Understanding Doctors

HARNESSING PROFESSIONALISM

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King's **Fund**

Royal College
of Physicians
Setting higher medical standards

Social and technological changes are challenging doctors, causing many to rethink their role, the way they practise and the nature of their professionalism. What does the future hold? The Royal College of Physicians and the King's Fund convened 10 events around England and Wales where doctors and other health professionals discussed their changing roles as clinicians, as managers and as members of multidisciplinary teams. *Understanding Doctors: Harnessing professionalism* presents the opportunities and challenges for doctors in their own words. Their strong and thoughtful views will make a significant contribution to the debate on the future of the profession.

The Royal College of Physicians

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Acknowledgements

Foreword

The world in which doctors work is changing, and changing in ways that challenge many of the assumptions on which the profession has based its practice for more than 150 years. It has led to a degree of introspection and self doubt about the prospects of the doctor in the 21st century. *Understanding Doctors* is an attempt to capture and understand how doctors themselves view those challenges and to consider the implications of this for them and the next generation.

There is a tendency in our over-centralised and largely state-controlled health system to blame government and politicians for all the ills facing the profession. Yet it is clear that many of the pressures and challenges on the medical profession are not confined to the United Kingdom or to this profession and instead reflect wider social and technological change. These changes have an impact on the expectations of patients and taxpayers, government, and doctors themselves: the emergence of an information revolution, which both diminishes the apparent omniscience of the doctor and also gives patients a greater understanding of their own condition as well as of the performance of the professional who is treating them; the decline in deference; the feminisation of the profession; the arrival of health managers as powerful players, and the growing confidence of other health care professions.

At times over the past 10 years the challenges to medicine have been quite explicit, raising fundamental questions about the role and responsibilities of the profession, and about the selection, training, monitoring, and regulation of doctors in this new world – the inquiries into the activities of Harold Shipman and into the management of the care of children undergoing heart surgery at Bristol Royal Infirmary were among the foremost of these challenges.

There have also been attempts to look again at the place of doctors in society, what it means to practise medicine today and whether it is possible to redefine medical professionalism in this modern context.

The background for this joint project between the King's Fund and the Royal College of Physicians lies in two such reports – a King's Fund analysis *On Being a Doctor: Redefining medial professionalism for better patient care* (Rosen and Dewar 2004) and the findings of a Royal College of Physicians working party *Doctors in Society: Medical professionalism in a changing world* (RCP 2005a).

Many publications are quickly forgotten, especially when they grapple with concepts such as professionalism that can seem amorphous and of little relevance to the day-to-day realities of clinical practice. But we believed that the issues raised in these documents were fundamental to the future of the profession and that it was important both to

disseminate their conclusions and, just as important, to stimulate debate within the profession and beyond.

We therefore set up a series of consultation events across England and Wales to debate the issue of medical professionalism with doctors, medical students, nurses, allied health professionals and managers as well as patients and carers. Our first aim was to facilitate a debate within the profession to encourage greater reflection and to understand more about how the profession's own views are developing. By capturing this debate, we also hoped to stimulate further discussion within and beyond the profession and to enable others, particularly professional leaders, politicians and policy-makers, to understand the way doctors think about their own professionalism and their consequent obligations to patients, the public and the health care system.

The consultation events produced a wealth of information and at times a range of views – hardly surprising at a time of such turbulence and uncertainty. What is striking, however, is the shared understanding of the challenges facing doctors. Thus, from the north-west to the south-east of England, there were strong and thoughtful messages about the selection for entry to medical school, about working as a doctor, engaging in management, the leadership of the profession, and the role of doctors within multidisciplinary teams.

There was also a fair degree of consensus about the need to act now in a number of areas.

First, an acceptance that the profession as a whole needed a greater understanding of the strengths and limitations of techniques for assessing professional qualities, particularly in those applying to medical schools. There was also a shared view that it was important for the profession to articulate what was meant by modern medical professionalism and that this should be explicit and be central to clinical practice, not least to ensure these values were passed on to and adopted by young doctors. And related to this was the recognition of a need to develop a clearer statement of the role of the doctor in an increasingly multidisciplinary clinical environment.

Second, there was a desire to develop relationships with government, patients and the wider community. Doctors remain among the most trusted of professionals but the nature of these relationships has been changing. Many of those who took part wanted a better and a more influential relationship with government, they wanted to continue to develop a less paternalistic and more facilitative relationship with their patients and they wanted to find ways of reconciling the doctor's obligation to their own patients with a wider set of responsibilities for the health of the population.

Third, there was support for the profession, and in particular its leaders, to find ways of achieving greater flexibility in medical roles and responsibilities; to ensure a swift and effective implementation of revalidation and to make its collective voice stronger in public debates about issues of health and health care.

This is an opportune time for this report – the concerns of the doctors at these events reflect and support the call from the Inquiry into Modernising Medical Careers for a 'consensus on the role of doctors'. There is agreement that the lack of a clear definition for doctors at all stages of their career has the potential to reduce the effectiveness of the profession.

The participants also reached the same view as the Inquiry on the need for a stronger, visible and more united medical leadership capable of providing the profession with a clear vision of its own future as well as helping to shape wider questions of health, health care and public interest.

We hope that this report will stimulate further debate and contribute to reaching that consensus about the role doctors will play. We plan to take this work forward into its next phase.

Do doctors have a future? The overwhelming response at these consultation events was 'yes'. But what that future is, and what the role of the doctor will be 20 or 30 years from now, is less certain. Providing clarity to the role of the doctor must therefore be the next challenge. We hope that the views of those who joined us and whose voices you find captured in this report will make a significant contribution to that debate.

Niall Dickson, Chief Executive, King's Fund
Ian Gilmore, President, Royal College of Physicians

Summary

The world in which doctors work is changing, and changing in ways that challenge many of the assumptions on which the profession has based its practice for more than 150 years. *Understanding Doctors* is an attempt to capture and understand how doctors themselves view those challenges and to consider the implications of this for them and the next generation. This report is based on 10 consultation events held at venues across England and Wales and hosted in a partnership between the Royal College of Physicians (RCP) and the King's Fund. Almost 800 people, including 406 doctors, participated in these events. The starting point for the discussion was a definition of medical professionalism as 'a set of values, behaviours, and relationships that underpins the trust the public has in doctors.'

Understanding Doctors is structured to reflect the course of a career: entering the profession; practising professionally; managing professionally; leading the profession; and building on professionalism in partnership. Each section gives a brief context to the key questions, and then moves on to report what we heard in the words of those who participated all of whom agreed to work under the Chatham House rule.

During the consultation events, doctors acknowledged and demonstrated their strong individualism, but there were also substantive areas of agreement.

ENTERING THE PROFESSION

Most of the doctors who participated agreed that attempts should be made to identify future medical students who were most likely to become effective and respected doctors. However, there was also a common acknowledgement that the methods available for doing this are currently limited. Two additional problems were also highlighted: first, that trying to decide between potential students when they apply for medical school may be too early as their character and maturity are still developing. Second, many doctors registered anxiety that the profession should not become too homogeneous and should have 'room for all sorts of personalities'.

Participants in this consultation exercise saw professionalism as more than the application of technical skills and commonly believed that the inculcation of professional values required all members of the profession to see themselves as teachers and exemplars. Doctors felt that students and doctors in training needed to be exposed to the essence of medical professionalism at first hand – learning what it means in practice not only from their teachers but from their colleagues and from the culture of the institutions and organisations in which they work.

PRACTISING PROFESSIONALLY

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.

Many doctors welcomed the continued shift away from paternalism in medicine and saw this as reflecting wider changes in society. All doctors recognised that the greater public access to information through the internet meant that they often needed to help patients understand and 'navigate' through a range of information sources – most doctors saw this as providing opportunities for them to demonstrate their professionalism in new ways.

Across all consultation events doctors debated what it was that made them distinctive – some highlighted the uniquely complex scientific and analytical approach of the doctor compared to the roles of other health professionals. Others pointed out that some members of other professions were being asked to bring the same qualities to bear. Although views on what was distinctive about the role of doctors varied, there was a clear consensus on the present situation. Doctors 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.

During the consultations doctors recognised that the changing personal and career expectations of those entering the profession was reshaping the job. Although many remained unclear about the impact that new attitudes to work–life balance might have, there was substantial support for the continued importance of altruism in medical professionalism. However, a notable minority doubted its relevance, believing that new contracts for GPs and hospital consultants mitigated against an active altruism in practice.

Across all the events there was support for regular robust testing of fitness to practice, although this was often accompanied by uncertainty about the cost, burden, quality and practicality of current proposals.

MANAGING PROFESSIONALLY

Participants accepted that collectively doctors needed to engage with management to a greater extent than in the past and that both undergraduate and postgraduate medical training needed to prepare individual doctors to manage professionally. The main debating point concerned the how and when.

Some doctors saw medical management as a separate specialty, for others it was a matter of being able to integrate managerial and clinical responsibilities. Some saw the attraction of taking on more managerial roles as their career advanced, while for doctors in the early or middle part of their careers the challenge was how to move seamlessly in and out of clinical practice without losing clinical skills.

LEADING THE PROFESSION

There is no easy way to sugar the pill – according to the doctors who took part in this consultation exercise, medical leadership (with a few notable exceptions) was

conspicuous by its absence. Doctors themselves often criticised the plethora of medical organisations, institutions, and individuals all claiming a legitimate place in the hierarchy of medical leaders and influencers. Some felt that if the most trusted of professions was to take its place at the heart of the debate about health and health care it needed to improve its ability to speak with one voice.

PROFESSIONALISM IN PARTNERSHIP

It is not only doctors whose roles are changing. Other professionals are also having to adapt to new social attitudes, greater public access to information and the move to more multidisciplinary team working. The doctors who took part in these events often focused their discussion on the question of who should lead such multidisciplinary teams. A full range of views was articulated, ranging from the case for routine medical leadership of teams through to the routine appointment of other professionals to take the leadership role according to appropriate skills, competence and experience.

Partnerships between doctors and other health professionals varied from place to place and person to person. Change is uneven and sometimes rested on a fragile and pragmatic consensus of how doctors should work with and alongside others. More than 40 per cent of doctors who participated in the consultation exercise did not think that doctors should be prepared to be clinically responsible to other health professionals. The consultation supported the need for doctors to seek greater clarity over their place in multidisciplinary teams – currently individual responsibilities within professional partnerships were not always well defined or well understood.

Each event generated enthusiastic engagement in the debate. Doctors often identified the opportunity to harness medical professionalism to the delivery of better patient services. A commonly understood and agreed professionalism was also seen as a powerful mechanism for shaping health policy, health care improvement, and assuring safety in the millions of daily individual interactions between doctors and patients. One message is clear, medical professionalism is alive and well and capable of exerting a powerful and positive influence not only on patient care but also on the future of the health system.

Introduction

The King's Fund and the Royal College of Physicians (RCP) series of ten consultation events entitled 'Do doctors have a future?' ran from May 2006 to April 2007. Our aim was to engage doctors and their colleagues in a discussion of medical professionalism in the context of a changing society and a dynamic health system. The consultation events were co-hosted by local organisers and held during the evening at a variety of predominantly civic venues. Almost 800 people, 406 of whom were doctors, attended these events.

Outside London we called on the help and assistance of a range of local partners and hosts: in Winchester we worked with the Wessex Institute; in Bristol, the Severn Institute; in Norwich with the lead consultant rheumatologist at the University Hospital; in Swansea, with the faculty and students from the Swansea School of Medicine; in Leeds, Liverpool and Birmingham we worked, respectively, with the Yorkshire, Liverpool and West Midlands Regional Offices of the RCP; in Manchester, with the North Western Deanery; and in Plymouth we worked with the Peninsula College of Medicine and Dentistry.

The starting point for our discussion was the definition of medical professionalism used in the RCP report: 'a set of values, behaviours, and relationships that underpins the trust the public has in doctors'. The report goes on to describe these values, behaviours and relationships:

> *Medicine is a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability.*
>
> *In their day-to-day practice, doctors are committed to:*
> - *integrity*
> - *compassion*
> - *altruism*
> - *continuous improvement*
> - *excellence*
> - *working in partnership with members of the wider healthcare team.*
>
> *These values, which underpin the science and practice of medicine, form the basis for a moral contract between the medical profession and society. Each party has a duty to work to strengthen the system of healthcare on which our collective human dignity depends.*
> (RCP 2005a)

Our aim was to challenge participants to consider what such a commonly agreed definition might mean for the role and responsibility of the future professional.

Event methodology

Each regional 'partner' would champion the event locally and provide a database of people to invite. RCP regional offices and postgraduate deaneries were contacted first, supplemented by others who had expressed an interest in taking the work forward.

The objective was to draw on a large population of doctors and their working colleagues so that each event would contain a mix of working backgrounds. The invitation list was compiled by the local partner and comprised approximately:

- 40–50 per cent doctors (consultants and trainees, general practitioners and medical students)
- 10–20 per cent managers (medical directors, chief executive officers and chairs of trusts and primary care trusts)
- 20 per cent nursing and allied health professionals plus personnel from social services
- 10 per cent lay or patient group representatives and carers.

Broadly speaking this mix was reflected in the composition of the final events. Each event consisted of four components.

- First, a series of presentations giving the context for our debate and presenting personal perspectives on medical professionalism.
- Second, a number of electronic 'straw polls' on a variety of questions pertinent to the future of the medical profession and the nature of its professionalism using hand-held voting technology. Where these were illuminating, the results are provided in the text.
- Third, participants were allocated to tables of 8–10 people mixed by background and role. Each table had a 'host' – a person selected locally to lead the round-table discussion.
- Fourth, a 'question time' style panel session.

The earlier King's Fund and RCP reports (Rosen and Dewar 2004; RCP 2005a) had identified the issues that provided the basis of the topics selected for the in-depth round-table discussion phase of each evening. Tables were allocated one of five topics:

- professional values
- leadership
- health care systems
- education and selection
- appraisal, assessment and revalidation.

Topic sheets, handed out by each table host, provided some background to the issues and some sample questions to promote and facilitate the discussion. At the later events, individual table discussion sessions were recorded and transcribed, thus yielding more than 100 hours of debate. Alongside summary feedback from the earlier events, this material has formed the basis of this report.

