

A black and white photograph of a woman in profile, speaking into a microphone. She is wearing a dark, off-the-shoulder top. In the background, an audience of people is seated at tables with white tablecloths, listening attentively. The room has large windows with a grid pattern. A large, bright green diagonal shape is overlaid on the bottom left of the image.

# Medical professionalism matters

*Report and recommendations*



# Introduction

Over the past 18 months, a partnership of healthcare organisations led by the General Medical Council (GMC), held a series of events to explore some of the challenges facing the medical profession today. This programme is called *Medical professionalism matters*.



Six events were held across the UK – from Glasgow and Belfast, to Newcastle, Cardiff, Birmingham and Bristol – with each one focusing on an issue that presents particular challenges for the modern doctor. Those issues were: ethics, resilience, collaboration, compassion, scholarship and patient safety.

Almost 600 doctors and other healthcare staff and patient representatives attended the events, which included presentations, panel debates and facilitated table discussions. Hundreds more joined the discussion online, taking part through videos, blogs and social media exchanges. In addition, we held a final event in Manchester to pull together this feedback and consider how to take the project forward.

You can find discussions from the events at [gooddoctors.org.uk](http://gooddoctors.org.uk)

## A note on our surveys

During the Medical professionalism matters series we held a number of polls, both at the events and online. More than 1,000 doctors responded to these polls,

and the figures from those polls are used in the charts and findings throughout this report. Similar to the feedback from participants contained in this report, the results of these polls are intended as a reflection of the feelings and perceptions

of the poll participants. We hope that they are of interest as they convey doctors' views at a particular point in time and that the results will generate further thought and discussion.

General  
Medical  
Council



# Foreword

## MEDICAL PROFESSIONALISM MATTERS: WHAT YOU TOLD US

*Medical professionalism matters focused on having open and honest discussion and debate about the very real challenges that so many doctors are facing today.*

This report gives an insight into the result of these discussions. It is not intended to be a detailed account of everything that was said – rather it provides a summary of the main points that came through in the discussions. You should read this report alongside other material at [gooddoctors.org.uk](http://gooddoctors.org.uk). While these views may not be shared across the entire profession, they do represent the participants' feelings. You should also note that participants at these events came from different parts of the UK and therefore were contributing to the discussion based on their experience of the local system. We recognise the health service operates differently across the UK, but the feedback was generally consistent regardless of local variations.

This report also presents the results of surveys of more than 1,000 doctors and other professionals on a range of topics. What emerges is thought provoking – and sometimes disturbing.

The GMC, in collaboration with partners from across the healthcare sector, decided to launch *Medical professionalism matters* in early 2015 because of growing concerns within the medical profession about doctors' role in a modern health service. Although the values underpinning professionalism may remain constant, the context in which those values are played out is always changing. Many doctors feel the current environment is the most challenging of their careers.

That relates not only to the pressures of day-to-day practice, but also to increased patient expectations and the often conflicting demands of employer and patients. And this has to be set against the backdrop of almost unprecedented upheaval in the NHS in England, with major reforms coinciding with one of the severest financial squeezes in its history. The long-running contract dispute in England can be seen as symptomatic of these growing concerns.

Some may be surprised to see a national regulator of professional standards

organising this programme of events. But we see it as central to one of our core educational functions – building greater understanding of, and working relationships with, frontline doctors and patients. Now more than ever, all of us involved in *Medical professionalism matters* need to be proactively identifying potential issues and helping to share notable practice.

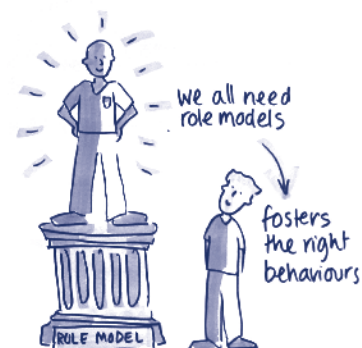
This has been an invaluable learning experience for everyone involved in this project.

The report's central focus is on the medical profession – a profession in a state of unease. However, many of the themes raised – including issues of teamwork, patient partnership and the tension between professional and organisational loyalties – will be equally relevant to health and social care professionals more widely.

The process of holding this extended conversation with many doctors has been of enormous value in itself. But we need to take it further. This is an ambitious project with an ambitious goal: we want it to help drive changes at both local and national level. In the same way that doctors spoke of their own 'lifelong journey' on professionalism, this will also be a journey for those organisations working to support doctors in an increasingly challenging health and care environment.

# Contents

The Advisory Group	4
Key findings and recommendations	5
Revisiting the themes of <i>Medical professionalism matters</i>	
The compassionate doctor	7
The resilient doctor	11
The doctor's dilemma	15
The collaborative doctor	19
Patient safety and quality improvement	23
The doctor as scholar	27
Medical professionalism in numbers	30
Conclusion: the way forward	32



# The Advisory Group

*Medical professionalism matters is a collaborative project developed by a group of healthcare organisations, led by the GMC.*

The series was led and informed by the project Advisory Group. The group brought together representatives from a range of organisations, to help us all better understand the challenges that health professionals face in their daily practice.

Together, the group agreed the focus of discussion for the events, participated as

panellists and speakers, and provided its input into the production of this report to summarise the series.

The Advisory Group has made a commitment to continue to work together and to deliver the recommendations highlighted in this report in 2017 and beyond.

**Stella Dunn**, *BMA*  
**Mark Porter**, *BMA*  
**Bill Reid**, *COPMeD*  
**David Behan**, *CQC*  
**Niall Dickson**, *GMC*  
**Katie Petty-Saphon**, *MSC*  
**Bill McMillan**, *NHS Employers*  
**Danny Mortimer**, *NHS Employers*  
**Peter Pinto**, *NMC*  
**Jackie Smith**, *NMC*  
**Maureen Baker**, *RCGP*  
**Judith Tweedie**, *RCP*  
**Winnie Wade**, *RCP*  
**Steve Cannon**, *RCS*  
**Clare Marx**, *RCS*  
**Fiona Moss**, *RSM*  
**Babulal Sethia**, *RSM*



# Key findings and recommendations

*A number of overarching themes emerged from the Medical professionalism matters events, as outlined in this report.*

Among the most frequently raised issues were the lack of time and support to make a reality of reflective practice. This applied at every stage of a doctor's career.

