Professionalism: what it means to doctors today

Current political, institutional and societal expectations have challenged the meaning of medical professionalism. This article summarizes the debates concerning what constitutes medical professionalism, how professionalism develops in doctors and the critical importance of professionalism within good medical practice.

'The practice of medicine is distinguished by the need for judgement in the face of uncertainty. Doctors take responsibility for these judgements and their consequences. A doctor's up-to-date knowledge and skill provide the explicit scientific and often tacit experiential basis for such judgements. But because so much of medicine's unpredictability calls for wisdom as well as technical ability, doctors are vulnerable to the charge that their decisions are neither transparent nor accountable. In an age where deference is dead and league tables are the norm, doctors must be clearer about what they do, and how and why they do it.' (Royal College of Physicians, 2005)

The above sentiments are key to furthering doctors' understanding of medical professionalism and the central role of the General Medical Council's (2006) *Good Medical Practice*. Maintaining a pivotal and trusting doctor–patient relationship is paramount if the standards of medical care are to be upheld in today's changing health-care systems.

The nature of the doctor's role is being questioned, and the consensus statement from the Medical Schools Council (2008) helpfully summarized what leading doctors consider the role of a doctor in today's society should encompass. The political and societal changes that have stimulated this debate on the role of today's doctor have encouraged an equally reflective examination of what it means for doctors to emanate the qualities of professionalism within their daily working lives.

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Medical knowledge and technical advances have ensured that current medical practice is radically different compared to even 5 years ago. Many of the traditionally held responsibilities of doctors are delivered by other health-care professionals, bringing both benefits and new tensions in multi-professional working. The need for doctors to work within teams has long been established but highlighting what only doctors can bring to multidisciplinary patient care has not been clearly articulated (British Medical Association, 2008). If it is, as stated in the Medical Schools Council (2008) consensus statement, that only doctors can regularly take ultimate responsibility for clinical decisions, then this shared opinion among senior doctors has several implications for the demonstrable professionalism of all doctors.

Furthermore today, doctors not only question what their current role in health care is but many also appear disempowered and dissatisfied with their profession. While changes to contracts, restrictions on working hours, introduction of shift working patterns and the loss of 'firm teams' may have radically changed the working environment for hospital doctors, doctors themselves have also changed with many expressing concern that such high professional expectations are not compatible with a life outside of work or family commitments (Royal College of Physicians, 2005).

In addition cases such as the increased mortality rates following paediatric heart surgery at Bristol highlight the necessary accountability of the medical profession and also draw into question the appropriateness of the profession's self-regulation (Ham and Alberti, 2002). Medical responsibility for individual patient care while balancing the medical needs of society as a whole is a highly controversial area. It highlights how the doctor's evolving role needs to also reflect an enhanced emphasis on medical management and clinical leadership as essential components of professionalism (Levenson et al, 2008).

Therefore, medical professionalism has been challenged and doctors are being asked to justify their responsible but privileged position. There follows a more detailed discussion of what defines medical professionalism, how it develops in doctors and its central role in good medical practice, highlighting the importance of medical management and leadership.

Defining medical professionalism

James Spence, in 1960, wrote:

'The purpose of the consultation is not the diagnosis or technical treatment of disease, it is the explanation and advice, with the diagnosis acting as a means to these ends.'

This article seeks to clarify whether these sentiments remain true today. However, first we need to examine what the term profession means before we can explore its defining components. Cruess et al (2004) have defined the term profession as:

'An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.'

Although applicable to all professions, this definition encompasses the core values required by doctors in demonstrating medical professionalism. Medical professionalism is a multidimensional concept depending on the perspective and demands placed on the profession by patients, health-care professionals, society and self (Van de Camp et al, 2004). Freidson (1994) identified autonomy as the characteristic central to professionalism, in that a profession is given the right to control its own work by determining who can do the work and how the work should be done.

