Professionalism in Medicine

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FOREWORD BY SEAN HILTON

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I dedicate this book to George for his support and encouragement during its long gestation. JT

I dedicate this book to Jessie for her company in the wee small hours. JS

Foreword

Professionalism has come to the fore as a topic in medical education only in the last 20 years. Prior to that there was little reference to it in the literature, and yet – of course – it was there; tacit, implicit, accepted by patients and professionals alike. It is interesting to chart the emergence of this aspect of medicine, which now occupies such a prominent place in undergraduate and postgraduate medical curricula.

For centuries professions have held a particular niche in society. Original professions of medicine, law and the clergy arose in the early universities and guilds, but the notion of *profession* goes back at least as far as Hippocrates. Medicine is, in part, the modern embodiment of the ancient art of healing – present since the earliest days of civilisation. The role of the doctor has continued through centuries of societal development and change and has generally brought a (sometimes undeserved) high place in society's esteem. In modern times sociologists have attacked professions as self interested and protectionist rather than altruistic, but the reputation of the doctor has been maintained and enhanced by the great advances of medical science. Most recently, however, a backlash has occurred against medicine and the powerful culture of biomedicine. This backlash incorporates, amongst other features, societal changes towards consumerism; a 'blame culture' that, in turn, generates a 'risk management' culture, and politicisation of healthcare systems fuelled by public concerns and rising costs.

As healthcare delivery has become relentlessly more complex and – in the acute sector – more pressured and high technology, doctors' professionalism has come under challenge from all directions. Respected authors have written of the need to 'renegotiate' medicine's social contract, and official and regulatory bodies around the world have identified the need to re-emphasise the role of the doctor and the purposes of education and training. As medicine

has had to redefine what it means by professionalism, medical education has had to dissect the components of this newly defined entity and consider how best to incorporate it into the curriculum and – a greater challenge – how to assess it in developmental and supportive ways.

And so, this book *Professionalism in Medicine* by Jill Thistlethwaite and John Spencer, is both welcome and timely. Both authors have long experience of medical education and of delivering medical care from the generalist perspective, and they have produced an admirable summary of the field. They have reviewed the history and context, and give an overview of the key literature. Chapters on the various aspects, or domains, of professionalism are presented in clear, comprehensively referenced format. Coverage is given to vital areas of ethical practice; communication; cultural sensitivity; and professional responsibilities including self-care. Chapters 10 and 11 address the challenges of curriculum development and assessment, and the final chapter tackles social responsibility for the profession – perhaps the most significant test of the adaptability of the profession. Unless our education and training instils the abilities and beliefs required to respond speedily to changing societal needs, the profession risks future marginalisation rather than leadership in delivery of healthcare.

Thistlethwaite and Spencer's book is an important addition to the field and will be of value to all those involved in medical and healthcare education, and to a wider audience interested in the development of those nascent professionals to whom we will be entrusting the future of medicine.

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education. He is a Specialist Advisor to the Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine, has been actively involved with the Association for the Study of Medical Education for many years, and is deputy editor of *Medical Education* and Editor in Chief of *Clinical Teacher*.

CHAPTER 1

The context

This chapter explores:

- the historical context
- what's in a word – definitions of professionalism
- the origins of the recent interest in professionalism
- the UK experience
- developments in North America
- trust in doctors
- patient-centred professionalism.