Doctors also returned again and again to problems around professional isolation, fragmentation and poor communication. Improved leadership, teamwork and stronger patient partnerships were seen as ways forward.

Of course, many of the solutions to these issues are the responsibility of local leaders. There is a need to build the right cultures of compassionate care that support NHS staff to deliver their best, working in partnership with patients.

There are also implications for national leaders and organisations, especially in continuing the debate and supporting the

kinds of changes doctors at the *Medical professionalism matters* events wanted to see.

Here we outline some key recommendations that the organisations represented on the Advisory Group – including the GMC – could take responsibility for beginning to implement.

## Undergraduate medical education

- The GMC and Medical Schools Council should work with medical schools to make sure there is a stronger focus on understanding medical professionalism within the undergraduate curriculum. This should help students reflect on the realities of practice and the complex human interactions involved. It should promote self-awareness, wellbeing, safe ways to challenge aspects of care-giving and an understanding of the medical humanities and applied ethics.
- Together, they should also complement their *Achieving good medical practice*

guidance with practical training and toolkits, focused on some of the key areas new doctors find most challenging, including caring for people at the end of their lives. Medical schools should strengthen their efforts to prepare students for the transition to practice. The principles set out in the GMC's Generic Professional Capabilities Framework could be translated into undergraduate medicine.

## The foundation stage and postgraduate medical education

- Foundation and postgraduate medical education programmes should place greater emphasis on the doctor's role in leadership and quality improvement. This could be based on the standards of the Faculty of Medical Leadership Management, which focuses on the leader as an individual, the leader in the multidisciplinary team, and the leader in the system.

## Lifelong learning and leadership

- The medical royal colleges and the GMC should work together to reinvigorate continuing professional development, with an emphasis on reflection and changing practice rather than ticking boxes. They should focus on the most challenging aspects of practice, including having difficult conversations and effective team working.
- There should be more focus on leadership development for doctors.
- The GMC and employers should support a greater emphasis in appraisal and revalidation on in-depth reflection, personal development and the doctor's contribution to quality improvement.



## Partnerships with patients

- Medical education and training should be more focused on meaningful patient involvement, including in-service design.
- In reviewing its guidance on consent, the GMC should work with partner organisations to enhance the materials available to help doctors make decisions in partnership with patients.
- Future *Medical professionalism matters* events should involve more individual patients and patient organisations.

## A supportive culture

- The GMC, alongside other systems regulators and improvement bodies, should intensify their efforts to promote a culture of openness, learning and candour, recognising that the professional may be the 'second victim' when things go wrong in healthcare.
- All education and training organisations should increase their focus on inter-professional learning and challenging professionalism tribalism.
- All organisations can do more to recognise the intense pressures on the profession and make it more acceptable for people to ask for help when they are struggling. The GMC should continue to implement its programme of reforms

to take account of doctors' mental health when facing fitness to practise procedures and to minimise their negative impact.

- NHS Employers and the GMC should work together, and with systems regulators and partners across the UK, to provide further advice on how doctors can contribute to create well-led organisations.

## Continue the conversation into 2017 and beyond

- All the organisations involved in this series of events should hold further discussions to make sure this important conversation continues.
- The organisations represented on the Advisory Group should come together again at the end of 2017 to review progress and take stock.



Revisiting the themes of  
*Medical professionalism matters*

# The compassionate doctor



Doctors should show compassion and empathy in their work. But what does that really mean? Are there limits? And is it possible to demonstrate this consistently in today's busy, businesslike NHS?

“

*We learn to cut off our feelings as doctors to try to remain objective. It's important to be empathetic and objective at the same time.”*

Some participants at the *Medical professionalism matters* events debated whether there was a difference between compassion and empathy or sympathy. Others preferred using more concrete language such as 'being personal'. But most agreed that the essence lay in focusing on the patient in front of you and listening to their concerns.

### Are doctors compassionate?

A majority of doctors in our survey did not believe that doctors were any less compassionate than 20 years ago. But 44% felt things had got worse, many blaming increasing time pressures combined with higher patient demand and expectations. Others identified organisational and management pressures while some focused on training failures.

One in five would describe their current place of work as a “supportive working environment” but most disagreed. Eighteen per cent dismissed it as pipedream and a quarter thought it was “talked about but rarely achieved”.

### Factors that undermine compassion

Many participants said organisations often failed to show compassion. Patients could be left confused by disjointed services where healthcare providers didn't seem to talk to each other. They consistently called for continuity and a single point of contact. Compassionate doctors should be responding to those demands.

But, it was pointed out, not every patient sees compassion as the priority. Some value detachment and sticking to the facts.

Many doctors complained there was not enough time to give patients the attention they needed. GPs said the 10 minutes they were allotted per patient was far too short. Paradoxically, it is precisely in the most pressured situations that compassion becomes even more important.

Organisations were increasingly businesslike. That meant they tended to focus on process and what was measurable – which meant compassion could be neglected because it was difficult to quantify.

It was generally agreed that a feeling of belonging and support underpinned compassionate care for others. If people showed compassion to you, you would

show it to others. But doctors in training in particular missed out on this teamwork because they move so rapidly from one post to another.

Some doctors felt increasingly they have responsibility but no longer have power. One consultant psychiatrist said she and her colleagues were in a situation of “learned helplessness... We have got an increasingly disenchanted and fragmented workforce.”

Is there a conflict between compassion and clinical objectivity? Some doctors were taught to remain detached, which could be seen as diluting compassion. On the other hand, some felt that being too empathetic and compassionate could lead to burnout.

## Do doctors show compassion to themselves?

Participants noted that compassionate teams and colleagues encouraged compassion towards patients. But support systems such as occupational health services were often non-existent (or there was a lack of awareness of what does exist). And doctors were very bad at caring for themselves.

This also applied to the pressures placed on students. As one delegate asked: “If failure in medical school isn’t tolerated, how can you tolerate failure in your patients?” In other words, it was felt that analogously stressful situations affecting a medical

student and a future patient were viewed very differently by the medical school administration.

Some felt compassion to patients was undermined because the different professions showed little respect for each other. Others disagreed. GMC chair Professor Terence Stephenson felt relationships were now much less hierarchical and compassion between the professions had improved.

Many also suggested the GMC was failing to show the compassion it called for from others – especially towards those who were under investigation.



