside healthcare, an apprenticeship model of development is being replaced with a lifelong learning model. Culture, of course, can take a long time to catch up with structural changes.

Even the idea of 'being up to date' may be becoming obsolete.

I would love to spend time reading up about stuff, following things through. I have a stack of things to look at. It would be lovely to have the time to look at that. Not to mention the niceties of the latest treatments.
(Maria-Teresa Claridge)

Things are changing so rapidly that we can't possibly hold it all in our own heads. The average lifespan of validity for a medical research paper is under five years; millions are published every year; you cannot possibly keep up to date. But many are still trained to believe that they have all the information immediately in their own mind to treat the patient in front of them.
(Jonathan Fielden)

This idea of the doctor as an all-knowing holder of all knowledge is over. The knowledge balance is shifting.
(Oliver Warren)

We have reached the point at which there is simply too little time, and too much evidence being generated, for anyone to be able to keep abreast of changes while at the same time remaining in practice – unless they specialise in an increasingly narrow field. Medical knowledge is becoming something that everyone can access, but that **no** single individual can claim to possess. As Donald Berwick has put it:

The romantic view – held tightly, romantically, still both by patients and physicians – that expertise means knowledge-in-the-mind is now simply a myth. It bears no reasonable relationship to the realities of the flow and accumulation of science in medicine today: thousands of journals, tens of thousands of studies, rapidly changing clinical armaments facing rapidly evolving disease challenges.[13]

That reference to 'romance' is by no means out of place, and reminds us that the rise of evidence-based medicine has been, for those caught up in it, an **emotional** experience. Berwick captures some of those emotions well when he imagines what he might have said to his own father, a doctor from a very different era:

You now cannot do it all alone. The tasks of healing have simply passed the capacity of any single human mind, no matter how skilled or altruistic or self-surveillant. You – and your patients – have now become irrevocably part of something far larger than yourself, and the craft of care has transformed into the machinery of care. Science and system have swamped art and autonomy. In return for possibility – in return for miracles – you have paid a dear price. The price is that you have lost control. If you define yourself by that sense of control, then the price has been even higher: you have lost self.[14]

5.4 Constructionism

The arguments so far in this chapter have all assumed that medical knowledge is something that does exist, albeit no longer in the head of a single individual or accessed only by an exclusive class of people. In this section, we turn to the more radical arguments of constructionism, which question the status of knowledge itself.

As one of the most important intellectual trends of the 20th century, constructionism is not easy to summarise. At its heart, however, lies a critique of authority based on claims to objective truth or knowledge. A constructionist typically denies (in a given social domain) that any such objective truth or knowledge exists, and argues that what we call 'truth' or 'knowledge' is instead a construct of the operation of power and authority, typically at the level of social institutions.

Consider, for example, 'good grammar'. There is no objective fact in the world that makes a given linguistic form such as 'we was' grammatically right or wrong. Instead one must look to patterns of usage, the power of broadcasters, the authority of teachers and grammar books, social conventions regarding regional forms and so forth. There are no facts other than the facts of what people do, and the various social institutions that create, confer and conserve authority and power. As a result, forms that were 'wrong' can become 'right', or even enter a kind of limbo state – such as that currently occupied by the split infinitive.

Constructionist arguments have been made in respect of virtually every sphere of human life – from language through to the natural sciences. On the other side of the argument stands the **essentialist**, who argues that there **is** such a thing as objective truth, independent of practice and power. The debate should not be seen as a simplistic either/or one, however: many subscribe to some version of a **critical realist** position, which recognises value in both positions. In the natural sciences, for instance, many people accept the essentialist contention that there are objective facts; but many also acknowledge the role played by social institutions (such as university career structures, scientific publishing, etc) in constructing the thing we describe as 'scientific knowledge'.

What impact have these intellectual trends had in the area of medical professionalism? The most obvious relevance of constructionist thinking to medical professionalism is in the area of conduct, where norms may change over time in a way analogous to grammatical rules.

Society is changing so fast. For instance, if you look at the sexual boundaries between healthcare professionals and patients, this is a really tricky area. We've become as a society extremely tolerant of a range of sexual behaviours in private, and extremely intolerant of any sexual behaviour in the workplace. Twenty or thirty years ago, a GP having an affair in their local village might have been considered wholly unsuitable; but patting the bottoms of nurses might have been considered ok. Now it's possibly the opposite. We're constantly going through social change, redefining the boundaries of professionalism – and the boundaries of public and private behaviour – and that makes it very difficult for health professionals to know where they stand.

(Harry Cayton)

However, constructionist arguments have also been used to question in a more radical way the claims of doctors and their professional bodies to authority based on knowledge, truth and objective fact. According to these arguments, it is the authority and power associated with the medical profession which explains why the things that doctors say become the 'truth'. The following is a good example of constructionist thinking applied to the history of the medical profession:

By defining the problems it claimed to be able to solve and securing ownership of a corresponding occupational territory, it [medicine in the 19th century] was able to control not only clinical practice and standards but also admission to training (eg excluding women and the working class), the competence and attitudes acquired in training, the regulation of qualified professionals, the acquisition and control of new knowledge and technology, and even the organisation and management of health services. This huge span of control established patterns and norms that persist to this day.[15]

For a strict constructionist, the paternalist claim that 'doctor knows best' is roughly equivalent to the claim that 'doctor has power'. The concept of medical professionalism, meanwhile, is just one of the institutions which allow that power to be maintained. Professionalism is not a quality of the individual (as the Traditional Perspective claims), but a kind of rhetorical tactic.

Think about where doctors were 100 years ago. They were often charlatans, using hocus-pocus. Nowadays doctors have a lot of power. What's the difference between then and now? This is the introduction of science, the evidence base and 'professionalism'. When you go to the doctor you often become powerless. […] But research has shown that one only has a 53% chance of getting the right treatment. 'Professionalism' is the emperor's new clothes. […] It can be a defence mechanism, a control mechanism.

(Peter Lachman)

To me, 'professionalism' suggests infallibility and hierarchy, both of which are bad for safety.

(Tony Giddings)

Not surprisingly, those of a more constructionist bent are likely to be sceptical of the role played by professional institutions in particular:

Doctor training is still based on guilds – medieval institutions. And the profession still has medieval hierarchies.

(Peter Lachman)

Constructionism has sometimes been seen as a purely negative or critical position – little more than a theoretical expansion of George Bernard Shaw's famous line that 'All professions are conspiracies against the laity'. In the hands of some of its academic practitioners this may be what it has become and the rhetoric of constructionism can be unhelpful and alienating at times. On the other hand, by forcing us to ask different questions of ourselves and our claims to knowledge, constructionism can also play a hugely positive role.

In the end, one does not need to be a strict constructionist to recognise the enormous value of a critical investigation into the dynamics of power and authority in medicine, both in the operation of professional institutions and in the interactions between individual doctors and others, including their patients:

As a doctor, you need to understand your role; you need to understand your power; and then you need to transfer that power to the patient.

(Peter Lachman)

6. Society

Key messages

– The possibility of 'curing' patients has tended to crowd out the project of 'healing' – helping the patient make sense of what is happening to them.

– The question of how to balance responsibilities to the patient in front of one and responsibilities to the wider community is one of the critical challenges for modern medical professionalism.

– Doctors are being asked to hold the line against unreasonable demand, while at the same time increasing the participation of patients in decisions.

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.[16]

According to one of the many (re)definitions of medical professionalism offered in the last decade, 'professionalism is the basis of medicine's contract with society'.[17] This pivotal relationship is also reflected, of course, in the title of the Royal College of Physicians' report quoted above: *Doctors in Society*. The relationship between doctor and patient lies at the heart of the Traditional Perspective but that relationship is seen to exist against the backdrop of a relationship between an entire profession and an entire society.

Unsurprisingly, then, changes in society have consequences for the roles doctors are expected to fulfil and the conception of professionalism associated with them. In this chapter, we discuss three key areas of social change that have had an impact on medical professionalism – starting with one that is itself the consequence of medical advances.

6.1 Curing

One of the main 'givens' that needs attention is how we define and understand health, illness and illness behaviour. These assumptions underpin what we think societies, communities and individuals can or should do to improve health, prevent illness, live with disability and deal with death and dying. Yet the debate rarely, if ever, surfaces in health policy circles. Illness seems to Western society to be an organic physical fact, but comparison with other cultures, or with our past, reveals that it is also socially constructed.[18]

Evidence-based medicine has brought about a revolution in the way that medical treatments and procedures are specified. In parallel, however, there has been an explosion in the number of treatments and procedures available. Modern doctors are increasingly able to do something that was for the most part beyond them a hundred years ago: cure their patients.

This is an unquestionably good thing. Our interest here, however, lies in the consequences of the growth of curing for medical professionalism and, more specifically, the relationship between doctors and society, and here the case is more complex. As it has become a realistic possibility, so too curing has moved to the fore in many people's understanding of the doctor's role – doctors and patients alike.

Indeed, if one asks someone who has not thought much about why people go the doctor, one is likely to be told 'to get better', or something similar. But this cannot be all they go for. People used to go the doctor in ages when their chances of being cured were slight or non-existent, and increasing numbers in the present day turn to alternative therapies for something they do not feel they are getting from their doctor. Clearly there is no single simple answer to the question 'Why do people go to the doctor?' – but alongside getting better, we should surely include the answer 'to make **sense** of what is happening' – what one of our interviewees described as 'healing'.

My view – what drives me, a core part of my professional being – is that it is a reductionist, deterministic philosophy of medicine – 'Let's work out what's wrong, then put it right, and all will be well' – that has got us to where we are. Yes, it's helped us succeed in establishing the genetic basis of diseases, getting new treatments, and so forth – but what it doesn't attend to is the psychosocial determinants of disease and suffering. Medicine sees itself as a science, but ignores the other reasons why people go to see the doctor. Why do people come to see you? We're taught they go because they've got symptoms. In fact they evidence is that they go because they're scared – scared of their symptoms. We reduce the presenting problem to symptoms, but we don't ask them what that symptom means for them.

(Alf Collins)

The fact that doctors in the past, healers in other cultures and alternative therapists in the present offer sense-making frames of reference with little or no scientific basis does not undermine the fact that they were and are providing something patients have always wanted and needed. For some, the increasing possibility of 'curing' threatens to crowd 'healing' out of modern medicine:

Health care is dominated by a medical model of health and illness that has limited use in many situations, especially prevention; public health; other conditions or settings where social causation is dominant; chronic and long-term illness and disability; care of the elderly; and social care. […] Other ways of interpreting the world and different models of health and illness have been sidelined.[19]

The trend towards curing as opposed to healing is almost certainly being amplified by increasing specialisation within medicine. The proliferation of treatments and procedures, and the increasing depth of evidence associated with each one, make it harder and harder for a single individual to keep up to date with a broad field of practice. A growing ability to cure is tied to a narrower and narrower focus on conditions or parts of bodies – as opposed to the whole patient, their experiences, and the sense they are making of them.

Once again, what is happening in medicine is happening in other areas too. A surprisingly good parallel is provided by the humanities. The days of the renaissance scholar, ranging across what we would now see as multiple fields, are long gone, and the process of specialisation has advanced to the point where, as one historian recently put it, '"Sorry, that is not my field" has become the watchword'.[20] One consequence has been an increasing sense of the irrelevance of the academic humanities to everyday life: the things academics write about no longer help us to make sense of our lives, though they may well be more grounded in detailed evidence. The same is arguably true of cures.

Some authors, typically those of a constructionist bent, have also drawn attention to the role played by the pharmaceuticals industry in the rise of 'curing' at the expense of 'healing':

[Medicine] is a key partner in the medical-industrial complex, an enormously important but barely discussed power nexus that now controls a billion-pound transnational business supplying drugs and equipment. It dominates the research and development agenda, and through this maintains the medicalisation of health and the biomedical domination of health services.[21]

For absolute clarity, let us reiterate: 'curing' is an unquestionably good thing. Nor is 'curing' inconsistent with 'healing' *per se*. Indeed, a positive trend in recent years has been the development of an evidence base to support the contention that the quintessentially 'soft' experience of making sense can have an impact on 'hard' health outcomes.

We use magic and juju all the time, but we don't know when. All the research suggests that much of what we do, especially in primary care, is down to magic, trust, placebo.

