

New ideas about medical professionalism

Public trust depends on promoting good practice and protecting the public from poor practice

Traditional medical professionalism derives from medical practice in the late 18th and early 19th centuries. In the past 10 years, the search has been on in the United Kingdom — and in other countries — for a “new professionalism” more in harmony with patients’ expectations and the nature of medical practice today.¹⁻⁵ Last month, the Royal College of Physicians of London affirmed its commitment to professionalism as the foundation of good quality medical practice through a Working Party report titled “Doctors in society: medical professionalism in a changing world”.⁶ That commitment is important, and has relevance beyond the UK. It comes at a time when some consider the very notion of “profession” and “professionalism” to be outmoded. The report and a supplement of excellent evidence⁷ (underpinning the report) is seen as the starting point for further development.

The case for rethinking medical professionalism is presented with conviction and passion. Located in the social context and environment of today’s practice, medical professionalism is defined as a “set of values, behaviours, and relationships that underpin the trust the public has in doctors”.⁶ Medicine is described as a “vocation in which a doctor’s knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability”.⁶ In their everyday practice, doctors are committed to integrity, compassion, altruism, continuous improvement, excellence and partnership in health care teams. These values should form the basis for a new “moral contract” between the medical profession and society.

Professionalism, the report argues, is as important as ever today because it codifies the idea that a doctor’s responsibilities go beyond a “mere” contract of employment. It advocates a concept that “recognises the complexity and uncertainties within clinical practice and which is based on an indissoluble partnership between patient and doctor in a radically new social context”.⁶ To this end, notions of knowledge, skills, science, practice, profession, society, service, commitment and integrity are retained. The report discards notions of “mastery”, “autonomy”, “privilege”, and “self-regulation” as out-dated or inappropriate. Competence, which describes “mere” capability, is replaced by excellence reflecting abilities of an “eminent” degree. The long tradition of the “art” of medicine yields to “judgement” as a characteristic more in tune with the application of clinical reasoning. Altruism and the idea of vocation are still there, but only just. And accountability is valued provided that it is “appropriate”, that it avoids creating a culture of suspicion and blame. All these ideas, some deeply controversial, will give doctors and the public much food for thought.

So far so good. Then we come to the implications and 19 recommendations for implementation. These cover six areas: leadership, teams, education, appraisal, careers, and research. Professional bodies in the UK are urged to create a common forum that would speak on behalf of medicine with a unified voice. The proposals are sensible but lack bite. They are full of gentle, permissive words like “review”, “revise” and “consider”. Moreover, the report shies away from areas where tough decisions are needed if public trust in the institutions of the UK medical profession is to be restored.⁸ For example, it is tentative about the profession’s responsibility for defining the boundaries of medical practice and

the standards, both the acceptable and the unacceptable, which it will expect individual doctors to observe consistently. In rejecting self-regulation — without discussion — it says nothing about the regulatory framework within which the profession and its professionalism must function. Revalidation, the most important recent development in medical regulation likely to improve patient safety if done thoroughly, is scarcely mentioned. Similarly, there is nothing about the role of rigorous peer review in quality assurance of doctors' professionalism. This may be no accident. The authors say that they are attempting to usher in a major philosophical shift in attitudes to medical practice in the UK. They believe that the regulatory pendulum has swung too far towards a new, rule-based orthodoxy in which good standards of medical practice are a matter of rigorously enforced dutiful conduct. They seek to revert to a "more balanced position" where there is an understanding that an environment that encourages a doctor's "goodness" is one that will promote positive patient outcomes.

This is a false dichotomy. Modern professionalism is about both the encouragement and celebration of good practice and the protection of patients and the public from suboptimal practice. They are one of a piece — indivisible. Public trust is dependent on both. Achieving that will require some hard, creative thinking and courageous leadership by doctors' organisations if professionalism, medical education and professional regulation are to put — and be seen to put — the interests of patients unequivocally first.^{8,9} The College has made a good start. However, fine words are no substitute for a track record of decisive action. The General Medical Council has had to learn that the hard way.¹⁰

Dame Janet Smith, who conducted the Shipman Inquiry,¹⁰ said to the Working Party that the public ought not even have to think

about whether they trust their doctors — it should be something they are able to take completely for granted. Quite so. Everyone expects to have a good doctor.

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