# Time for hard decisions on patient-centred professionalism

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## ABSTRACT

- Patients want doctors who are competent, respectful, honest and able to communicate with them. That is patient-centred professionalism.
- Professional self-regulation, as practised hitherto, has failed to achieve this for all patients.
- In the United Kingdom, a new way of looking at professional regulation has been developed — as a partnership between public and doctors.
- At its heart is a code of good practice, agreed between public and profession, in which doctors' licence to practise is conditional on regularly demonstrating continuing compliance. That means revalidation–relicensure.


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Every one of us at some time will need medical attention, with potential consequences that may remain with us for life. So, it is not surprising that the public wants to be confident that doctors are skilled, competent, respectful and honest — in short, truly professional. Equally, the public expects the profession and its system of regulation to guarantee this. Indeed, how doctors and the medical profession function is critical to clinical quality and safety.

But where are we in creating a culture of professionalism in medicine in tune with public expectations? My conclusion is that, despite excellent recent progress, we are not yet taking our collective responsibility for our professionalism as seriously as we should and as the public expects. Cruess and colleagues have pointed out that this may be because the medical community has not analysed extensively the fundamental principles of professionalism.[1] In any event, the way forward lies primarily with our professional institutions, which, in the United Kingdom, include the General Medical Council (GMC), medical Royal Colleges, professional societies, medical schools, and the Academy of Medical Sciences (Box 1), and not with individual doctors who are relatively powerless to affect group behaviour. The real question is whether these institutions can deliver leadership on professionalism to the medical profession so that it becomes a coherent, positively motivated force for the public good, and is seen by the public as a valued, reliable asset for the benefit of all.

## What is professionalism?

The words "profession" and "professionalism" have a fine and reassuring ring. People think of professionalism in three main ways:[2]

- the mastery of technical knowledge and skills;
- strong ethical principles and values, such as honesty, respectfulness and reliability; and finally
- notions of a calling and of service, in which altruism comes before anything else.

True professionalism begets trust, which has to be earned and sustained by strict personal self-discipline — literally self-regulation — along with equally rigorous collective self-discipline through professional institutions. Professionalism is the outward visible expression of a profession's culture, and what a profession stands for.

How do these general principles equate with patients' expectations of doctors? Patient surveys show that technical knowledge and skill — clinical competence — come first.[3,4] But patients also expect doctors to be honest, to involve them in decisions about their care, to communicate empathetically, and to treat them with the respect and courtesy to which they are entitled. They want to feel special and have their doctor's undivided attention. And they want time. Beyond that, patients want to be sure that the hospital or the primary care team work effectively and deliver quality care.

What is the reality? We know that most patients think well of their own doctors.[5] This collective anecdote almost certainly explains why the profession is regularly among the top in polls of occupations the public consider trustworthy.[6] But polls can create a false sense of security. Dig deeper and we find that, for some patients, their doctor's care is not acceptable, and, for a minority, it is best described as indifferent.[7] Yet, these patients have the same right to good practice. Their acquiescence does not always signify their acceptance.

Furthermore, the respect and trust patients show for individual doctors does not extend to the profession's institutions, where the public perception is of self-interest arising from a failure to make self-regulation work for all patients.

In the United Kingdom, matters came to a head with the tragedy in paediatric cardiac surgery at Bristol.[8] Leaving aside the individual doctors involved, it was the insights into the darker side of the profession's culture that made such an impact on the public through the GMC's open hearing in 1998.[9] Laid bare were doctors' collective attitudes to audit, teamwork, whistleblowing, consent to treatment and complaints about poor practice that evoked words such as reactive, protective, and inward-looking. As the picture unfolded, the force of the public's response shook the profession. Richard Smith captured this in a watershed editorial in the *British Medical Journal* when he evoked Yeats' words, "All changed, changed utterly".[10]

Today, 5 years on, we have the UK Government's response to Bristol, introducing new rules and regulations, new councils and committees.[11] We have seen the profession's response, particularly to the proposal for revalidation.[12] Many doctors have reacted positively, but others think that the profession has been unfairly treated, especially by the media. They see themselves as victims.[13]

## Lessons from the past

So what went wrong? How did we get into this position? I have set out the story in *The doctors' tale*, which describes the longstanding history of institutional complacency, introspection, excessive pro-

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**1 Institutions involved in regulating the medical profession in the United Kingdom**

*General Medical Council:* The principal regulator of UK doctors, which sets generic professional standards, registers and licenses doctors, supervises basic medical education, and disciplines doctors who breach its standards.