**44%** believe doctors are less compassionate than 20 years ago




**78%** do not believe their place of work offers a supportive working environment

**66%** believe empathy can be taught

### USEFUL LINKS

You can find more resources for medical professionals at [gooddoctors.org.uk](http://gooddoctors.org.uk)

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## What doctors recommend as a standard of professionalism

Here are some of the suggestions put forward by doctors at our events:

- **PATIENT-CENTRED** Doctors must always centre their care on the individual patient and respond to their particular concerns. Always start by listening to the patient – they hold invaluable knowledge about their own condition. “You should ask: is this care good enough for my mother or brother?” said Ilora Finlay, chair of the National Council for Palliative Care. “If it is not then you have a responsibility as a professional to do something about it.”
- **TEACHING COMPASSION** Important components of compassion are knowing what to say and how to pace the information you are giving. Compassion is about saying the right things and also using body language to communicate genuine concern. It’s about active listening and making eye contact. Learning how to break bad news, for instance, really matters. Many suggested that there should be greater

emphasis on compassion as a criterion for recruitment as well as a topic within the curriculum.

- **LITTLE THINGS CAN MAKE A BIG DIFFERENCE** For example, giving the patient a bullet point list to recap what you have said, and positioning yourself at their level. The first and last things you say to a patient in a consultation are likely to stick the longest.
- **TEAMWORK** More teamwork and better support systems allow doctors to show greater compassion to their patients. Schwartz rounds and weekly team meetings are ways of building this teamwork and ensuring good liaison – but avoid them becoming talking or whingeing shops!
- **SHADOWING** Shadowing both in training and at later points in people’s career can offer important insights and help appreciation of colleagues’ dilemmas.
- **AVOID BURNOUT** Be compassionate but maintain a degree of detachment to avoid becoming overwhelmed.



Revisiting the themes of  
*Medical professionalism matters*

# The resilient doctor



Possessing the necessary resilience to withstand the ceaseless pressures of today's health service is more vital than ever. But what exactly is resilience? Is it an inherent characteristic? Or is it something that needs to be learnt?

Some of the doctors we spoke to believe that it comes with the territory. In our survey over a third (37.8%) felt that doctors were already resilient so did not require further training on this while another 5.8% felt it came largely from experience. But most believed it was something that could be learned.

However, the characteristics of resilience are less clear than might be first thought. It's not necessarily the same as mental toughness, consultant liaison psychiatrist Alys Cole-King told one of the *Medical professionalism matters* events. In fact it can be the opposite. And the aim should be not just to survive, but to flourish.

Doctors at our events identified a range of pressures that test their resilience:

## Internal pressures

Perhaps the greatest pressure on doctors comes from themselves, it was suggested. Many doctors were perfectionists. They tend to be winners and don't expect to fail. At the same time, some older consultants had the philosophy that "bad things happen: get on with it".

This approach meant they found it difficult to see themselves as being potentially vulnerable, which had consequences when things went wrong. One participant noted that in their area 40% of the doctors were not signed up with a GP. And few took advantage of counselling services.



*Perhaps the greatest pressure on doctors comes from themselves, it was suggested. Many doctors were perfectionists. They tend to be winners and don't expect to fail.*

## External pressures

External pressures that were identified included workload, lack of time and patients' and colleagues' expectations.

Many felt "the forgotten tribes" of doctors in training were especially vulnerable. The constant rotations meant they never felt part of a team – this also made it harder to identify when they were struggling.

Professionally isolated groups, such as locums, GPs and community doctors, could also be at risk because they lacked support networks.

Participants felt there was less camaraderie than in the past, complaining that professions and disciplines have grown apart and looking back fondly to when people worked in fixed teams with colleagues they knew. The competitive ethos of the modern NHS had helped sharpen divisions between professions and between managers and clinicians, some claimed.

# 38%

believe doctors are already resilient and don't need training for this



# 38%

say the main problem lies with organisational structures and work pressures

# 47%

believe they might be penalised if they asked for help because they were struggling

## Systemic issues

Our survey indicated many believe the current system does not help doctors to help themselves. Nearly half felt they would not be able to ask for help if they were struggling with the pressures of their job without being penalised in some way. Under a third felt confident they could do this without fear of consequences.

Many consultants at our events said they felt under extreme pressure. It was also

noted that the repercussions can be more extensive if a team leader breaks down.

Some suggested the GMC compounds the problem by the way it treats doctors facing a complaint. All suspended doctors should be treated as innocent until proven guilty, several insisted.

It was also observed that many doctors still were not aware of occupational health services that they could access.


# “

*Seeking help is not a sign of weakness. It can be one of the bravest things a doctor ever does. It may save his or her life.”*

### USEFUL LINKS

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## What doctors recommend as a standard of professionalism

So how can doctors learn or cultivate resilience? Here are some of the suggestions made by doctors at our events:

- **IT'S GOOD TO TALK** It's vital to talk, especially to other professionals – that applies especially if you are a single-handed GP. Doctors really appreciate talking to others, said Mike Peters, head of the BMA's Doctors for Doctors Unit. One of the most valued responses was: "I know. I've been there too."
- **TEAMWORK** Functional teams are vital in the modern health system. Many teams work well despite their organisation, not because of it. Medical leadership and a shared sense of team spirit need to spread to the whole organisation. Schwartz rounds (a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare) were cited by many as a way to help foster this. But this is only one approach.
- **BE OPEN** Doctors need to be encouraged to open up, to talk about themselves and accept vulnerability and weaknesses. See yourself and your colleagues as patients when things are tough. And leaders should set the tone by admitting errors, so giving others permission to admit their own.
- **SUPPORT** Counselling, mentoring and appraisal can all be important support mechanisms for doctors to help them get the comparative downtime needed to build up resilience. One group proposed a National Support Service.
- **PRACTICAL GUIDANCE** It was suggested that the GMC could produce a simple booklet on coping with a medical error. This could outline the stages a doctor might go through when they've made a mistake – similar to its 'Coping with stress' booklet.
- **KNOW YOUR LIMITS** Have the confidence and strength to say: "Sorry, I can't do this". You can't stretch forever.
- **TIME TO 'DECOMPRESS'** Doctors need time to 'decompress' after an emotional event. In an emergency they have to think quite technically. It's important to be given time to address the emotions afterwards rather than just suppressing them and battling on.
- **SAFE SPACE** Doctors need a safe space to share and talk – bringing teams together more regularly to discuss issues, which can prevent them from stacking up and becoming too great to tackle.
- **LOOKING BEYOND THE ACADEMIC** Some discussion focused on the division between academic and 'non-academic' abilities – for example, empathy and compassion. But it's also a mistake to accept candidates who cannot manage the academic work – that is a recipe for failure.