The Swansea event, in October 2006, was exceptional in that the majority of those attending were students from the newly formed postgraduate entry medical school. It proved to be the stimulus for a subsequent series of similar evening events aimed specifically at medical students (but not reported here).

The issues presented here are a reflection of the views of those attending the consultation events. The division of the material into the subsequent sections of this report reflects the

weight of opinion of our contributors and the issues that emerged with the most frequency and consistency. When analysing the material, what was remarkable was the similarity of views across the country and the passion with which those views were expressed – a facet that is reflected in the many quotations that support our analysis.

Entering the profession

Context and challenges

Doctors do not become professionals by virtue of starting their first job as a qualified medical practitioner. The process of becoming a professional begins at medical school and the task of sustaining professional behaviour continues for a lifetime. Indeed, as people compete to enter the profession, doctors, educators and policy-makers are exploring ways of selecting students for their potential to become 'good' professionals.

SELECTING FOR PROFESSIONAL QUALITIES

Many UK medical and dental schools now use a variety of selection methods to assess professional attitudes as well as skills and competences. This has been a recent and significant development.

The UK Clinical Aptitude Test (UKCAT) is used in the selection process by a consortium of UK university medical and dental schools. It is a recently developed tool, and is now used by many, but not by all, medical schools. It was developed for several reasons: first, to discriminate between candidates as there are so many applicants with good A-level results; second, to try to identify those candidates who have the right attributes to be doctors; and third, to widen the diversity of medical students.

The UKCAT website claims:

> *The test helps universities to make more informed choices from among the many highly qualified applicants who apply for their medical and dental degree programmes.*
>
> *It ensures that the candidates selected have the most appropriate mental abilities, attitudes and professional behaviours required for new doctors and dentists to be successful in their clinical careers.*
>
> *The UKCAT does not contain any curriculum or science content; nor can it be revised for. It focuses on exploring the cognitive powers of candidates and other attributes considered to be valuable for health care professionals.*
>
> (UKCAT 2008)

Although the UKCAT is widely used and is based on tests that have been validated, it is too new to tell how successful it can be as a predictor of either cognitive or non-cognitive abilities as students work their way through their medical careers.

Some medical schools use the Graduate Medical School Admissions Test (GAMSAT) or the BioMedical Admissions Test (BMAT), though these do not make similar explicit mention of

wider issues of professionalism other than suitability for studying the curricula at medical schools.

As the regulatory body, the General Medical Council (GMC) has a strong interest in the suitability of medical students in terms of their fitness to practise. In September 2007, the GMC published new guidance, aimed at medical students and anyone involved in medical education, entitled *Medical Students: Professional behaviour and fitness to practise* (GMC and Medical Schools Council 2007). This guidance sets out the professional behaviour expected of medical students, areas of misconduct and the sanctions available, and the key elements in student fitness-to-practise arrangements. It should be noted that consultation event participants gave their views before the GMC's guidance appeared.

TEACHING AND ASSESSING PROFESSIONALISM

Determining which students will grow into doctors with high professional standards will always be fraught with the uncertainty that accompanies any prediction of human behaviour. Leaving aside the desirability of this endeavour (the arguments for and against this are aired in the account of the consultation events, below), there are different views on how to test for incipient professionalism, and how feasible it is to do so at the early stages of a medical career.

A systematic review from the University of Leeds (Jha *et al* 2007) typifies the research. It provides a summary of evidence for measures that have been used to assess appropriate professional attitudes and the psychometric rigour of these measures. The review concludes that there is little evidence that reported measures are effective in assessing professional attitudes in medicine as a whole.

Similarly, literature from the United States (Stern *et al* 2005) also concludes that no data from the admissions material was found to be predictive of professional behaviour in the clinical years. In short, it appears that little is known about reliable predictors of professional behaviours, though whether this reflects the difficulty of measuring professional outcomes, the limitation of establishing reliable correlations over long time periods, or the enormous complexity of human behaviour and motivation is uncertain.

A number of authors (Benbassat and Baumal 2007) have, however, highlighted the potential for self-assessment to contribute to an effective process for deciding in favour of students who show a capacity for future professionalism. They argue that, rather than using non-cognitive admission criteria, admissions officers should assist prospective applicants to make informed decisions based on a reflective self-appraisal of whether or not to apply to medical school. To this end, medical schools should disseminate information on the stresses of medical training and practice, the frequency of medical errors, and the most common causes of dissatisfaction and burn-out among practising physicians. Such information may improve the self-selection process and thereby enrich the pool for individuals with appropriate motivation.

Whether or not it is possible to identify professional traits at an early stage, many doctors and policy-makers are exploring how medical education can best prepare students for the challenges of being a 21st century professional. A common theme of the extensive discussions at our consultation events was that formal teaching of professionalism is only

part of the issue, as role models may play a highly significant part in the development of professional behaviours. This accords with work at the University of Washington School of Medicine in Seattle (Goldstein *et al* 2006), where feedback on curricular innovation led to more emphasis being placed on the clinical encounter. Heightened attention to professionalism at the medical student level led to awareness of the need for increased attention to teaching and modelling professionalism among faculty, residents and staff.

What we heard – listening to the dialogue

Many of the issues raised by doctors and non-doctors at the consultation events related to both the process of selection and the education provided for medical students. The discussion tended to focus on three fundamental issues:

- feasibility: is it possible to make judgements about a person's potential for adopting the tenets of professionalism?
- effectiveness: is it possible to devise a curriculum and methods of learning that build on that selection to nurture an individual's professionalism?
- risk: what are the costs and benefits of trying to pave the way for professionalism at the selection stage and throughout undergraduate medical education?

IS IT POSSIBLE TO IDENTIFY PROFESSIONAL QUALITIES WHEN SELECTING FOR MEDICAL SCHOOL?

Although the idea of being able to select the people who were most likely to develop into respected professionals was attractive to some, many participants expressed doubts about whether that would be possible in practice.

The biggest doubt was around the maturity – or otherwise – of applicants. Indeed, among participants at the consultation events there was a consensus that assessing the potential for professionalism in young applicants and students was necessarily limited.

Medical students [are] not mature enough yet to demonstrate whether they have got it or not.

(Liverpool)

You can't expect a 19/20-year-old to behave like a proper doctor. They may well do boyish pranks.

(Liverpool)

'Boyish pranks' may be more than a figure of speech: with medical schools accepting an increasing proportion of female students, at the point of selection, young women were often perceived to be more mature and more articulate than their male counterparts.

However, participants recognised that if there were more graduate entry places, the potential for identifying appropriate professional qualities might increase.

A graduate intake might colour the view on this. I came in after A-Levels and I would have struggled to demonstrate an awareness of professional attributes when I was 17.

(Swansea)

IS IT DESIRABLE TO SELECT FOR PROFESSIONALISM?

Regardless of the feasibility of making accurate predictions about which students would develop appropriate professional attributes, many participants expressed doubts about whether it was desirable. Some of this reflected concern about how such judgements would be made.

> *I do not want us to start measuring anything to do with selection. I think we are in this model that things are only valuable if you can quantify them. I am all for subjectivity. I trust human judgement. I do not trust tick charts and percentages and psychometrics.*
> (Manchester)

Others were simply doubtful that the skills were, as yet, developed to make a successful assessment of the qualities needed.

> *We need much more research, know what we are looking for and then revisit our selection tools, because I do not think we have them right at present... We need to think through quite carefully what the attributes are that we are looking for, but I am not sure that we are good at selecting on professionalism. We might begin to look at how we assess emotional intelligence more effectively, and look at the sorts of behaviours that do not do particularly well.*
> (Manchester)

Some participants were worried that selecting for professional qualities might result in a 'tick box' approach to selection, and that, among other problems, this could have unintended consequences in terms of the creation of a less varied workforce, without necessarily resulting in a better one. Others participants pointed out that even now there was a whole industry around applying for medical school. There was concern that applicants would learn to play the game and would be rewarded for their ability to work the system, rather than their potential to make good doctors.

> *Having gone through the interview process myself, in the case of an interview it is easy to say something to please someone. So if you know the qualities that the university is looking for, you will try to get those qualities across. So it would be difficult to search out those qualities innately. Perhaps more team activities would help to assess this type of behaviour.*
> (Swansea)

However, the greatest concern was that a refined system aimed at recruiting based on a set of attributes would result in the selection of too homogeneous a group. The individuals thus chosen might, indeed, have laudable qualities, but this could be at the expense of excluding a range of individuals with different qualities and attributes, all of whom might make a valuable contribution to a profession that offers many different kinds of jobs.

> *Do we want all doctors to be clones? And this is my concern about going down the road of selection into medical school and having certain criteria to tick boxes. Medicine is a broad career. Within the envelope you can fit different types of*

personalities – so I caution that if we select in a particular way we will end up with a bunch of clones.

(Manchester)

Well, there is room for all sorts of personalities in medicine; an individual doesn't make the profession and there are eccentricities that are entirely acceptable.

(Birmingham)

EDUCATION FOR PROFESSIONALISM

There was a great deal of interest in how best to educate medical students and young doctors so that they could develop their professionalism and maintain it throughout their careers. As with the debate about selection, there was a range of opinion about the feasibility of the endeavour. Some participants were sceptical about how far any education could inculcate appropriate values and behaviours, while others were fairly optimistic that this could be done.

There was support for the idea that, although professionalism could be nurtured and refined if the potential was there in the first place, teaching was unlikely to make much difference where an individual lacked the personal qualities, values and attitudes that were the foundation of professionalism. An interesting distinction was drawn between 'teaching' and 'learning' professionalism, with more optimism about the latter than the former, as students and young doctors can learn in ways that go far beyond formal teaching.

It can certainly be learnt, but not really taught… it's probably a mistake to have a starting point that says 'this is about professionalism, you must learn this'. We need to start with something that talks about behaviours, and what professionalism is about, then we can teach it, and certainly teach it by example.

(London)

In addition, timing was felt to be important. Too soon, and students might not appreciate the relevance of what they might learn about professionalism. Too late, and they would miss opportunities to shape their practice.

I don't think you learn the basis of how to be professional until you go out and do it yourself.

(Swansea)

Teaching the guidelines on professionalism is crucial; if you cannot understand the guidelines, you cannot follow them – along with the tradition of the values, the ethics and their historical background.

(Leeds)

However, it was clear that whatever the range of views on how far professionalism could be taught, it was not seen as an exclusively classroom subject. Students who had recently begun their studies felt that they learnt a lot more from watching 'real doctors being doctors' than from sitting in a lecture hall.

Opportunities to learn from positive role models (and to learn what not to do from less positive ones) were seen as very important. However, the ability to know one from the other was questioned. Some doctors recalled that they had been surrounded by both good and bad role models when they were students, and that it was only in retrospect that they could confidently make that distinction.

> I think decision-making you pick up from good role models and from interaction with the patients and watching others like your boss or senior registrar. You glean that. You uphold models as you go through and you reflect how that doctor interacted with that patient.
> (Swansea)

Many participants stressed the importance of learning about professionalism from others, not only from individual role models but also more widely from the prevalent values and behaviours of colleagues and teachers, alongside more formal teaching.

Some doctors and medical students feared that learning from role models was being undermined by the way that shift work and rotation had reduced a sense of attachment to a particular doctor or 'firm'. As one person observed:

> It's difficult to learn from role models as we are no longer attached to one group of doctors to learn in training; it's all being dissipated.
> (London)

WHAT TO TEACH AND WHEN

The questions of what to teach and when to teach it are at the heart of how to educate the next generation of doctors on professionalism. By and large, students and their teachers and professional medical colleagues saw many advantages to teaching and demonstrating professionalism from the earliest stages. However, timing is critical, and constant reinforcement is necessary, in line with growing experience and the ability to take in what is being taught.

> There needs to be more building on what you have learnt and continuing it.
> We have only been given a couple of sessions so far and I think it is something that needs to be ingrained more in the course.
> (Leeds)

> Do you wish you had been taught professionalism? … I don't think so, because I think we were too busy, we had lots to learn in a very short time and I think it would have gone straight over our heads.
> (Manchester)

As with the discussions on selection, some participants feared that defining professionalism, and seeking to shape medical education in line with that definition, carried the risk of producing doctors who were too alike – the recurrent spectre of clones.

Is there a danger that if you say I think I know what a doctor should look like then you start creating clones? In fact medicine is so wide that the attributes of a surgeon or of a pathologist are so different.

(Swansea)

This represents a challenge to the development and inculcation of professional values. Meeting the challenge will require a definition of professionalism that respects diversity while refining and retaining the values, attributes and behaviours that transcend the different branches of medicine.

TESTING FOR PROFESSIONALISM

If professional behaviour is to become a more extensive part of the curriculum, whether learnt and taught in the classroom or in the consulting room, questions arise as to how to assess a student doctor's professionalism. Participants at the consultation events expressed some support for 360-degree appraisals, taking into account the views of peers, seniors, teachers and patients – described by one doctor as 'biopsying your behaviour'.

Issues for the future

There is some way to go in resolving questions about the extent to which professional qualities can be identified at an early stage and then nurtured. There is scepticism about whether it is possible to identify, at the point of selection, those who will develop, or fail to develop, appropriate professional skills. However, this does not mean that there is no potential for doing so, and indeed most participants expected this to be attempted.

Participants in our consultation suggested that any selection methods would need to recognise the limitations (taking account, for example, of the age and relative maturity of applicants) and the risks (homogeneity and game-playing – telling the selectors what they wish to hear) of any approach. Indeed, rather than assuming that the basket of personal attributes, values and behaviours that we call 'professionalism' could be identified and assessed even before a student begins medical school, some suggested that it would be better for the profession to refine its skills at weeding out those who behave in a way that might call into question their potential to become professionals.

The evidence from the consultation events is that professionalism needs to be learnt in a variety of ways – particularly through experiencing and discussing exemplary professional behaviour. This implies a sharing of responsibility for promoting professionalism so that it is not seen as the exclusive province of formal teachers, but also of colleagues within and beyond the medical profession, and, of course, of the prospective doctor him- or herself. The challenge, which we will explore in greater detail later, is how to ensure that the organisation of education supports medical professionalism for those entering the profession.

The concept of medical professionalism is not a monolith, and is not unchanging. Discussions along the lines of these consultation events, and dialogue with other professions and the wider public, will remain essential to the development and embedding of a sustainable approach to developing medical professionalism at the point of entering the profession and at all stages of a doctor's career.