*Medical Royal Colleges:* Set standards of practice and education for their respective specialties, including general practice, and control entry through Membership and Fellowship qualifications.

*Specialist Training Authority of the Royal Colleges (STA):* Formerly the competent authority supervising specialist training.

*Postgraduate Medical Education and Training Board (PMETB):* Appointed by government, it replaced the STA in 2003 as the competent authority for the specialties and general practice.

*Academy of Medical Sciences:* Brings together biomedical scientists and clinical academics to translate advances in medical science rapidly into benefits for patients.

*British Medical Association:* Professional representative body and registered trade union.

*Royal Society of Medicine:* Independent professional organisation providing educational activities and opportunities for doctors.

tectionism and self-interest, and failed leadership.[14] What lay behind these problems?

First, the profession remained wedded to a 19th-century professional culture, when society was changing profoundly. In the 20th century, the profession was vigorously progressive in developing medical science and technology, while remaining deeply conservative on matters of attitude and human relationships about which patients care greatly. Attitudes to paternalism, communication and patient consent exemplified this.

Unqualified professional autonomy, previously unquestioned by both patients and doctors, became demonstrably inappropriate. For example, it has been difficult to persuade some doctors that complete clinical freedom is incompatible with evidence-based practice. In our professional institutions, inappropriate autonomy, manifest as divisive tribalism aggravated by the fragmentation caused by specialisation, has resulted in a profession less and less able to act creatively as a coherent entity.

We got professional regulation the wrong way round.[2] The emphasis was on reacting to serious events through central mechanisms, such as the GMC. Prevention, and the early recognition, diagnosis and action on problems, were not priorities. Hence, the ad hoc nature of the arrangements for supervising the quality of medical practice at the point of service delivery, and the highly variable informal systems to deal with problem doctors.[15,16]

There was the widening gap between the profession's laid-back approach to accountability and transparency, and the public's increasingly explicit requirements. Hence, the growing public criticism of the profession's secretive attitude to risk and to the disclosure of information that would shed light on doctors' personal conduct and performance.[17] Another example was the unwillingness of professional regulators to insist on proper compliance with professional standards that they said were necessary. Thus, for instance, it was not until 1992 that the GMC started to insist that medical schools comply with its requirements for training new doctors.[18] Similarly, the Specialist Training Authority of the Royal Medical Colleges, which had the statutory function of certifying specialist training, failed primarily because it could not get individual Colleges to modernise that training.

All professional institutions tended to be tactical. There has been no history of coordinated strategic planning, of looking ahead, of not being taken by surprise. So the profession has lacked a clear sense of direction. Hence, it has been invariably pushed onto the back foot by government and others, rather than leading change.

The profession was slow to engage with the newly emerging science directed to measuring and improving quality in healthcare. It had a wonderful chance to lead. In fact, indifference and a determination to resist new ways in many institutions diluted the impact of some outstanding professional initiatives.

To an extent that many people do not recognise, responsibility for the totality of professional standards in the National Health Service (NHS) was split between NHS contracts and professional regulation. This might not have mattered had it not been for a longstanding, strongly collusive relationship between successive governments and their NHS managers, on the one hand, and the British Medical Association (BMA) and, to an extent, the Colleges, on the other. The profession was the dominant partner in that relationship until quite recently. Consequently, the BMA — the registered trade union — came to negotiate a tranche of professional standards by contract. It did its best to protect doctors, sometimes at the expense of patients. The tolerance shown to poor general practice by the NHS was one example. The profession's tight protective grip on local NHS complaints procedures, patients would say, was another.

Last but not least, there has been the curse of misplaced collegiality, or the tendency of the profession to close ranks in the face of perceived adversity. Think of the instinctive response "there but for the grace of God go I" in the face of clinical error, and doctors' social ostracism of whistleblowers such as Steve Bolsin. This is not, incidentally, an argument against collegiality, which, when well directed, is one of the strengths of the medical culture that gives professional identity.

Overall, the medical profession was used to seeing patients' interests through its own eyes and on its own terms. We know that now. Hence, the efforts to reverse many of the behaviours I have described by changing the culture. This began patchily in the 1970s, from within the profession itself, and then accelerated from 1995, especially after the GMC Bristol hearing.[14]

## The new model of professionalism

Let us now look at the model that Stacey called the "new professionalism".[19] Starting from the principle of patient autonomy, it unifies the profession around the basic duties and responsibilities of a doctor, agreed between the profession and the public and spelled out in the GMC's *Good medical practice*.[20] To ensure compliance, the standards described in *Good medical practice* have been tied to doctors' licence to practise. The licence therefore becomes the basis of the professional contract between patients and their doctors, in which doctors' obligations to practice go with the rights and privileges of GMC licensure.