The components contributing to professionalism, by their nature, are broad and subject to interpretation thus challenging the medical profession to produce a consistent definition. There have been many efforts to define professionalism in medicine. European and American organizations established the 'Physician's Charter' with professional responsibilities and principles that demonstrated professionalism in medicine (Medical Professionalism Project, 2002). In the UK, the General Medical Council (2006) has clearly articulated the key principles of professionalism in *Good Medical Practice*, which summarizes the duties of a doctor as a professional in the following specific areas:

- Good clinical care
- Maintaining good medical practice
- Teaching and training, appraising and assessing
- Relationships with patients
- Working with colleagues
- Probity
- Personal health (General Medical Council, 2006).

A 'normative' definition allows a common dialogue, understanding of what is expected and assessment of what it means to be a professional as a doctor (Swick, 2000; Jha et al, 2007). There are many definitions of professionalism in medicine which vary according to the understanding and experience of the individual. In the USA, Swick (2000) defines medical professionalism as comprising of core humanistic values, subordination of own interests, adherence to high ethical standards, a commitment to excellence, the development of self-reflection, accountability and a social contract responding to society's needs.

Hilton (2004) described a most helpful UK model which introduces six domains to professionalism. These can be divided into personal (ethical practice, reflection and responsibility or accountability) and cooperative attributes (respect for patients, teamwork and a social responsibility).

The Royal College of Physicians (2005) convened a working party to explore professionalism in modern society and defined professionalism as 'a set of values, behaviours and relationships that underpins the trust the public has in doctors'. This is one of the simplest definitions of medical professionalism but attempts to describe what is at the heart of being a good doctor.

It is important that a shared understanding of what professionalism means exists both between society and the profession and across all levels of doctors. This article aims to facilitate the continuing conceptualization of medical professionalism. This is essential not only for good patient care but also for doctors' own professional development and continuing revalidation.

Developing professionalism

Identifying the underpinning processes of medical professionalism contributes to a shared understanding of what constitutes professionalism for doctors in training and their educators. Unfortunately because of a lack of transparency in everyday medical practices the tacit components of professionalism in action are often not fully considered by educators or doctors themselves. Fish and de Cossart (2006) say that:

'The challenge of the complexity of practice is what doctors and surgeons value and thrive on; and such thriving drives, and is vital for, good patient care.'

They also go on to highlight that 'making explicit the elements of doctors' practice that lie beneath their observable performance is vital if that practice is to be developed' (Fish and de Cossart, 2006).

Educators must clarify which essential components of a doctor's practice, that are not easily observed or assessed, significantly contribute to medical professionalism. The Medical Schools Council (2008) consensus statement reinforces fostering the development of appropriate professional judgment in doctors throughout their careers, starting from their undergraduate training. It is how professional judgment develops and is enacted that the authors believe Fish and de Cossart (2006) are referring to when they talk about the 'real character of professionalism' and the 'artistry of practice'.

Similarly Hilton and Slotnick (2005) and Eraut (2004) discuss the 'practical wisdom' shown by mature professionals in addition to their specialized knowledge and technical skills. This practical wisdom or phronesis is central to medical professionalism and facilitates critical decision making amid the uncertainty and complexity often found in clinical practice.

It is questionable whether current assessment strategies used during the foundation years can fully elicit these underlying elements of professionalism (Postgraduate Medical Education and Training Board, 2008). Fish and de Cossart (2006) claim that what is in fact a rather superficial 'tick box' approach to assessing professionalism cannot facilitate the development of the underpinning qualities required for developing professionalism.

Following on from this both educators and the senior doctors who evaluate the performance of doctors in training must consider further methods for effectively teaching and assessing professionalism that do not overlook the depth and detail of the tacit aspects of clinical thinking thought to be so essential in clinical teaching, learning and good medical practice.

Proto-professionalism

Hilton and Slotnick's (2005) model of proto-professionalism has been advocated to foster professionalism across the continuum of medical education.

This model, alongside other models of developing professionalism within doctors in training, emphasizes the importance of the individual learning doctor's reflections on his or her clinical experiences (Steinert et al, 2005). Phronesis in this context is derived from the insights and growing tacit knowledge gained from complex and often ambiguous clinical experiences. However, Hilton and Slotnick (2005) firmly believe that this practical wisdom can only be gained by active reflection on the professional's experiences.