Professionalism in practice

Context and challenges

Among the challenges for an ancient profession in a modern world is the need to define and assure professional behaviour in the rapidly changing health care environment. Changes to contracts, restrictions on working hours, changes to the composition of the medical workforce, and a shift in what patients and the public expect of their doctors, have all played their part in challenging the traditional roles and responsibilities of the doctor. In this section, we review some of this context, before reporting what doctors and non-doctors said about professionalism in practice at the consultation events.

BRINGING MEDICAL PROFESSIONALISM UP TO DATE: *GOOD MEDICAL PRACTICE*

In 2006, the General Medical Council (GMC) brought out a new edition of *Good Medical Practice* (GMC 2006). Horton and Gilmore (2006) describe the new guidance as 'a radical reinterpretation' of what has gone before. *Good Medical Practice* sets out the principles and values on which good practice is founded; the GMC sees these principles as describing 'medical professionalism in action'. Although the guidance is addressed to doctors, it is also intended to let the public know what it can expect from doctors. *Good Medical Practice* sets out the duties of a doctor as follows:

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:
- *Make the care of your patient your first concern*
- *Protect and promote the health of patients and the public*
- *Provide a good standard of practice and care*
  - *Keep your professional knowledge and skills up to date*
  - *Recognise and work within the limits of your competence*
  - *Work with colleagues in the ways that best serve patients' interests*
- *Treat patients as individuals and respect their dignity*
  - *Treat patients politely and considerately*
  - *Respect patients' right to confidentiality*
- *Work in partnership with patients*
  - *Listen to patients and respond to their concerns and preferences*
  - *Give patients the information they want or need in a way they can understand*
  - *Respect patients' right to reach decisions with you about their treatment and care*
  - *Support patients in caring for themselves to improve and maintain their health*
- *Be honest and open and act with integrity*
  - *Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk*
  - *Never discriminate unfairly against patients or colleagues*
  - *Never abuse your patients' trust in you or the public's trust in the profession*

- *You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.*

(GMC 2006)

REVALIDATION: RELICENSING AND RECERTIFICATION

Another major issue for medical professionalism is revalidation. This is not a new concept. (For a concise summary of the history of regulation and revalidation, *see* Shaw *et al* 2007.) However, the large number of murders committed by Dr Harold Shipman raised questions about patient safety and professional standards. In 2006, this refocusing of interest culminated in a report from the Chief Medical Officer (CMO) entitled *Good Doctors, Safer Patients* (CMO 2006). The CMO's report was the subject of consultation, after which the Department of Health published a White Paper called *Trust, Assurance and Safety – The regulation of health professionals in the 21st century* (Department of Health 2007d) based on the CMO's report and the responses to it. Details of this report have been widely circulated and need not be repeated here. Suffice it to say that the White Paper proposed a system of relicensing for all doctors, and a system of recertification linked to specialist and general practice registers. In summary:

> *This licence to practise will have to be renewed every five years. In order to bring objective assurance of continuing fitness to practise, the appraisal process will include 'summative' elements which confirm that a doctor has objectively met the standards expected. Specialist recertification will apply to all specialist doctors, including general practitioners, requiring them to demonstrate that they meet the standards that apply to their particular medical specialty. These standards will be set and assessed by the medical Royal Colleges and their specialist societies, and approved by the General Medical Council.*

(Department of Health 2007d)

The commitment to this system of revalidation combining relicensing and recertification represents a significant shift in the way in which professional practice is understood and assured. The concept of revalidation moves the profession away from autonomy and self-regulation over its professionalism, to a position where the key characteristics of professionalism in practice are greater accountability and transparency. This reflects a shift in social values where traditional assumptions around professional competence have been increasingly eroded alongside an increased expectation of what professionals should deliver.

There is, of course, a clear link between *Good Medical Practice* and the plans to enact and implement the recommendations of the White Paper. As Shaw and Armitage point out (Shaw and Armitage 2007), the principles of *Good Medical Practice* became the foundation for annual appraisal, and revalidation builds on these systematic processes for assuring quality of care.

During the consultation events it was evident that the principles of revalidation commanded widespread support among doctors. However, participants expressed particular concerns about their efficacy and practicability, indicating that some long-standing issues over implementation are yet to be laid to rest.

PROFESSIONALISM AND THE POLITICIANS

Some of the comments about politicians and political control of the National Health Service (NHS) were among the most vehement of all contributions to the consultation events. The medical profession does not perceive itself as having a trusting relationship with politicians. The perception that the NHS has been reorganised on a near-continuous basis without adequate clinical engagement has done little to address scepticism among doctors about whether their views, or those of other health professionals (and the public), have been properly heeded.

The announcement made by Alan Johnson, as he took up his post as Secretary of State for Health in July 2007, of a review of the NHS that would advise on how to meet the challenges of delivering health care over the next decade (Johnson 2007) set a different tone. Speaking about the review the Prime Minister said:

> *Lasting change can only come from clinicians and staff. We need to do much more to empower staff, to give them the time with patients that they need to improve patient care, to put them in the lead in developing ideas on improving patient-care, and to respect their professionalism.*
>
> (Department of Health 2007a)

As the Secretary of State for Health told the House of Commons, it is his intention to 'forge a new partnership with the profession' (Johnson 2007). However, despite these aspirations, it is unclear what clinical involvement will mean in practice, and how such involvement might be effectively combined with an appropriate accountability at all levels within the health care system. It will be interesting to revisit the discussions about professionalism in future years to see whether this intention has been translated into the difference that both parties apparently desire.

What we heard – listening to the dialogue

In the context of the current crowded policy environment, there was no shortage of views on factors that impacted on medical professionalism in practice. Although many of these factors are interrelated, for the sake of clarity they are presented separately.

THE IMPACT OF TARGETS ON PROFESSIONALISM

There was considerable discussion about whether, and to what extent, centrally driven targets might undermine the freedom of doctors to make professionally defensible clinical judgements about clinical urgency and the needs of their patients.

A broad spectrum of opinion was expressed, ranging from those who took an absolutist position that imposed targets were always harmful, to those who thought that they were necessary, if not totally desirable, in order to improve services and make access to care more equitable.

> *[At] the hospital end [of things, there] is this sense that the professionalism of both doctors and nurses is being undermined by a tick-box target-setting culture and also partly by the pressure itself: patients lying there, boxes to be ticked, specialties to be*

satisfied and the patient could just die in front of you because there's something you may overlook which induces a fear and demotivation.

(London)

In a way, the cancer targets have really energised the trust, and I think they are really focused on the quality of service they are giving.

(Manchester)

For some, there was an awareness that the pre-target era was not a golden age, either for the patient experience or for medical professionalism. Some participants suggested that targets had been imposed precisely because the medical profession had not taken it upon itself to change and make services more accessible.

Clinicians who have bleated about [how targets are] going to damage patient care have not stepped forward to improve outcome measurements in any way that would defend their case and strengthen their hand.

(Liverpool)

I mean the target of the four-hour wait – OK, there are some down sides, but it was motivated by the fact patients were getting a very raw deal.

(Manchester)

Between the two poles of opinion, many doctors disliked working to imposed targets, but some could see that they had a place in a modern health care system and acknowledged the effective role they could play in driving change forwards without fatally undermining professional practice. Some participants took the view that targets were inevitable and that the question was rather how to make them appropriate and realistic. In particular, there were expressions of support for leaders of the medical profession to engage with government on defining targets, particularly across primary and secondary care.

[There is a] need to get primary care and secondary care working together on targets… It would be incredibly refreshing to have clinically relevant objectives rather than these utterly tiresome, easily measurable things which dominate the lives of working doctors.

(Liverpool)

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.

I'm quite happy not to have freedom from aspects of targets if I feel those targets are about the clinical welfare of a group of patients I have to treat….

(London)

The alliance between doctors and patients is the crucial one to get common interest there around quality of outcome... that would be very compelling…. It could win trust and drive forward different ways of setting targets and standards.
(Liverpool)

Whatever the views on the specific question of trust the discussion revealed concern about the role of politicians more generally. This concern was expressed across the country.

What fascinates me is that very often there is less state interference in former Eastern European countries than there is state interference in the way medicine is done in this country.
(Manchester)

Politicians want to deprofessionalise medicine because professional groups are sources of power and are thus competitive to sources of political power.
(Winchester)

It remains to be seen whether these views will change in response to explicit attempts by politicians to engage more meaningfully with clinicians.

THE CHANGING DOCTOR–PATIENT RELATIONSHIP

The relationship between the doctor and the patient was widely thought to be changing. Even those who felt that the fundamental values underpinning professionalism were relatively unchanged accepted that the way in which they were put into practice changed with the times. Several aspects of this changing relationship were seen as particularly relevant and are considered below.

Paternalism

At the heart of the changing relationship between doctors and patients is a gradual moving away from paternalism and 'doctor-knows-best' to a more equal relationship. Increasingly, the doctor is expected to have both technical expertise and professional experience, and to harness these in the patient's interest, while not assuming that this confers power over the patient as a result.

Most people recognised that this move had taken place, and that the trend away from paternalism in medicine continues to reflect wider changes in society. Opinion differed somewhat, however, on how to interpret these changes. Many people welcomed the shift or, at the very least, accepted it as inevitable. Some doctors also described changes in their own attitudes.

Now I do much more negotiating… A kind of adaptation to people's expectations.
(Swansea)

I think there has been a change in the last 10–15 years because we are all consumers now, and I think this consumerism has really affected us as doctors: the idea that we are providing a service which previously was thought of as, can I say, as being based on paternalism; the doctor knows best. The patient and the doctor now are on a

much more equal footing because of better education, better information and the change itself in society which makes us more autonomous as individuals.

(Swansea)

Some doctors were very aware of the power differential between themselves and their patients.

I think a lot of the problem seems [to be] because we haven't really engaged terribly well with patients and patient needs. Professional meetings and medical meetings – everything that goes on all our professional life – [are] spent around working and mixing with other professionals and you only meet a patient or family when you are in a clinic or consultation and then you are in a dominant position and the patient and their carers are in positions of fear and anxiety.

(Birmingham)

A number of comments recognised that different patients, or the same patient when faced with a range of situations, might take different views about the degree to which they wished to take their own decisions or rely on a trusted doctor to decide what was best. At the very least, negotiation and judgement were required in order to assess the extent to which patients wanted to be involved in decisions about their care. Indeed, sometimes the case was stated with considerable force.

If a doctor automatically is paternalistic to a patient it is a violation of their human rights because as long as the patient is competent to make a decision, they should be the first one to make the decision and the first decision for them to make is, do I want this doctor to help me?

(Swansea)

Better informed patients

Discussions about paternalism should be understood in the context of patients who are more informed, in a world where information sources are more widely available, particularly through the internet. Unsurprisingly, there was a wide range of views on how this might continue to impact on patient care and on medical professionals.

My grandparents would never ever question a doctor, whereas we go to the doctor now and if we want further information we just go and get it.

(Swansea)

The participants did recognise that access to information was not evenly spread throughout society, and many people noted that better-educated patients, and often better-off patients, were more easily able to find and understand information related to their health.

Unsurprisingly, the event with the greatest proportion of medical students appeared to be particularly engaged with this issue, though experienced doctors at other consultations also shared the view that major changes in the doctor–patient relationship were shaped by the information revolution.

Part of the job of the doctor is to take any of this information presented to them by patients and work out what is actually going on and explain to the patient in a language the patient can understand.
(Swansea)

I think that some of our relationships will have to change. In clinic now people come with a printout from the internet and say let me question you about this in relation to what you told me last time. It changes your style of consultation. People want full disclosure – to understand things – and they won't have the load taken off them unless they specifically ask for it.
(Liverpool)

On the whole, this was seen as positive, and, far from being a threat to professionalism, many people in the medical profession welcomed the trend, feeling that it gave them opportunities to demonstrate their professionalism in new ways. Some positively welcomed patients who looked for information, as they acknowledged that there was a wealth of material available that the doctor would not necessarily have come across. The doctor's job, then, became more focused on helping to ascertain whether the information was accurate, relevant and correctly understood; in other words, as well as helping patients to appraise and understand information that they had found for themselves, doctors would have to develop their skills in communicating with patients who had formed a view about their condition from a range of sources, and whose self-diagnosis may or may not be accurate.

There was extensive discussion on how dramatically increased public access to information was changing the doctor–patient relationship. In future, such publicly available information will include benchmarking measure and patient-reported assessments of individual institutions and doctors, yet the impact of such data on the development of professionalism in practice was not widely discussed.

The growth of consumerism

An apparent growth in consumerism was noted by many participants. This is tangentially related to the increased knowledge of patients – but is not identical to it. For participants at these events, consumerism was equated to choosing from whom to receive services and expecting those services to be orientated to their needs as opposed to those of the heath service provider, as well as being able to obtain redress when a service was not of the quality that they expected or were promised. This was in contrast to a less critical approach in which the patient might be a more passive and grateful recipient of medical and other services. This apparent change in attitude was not always commented on favourably.

The public is always demanding the next step and seldom grateful.
(Winchester)

In its extreme form, it was feared that consumerism equated with complete consumer choice, in which the consumer (or patient, in this instance) would insist on a personal choice irrespective of any advice from 'an expert doctor'. For some, this position was characterised as a relationship in which patients might be increasingly demanding, critical and possibly litigious.

There was some concern that such consumerism might result in people making choices that were not affordable for society as a whole, such as opting for a Caesarean section when it was not clinically necessary. Other participants suggested that the trend towards consumerism was not universal; one contributor suggested that it was an urban phenomenon, and hardly impacted on rural practice.

Some raised the possibility that consumerism and increased patient choice might mean that patients may not choose a medical approach to their ill health as the first port of call, and that doctors may become one of many sources of help for patients. Indeed, this may well already be the case. Many other health professionals – such as nurses, physiotherapists, occupational therapists and pharmacists, both inside and outside the NHS – already see patients directly.

For some participants, consumerism was seen to have a number of positive attributes. It was thought that it had been instrumental in driving up standards of patient care and accessibility of services, as the public made it clear that they had paid for services and did not see why they should have to experience long waiting lists for treatment. Doctors themselves sympathised with the frustration of patients who wanted easier access to high-quality services, and they wanted no less for themselves. The question is whether the growth of consumerism poses a threat to medical professionalism, or is merely a stimulus to adaptation and change in the light of increasing expectations from patients and the public.