(David Haslam)

Only now is research beginning to demonstrate the validity of the subjective experience that feeling better is intrinsically linked with getting better – and that the psychological wellbeing facilitated by excellent care is as crucial to recovery as the surgeon's knife or the medication.[22]

Moreover, there are plenty of doctors (especially, although by no means only, in areas such as palliative care or the management of long-term conditions, for which the concept of a 'cure' is of little use) who are alive to the importance of 'healing', and recognise the potential for scientific medicine to supply the 'magic and juju' on which it is based:

When doctors 'knew nothing', we made people feel good rather than cure them. When we then could cure them, we became godlike – very hierarchical. Now we have to go back again to making people feel good as well as be cured. A lot of the focus in the quality improvement world is about self-management, patient activation … a reflection of what we have taken away and now need to reintroduce. We need to go back to something we've lost. Not giving up what we've got now, but sharing it.

(Peter Lachman)

What drives angina pectoris is not pain so much as fear of what the pain means. Asking the question 'What do you think is causing your angina pectoris?' can help to resolve this. You can explain: this is your heart making yourself better, blood going through new channels. And all this is driven by science, not a made-up explanation.

(Alf Collins)

We can, and should, set aside any false opposition between 'curing' and 'healing'. At the practical level, however, we should also recognise that the two activities may require very different mindsets, capabilities and training in their practitioners:

I wrote a paper a couple of years ago where I looked at the psychological attributes of clinicians going into long-term conditions. I found that 14 year olds drawn to medicine are already drawn to disciplines that are curative. Later they start to understand that you can't fix most people. My feeling is that we really ought to be opening that up in medical school, and helping people think through the implications of their career choices.

(Alf Collins)

The difference may even come down to more fundamental things, such as outlook and vocation. Some doctors are undoubtedly good at both 'curing' and 'healing': but we may be asking too much of doctors if we expect them all to be equally capable in both roles. (We develop this line of thought further in section 8.3.)

6.2 Demand

Evidence-based medicine and the growth of 'curing' have transformed the things that modern medicine is able to supply. In the process, however, they have also changed the scale and quality of **demand** for healthcare. The successes of modern medicine in keeping alive people who would once have died, combined with broader social changes (eg around lifestyle and diet), has created a problem previously undreamed of: as a society, we simply cannot afford to do everything we are now capable of doing.

We cannot continue to do what we have been doing because it's unsustainable – demand, cost, the form of services, skills and competencies, the workforce, everything.

(Susan Went)

I remember talking to a consultant cardiologist about this. He said 'I always treat my NHS patients as I would my private patients'. Well, I said, that's all very well for the private patients because someone is paying, but if you transfer that to the NHS you will bankrupt it.

(Hugh Reeve)

Although by no means unique to the UK, the character of this crisis is shaped uniquely by the principles of the NHS. How can we reconcile a universal health service free at the point of care with escalating demand that threatens to bankrupt the nation within years?

The answers being offered to that question invariably involve fundamental shifts in the role of the doctor:

– From treating people when they get ill, to keeping them healthy in the first place.

– From doing something to people, to persuading and enabling them to do things for themselves.

– From meeting the needs of an individual patient, to meeting the needs of a whole community.

All three shifts represent challenges to a Traditional Perspective which defines medical professionalism in terms of the relationship between a doctor and a patient, because all three – and in particular the third – imply responsibilities to people other than the person in front of one, including some one never actually sees.

The biggest single change in terms of the professionalism of a doctor is that we will essentially change our oath from a duty to the patient in front me to a duty to patients as a whole and to the health of the public that I serve.

(Oliver Warren)

Doctors were previously trained to look after the patient in front of them; now we need to know the impact on other patients and the healthcare system. That means fundamentally rejigging the way we train our doctors. [...] Doctors don't typically see the need for them to be stewards of resources.

(Jonathan Fielden)

Indeed Sokol has argued that, in light of considerations such as these, the first rule of the GMC's *Good Medical Practice*, 'Make the care of your patient your first concern', becomes when fully unpacked something altogether less pithy: 'make the care of your patient your first concern, acting within morally and legally acceptable limits and bearing in mind your other patients, including at times future patients and their particular needs as well as any protective obligations to the broader community, your own obligations to develop your skills and knowledge as a clinician, and obligations you may have towards others for whom you are responsible.'[23]

The question of how to handle the tension between responsibilities to the patient in front of one and responsibilities to the wider community is emerging as one of the critical challenges for modern medical professionalism. In part, this is a matter of doctors acquiring new skills around saying 'no' but there are deeper issues here too, concerning the very nature of the trust patients have in doctors (see section 7.2; also section 8.3).

6.3 Consumerism

[The 1940s] vision of welfare provision through professional authority and benevolence also relied on a view of service users as essentially passive. […] The intervening decades have seen a radical reassessment of this perception of passive, deferential users. Rising levels of education, plus increased expectations through rising prosperity, have produced a more discerning and assertive type of service user. Against new consumerist, market and choice-orientated standards, the public services of old and the professionals who represented them began to look unresponsive, inefficient and dominated by an unhealthy paternalism.[24]

Consumerism is outpacing the social contract of professionalism.[25]

Everybody knows that our society is more consumerist, and less paternalist, than it was 50 or 60 years ago. But what does that claim actually mean? The Oxford English Dictionary distinguishes two senses of the term 'consumerism': one, first used in 1915, referring to the 'advocacy of the rights and interests of consumers'; the other, first used in 1960, referring to an 'emphasis on or preoccupation with the acquisition of consumer goods'. In which sense is our society more consumerist? And what has the impact on medical professionalism been?

Let us consider first the second sense of the term, 1960-consumerism. The sense is usefully expanded on Wikipedia thus: 'Consumerism is a social and economic order that is based on the systematic creation and fostering of a desire to purchase goods and services in ever greater amounts'. If paternalism represents a concern for what experts believe is **good** for people, irrespective of what those people **want** or think, then 1960-consumerism represents a concern for what people want, irrespective of whether or not it is good for them.

That our society has become more 1960-consumerist is hard to dispute. The reasons are manifold, but include the activities of commercial organisations, who have a vested interest in persuading people to want whatever they are selling, along with certain kinds of market philosophy which hold (crudely) that what people want (in aggregate) **is** what is good for them. Inevitably, 1960-consumerism has also had an impact on behaviour around healthcare – especially in light of the trend towards 'curing' and the prevalence of cultural narratives about miracle cures:

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.[26]

Unlike a commercial organisation, the NHS does not have an interest in persuading people to want more and more of what it is 'selling': quite the reverse in fact, as the discussion of demand in the previous section made clear. The NHS Constitution, for instance, includes tentative efforts to get the public too to share in the joys of stewardship, stating that one of the responsibilities of patients and public is to 'recognise that you can make a significant contribution to your own and your family's good health, and take some personal responsibility for it'[27] – ie to want less.

In line with this, doctors, far from being required to become more responsive to 1960-consumerism, are in fact increasingly being asked to hold the line against its potential consequences:

We should not be afraid to say 'I can't advise you have this treatment because so many others will be denied'. Politicians have not got a very good record on this.

(Tony Giddings)

It's certainly easier if doctors have someone else to blame. Perceptions of the downgrading of NICE are not helpful: it takes away that diffuse national organisation that doctors can moan about to their patients while secretly thinking thank God there's someone to blame.

(David Haslam)

The option of doing so by resorting to old-style paternalism, however, is no longer available, thanks to an increasing emphasis on the other sense of consumerism, 1915-consumerism, 'advocacy of the rights and interests of consumers'. Moreover, the contrast with paternalism is very different in this case. If paternalism represents a concern for what experts believe is **good** for people, irrespective of what those people **want** or think, then 1915-consumerism represents an insistence that what is good for someone cannot be defined without the participation (in so far as possible) of that person. The concept is well captured by the phrase, 'No decision about me without me'.

Take a hip replacement. Someone who's 60, fit and active may be prepared to go through the process given that they know they have certain risks of dying or being worse. This is what they want. But if I'm 85 and have a painful hip, and have a 1 in 10 chance of dying in the operation, I may take a different view.

(Jonathan Fielden)

Whether or not our society as a whole has become more 1915-consumerist is a moot point, especially in so far as consumers' relationships with private companies are concerned. In the public sector, however, 1915-consumerism has been an important force for change for some years now. One can even point to examples of government bodies engaging in (ironically enough) paternalistic efforts to persuade people to act like consumers, for their own good! It is to 1915-consumerism that doctors are being asked to respond – at the same time as holding the line against 1960-consumerism.

These dynamics lie at the heart of the changing relationship between doctors and patients – the subject of the next chapter.

7. Patients

Key messages

– Paternalism has existed, not for a single reason, but for many different ones: it is easier to reject paternalism than to say what goes in its place.

– The pressures on paternalism are equivocal; doctors may still be expected to take paternalist roles either by patients or, when managing demand, by the state.

– Doctors need new skills and capabilities to deal with the changing relationship with patients.

For doctors 'patient-centredness' might mean one of four things: that they work in patients' interests; that they practise in accordance with patients' preferences or wishes; that they are in partnership with, or involve, patients; or that they take a person-centred approach. These four approaches can be identified with key themes which underlie much of the debate over the past 30 years or so about the changing role of the medical profession, patients, and the organisation of health care in modern societies: activity and passivity; power and autonomy; conflict and collaboration; emotion and objectivity.[28]

The doctor–patient relationship lies at the heart of the Traditional Perspective. In this chapter we draw on themes introduced in previous chapters to discuss the ways in which that relationship has been transformed and the potential implications of these changes for medical professionalism.

A key theme of the chapter is that the relationship between doctor and patient has changed not in one single way, but – as argued in the quotation above – in many distinct if overlapping ways.

7.1 The decline of paternalism

At dinnertime, the telephone rang. A patient was calling. I watched my father listen, and then scowl. 'I'm the doctor,' he seethed. 'You're not. You'll get penicillin when I say, and not a moment sooner.'[29]

According to the Traditional Perspective, the relationship between doctors and patients is essentially paternalist. As Askham and Chisholm note in the paper quoted above, this paternalist conception of professionalism can just about accommodate the idea of working in patients' interests – albeit by stipulating that those interests are defined by the doctor. It has not, however, been flexible enough to accommodate broader changes in the relationship between doctor and patient. The days of 'doctor knows best' and 'your job is to do as I say and get better' are gone – or at least, if not yet gone from the mind of every single doctor and every single patient, numbered.

This particular dragon has, however, been slain not by a single arrow – the rise of the internet, consumerism, increased education. Rather, it has been laid low by attacks from different quarters (most of which we have already encountered in preceding chapters). Indeed, at least five distinct reasons for the decline of paternalism in medicine can be identified:

Reason 1

An essentially moral rejection of paternalism, closely associated with the 1915 variety of consumerism discussed in section 6.3. Sometimes this argument may be backed up with a reminder that it is citizens who are paying for the NHS with their taxes (or for private care directly). But for most people, the principle of 'No decision about me without me' does not require any support beyond its own self-evident truth.

The big change has been from professionals being put on a pedestal – do what they say, the white-coat god – to a position of: 'Yes, you have a professional opinion which I value, but we are equals. As a patient, I have as much or even more right to make the decision, based on our discussion and weighing up the value of the opinion you give me.' That's a fundamental and challenging change for doctors. My cohort and above, and several years below, were not trained with that in mind.

(Jonathan Fielden)

Reason 2

The transformation of medical knowledge from something possessed by the doctor to something anyone can access (see section 5.2). The internet has, of course, played a critical role in this process – but only alongside the rise of evidence-based medicine.

In the past the doctor had the knowledge and the patient brought the problem. That was the compact on which the interaction was based. Now that's changed. A lot of patients know a lot more about their problems than I do and this makes a big difference to how the doctor and the patient work together. Many doctors feel incredibly threatened: it's not what they signed up to do. What is the role of the doctor when that position of knowledge and authority is no longer available? Many doctors are scared, and many patients are puzzled.

(David Haslam)

Reason 3

Growing evidence that the subjective meanings and experiences of the patient have a substantive impact on health outcomes, and that this kind of 'healing' risks being crowded out by an emphasis on 'curing' (see section 6.1).

People go to complementary therapists to be told total twaddle – but with good results and satisfied customers, because of the magic of the relationship and the juju. How do we retain that in medicine while also being scientific? What is the risk of our damaging that by our behaviours? On the other hand, if you know you're doing juju, isn't that paternalistic?

