Examining professionalism
BMA discussion paper and member consultation
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Summary
The Francis report makes it clear that medical professionalism is at a critical juncture. Core medical values – values that underpin the trust patients and society have in doctors – are under intense pressure. For complex reasons patients’ needs can get overlooked in modern health systems. The failings at Mid Staffordshire and in other NHS organisations across the country reinforce and encourage a stronger medical professionalism. The future of good patient care, and of the profession itself, depends upon finding ways to configure health systems to enable professional values to flourish. The medical profession needs to reflect on its role in those systems, and decide how its approach to professionalism should respond to the challenges of the Francis report and of modern day practice in the NHS. The NHS requires a strengthened medical professionalism now more than ever.

The following discussion paper reviews the problems and challenges for doctors in this area, and poses thought-provoking questions throughout. Members’ responses to these will help inform forthcoming BMA recommendations for change. Your views are essential, and we would urge you respond to the questions via our website as fully as you can. http://bma.org.uk/working-for-change/the-changing-nhs/nhs-culture

Introduction
The report of the Francis Inquiry into the failings at Mid Staffordshire NHS Foundation Trust shook the medical profession. Not just because of the terrible problems that were uncovered, but in calling into question the ability of doctors to implement in today’s NHS the professional values that underpin medicine. Why were vulnerable patients, who were looked after in a sophisticated modern health service, subject to appalling and unnecessary suffering? Why did highly qualified health professionals fail to properly exercise their fundamental duty of care? Why were the basic human needs of patients – for water and food, for cleanliness and dignity – allowed, on some wards, to be forgotten? In short, why were people, during some of the most vulnerable times of their lives, so badly let down by a system designed to care for them?

Finding answers to these questions has been high on everyone’s agenda. NHS organisational leaders, clinical staff and managers at all levels, continue to reflect on them, recognising that many of the problems were not exclusive to Mid Staffordshire and can be found throughout the NHS and elsewhere in the UK’s health sector.

Modern NHS care is complex – for many patients, and even some professionals, impenetrably so – and under extreme pressure. The demand for services outpaces resources, giving rise to calls for greater efficiency. The NHS is always a significant electoral issue, so political pressure on the service is intense and restructuring (itself highly politically contentious) is a permanent condition. Responses to Francis recognise that there are no easy answers, and often have a lot to say about how to improve structures and systems, how to improve monitoring, regulation and oversight. Necessary as they are, systems alone do not make for excellence in the provision of health care. Excellence also requires skilled and dedicated health professionals: it needs, in short, the highest standards of medical professionalism.

In this paper we explore the concept of medical professionalism in reviewing the failures at Mid Staffordshire and consider what part it can play when properly strengthened both in the response to the Francis Inquiry and in building health services that are consistently focussed on the needs of patients. Essentially, what can doctors as professionals contribute to the development of an open and honest culture in the NHS, and what role should the BMA, as their representative body, play in equipping them to restate their professional values? How can the BMA help to support doctors to ensure these values are upheld throughout their clinical practice? Your answers to the questions posed in this paper will shape the BMA’s forthcoming recommendations on professionalism.
Defining professionalism

Firstly, what do we mean by medical professionalism?

Medical professionalism is central to the relationship of trust between patients and doctors. In its 2005 report *Doctors in Society* the Royal College of Physicians (RCP) defines medical professionalism as:

*A set of values, behaviours, and relationships that underpins the trust the public has in doctors.*

The RCP then goes on to describe what 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.*

It then lists those values necessary to realising this purpose:

*integrity, compassion, altruism, continuous improvement, excellence and working in partnership.*

For the RCP, these values ‘form the basis of a moral contract between the medical profession and society.’ This can be summarised as:

*Medical professionalism signifies those values, principles and standards of behaviour that are essential to the realisation of the proper purposes of medicine.*

Medical professionalism refers therefore to that set of values and principles that guide the actions of doctors as they seek to deliver the best available health care to patients.

In turn these values are given concrete expression by the General Medical Council. In the ‘professionalism in action’ section of the new Good Medical Practice the GMC states:

*Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
Barriers to professionalism

In complex health systems, personal and professional values, though essential, are not by themselves sufficient to ensure high-quality patient-centred care. As Mid Staffordshire made clear, the environments in which doctors work are also critical. Environments include, of course, the systems within which care is delivered: the physical environment, the working conditions, the staffing levels. But they also include the cultures within which medicine is practised.

Good health care requires both good doctors and good systems to support them. All other members of the health care team, including those in managerial or leadership roles, therefore also have a critical part to play in ensuring the highest standards of professionalism are able to flourish. Our forthcoming paper on medical management and leadership raises further discussion about the role and responsibilities of doctors as leaders and managers in the NHS.