Patient and public involvement
Although consumerism was construed in terms of individuals, there was also consideration of the impact of changes of a more collective nature. The development of mechanisms for involving either patients or the wider public in the shaping of health services was also seen as having an impact on the nature of medical professionalism.

Although many participants acknowledged that such involvement might provide an opportunity for greater dialogue between doctors and the wider public, some feared that involving the public (as opposed to patients) might bring unrealistic or uninformed attitudes to this process. More commonly, however, the tone of the discussion was generally positive, and such engagement by patients or public was seen as contributing towards trust in the medical profession. Some participants thought that greater involvement would lead to a greater understanding of the pressure on resources and would lead to a more positive dialogue about resource allocation. Some thought that involving patients, in particular, would lead to alliances that could enhance doctors' influence and power.

> *The power is to involve the patient in your agenda – I don't necessary think the power is always with the doctor but if you get the patient on your side, if you can build an alliance or allegiance with the patient, you then definitely have the power.*
> (Plymouth)

Will doctors become technicians rather than professionals?
The discussion about the changing doctor–patient relationship highlighted a level of concern about whether better informed and more involved patients might lead to a downturn in the professional role of doctors. This was closely related to the volume of

information available on the internet, and patients' preference for taking on a decision-making role. It was expressed most starkly in the following terms:

> *Patients can, in certain situations, tell us what to do, and in a way it demeans our roles as doctors, and to a certain extent we become almost technicians.*
> (Swansea)

The idea of being like a technician or a car mechanic did not seem an attractive proposition to the doctors present, but many seemed to be reasonably confident that the skills and judgements required of a doctor were such that they were unlikely to become 'technicians', even if knowledge was more evenly shared with patients in the future. Moreover, some recognised that both patients and doctors had their areas of expertise, and that good medicine required them to work together.

Some people wondered whether technological changes – ranging from electronic records to new techniques for treating patients – might also change medical professionalism. Many participants, however, made the point that such changes might not mean a loss of professionalism, but rather require an adaptation of professionalism in practice – an adaptation that would always be rooted in recognisable professional values.

> *Professionalism transcends technology; it should be that you respond to the technology. We may have been influenced by society but the response to professionalism should be the same.*
> (Leeds)

Is being a doctor different from being in other professions?

There was considerable discussion about whether being a doctor is different from other occupations and professions. Many people saw being a doctor as different from other jobs, although some people felt that other professions (including nurses, other health professions and fire-fighters) shared many of the characteristics of a profession. Those who saw medicine as distinctive often did so because they thought that doctors carried ultimate responsibility for patients in ways that others did not.

Another reason advanced in defence of the distinctiveness of the doctor's role was the view that what doctors did was more complex, scientific and analytical in comparison with the roles of other health care professionals. Much of this discussion highlighted arguments about the respective roles of doctors and nurses, and arguments were put forward on both sides:

> *I don't work to protocols because I use my judgement all the time, and that is what I have developed and I can go and look at a patient and make certain decisions that I can't justify in black and white but I have an understanding of what I do and I think that is the difference between a nurse and a doctor. We fundamentally work in a different way.*
> (Manchester)

This view was disputed by those who felt that other professions were beginning to enjoy higher levels of responsibility and had comparable ethical codes.

I think there are other professional groups who accept a great deal of responsibility and account for their professional ethics... Nurses now, and midwives, are taking that much extra responsibility; there is no difference between their stakes and that of a doctor's.

(London)

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.

I subscribe to every single one of those characteristics and I cannot understand how it is possible for anybody to describe health care management as not being a caring altruistic profession, because that is what we do. We care about the service that we are giving, but it is different from being a doctor, so in that sense it is different but not different on the basis of these values.

(London)

There is a fundamental difference in the framework that you work within, it may well be very broad but the clinical autonomy a doctor has seems to me to be different.

(London)

Doctors are used to handling uncertainty and they have the ability to adapt to different environments... But what is interesting is that as nurses are doing more and seeing more and prescribing more, they too are becoming experienced in dealing with uncertainty.

(Winchester)

It may be that the real difference is in the way that so many medical roles combine these common differentiating dimensions of professional practice; the way in which their combined impact on practice and professional identify is so deeply rooted in the profession; or in the reality on the ground. This reality is that medicine is one of the most difficult professions to enter, with a long and intellectually demanding training. Doctors are the highest-paid health professionals with the most public trust and are most commonly still leading the clinical team.

Nevertheless, looking forward participants taking part in our debate agreed on two fundamentals. First, that there is a blurring of boundaries and confusion of professional roles and identities. Second, that there is a need for clarification – without which there is a risk of eroding strong professional identities and the potentially positive values that they sustain.

As yet, there has not been a sensible discussion with the nursing professions about what nurses and doctors respectively bring to a therapeutic relationship. A debate is needed about the difference between nurses and doctors.

(Winchester)

It is not for me to say what the core attributes and skills of the caring professions or the therapy profession clusters might be… But clarity about the route you are on and the core attributes required to succeed gives students in that professional cluster something that they see as valued in its own right. If we do not have this what we end up with is a mish-mash of role substitutions of people who may be imperfectly prepared in terms of their foundation of education… and this is a potential problem and will ultimately erode not just medicine but the values associated with the other professional clusters as well.

(Plymouth)

CHANGING CAREER EXPECTATIONS

Professionalism in practice is changing: first, as a result of wider societal changes that are influencing the roles and responsibilities of doctors; second, because the changing personal and career expectations of those entering the profession are reshaping the job.

Work–life balance

Do today's doctors have different expectations from doctors in the past about how their working lives will co-exist with their personal lives? All our participants recognised that big changes in attitude have taken place. However, there was much less of a consensus about what these changes mean in practice and, in particular, what impact aspirations for a different work–life balance might have on the professionalism of doctors. Above all, does a high degree of professionalism necessarily correlate with the number of hours worked, or a doctor's availability around the clock? And is altruism still an intrinsic part of professionalism? If so, what does altruism mean in the modern context?

Changing attitudes to the work–life balance are sometimes attributed to the greater number of women in the workplace – a trend that is as apparent in medicine as it is in many other professions. The idea that an increasingly female profession would have lower status than a predominantly male profession was discussed but dismissed. Many saw the feminisation of the medical profession as a positive force on professionalism.

However, some challenges to traditional career patterns were noted and expected.

We have more women graduating from our medical schools – with two having more than 75 per cent female graduates. The challenge for us is that few of these women will want to work full-time, few of them will want to do the acute medical specialties… So the worries are that if one is ill at 2.00am with a myocardial infarction, will [there be] a doctor to look after you?… How do I persuade women doctors to go into every bit of medical practice?… And how do I persuade them… to take on the roles of academic medicine?… How do I persuade them to be the medical directors of the future, with all the other things they naturally want to do, which is part of being a woman?

(Winchester)

Young male doctors also wanted to be more active parents, or to work shorter or more flexible hours, for other reasons.

*There has been an enormous shift in attitudes of younger doctors to say I want a life;
I don't just want to be a doctor. The idea of full-timers is being eroded in primary care.*
(Swansea)

People were mindful of the possible effects of tipping the balance too far in the direction of work, citing the possibility of burn-out, depression, alcoholism, divorce and even suicide as possible consequences. Overwork was associated with inefficiency and with possible threats to patient safety.

ALTRUISM

The concept of altruism was still widely held to be important, even when doctors aspired to a different balance between work and the rest of their lives. What was not clear was whether doctors saw altruism differently depending on their age. Some suggested that older doctors, and doctors who had been in practice years ago, were more altruistic, but this was by no means a universal view. Either way, for very many, altruistic values lived on.

*I do not think [altruism] is outmoded at all, and we do need to continue with it and
encourage it. We need to lead by example and encourage our younger generation to
consider what it means to them because what altruism meant for our generation may
be different for the younger generation.*
(Manchester)

*I think generally most doctors are quite altruistic. You see a patient on one-to-one
and you really do care about what is happening to your patient, you want to get it
right, you really do.*
(Plymouth)

Be that as it may, there were some doctors who questioned the ideal of old-style altruism. Some doubted the continuing relevance of altruism, or felt that altruism was also associated with personal job-satisfaction and was not a free-standing ideal dissociated from other values and rewards.

Perhaps, thought some, altruism could be combined with putting limits on the amount of work one did, or with seeking financial rewards as well as the warm glow associated with helping people. Indeed, it was thought possible that public expectations of the extent to which doctors should be always available and self-sacrificing have also changed. It was stated firmly:

*As a non-medic, I don't think a doctor should be expected as a matter of course to
put in the extra mile. People should be entitled to the right balance.*
(Manchester)

Some doubted the continuing relevance of altruism. They believed the conditions of the new contracts, both in primary care and in hospitals and in relation to other factors such as the European Working Time Directive (EWTD), mitigated against an active altruism in practice. Their views are explored in some detail below.

CHANGES TO WORKING PATTERNS

The European Working Time Directive (EWTD)

There was a great deal of discussion about whether medical professionalism was affected by changes to the working lives of doctors. In particular, there was a great deal of discussion about the impact of the EWTD.

Feelings ran high and a number of people described the EWTD in terms such as 'an utter disaster', 'a new kind of tyranny' or 'the worst thing that has happened in medicine'. They rejected the view that old-style working had resulted in doctors who were too tired to ensure the safety of patients, and they were adamant that reduced hours would damage patient care, medical education and doctors' professionalism.

> *I think that putting in all these working time directives and having incentives and targets, they are actually removing the professional label from a doctor and it is becoming a job.*
>
> (Swansea)

> *[Restricting working hours] does remove the altruistic element of the job. It changes the whole nature of what being a doctor is.*
>
> (Swansea)

They feared that a '9 to 5' culture would permeate medical practice and doctors would not be able to be as caring and committed to their patients as they wished to be and as they had been in the past. Tales were told of clocking-in and clocking-out machines to ensure that doctors did not exceed their hours, and others blamed officious managers for a rigid enforcement policy.

> *The problem is when managers go on to the ward at 5 o'clock and 'push people out of the door'.*
>
> (Winchester)

However, there was another side to the story, and some people felt that EWTD was not, in itself, a threat to professionalism, provided that it was applied with common sense and humanity. As one participant said:

> *Reducing hours per se will not deprofessionalise any doctor. The problem is how the directive has been implemented up and down the country.*
>
> (Winchester)

Those who saw a positive side to the EWTD spoke with equal conviction. They saw heroically long hours as counterproductive, unsafe, and incompatible with a work–life balance and the demands of modern family life. In fact, some people felt that ensuring safety by reducing hours was an aspect of professional practice.

> *We need to remember that EWTDs are health and safety issues and surely one of our professional values is patients' health and safety, and our own.*
>
> (Manchester)

There was a large measure of agreement that reduced working hours could not be implemented without changes to the ways in which doctors (and others) worked. Some of these changes might well impact on how doctors put their professionalism into practice, but that did not mean that professionalism was necessarily undermined. Foremost among the changes that were required was teamwork; if doctors were going to leave at a fixed time, proper arrangements for sharing responsibility and handing over to colleagues was essential, and this would need to be planned and implemented in a carefully considered manner.

> *It is too easy to assume that because some of us worked 140 hours a week and it was our whole life that we were necessarily more professional as a result of that – that is just the way it was and I honestly think that there is just the same possibility for the same standards of professionalism as well as having another life. As has been said, it is all about having proper hand-over and being able to work in teams, but not about the individual working themselves into the ground.*
>
> (Birmingham)

New contracts

Essentially similar arguments were advanced about the impact of the new contracts, both for hospital consultants and in primary care. The new consultants' contracts were introduced on 30 October 2003, and those for GPs in April 2004. Many participants thought that the perception of doctors was adversely affected by the new contracts, as doctors were seen as becoming 'clock watchers', and over-interested in the financial rewards they would get for each and every aspect of patient care, as well as for educating their juniors. The new emphasis on consultants' job plans was not seen by all as helpful, since it could result in every minute of the day being accounted for, leaving no time for duties that might be seen as part of professional life, such as supporting junior colleagues. Some people lamented that doctors were being paid more for doing less, and that, overall, professionalism had been diminished by an increasingly money-orientated approach.

> *Altruism has certainly been threatened or damaged by the new contracts, certainly the new consultant contracts.*
>
> (Liverpool)

> *The contract is actually anti-professional. The role of the professional is that you have a task, a duty, a job and you fulfil that role. The contract says we are employing you from 9 to 5, and we are paying you from 9 to 5, and after 5 o'clock you can go… and you have a generation of doctors, certainly in the hospital setting, who are growing up around that ethos.*
>
> (Manchester)

For some, the new contracts epitomised a threat to a former way of working and a different approach to practising medicine.

> *I worked long hours and loved it. And I knew the patients well. I think that the new contracts are in danger of finally extinguishing that fire that used to burn – that in many of us has become embers. What we really need when we are down to embers is a little bit of a draft to get that fire back.*
>
> (Swansea)

But, as ever, there was no shortage of people with contrary views and experiences. Some people challenged accounts of an idealised past and suggested that new contracts were needed because some consultants were not working their full hours. Some took the view that no contract would determine how they did their job, and it was their values rather than 'a bit of paper' that were paramount.

Some were in favour of new contracts and a new approach to match, with one participant being positively cheerful at the idea of clocking in and out.

> *That would cut out a lot of resentment if it was just clock in and clock off. There are plenty of people who won't be happy to stay on the extra half-hour or hour or whatever, and that is going to breed a lot of resentment with their colleagues, and so if it was a clear-cut way of working then it might make things a lot cleaner and easier across the board.*
>
> (Swansea)

Others pointed out that the quality of management was a key factor. In some trusts, the new contracts were handled well, whereas in others there was 'near warfare'. It was pointed out that there are many walks of life where hours of work are limited and yet people would be extremely offended if it was suggested that limitations on their hours of work resulted in their not delivering a high-quality, professional service.

A STRAW POLL OF PARTICIPANTS: THE 'NEW' CONTRACTS

Across the ten roadshows a total of 406 doctors and 376 non-doctors (including 79 medical students), voted on the impact of the 'new' contracts. Only 4 per cent of doctors and 13 per cent of non-doctors felt that the new contracts were good for medical professionalism; 60 per cent of doctors and 43 per cent of non-doctors felt that the new contracts would damage professionalism.