(David Haslam)

As the above quotation suggests, however, this particular trend is equivocal in so far as its relationship with paternalism is concerned. To put the point crudely, patients – especially patients in fear – may crave precisely the kind of parent-child relationship implied by paternalism. As Lupton has put it: 'the privileged representation of the patient as the reflexive, autonomous consumer simply fails to recognise the often unconscious, unarticulated dependence that patients may have on doctors'.[30] The interviewee cited above gave an example from personal experience:

I remember when my son needed surgery. The surgeon treated me in a very adult way – sharing statistics and risks – but after we got through about two minutes, I stopped him. All I wanted to ask was: are you the best, and is he going to be alright? When I went home, I thought: how immature, I couldn't handle the information. But frightened ill people often do want a parent to take over. And how do we balance that one in the future?

(David Haslam)

Reason 4

A growing emphasis in medicine on the patient's role as an active partner in the maintenance of their own health. This is again partly driven by evidence of improved outcomes, but also by the recognition that the NHS cannot tackle the changing profile of demand for healthcare unless the old model of 'doing things to people' is replaced by one of 'persuading and enabling them to do things for themselves' (see section 6.2).

The ideal is to get to true shared decision-making. In the case of long-term conditions, for instance, you really need patients to drive most of the decisions. When patients are expertly involved, they can improve their healthcare more than we can. A patient with diabetes knows more about their diabetes.

(Jonathan Fielden)

Reason 5

A greater awareness that doctors in general are not perfect and that individual doctors may be very bad – leading to a greater willingness to question doctors. (This trend also has to be understood against the backdrop of the changes discussed in chapters 9 and 10.)

The confidence that doctors will not abuse their position is being diminished – or accorded on a more conditional basis – in the less deferential, less hierarchical societies of today, where there is mass communication of information about doctors, more state guidelines and monitoring, and more formal channels for complaining about doctors. This means that the collective medical profession has to work harder to convince the public that they are worthy of trust. More transparency is seen as needed, an openness to scrutiny by patients, the public or their political representatives, and sets of procedures for assuring the public that their confidence is

justified. This brings patients, or the public, collectively into greater contact with doctors collectively than used to be the case. This diminishes the autonomy of the medical profession, gives patients a more active role, and again enhances the potential for both conflict and collaboration.[31]

7.2 A new paternalism?

The trends above are all leading to a decline in old-style medical paternalism – albeit for very different reasons: the first on moral grounds, the second as a matter of fact, the third and fourth in connection with health outcomes and the sustainability of the system, and the fifth as a result of changing attitudes among the public.

At the same time, however, doctors are increasingly being expected to take on what might be described as a 'new paternalism': saying 'no' to the patient not because of their own expert opinion about what is good for that patient, but because of expert opinions (often not their own) about what is good for the community as a whole (see section 6.2).

This means that, just like Berwick's father in the quotation that began this section, doctors have to explain to people why they cannot have the particular treatment they want. They can no longer use paternalist means to do so – however much they may sometimes want to say: 'I'm the doctor: you're not.' But the project itself is inescapably paternalist in its overall objectives, requiring a prioritisation of the views of experts on what is good for people over what those people themselves want.

Moreover, doctors are being required to hold this particular line in the face of the 1960 variety of consumerism:

The importance of being able to balance and negotiate choices and treatments in such a context is enhanced as GPs find themselves facing more assertive and demanding patients, armed with potentially unrealistic expectations.[32]

Then people want to know why they are not getting [the drugs they want] or why I am not prescribing them if they are cheap. [...] If we have got someone who absolutely insists that [one drug] is absolutely necessary compared to [another] and they want to argue the point out, you have to get quite good at saying no.[33]

As one of our interviewees noted, there are real risks for the relationship between doctor and patient unless this new role is handled with great care:

For me one of the absolute key attributes of a good doctor is that they're trusted. The NHS runs on trust – and there is an extraordinary risk in some of the changes going on at the moment that that trust will be damaged, and with it the ability of the NHS to absorb demand and anxiety about health. If one of my patients comes with a headache, and I don't arrange an MRI scan and they ask me why not, then the fact that doctors are trusted means they believe my answer is on their side, not on the side of saving money. There is an extraordinary potential for damage, for the over-medicalisation of health problems … . If trust and humanity are lost from the interaction between doctors and patients, then we're all doomed.

(David Haslam)

It is worrying to note that 'in the US where the doctor's gatekeeping role is used to reduce costs (unlike in the UK where it is more about access to specialists), evidence suggests that this has led to a reduction in patient–physician trust'.[34]

7.3 Skills and capabilities

One of the recurrent themes in both the literature and our interviews is that doctors need new skills and capabilities to deal with the changing relationship between doctor and patient. These include, but are surely not limited to, the skills required to do the following.

– Manage a discussion in which information and knowledge are accessed, not possessed.

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? 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?[35]

Doctors need to understand how to find the evidence, and be humble enough to check it out in front of the patient, even check the level of the drug – doctors' prescribing practice is dreadful. We need to change our way of doing things – and admit we need to be looking at the evidence.

(Jonathan Fielden)

– Negotiate in the context of tensions between the needs of the individual patient and the needs of the community.

The rise of the assertive citizen requires a new and more nuanced understanding of user-professional communications, recognising the balancing act or negotiating role that professionals often have to play, and, increasingly, their role in justifying to users decisions or requirements that are actually outside their control – eg around which drugs are available. This means a focus on soft skills for professionals, whose role it is to guide service users.[36]

– Engage with the experiences and emotions of patients.

If people were supported with appropriate defence mechanisms, they might not dehumanise. But by the time you are a doctor, people are diagnoses. If one could build a system of reflection into medical school and, as soon as people see patients, build a system of support …. I have medical students who say 'Yes, we learned some of these principles, but they were the soft stuff, and we don't really see people doing it in a consistent way.'

(Alf Collins)

– Manage an ever-present tendency to fall back into paternalism.

The medic's desire to control, instilled throughout training, colludes with the patient's desire for certainty and willingness to be submissive in the face of the threat of illness.[37]

7.4 What *is* the relationship between doctor and patient?

The main lesson of this chapter is perhaps that it is easier to reject paternalism than to say exactly what goes in its place. The lack of a generally acceptable word to replace the (obviously paternalist) word 'patient' is just one very obvious symptom of this difficulty.

Take, for instance, Berwick's formulation of the relationship that replaces the one his father had with patients:

Some say that doctors and patients should now be partners in care. Not so, I think. In my view, we doctors are not our patients' partners; we are guests in our patients' lives. We are not hosts. We are not priests in a cathedral of technology.[38]

There is plenty to endorse in this statement – and it was, of course, designed for a specific context and setting, in which it communicated a powerful point. Taken, however, as a general definition of the new relationship between doctor and patient (with apologies to the author), it omits some obvious and crucial details: guests, for instance, do not control their hosts' access to services and treatments. The same kind of criticism is possible of any attempt at a succinct redefinition of the relationship between doctor and patient.

Perhaps the real change is that a single paternalist relationship between doctor and patient has been replaced by a multiplicity of relationships which vary with situation, need, and the specific role being taken by both patient and doctor:

We may make it more complicated than we need to. It's about situations. Today I'm a citizen and taxpayer; at Sainsbury's I'm a consumer. We can all handle multiple roles. I remember talking to a fantastic group of cancer survivors: 'When I'm feeling well I'm a citizen-consumer, and when I'm feeling sick, I'm sick and I want a nurse'.

(Harry Cayton)

I've always felt relatively comfortable and hypocritical: perfectly comfortable in my own consulting room saying 'I will do all I can to help you and put your case to the funding authorities', and then in the afternoon to be wearing a different hat and to judge the case against other applicants and to come out against it. It's possible, if extremely difficult, so long as you are clear that you are wearing different hats on different occasions.

(David Haslam)

If true, this has significant consequences for the concept of medical professionalism. Professionalism would no longer be simply about fulfilling a pre-defined role but also about recognising which role any given situation calls for. It seems to us that the concept of judgement might prove very useful in this respect.

Take, for example, the following quotation from a patient with a long-term condition who participated in work to develop NHS Values led by one of the authors of this report:

I went to sit in the normal chair and my consultant said: 'No, there's your chair today', sat me in his chair and said, 'Right, now, what do you want me to do for you?'[39]

What makes this an example of something we might want to call 'new medical professionalism'? If every doctor took this as their model for dealing with every single patient, then 1960-consumerism would run amok. It is not the behaviour alone that we applaud, but the behaviour in context. The consultant recognises the role that the patient wants and needs to play, adopts the corresponding role, and communicates this clearly to the patient.

Perhaps the most insidious paternalist strand in the Traditional Perspective is the assumption that the doctor can know, without reference to the patient, what kind of doctor–patient relationship is required. Attempts to define a single new doctor–patient relationship, or find a single replacement word for 'patient', risk perpetuating this form of paternalism.

8. Teams and other collective endeavours

Key messages

– Modern healthcare is delivered by teams, not by individuals.

– Doctors need to develop their skills in areas that have not been traditional strengths, such as influencing and being influenced.

– Collaborative judgement can be better judgement, but raises larger questions about accountability in teams.

– Modern medical professionalism may be better thought of as a quality of teams as much as individuals (much as the concept of leadership is now understood).

– There are reasons to question the usefulness of the idea that there is a single, distinct medical professionalism which unites and distinguishes all doctors across many different contexts; instead, the term 'doctor' may describe a network of 'family resemblances'.

Care co-ordination depends less on organisational integration than on clinical and service integration, because the experience of service users is influenced more by the nature of team working and the adoption of shared guidelines and policies than by the nature of organisational arrangements.[40]

So far our discussion has proceeded as if doctors delivered healthcare in a vacuum, without the involvement of any other professionals or healthcare workers. Implicit in the Traditional Perspective is the model of the heroic doctor, single-handedly treating his (or her, but traditionally his) patient: if others (including the patient) do get involved, then they are at best in a supporting role.

Maybe this model once had some value in the distant past, when society and medicine were very different things. But as doctors themselves are the first to point out it has little or no relevance to the modern realities of healthcare. The quality of the care received by a modern patient depends on a collective endeavour, one that spans professional boundaries, organisations and traditional policy divides such as that between health and social care. In this chapter, we discuss the consequences of this fact for medical professionalism.

We suspect that this is one of the areas in which discussion of medical professionalism – or perhaps, anticipating the last section of this chapter, clinical professionalism – might most engage current practical concerns. For instance, a relatively recent series of consultation events with doctors found that:

Some of the issues relating to new kinds of partnerships are in the areas where there is the greatest need for more thinking. For example, despite a considerable level of anxiety about the respective roles of doctors and nurses, participants reported that individual professional responsibilities within professional partnerships were not always well defined or well understood.[41]

It would have been more elegant to have given this chapter a single word title: 'teams'. While the word conveys both the sense of a shared aim (the experience and health outcomes of a patient) and the collaboration and cooperation required to achieve that aim, it also suggests a continuity of relationships that will usually be missing from the team brought together by a single patient's care pathway.

Even within the context of a single organisation, the formation of genuine teams can be problematic:

Effective team-working in modern medicine is made more difficult by the fact that teams in many healthcare settings, notably acute care, are inherently unstable. They are forever changing, forming and reforming with every new shift.[42]

Where care pathways cross multiple organisations, the idea of a team may be even less applicable. Some have argued that current reforms will push the members of the patient's team even further away from the possibility of real relationships and towards transactional arrangements. If true, then the professionalism of all parties in the collective endeavour of healthcare will be even more critical to the experience and outcomes of patients.

Some social science researchers have stressed that 'professionalism' defined as the values or moral obligations of service and trustworthiness to which for example doctors adhere could help to 'restrain excessive competition and encourage the collaboration which is so important for inter-professional work'.[43]

8.1 Influencing and being influenced

The importance of teams and collective endeavours in modern healthcare clearly put a premium upon the basic skills of empathy and communication which underpin effective teamwork.

Your ability to interact with others is increasing in importance. Today, I must have worked in close proximity to 20-25 people in one day. I operated in two operating theatres, so two sets of people there, one set of surgeons, my team on the ward, the ICU team, medical teams … an awful lot of interactions. It's not revolutionary, but it's getting more and more essential that people can communicate well and behave in a certain fashion.

(Oliver Warren)

The need to communicate in teams is fairly fundamental. If you look at businesses outside healthcare, they know how to get this right – how you integrate, how you get people working more closely together.

(Jonathan Fielden)

Collaboration also shifts the focus away from control and towards influence. To understand why this is the case, imagine a situation in which the quality of care received by a patient really did depend not on a group of people but on one individual doctor. What would that be like for the doctor? In many ways, things would be much harder for them; but in one crucial way, life would be a great deal simpler, because the doctor would at least control all the levers of quality. The one thing a person can meaningfully control is their own behaviour. The only thing such a doctor would need to do to improve quality is, as one of our interviewees put it, 'try harder'. In a collective endeavour, by contrast, no one person controls all the levers of quality. 'Trying harder does not make us better' (Tony Giddings). Everyone can, however, exert a positive influence.