Effect of political culture

Beyond the immediate working environment, the impacts of the broader, political culture also need to be looked at. After Francis, searching questions have been asked about the effects, both good and ill, of a target-based institutional culture on professionalism. Do targets help focus clinical judgement on patient priorities, driving up standards and ensuring proper measures are in place, so better judgements can be made about effective care? Or do they undermine clinical independence and risk dehumanising patients, turning them into numbers to be achieved and boxes to be ticked rather than seeing them as suffering people in need of care?

There is an overwhelming view from doctors who provided feedback to the BMA after the Francis report’s publication that political pressure over the years has eroded medical professionalism to ill effect. Some commentators have even argued that where once clinicians were the authority on all matters relating to patient care, now, tasked with achieving targets and adhering to protocols, they are merely minor cogs in their employer’s machine, geared towards improving their organisation’s position in performance ratings tables. Whilst there is clearly a place for standards and protocols in the NHS, the over-reliance on these measures to ensure quality has arguably weakened clinicians’ expert status and even prevented patients from being viewed as individuals. Medicine requires professional judgement in the face of irreducible uncertainty and guidelines can create a false sense of certainty. There is also a real risk that, by replacing independent clinical judgement, an excessive focus on guidelines will undermine professionalism and jeopardise those patient interests they are designed to serve. There is simply too much complexity and unpredictability in medicine to allow guidelines to be a substitute for sound professional judgement.

Our members have argued that their professionalism has been eroded through political interference including:

• The prioritisation of financial targets over those governing quality of care;
• The setting of targets with little clinical relevance or necessity;
• The constant restructuring of the NHS and regulatory organisations, causing confusion in accountability and responsibility;
• The perpetual under-funding of staffing costs, resulting in shortages and time pressures on clinicians;
• The failure to recognise the crucial importance for patients and for the NHS of clinicians’ continuing professional development activities;
• The focus on driving up competition between providers; and
• The wilful disenfranchising of clinicians’ views in favour of those of non-medical managers, whose numbers have increased substantially in recent decades.

Our members have commented that the time is now right for clinicians to reclaim their professionalism and reassert themselves as expert advocates for patients in the complex and fallible NHS system.
Social changes
Finally, there is the influence of wider social changes on professionalism. The doctor-patient relationship is changing. The internet offers patients instant access to the most up to date health information. The deference once traditionally owed to doctors – and to the other professions – is increasingly a thing of the past and a more consumerist mentality is making itself felt in health care. Patients increasingly expect immediate access to the highest quality care and see doctors and nurses as service providers.

We will provide further discussion on the changing doctor-patient relationship in a forthcoming discussion paper.

Q: How has your approach to professionalism been affected in recent years? Do you think professionalism is being eroded? Please give reasons for your answers.

Barriers to professionalism at a local level
Although management decisions and cultures played a critical role in the failings at Mid Staffordshire, there were several other factors that bear scrutiny, including the contribution of doctors and other healthcare professionals at the trust. Notwithstanding the fact that staff from all groups were constrained in their practice by a range of external system factors, it is important to examine how staff acted and how their professionalism was affected if we are to derive vital learning from the tragedy.

Losing sight of the patient
The primary purpose of the NHS, like the primary purpose of medicine itself, is to deliver high quality care to patients. As the NHS Constitution in England states:

The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focussed on patient experience.4

Mid Staffordshire NHS Trust and too many of the health professionals working for it incrementally lost sight of this purpose. The Board, by allowing its primary purpose to be undermined in its drive to attain Foundation Trust status, failed in its responsibility to create the conditions in which professionalism and excellent patient care could flourish. In trying to do their best for patients, doctors and others regularly found themselves in conflict with senior colleagues and with implicit management priorities that did not match their own professional ones or those of their patients. Those who made frequent attempts to raise concerns or voice objections to the Trust’s approach were intimidated, increasingly isolated and perceived as trouble-makers. Discouraged, such staff often gave up their attempts to make changes and withdrew their engagement or left the Trust’s employment altogether. Individual failures by health professionals became absorbed in a general culture of neglect and the patient experience almost became a peripheral concern.
Trust’s focus on the wrong priorities

If the first step towards losing sight of patients was the substitution of patient interests for the organisation’s own managerial and financial priorities, a second lay in the lack of response to warning signs. Not only did patients cease to be priorities, evidence that they may be at risk of actual harm was systematically marginalised and downgraded. Professionalism requires critical vigilance, and potential sources of harm to patients have to be as rigorously assessed as potential benefits. The single-minded focus on financial targets and Foundation Trust status at Mid-Staffordshire first undermined professionalism, then effectively sealed management and professionals from evidence of the damage it was doing.\(^5\) Even clinical targets, when not implemented properly can cause similar problems. Developed with the best of intentions, clinical targets and protocols can have unintended consequences. With improved clinical involvement, such problems can be anticipated and a strategy implemented to avoid them.