> A professional is a man who can do his job when he doesn't feel like it. An amateur is a man who can't do his job when he does feel like it.[1]
>
> *James Agate (1877–1947), British diarist and critic*

HISTORICAL CONTEXT

Doctors have been considered 'professionals' for as long as the concept of a profession has existed. Since Hippocrates' time in Western cultures, and for at least as long in Oriental cultures (e.g. China), doctors have held a special place in their communities, operating through an implicit social contract. In return for deploying their special (and usually carefully guarded) knowledge and skills, and being seen to act in a principled manner in the best interests of their patients, the privilege of autonomy and the freedom to self-regulate was bestowed upon them, as well as considerable social status. This arrangement endured for millennia, essentially unquestioned until well into the twentieth century, notwithstanding periodic assaults and critical analyses by

sociologists, anthropologists, politicians, academics and patient/consumer groups. Nonetheless, the potential for doctors to act in an unethical manner and abuse their powerful status, or to act incompetently and harm patients but get away with it, was well recognised by both satirists (the famous line in George Bernard Shaw's play *A Doctor's Dilemma*, 'All professions are a conspiracy against the laity',[2] comes to mind) and philosophers (e.g. Ivan Illich in his scathing attack on medicine and the medical profession for the 'expropriation of health' in the mid-1970s[3]). However, it has only really been in the last 10 years or so that professionalism has come under intense scrutiny and stimulated such wide-ranging and far-reaching debate. Some of the reasons why this is so are briefly explored in this chapter, but first . . . what's in a word?

WHAT'S IN A WORD?

As most authors on the subject observe, one of the problems bedevilling discussion about 'professionalism' is its definition. The word is full of nuance and, as with such words as 'love' or 'quality', perhaps each of us is clear what *we* understand by the term, but we find it difficult to articulate. In fact definitions of professionalism abound, and some of the more important ones that have emerged recently are discussed in this chapter (Hilton and Slotnik of St George's Medical School, London, suggested the most pithy to date, namely 'A reflective practitioner who acts ethically'[4]). However, if only to marvel at the richness of language, it is worth considering how the concepts of 'profession' and 'professional' may be understood by the general public. Many people would see a 'professional' as being the opposite of an 'amateur' – for example, in music or sport, in which context the professional is usually thought to have skills superior to those of the amateur, and is of course paid to perform or to compete. However, there was also the notion of the 'gentleman amateur' – the sportsman who did not sully himself by being paid to perform, unlike the professional who took money and thus demeaned the spirit of sportsmanship. A soldier or a killer may also be described as 'professional', which here implies carrying out a job with calculated efficiency without fuss or emotion. Interestingly, the word 'clinical' is sometimes also used in this context. Finally, a footballer or rugby player will be cautioned for committing a 'professional foul', a 'deliberate act of foul play, usually to prevent an opponent scoring.'[5]

WHY THE RECENT INTEREST IN MEDICAL PROFESSIONALISM?

Recent interest in medical professionalism, at least in the UK, dates back to the early 1990s. It could be argued that reform in undergraduate medical education, led as it was by the General Medical Council through its 1993 recommendations, *Tomorrow's Doctors*,[6] helped to catalyse thinking in this area. Although the word 'professionalism' was not used in the document, the principles were implicit – for example, with increased emphasis on communication skills, ethical reasoning, the development of appropriate attitudes, and so on. The recommendations and the visits that followed empowered educators in medical schools, previously marginalised, to develop teaching, learning and assessment in relevant areas, and raised awareness about the need to address these issues effectively and systematically.

In 1994, Sir Kenneth Calman, then Chief Medical Officer, published a paper in the *British Medical Journal* in which he argued that it was timely to consider the nature of professionalism, in the light of 'increasing public and professional interest in medicine, and a questioning of professional standards and the quality of care.'[7] He acknowledged that it was not easy to define 'a profession', but suggested that it was likely to have all or most of the characteristics listed in Box 1.1.

BOX 1.1 CHARACTERISTICS OF A PROFESSION[7]

- Driven by a sense of vocation or calling, implying service to others.
- Has a distinctive knowledge base, which is kept up to date.
- Sets its own standards and controls access through examination.
- Has a special relationship with those whom it serves.
- Is guided by particular ethical principles.
- Is self-regulating and accountable.

Calman offered a statement about what kind of doctors society needs and the requisite underlying attitudes and competencies. In essence he argued that 'Doctors need to have a broad vision of the world and be able to change and adapt as the knowledge base changes. They need to have outside interests and be rounded people, with breadth as well as depth.'[7] For Calman, the most important implication of all this was for medical education and training.

