



Royal College  
of Physicians

# Advancing medical professionalism



‘There is increasingly a gap between what doctors are trained to do and the realities of modern practice.’

– *Advancing Medical Professionalism*

The current pressures and identity crisis afflicting medical professionals are competing with, and even undermining, the vocational ideals that led many into the profession, causing some to question their initial choice and whether they should carry on. How one views oneself in an occupational role, and the sense of achievement and value that arise from it, are critical for motivation. So, how do we prepare and educate students and junior doctors for the realities of modern medicine? And how do we support doctors to improve their practice and maintain professional satisfaction throughout their careers?

The RCP and partners hope that *Advancing Medical Professionalism* can be part of the answer. This short document summarises the key points from our full professionalism report. The report was developed in consultation with healthcare professionals, patients and other stakeholders, through a series of interviews, focus groups and workshops held during 2017.

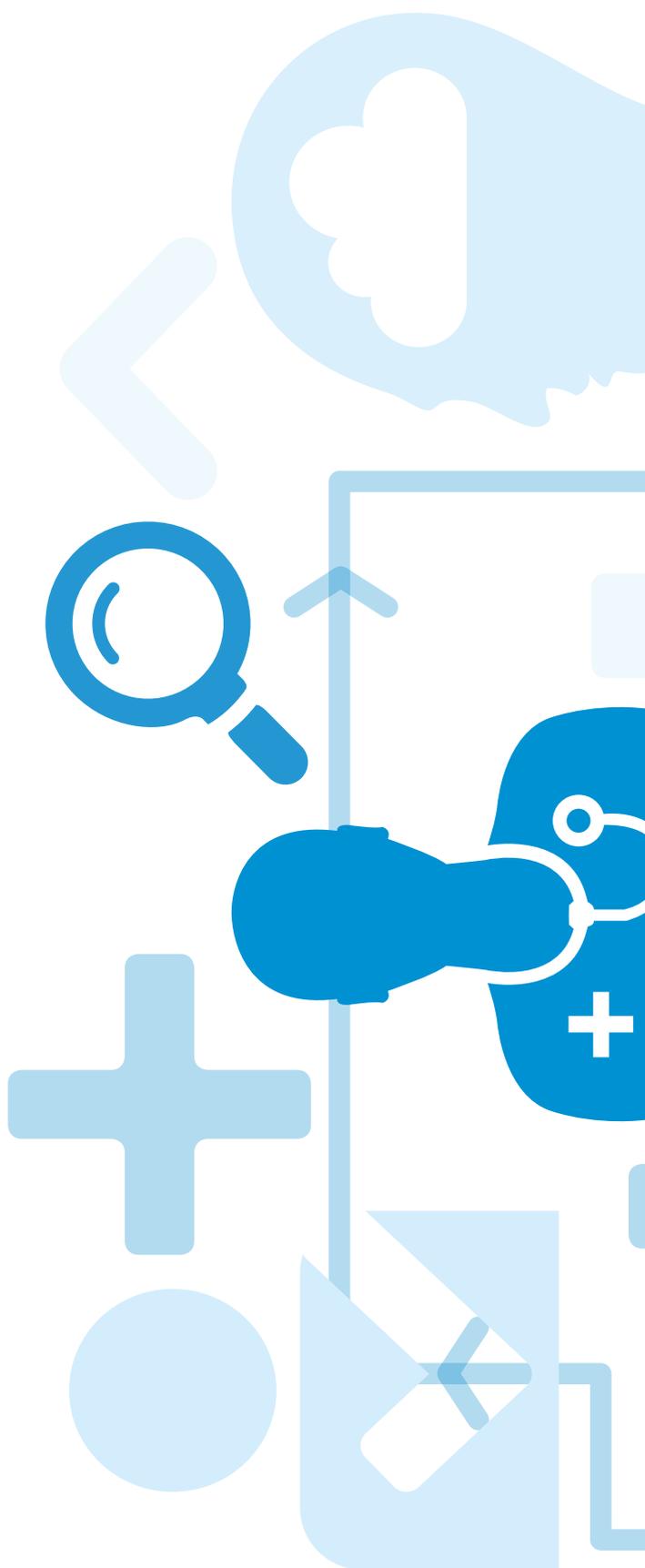
The report focuses on seven key aspects of professional practice; doctor as healer, patient partner, team worker, manager and leader, learner and teacher, advocate, and innovator. These seven characteristics are not yet viewed as part of the core professional identity of the doctor, but we hope that individuals, teams and institutions will use these to help them explore and develop professionalism. The attributes of the modern professional doctor, which relate to all seven aspects of professional practice, are summarised below.

## The key attributes of the professional doctor

The modern professional doctor...