Medical professionalism primarily looks outward to patient care, but in some respects it also looks inward, to what motivates doctors, what drives them and what rewards them. For many if not most doctors, medicine remains more than a job. For many it is a vocation. A decision to be a doctor is not just a decision about a career, it is also a decision to be a certain kind of person: one highly skilled in the relief of human suffering. The successful relief of such suffering provides some of the most significant of medicine’s internal rewards. Where the care environment is driven by priorities other than excellence in the treatment of patients, the ability of health professionals to realise these internal rewards can sometimes be frustrated. Ongoing and systemic frustration of this kind, where doctors simply cannot bring the ordinary benefits of care to patients, detachment, and, in the extreme, even cynicism can set in. Francis called this process ‘professional disengagement.’\(^6\)

Q: Do you think incentives can skew systems to unhelpful priorities? Does this impact upon doctors’ motivations? How?

Professional disengagement

Why is it that some doctors and health professionals disengage from management and other collective activity within their workplace? We know that responsibility can easily get dispersed in large, complex and poorly-understood systems. We have considered the effect of perverse incentives and the usurpation of priorities. But every patient who is let down by the NHS is under the direct care of doctors and other health professionals. So why was there, as Francis puts it, a loss of individual and collective professional responsibility and engagement? Why were some doctors willing to tolerate for so long and at such cost to patients, ‘an engrained culture of tolerance of poor standards, a focus on finance and targets, denial of concerns, and an isolation from practice elsewhere?’\(^5\) Why were doctors unable to oppose poor management thinking, and unwilling to speak out? These questions may never be answered to everyone’s satisfaction, but from the BMA’s own work and from the Francis inquiry’s evidence we know that demotivation is a key factor. Where staff raise concerns but do not see any improvement or change in practice, where their opinions and warnings go unheeded or where they are excluded from decision-making, demoralisation and disengagement can easily set in. This type of incremental demotivation can in some circumstances bring about an acceptance of poor standards over time: as one consultant at Mid Staffordshire reported, he acquired a “resigned state of mind” about the concerns he tried and failed to address.

Fear is another factor that doctors report as a reason for being unwilling to challenge management decision-making: concern about bullying or other recriminations; fear of the impact on their careers, professional relationships and on their practice. Personality clashes can sometimes lead doctors to disengage, as can poor communication and internal committee structures that do not involve the most appropriate staff or that do not allow clinicians a real voice.
These factors are the product of both complex and at times dysfunctional systems and of myriad individual decisions taken by health professionals within them. They also invite another important question. If, as the RCP report suggests, clinicians are – and must be – the stewards for quality, how can their role be strengthened? How can doctors, both individually and collectively, work to promote their primary professional obligation: ensuring that the health needs of patients always come first?

Q: Do you feel your organisation encourages meaningful engagement with clinicians? If so, how? If not, what needs to change?

A small number of BMA members have contacted us cautiously welcoming the NHS Employers initiative Listening into Action, which is a programme of engagement activities aimed at “putting staff at the centre of change” in local Trusts, and led by the Trust Chief Executive. We would like to find out more of doctors’ experiences of this programme.

Q: Has your employer implemented the Listening in Action initiative? What has been your experience of the programme so far?

A modern and strengthened professionalism
We have looked at some of the changes in the NHS and society in recent years and how they have changed the way in which doctors work. We have also looked at how doctors as individuals and collectively can, on occasion, be on the periphery of decision-making within local organisations and feel unable to bring about the changes that they believe are necessary for their patients. If the medical profession is to continue as a trusted and highly valued institution charged with delivering the highest standard of care there is a challenge to be faced in adapting medical professionalism to the modern healthcare environment. So what adaptations might be necessary?