ASSESSMENT, APPRAISAL AND REVALIDATION

The strength of feeling that characterised debate about different working patterns was at least equalled by the degree of concern about issues relating to assessment, appraisal and revalidation. There was a great deal of support for regular, robust testing of fitness to practise, though it was often accompanied by uncertainty as to how it should be done and what benefits would accrue to the profession, to patients and to the public.

A STRAW POLL OF PARTICIPANTS: REVALIDATION

Across the ten roadshows, a total of 406 doctors and 376 non-doctors (including 79 medical students), voted on revalidation. Participants were asked if doctors should be working to ensure a robust process of revalidation that included regular testing of clinical competence. The result was strongly supportive, with 85 per cent of non-doctors and 70 per cent of doctors supporting this statement.

Some people were broadly in favour of ensuring that doctors remained up to date in their chosen field, but took issue with some of the specifics of proposals made in the report of the Chief Medical Officer (CMO 2006). Many participants doubted that the new proposals would achieve anything, and some people took the view that recent proposals would not identify dangerous doctors.

Many participants, especially doctors, were greatly preoccupied with the case of Dr Harold Shipman. This was often cited to suggest that regular testing would not catch those who do the most harm. The following comments illustrate the impact of the Shipman case on those at the meetings.

> *Shipman never had a single complaint about him... Sadly, patients do not know a good doctor from a bad one, and it is often said as a joke in medical school [that] the worst possible [combination] is the incompetent doctor with an excellent bedside manner.*
> (Liverpool)

> *Shipman would have passed any knowledge-based assessment.*
> (Liverpool)

> *If we have this set of standards and appraisals would that ever absolutely stop the Shipmans of the world? And the answer is no, it never would. Because there will always be a rogue and the only way to pick that up would be to look very critically at the bald facts like mortality rate, number of complaints generated.*
> (Manchester)

However, as debates about professional standards within and beyond the profession pre-date the Shipman case, some participants questioned whether the means of upholding and assessing clinical competence and professional standards in practice should be judged by their ability to spot someone whose behaviour was, by any standards, exceptional and appalling. For most, the bigger issue was considering the systems necessary to ensure that the non-homicidal doctor was keeping his or her professional practice up to date and safe. As one participant observed:

> *I think [Dame Janet] got it right, but the government got it wrong. Her job was to analyse the data from Shipman, the consequences, the implications for the profession, and her job was to produce a challenging report that challenged every assumption; to look forensically at the history of where we got to with revalidation, and she made some very pointed criticisms. But the mistake that then happened was to believe that Shipman represented a systemic failure across medicine.*
> (London)

A STRAW POLL OF PARTICIPANTS: ACCOUNTABILITY

When we asked a total of 782 participants the question: 'Are doctors sufficiently held to account for their clinical performance?', a total of 60 per cent of doctors and 37 per cent of non-doctors voted 'yes'. 63 per cent of non-doctors from audiences across the country expressed concern about doctors' accountability for their clinical work.

Many of the more specific doubts centred on how to appraise doctors, rather than whether to do so. They highlighted the difficulty of deciding what methods to use, and particularly wondered how to test attitudes as well as knowledge. This was a concern echoed by those who were actually in favour of revalidation as a matter of principle. There was a related concern that no testing system could be devised to assess all the attributes of good professional practice, and that there was therefore a risk that tests would be devised about aspects that were measurable rather than those that were important. Some simply feared the burden of paperwork and bureaucracy.

> *Regular, robust testing. How regular do they mean and how robust? Is it more paperwork for doctors, especially senior doctors? More paperwork, suing and litigation.*
>
> (Swansea)

Others were concerned that testing would be burdensome, disproportionate and expensive, and probably pointless too.

> *It will be judgemental, nasty and expensive, but 99 per cent of us will get through it having spent weeks preparing for it.*
>
> (Plymouth)

> *I think that a lot of people worry that perfectly good doctors could get caught by it and that incompetent fools could slip through.*
>
> (Liverpool)

Others made the point that testing alone would not promote trust, either between doctors and managers, or between doctors and patients. The solutions to any shortfall in trust would, in any case, need to be addressed in ways that were far more complex and diffuse than the periodic appraisal and revalidation of doctors. One participant suggested that media coverage might undermine trust in the professionalism of doctors if it were presented in a way that focused on doctors having to take exams.

Some of the fears about revalidation stemmed from a concern about who would oversee the process. One participant, who started from what he described as 'a position of great scepticism', suggested:

> *It gives a new role to the colleges so the medical establishment might well wish to take part, but that does not necessarily mean it is a good thing, and at every level in these discussion there are problems of who guards the guardians.*
>
> (Leeds)

The sceptics were matched by many participants who broadly supported the trend towards regular reassessment of doctors. Some spoke sadly of their own experiences with underperforming colleagues.

> *I tell you, it is a very distressing experience to sit in surgery and watch a barely performing doctor. I do [so] quite regularly and it is very upsetting.*
>
> (Plymouth)

...there is very often a degree of awareness in the community of a problem where warning signs have been ignored year in, year out. Going back years ago, I suspect most of us have been in this situation – you go into a new institution and in the first day or two you pick up who you don't refer to.

(Plymouth)

Many other reasons were given in support of regularly ensuring that doctors were fit to practise. Some had had positive experiences of appraisal and had learnt from the process, even felt 'liberated and empowered' by the experience of someone validating their competence. Doctors had also learnt from being appraisers of others. It was thought that 360-degree appraisals were useful, but that they are easier to do in general practice than in hospital, where personnel change more frequently. In fact, those in general practice appeared to take a much more positive view of appraisal than many others.

I set up an appraisal in a GPs' practice. Our feedback was very positive, a positive process... You can identify people who need to be developed, helped in different stressful situations, people who are not functioning well and you can develop strategies to get around that.

(Manchester)

It was also thought that regular testing would enhance professionalism, as patients would be able to have more trust in the profession as a result. For some, it was just a question of being seen to be up-to-date – a not unreasonable thing to do, they felt, as people's values, skills and competencies change over time.

A number of people compared doctors and pilots, noting that pilots undergo regular testing and that this was a key aspect of ensuring the safety of themselves and their passengers. In particular, one participant noted:

You would have no worry flying in an aeroplane piloted by the worst 1 per cent of all pilots – and that, as a standard for testing the quality of the profession, is really quite impressive.

(Manchester)

By contrast, there was agreement that it would, perhaps, not be so safe to be treated by the least able 1 per cent of doctors.

A STRAW POLL OF PARTICIPANTS: PROTECTION FROM POOR PRACTICE

Across the ten roadshows, a total of 406 doctors and 376 non-doctors (including 79 medical students) were asked: 'Are patients adequately protected from poor practice by doctors?'

40 per cent of doctors and 35 per cent of non-doctors thought that patients were either well protected or as well protected as possible.

60 per cent of doctors and 65 per cent of non-doctors believed that patient protection needed to improve.

Issues for the future

Although roadshow participants' opinions varied about the current state of affairs, there was a considerable amount of agreement on how professionalism in practice might – and should – develop in the future.

First, it is clear that participants at the consultation events believed that the development of professionalism in practice would be greatly enhanced if the tentative beginnings of a new relationship between government and the medical profession could be fostered further. The engagement of the medical profession in developing local performance indicators was seen by many as a step that could go some way to reducing persistent worries that professionalism is undermined by a lack of due regard for professional expertise. But this is not all one-sided; doctors, too, it was felt, must take a more active role in influencing change.

Second, both the profession and the public must find ways to function in a world where patients may neither expect nor want the degree of paternalism that was commonplace in the past. Mature relationships between patients and doctors will, of course, need to be supported by better information for patients – especially for those who may lack easy access to reliable material, or who may have difficulties in understanding or assimilating the material they do have. Doctors will need to take an ever-greater role as moderators of information, and as informed advisers on how information can best be understood and utilised by a patient in a one-to one consultation. The level of judgement required to get that right for all patients may be seen as a test of professionalism that is far more stringent than anything that has gone before.

Third, as we have seen, the involvement of patients in their own care, and both public and patient involvement in broader health service issues, has increased enormously. Indeed, the structures – particularly to support public involvement – have been in a permanent state of flux. Collective engagement with the community is an important part of shaping new services. This engagement needs to include the medical profession. In short, there needs to be an acceptance that doctors are under a professional obligation to play a part in improving the health system, and that many doctors bear an obligation to play a part in influencing the shape of local services – taking on the necessary mature relationship between profession, community and health managers.

Fourth, participants gave a tentative account of what they felt were distinctive attributes of being a doctor. A similar analysis has subsequently been presented by the Inquiry into Modernising Medical Careers (Modernising Medical Careers Inquiry 2008), where emphasis was put on the doctor's role as a 'diagnostician and handler of clinical uncertainty' alongside a clear concern that it was becoming harder to draw a hard and fast boundary between the role of a doctor and the contribution of other professionals. Our participants agreed with the conclusion of that Inquiry that a clearer definition would better enable doctors to play their full role in a more multi-professional future and to do so with more confidence.

Fifth, the realities of the modern world, the changing attitudes to work and family life, and to the protection of both patients and doctors from the effects of over-long working hours, are here to stay. To achieve an accommodation with changing social expectations, new practices and ways of working within each corner of the profession will need to be found to

enable medical directors, doctors, or leaders of institutions to accommodate flexibility into working patterns. This will require a greater acknowledgement that a modern commitment to the continuity of care requires a move from individual responsibility to a professional responsibility for the whole system of care.

Finally, doctors need to engage with the task of ensuring that revalidation becomes a genuine means of improving patient care and enhancing professional development. It is interesting to reflect that the debate over revalidation is no longer centred on the question of whether to accept the notion of revalidation, but rather on the practical mechanics of recertification. The discussions emphasised a very real danger: that the public confidence that revalidation is supposed to build will, paradoxically, be further damaged unless the profession can move quickly to ensure effective implementation. This is a question of leadership, and work will need to be undertaken with the public to ensure a mature understanding of the problems and risks of this process. Leaders of the profession will need to acknowledge the views expressed at these consultation events, as well as shaping a new debate about how revalidation and recertification will work in practice. The starting point for this needs to be an acknowledgement that medical standards are not yet satisfactorily described or understood.

Managing professionally

Context and challenges

A NEW APPROACH TO MANAGING HEALTH SERVICES

In recent years, the nature and quality of the management of the National Health Service (NHS) has been the focus of unparalleled interest. Media criticism has been commonplace, and it has not been unusual for both doctors and NHS managers to be openly critical of each other. However, there is a growing interest in the role that doctors can play as managers, and how they can best work together with career NHS managers who, typically, are not medically trained. The medical profession is interested in how doctors can engage in management at all levels and, indeed, in how doctors – some, at least – can become managers.

The importance of such 'clinical engagement' is being promoted and supported at a very high level. In September 2007, the NHS Chief Executive, David Nicholson, described the role of the new NHS Medical Director, Professor Sir Bruce Keogh, as 'championing clinical engagement throughout the service' (Department of Health 2007b).

DEFINING TERMS

One of the first things to note is that, in the context of health services, the terms 'management' and 'leadership' are often used loosely, and even interchangeably. However, it is useful to make a clear distinction between the two. Management might be thought of as 'working with people and processes to produce predictable results' (Reinertsen 1998). In contrast, leadership can be usefully thought of as focusing on establishing the conditions for more radical change, or representing the collective profession as a whole. Neither concept should be seen as superior to the other; we need doctors who can both lead and manage.

This section presents the views of participants at the consultation events on clinical engagement as it relates to both specific operational management tasks and broad strategic questions. We are interested in both. As a matter of convenience, we will use 'management' as a shorthand term, so that we can reserve the term 'leadership' for a discussion of how the medical profession as a whole is led (this will be developed in the next section).

ENGAGING CLINICIANS IN MANAGEMENT

There are signs of an expectation that doctors (and other clinicians) will be more involved in management. Recently, a UK-wide project to support medical leadership has been jointly developed by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges (*see* NHS Institution for Innovation and Improvement 2007/08). As one observer noted, this project aims high: 'In the future, doctors and NHS managers

will work in harmony. Doctors will not only fully understand the complexities of commissioning but they will also be able to design and lead service improvements – they may even become managers' (Hunt 2007).

Even relatively recently, doctors might not have seen these issues as part of their professional remit. However, as Bishop noted in 2003, of the 11 Commission for Health Improvement investigations into serious service failures that had been published at that time, clinical leadership was found to be lacking in ten, together with unclear accountabilities and poor multidisciplinary working (Bishop 2003). Similarly, a publication from the NHS Confederation (2007) notes that clinical engagement, and managerial engagement with clinicians, is key to success, and often falls short at every level.

As we shall see from the discussions at the consultation events, not all doctors embrace management with equal enthusiasm. Perhaps they do not need to do so. The question is, how can the medical profession as a whole support the development of managers from among its ranks. Indeed, it may well be that concerns about targets, and a sense that doctors have had to work to performance indicators that they may not wholly embrace, can be a catalyst for the growth of medical involvement in management. Doctors may see this as a way of controlling their own destiny and protecting the interests of their patients as they see fit, in line with their professional values and responsibilities.

TRAINING AND SUPPORTING CLINICIANS TO MANAGE

It is widely recognised that doctors and other clinicians need training and support to enable them to become more involved in management. The authors of a *British Medical Journal* article (Empey *et al* 2002) make the point that, to be consistent, there should be a system of training, evaluating and then competitively appointing medical managers which is similar to that used when appointing consultants.

Indeed, the need for management training is now widely recognised. In April 2007, the British Association of Medical Managers and the British Medical Association issued a joint statement (British Association of Medical Managers and the British Medical Association 2007) in which they stated that doctors should be taught management skills as part of their medical training. They went on to say:

> *Every doctor should be able to demonstrate management and leadership skills to an agreed standard. All doctors should, therefore, receive basic level of management and leadership development and education during their undergraduate years and subsequently throughout their postgraduate careers. There should be opportunities for hands-on experience in management and to take on serious management roles with real authority and responsibility thereby gaining experiential learning about complex management issues. This management and leadership training should be to agreed standards and monitored for consistency and quality.*

(British Association of Medical Managers and the British Medical Association 2007)

They also argued that at every stage in the career pathway, doctors should be able and expected to access relevant education, training and development opportunities. These include taught programmes, coaching, tutoring and mentoring, such as the British Association of Medical Managers' Fit to Lead programme. However, enabling clinical

management requires both medical and non-medical managers to understand how they can work together in ways that promote the professionalism of both.