- > **Creates** – nurturing a strong sense of purpose and meaning in their work and creating a strong professional identity based around the needs of patients and society.
- > **Commits** – dedicating themselves to developing, refining and modifying the seven characteristics of the modern doctor throughout their career.
- > **Demonstrates** compassion, integrity and respect in dealing with self, patients, team members and other colleagues.
- > **Develops** others, supporting patients, colleagues and organisations to achieve their goals through teamwork, education, leadership, advocacy and innovation.
- > **Exercises judgement** – combining current evidence with patient preferences and their own professional judgement to support patients in making informed choices.
- > **Innovates** – embracing and leading innovation in all forms, using the skills of critical appraisal and the principle of patient benefit.

*Barriers to developing these attributes include lack of time and support for skill development, and the structures and systems which undermine principles such as teamwork, clinical leadership, learning from error and advocating for patient welfare.*



# Doctor as healer

‘Society and the delivery of healthcare changes, and the treatment of disease evolves, but the need for healers remains unchanged.’

## – *Advancing Medical Professionalism*

The origins of the word healing mean to ‘make whole again’. Healing answers a fundamental human need to be cared for in times of difficulty. It has persisted despite technical, scientific and industrial advances and can be found in virtually all cultures and religions. Healing is still needed because as professor of integrative medicine, Rachel Naomi Remen, has said: ‘We thought we could cure everything, but it turns out we can cure only a small amount of suffering. The rest of it needs to be healed.’

The doctor-healer must combine both expertise and compassion. Reconnecting with the role of healer based in scientific knowledge and commitment to moral practice can enhance professionalism and professional satisfaction.

## Key attributes of healers

- > The little things such as how patients are greeted; healers stand up, make eye contact, smile, introduce themselves, ask patients how they would like to be addressed and acknowledge others in the room.
- > **Active listening is at the heart of healing.** ‘Listening well’ takes time and effort. For patients to be healed they need to feel they have been understood. Even in a brief consultation, questions about family and occupation can help build the relationship central to healing.
- > **Be open.** Doctors responding emotionally to their patient’s pain will enhance their power as healers. This is a difficult balance to get right, but showing the appropriate, intelligent emotional response demonstrates the humanity and vulnerability of the doctor.
- > **Find something to like in the patient.** Research indicates that this helps healers to generate the compassion needed for healing.
- > **Removing barriers.** These include physical barriers such as a desk or computer but also other barriers such as adopting a superior attitude or using technical language which patients cannot understand.
- > **The difficult conversation.** It can be easier to prescribe more drugs or a further operation than to have ‘the difficult conversation’ (for instance about end-of life-care). Doctors who wish to be healers rather than technicians will choose to have those difficult conversations.
- > **Caring for yourself and the patient.** Patients and the public must believe that doctors put their interests first. To achieve this, doctors must care for themselves. A basic building block of professionalism is to understand and manage oneself.

## The importance of vocation

Vocation is also an essential component of healing and professionalism, and involves a strong sense of suitability for a particular career or profession. In medicine this is usually characterised by capability in science, a desire to help others, and commitment to a greater good. Unfortunately for many doctors, current pressures and the identity crisis afflicting medical professionals are competing with the vocational ideals that lead them into the profession.

## What you can do

### Organisations

Support doctors to develop fulfilling, rewarding careers. Ensuring job plans commit at least 20% of time to the activities most meaningful to the professional is associated with a 50% reduction in the risk of burnout and will help recruitment and retention.

### In education

Support students and early career doctors to understand their needs and motivations and to choose a career or specialism suited to this. Support doctors in training to read and discuss the purpose of medicine and healthcare as a complement to their technical training.

### The individual

Take time to reflect on your sense of vocation as a doctor. How did it start and how has it developed? What does it enable you to do for others? What do you enjoy in your job and how can you do more of it? Reflect on your daily work as a professional in relation to the attributes of healers. What systems and relationships need to be in place to sustain you as a healer for the years ahead?



# Doctor as patient partner

‘The level of deference given by patients to their doctors is changing and the need for a more balanced relationship growing.’

## – Patient representative

The patient-doctor relationship is at the core of the doctor’s work. The traditional relationship of patient deference to doctors has changed; the law now states that doctors must engage in shared decision making with patients and patient autonomy has become an important principle.