The skill of influencing is not one in which doctors are always very strong – in part as a result of training that has not seen influencing skills as a key component of medical professionalism. Just as important in a collaborative healthcare setting, moreover, is the skill of **being influenced** – another skill which has not traditionally been required

in doctors. The new relationship between GPs and providers is one area in which doctors' skills in being influenced look set to be put to the test. GPs at least have the advantage of being doctors themselves, with all the influencing authority that brings. In reality, however, doctors need to be influenced by more than just other doctors.

If you look at the way that some medical services work, there's a huge gap between the consultant that delivers the top bit of the care and the nursing staff that make all the other jobs possible. If you contrast that with, say, a really good Intensive Care Unit – the doctors there work seamlessly with the nurses, they all work to a protocol, and are bound by the same rules. The consultant may take ultimate responsibility for clinical decisions, but it's never done without reference to all the nurses. It's a very useful mirror for different kinds of professionalism.

(Tony Giddings)

Moreover, the skills of doctors in working in teams, influencing and being influenced vary widely between different contexts – making any generalisations about doctors in this area highly questionable.

Not all clinicians behave the same. There are subtle but also obvious differences between the ways in which different groups of clinical professionals understand the terms you use. A team can be drawn together quickly about a focused intervention of short duration. A team can be a widely distributed group of people with long-standing relationships, autonomous decision making and mutual clinical responsibility. The latter model of team working is much more apparent in mental health, community, or primary care than in specialist settings. The word 'team' is used in all cases, but the behaviours can be very different.

(Susan Went)

8.2 Collaborative judgement

The skill of being influenced is closely linked to recognition of the fact that judgement (a central component of the Traditional Perspective) may in fact be enhanced if it is seen less as a quality of individuals and more as a collaborative activity.

It should be stressed that there is nothing especially new about the concept of collaborative judgement in and of itself. For instance, the idea of a 'second opinion' is well established, though the idea that that second opinion might come from someone who is not a doctor, even from the patient, is a more recent phenomenon (see section 5.2). And the example of a good Intensive Care Unit in the last section provides a concrete example of collaborative judgement in current practice.

There are, however, good reasons for thinking that there is not enough scope for collaboration in judgement in current conceptions of medical professionalism and practice.

In making intuitive decisions, the doctor is relying on a largely unconscious process. We all make these intuitive leaps, and 95% of the time they're very useful and quick, 5% of the time they're off-beam. Unless we have either someone around who can say 'Hold on, is that x-ray upside down?' or 'Might this be atypical meningitis?' the brain does not invite us to review these unconscious judgements. The problem with the concept of medical professionalism is that you get the feeling you're going to someone very wise, that it's not right to question them. Whereas the reverse is true – they won't pick up the 5%, and in a hierarchical situation, there might not be the mechanism for challenge. A junior might well think 'Well, you don't always get the spots', but would they be able to say that to a consultant?

(Tony Giddings)

Moreover, while collaborative judgement sounds like a very nice idea, it is clearly in need of further clarification. The reality is that, usually, an individual still has to make a decision and take accountability for it. In their review of patient-centred professionalism, Askham and Chisholm identify three approaches to handling uncertainty: 'evidence-based practice; involvement of patients, and their values and preferences, in the decision; multi-professional practice, or team-working'. It is interesting that they do not include **individual** judgement in this list – before noting that 'The debate about who has to assume the responsibility or be held accountable for a health care decision in different circumstances is ongoing'.[44]

Of course, if we view judgement as a collaborative activity, this may mean rethinking the way that responsibility is attributed when things go wrong. In fact, this may be necessary even when no-one else has been directly involved in a particular decision.

Medicine is supposed to be a caring profession, but if you look at the care we generally extend to our colleagues it's not very good. In particular, where there are problems, say a drug error or mishap, you'd hope the team would come together; but unfortunately this doesn't usually happen. Perhaps the error is latent in the organisation: but it's not common that the team as a whole takes responsibility, or that the individual's error is put in the context of the whole system. Culturally that's a very important indicator of whether an organisation has the right attitude to safety.

(Tony Giddings)

While doctors are well trained in communication skills these days, they are not well trained in communicating with each other constructively. If a colleague makes a mistake, they are not trained to intervene – or accept sanction. Medics could be trained to be better at giving

feedback and responding less defensively when they receive it. Giving constructive feedback is an ideal practical vehicle for changing local practice.

(Mary Dixon-Woods)

8.3 Team professionalism

Trying harder does not makes us better. What does make us better is understanding more about ourselves, our personality preferences, strengths and weaknesses – and then working in the kind of team in which our strengths are well deployed and our weaknesses matched by strengths in colleagues.

(Tony Giddings)

One of the major themes emerging from the previous chapters has been the extent to which we want different and sometimes conflicting things from doctors. For instance, we want doctors to:

– be good at 'curing' and 'healing' (see section 6.1)

– treat people when they get ill and keep them healthy in the first place (see section 6.2)

– balance the needs of the patient in front of them with the needs of the whole community (see section 6.2)

– embrace 1915-consumerism while holding the line against 1960-consumerism (see section 6.3)

– adopt different kinds of role in response to different kinds of patient (see section 7.3)

– influence quality of care while maintaining personal standards of excellence (see section 8.1).

This is quite a lot to expect from any individual doctor or, indeed, any other individual member of a healthcare team. It is not just that there are some very difficult balancing acts involved. In each case, the different parts require different capabilities and appeal to different motivations. How many people both can and want to do all of these things? If this is new medical professionalism, where will we find any doctors?

Moreover, if the quality of the care received by a modern patient depends on a collective endeavour, why would we want to do this? Is not making demands such as this of individual doctors merely replicating the model of the heroic doctor from which we are trying to move away.

Consider, for instance, the following question: 'Which would you prefer, a surgeon who was technically proficient, or a surgeon who was highly skilled at explaining the procedure and its implications to you?' The heroic response to this question is 'The surgeon should be both'. The defensive riposte is, 'That's all very well, but really technical proficiency is what matters most in a surgeon'. The existence of a team allows us to break out of this rather fruitless spiral and say simply, 'I want the surgeon to be technically proficient, to recognise any weaknesses they have in their communication skills, and to ensure that these are made good by someone in their team (in the same way that, say, people who go for HIV tests are also offered access to a counsellor).'

For some readers, including some doctors, such a proposal may seem to belong to the technical category of the bleeding obvious. The problem, as one of our interviewees pointed out, is that 'the idea that all professionals are an island is a strong cultural element, and one that is quite hard to dislodge' (Harry Cayton). It is striking, for instance, that a number of the most popular case studies of excellent interdisciplinary working are from US organisations such as Kaiser Permanente or Geisinger; but that even in the US, this represents an exception rather than a rule:

It is important to note that most physicians in the United States work in solo practice or small groups rather than in large integrated medical groups. This may be because of either a preference for working independently or in small groups or the lack of opportunity to join a large medical group.[45]

Without wishing to stereotype doctors, a 'preference for working independently' appears to be quite widespread on this side of the Atlantic. However entrenched the idea of the heroic doctor may be though, there also appears to be real potential in any move to rethink professionalism as a quality of teams as well as individuals.

The Royal Colleges are starting to see professionalism as something that operates in a context, as opposed to a set of personal attributes. Teams lend themselves much better to the concept of professionalism. I'm a professional in a team, my behaviour influences and is influenced by the behaviour of others, the outcomes for patients improved or made worse by behaviour of people working together rather than individually.

(Harry Cayton)

Professionalism isn't just about ensuring that your individual practice is up to scratch, it's about taking responsibility for the quality of the work of your clinical team and of the wider service in which it is embedded.

(Paul Lelliott)

Of course, such a conception of professionalism will still need individual components – the minimum standards of conduct and competence expected of anyone fulfilling a role – and its shared aspirations – the values that motivate each individual in the team. Crucially, it will also include a new individual requirement: the requirement to recognise one's own areas of weakness and take responsibility for ensuring that they are matched by strengths in colleagues.

At the same time, such a conception of professionalism could free up individual doctors to make their own unique contributions, in line with their particular aptitudes and motivations. Herein, perhaps, lies the great opportunity of team working for doctors themselves.

Different doctors are stimulated by different things. I would leave medicine before I did certain medical jobs. It's not like I'd be a doctor in any role. I went into surgery because it's intensely gratifying – you see the results. Fixing, mending people – it's relatively rapid, in an overt, obvious way. They're saying doctors need to become more focused on health, not illness: but that's not for me! The system needs to be interested in health, but we still require there to be people who enjoy and get satisfaction from looking after people when they are very sick. I enjoy trying to make these people better. Now, a friend of mine who's a GP is passionate about smoking cessation. Because of what he does, bad things don't happen – and of course he never sees what doesn't happen. But he gets huge satisfaction from that.

(Oliver Warren)

The risk is that we try to identify a particular sort of doctor that we should all be aspiring to, and we lose the fact that medicine is a really diverse profession. There are cardiac surgeons who have limited leadership skills, but have really excellent technical skills when it comes to carrying out heart surgery.

(Alf Collins)

Is there a difference fundamentally between, say, the surgeons that need good technical skills and the kind of doctor that needs to deal with uncertainty, something that requires a different set of skills, and much more in terms of communication skills? Do we even need to restructure the profession? And then what does that mean for how we select people to be doctors?

These days you need very good maths and science A levels, which make you very good in a binary situation, whereas a lot of healthcare is uncertain. Are we putting the people who are academically least able to cope with this in the situation where they most need to cope with it?

(David Haslam)

I think it would be quite unusual to see people early on in their career as a GP (unless heading off to public health) thinking much beyond their interactions with individual patients, or the interaction of the team with patients. Early in your practice as a GP, the concept of looking after a population isn't well formed: it's not something that really comes home to you until you've been at it for a while. Later on you start thinking about auditing for a population, things like that. I see guys after four or five years saying, 'I'm getting interested now in the bigger picture'. Then I've several colleagues in their 40s or 50s saying, 'I've got 10 years to go and I want to make a difference in an improved health service'. It's not for everyone though, not everyone follows that trajectory. […] I don't think it will ever be that every GP wants to take a whole-system approach – you have to have a particular mindset.

(Hugh Reeve)

My passion is education. I'm involved with medical schools, performance issues and appraisals, nurse practitioners and so forth. It's a big part of my personal role. Others get involved in research, or other areas. We don't all have the time to do everything – so you play to your strengths.

(Maria-Teresa Claridge)

8.4 Do we need the concept of *medical* professionalism?

The concept of a 'doctor' as a single unified role spanning many different contexts is, manifestly, a historical construct: a quick tally of the titles used by doctors or review of the history of Royal Colleges is enough to establish that. It is not unreasonable to ask, therefore, whether that historical construct is still valid in a modern context. If the role of 'doctor' did not already exist, would we feel any need to invent it?

It is worth being very clear about the question we are posing here. Clearly we need all those real people, doctors, and the jobs they are doing. In many cases, we also need to make sure that those specific people (or people like them) do those particular jobs and that others do not, for all sorts of reasons.

The question is, do we gain anything by grouping all of these people together under a single heading, 'doctor', and then seeking to identify a 'professionalism' which they and only they have in common?

There are a number of reasons why the question 'What is a doctor for?' has become harder and harder to answer. Four key themes stand out.

The first theme is the steady erosion of the traditional exclusive domain of the doctor. This could once easily be defined by the possession of knowledge and skill but, as we have seen (see section 5.2), medical knowledge has steadily been transformed from something **possessed** into something **accessed**. In many areas, this has led to the wholesale transfer of activities out of the exclusive sphere of doctors:

Things that become more technical can be taken out of the professional realm. The better the diagnosis, the more specific the treatment, the less need there is of someone with high training. Other people can undertake the tasks.

(Hugh Reeve)

It has also led to a blurring of boundaries between doctors and other groups of clinical professionals.

Doctors [at consultation events] felt that there was currently a blurring of professional boundaries and that this confusion could potentially undermine the positive values that a distinctive professionalism could sustain.[46]

The process has been driven in part by workforce issues, as Armitage and Shepherd explain. 'The numbers of medical school graduates have not kept pace with the requirement for doctors, but some of the deficit has been met by training other healthcare professionals to undertake tasks previously performed by doctors.'[47] Interprofessional dynamics have also played a role. Salvage[48] quotes Abbot's view that '"the real, the determining history of the professions" lies in competitive struggles between occupations for jurisdiction over realms of expertise. Experts are continuously engaged in making such claims and counter-claims over existing, emergent and vacant areas of expertise.' Or as one of our interviewees put it:

Now it's job protectionism that's at play. Everyone is hacking bits and pieces away. It's all about who's allowed to do what.