Embracing leadership and taking action
Organisational culture is often determined from the very top and there is much for the health service to learn about how the NHS leadership can show the way forward. However, doctors at every level help shape the cultures within which they work. Although many senior doctors hold formal leadership and managerial roles and are in a strong position to influence the cultures in which they work, even those without a recognised managerial role retain leadership responsibilities. From the foundation doctor nervously on-call in the hospital at night, through to the experienced GP who has relinquished formal managerial roles as she nears retirement, all doctors are leaders in the NHS (and wherever they practice) and should be expected to exert an authoritative and positive influence within their organisation, and beyond it, on behalf of their patients at all stages of their careers. If doctors can re-identify with their role as leaders and regain confidence within themselves as autonomous professionals responsible for ensuring high standards of patient care, the fear of voicing and acting on concerns about poor systems and bad decisions may dissipate. Part of the solution will be in promoting leadership as a key element early in doctors’ careers. Most medical schools’ curricula have been updated in recent years to cover managerial and leadership skills, with many students now recognising their role as leaders in the NHS of the future. Building on this in the early stages of doctors’ careers through encouragement from senior clinicians may bring about a move away from the current situation where often doctors find themselves waiting to be told by managers what changes they can and cannot attempt on behalf of patients. However, medical education and training should continue to ensure that doctors are trained to be doctors, rather than purely to fit the mould of service roles within the NHS.
Membership of the wider team

Leadership can often require different skills and calls upon different dimensions of professionalism. *Doctors in society* states: ‘A doctor’s corporate responsibility, shared as it is with managers and others, is a frequently neglected aspect of modern practice.’ Some commentators, for example Don Berwick and also The Health Foundation, have questioned whether doctors’ professionalism today should also encompass an undertaking to work within the system and in partnership with other stakeholders to best effect. If modern professionalism also involves working productively with and beyond health care teams, health professionals and their representative organisations will need to improve how they work together with managers and health service leaders. This will help in the drive to build transparent, patient-centred systems that actively seek to identify poor practice, to learn from mistakes and to forge a culture in which poor care cannot and will not be tolerated.

Without safe, well-led and well-run health systems, good patient care cannot flourish. Doctors can and should help shape these systems. They can do this formally either as leaders of clinical teams or by taking on management roles. They can also do it less formally by acting as mentors or exemplars.

Q: Would you agree that modern medical professionalism requires more than just a commitment to good therapeutic practice? Is this a positive thing? Should doctors now accept they have an element of corporate responsibility? What happens where there is conflict between the two elements?

Approaches to scrutinising doctors’ practice and performance

There have been a number of changes in recent years focused on evaluating and affirming a doctors’ fitness to practice, not least the introduction of revalidation in 2012, which aim to help to reassure the public’s confidence in the profession. However, moves to expand the level of publicly available information on clinical outcomes and individual performance has been more controversial, and with doctors being rightly cautious about how this is done. Whilst being a very complex and difficult area to solve, it is increasingly viewed as an essential part of ensuring we have a more open and transparent NHS. How the medical profession responds to these issues will be crucial.

Further discussion papers examining the changing doctor-patient relationship and the introduction of published performance measures and outcomes will be published shortly.

Moving forward: time to restate professional values

The Francis Report makes the importance of professionalism plain. Professionalism is neither a luxury nor an anachronism. Across all its dimensions it is absolutely integral to good clinical care and lies at the heart of a trusting clinical relationship. Without professionalism, patients will suffer. As the RCP makes clear:

> Professional values constitute the social capital of medicine.
> The organisational culture of health – the shared values and norms that govern patterns of behaviour in health settings – remains a neglected determinant of quality in the UK’s health system.9

In the face of ceaseless change, increasingly constrained resources and political interference, the need for doctors to restate their primary professional obligation – to put patients first – is arguably becoming more and more important. Where patient interests are usurped by institutional interests, it should be the expectation that doctors will speak out – indeed the GMC imposes an obligation on them to do so – and that they will be fully involved in plans to improve healthcare delivery locally and nationally. A modernised approach to professionalism could be the key to bringing about better engagement and a strengthened role for doctors.
But what could restating professional values look like, both individually and collectively? Examples might include:

- Developing a positive partnership with colleagues in managerial roles, both medical and non-medical, and continuing a constructive dialogue with them – making a ‘new start’ with managers if necessary
- Demanding meaningful and constructive engagement in managerial decision-making to provide the clinical perspective
- Questioning initiatives and funding decisions that do not appear to have patient care at their heart
- Using organisational and national mechanisms already available to voice concerns/ideas and act on them
- Greater participation in strategy/planning meetings
- Fostering networks with other clinicians and healthcare professionals, both internally and externally
- Prioritising CPD activities and demanding adequate time for this in job planning
- Taking the initiative to start new improvements in healthcare delivery oneself, involving other stakeholders and keeping them informed
- For trainers, underlining professional principles throughout undergraduate medical education and postgraduate training

Q: Do you think these ideas are realistic? In what other ways could doctors begin to restate their professionalism?

Thank you for responding to our consultation. Your responses will direct the BMA’s recommendations on influencing and changing NHS culture.

References

1 Unpublished feedback from BMA members following Francis report publication, February 2013