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### USEFUL LINKS

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Revisiting the themes of  
*Medical professionalism matters*

# The doctor's dilemma



Doctors face ethical dilemmas every day. But do they always recognise them? And what stops them doing what they know is the right thing?

Participants attending the events and also joining the discussion online, indicated how tricky it can be to make the right decision and how this weighs on doctors' minds.

### The limits of ethics: internal and external pressures

Doing the right thing is hard work, participants agreed. Many indicated that upon reflection they weren't always sure they had followed the best course of action. Others noted that there was a risk of following the line of least resistance to avoid making waves. At another event, it was suggested that doctors often put the greatest amount of pressure on themselves (page 12).

Disagreeing with colleagues is especially difficult. That personal relationship can act as a barrier. If the individual has power over you, that becomes even trickier. And being ethical can be unpopular. One doctor commented: "It's a bit like being the geeky kid in school when you try and point out what should really happen."

Many doctors reported facing continual conflicts between the needs of the patient and the resource limits of the service. Constant organisational pressures on professional decisions relating to referrals, discharge procedures and prescribing were a particular challenge. These systemic issues were also highlighted in a later discussion on resilience (page 13).

In addition, many felt hierarchies and power relationships can stifle challenge. Some of the most vulnerable groups are locums, BME doctors and those in primary care. One doctor said: "As a locum I can't challenge because then I will never work again." Junior doctors also reported feeling very vulnerable.

Doctors also had to balance the needs of the individual patient versus the general population and one patient against another. We live in a consumer culture – many patients expect the impossible and complain when they don't get it, one doctor said. Their expectations may also fly in the face of best practice.



*Many doctors highlighted the increasing pressure to get people to sign consent forms to ensure an organisation is covered legally.*

## Confidentiality and consent

Many doctors highlighted the increasing pressure to get people to sign consent forms to ensure an organisation is covered legally. But a lack of time and the lengthy, legalistic forms mean this is often not informed consent. So what should doctors do?

Most doctors were clear there were limits to confidentiality. More than 90% in our survey agreed that while patient confidentiality was important it shouldn't prevent doctors sharing information in the public interest with bodies such as the police and the DVLA.

Participants identified other barriers such as language problems, disagreements

between professionals and the fact that many patients may not take in the information or fully understand the risks.

## Raising concerns

Whistleblowing came up frequently during the series as part of a wider discussion about raising concerns. It takes enormous courage and can leave people exposed and deeply unpopular.

Despite all the safeguards that have been put in place for whistleblowers, a majority of the doctors we surveyed were sceptical about their effect. A total of 58% said they were not at all confident or were unsure they'd be supported by clinical and other leaders if they raised a serious concern in their organisation.

“

*The major dilemma for doctors is this: Do we do what is best for society, or what is best for the individual?”*



**81%** are occasionally or often unsure they made the right decision




**91%**  
agree there are limits to patient confidentiality

**58%**  
are unsure they would be supported if they raised a serious concern

### USEFUL LINKS

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## What doctors recommend as a standard of professionalism

So how can doctors learn to handle the dilemmas they will face in practice? Here are some of the suggestions put forward by doctors who participated in the programme:

- **PUT PATIENTS FIRST** Always put the patient first. As the GMC says, "the patient is your first concern". BMA chair Mark Porter noted at one of the sessions that: "It's a lifelong journey to understand what that means".
- **THE IMPORTANCE OF TEACHING ETHICS** Can you teach ethics? This was a constant debate throughout the series. Most believed it was possible, pointing out that culture and ethical issues change so students need to learn how to respond. Many noted that teaching can also help develop the ability to spot good role models and reject the bad. But there was a note of caution: the teaching must be practical, use real life scenarios and demonstrate how ethics translate into behaviour.
- **ADDRESS CHALLENGING CULTURE** Ultimately, the culture and actions of the organisation will influence behaviours within the team. Good team working and supportive, effective leadership will help people air concerns and reduce the risk of a blame culture. It is important not to be isolated – but beware the dead hand of group think.
- **RAISING CONCERNS** One of the key bits of advice from those at the sharp end was: try not to get isolated if you are raising concerns. But it was recognised this can be difficult in some environments, especially primary care. When raising concerns be factual and straightforward. If possible, try to keep emotions out of it.
- **ROLE MODELLING AND MENTORING** Doctors need space for discussion and debate and time to reflect. All doctors, whatever their level of seniority, should have a mentor to enable them to discuss ethical dilemmas in confidence. The mentor would need to be non-judgemental and have no involvement in their mentee's appraisal.
- **CONSENT** Partnership and transparency between the patient and doctor is the foundation stone for genuine consent. It should also be seen as the end point of the process not the start.
- **PRACTISE YOUR RESPONSE** It is important to rehearse your response to ethical dilemmas such as bullying in the same way you practise medical procedures.
- **REFLECTIVE PRACTICE** Everyone makes mistakes – the critical thing is what you do afterwards. Admitting your own mistakes can encourage others to come forward and promotes a more open culture.
- **APOLOGISE** When things go wrong always tell the patient and apologise.

Revisiting the themes of  
*Medical professionalism matters*

# The collaborative doctor

Teamwork and the importance of effective collaboration were raised regularly throughout the series. Good teamwork makes for good outcomes – as does genuine patient involvement. There is substantial evidence that effective teams reduce mortality and morbidity and increase patient satisfaction.

“

*We see a lot of complaints that are about the whole system. One thing after another goes wrong, even though each individual has done their best.”*

The workforce is changing with different work patterns and different priorities of individuals that did not widely exist a generation ago. How do we work together to support the diverse range of professionals in the sector?

In an ever more complex healthcare service the need for joined up working is greater than ever. But the pressures faced by services today make achieving that more challenging than ever. How can doctors make it happen?