### Patient autonomy

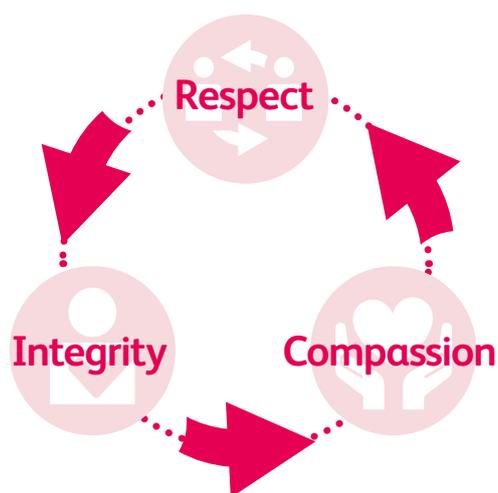
Patient autonomy, however, offers some challenges and doctors and patients need to grasp the complexity of the changing relationship for it to prosper. Patients can end up feeling abandoned to their autonomy if the clinician refuses to do more than ‘inform’ them. The nature and severity of illness, and capacity of the individual for informed consent, are also important factors affecting patient decision making. Carers, parents and advocates may not wish to have decision making responsibility on behalf of others.

The answer is not to return to the idea of ‘doctor knows best’ but for patient and doctor to each understand their roles. Shared decision making brings together the patient’s individual values and wishes with the doctors’ professional knowledge and experience to make the best decision for each individual patient.

### Vulnerability of patients

The doctor-patient relationship is special among professional relationships because patients are innately vulnerable, relying on others to safeguard their health and wellbeing. The vulnerability at the heart of the patient-doctor relationship is both a challenge and an opportunity. It can result in suspicion and the need for patients to question and analyse actions and decisions, which may be uncomfortable for doctors. At the same time, it can be a driving force for creating a safe, high-quality and equitable healthcare system.

### Importance of professional values



The RCP’s Patient and Carer Network were asked to identify the values they believed doctors should have, which were considered under three headings: integrity, respect and compassion.

### Integrity

In this context, integrity centres on putting the patient’s interests first: this includes doctors staying up-to-date with advances in practice but also having the humility to realise their limits and seek answers when needed.

### Respect

In a respectful interchange, the views of both participants are acknowledged as important. Respect may involve: listening to patient concerns, involving them in decisions, respecting their choices and involving family and carers (with consent). Feeling listened to is perhaps the most fundamental element in building respect.

### Compassion

Compassion is the value or quality of doctor and patient-doctor relationships that not only recognises suffering but also wants to do something to relieve it. It facilitates companionship amid uncertainty, a sensitive approach to risk, and intelligent reasoning and decision making. Compassion moves the patient-doctor interaction beyond the purely transactional and is strengthened when bounded with respect and integrity, enhancing morale and wellbeing.

## What you can do

### Organisations

Expect staff to demonstrate the key values of integrity, respect and compassion at all levels of the organisation and reflect these values in organisational policies, objectives, and procedures.

### In education

Ensure undergraduate and postgraduate medical curricula stipulate a more complex and nuanced understanding of patient autonomy and shared decision making in teaching and assessment systems.

### The individual

Set aside ten minutes a day for the next two weeks to reflect on a significant patient consultation. This might be one that went particularly well or perhaps was particularly challenging. Think about this in relation to the key attributes of integrity, compassion and respect and consider what you might do differently in future.



# Doctor as team worker

‘Teamwork is like any other skill and benefits from practice, training, and feedback on performance.’

## – Advancing Medical Professionalism

In the 21st century the success of professionals will be defined by their ability to work collaboratively in complex teams. Teamwork is an important component of professional satisfaction and engagement, and effective teamwork improves patient outcomes, as well as organisational performance and productivity. Doctors may inhabit multiple teams in a day, eg a theatre team, a ward team, and an outpatient clinic team, even if each of these teams are short-lived.

Despite its importance, team working in healthcare is not prioritised by organisations nor seen as particularly glamorous. Modern medicine often offers fewer opportunities for feedback and improvement, less coaching/mentoring, and loss of a crucial support network. Analysis of adverse event and malpractice claims shows that poor teamwork is at the root of between half to three-quarters of events.

### Box 3.1 Behaviours of team members in successful teams

#### Demonstrate understanding

Understands themselves and recognises their impact on others.

#### Commit

Recognises the importance of the team’s goals and works with purpose to achieve these.

#### Support

Helps others to achieve individual and team goals, supporting through difficulties and maximising success.

#### Negotiate

Works to solve conflicts in the group and create consensus where possible.

#### Communicate

Is respectful in the way they converse and communicate with other team members and keeps the team up to date.

### Box 3.2 Behaviours of successful teams

#### Speak up

Team members are expected to speak up, ask questions, acknowledge errors and raise issues.

#### Reflect

Team members meet on a consistent basis to discuss, observe and question the work of the team.

#### Disagree

Team members will have different viewpoints; this is a core reason for teams to exist. Resolving conflict effectively creates opportunity.

#### Experiment

The team adapts work to solve the problem. Errors are acknowledged and lessons learned.

#### Listen

Team members work hard to understand each other’s opinion and respect the expertise of all members.