We are now at the stage where that fact needs to be fully digested, understood and acted upon by every doctor who wants to practise in the UK.

To further this, *Good medical practice* is being embedded in the training of doctors, as it is largely through medical education that real cultural change will be achieved. In addition, it is being incorporated into clinical governance through doctors' contracts of employment.

**2 Good medical practice[20]**

This is the core statement from the General Medical Council on the duties and responsibilities of doctors. It describes the principles of good medical practice and the standards of competence, care and conduct expected of doctors. These fall under seven main headings: good clinical care; maintaining good medical practice; teaching and training; relationships with patients; working with colleagues; probity; and health.

Serious or persistent failure to meet these standards may put a doctor's registration at risk. Each medical Royal College and Faculty has produced a version tailored to its own specialty.

*Good medical practice* is applicable to all medical training and continuing professional development. From 2005, when licences to practise and revalidation are introduced, all assessments of evidence of doctors' competence and performance will be made using the principles.

*Good medical practice* also outlines 14 duties of a doctor, which are increasingly used by medical schools at graduation as the modern rite of passage into the profession. Examples include:

- Make the care of your patient your first concern
- Respect patients' dignity and privacy
- Give patients information in a way they can understand
- Keep your professional knowledge and skills up to date
- Recognise the limits of your professional competence
- Be honest and trustworthy
- Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise.

The model has inherent flexibility. It is dynamic, able to adjust to changing societal expectations of doctors and to changes in practice brought about by advances in medical science and information technology. It is capable of being applied in any foreseeable working environment.

## Rethinking professional governance

The ultimate responsibility for defining and enforcing professional standards now lies unambiguously with the GMC, the statutory licensing authority. But it cannot do this alone. It has to have partners. Within the profession, these are primarily the Royal Colleges and Faculties, the specialist societies and the medical schools. Alongside this alliance of standard-setters, teachers and researchers are the employers, the patient organisations, the sister health professions, and the other healthcare regulators. There are also organisations such as the Picker Institute Europe, an independent charity which measures patients' experience of healthcare, and Dr Foster, a private company which specialises in patient-friendly presentation of mortality data and information about doctors and hospitals through the *Good hospital guide* (published annually through a national newspaper).

Creating an effective partnership is therefore vital. It demands institutional cooperation and coordination on a scale and of a sophistication never before attempted. It requires visionary leadership and a willingness on the part of individual players to work for the greater good. The complex nature of the task demands a redesign of institutional professional governance. If we were in business, we would be surgical and bold, as we would recognise that our 19th-century structures could not possibly cope with 21st-century functions. It would help if we stopped thinking of medicine as an ancient profession, and started to think of it as a modern, complex system. We would redesign for optimal function.

Given this, I think the functional case for an overarching collegiate body for British medicine is now compelling. The idea has been floated before, but always in representational terms. But now the standard-setters have to confront their collective duty to ensure that the medical profession not only works properly, but also is leading edge. This is the only sure way of seeing that the profession can move forward and engage with the public around a common purpose. Partly it is about leadership, partly about developing policy clout. We need to create our policy equivalent of the US Institute of Medicine.

To this end, there is a strong case for a much clearer separation between the standards arm of the profession — the GMC, the Royal Colleges and specialist societies, the universities and the Academy of Medical Sciences, all of which have well-defined responsibilities for delivering high-quality professionalism — and professional bodies such as the BMA, which are essentially representative. That separation would make it less likely that any compromises on standards could be concealed. It would contribute to transparency.

One way of strengthening the standards arm would be to rebuild the Royal Society of Medicine as the overarching body, making all the existing professional institutions with standards responsibilities corporate stakeholders. It would be a radical step that would demonstrate the seriousness of our commitment to patient-centred medicine. But there will be other ideas for achieving the same end. The Picker Institute Europe and The King's Fund, an independent health think-tank, are exploring some of these with professional leaders and opinion formers. One thing is clear: the status quo is not a viable option. It is decision time.