(Peter Lachman)

To the extent that this is true, it is obviously not conducive to the sort of collaborative working we have been discussing in this chapter. At the individual level, the erosion of the traditional exclusive domain of the doctor also makes it harder and harder to be sure about what is left.

I think there's a sense of: 'I went to medical school, did six years, worked my butt off' and then, as roles change, with the advent of nurse practitioners for instance (in my opinion rightly)… it starts to challenge doctors, 'Why did I bother with all that? What do I do that isn't what others do? What's different about me now?' The answers I've heard include dealing with uncertainty, interpreting the evidence, coming up with plan of action.

(Claire Lemer)

I think this whole issue of other professional groups almost taking over what doctors have done is quite a challenge for the medical profession. The question we have to ask is: what are the opportunities to move into?

(Hugh Reeve)

I would hate to turn into some sort of manager of healthcare, rather than a deliverer of medicine. Yes our roles will change, and we will be more akin to a director, but I still want to keep my medicine.

(Maria-Teresa Claridge)

It is often remarked that the doctor used to be God: the modern doctor risks becoming a 'god of the gaps'. Consider for example the following which (according to the webpage from which it can be downloaded) 'responds to the need to provide clarity on the doctor's role':

Doctors alone amongst healthcare professionals must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty, drawing on their scientific knowledge and well developed clinical judgement.[49]

The telling word in this statement is the word 'regularly': the implication is that doctors' defining quality is not that they do something others cannot, but that they do it more often. At a consultation event run in the same year that the above statement was published, doctors struggled to find a convincing answer to the question of what made them different:

When challenged to identify the difference between doctors and other health care professions participants would commonly identify a number of dimensions where doctors might differ – their altruistic

values, their professional ethics, their broad span of responsibility, their diagnostic skills or their management of uncertainty. Yet on each dimension of possible difference other non-medical participants also found examples of how that particular aspect of professionalism was either already an element of their practice or was becoming incorporated into extended roles within their profession.[50]

At the same time that the traditional exclusive domain of the doctor has been eroded, so the common ground between doctors has increasingly been fractured – our second theme. We have already drawn attention to the increasing specialisation of doctors – a trend which of course includes those who specialise in being a generalist. However, this specialisation is not just a matter of knowledge and skill. Different doctors work in radically different settings, with different priorities and concerns:

Within the profession itself there is enormous variety. Medical work ranges from high-technology, hospital-based specialities, such as neuro-surgery, to community-oriented branches of paediatrics and psychiatry. Doctors can be anything from full-time hospital consultants to part-time, single-handed GPs. They carry out an increasing variety of roles as clinicians, managers, academics, strategists and advisers. With these diverse roles come multiple and at times conflicting interests.[51]

There is a huge difference in contexts. It's not explained very much at medical school, but the differences are huge. It's like comparing a taxi driver and a Formula One driver – they both sit in a car, but that's about it.

(Oliver Warren)

These contextual differences can have big implications when we ask what medical professionalism means in practice for different doctors. The interviewee quoted above, for instance, noted how the tension between responsibility to the patient in front of one and responsibility to a wider community may play out differently in different settings:

You'll be forced to deal with that more in certain specialities than others. It's harder to do in surgery: if the bowel is perforated, you need it done then and there. But in other areas – diabetes, for instance – it will be a much bigger issue.

(Oliver Warren)

The team itself is another critical variable in the contextual mix, with a recent consultation with doctors finding that:

Partnerships between doctors and other health professionals vary from place to place and person to person. Changing roles and a variety of contextual factors have necessitated change, but that change is uneven, and sometimes rests on a fragile and pragmatic consensus of how doctors should work with and alongside others.[52]

Individual doctors may, of course, have a clear sense of what professionalism means in their own particular context. Nevertheless, seeking a single, unitary 'medical professionalism' which they all share may still be a bit like seeking a single definition of the word 'game': as Wittgenstein famously argued, games share multiple 'family resemblances', but there is no one characteristic that unites them all.

A third theme concerns the comparable multiplication of specialisms and roles that has taken place in other clinical and healthcare professions. It would be much easier to say what a doctor was for if one could say definitively what they were not for. However, the simple binary distinction between doctor (father) and nurse (mother) is, if not quite dead yet, then definitely on its way out. Doctors must now find their place in a complex ecosystem of roles and responsibilities – with different doctors needing to adapt to very different ecosystems.

For doctors, as for other health professionals, it is vital that they are clear about their specific areas of responsibility and understand the value of what they are adding to the team – a contribution that will vary according to time and place. To equip doctors to work in this way 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.[53]

Those roles, of course, also include non-clinical roles, and in particular managers, who are on their own journey to establish an identity and place in the collective endeavour of healthcare. According to the Royal College of Physicians working party:

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.

They go on to argue that:

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.[54]

There is almost certainly a risk that the clinician/manager distinction has become a new binary distinction, a way of defining what doctors are by being clear about what they are not. There are two problems with this approach. First, in light of an emerging consensus that doctors themselves need to act as 'stewards of precious resources', it is probably already out of date. Secondly, it works only by ignoring all the other clinicians who are not doctors.

Perhaps the biggest challenge for the concept of medical professionalism – the fourth and final theme – lies in the fact that doctors are no longer indisputably at the centre of the team. To some extent this is a result of the recognition of the claims of other professions:

> *What appears to be changing is that the areas of knowledge and skill which doctors see as relevant to health care and over which they do not claim mastery are also growing – for example, patients' values and preferences, alternative therapies, pharmaceutical skills […] .[55]*

Even more important, however, is the recognition of the patient as an active participant in the delivery of healthcare. The most profound binary distinction underpinning the Traditional Perspective was that between the passive patient and the active doctor. As long as the patient remained passive, the doctor could take the role of leading actor. But if the patient is now the leading actor, what role does that leave for the doctor: best supporting actor?

Again, it is very important to be clear about the question being posed in this section. The themes we have been developing are all completely consistent with individual doctors having a very clear sense of the particular role they play in their particular teams, and an equally clear sense of what professionalism therefore means for them. They are even consistent with the idea that **all** individual doctors in existence might have that kind of personal clarity.

The question concerns the value of seeking a single answer to the question 'What is a doctor for?' and, with it, a single definition of medical professionalism which both unites and distinguishes the medical profession.

On the one hand, there is the argument that the basic values and standards which unite all doctors are and indeed should be shared by others in healthcare, and therefore do not distinguish them.

> *There is a growing literature on ethics in healthcare – I would argue that it is less helpful to have different ethics for different professions but rather to consider professional ethics in a multicultural context. We need to ask also: what are the important ethical values from the patient's point of view?*
>
> (Anne Gallagher)

> *One of the problems in this country is that there are so many codes of practice. Why not focus on an integrative code of practice, we should learn from the Health Practitioners Competence Assurance Act (2003) in New Zealand, for instance.*
>
> (Debra Humphris)

On the other hand, there is the argument that the things which distinguish doctors are not shared across the medical profession as a whole.

> *Doctors are incredibly diverse, and there are risks associated with generalising professionalism between, say, a cardiac surgeon and a public health doctor.*
>
> (Alf Collins)

Taken together, these arguments raise real questions about the value of seeking something in between.

> *Is the idea that there is medical professionalism really helpful? It started off in the minds of many as the distinction between someone who was acting in the interest of business success and someone acting in the interest of the client. That was what I naively thought professionalism was all about. And of course, professions were cloaked in uniforms, behaviours, and so forth – we were almost a priestly class.*

As time has gone by, though, knowledge has increased and become more scientific, we've shared that knowledge more openly with our patients, our patients have become more inquisitive – and the whole concept of medical professionalism may be slipping into the unhelpful basket. It suggests that there is some function, behaviour, attitude which is self-sustaining and important in itself. I think we need to refocus clinicians back onto the patient's interest. That's something that's become clearer to me as I've watched what's happened to people I know when they've been patients.

(Tony Giddings)

This is not about disbanding the idea of professionalism, junking shared values and standards or dismissing people's very real vocations. It is about asking whether – in the context of the collective endeavour of modern healthcare – the things that are most precious in medical professionalism may be better served if we recognise that the historical construct of 'a doctor' is getting in doctors' way.

A promising alternative to the principle of autonomy as the centerpiece of physician professionalism is the concept of professional interdependence. Today, changing economic, social, and medical factors threaten the independent physician model with extinction. Ironically, many of the factors driving physician dissatisfaction – managed care, the liability crisis, the expansion of specialization, and increased financial and time pressures, for instance – are issues that demand collective solutions, and in so doing point to the shortcomings of continued autonomy. Rather than resisting these trends by clinging to the value of autonomy, physicians should embrace a new model of professionalism in which teamwork and collaboration are valued over independence. By pooling, instead of compartmentalizing, the talents and resources of the health care community, physicians will have the opportunity to achieve professional satisfaction by filling defined roles within an integrated health care system.[56]

Part 3: Profession and state

9. Regulators

Key messages

- Aspects of past debates around regulation have created a negative emotional context for further dialogue around professionalism.

- Recent writing about regulation clearly positions regulators as participants in the collective endeavour of healthcare, playing a role alongside, not above, professionals.

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.[57]

In this chapter, we review the recent relationship between doctors and their regulators. The most important feature of recent years, of course, has been the intervention of the state in regulation following a series of examples of manifest failure in existing mechanisms of self-regulation.

This was happening at the same time that the state was also becoming more assertive in another role, that of employer (see chapter 10). There has been plenty of cross-pollination between the two trends. However, there is also a good argument for not confusing the two. For one thing, regulation of membership has always existed in **some** form as a feature of professionalism, whereas employment is a much more recent experience for the medical profession. There are also grounds for dating the crisis in regulation to specific events, which the growing assertiveness of state as employer antedated by some years.

Our task in this chapter is not to argue for any particular approach regulation, but to highlight some issues which have had an impact on medical professionalism and, in particular, shaped the **emotional** context for future dialogue.

9.1 Who regulates?

The rights and wrongs of self-regulation is not a topic we can do justice to in a very brief overview. For some, self-regulation remains an essential component of professionalism; but the arguments behind that view are varied.

It is worth teasing out three very different kinds of question which lie behind the 'Who regulates?' debate.

- Who has the right to be involved in regulating doctors?

- Who has the expertise required to fulfil specific regulatory functions?

- Who can be trusted to do these things?

The first two questions raise interesting issues which could be discussed at length, but which we shall not discuss further here. It is the third question, unsurprisingly, that has given the debate about regulation a highly emotional colour.

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.[58]

Unsurprisingly, counter-narratives were developed by those who felt themselves mistrusted.

There have been several headline-grabbing cases in the past 10 years related to the practice of medicine. These include paediatric heart surgery at the Bristol Royal Infirmary, organ retention at Alder Hey Hospital, Liverpool, Harold Shipman and Kerr/Haslam, among others. Each highlighted specific problems related to self-regulation by the medical profession. As a consequence, the General Medical Council was seen as a weak and ineffectual body and the medical Royal Colleges as indolent, self-serving and self-absorbed. High-level and clear executive action had to be seen to be taken. […] Under the banner of public safety, increasingly draconian 'external' control has been imposed upon doctors. […] A cynical interpretation of this control might be that it is to demonstrate to the public (who in surveys continue to trust and support doctors more than they do politicians) that politicians are in charge and know better than doctors about issues of risk and public safety.[59]

Unfortunately, all of this was happening at a time when the Government's approach to management was embodying a different kind of mistrust of doctors' motivations (see section 10.2). Unsurprisingly, these twin experiences of being cast as 'knaves' rather than 'knights' mixed with and reinforced each other. We shall discuss their impact further in the next chapter.

Standing back from the emotions of these debates, it is worth noting that a lack of trust in the institutions of mistrust is not the same as a lack of trust in doctors. Indeed, some of our interviewees (themselves doctors) expressed views which combined a desire for self-regulation with scepticism about existing arrangements:

I think we should be responsible to each other. […] Revalidation is clearly important and has been around for ages, but it's not sorted. And I can give you examples of doctors with performance issues who have sailed through appraisals.

(Maria-Teresa Claridge)

There's something about true self-regulation and self-policing. If doctors don't sort out the bad amongst them, if we ignore them, go along with it, that's something really unprofessional. […] Traditionally it's been the case that your first loyalty is to other doctors: that I do find really annoying.