'Phronesis arises from 2 components – experience and reflection on experience – interacting with the professional's evolving knowledge and skills base. Professionalism is thus a state reached only after a prolonged period of learning,

instruction and reflective experience. The period leading up to this as one of proto-professionalism.' (Hilton and Slotnick, 2005)

What do medical educators need to do to facilitate proto-professionalism and hence the development of practical wisdom? Hilton and Slotnick (2005) describe how the knowledge and skills gained from learning and experience and the phronesis arising from reflection on that experience are responsible for the doctor in training's developing professional identity. They see mature professionalism as a product of two simultaneous processes: attainment and attrition occurring during proto-professionalism. *Figure 1* shows how a naïve new medical student progresses through the curriculum attaining not only the skills and knowledge required to practice independently but also by virtue of positive aspects from the curriculum, such as clinical experience, the prerequisites for phronesis.

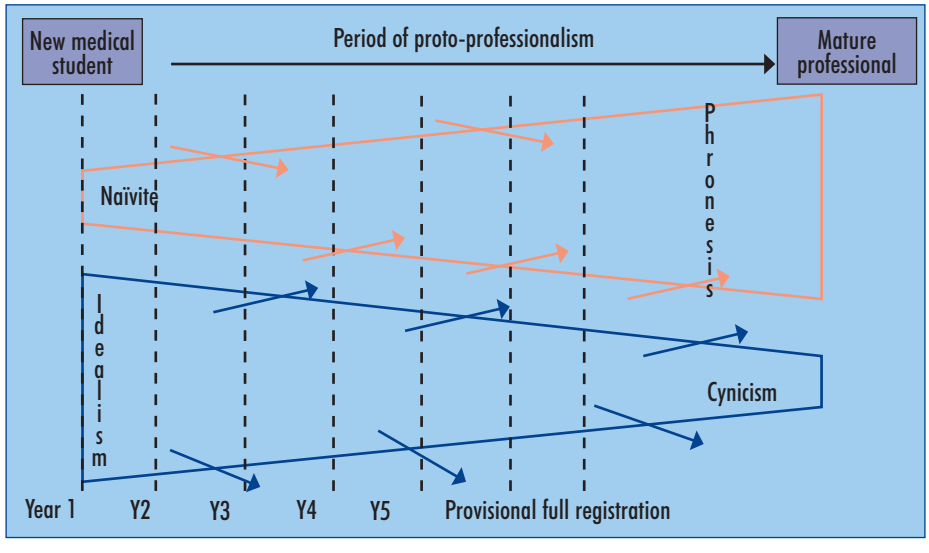
Conversely attrition, the loss of positive attributes which are often replaced by less desirable characteristics, such as taking short cuts and patient insensitivity, may result from inappropriate role-modelling and negative experiences within the hidden curriculum (Hafferty, 2003). This is further stressed by Archer et al (2008b) who concur that to teach professionalism successfully an agreed definition is required and that the integration of professional behaviours into practice can be problematic when the hidden curriculum provides a conflicting message to the development of positive attributes.

Medical educators need to emphasize curricular opportunities for attainment and minimize inappropriate attrition of the prerequisite underpinning qualities in proto-professionalism that lead to the full development of professionalism. Hilton and Slotnick state that this requires explicit learning opportunities, a long-term combination of experience and reflection on experience, with specific attention paid to their six domains of professionalism. Appropriate role-modelling showing successful practical wisdom in authentic medical practice and the appropriate assessment of such activities are essential. Such behaviour does not necessarily come naturally from medical teachers and all good teachers will need staff development to be able to fully meet these taxing teaching objectives, as explained by Steinert et al (2005):

'Faculty must now be able to teach professionalism explicitly by articulating its core concepts and demonstrating appropriate behaviours. This requires that faculty development should start with a cognitive base that includes the definition of professionalism, its historical roots, its relationship to the ever-changing social contract between medicine and society, and the obligations necessary to sustain professional status.'

They go on to say that activities that promote self-reflection, awareness and the ability to cope with change must be highlighted. The authors would include both undergraduate and postgraduate curricula in this. Alongside the other core clinical competencies professionalism needs to be effectively assessed, otherwise its value is questioned both by the doctors asked to demonstrate its components and by the institutions required to role-model, teach and assess it.