### Multidisciplinary teamwork

Many participants recognised that the workforce is always evolving and changing. Individuals' priorities, motivations and approach are as diverse as the medical profession itself. Some felt that shift work and impact of changing work patterns were making effective multidisciplinary working more challenging, citing practical issues such as attending meetings and retaining an overview. And who, it was asked, should have overall responsibility for the individual patient?

Shared decision-making was also trickier as care becomes more complex, involving more professionals.

It was agreed that collaboration was much easier in stable teams but this was no longer the norm. Increasingly teams were fluid, forming and re-forming all the time.

One consultant said: “In hospital we used to work in firms so you knew exactly who your team was and how it worked. We now have a fragmentation of services, particularly more and more shift work and part-time working. It's hard to build up memory within a team and so learn from things.”

A GP commented: “Single-handed GPs used to be a problem but now all GPs are isolated even in big practices because there is just no time for them to build relationships.”

Nearly everyone in our survey believed that multidisciplinary teamworking was an important aspect of collaboration. But while 27% labelled it essential if the system is to be sustainable, most felt that, though useful, it had been overstated as a panacea for the challenges facing the system.



## Integrated care

The biggest complaint was about the yawning communication gap between primary and secondary care, which many felt had worsened in the last 20 years. This prevented personal contact and meant neither sector really knew what the other did.

“We’re increasingly [working in] silos and bogged down with specialist stuff,” said a geriatrician. “When you’re relating through just a name or a function, then we’re lost.” Another participant noted: “Computers don’t talk to each other.”

It was also difficult to build relationships because of the high number of staff often involved. Things were more likely to slip through the net.

## Respect for colleagues

Half of the respondents in our survey felt there were reasonable levels of collaboration and respect among doctors and 10% believed those levels of collaboration were high. But a sizeable minority – 40% – said some doctors’ attitudes undermined respect within the profession and prevented effective collaboration.

Many at our *Medical professionalism matters* events agreed that respect for others had diminished as understanding of each others’ roles decreased – general practice seemed to be particularly stigmatised. One GP who set up a GP service in the local hospital said they were treated “like cuckoos in someone’s nest.” The hospital still resented us being there.”

Research by Peter Lees, head of the UK Faculty of Medical Leadership and Management, showed that every professional group felt they had a particularly raw deal – that was not helpful to good teamwork and respect for each other, he said.

## Patient involvement

The biggest barrier to good patient involvement, it was widely agreed, was lack of time. Continuity was also a problem. Clinicians rarely had an overview of the patient. It was difficult for the patient to know who to contact.

It was acknowledged that communication between doctors and patients was sometimes poor. Patients also had increasing expectations. Doctors might be inclined to resort to defensive medicine by offering every option.

In addition, some patients might not wish to be involved. What they wanted from the consultation might be quite different to what the clinician thought they wanted.

**70%** feel multidisciplinary working has been overstated as a panacea




**40%**  
say some doctors' attitudes undermine respect and prevent effective collaboration

**75%**  
believe there is shared decision-making with patients but 25% feel it's more talk than action

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## What doctors recommend as a standard of professionalism

These are some of the suggestions put forward by doctors at our events:

- **PATIENT INVOLVEMENT** Patients should be included in multidisciplinary team meetings. This challenges the way people work and keeps the patient at the heart of all decision-making. Patients should also be involved in other decisions – could we involve them more in designing units, for example?
- **INVOLVE CARERS** Carers should be sharing in decisions. One idea is a 'carer's passport', a simple way to share useful information with carers and ensure they play a central role in the patient's care.
- **INFORMED CONSENT** Genuine informed consent can be challenging. It's important the patient emerges feeling satisfied with the explanation they have received – some may require more detail than others. Informed consent should not be a single event, it should be a dialogue where the doctor listens to the patient as well as the other way round.
- **'TEAM TIME'** Leaders should encourage staff to dedicate more time to team and relationship building and quality improvement projects. Ways to address this include: more social staff areas, protected discussion spaces and encouraging

staff to interact with others. But others suggested that we're a long way from being able to achieve this in the current NHS.

The email culture should also be challenged. There should be more guidance on the circumstances in which it should be used and avoided.

Other suggestions for boosting teamwork included colour codes for teams in hospital and chambers within practices.

- **LINKS WITH ISOLATED PROFESSIONALS** Locums can feel they are not part of the team. Using technology such as video conferencing as well as 360 degree appraisals were suggested as potential ways forward.
- **SHARED DECISION-MAKING** Everyone needs to be involved in meetings and decisions. The most junior should be able to challenge the most senior – within and across professions. All should be able to be leaders and followers. One doctor in training described how he is always asked for his view first in multi-disciplinary team meetings, to encourage participation across all levels.
- **RESPECT FOR OTHERS** The key to successful teamwork is having common clinical goals and respect for colleagues and what they do. "Ultimately, we depend on each other," noted one doctor.



Revisiting the themes of  
*Medical professionalism matters*

# Patient safety and quality improvement



Most agree that quality and patient safety should be the NHS's prime objective. So what prevents that happening in many situations? And what can doctors do to keep it uppermost in everyone's minds?

“

*The problem with patient safety is it's everyone's day job but nobody's child.”*

A series of NHS scandals have demonstrated that quality and patient safety suffer where there is poor leadership and an unbalanced focus on costs and targets. The inquiry into maternal deaths at Morecambe Bay Trust, for instance, exposed a disconnect between clinicians and managers that was partly responsible for the failures in care.

The evidence suggests that a focus on quality not only improves patient safety but is also cost effective in the long run. The big challenge is how to combine the need to maintain services at a time of huge pressures with the professional obligation to improve – how to turn a 'should' into a 'must'.

### The obstacles

Doctors at our *Medical professionalism matters* event identified a potential conflict between the quest for quality and the need to cut costs and meet targets. This was exacerbated by time pressures. One delegate talked about the drive to ensure everyone who needed it had a CT scan – but no-one had the time to interpret the results or report back to patients.

Some participants suggested we were measuring the wrong things. Too much audit focused on tasks and process rather than the underlying issues.

Many also pointed the finger at professional tribalism, which can lead to disjointed and therefore unsafe practice. The gap between primary and secondary care was particularly worrying. And there was not enough shared learning within and across professions. Could the 'doctors' mess' be usefully reintroduced, some wondered.