(Oliver Warren)

Interestingly, this desire to take some responsibility for the shortcomings of other doctors – a positive desire for self-regulation – is exactly the sort of desire we need to tap into if we want doctors to take a greater interest in quality across teams or wider collective endeavours. The contexts are, of course, radically different but (as outsiders) if only the feelings of mistrust could be overcome and a sense of continuity established, then maybe the self-regulatory desires of doctors might turn out to be an important asset for the NHS.

9.2 Managing risk

Given the nature and scale of some of the failures of medical professionalism which sparked what might be called the regulation crisis, it is not surprising that reactions have tended to focus on regaining and deserving trust, rather than on what one could do once that trust was secured. Many felt that they were **over**-reactions – and pointed out that, ironically, regulation which seeks to eliminate risk entirely actually creates new kinds of risk for quality.

Reacting to the worst undermines the good. […] Regulatory and accountability mechanisms should avoid focusing solely on extreme cases, since this may encourage the misguided belief that professional identity should be based on the task of eliminating any possibility of bad practice.[60]

If you take no risk you harm people. If you're not prepared to take risks you shouldn't be in medicine. […] These days the whole notion of uncertainty seems to terrify young doctors. Perhaps that fear was always implicit, but now it has become explicit because of the fear of making the wrong call – as opposed to seeing the uncertainty as a source of creativity.

(Iona Heath)

Regulation does not seek to address all aspects of risk, and regulation (of health professionals or in its other forms) is not the solution to prevent every possible thing that could go wrong. Indeed over-regulation could give a false level of assurance and lead to increased risk. […] There is an inherent risk in all interventions in healthcare and nothing can be said to be completely safe.[61]

It is noteworthy that the last of these three quotations comes from a recent statement by the Council for Healthcare Regulatory Excellence.

On the other hand, it is a little worrying that a study of undergraduate students in UK medical schools[62] found that 'professional behaviour was described as a "burden" and metaphors such as "like a robot" were used. Upholding professional standards was perceived to involve sacrificing the freedom of the individual; this was mostly attributed to "being watched".'

Rather as with the feelings of being mistrusted discussed in the last section, feelings of being watched and controlled arising from new approaches to regulation coincided with similar feelings arising from the Government's approach to management (see section 10.1).

9.3 Regulating people or regulating behaviour?

I was at an international conference recently. There was a striking contrast between the infantilisation of young doctors in our country – who don't feel competent because they're constantly surveyed and not trusted – and the lives of doctors in remote, rural countries. We don't want to be at either extreme.

(Iona Heath)

A really good quality professional is one that's constantly running over their own behaviour, learning from errors and successes, and constantly self-aware in what they do. Those of us who are not in the clinical world can be left slightly open-mouthed by the level of angst some doctors go through about appraisal and revalidation.

(Harry Cayton)

The question of where the right level of oversight lies is one which, once again, could be discussed at length, but which we will not explore in detail here.

Given that the pace of change in evidence, treatments and procedures has accelerated, and that the apprenticeship model of development is being replaced with a lifelong learning model (see section 5.3), it is not surprising that the level of oversight of doctors has increased in absolute terms. As such, one cannot help wondering if some of the anxiety felt by some doctors about this oversight may link back to the broader challenges around evidence discussed in chapter 5. That, however, would not seem to explain young doctors – who expect still to be learning – not feeling trusted.

A deeper question to be posed here is: **what** is being regulated? Behaviour or people?

In the Traditional Perspective, regulation (in so far as it existed) was focused on people. Once a person had established that they were trustworthy, they were trusted to deliver the right behaviour. The system was (in theory at least) based on doctors having the right values. The manifest problem with this approach is that values are hard, if not impossible, to assess reliably from the outside.

By contrast, some doctors now feel that it is their behaviour that is being regulated. This approach gets around the measurement problem, but only by requiring compliance with rules rather than the expression of personal values. The result: as in the last section, some doctors feel watched and not trusted (and as before, see section 10.1 for further discussion).

Professionalism is an essential component of any system that is trust-based. Arguably, however, it's no longer trust-based, but regulation-based. That's extremely detrimental both in the costs to society and the costs to patients. Everybody becomes defensive and normative, the service is no longer flexible, no-one is prepared to adjust to individuals because you have to follow rules.

(Iona Heath)

In light of this, it is interesting to consider (as what might now be thought a historical artefact) the following from a paper by Donald Irvine in 2001:

Founded on the General Medical Council's (GMC) Good Medical Practice, the new professionalism is an explicit statement of professional duties, responsibilities, values, and standards for doctors, developed and agreed on by the public and the profession. Compliance is being secured by embedding the culture of Good Medical Practice into medical education and by linking it directly with medical registration (licensure).[63]

What is so striking about this passage is the rhetorical shift from a mention of 'values' in the first sentence to the focus on 'compliance' in the second. A value is not something with which someone complies, let alone something with which compliance can be 'secured'.

Contrast the rhetoric of the following statement from the Council for Healthcare Regulatory Excellence, which carefully puts regulation at the service of professionalism, and makes clear its focus on the standards which underpin it – compliance with which is, even according to the Traditional Perspective, just one expression of one's values (see section 3.1).

We believe that it is primarily the professionalism of doctors, osteopaths, pharmacists, nurses, physiotherapists and the other 25 regulated professions that deliver quality care. Regulation is working in the public interest when it supports professionalism and allows it to flourish. It can do this through promotion of standards of competence and conduct, by taking action where these standards are breached, and through quality assuring the education of professionals.[64]

To put the point in another way: regulators are themselves participants in the collective endeavour of healthcare, with a clear role to play alongside, not above, professionals.

10. Employers

Key messages

– Evidence suggests that most doctors now accept the **fact** of management; but debates remain about the **how**.

– Aspects of the way in which management was undertaken in the past have left a negative emotional legacy: these include the failure to establish a new compact with doctors, which addresses both medical professionalism and its *quid pro quo*.

– In the future, doctors' 'compact' will increasingly be with organisations, rather than with society or the state.

– Doctors need new skills and capabilities to thrive in an organisational setting.

The creation of the modern welfare state under the post-war Labour administration meant that pay and conditions for service providers were determined outside the professional organisations for the first time. Since then, state control over the professions has continued to expand.[65]

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.[66]

During the latter part of the 20th century, two trends – the increasing accessibility of an evidence base to non-doctors, including policy makers and managers (see section 5.2), and the increasing visibility of individual performance across all areas of work thanks in large part to technology – combined to make possible something that had not been attempted in the early days of the NHS: management.

The relationship between a doctor and their employer has clear implications for the Traditional Perspective on medical professionalism, which leaves little room for accountability for organisational objectives. In this chapter, we review some of these implications.

Of course, not all doctors are employed in the technical sense but the majority of those who are not, such as GPs, still have contracts. We shall use the word 'employers' rather lazily to refer to the organisation on the other end of these contracts. It is also important to remember that not all doctors work in the NHS (and many have some work outside the NHS): nevertheless, the relationship between doctor and state dominates discussion.

The **fact** of management has implications for the Traditional Perspective. There is evidence that most doctors now recognise the need for management, and accept these implications (see section 10.1). The **how** of management, however, remains an area of debate. And it is aspects of the way in which management was attempted during a significant recent period that have left the biggest emotional legacy in this area. Much as in the last chapter, it is not our task here to argue for a particular approach to management, but to highlight how the approaches taken have shaped the emotional context for future dialogue.

One of the other striking features of the last 20 years has been the speed at which management structures have been introduced and rejected again. The current trend appears to be away from centralised command-and-control approaches of the kind that dominate recent history. The introduction of clinically-led commissioning will mean that some doctors are, in our lazy sense of the term, 'employed' by other clinical teams. At the rational level, these changes create new opportunities and challenges for the relationships between doctors and employers. At the emotional level, however, history has a habit of living on until it is acknowledged and set aside.

10.1 Targets and judgement

In section 5.1, we discussed the relationship between judgement and evidence. Evidence, in so far as it determines the right thing to do, renders judgement irrelevant; but many believe that judgement remains important in the application of evidence in specific situations.

There is an analogous relationship between judgement and targets, policies, protocols and so forth. In some cases, indeed, the relationship is the same one: NICE guidelines, for example, are evidence-based guidelines. In other cases, the involvement of evidence may be tenuous or non-existent. There is a spectrum between empirically validated generalisations granted the status of a guideline at one end, and generalised expressions of will at the other. Whether evidence based or not, however, these various instruments of management all erode the scope for individual judgement.

Some have feared that the logical endpoint of this process of erosion is that doctors will become little more than robots, applying protocols and algorithms.

Systematic reviews have been used successfully to guide policy and clinical practice but what is their impact on everyday practice? […] There is a clear danger in that as 'technicians' we will be expected to follow guidelines faithfully and

the possibility that (foundation) trusts and other healthcare providers will demand that psychiatrists and mental healthcare workers simply log on and follow the care protocol, or that algorithms will take away the humanity of the clinician-patient interaction.[67]

Targets and their ilk, that is, have sometimes been seen as a threat to the very concept of medical professionalism.

Looking back, what is clear is that the real objections have been focused less on the idea of targets than on the ways in which they have been used in practice. A recent consultation with doctors, for instance, found that:

Doctors held a wide range of views on the value of targets for the health system. However, whatever their position on whether targets could improve or distort care they agreed that their professionalism required them to engage in the process of establishing targets so that they could ensure that they were in the patients' best interests. In essence, if targets were seen to be beneficial to patients, and could be developed by harnessing doctors' professionalism, rather than by trying to stifle it, the balance of opinion appeared to shift from hostility to acceptance, and sometimes to a response that was rather more positive than that.[68]

Far from seeing a conflict between targets and professionalism, these participants thought that professionalism required them to get involved in target-setting. (Comparison with the process by which doctors have embraced and taken ownership of evidence-based medicine is probably not out of place.)

Two particular features of the command-and-control use of targets stand out as problematic.

– The first problem lay in a failure to involve doctors adequately in setting those targets. The result was that doctors were **made accountable** for things they did not **feel responsible** for. In many cases, it also led to doctors feeling mistrusted.

– The second problem lay in the lack of adequate scope for judgement in the implementation of targets, often as a result of focusing on process rather than outcomes. The result in this case was that doctors felt deprofessionalised and undervalued.

Obviously it is not the ultimate goal of a performance management system to make doctors or any other group of staff feel good about themselves. Since feeling good about yourself is typically a precondition of performance, however, a performance management system that makes most doctors feel bad about themselves is manifestly shooting itself in the foot. There are arguments that what has been called the 'targets and terror' regime worked: Julian Le Grand,[69] for example, cites several independent studies as evidence for this claim, pointing out that, 'In particular, waiting times fell dramatically across the service – and did so within the time frames specified by the performance management regime'. Whatever one's view on this question, however, it is also clear that the regime has left an emotional legacy, characterised by:

– feelings of being watched and mistrusted

[If alive today, my father] would ask, 'Why do they doubt me so?' He would feel watched. He would not understand why. Strange words would swim around him, overheard from corridors he would not recognise, spoken by people he never met: 'accountability,' 'performance management,' 'pay for performance,' 'clinical guidelines,' 'patient empowerment,' 'the healthcare market,' 'value purchasing,' — words of surveillance, of suspicion.[70]

– a loss of professional dignity

Professionalism and the values associated with it need to be considered at different levels: at a micro-level (individual professional); meso-level (organisations); and macro-level (political and social context). Professionals can experience conflict or moral distress when their professional values conflict with organisational or professional values and targets.

(Anne Gallagher)

[In] a culture subject to externally-determined time targets that are enforced by a top-down system of surveillance and management […] nurses may lose their sense of professional competence and responsibility, moral agency, and integrity, to their own personal detriment, as well as to the detriment of patients with whom they work.[71]

– reduced motivation.

Over the last 20 years, the loss of clinical autonomy to the state has really stifled people's ambition, creativity and willingness to engage.

(Alf Collins)

A regulatory approach which many felt was too focused on the elimination of risk contributed further to this legacy (see section 9.2).