Later the same year, the British Medical Association (BMA) organised a 'summit meeting' of the profession's leaders to debate medicine's 'core values', and this was apparently the first such meeting for over 30 years.[8] The need to revisit these values was presented in a no-nonsense fashion by Sir Maurice Shock,

former Rector of Lincoln College, Oxford, who argued that the profession had failed thus far to appreciate the massive shift in societal attitudes which had occurred, particularly the advent of the 'consumer society', in the context of unprecedented medical advances and changing demography. He contended that 'the doctor is different, the patient is different, and the medicine is different' – indeed, 'everything is different, except the way you organise yourselves.'[8]

The assembled great and good discussed six core values, namely confidence, confidentiality, competence, contract, community responsibility and commitment. One issue that taxed the participants was whether the doctor's responsibility began and ended with the patient in the consulting room (the traditional view), or whether it extended to other patients, the community and the healthcare system, and beyond (a broader and more political view). After much debate, the list of core values was enhanced thus:

- commitment
- integrity
- confidentiality
- caring
- competence
- responsibility
- compassion
- spirit of enquiry
- advocacy.

A report of the summit meeting was duly published.[9]

Around the same time, the General Medical Council (GMC) was discussing proposals to shift the focus of its guidance to doctors away from a list of things that they must *not* do (the historic position, laid out in what was known as the 'Blue Book'), to a description of what a good doctor *should* do. These guidelines were published as *Duties of a Doctor*[10] and *Good Medical Practice.*[11] In *Good Medical Practice* (*GMP*), the GMC outlined 'the principles and values on which good practice is founded', and although the guidance was predominantly addressed to the profession, it was also intended to inform the public about what they should and could expect from their doctors. This signified a major change in the focus of thinking about the purpose of such guidance, although interestingly the actual word 'professionalism' was not used in the first edition.

The seven headings of *Good Medical Practice* will be familiar to most UK readers, having been adopted as the framework, among other things, for revalidation and appraisal, and the curriculum for the Foundation Programme for newly qualified doctors. The headings are shown in Box 1.2.

BOX 1.2 THE SEVEN HEADINGS OF *GOOD MEDICAL PRACTICE* [11]

- Good clinical care
- Maintaining good medical practice
- Teaching and training, appraising and assessment
- Relationships with patients
- Working with colleagues
- Probity
- Health

The 'bottom line' of *Good Medical Practice* was that patients must be able to trust doctors with their lives and health, and that doctors should make the care of their patients their first priority.

Although Calman's paper, the BMA report and *Good Medical Practice* doubtless promoted debate and discussion, it is arguable that they had little impact on the 'doctor on the Clapham omnibus.' Sadly, that required the stimulus of external forces. The Bristol paediatric heart surgery scandal, news of which broke in early 1996 through the satirical magazine *Private Eye*, could be said to be the point at which the public and the Government *really* began to take an interest in professionalism. Other cases followed Bristol – for example, that of Rodney Ledward and Richard Neale, two wayward gynaecologists who were eventually struck off the GMC register on grounds of serious professional misconduct, and of course the mass-murdering GP Harold Fred Shipman.

The 1998 Bristol Inquiry, chaired by Professor Ian Kennedy, identified a catalogue of lapses in professionalism at both individual and team levels, and also serious failure within the organisation. The Inquiry's report (known as the Kennedy Report) was a no-holds-barred indictment of an anachronistic mode of professionalism, characterised by paternalism, misplaced collegiality (described as a 'club culture'), failure of self-regulation and ultimately failure to protect patients.[12] This had come about precisely as Maurice Shock had said, because changes in medical culture had not kept pace with changing societal values and expectations. In the words of Sir Donald Irvine, President of the GMC at the time, Bristol 'signalled the moment at which change became inevitable.'[13] Richard Smith, then editor of the *British Medical Journal*, was even more forthright. Quoting Yeats, 'All changed, changed utterly', he suggested the implications were so profound that Bristol would prove more important to the future of healthcare in the UK than any number of Government White Papers, and that its ramifications would be felt for years to come.[14] The list of issues raised by the Bristol Inquiry was long and challenging, largely focused around the need for greater accountability and improved self-regulation.[10] Inevitably