Figure 1. Proto-professionalism: a model to describe influences on development of professionalism from medical student to mature professional (Hilton and Southgate, 2007).



Demonstrating professionalism

Concerns have been raised about the appropriateness of the methods currently used to assess professionalism, both at undergraduate and postgraduate levels. These are particularly important as UK revalidation plans to focus on explicit outcomes that relate to professionalism (Shaw and Armitage, 2007; General Medical Council, 2009).

Evidence for measures that have been used to assess appropriate professional attitudes and the psychometric rigour of these measures has been summarized by Jha et al (2007). They found little evidence that reported measures are effective in assessing professional attitudes in medicine as a whole. Not only has the validity and reliability of these assessments been questioned but also the potential damage that may be caused to the actual development of professional attributes by applying inappropriate assessments has been highlighted (Arnold, 2002; Arnold and Stern, 2005). If medical professionalism is core to clinical competency then effective assessment strategies are required. Clearly more research and development is required in this area.

No single reliable and valid assessment tool is available to appraise the professional behaviour of medical students and doctors. There is also confusion over whether professionalism should be viewed and assessed as part of clinical performance, or as a specific competency domain by itself, or even as individual traits, such as humanism, self-assessment, dutifulness, altruism, empathy and compassion, integrity, and ethical behaviour, as well as communication (Arnold, 2002). Peer assessment, previously having shown both reliability and validity in assessing clinical competencies, may increasingly come to play a significant role in this domain (Dannefer et al, 2005).

Peer assessment is carried out by 'individuals who have attained the same general level of training or expertise, exercise no formal authority over each other, and share the same hierarchic status in an institution' (Arnold and Stern, 2005). Commonly peer

assessment uses rating tools which have been designed to identify the hard-to-measure characteristics or individual traits that make up professionalism (Ramsey and Wenrich, 1999). Ramsey et al (1993) found that peer assessment is a reliable and valid method for assessing their two dimensions of clinical performance: cognitive or clinical management and the humanistic or psychosocial dimension.

Subsequent work has highlighted a variety of concerns when using peer assessment such as the reluctance of some peer assessors to take part, either because lack of confidence in the assessment tools or concerns about confidentiality. These concerns can be reduced by peer assessor training and adequate briefing (Arnold et al, 2005). The benefits of using peers to assess professionalism alongside more traditional methods increases the likelihood that authentic behaviours will be observed because peers spend more time with each other, and are in a good position to give appropriate feedback (Dannefer et al, 2005). This kind of personal relevant feedback is important in developing self reflection which is essential to both the development and maintenance of a doctor's professionalism.

In the UK, current undergraduate programmes, the foundation years' curricula, continuing professional development and the appraisal system all feature domains of *Good Medical Practice*. The Postgraduate Medical Education and Training Board (2008) and General Medical Council (2006) consider peer ratings as suitable for postgraduate assessment and revalidation.

An example of this is the mini-PAT (peer assessment tool) which plays a significant role in the assessment of foundation year doctors alongside other assessment tools. Mini-PAT was modified from SPRAT (Sheffield Peer Review Assessment Tool), which used multisource feedback (360°) to assess senior doctors. The mini-PAT reflects the domains of the Modernising Medical Careers curriculum and provides feedback from a range of doctors, nurses and related health-care professionals concerning the attributes outlined in *Good Medical Practice*. This does not follow the strict definition of peer as outlined above but, as part of an assessment programme, mini-PAT provides a valid way of collating colleagues' opinions to facilitate reliable assessment of foundation year doctors (Archer et al, 2008a).

Revalidation aims to ensure that doctors are fit to practise through regular review of their work by peers and members of the public (Irvine, 2001). The concept of revalidation moves the profession away from autonomy and self-regulation over its professionalism, to a position of greater accountability and transparency. This reflects a significant change in what society expects from the medical profession as outlined in *Good Doctors, Safer Patients* (Chief Medical Officer, 2006) and the subsequent White Paper (Department of Health, 2007). As Shaw and Armitage (2007) point out the principles of *Good Medical Practice* became the foundation for annual appraisal, and revalidation builds on these systematic processes for assuring quality of care. The challenge lies in ensuring that these professional attributes are attained as part of integrated personal and professional development and not simply viewed as a checklist of values and behaviours.