10.2 Intrinsic motivation

The design and implementation of most forms of public policy usually [have] buried within them untested assumptions about the motivation of the people who implement the policy concerned. At one extreme, the motivational assumption was that the relevant public servants were completely self-interested: knaves […]. At the other extreme, the assumption was that they were not entirely driven by self-interested concerns, but by almost the complete opposite: a spirit of altruism and the desire to perform a public service. That is, they were not knaves, but something closer to those we might think of as knights.[72]

Twentieth century management science (along with large swathes of psychology) has been dominated by theoretical assumptions about human beings derived from economics: in particular, the assumption that human behaviour is motivated entirely by calculations of gains and losses. As such, it is assumed, behaviour can be manipulated through the appropriate structuring of incentives and disincentives. Vocation – the intrinsic motivations and values which a person brings to their job – is irrelevant, because human agents are all basically the same (ie self-interested) at the motivational level. Management, on this view, is all about getting the rewards and punishments lined up with the right behaviours.

So embedded is this perspective as a foundational assumption in empirical research that it is often treated as if it were empirically based itself. It is not, being derived instead from philosophy (notably the ideas of Bentham). As Keen[73] notes, 'the misplaced focus upon individuals as self-oriented utility maximisers may ignore the most essential difference between humans and other species – the development of ethical behaviour'.

In the real world, individuals in many walks of life demonstrate an annoying tendency to **care** about things even when they have not been incentivised,

and experience unsustainable levels of stress if their personal values (intrinsic motivations) do not fit with what the organisation they work for expects from them. Human beings are not infinitely malleable but have a sense of who they are and what they care about.

I don't get any money or incentive to care for these things, that's not my motivation. It's not why I do it. What incentive is there for me to look after these patients other than that I get a real kick from doing it?

(Maria-Teresa Claridge)

Worst of all, empirical studies have shown that efforts to incentivise behaviour which people were already intrinsically motivated to perform can actually undermine their intrinsic motivations – making them less likely to do what they would have done anyway when the incentives are removed again (see for example Deci,[74] Lepper et al.[75]).

If you treat people with carrots and sticks, you end up with donkeys. […] Starting out a knight and ending up a knave, that was a profoundly depressing and demoralising experience: and what's the impression it's made on the new generation? That altruism is there but somehow inadmissible.

(Iona Heath)

The collision between assumptions about human behaviour as essentially self-interested and doctors' subjective experiences of their own vocation and values combined with explicit questioning of doctors' trustworthiness to self-regulate (see section 9.1) has led to many doctors feeling profoundly mistrusted.

I still have patients who come in and say, 'Well, you play golf and earn quarter of a million' or 'You're killing half your patients because you're like Shipman'. That's really hurtful.

(Maria-Teresa Claridge)

The whole notion of vocation is open to accusations of self-interest and bias – but if you don't appeal to the best in human nature, you won't be able to exploit it. It's better to nurture it than spit on it.

(Iona Heath)

As with the issue of regulation, counter-narratives have developed questioning the motives of those perceived to be on the other side. Government and its agencies have been particular targets in this respect but there have also been negative consequences for the relationships between doctors and managers (though it should be remembered that managers too have been on the receiving end of targets and assumptions of self-interest).

On the positive side, there are plenty of examples of schemes that do successfully appeal to the best in human nature, such as the Health Foundation's own Awards Scheme, or the Royal College of Psychiatrist's Accreditation Programmes.[76] Schemes such as the last can achieve impressive levels of engagement, 'We expect to get up to 75% of eligible services enrolling for accreditation without the incentive of the CQC getting interested' (Paul Lelliott). Although called an 'accreditation programme', the approach has much in common with the principles behind awards:

We emphasise recognition of excellence. This is not about minimum standards or scraping through: this is a formal and public statement that you are good. If you are excellent then you really have your head above the crowd. We're rewarding services for doing well, not punishing those that fail or choose not to take part.

(Paul Lelliott)

It is interesting, as a brief aside, to consider a constructionist take on this recent history. As we saw in section 5.4, constructionists argue that what we call 'truth' or 'knowledge' is instead a construct of the operation of power and authority, typically at the level of social institutions. The medical profession has been a popular target for constructionist

argument. But doctors can draw some comfort from the fact that the same arguments can be made in regard of scientific management. After all, elaborate systems of targets and incentives, however impersonal, have to be designed by somebody. That somebody is invariably an economist (.e an expert), doing what they sincerely think is in the best interests of others (ie acting paternalistically), and claiming authority about human behaviour on the basis of 'objective facts' which, on closer examination, turn out to be theoretical assumptions about human beings with no empirical support whatsoever. As one paternalist profession declines, another seeks to establish itself.

Probably the safest conclusion to draw is that both the Traditional Perspective and the management science that has challenged it are guilty of the same basic mistake: making overly simplistic assumptions about people's motivations. Real human beings – a category that includes doctors – are neither wholly self-interested nor wholly altruistic, neither immune to extrinsic motivations nor totally guided by them, neither knights nor knaves. Moreover, finding a sensible midway point between these two perspectives is not achieved by the rhetorical trick of jumping back and forth between them:

I keep hearing, 'Doctors are the answer to all the challenges that face healthcare delivery, without clinical leadership etc etc', and then from the same person, 'The main problem is doctors'. Can we really be the solution and the problem? Perhaps, but that requires a lot of unpicking and a lot of thinking.

(Oliver Warren)

10.3 The changing compact

The defensiveness of doctors is understandable: the changes to the old compact have arisen without their involvement or dialogue.

(Jack Silversin)

The idea that talking about professionalism means including what is given to the profession in return – that would be really radical, and could make for some really radical discussion.

(Oliver Warren)

One side of the bargain has changed, but the other hasn't.

(Claire Lemer)

The Royal College of Physicians[77] defines medicine as 'a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being'.

So what do doctors get in return for this service? The idea of reward for services is implicit in the notion of professionalism. It makes no sense to talk about professionalism in relation to equally important social roles which do not involve some explicit expectation of return – such as that of a parent. Yet the literature on professionalism is surprisingly coy on the topic of *quid pro quos*.

The reason, perhaps, is that the idea of rewards seems at first sight to conflict with the fundamental value of altruism. Surely someone who is rewarded for what they do is acting out of self-interest after all? This, however, is a simplistic position, born of an obsession with extrinsic rewards such as money, power or status. The word 'reward' is also buried in the phrase 'a rewarding job' – that is, a job which delivers the intrinsic rewards associated with doing what you really **want** to do.

In line with the discussion of the last section, there is no need to be precious here. Doctors do also receive quite substantial extrinsic rewards in the form of money, power and recognition. These too can act as motivators – or if not as motivators, then at least as 'hygiene factors': things that are not the

reason why one does something but which, if taken away, might well become a reason for stopping. A doctor can be motivated by extrinsic rewards such as these **and**, at the same time, be genuinely motivated by the intrinsic rewards of the job and the fulfilment of altruistic values. Any desire to see this as an either/or scenario derives from a love of theoretical tidiness, not from a knowledge of human behaviour.

The rewards of being a doctor, intrinsic and extrinsic, form one half of a compact of which professionalism is the other half. According to Silversin and Kornacki:

The physician compact is the quid pro quo or 'deal' between the physicians and their medical group, IPA, hospital, or strategic partner. It defines what physicians expect to give and what they expect to get in the relationship. Typically these expectations are not written down and formalized, but they do shape physician behaviour and in turn the organization's culture.[78]

Traditionally, doctors have seen their compact as being with society. In the modern world, however, society supplies only a few of the more abstract rewards, such as trust and respect. Although one might not realise it from many discussions of professionalism, most doctors in the UK now have an employer (at least in the lazy sense in which we use a term), responsible for supplying not only extrinsic rewards, such as pay and recognition, but also the enablers of intrinsic rewards, such as resources and – perhaps most important of all – time:

Doctors must have the time to see patients, to keep up to date with developments in their specialty, to review their practice with their colleagues, and to think. […] the Government, as employer, has a duty to do everything in its power to create the conditions under which the new professionalism can flourish.[79]

People need space in practice to reflect on ethical issues.

(Anne Gallagher)

In the early days of the NHS, the compact between doctors and their new employer, the state, was relatively straightforward, 'A self-regulating medical profession was expected to maintain clinical standards and work with strictly limited resources in return for significant clinical freedom and minimal accountability'.[80] Famously, doctors' mouths were also 'stuffed with gold'.

Both parties to this compact could argue that they have since been let down:

– From the NHS perspective, doubts have arisen about doctors' willingness and ability, collectively and individually, to maintain standards and work within limited resources.

– From the doctor perspective, clinical freedom has been eroded, and the fundamental rewards of the job – the intrinsic rewards associated with doing what you really want to be doing – replaced by various requirements to do what someone else wants you to do in return for things that someone else believes you want.

The old compact – what is left of it – has also proved inadequate in a world in which medicine and healthcare have been transformed beyond recognition – the topic of part 1 of this document.

Elements of the old promise to doctors are clearly unsustainable given the need to modernise the NHS and other healthcare systems and improve care. Indeed some elements of the old compact are a positive barrier to improvements in medicine and healthcare, particularly in as much as it perpetuates the ethos of what one physician speaker at the US workshop called 'practising alone together.' A new and more sustainable compact is required.[81]

It is no accident that this discussion has led us, through the last quotation, back to the topic of collaboration and collective endeavour. Gone are the days when, as in the Traditional Perspective, professionalism was defined with reference to the individual and the profession. The team and the organisation are the new contexts in which medical professionalism must establish itself.

10.4 The organisation: a new context for professionalism

Traditionally, doctors have seen their compact as being with society. In 1948, the state began its slow progress to centre-stage as the other partner in the physician compact; in the modern world, the state seems to be retreating again, and making space for the organisation – the trust, the consortium, the practice. Increasingly, it is organisations such as these that will both shape the practice and determine the *quid pro quo* of medical professionalism:

It's clearly important to have a definition of professionalism – but how much difference does that make to the doctor on the ward or theatre? Most don't look up the definition, but go with their gut instincts. And those are created by everyday norms – and those are defined by the local medical director.

(Claire Lemer)

Increasingly, successful organisations will be looking to ensure that the people working with them have the right vision and values. They will be more and more willing to say, 'You're not right for this organisation.' […] There will be room for different people in different places: organisations will have different values.

(Jonathan Fielden)

The growing importance of the organisation is a source of both challenge and opportunity for doctors.

On the challenge side, organisations are complex and imperfect environments in which difficult balancing acts such as those discussed in section 6.2 may be overlaid by the distractions of systems, procedures and politics. Organisations, in short, can be hostile environments for professionalism:

Those who direct critical care units have to triage, prioritise, and manage institutional requirements. In dispensing the social

justice of trying to benefit patients most in need of a bed in an intensive care unit, the intensive care unit medical or nursing director may be faced with all the arguments of a 'balloon debate' and have to decide the winner. If the director does the best possible with what is available, then the precepts of professionalism are satisfied. If the director has to give way to the internal politics of an institution, he or she will have been compromised and, unfortunately, given administrative praise for cooperation! This is a demoralising situation for all unit staff.[82]

To make matters worse, many doctors may lack the skills required to deal with such situations, having been inadequately prepared to thrive in an organisational setting (compare the discussion in section 8.1):

Medicine has been based on a model in which doctors are trained to deal with individuals, not organisations; to take personal responsibility rather than delegate; and to do their best for each patient rather than make trade-offs in a resource constrained environment. [...] professional values and training based on an individualistic orientation do not prepare doctors to function successfully as members of large, complex organisations. Little training is given to equip doctors for this, and the difficulty that many consequently experience leads to stress and frustration.[83]

Doctors sometimes lack the mindset to see how everything hangs together in the health system, and understand the indirect things they can do to impact on quality.

(Paul Lelliott)

The sense of professionalism as the ability to do the right thing is challenged by a world that doesn't enable you to do the right thing. The challenge for a professional is to develop the skills to work the system, rather than succumbing to the system. Young doctors start very idealistic, but I fear we beat it out of most of them by the time they are 30.

(Harry Cayton)

I know a consultant who was initially really motivated to change things, but he got ground down by the system. Now he just sends emails left right and centre and files things, and feels like that's the end of his responsibility. He's stopped trying to change anything. We don't get trained at medical schools in the things we'll require as a consultant or GP partner – how to negotiate, for example, or how the wider system works.

(Claire Lemer)

On the opportunity side, the scale of organisations is far better suited to the re-evaluation of the 'physician compact' than the entire NHS. For doctors to **feel responsible** for new roles – rather than merely to be made accountable – then they need to be involved **as individuals** in shaping those roles, in working out their practical implications, in specifying *quid pro quos* such as organisational support or areas of flexibility, as well as, where necessary, moving past the emotional legacy of recent history. Involvement on that scale across the whole NHS would be a practical impossibility. At the organisational level, by contrast, practical and documented approaches to 'compacting' (albeit developed in US organisations) already exist.[84]

We are confident, moreover, that plenty of examples will be forthcoming in the UK of a refreshed compact between organisations and doctors delivering a 'new medical professionalism'.