the role of the GMC was heavily criticised, and the report catalysed major change in both its organisation and function, which at the time of writing are still continuing. Smith (and others) exhorted the profession to 'maintain the impetus for improvement . . . and turn the fine words into effective action.'[14]

NORTH AMERICAN DEVELOPMENTS

It was not only in the UK that such deliberations were taking place. For example, the American Board of Internal Medicine (ABIM) established the Professionalism Project in 1992. The aims of the latter were to define professionalism and raise awareness in all those within internal medicine, and to provide a means for including professionalism within training curricula. Recommendations were published in 1994,[15] including the requirement that doctors seeking board certification, and hence medical registration, should *demonstrate* that they have acquired the values of professionalism. A transatlantic collaboration between the American College of Physicians and the American Society of Internal Medicine, the ABIM and the European Federation of Internal Medicine, known as the Medical Professionalism Project, followed this in 1999. The aim was to produce guidance for the new millennium, to which all medical professionals could and should aspire. The Project approached the problem from a different starting point, the basic premise being that medicine's commitment to the patient was being challenged by a wide range of factors. These included the technological and information revolution, changes in demography and healthcare delivery, the twin threats of bioterrorism and globalisation, and changing market forces. As a consequence, doctors were finding it increasingly difficult to fulfil their responsibilities to their patients. In this respect, the debate in the USA was more explicitly a response to what one author described as 'the corporate transformation' or 'industrialisation' of healthcare[16] than it was to scandals such as Bristol and Shipman, as in the UK.

Whatever the case, the new millennium provided an opportunity to reaffirm the basic principles of professionalism in a way that might help to reform healthcare. The product was a 'charter', which was published simultaneously in 2002 on both sides of the Atlantic in the *Lancet* and the *Annals of Internal Medicine*.[17] The basic tenets were familiar. The foundation of medicine's contract with society is 'professionalism', the elements of which must be clearly understood by both the profession and society. Underpinning this contract is public trust in doctors, which depends upon their integrity. The charter consisted of three fundamental principles and a set of professional responsibilities (*see* Box 1.3).

BOX 1.3 MEDICAL PROFESSIONALISM IN THE NEW MILLENNIUM: A PHYSICIAN CHARTER[17]

Medical professionalism is underpinned by:

Three fundamental principles

- Primacy of patient welfare
- Primacy of patient autonomy
- Principle of social justice

Ten professional responsibilities

- Professional competence
- Honesty with patients
- Patient confidentiality
- Maintaining appropriate relationships with patients
- Improving quality of care
- Improving access to care
- Just distribution of resources
- Scientific knowledge
- Maintaining trust by managing conflicts of interest
- Professional responsibilities

The principles were uncompromisingly political. The primacy of patient welfare is based on altruism, which must not be compromised by factors such as market forces or political and administrative demands. Respect for patient autonomy involves doctors empowering patients to make informed decisions about their treatment, but this has to take place within an ethical framework. Finally, doctors must strive to promote social justice – for example, through fairer distribution of resources and by challenging discriminatory policies and practices. These principles were developed further in the set of responsibilities, which highlighted both individual and broader professional obligations. Whilst acknowledging that the practice of medicine was embedded in diverse cultures and value systems, and subject to different and wide-ranging pressures, the authors of the charter intended it 'to promote an action agenda . . . universal in scope and purpose.'[17]