What we heard – listening to the dialogue

SHOULD DOCTORS BE MANAGERS?

Discussion at the consultation events revealed considerable support for the principle of doctors being encouraged to take responsibility for leading and managing the health system. However, an underlying issue was that some doctors have a low regard for management, or at least for those of their colleagues who have become managers.

> *I suspect that medics who have gone into management have been seduced by the dark side… and they all come out speaking management, ie, speaking all the jargon. I think they lose sight of what they are supposed to be doing… I suspect a significant number of people go into medical management because they are maybe not as confident as they feel they ought to be in clinical practice.*
>
> (Leeds)

Those who were wary of medical management were chiefly worried that it was a waste of their vocational training as doctors, or that they had not received adequate training to equip them to be managers. A far greater number of people felt that doctors needed to be managers, and that the opportunity for involvement in management had slipped away from the profession.

> *We gave away medical leadership when Griffiths came in – we said, 'we are going to have all these managers, we will just ignore them, and put our heads down and do clinical medicine'. How stupid we were.*
>
> (Winchester)

> *I think the perception is that we allow ourselves to be pushed around a lot as a profession and then you have the indignity of seeing decisions made on managerial levels, which you know are going to impact on patient care [but] which you have great difficulty in resisting.*
>
> (Swansea)

However, it was suggested that it was not enough for individual doctors to become managers as they could find themselves part of a management culture that continued to fail to relate to fellow clinicians. Many doctors believed that doctors in management should work to engage clinical colleagues in management at all levels, and ensure that the views of doctors influenced decision-making wherever that was appropriate.

DECIDING ON THE ALLOCATION OF RESOURCES

Management consists of many strands, and doctors who become managers may be more comfortable with some aspects of management than with others. For example, most senior doctors have experience of 'people' management, and all doctors have to manage their time and organise their workload. But when it comes to allocating resources, there were

differences of opinion about whether doctors should respect the authority and legitimacy of managers to do this, or whether doctors should be integral to the process.

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A STRAW POLL OF PARTICIPANTS: A DOCTOR'S RESPONSIBILITY AND THE QUESTION OF RATIONING CARE

Across the ten roadshows, a total of 406 doctors and 376 non-doctors (including 79 medical students) voted on the question: 'If you are a doctor do you believe your prime responsibility is to… the patient or the best needs of the wider community?' The result was strongly supportive of a prime responsibility to the patient in front of them, with more than 75 per cent of both doctors and non-doctors supporting this option.

We went on to ask whose responsibility it was to ration care. When asked the question: 'In a publicly funded system who should primarily be responsible for rationing care?', an average of 6 per cent voted for patients, 21 per cent for national politicians, 22 per cent for doctors, and 51 per cent for the local commissioning organisation.

Differences in the views of doctors and non-doctors were less striking though more non-doctors (29 per cent) than doctors (15 per cent) said responsibility should lie with doctors themselves.

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Some saw a division between the roles of doctors and non-doctor managers as a strength and a safeguard, at least in relation to resource allocation. As doctors, they saw it as their duty to be focused on the needs of their own patients, but they recognised that there was a wider picture, and that someone other than themselves needed to take account of this.

> *I think managers are important… but I care for my patients, and I may have 20 [and they're] the only ones I care about. The manager cares for about 500 that come under their directorate and it is important to have someone who has a better overview.*
>
> (Birmingham)

Another participant made the point even more strongly, saying that if doctors have the responsibility for deciding how resources are going to be distributed, they would be placed in an almost impossible position: they would have to make all sorts of decisions before treating their patients and would then have to deal with their guilt when they allocated resources elsewhere.

Those who were most unhappy about the medical profession being drawn into explicit rationing usually expressed their views in relation to concerns about the needs of individual patients or the effect on the doctor–patient relationship of not being an advocate for the individual patient. Some simply did not feel equipped for this role.

> *Patients want the best treatment they can have, not the best treatment that other patients can have. Personally I am not sure how our training would equip us to deal with that kind of managerial role.*
>
> (Swansea)

Those who saw a role for doctors in making difficult decisions about resources tended to express their views in terms of ensuring greater equity between different groups of patients, all with pressing needs.

> *That we should all push for the individual is absolutely right, but we are working in a constantly strained environment. The cost, the technology of treatment [have] escalated, and you cannot now give the best possible treatment to everyone. You have to ration it, and the government have never quite admitted that there is rationing.*
> (Leeds)

Many argued that it was not possible to avoid tough decisions about the allocation of resources, and that choices that amounted to rationing took place as a matter of routine. There was a good deal of anguish about this, since few people argued that rationing was wholly avoidable, and therefore someone had to grasp the nettle.

> *I feel in a sense we should take responsibility towards rationing the resources by the way we develop our services, but this is in direct conflict with our academic interest in our subject. How can we take medicine academically further and further and, at the same time, ration our resources? Because usually most developments that come along are not cheaper options – they are often potentially more expensive options.*
> (Plymouth)

Many people regarded a partnership between doctors and non-medical managers as the best way forward, particularly for the hard decisions, and were optimistic that this was achievable. There were some indications that attitudes had changed and more co-operation was likely to take place.

> *Times are changing – doctors and manager have more in common. I was told by a very senior consultant when I was a junior student 'ignore managers, never ever work with managers because managers only have business at their hand – they are not bothered about patients'. And yet, as I said, I think times are changing and when I sit down with managers I think there are some strong correlations between what they want to do and what I want to do.*
> (Manchester)

MAKING IT POSSIBLE FOR DOCTORS TO MANAGE

Most people accepted that doctors needed to engage with management to a greater extent than in the past. However, even when that principle was accepted, a number of issues remained to be addressed.

The biggest of these was training and development. Participants recognised that if doctors are to be managers, they must be trained for the role. However, the question of how and when doctors should receive this training was unresolved. Some participants saw medical management as a second specialty, and there was discussion about the need for training to enable this to happen. For other participants, it was more a matter of being able to integrate managerial and clinical responsibilities.

For doctors who may take on management roles, there are other considerations, too. Some saw the attraction of taking on more managerial roles as their career advanced, enabling them to draw on a wealth of experience. However, for doctors in the early or middle part of their careers, a different set of challenges prevailed: it might not always be easy to move seamlessly in and out of clinical practice; and if too much time was devoted to management there was a fear of losing clinical skills at the height of one's career. Indeed, this may become an even more challenging issue when the implementation of revalidation requires clinical skills to be continually honed and kept up to date. One participant described being at a career crossroads and being 'desperate' to get back to being a clinician again. Another participant asked:

> *What do you do if you achieve a medical directorship at quite an early age? It is, I think, legitimate for anybody at whatever stage to then go on and do something different. In the old days, people [didn't] change quite as much as they do now, and I think we are not good in the whole health system about managing people who want to do things for a few years and do something different, and you must feel that, just starting out.*
> (London)

From what we heard, there is more than one view of how doctors can be involved as managers and ensure that they manage professionally. There may well be a cadre of doctors who see management as a specialty and who make it the focus of their careers from an early stage. Many others may combine management with clinical practice, and yet others may wish to spend the greater part of their careers in clinical practice, while shifting the balance later on. Each option will require appropriate support.

Issues for the future

Listening to the conversations of nearly 800 participants around the country, it is clear that participants agreed that if doctors are to become more involved in management, as seems likely, the key question is how they can be supported to manage professionally. This question applies to doctors who manage as part of what they do, but who are not primarily managers, as well as to doctors who opt for a career in medical management. In all instances, the key issues for the future are the same.

First, the skills of management need to be properly appreciated and respected whether or not they are carried out by doctors. It is becoming increasingly clear that doctors cannot fully exercise their professionalism unless they understand what managers do. A cultural change where management is better understood and valued, within and beyond the medical profession, is necessary. The onus is on the medical profession and non-medical colleagues alike to work towards that goal.

Second, medical professionals will almost always need to undertake some aspects of management as part of their own work, and there is no reason to see this as an area for amateurs. Doctors' involvement in management is likely to increase, and both undergraduate and postgraduate medical training needs to prepare doctors to manage professionally. This will no doubt include opportunities to think through the dilemmas that participants at the consultation events identified, since these are issues that cannot be wholly avoided.

Third, for some doctors, a more advanced and sophisticated management training will be helpful, and that needs to be recognised and valued, just as other specialist training is valued by medical colleagues. This, perhaps, is a challenge to be taken up by the royal colleges – ensuring that their members understand the contribution of clinicians to management and the need to equip doctors to manage skilfully. In other words, the profession has to value management and has to ask itself what symbols of recognition it can accord to colleagues who take a major role in management, thereby ensuring that the experience and expertise of doctors is fully integrated into the running of a well-managed service.

Finally, if there is to be more traffic between clinical practice and management, more flexible career paths will be needed. That does not minimise the challenge of needing to keep clinical skills up to date. However, it does indicate the need for a shift in attitude so that those who engage in careers that successfully and safely mix clinical practice and management are accorded the same respect and seniority as those who follow a more conventional path. Indeed, it may well be that, with consultants being appointed at a younger age, and with a more diverse workforce, career development will become more diffuse and less linear, and a period in management may be one of many paths that can enhance the professionalism of the 21st century doctor.

Leading the profession

Context and challenges

The consultation events have demonstrated widespread interest among doctors about how they could be involved in managing health services, and in how they can offer leadership in the places where they work or within the wider health community. However, when discussion turned to the leadership of the medical profession itself, there was much concern about the perceived lack of coherent leadership and a great deal of criticism of those in leadership positions.

This may be linked to the fact that there are many different kinds of leadership, and that, for a variety of historical and other reasons, no single body has responsibility for leading the profession on all the matters that might legitimately concern it. Of course, some division of labour is to be expected; it is reasonable that the profession (and the wider public) might, for example, expect doctors' views on their pay and conditions to be represented by one body, whereas the profession's views on issues about the health of the nation might best be expressed by another.

However, the medical profession's various organisations may need to transcend their boundaries in order to be able to take a more integrated and professional approach. For example, at the consultation events doctors' views on their own contracts were connected to their views on how they should best meet their professional duties to patients. On this matter participants could not make a clear distinction between the issue of payment and the questions of perceived and actual professional responsibility. The issue did not fit neatly into the current organisational boundaries of those bodies that represent medicine.

Unfortunately, it is clear that the different organisations involved in the leadership of the medical profession have not always viewed each other in a positive manner. The question must be asked: would the troubled history of Modernising Medical Careers (MMC) and the Medical Training Application Service (MTAS) have been different if doctors had been better able to make unified representations on behalf of the profession as a whole? And: would centrally driven targets have been modified sooner if doctors had been better able to show that they were agreed on how they could raise standards in some other way? These are the kinds of questions that one might ask in order to assess the robustness of the current arrangements for medical leadership.

With an increasing interest in professional leadership, there has also been a renewed interest in the structure and governance of the various organisations that play a part in leading the profession. For example, as we have seen, the General Medical Council (GMC), like all regulatory bodies, has been the focus of intense scrutiny, and the Donaldson Report (Chief Medical Officer 2006) made a number of fundamental recommendations for change. More recently, there has been a new level of interest in the work of the Royal

Colleges of Medicine and Surgery. In a controversial article, Maynard and Ayalew (2007) questioned the proliferation of the royal colleges and challenged their cost effectiveness. The authors asked whether a single organisation, with national standards of training and examination, would produce and maintain practitioners better equipped for their long and demanding careers.

As we shall see from discussions at the consultation events, there is a great deal of interest not only in the organisations that have a leadership role but also in the role of the Chief Medical Officer (CMO). Considerable doubts have been expressed about the independence of the CMO's role, and the CMO himself clearly recognises the issues at stake, explaining: 'I represent the Government, for which I work, the medical profession, which I try to listen to, and the public. My moral principle is that if ever there is a conflict it is the public who wins' (Department of Health 2007c).

The CMO goes on to explain his leadership role:

> I do not have a role in the employment or management of NHS doctors. However, my responsibilities include providing national leadership to the medical profession, helping to explain the health policies of the day and listening to the concerns of the profession and their ideas. In this way I can provide, where necessary, a bridge between the medical profession and the government.
>
> (Department of Health 2007c)

The complexity of the leadership of the medical profession raises the question of whether the current structures are intelligible to those who wish to engage with the profession as a whole. A brief summary of the different bodies that play a leadership role in the medical profession is given in Appendix I.

Patients and the public may well be mystified by the proliferation of organisations that lay claim to some kind of professional leadership role for doctors as a whole, but the consultation events revealed that many doctors were also uncertain about who does what.

If the leadership of the profession is fragmented, then the profession may have a problem in terms of wasted opportunities to impart its collective wisdom. Equally, society as a whole has a corresponding problem if a lack of transparency about professional leadership, or a lack of agreement within the profession, makes it difficult for politicians, policy-makers, patients and the public to engage in dialogue with the medical profession as a whole.

As we shall see, doctors are keen to make their voices heard on a wide range of issues. There is clearly scope to develop the leadership of the profession so that they are better able to do so.

What we heard – listening to the dialogue

There was a huge amount of interest in the leadership of the medical profession. This extended to a consideration of the issues on which the medical profession might expect to speak out, and how best it might do so. Two key themes emerged. First, there was a good deal of questioning whether the medical profession itself was particularly difficult to lead,

and hypercritical of its leaders. Second, there was widespread bewilderment, sometimes amounting to outright confusion, about who actually leads the medical profession.

A STRAW POLL OF PARTICIPANTS: LEADERSHIP OF THE PROFESSION

Across the ten roadshows a total of 406 doctors and 376 non-doctors (including 79 medical students) voted on leadership of the profession, and the results showed a grim state of affairs: 86 per cent considered the leadership of the medical profession in the past 10 years to be 'poor' or worse than poor.

IS THE MEDICAL PROFESSION CAPABLE OF BEING LED?

Several people wondered whether doctors were capable of being led. One participant, reflecting on both professional leadership and operational management, pondered:

…so if we are trying to encourage more doctors to go into leadership positions, why are we spending all our time slagging off our leaders?

(London)

There were signs of ambivalence about how far doctors apparently wished to put aside the issues that divide them, and to be seen as a profession with a more identifiable leadership. As one participant observed:

No one leads it – that is part of the beauty and problem of medicine.

(Norwich)

Others were clear that the medical profession was not easy to lead, and viewed this as wholly negative.