Highlighting neglected aspects of medical professionalism

The importance of medical management and leadership are overlooked. Fortunately both the Royal College Physicians (2005) report and the Kings Fund collaboration with the Royal College Physicians (Levenson et al, 2008) highlight the importance of both in today's medical arena.

Within health services medical management and leadership are terms that are sometimes mixed up but the above articles, which discuss at length the views of doctors and others concerning medical professionalism, indicate that there is a clear difference but that both attributes are required in medical professionalism. Management is concerned with processes and quality assurance whereas leadership relates to outlining a strategy to take the medical profession forwards and representing the profession.

Modern medicine desperately needs doctors who can contribute to management and lead. While only a minority of doctors play a significant role in either management or leadership all doctors need a basic understanding of the principles and, more importantly, need to know how to work appropriately alongside those that do take on the more extensive roles. The Royal College of Physicians (2005) says:

'Professionalism therefore implies multiple commitments – to the patient, to fellow professionals, and to the institution or system within which healthcare is provided, to the extent that the system supports patients collectively. A doctor's corporate responsibility, shared as it is with managers and others, is a frequently neglected aspect of modern practice.'

Clinically trained managers have a unique and valuable contribution to make in discussions about resources, team working and priorities in providing good patient care. Most decisions made by doctors about patient care have both clinical and managerial components. It is therefore key for the ongoing professionalism of today's doctors to fully engage with the introduction of systems to monitor the quality of patient care and influence the accountability of the medical profession in providing that care. This requires training and many doctors are calling for the introduction of management and leadership skills as part of both undergraduate and postgraduate training (British Association of Medical Managers and the British Medical Association, 2007). The dual participation in clinical and managerial roles is an important aspect of a doctor's professionalism and new ways should be investigated that foster clinicians spending time in management.

Similarly, the Modernising Medical Careers Inquiry, *Aspiring to Excellence*, led by Professor Sir John Tooke (2008), called for greater attention to both the management and leadership skills training of all doctors as they frequently lead health-care teams and are largely responsible for significant resources.

The Modernising Medical Careers Inquiry was influential in the instigation of the Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2009), which describes an effective model of medical leadership that can be used to develop both undergraduate and postgraduate training, with the overall intention of improving the delivery of health services and patient care. The framework identifies five domains, each with stated competencies, which outline the characteristics of an effective medical leader working in today's health-care services. The competencies set out the desired requirements of both developing and mature medical leaders depending on their chosen career pathway

and stage. These provide an ideal basis for developing an effective assessment strategy examining the management and leadership skills needed by practising doctors.

Conclusions

The professionalism of doctors has been challenged. Society has demanded that doctors become more transparent and accountable for their actions. While medical professionalism remains at the heart of good medical practice, developing a shared understanding of what today's medical professionalism means is paramount if therapeutic relationships between patients and their doctors are to be maintained. Similarly the introduction of management and leadership training, neglected areas of professionalism, are vital in ensuring the standards of medical care are upheld in today's changing health-care systems. Professional judgment and the practical wisdom of mature doctors are the key characteristics of professionalism in action. A far better understanding of how professionalism develops within doctors, its facilitation and valid assessment is required if medical professionalism is to become the cornerstone of revalidation. **BJHM**

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KEY POINTS

- Professionalism in medicine is pivotal to the doctor–patient relationship and is 'a set of values, behaviours and relationships that underpins the trust the public has in doctors'.
- It is essential to identify and appropriately assess those components of a doctor's practice that significantly contribute to medical professionalism.
- At the heart of good medical practice lies complex decision making, sound professional judgment and actions depicted by the 'practical wisdom' of mature professional doctors.
- Medical educators need to emphasize curricular opportunities for attainment and minimize inappropriate attrition of the prerequisite underpinning qualities in professionalism, a process which requires explicit learning opportunities and a long-term combination of experience and reflection on experience.
- The concept of revalidation moves the profession away from autonomy and self-regulation over its professionalism, to a position of greater accountability and transparency.
- The doctor's evolving role needs to also reflect an enhanced emphasis on medical management and clinical leadership as essential components of professionalism.