In the context of the threats to professionalism described above, Herbert M Swick (of the Institute of Medicine and Humanities, Montana) proposed a 'normative definition' – one that was grounded in the everyday work of physicians, and their interactions with patients and families, and with their colleagues.[16] He intended it to be 'precise and inclusive' so as to have relevance for a wide constituency within the medical profession. He proposed a set of nine behaviours (*see* Box 1.4). As a professional, a physician must:

- subordinate their own interests to those of others (including managing conflicts of interest such that patient needs remain paramount)
- adhere to high ethical and moral standards (if their work has a high moral and social value, it follows that doctors must behave morally – 'Patients have a right to expect no less')
- respond to the needs of society (reflecting the 'compact' between the profession and the communities they serve)
- display core humanistic values (including integrity and trustworthiness, compassion and altruism – 'The practice of medicine is a human endeavour')
- exercise both individual and collective accountability (in return for the bestowed privilege of autonomy)
- demonstrate a continuing commitment to excellence (whilst recognising their limitations) as well as to scholarship and advancement
- deal with a high level of complexity and uncertainty (characterised by exercising independent judgement)
- reflect upon their actions and decisions (ultimately to bring balance to professional and personal life).

BOX 1.4 SWICK'S 'NORMATIVE' DEFINITION OF PROFESSIONALISM[16]

Medical professionalism comprises the following set of behaviours:

- Physicians subordinate their own interests to the interests of others.
- Physicians adhere to high ethical and moral standards.
- Physicians respond to societal needs.
- Physicians evince core humanistic values.
- Physicians exercise accountability for themselves and for their colleagues.
- Physicians demonstrate a commitment to excellence.
- Physicians exhibit a commitment to scholarship and to advancing their field.
- Physicians deal with high levels of complexity and uncertainty.
- Physicians reflect upon their actions and decisions.

As a response to the 'industrialisation' of medicine, Swick felt that it was important to reiterate aspects of professionalism that pertained to its social functions, not least because 'Without a strong sense of the public and social purposes served by professional knowledge, professionals tend to lose their distinctive voice in public debate.'[16]

Meanwhile, in Canada, the Royal College of Physicians and Surgeons

had initiated a project, known as CanMEDS2000, to reform postgraduate education and ensure that all programmes were responsive to societal needs. The result was a framework describing a set of 'competencies' clustered into seven main roles.[18] The role of 'medical expert' lay at the heart of the CanMEDS framework, the others being 'manager', 'communicator', 'scholar', 'collaborator', 'health advocate' and 'professional.' The underlying principles of the last were that physicians should deliver highest-quality care with integrity, honesty and compassion, and should be committed to the health and well-being of individuals and society through ethical practice, professionally led regulation, and high personal standards of behaviour. A list of 14 'enabling competencies' expanded the basic principle. The framework was carefully implemented and has now been incorporated into accreditation, assessment and standards at all levels of medical education.

PROFESSIONALISM MUST BE TAUGHT

In parallel with the emerging literature that was attempting to 'nail down' the complexities of professionalism and its place in the modern world, educators were also starting to discuss and debate the challenges of teaching about professionalism. That it *must* be taught was not in question – the challenge was how and when, and in particular how it might be reliably assessed. Sylvia and Richard Cruess from Montreal offered some fundamental principles to guide educators.[19] They suggested that there should be identifiable content in undergraduate medical curricula, reinforced in postgraduate programmes and continuing professional development. Important concepts to highlight include altruism and the notion of 'calling', knowledge of codes of ethics, understanding the nature and limitations of individual and collective autonomy, and making explicit the links between professional status and societal obligations. Relevant material should be drawn from a wide range of disciplines outside medicine, including sociology, moral philosophy, economics and political science, so as to avoid allowing the profession 'to build and maintain its own myths while avoiding ideas challenging them.'[19] Other authors discussed ways of increasing students' self-awareness as a way of promoting better patient care,[20] or helping them to develop a sense of social responsibility through learning and working in the community.[21] Quoting Kenneth Berns, they contended that 'essentially the goal of medical education must now be to turn out Renaissance physicians – individuals capable of addressing patients' needs from the level of their molecules to the level of their participation in society.'[20] Another helpful contribution to thinking on the subject came from Hilton and Slotnick, who proposed a developmental model which saw professionalism