Part 4: Discussion

11. Is 'medical professionalism' the right topic for dialogue?

The findings of this report suggest, and in particular the conclusions that the team and the organisation are the new contexts in which medical professionalism must establish itself (chapters 8 and 10), that any meaningful dialogue about professionalism must involve all members of that team, including other clinical and healthcare professionals and health managers.

There are pragmatic reasons for a focus on doctors. Rightly or wrongly, doctors still carry considerable weight in healthcare organisations. They can be powerful agents of change – or, if not engaged, powerful obstacles. As one interviewee put it, 'You can have 500 consultants in an organisation, but it only takes 5 to make mud stick.'

Our interviews suggest that the term 'medical professionalism' has pragmatic value in this respect, provided it is approached in real contexts. The word 'professionalism' speaks to the positive values and intrinsic motivations which doctors bring to their roles, and which many feel have been at worst openly questioned, at best blocked or inadequately enabled (see chapters 9 and 10).

Even doctors, however, express scepticism about the attempt to identify some characteristic or characteristics shared by all doctors in all the many varied contexts in which they work (see section 8.4).

If there are common threads between the contexts in which doctors work, we would suggest that they are fairly generic ones: the universal focus on patients; collaboration and teamwork with others, including many who are not doctors; and the growing importance of the organisation.

The term 'medical professionalism' brings clear risks in these contexts. To anyone who is not a doctor, a focus on medical professionalism will communicate the message, 'This is not about you'. As one interviewee put it, 'You can't say it's all about teamwork and then talk only to doctors. The language has to support the message.'

Moreover, by focusing on medical professionalism, the Health Foundation runs the very real risk of giving the impression that, behind a rhetoric of change, it is in fact seeking to perpetuate certain power structures and dynamics.

A focus on medical professionalism could also lead to distraction, since it naturally prompts questions about what it is that unites and distinguishes doctors as a collective from others. We have suggested (see section 8.4) that this question may no longer be possible to answer. The term 'a doctor' – itself a historical construct which pulled together previously distinct roles – may reflect a network of family resemblances between different roles in different contexts, but no single linking characteristic.

The question is, therefore: what focus could avoid distractions such as these, clearly communicate the Health Foundation's commitment to real change, and fully involve all members of the collective endeavour of healthcare while also keeping doctors fully engaged?

It is our view that what excites and engages doctors is 'professionalism'. The term 'medical' is a way of establishing the context, albeit by reference to a specific group of people.

Other broader terms are possible, eg 'clinical professionalism', 'healthcare professionalism'. We have not tested engagement with these terms, but to us they sound like neologisms designed to paper over rather than address the fact that multiple professions with their own definitions and codes of conduct still exist. We also wonder if these terms would have much resonance with patients.

The term 'clinical professionalism' also involves its own exclusivity, creating a binary distinction between clinicians and managers.

We therefore suggest establishing the context of professionalism in a more direct and 'plain English' way. Given the new contexts in which professionalism (medical, clinical, healthcare, etc) must establish itself, we suggest that the foci of dialogue should be:

– professionalism with patients

– professionalism in clinical/healthcare teams

– professionalism across care pathways

– professionalism in healthcare organisations.

If a single overarching term is required, we suggest that his might be:

– professionalism in modern healthcare.

12. What questions are worth discussing?

We have spoken to a very small number of people. Our views on questions which are worth discussing are, inevitably, provisional. Dialogue may establish that some areas we consider interesting are in fact of little practical relevance; or that we have missed other areas of significant interest.

What is clear, however, is that questions must be rooted in practical contexts.

12.1 Contexts

In the preceding section, we have suggested four key contexts in which to explore what professionalism means in practice:

– with patients

– in clinical/healthcare teams

– across care pathways

– in healthcare organisations.

For pragmatic reasons, the Health Foundation may decide to focus on one or more of these contexts in the first instance. The choice of focus might be guided by current opportunities: for instance, the introduction of clinically-led commissioning has created an appetite among many to tackle issues around professionalism across care pathways.

12.2 Types of question

In all of the above contexts, we believe it is valuable to distinguish three broad types of question:

– **Practical dilemmas and challenges** on the ground. These are often highly situation dependent, meaning that the answers developed in one situation may not be directly applicable to another. This is not to say, however, that learning between situations is not possible, only that stories and narratives may provide better mechanisms of learning transfer than processes and rules.

– **Reflective questions**. Practical dilemmas and challenges on the ground are often best tackled by creating the time and space to stand back, reflect, discuss, look around one, and look outwards to other areas of practice or domains of thought. Often these questions have a more philosophical or ethical feel – though they remain firmly rooted in reality. The answers to these questions tend to be more directly applicable from one situation to another, and can often be expressed discursively – though they normally benefit from illustration with stories, to maintain a connection with reality.

– **Skill requirements**. In order to fulfil new roles in new contexts, modern professionals are likely to need new skills. In many cases, these will be 'soft skills', with implications for the pedagogic approaches employed. These skills are likely to be generic across many situations. Some generic skills may also cut across the four contexts we have identified, for example the skills associated with emotional intelligence.

Table 1 offers examples of each type of question for each of the four contexts.

Table 1: Sample questions for each context

	Practical dilemmas and challenges	Reflective questions	Skill requirements
With patients	What are my responsibilities in this situation – including responsibilities to the patient, but also responsibilities to the wider community, to the evidence, etc? How do I balance these effectively while maintaining trust? What kind of relationship will best serve this patient right here and now? How can I help to establish and maintain a relationship like that?	What tensions exist in the modern responsibilities of professionals to patients? How does a professional balance these while maintaining patient trust? What different sorts of relationships exist between patients and professionals? How does a professional work out which relationship will best serve any given patient? What is the role of experience and judgement in the above?	What knowledge and skills does a modern professional need to underpin professionalism with patients? – eg negotiating with patients. How can they acquire these skills?
In clinical / healthcare teams	What are the collective purpose and values of this team? What does it mean in behavioural terms to take collective responsibility for our purpose and values? What do we do when we fall short? How are roles within the team delineated? Who does what? How do we ensure that individual weaknesses are matched by others' strengths?	Is there value in thinking of professionalism as a quality of a team, not an individual? What would this mean? What are the minimum requirements of individuals to make this work? – eg acknowledgement of weaknesses, openness to influence and feedback. What are the aspects of team professionalism which need to be delivered by someone, but not everyone? – eg seeking to influence the system as a whole.	What knowledge and skills does a modern professional need to underpin professionalism in clinical/healthcare teams? – eg influencing and being influenced, feedback skills. How can they acquire these skills?

Table 1: Sample questions for each context (continued)

	Practical dilemmas and challenges	Reflective questions	Skill requirements
Across care pathways	As above, with the word 'team' referring to the group, often spanning many teams and organisations that must collectively deliver quality care to patients.	As above, with the word 'team' referring to the group, often spanning many teams and organisations that must collectively deliver quality care to patients.	What knowledge and skills does a modern professional need to underpin professionalism across care pathways? – eg influencing and being influenced, feedback skills. How can they acquire these skills?
In healthcare organisations	What is the compact between this organisation (trust, consortium, practice, etc.) and the professionals who work in it? How is that compact reflected in daily realities?	What are the quid pro quos of modern professionalism? How are the intrinsic motivations of professionals valued and enabled within an organisation without compromising organisational goals? What does 'autonomy' mean for the modern professional and the organisation they work in? Which of its many senses should be preserved and valued?	What knowledge and skills does a modern professional need to underpin professionalism in healthcare organisations? – eg negotiation, getting things done in organisations. How can they acquire these skills?

We believe that all three types of question are worth asking in each of the four contexts. Indeed, it is hard to see how they can be separated. It is practical dilemmas and challenges on the ground that give reflective questions and skill requirements their meaning, but it is only by addressing reflective questions and meeting skill requirements that dilemmas and challenges on the ground can be resolved.

12.3 Types of dialogue

Different types of dialogue lend themselves to different emphases within the three questions. The table below gives examples of how this might work in practice. Note that some kinds of dialogue may be focused less on answering the questions above than on engaging new audiences in thinking about these questions.

Dialogue type	Emphasis
Single-site dialogue/intervention – eg compacting exercise in a specific organisation.	Primary focus on practical dilemmas and challenges. Needs time and space to identify and address reflective questions and skill requirements. May also require training/ coaching around specific skill needs.
Action learning group, bringing together individuals involved in different single-site dialogues/interventions.	Primary focus on reflective questions, but rooted in experience of practical dilemmas and challenges.
Dialogue events, eg regional, profession or cohort-based.	Can be used to tackle reflective questions or skill requirements, drawing on individual experiences of practical dilemmas and challenges. In general, a specific area of practical dilemma and challenge should provide the focus and guide recruitment.
On-line discussion groups, blogs, etc.	Opportunity to engage a more varied audience around reflective questions and skill requirements. Audience could be invited to link to their own practical dilemmas and challenges.
National panel, drawing together inputs from all of the above strands.	Primary focus on skill requirements.

There may be opportunities for and value in broadening out the debate even further: for instance, one of our interviewees suggested that some of these topics might provide the basis for a television or radio programme.

We recommend that the Health Foundation employs a mixed approach to dialogue activities to ensure that each type of question is being addressed. This will also ensure that the outputs of different kinds of activity feed into each other.

13. Who needs to be involved in the discussion?

The short answer to this question appears to be: everyone!

Even if a pragmatic focus on doctors remains in certain areas, it is clearly essential to ensure that all partners are engaged. This obviously includes other clinical and healthcare professionals and managers. Other partners in the collective endeavour of healthcare, such as regulators, will also have a role to play – for instance, through representation on a national panel.

To a large extent, the specific audiences to be engaged will be a direct function of the combination of context, type of question, and type of dialogue. The framework in the last section, that is, also provides a structure for thinking about who to engage.

Given the importance of skill requirements, medical educators will be an important constituency. As was noted in interviews, this may raise specific challenges.

You not only have medical identities to deal with, but also educator identities; and these may be even more entrenched.

(Mary Jane Kornacki)

A number of our interviewees pointed to the importance of involving young professionals in the process. With appropriate technical research support, younger professionals could play a pivotal role not only as participants in the process, but also as action researchers, working to draw out and report on themes from diverse dialogue activities. Young professionals supported in this way might also undertake specific research-style activities, eg to explore the state of current opinion on key issues among doctors and other professionals.

On the other hand, it is equally important to engage and address the needs of older professionals. In particular, given the length of professional careers, urgent skill requirements cannot be met solely by addressing the training of future doctors.

One obvious question remains: what about patients? At the level of tackling practical dilemmas and challenges, it is hard to imagine how this could be done without some kind of patient involvement, given that the patient is a member of the team. Patients' stories and input are also critical to ensure that reflective questions and skills requirements are addressed in a way that reflects the paramount needs of patients.

14. How can we make sure the discussion is constructive?

The expression of emotions is often considered unprofessional. However, emotions are facts and expressions of emotion are therefore a kind of evidence. To try to ignore this evidence or pretend it does not exist is equally unprofessional.

The reality is that any dialogue about professionalism will take place in the context of a very difficult emotional legacy. Individuals on all sides have felt mistrusted, let down and undervalued. In our conversations, people have described what is needed from a dialogue using metaphors such as 'marriage guidance' and 'truth and reconciliation'.

We believe that the best response to this emotional reality is not to seek to control or, worse still, exclude emotions, but to establish a clear framework for their recognition and discussion. We believe that this may best be done by borrowing from professionalism the concept of values.

What should the values of the proposed dialogue be? We suggest that they might include:

– **Empathy** for the feelings of others

– **Respect** for the intentions of others, and an assumption of positive intent

– **Curiosity** and open-mindedness about the beliefs of others

– **Honesty** about one's own feelings, intentions and beliefs, and a willingness to challenge others

– **Pluralism**, as opposed to a desire to achieve a consensus that probably will never be achieved

– **Reflexivity.**

It is not enough, of course, simply to state a set of values for dialogue, although that is a good start. Thought will have to be given to how the commitment to these values is maintained in practice.

For instance, the Health Foundation will need to be honest about its own feelings, beliefs and intentions as a participant in the dialogue, in line with these values.

Reflexivity will be critical throughout. We must always ask ourselves: are we using the rhetoric of 'evidence' to maintain power in the dialogue, and exclude those whose evidence lies in stories? Are we pushing for a consensus to avoid acknowledging the depth of disagreement? Are we falling into the traps that we have fallen into before?

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We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.