There was also concern that hierarchies and fear of failure were stifling innovation. Doctors still hesitated to raise concerns because of a fear they would be singled out and labelled as trouble-makers. The GMC's response to whistleblowers and to patient complaints didn't instil confidence. It was also considerably easier to raise a safety concern if you were a consultant than a doctor in training.

Some believed that rotating all doctors in training on the same day was a safety risk. The length of placements also bred a feeling of disconnection among F1s and F2s because they didn't have time to become part of the team.

Performance data from organisations was valuable but could be overwhelming, said others. Many doctors were not making use of the Datix risk management system.



Some participants felt quality improvement was not yet part of the NHS's DNA. There were not enough local system levers to embed quality improvement (QI) within the culture. One in five doctors (22%) in our survey said they were rarely – if ever – able to prioritise QI, with 44% saying they could only do this some of the time. Only 5.5% of doctors were always able to make quality improvement a priority although over a quarter said they did this most of the time.

**85%**

of doctors say they are able to prioritise patient safety



**22%**

are rarely or ever able to prioritise quality improvement


**44%**

can only prioritise quality improvement 'some of the time'

#### USEFUL LINKS

You can find more resources for medical professionals at [gooddoctors.org.uk](http://gooddoctors.org.uk)

#### JOIN THE CONVERSATION

 #gooddoctors

## What doctors recommend as a standard of professionalism

Here are some of the suggestions doctors made for improving patient safety:

- **RESPONSIBILITY** Too often, managers blame doctors and doctors blame managers. But all professionals must take responsibility, and be accountable, for patient safety.

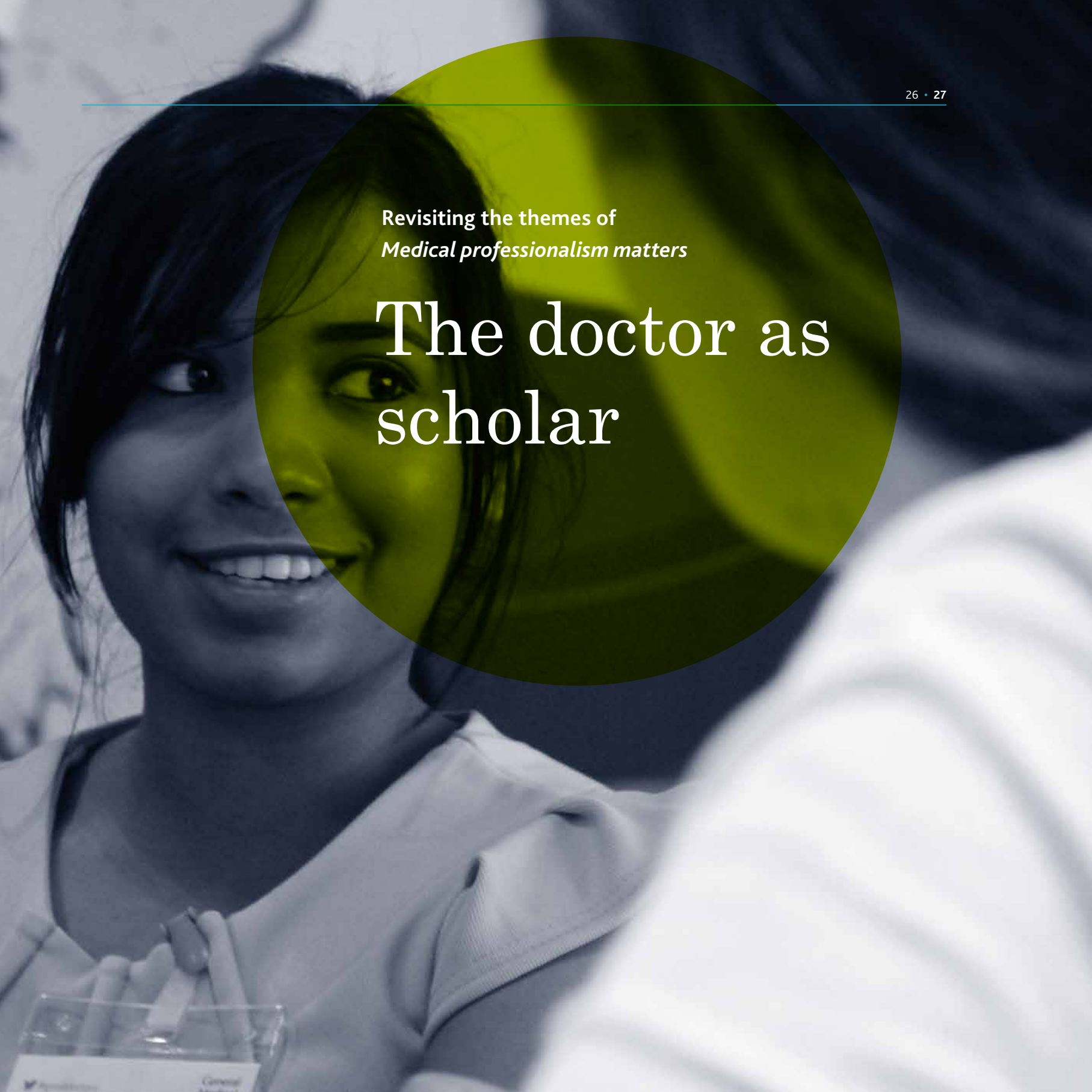
As mentioned at other events, there needs to be a culture of openness and no-blame. All staff should believe they can influence the way a service is run and feel empowered to raise concerns. Morbidity and mortality meetings should take place in an open, non-recriminatory climate. Many delegates referenced the airline industry which has a no-blame culture that has engendered an enviable safety record.

- **SHARED LEARNING** Shared learning across disciplines and professions is important and needs to include hard-to-reach professionals such as locums and single-handed GPs. Could there be a slot at every board meeting to hear the story of a doctor in training?
- **MONITORING** Clear systems are needed to monitor and improve safety and quality and to differentiate between the avoidable and unavoidable. Staff should be encouraged to feed back after any incident. Audit trails and patient feedback are also critical.
- **LEADERSHIP** Strong clinical leadership is vital. Often this comes through small things such as offering help to someone who is struggling, praising good work, taking time for coffee breaks and encouraging staff to raise concerns. Collaborative leadership is often the key to quality improvement.
- **CHAMPIONS** We need to establish a culture of improvement. Is there a case for local 'improvement champions'?