not as a trait, but as an acquired state.[4] They defined six domains of professionalism (ethical practice, reflection and self-awareness, responsibility for action, respect for patients, teamwork, and social responsibility) which, they argued, are developed through experience, and reflection on experience, in parallel with the development of technical competence. They defined the early phase of this as 'proto-professionalism', and discussed some of the factors that both enable and hinder the process.

Thus as the new millennium dawned, 'medical professionalism' was high on the agenda of a wide range of stakeholders, including politicians, regulators, academics, educators, practitioners and, not least, the general public. A steady stream of publications about professionalism, what it is and how to teach and assess it, flowed from the major journals. Medical education conferences dedicated symposia and workshops to the topic. Regulatory bodies, such as the GMC, and policy makers wrestled with the issues.

A QUESTION OF TRUST

In 2002, Onora O'Neill, philosopher and ethicist, and Principal of Newnham College at Cambridge, gave the BBC Reith Lectures on the subject of 'trust.'[22] Her thought-provoking central thesis was that, despite received wisdom and extensive media hyperbole, the evidence in support of a supposed 'crisis in trust' was mixed. She argued that failures and abuse of trust were by no means new phenomena, and that despite the rhetoric, the evidence of increased *un*trustworthiness was thin. Actions speak louder than words, and if anything it seemed that people were placing as much trust in professionals and institutions as they had ever done before, albeit perhaps in a climate of increasing suspicion. This was perversely creating new situations which were worsening the problem. She singled out the human rights movement, new approaches to accountability, the media's apparent mission to spread suspicion and undermine trust, and new ideals of transparency. 'Rights' were promulgated without consideration of reciprocal responsibilities and obligations. The new bureaucratic accountability – including audit, league tables and performance targets – was distorting the proper aims of professional performance rather than enhancing it, and was damaging professional morale and integrity. She called for an 'intelligent' accountability that, among other things, would involve less top-down micro-management and a greater margin of responsible self-government. She used the recommendations of the Kennedy Report as an example of this kind of approach.[12] The pursuit of truth and transparency, she felt, was also paradoxically damaging and unhelpful: 'Increasing transparency can produce a flood of unsorted information and mis-information

that provides little but confusion unless it can be sorted and assessed. It may add to uncertainty rather than to trust.'[22] She considered that a more effective strategy would be to reduce deception rather than to increase transparency. She suggested that claims about a crisis of trust were evidence of an unrealistic hankering after a world of total safety and compliance in which breaches of trust were totally eliminated, and that some of the 'new' institutions might actually be more damaging to trust than nurturing it: 'Plants don't flourish when we pull them up too often to check how their roots are growing; political, institutional and professional life too may not flourish if we constantly uproot it to demonstrate that everything is transparent and trustworthy.' To avoid a 'crisis of trustworthiness' brought about by the use of measures designed to stem the *supposed* crisis in trust, she concluded, we need to start communicating more openly.[22]

In 2004, the King's Fund published the results of a consultation exercise exploring medical professionalism.[23] Its main aim was to promote further debate, but also to offer a way forward, at least on some issues. They called for renewed emphasis on ensuring that patients' interests were at the heart of professional practice. They suggested the need for a new and explicit compact between government, the profession and the public in tune with prevailing values and expectations, strengthening medical leadership, and clarifying the relationship between doctors and managers. The same year the Royal College of Physicians established a Working Party to define the nature and role of medical professionalism in modern society. After an extensive inquiry, involving a literature review, oral and written evidence from a wide range of witnesses and informants sampling both medical and lay opinion, and questionnaire surveys and focus groups, it published its report in December 2005.[24] The basic principles of medical professionalism were revisited, and although it covered familiar territory, it took thinking about professionalism a few bold strides forward, not least in putting professionalism firmly in the context of partnership with patients. The report defined professionalism as 'a set of values, behaviours and relationships that underpins the trust that the public has in doctors', and further elaborated this in a description of medical professionalism (*see* Box 1.5).