The profession is unleadable – like herding cats. This would be the view of those of us who try to organise the profession and lead it in change. They are extraordinarily awful – we have such dysfunctional personalities in the system that when challenged with change they become abusive and insulting. We do not value our colleagues who put themselves in positions to lead… Individuals think they have the right to say 'no'.

(Norwich)

Many participants noted the multifaceted nature of the profession, and wondered whether the range of different specialties, overlaid by regional affiliations and many other differences of interest within the medical profession, resulted in insurmountable difficulties in achieving and supporting a coherent leadership. In a similar vein, another participant felt that:

We are not generous with the concept of leadership, we don't 'do' leadership or comradeship, or 'followship'. We don't want to be led.

(London)

In so far as the medical profession lacked adequate leadership, this was usually seen as a lost opportunity.

> *We have failed to articulate a clear manifesto of the public good and what science has brought to health care... As a result, politicians have walked right through the middle of what we are. Instead of being seen as patient advocates... we are now seen as the problem. We are seen as in opposition to a patient-centred health service. How have we allowed this to happen? Because we have had inadequate medical leadership.*
> (Winchester)

WHO LEADS THE PROFESSION AT PRESENT?

In view of the perceived difficulties of leading the medical profession, perhaps it should not be surprising that there was such confusion and disagreement about who, if anyone, actually led the profession at present. However, the strength of feeling was considerable.

At one extreme, some doctors suggested that the profession did not have a leader. This was seen as unhelpful to the profession and confusing to the public. One participant commented on the difficulty of actually identifying who was speaking as a professional leader, adding that it was hard to know if any particular statement was being made from a leadership position, or from 'a rogue individual expressing a personal point of view'. Others listed a number of contenders for leadership roles (typically including the British Medical Association [BMA]), GMC and the royal colleges), but as one participant expressed it:

> *They are all putting their oar in; there is no coherent leadership.*
> (Liverpool)

That view – although not unanimously held – was widely shared. Some thought that the fact that the BMA, the GMC and the royal colleges represented different aspects of medical professionalism weakened the influence of doctors on policy, but others were relaxed about this. They saw the GMC as the profession's regulatory body, the BMA as a trade union and also having a strong involvement in ethics and education, and the royal colleges as representing the profession on standards and education issues. However, the number of royal colleges and faculties was thought to undermine the possibility of speaking as one voice on behalf of the profession.

Cutting across the issue of whether the division of roles between different organisations was a problem, participants were highly critical of virtually all the bodies with a role in leading the medical profession. The following comments were typical:

> *Half the profession wants the BMA to be a very militant union, and the other half wants some type of professional leadership, and I don't think it does suit either purpose.*
> (Manchester)

> *We have never been clear enough to differentiate whether our leaders are leading us as workers or leading us as professionals. The BMA has perpetually been in a complete muddle as to whether it is a trade union or a professional body (which is*

really what the colleges should be doing, setting standards). It has never had the insight to sit down and acknowledge the fact.
(Leeds)

The GMC sets standards but [is] not seen as a leader in other respects by most of us – [it is] seen more as a policeman than a leader.
(Bristol)

I think it's very hard for the colleges… I think they tend to have to sing the government's point of view; they have to, or they'll be out. So they are rather bullied into submission.
(London)

WHAT THE PROFESSION WANTS

Whatever the difficulties of improving the leadership of the medical profession, the benefits of clear leadership were often acknowledged. Stronger leadership was seen as a vehicle for strengthening the professionalism of doctors, and for increasing their influence as a profession. Difficult though it may be, there was a measure of agreement that the profession needed to move towards a greater unity in order to achieve that influence.

I think what I would like is someone who I feel can represent the values of my profession to government, someone who defends those values which seem to be in danger [of] being eroded by the policy, someone who can actually speak for them.
(Plymouth)

Some doctors felt that too often their medical leaders worked to protect the narrow interests of just one 'silo' or set of medical interests. Although they recognised that giving ground was not easy, it was suggested that greater unity would have strengthened the profession's voice on issues such as medical manpower. However, the range of suggestions about who or what might be the focus for such unity was itself a measure of the distance to be travelled to achieve it. As one participant said:

The GMC, BMA and royal colleges are progressing the agendas that seem to be most important to them but there are conflicts between them.
(Liverpool)

There seemed to be some hope that the Academy of Medical Royal Colleges (AoMRC) could play a more significant role, but this was contingent on there being a democratic mechanism for ensuring that the AoRMC leadership can reflect both the colleges and their respective membership and fellowship.

THE ROLE OF THE CMO

In addition to the roles and remits of representative or regulatory bodies, some people thought that the position of the CMO offered a natural place from which to offer leadership to the medical profession and to speak out on its behalf. However, the tensions inherent in the CMO's role were usually seen as inimical to this. The CMO has himself recognised that his ability to speak up for the profession is constrained by his role as a senior civil servant working to serve a democratically elected government. Some participants acknowledged

that the CMO's role allowed him to represent the views of the profession to government, but not necessarily to represent the profession more publicly. Others were more critical.

> *I personally see [the CMO] as an organ of government rather than anything particularly to do with the medical profession.*
> (Liverpool)

DOCTORS SPEAKING OUT

The consultation events provided an opportunity for participants to discuss how, and in what circumstances, doctors should exercise their professionalism by speaking out on issues of health-related public interest. In many contexts it is the professional organisations that need to speak out. However, in other circumstances, individual doctors may see it as part of their professional duty to do so. In both contexts participants saw a willingness to speak out as an aspect of professional leadership.

There was a high level of agreement that doctors could offer leadership on issues where their professional knowledge was particularly relevant. For some, it was a duty to do so, and was seen as part of the professional obligation of a doctor, particularly since the public, it was suggested, was more likely to take advice from doctors than from government.

> *Dietary choices, us or Jamie Oliver? There is some high ground for us to recapture.*
> (Leeds)

> *The public expects you to speak loudly if you think that the care the public expects is being eroded.*
> (Leeds)

> *I think you have a responsibility as a profession to argue against those things that are unsafe.*
> (Liverpool)

Although there were few dissenters from the view that doctors should speak out on issues such as smoking or healthy lifestyles, there was less certainty about whether it was part of a doctor's professional remit to speak out on broader issues, such as National Health Service (NHS) funding.

Participants at the consultation events were asked to consider how far the medical profession is under an obligation to accept and work within the boundaries of government policy. Most participants saw themselves as needing to work within the boundaries of public policy but reserved the right to speak out if they felt that policy ran counter to their professional values.

> *We should work within the democratic political framework but equally we have all got a responsibility to speak out when we think there is something going wrong, and that responsibility falls on doctors just as much as it falls on patients, users and carers.*
> (Leeds)

We are duty bound to speak when we disagree with public policy; that is part of our professional duty.

(Liverpool)

Doctors were particularly exercised by the quality of health management decision-making, which was commonly viewed as lacking appropriate clinical input. To counter this, participants were inclined to urge a more vocal approach that combined criticism with a willingness to get involved in decision-making where possible.

We are duty bound to educate our commissioning groups, the commissioners, other members of the multidisciplinary team and the patient representatives and our professional organisation if there is a wide-of-the-mark policy that will impinge directly on them; a concerted and cohesive approach.

(Liverpool)

Issues for the future

The medical profession is a varied one, with many strands of interest and expertise. Furthermore, the historically strong sense of professionalism in medicine may well have accentuated a tendency towards individualism and a resistance to being led. So it is difficult to identify and support leaders of the profession. However, the consequence of not having effective leadership is a relative lack of opportunity to have influence, both on matters that affect the future of the profession and on matters where doctors can contribute to the well-being of society as a whole.

It is clear that personal responsibility or accountability is valued within the medical profession. Indeed, participants agreed that, as individual members of a respected profession, doctors need to continue to speak out on public policy.

It is less clear when such individualism might make the profession unleadable. It may well be that neither leading nor being led is easy, but modern professionalism may require individuals to steer a course that retains their individual professional integrity, while also reaching an accommodation with others in order to enable a strong collective voice to articulate professional values in public debate.

These consultation events illustrate an appetite for action. First, for there to be a serious debate among the current medical leaders on a more visible and coherent leadership of the profession and the actions necessary to support its development.

Second, it is essential that the profession works towards greater clarity over the respective roles of the existing organisations that represent doctors and a greater commitment to co-ordinate those roles. This will mean a willingness to rethink remits and to work in new ways across organisations.

Finally, it cannot be assumed that either doctors or the general public will have a full understanding of the organisational structures and leadership roles, even though these might appear clear to those who are most intimately involved with them. There is a substantial job in terms of communication to be undertaken, and all organisations that assume leadership functions can do more to be transparent and inclusive.

These areas of common accord and the concerns that drive them are also reflected in the subsequent conclusions of the Inquiry into Modernising Medical Careers (Modernising Medical Careers Inquiry 2008). Its recommendations put the future challenge well:

> ... the medical profession has frequently failed to proffer coherent advice on key issues of principle, reflecting in part a very complex organisational structure, which owes more to history than necessarily function or purpose. There has been a dearth of medical professional leadership over this period. Too often opinion that could influence policy has reflected the interests of a particular constituency rather than the profession and service as a whole.

Professionalism in partnership

Context and challenges

One conclusion that emerges from all the previous sections of this report is that the future of medical professionalism will be located in a different context from that of the past. Although doctors enjoy enormous trust and respect, we live in a society that is far less hierarchical and far less deferential than it used to be. Changes to doctors' working hours, together with the emergence of new roles for nurses and others, have blurred some of the boundaries between what doctors do and what others do. Teamwork has become essential to patient safety and patient care. Also, although medicine has become more specialised in many fields, the corollary of this is a far greater acceptance that doctors cannot work alone. In many specialties, the multidisciplinary team is well established and is seen as wholly necessary for effective patient care. All these changes are continually nudging medical professionalism towards new partnerships and new relationships with medical colleagues, nursing colleagues and other health care professionals, as well as with patients and the public.

Multidisciplinary teams are not new, but in the past the senior doctor in the team was possibly more clearly at the helm, and medical leadership of multidisciplinary teams was the norm. Now, while the doctor may often be the clinical lead and titular head of the team, he or she is not necessarily 'in charge' of colleagues from other disciplines. Effective leadership may also come from other professionals and, whatever the formal arrangements, doctors, nurses and other health care professionals are accountable to their own hierarchies and need to ensure that they fulfil their own professional obligations, while respecting and working alongside those from other disciplines. However, as we shall see, there is still a significant groundswell of opinion among doctors suggesting that ultimate responsibility rests with the medical members of the team and that medical professionalism is therefore different from that of others. This poses questions about the nature of partnerships between different kinds of professionals, and it would be fair to say that there is a range of views on how equal those partnerships are and can be.

What we heard – listening to the dialogue

At the consultation events, there was detailed consideration of how partnerships might develop with other professionals, and acknowledgement that it is not only doctors whose roles are changing. We also heard doctors, and others, reflecting on the trend towards patients having much greater access to information, and how that affects professionals' partnerships with patients. In this section, we pick up on some specific areas where the dialogue at the consultation events threw further light on how these partnerships with fellow professionals and with patients might develop as part of the adaptation of medical professionalism in the 21st century.

MULTIDISCIPLINARY TEAMS – PARTNERSHIP AND LEADERSHIP ISSUES

Although participants reported that shared decision-making was now more evident in daily practice, that non-medical leadership of multidisciplinary teams was becoming a reality, and that partnerships within teams were more egalitarian, there was little consensus over who should lead the team.

We heard many participants sharing a belief that doctors should usually lead multidisciplinary teams. Many doctors felt that 'the buck stopped here', and that doctors should assume the leadership of multidisciplinary teams as they were left with the responsibility for ultimate decisions.

> *I say to junior doctors when they join: you have got to remember one thing when making your decisions – everybody wants to have a say in the matter, [but] when it hits the fan everybody walks away except you.*
>
> (Liverpool)

Those who tended towards the view that doctors should remain the leaders of multidisciplinary teams advanced a number of arguments, including the view that being a doctor was a sign of having the training, skills and abilities required for the role. Those arguments did not always look at whether members of other professions shared such attributes. More specifically, some doctors thought that it was clinical skills and experience that should determine who takes the ultimate responsibility for a team. As one participant explained:

> *There will always be a leadership role for doctors because the chances are it is going to be a doctor or a person with a similar competence, experience and sorts of abilities that knows what's wrong and works out what to do in patient care.*
>
> (Swansea)

On the other hand, another participant used a sporting analogy to suggest that 'the best player does not necessarily make the best captain': it was not just a matter of having the clinical competence and experience – teams should be led by whoever was best suited to the job, which may or may not be a doctor.

> *I personally think it depends on the leadership skills actually. Sometimes people I work with can be very uncomfortable about leading a team because they know they haven't quite got the skills to do it, but because they are the doctor they got landed with it.*
>
> (London)

> *I don't think doctors necessarily need to [lead multidisciplinary teams]. There are now very specialised clinical nurses and I think the point of a multidisciplinary team is [that] each member brings their particular expertise to it.*
>
> (London)

Those who were open-minded on who might lead multidisciplinary teams tended to think that medical professionalism was enhanced by teams where people worked in true partnership. As one participant said:

I believe that if you have got a team that is truly a team, then each individual will want the team to do well and therefore you do not decrease professionalism, you increase it.

(Leeds)

One participant illustrated the point by explaining that a real team is indeed a multidisciplinary team. The clinical director is seen as being in overall charge but the real influence on how it operates is just as much with the manager and the nurse, who each run their parts of the system. The clinical director chairs the team's meetings, 'but there are many occasions where you can clearly see he is not in charge of it, he is simply acting as a conduit for the discussion'. The participant concluded:

It is a healthy system: people can express their views freely, there is no sense that the doctors are having a final vote on things, the guidelines are agreed together.

(Leeds)

A STRAW POLL OF PARTICIPANTS: TEAM WORKING

Across the ten roadshows, a total of 406 doctors and 376 non-doctors (including 79 medical students) voted electronically on team working and clinical responsibility. When asked the question: 'Should doctors be prepared to be clinically responsible to other health professionals?', an average of 64 per cent of participants voted 'yes', with the remainder voting 'no'. However, responses showed that doctors were less enthusiastic about this proposition, with only 56 per cent of them voting 'yes', compared with 70 per cent of non-doctors.