## Defining acceptable and unacceptable practice

Since *Good medical practice* was published in 1995, the profession's thinking about patient-centred medicine has progressed. Now the GMC and the Royal Colleges need to broaden the consensus on which these standards rest. Our North American colleagues, following a similar path, are going to great lengths to secure consensus between doctors and members of the public.[21]

Furthermore, we need to establish a broader consensus around serious breaches of the professional code that could result in removal from the profession. There may be important differences between the doctors and the public. For example, are doctors who lie about their practice, or who abuse their patients sexually, fit to be in the profession? Exploring issues of trust such as these in a very public way — including using radio and television, as well as the more usual focus groups and surveys — could help to establish where society stands. That would help doctors to know the boundaries, and disciplinary committees and the courts to have a better feel for the appropriate sanctions.

Finally, the trustworthiness of the profession could be strengthened even further if the institutional standard-setters were to give leadership on values important to the public and the furthering of good practice. For example, they could show all doctors that the routine external scrutiny of clinical decision-making accords with the openness of science and scholarship. Similarly, their public commitment to transparency could help transform doctors' attitudes to the publication of information about professional performance. Matters that should remain confidential would then

have to be justified. Examples such as these would be powerful indicators of changing attitudes.[22]

## Clinical governance

Clinical governance is important as the missing piece in the local arrangements for managing clinical quality. The nub lies in the acceptance by clinical teams of their collective responsibility for their professional conduct and performance, and their ability and willingness to give effect to that through internal quality assurance.

We need to sharpen the focus on this. Many teams are still struggling both with the concepts and the practicalities, and need help. It is up to the standard-setters and employers together to make clinical governance work properly at the team level. It requires the investment of time, money, expertise and effort. The more thorough the processes, and the better the quality of performance data, then the lighter the touch needed for external review, especially revalidation. We need to keep reminding ourselves of this.

Accreditation of hospital clinical units and general practices would help, because it would require standards to be set for clinical teams. That, rather than star ratings for hospitals, would make more sense to patients, because it would indicate institutional quality at the point where it matters to them.

## Revalidation

Clinical governance leads us naturally to revalidation. Clinical governance is about teams, while revalidation is about individuals. The starting point for revalidation is the patients, who are entitled to expect their doctors to be competent, up to date, ethical and in all other respects fit to practise. Revalidation is the process through which doctors demonstrate that fitness on a regular basis. In addition to demonstrating good practice, revalidation will help identify suboptimal and poor practice requiring further action. The areas to be covered by revalidation and its basic standards are set out in *Good medical practice* and the more detailed elaborations published by the Royal Colleges. The Colleges also indicate acceptable and unacceptable practice. The task now is to concentrate on the detailed criteria, standards and evidence illustrating competence and performance, especially on the technical aspects of medicine.

But revalidation had another purpose — it was intended to be a prime driver of quality improvement and quality assurance. It would reinforce local management processes that were predicted to be highly variable and subject to immediate pressures created by operational demands. There is a danger that this original objective may be lost in the working of the revalidation processes themselves.

The evidence demonstrating compliance with the standards accepted and agreed by the profession and the public from time to time is at the heart of revalidation. For the vast majority of doctors who are in employment — mainly in the NHS — we decided early on that the evidence for such compliance should be drawn, where possible, from clinical governance. That evidence would be rigorously reviewed at the annual appraisal, and every 5 years the GMC would decide whether to revalidate, taking account of the totality of the evidence and any comment made on it during appraisal.

Given this, the GMC needs to give doctors clear guidance on the nature, quality and standard of the evidence, and the standard of practice that it is prepared to accept for revalidation. The evidence has to fully represent a doctor's practice, not simply the elements the doctor chooses to present.

Evidence from appraisal was originally intended to be merely one part of revalidation, not the main driver. Appraisal can be both formative and/or an assessment. Both purposes are equally valid, and both are desirable, but they cannot be used together effectively on the same occasion. They need to be separated, so that both appraiser and appraised are clear about the aim of the process. Revalidation is unequivocally about assessment.

Moreover, appraisal needs to be professionalised. We take great care with the selection and training of the doctors we choose as teachers. Why is the NHS not taking the same care in choosing and training doctors who will have such an important role in regulation? The training varies greatly in length and quality. The credentials of appraisers should be impeccable. How else will anyone have confidence in the system?

And, finally, Sullivan has written about the civic duty of the medical profession to contribute to the development of health and healthcare in local communities and nationally.[23] The idea cannot be considered in abstract. The value and acceptability of this broader contribution will be directly proportional to the public's perception of the trustworthiness of the profession. That is the starting point. That is the importance of true professionalism.

## Competing interests

None identified.

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