BOX 1.5 ROYAL COLLEGE OF PHYSICIANS' DESCRIPTION OF MEDICAL PROFESSIONALISM[24]

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 mutual 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.

Several concepts were abandoned and replaced with more contemporary ones. For example, 'mastery' was felt to carry connotations of control and authority that were incompatible with contemporary notions of partnership. 'Autonomy' and 'self-regulation' were rejected on the grounds that they implied the right and authority to act independently of the wishes of the patient and the weight of available evidence, and also ran counter to the concept of team-based care. 'Privilege' was thought to be outmoded in this more egalitarian era. 'Excellence' replaced 'competence' as a higher standard to aim for. 'Judgement' was felt to better capture the processes of critical thinking that doctors apply in helping to solve patients' problems than the concept of 'the art of medicine.' The use of the term 'moral contract' added an ethical and moral dimension to the somewhat neutral concept of the 'social contract.' The concept of 'vocation' or 'calling' was felt to be worth preserving, and the Working Party was keen to stress the need for '*appropriate* accountability' to avoid creating and perpetuating a culture of blame and suspicion (*en passant*, they were refreshingly explicit about the damage to professionalism posed by the 'unrelenting focus' on targets in an environment in which, the report suggested, the 'regulatory pendulum' had swung too far and in which there was an undue focus on weakness rather than virtue). 'Altruism' was also retained as an underlying core principle, the Working Party declaring itself impressed by the trainee who said that medical practice 'requires neither humility nor altruism . . . good medical practice . . . requires both.' The report raised particular concerns about what it saw as a failure of medical leadership, alongside an

increasingly neglected clinical input to management. Several other interlinked themes emerged, such as team working, appraisal, and careers, with implications for education and research. Overall the report was a commendable attempt 'to usher in a major philosophical shift in attitudes to medical practice'[24] and to put medical professionalism back on the political map.

PATIENT-CENTRED PROFESSIONALISM

The fact that the patient's interests should lie fairly and squarely at the heart of professional practice was central to the continuing debate about the meaning of 'professionalism' in the twenty-first century, and saw the emergence of a new(ish) term – 'patient-centred.' However, in the words of one author, 'Patient-centredness is becoming a widely used but poorly understood concept in medical practice. It may be most commonly understood for what it is not – technology-centred, doctor-centred, hospital-centred, disease-centred.'[25] In a thought-provoking discussion paper, Janet Askham and Alison Chisholm of the Picker Institute discussed some of the issues. 'Patient-centredness' could be one of four things:

- when doctors work in patients' best interests (but who defines those interests, and what happens when there is a conflict?)
- when doctors work in accordance with patients' *preferences* (this may be what a lot of patients want, but do people always know what is best for them?)
- when doctors work in partnership with patients and/or involve them closely in decisions (but how far should this go? what about power imbalances? do patients have to become 'quasi-doctors'?)
- when doctors take a 'patient-centred approach'[25] – that is, try to understand patients in a wider context, including their ideas, concerns, expectations and values.

However, the authors acknowledged that this may involve an altogether more complex kind of relationship which may not always either be desired by the patient, or be necessary for effective care. These four approaches, Askham and Chisholm argued, highlight some of the tensions underpinning much of the debate about the changing role of doctors, represented as a series of dichotomies. These were activity *versus* passivity, power *versus* autonomy, conflict *versus* collaboration, and emotion *versus* objectivity. Whatever the case, patient-centredness was clearly a complex and dynamic concept. After discussing contemporary roles of both 'patient' and 'doctor', and in particular areas of potential conflict, the authors concluded that patient-centredness can