DOCTORS AND NURSES – PROFESSIONAL PARTNERSHIPS

Extended roles for nurses and other health professionals have an impact on how doctors perceive their own professionalism. One participant explained:

If you are a junior doctor and you are part of the hospital night team and the team leader happens to be a senior nurse then clearly you are responsible to that senior nurse.

(Liverpool)

Others said that it was a very unwise newly qualified doctor who did not take advice from a ward sister or charge nurse; that was part of how doctors learnt to do their jobs. Many participants could see the benefits of teamwork with professional colleagues, and noted that nurses and other health professionals did not necessarily defer to doctors' decisions as they once did. One participant was quite grateful for the greater sharing of decision-making as it made the burden of responsibility less onerous. Some went further still:

The management training that nurses get is a damn sight better than the management training doctors get, and perhaps by having a nurse as our managing day-to-day service manager, that would let us all get on with the medicine.

(Swansea)

However, it remains the case 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.

Issues for the future

It was clear from the consultation events 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.

Discussions at several consultation events led to calls from participants for a wider debate on how medical and other health professions fit together. This was not a call for rigidity, but a call for a review of where the evolutionary approach has reached, and for greater open debate about how the professionalism of doctors has changed, or may change, in the light of factors such as team working, new roles and changing patterns of work. The appetite for such discussions has been amply demonstrated in the consultation events, and it is reasonable to suppose that an even wider audience could add value to what is already known.

The tenor and the content of contributions up and down the country closely mirrored the subsequent findings of the Inquiry into Modernising Medical Careers (Modernising Medical Careers Inquiry 2008). This specific inquiry identified the same weaknesses and needs as our more general consultation: that 'service needs cannot be met now or in the future unless there is a clear understanding of what part each healthcare professional plays. This is particularly true for doctors and needs to be articulated for each career phase…' The Inquiry report went on to make the link with the vital concept of professionalism and pointed to a 'lack of acknowledgment of the essential professional attributes the doctor brings to the health team' as part of the problem.

One challenge for the medical profession (and other professions too) is how to have clear lines of responsibility and accountability in a less hierarchical work setting, one in which patients may be expected to be increasingly active partners, both as individuals and collectively as members of communities and interest groups. A further challenge is how to play to the strengths of what the medical profession has to offer, while ceding to others what they can do as well – or better. This may not be easy, but avoiding the issues is not easy either. Lack of clarity on these issues could result in threats to patient safety, demarcation disputes and a waste of scarce medical expertise.

A failure to engage fully with these issues could result in a downgrading of medical professionalism, and the consultation events revealed an appetite to redefine it for the next generation. At the same time, the benefits of engaging with these challenges are substantial. The best outcome is a clear view of what doctors do as a better basis for maintaining professional standards, and more constructive and rewarding partnerships with all those who share aspirations for better health care.

Conclusions

This report is based on ten consultation events attended by almost 800 people, 406 of whom were doctors. All of those who participated responded passionately to the debate. Each event elicited opinions on:

- how medical professionalism should influence the selection of future medical students
- how practice could reflect professional values in a modern and changing health system;
- what professionalism should mean when it comes to collective medical leadership;
- how professionalism might guide a stronger voice on public debates about health and health care
- how doctors should work with others to ensure that the health care system is shaped by the application of professional values to the task of bringing the best-quality health care to all.

During the debates there was no dispute with the Royal College of Physicians' (RCP) definition of medical professionalism as 'a set of values, behaviours, and relationships that underpins the trust the public has in doctors' (RCP 2005a). Indeed, there was considerable optimism that such professionalism was alive and well. However, there was widespread acceptance that doctors needed, both individually and collectively, to reconsider how these values should be put into practice in a rapidly changing society.

Doctors are principled, intelligent, critical and passionate. Despite the often lively exchanges, there were many areas where there was substantive consensus, either over the way forward or the barriers faced. The following are the areas of common accord.

- Many doctors supported the idea of assessing and subsequently selecting for medical school people who showed nascent professional qualities. However, alongside an attraction to the idea, there were also some strong, commonly expressed reservations:
  - for undergraduate entry programmes, there was concern that interviewees might be too young to reveal such qualities
  - there was uncertainty about the ability of current assessment techniques accurately to select those with a professional aptitude
  - there was a significant anxiety about how to implement such assessment in a way that valued the heterogeneity of the profession.
- Most doctors were unsure of the best way to incorporate medical professionalism into the teaching of young doctors, but many acknowledged the powerful effect that role models could have in inculcating such values. These doctors promoted a sharing of responsibility for promoting professionalism beyond the province of formal teaching.
- A majority of doctors were clear that putting professionalism into practice started with an influential relationship with the government of the day. For many, medical engagement in performance indicators was seen as key to developing such a relationship. Most doctors recognised that they and their leaders needed to take a more active role in establishing such constructive relationships.

- Many doctors recognised that their practice was changing and needed to continue to change in order to fit a world where patients often didn't want or expect the degree of paternalism that used to be commonplace. They acknowledged the need to develop their skills as moderators, as opposed to sole providers, of health information.
- Despite agreement on a number of distinctive characteristics common to being a doctor, many doctors expressed a clear concern that it was becoming harder to draw a hard and fast boundary between the role of a doctor and the contribution of other professionals. Many of the consultation participants felt a clearer definition of the role of the doctor would better enable doctors to play their full role in a more multi-professional future and to do so with more confidence.
- Some doctors accepted that they needed to be part of a collective engagement with the community that they sought to serve. These doctors accepted that their professionalism put them under a professional obligation to play a part in improving health systems, and saw such engagement with the community as an important part of that responsibility. This sat alongside a substantial concern that public engagement in shaping future health services needed to be informed and realistic.
- A lot of doctors accepted that the realities of the modern world meant that they needed to find ways – in every corner of their profession – to enable greater flexibility in working patterns. They accepted that this meant that 'continuity of care' required a move from individual responsibility to a professional responsibility for the system of care.
- Across all the consultation events there was strong, 'in-principle' support for the concept of revalidation. Alongside this was a shared anxiety about the practicalities of its implementation, and an acknowledgement that public confidence will, paradoxically, be damaged unless the profession can move quickly to ensure that the implementation is effective.
- Many doctors accepted that the profession overall needed to be more involved and equipped to take on management tasks. Many individuals felt that to do this they would need more advanced and sophisticated management training. Many doctors believed that to support this development the profession as a whole had to find ways to value, recognise and reward doctors in management and bring about the flexible career paths necessary in order to support people who spend time in management.
- Almost unanimously, doctors wanted more visible and coherent leadership of their profession. They wanted current medical leaders to discuss how this might be delivered, even if this entailed the rethinking by the leading medical institutions of their respective roles and responsibilities. Alongside such potentially radical change, most doctors felt that there was a need for much greater transparency and public communication from their collective institutions so that their voice, singularly and increasingly in partnership with others, could be stronger on issues of public interest concerning health and health care.
- Most doctors agreed that an increasingly multidisciplinary health system needed a more sophisticated and commonly understood definition of individual professional responsibilities within multidisciplinary teams.

Although agreement was not unanimous, this broad consensus can be summarised as a desire for action in the following three areas.
- First, for the medical profession collectively to:
  - seek a greater understanding of the strengths and limitations of particular assessment techniques for recognising and assessing professional qualities, particularly in potential future medical students

- put an explicit articulation of modern medical professionalism at the heart of its behaviour in order to support the collective understanding and inculcation of these values in young doctors
- work with others to develop a clearer statement of the role of the doctor working in an increasingly multidisciplinary clinical environment.
- Second, for the profession at all levels to work towards developing new relationships with government, patients and the local community. In this way, the profession might take responsibility for:
  - establishing a more constructive and influential relationship with government
  - continuing to learn how best to meet patients' preference for a less paternalistic and more facilitative relationship with their doctors
  - finding ways to engage with the community served by the health care system in which doctors work, in a way that builds a realistic and informed understanding of services and resources as well as a constructive engagement in future improvement.
- Third, for the profession, particularly the leaders of its national institutions, to take a hard look at how the collective profession might:
  - adopt a greater flexibility to patterns of work across all medical roles and responsibilities
  - ensure a swift, effective and widely understood implementation of revalidation
  - make its collective voice stronger in public debates about issues of health and health care.

Our aim in this work was to help facilitate a debate within the profession, and, by reporting this debate, enable others, particularly professional leaders, politicians and policy-makers, to understand the way doctors think about their own professionalism and their consequent obligations to patients, the public and the health care system.

The conclusions drawn from this lively national conversation are not easy to implement. It is a difficult agenda and we have avoided presenting simplistic or specific recommendations.

During the consultation events, doctors acknowledged and demonstrated their strong individualism. This might make leadership of the profession difficult, and the ongoing development of a constructive web of relationships between doctors, patients, public and politicians problematic.

However, many doctors identified the opportunity to harness medical professionalism to the delivery of the public good. Professionalism offers a strong value-based framework within which doctors can shape the improvement of health care and exercise a constructive influence on health policy in the public interest. Professionalism is a powerful and valuable concept; its discussion is, quite rightly, passionate, interesting and vital.

Appendix: A summary of the organisations that play a leadership role in the medical profession

The box below gives a summary of some of the key players in the leadership of the medical profession, including medical education, outlining their remit.

British Medical Association (BMA) www.bma.org.uk
The British Medical Association represents doctors from all branches of medicine all over the United Kingdom. It has a total membership of over 139,000, rising steadily, including more than 2,900 members overseas and more than 19,500 medical student members. It is a voluntary professional association of doctors and speaks for doctors at home and abroad. It provides services for its members and is an independent trades union. It is also a scientific and educational body and a publisher.

General Medical Council (GMC) www.gmc-uk.org/
The General Medical Council (GMC) was established under the Medical Act of 1858. The purpose of the GMC is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The GMC has four main functions:
- keeping up-to-date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

Academy of Medical Royal Colleges (AoMRC) www.aomrc.org.uk
The objective of the Academy of Medical Royal Colleges is to co-ordinate the work of the medical royal colleges and faculties. The AoMRC has existed in its present form and has had charitable status since 1993, before which its predecessor body existed as a Conference of Royal Colleges and Faculties.

Royal Colleges
The mission of each royal college and faculty varies according to its particular remit. Broadly, they all exist in order to ensure high-quality care for patients by promoting the highest standards of medical practice. Most provide and set standards in clinical practice and education and training, conduct assessments and examinations, quality assure external audit programmes, support doctors in their practice of medicine, and advise the government, public and the profession on health care issues.

The royal colleges and faculties in membership of the AoMRC are:

Royal College of Anaesthetists www.rcoa.ac.uk/
Faculty of Dental Surgery www.rcseng.ac.uk/fds
College of Emergency Medicine www.emergencymed.org.uk/CEM/
Royal College of General Practitioners www.rcgp.org.uk/
Royal College of Obstetricians and Gynaecologists www.rcog.org.uk/
Faculty of Occupational Medicine www.facoccmed.ac.uk/
Royal College of Ophthalmologists www.rcophth.ac.uk/
Royal College of Paediatrics and Child Health www.rcpch.ac.uk/
Royal College of Pathologists www.rcpath.org/
Faculty of Pharmaceutical Medicine www.fpm.org.uk/
Royal College of Physicians of Edinburgh www.rcpe.ac.uk/

Royal Colleges (cont'd)
Royal College of Physicians of Ireland www.rcpi.ie/
Royal College of Physicians of London www.rcplondon.ac.uk/
Royal College of Physicians and Surgeons of Glasgow www.rcpsg.ac.uk/
Royal College of Psychiatrists www.rcpsych.ac.uk/
Faculty of Public Health www.fphm.org.uk/
Royal College of Radiologists www.rcr.ac.uk/
Royal College of Surgeons of Edinburgh www.rcsed.ac.uk/site/o/default.aspx
Royal College of Surgeons of England www.rcseng.ac.uk/
Royal College of Surgeons in Ireland www.rcsi.ie/

The Medical Schools Council   **www.chms.ac.uk/**
The Medical Schools Council, formerly the Council of Heads of Medical Schools (CHMS), represents the interests and ambitions of UK medical schools as they relate to the generation of national health, wealth and knowledge through biomedical research and the profession of medicine. The new name, the Medical Schools Council, reflects the fact that the organisation draws on expertise at various levels within schools, for example from administrators and admissions tutors, and values the contribution of not just the heads of schools, but also all the other dedicated members of staff.

The aims of the Medical Schools Council are:
1. To be the authoritative voice of all UK medical schools for informed opinion and advice on all matters relating to medical undergraduate education and to be the key reference point for government, higher education generally and health-related professional bodies for such matters.
2. To develop a close working relationship with NHS partner institutions and to facilitate the development of academic medical centres.
3. To explore proactively the role of the doctor in the future and pursue educational solutions for workforce requirements involving doctors.
4. To work to improve and maintain quality in medical education. Through engagement with agencies involved in postgraduate medical education, to work to facilitate the seamlessness of medical education and optimal preparation of medical students for the postgraduate environment and to influence the provision of that environment as a guardian of best medical education practice and the continuing educational needs of the doctor.
5. To promote clinical academic careers.
6. To enhance clinical leadership and develop leaders within medical schools.
7. To promote the conduct of high-quality, health-related research in all medical schools, recognising that the nature and scale of such research will differ between institutions.
8. To take due account of the views of the public on society's needs of a doctor.

Conference of Postgraduate Medical Deans (COPMeD)   .
COPMeD provides a forum in which postgraduate deans meet to discuss current issues, share best practice and agree a consistent and equitable approach to medical training in all deaneries across the UK. It acts as a focal point for contact between the postgraduate medical deans and other organisations, for example, medical royal colleges, GMC, BMA, AoMRC, CHMS, PMETB and health departments for postgraduate medical and dental education matters

Chief Medical Officer
The Chief Medical Officer (CMO) provides advice to the Secretary of State for Health and other health ministers, ministers of other government departments and on occasions to the Prime Minister directly.

The role goes beyond a simple advisory remit. The CMO's responsibilities are to:
■ prepare policies and plans and implement programmes to protect the health of the public
■ promote and take action to improve the health of the population and reduce health inequalities
■ lead initiatives within the NHS to enhance the quality, safety and standards in clinical services
■ prepare or review policy in particular areas of health or health care (as the senior doctor within government). For example, this can be in areas where there is public concern or controversy, in new and emerging fields of medical science or where there is a need for change to the medical workforce.

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