- **PROTECTED TIME** Every doctor should have at least 10% protected time to engage in quality improvement work and training. This could be incorporated into the annual appraisal.
- **JUNIOR DOCTORS** Junior doctors' hours need to be carefully monitored to make sure limits are not exceeded. One suggestion was for a single national phone number that people could contact with safety concerns.
- **HANDOVERS** High quality, consistent handovers are crucial to safe care.
- **INTEGRATION** Clinical and non-clinical managerial roles need to be integrated – and the divide bridged between 'them' (managers, organisations) and 'us'.
- **SHARING BEST PRACTICE** Examples include: the Scottish Patient Safety Programme, which has been demonstrated to save lives, practice-based small group learning and significant event analysis.
- **PATIENT INVOLVEMENT** Patient involvement is fundamental to both improving quality and ensuring safety. This can come through complaints and feedback – not just surveys but also from individuals. Bear in mind that patients may be more open about their experience in some specialties, such as palliative care, than others, such as oncology.
- **COMMUNICATION** Good communication between doctor and patient is critical. There should be a duty of candour and a culture of immediate apology when something goes wrong.
- **CONTINUITY OF CARE** There has to be better information sharing. Some doctors are inclined to say 'it's our data' and hold on to it. Electronic records need to 'speak to each other' – there should be one single medication chart. WhatsApp could also be used to coordinate clinical activities.
- **CELEBRATE** Celebrate success and positive outcomes.

Revisiting the themes of  
*Medical professionalism matters*

# The doctor as scholar



Should all doctors be scholars? And what does being a scholar mean anyway? Participants debated these issues during the course of the *Medical professionalism matters* events and came to some tentative conclusions – as well as raising concerns for the future.

## Being a scholar

There were, it was generally agreed, a number of different levels of scholarship, ranging from full-blown research to evidence-based clinical practice. But at heart, it was felt, all doctors should meet the basic definition – that is, they should be questioning (themselves and others), challenging and innovative in practice.

Of course that doesn't mean that all doctors are putting theory into practice and operating as scholars. Participants identified a number of barriers to this goal:

### • TIME

Scholarship involves reading, research, keeping up to date. Doctors pointed out this often had to be done over and above normal work hours. They also complained they had little time to reflect on the job. Two thirds of doctors in our survey said they did not have the time to pursue scholarly activities.

### • TRAINING

Some believed that medical schools' focus was increasingly on competence rather than excellence. This mechanistic approach militated against scholarship.

### • FRAGMENTATION

Doctors felt services had become worryingly fragmented in today's health service. There was not the same camaraderie there had been between different parts of medicine and across professional boundaries. The three-monthly rotation of doctors in training prevented them from feeling part of a team.

### • ROUTINE

Participants were asked whether the spirit of inquiry is maintained throughout doctors' careers. Many agreed students and junior doctors were curious and questioning but wondered whether this continued – especially for isolated practitioners such as locums. Scholarship can be a very lonely place, said one doctor, especially if you want to do something different.

### • ORGANISATIONAL PRESSURES

Trusts' emphasis was on productivity not quality, and process not outcomes, many participants felt. Does the job description allow for reflective practice, let alone innovation and risk taking?

### • FUNDING

All doctors should teach and research, said one doctor. The problem is there's not the funding to do this.

# 67%

of doctors say they do not have the time to pursue scholarly activities



# 31%

– and 45% of GPs –  
oppose publication of  
team and individual  
results

# 69%

support further transparency  
but warn of perverse  
consequences

#### • REGULATION AND GUIDELINES

Many felt there was too much regulation in society and that we were becoming increasingly risk averse and that the demands of guidelines often hampered innovation. But it's in doctors' DNA to innovate, experiment and contemplate risk, they noted.

Guidelines were only as good as the evidence they're based on – they should be a direction of travel, not the destination. Regulation makes you think inside the box – innovation (and scholarship) is thinking outside the box, said one.

Some suggested that regulation and guidelines increased the temptation to practise defensive medicine, which was seen as the opposite of the scholarly approach. One group felt doctors were subject to higher levels of scrutiny than other health professionals.

#### • EVIDENCE

Is there such a thing as genuinely evidence-based practice anyway? Some referred to a recent *New England Journal of Medicine* leading article suggesting that it was “simply no longer possible to believe much

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*Scholarship is at the heart of professionalism and curiosity is the key ingredient.”*

of the clinical research that is published”. However, most participants rejected this argument.

## What doctors recommend as a standard of professionalism

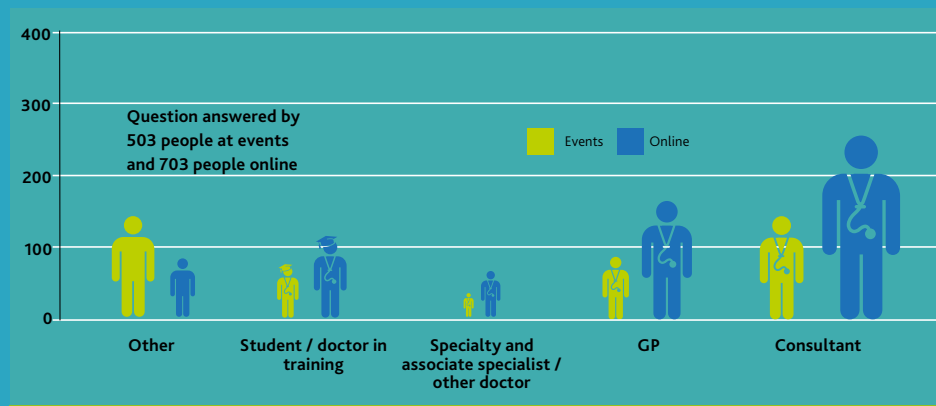
Doctors suggested a number of ideas to improve matters:

- **LIFELONG LEARNING** Many participants felt scholarship was closely aligned with lifelong learning. Employers, as well as individual doctors, need to work to make this happen. And should learning literally be for life? One doctor noted that now he was retired he at last had the precious gift of time: “Perhaps old scholars never fade away, they only die.”
- **CREATE SPACE** We need to create space for scholarship. It is important to have a safe place to reflect. There needs to be protected learning time within the job.
- **LEADERSHIP** Doctors need to have the courage to be leaders – again. “It has never been more important that we have the courage and conviction to stand up and be counted,” said one doctor.

- **MENTORSHIP** Mentorship is another vital ingredient of scholarship at all levels – though maybe it works best when it is informal rather than compulsory.
- **PATIENT FOCUS** We should all be learning from, and working with, patients.
- **TEAMWORK** Working in teams, networking, and multidisciplinary work all enhance scholarship, encouraging debate and discussion and providing a protective culture.
- **SHARING LEARNING** Scholarship is also about teaching others. We should be sharing what we have learnt. Peer learning groups are also very valuable – everyone should be part of one.
- **RISK TAKING** We have to enable people to take risks.
- **ORGANISATIONAL RESPONSIBILITY** Organisations as well as individuals need to be responsible and accountable for their training.

# Medical professionalism in numbers

## Who we talked to

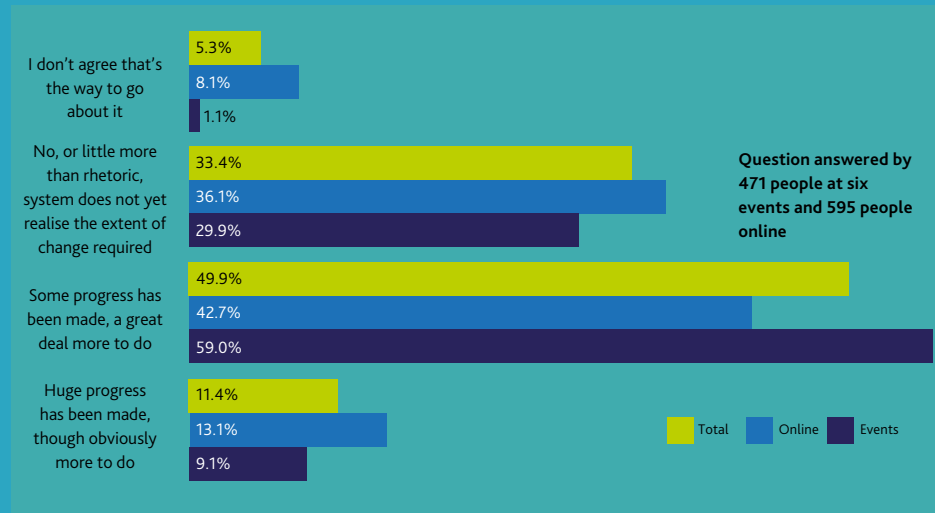


Doctors are expected to use their professional judgement to decide the right course of action and what is in their patients' best interests. How often are you uncertain you made the right decision?





Don Berwick said the NHS should continually and forever be reducing patient harm by embracing wholeheartedly an ethic of learning. How far is the health system achieving that?



44%

supported the contention that doctors are less compassionate now than they were 20 years ago

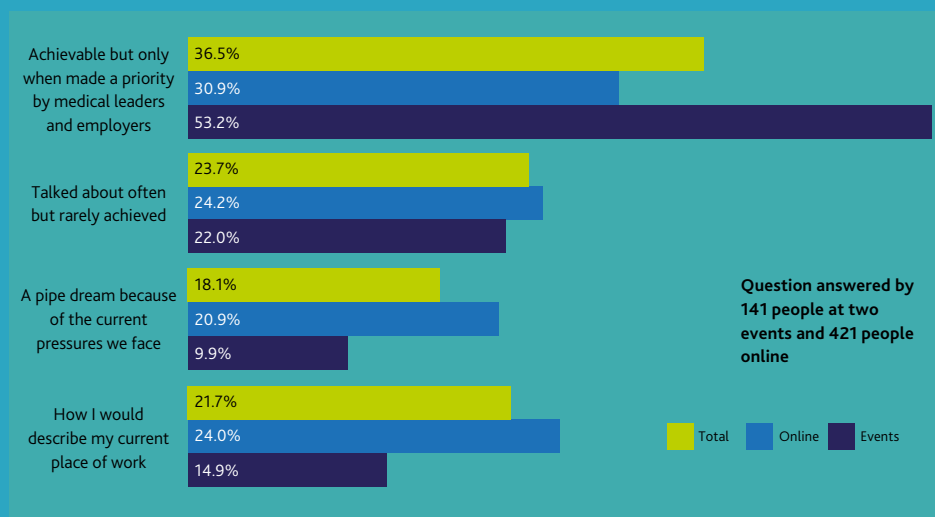
58%

of respondents were either unsure or not confident that they would be supported if they were to raise a serious concern

66%

of participants thought it was possible to teach empathy

A supportive working environment is...



# Conclusion: the way forward

*The Medical professionalism matters series was held in the face of a number of challenges in the healthcare system. While doctors expressed considerable unease during the course of these events, the overriding message remained one of optimism and humility. They spoke time and time again of the privilege of being a member of the profession, their fascination with their work and their potential to make a real difference to people's lives.*

Medicine is immensely challenging but it is also immensely rewarding. This series was of course deliberately focused on the challenges and the areas that need to change. But in taking the findings forward, we need also to celebrate everything that is astounding and transformational about the profession. That includes world class scholarship, the extraordinary commitment to delivering the best for patients even under acute pressure, the teamwork and mutual support and the day-to-day human and scientific miracles that too often we take for granted.

The organisations involved through the *Medical professionalism matters* Advisory Group have each committed to taking forward the learning – and the conversations – through further deliberations, all of which will be hosted on the [gooddoctors.org.uk](http://gooddoctors.org.uk) website. This will also contain a range of tools and resources to help doctors reflect on these issues with colleagues locally.

As a first step, the Royal College of Physicians of England (RCP) is hosting a series of interactive workshops working with the GMC's Regional Liaison Service to develop training tools to assist doctors communicating difficult messages to colleagues.



In addition, the Regional Liaison Service will continue to work with doctors and medical students on applying professional guidance to the often challenging situations they face. The Regional Liaison Service is increasingly working to focus its support for doctors with those that may find it most challenging.

The Royal College of Surgeons in England (RCS) has released new resources, including podcasts, to support surgeons with good consent practices.

The BMA will continue to support doctors by providing ethical guidance, professional development workshops and counselling services.

At a time of unprecedented unease for medical professionalism, the onus is on each of us to rise to the occasion by making time to think, talk and work together to address these challenges collectively.

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