(Box 3.2 Adapted from Edmondson, HBR 2012)

There are good tools and resources available to promote high-quality teamwork in even the shortest duration team. However, it is important where possible to also have more established teams working together over a longer time period.

The three areas that teams should focus on to improve effectiveness are improving **culture, communication, and reflexivity** (the ability to reflect on events and learn from them).

### Team culture

can be summarised as ‘how things are done around here’. Improving team culture involves recognition of the contributions of individuals, creating a supportive working environment, containing disruptive behaviour, and enabling open communication.

### Team communication

Effective communication is a challenge because healthcare professionals work in stressful environments, have high levels of responsibility and are often distracted and interrupted. In these circumstances, communication needs to be actively worked on and developed.

### Team reflexivity

Team reflexivity is the ability of teams to reflect on events, learn and then act. In the best teams this is a continuous process embedded in daily working routines. Team debriefs offer an effective tool for teams to reflect and adapt their ways of working.

## What you can do

### Organisations

Prioritise time for teams to meet for a short time on a regular basis. Invest in off-site training in the skills needed to work in teams. Provide relevant feedback data to enable teams to assess their performance and modify their practice as needed.

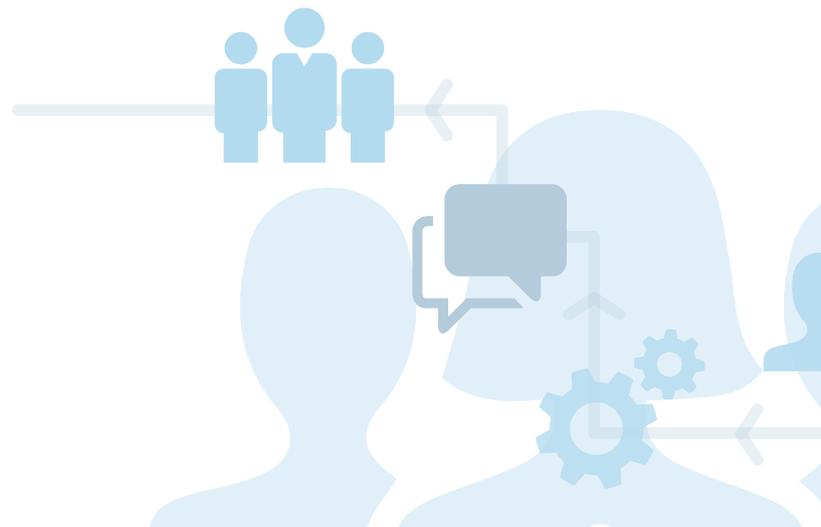
### In education

Ensure that skills related to team work are embedded, prioritised and rewarded in education and training programmes, including the skills of group reflexivity. Develop techniques to and assess team performance.

### The individual

For a minimum of one week, introduce a team huddle in your department at least once a day. Huddles should last for 10–15 minutes, optimise staff engagement, and focus only on essential information. See full report for checklist.

## How to improve teams



# Doctor as manager and leader

‘If you want to engage people, it has to mean something. There are a few trusts where you feel it: good leaders surrounded with good people, given the freedom to get on with it.’

– Senior health leader

The impact of good clinical leadership on individuals, departments and services cannot be underestimated. Doctors are uniquely placed to understand the trade-off between medical science and organisational imperatives, while their professional identity prioritises what is best for patients – making them effective managers. Good clinical leadership can transform patient outcomes.

Leadership exists at all levels, from the individual role-modelling professional behaviours through to chief medical officers and national medical directors. Beyond formal leadership roles, doctors can also have a strong influence on shaping healthcare through effective leadership of teams, wards, clinics and by modelling good practice.

Formal clinical leadership is often seen as a challenge, which requires dealing with a stream of new and conflicting initiatives, exacerbated by low staff morale and a limited budget. It may even seem to compete with the doctors’ professional oath to put the interests of patients first. Developing the skills to balance these competing priorities is vital but has traditionally been underdeveloped in medical training.

Doctors moving into a leadership role should be offered formal management and leadership training. Creating strong triumvirates between doctor, nurse, and manager at each level in an organisation can offer support and enables clinical leaders to work more effectively. Bureaucratic restructuring alone, however, is unlikely to yield sustainable results. Medical professionals should be empowered to lead and have authority in the delivery of healthcare. Collaborative, rather than competitive, leadership should be encouraged.

## Questions clinical leaders should regularly ask themselves

Is the content of employees’ work primarily related to their higher goals: delivering the highest standards of patient care?

Are employees adequately supported to develop their professional attributes? Could more be done, or could it be done in a better way?

Do the culture, structures and processes enable or hinder team working?

Are employees trusted and given the flexibility to use their professional judgement?

## What you can do

### Organisations

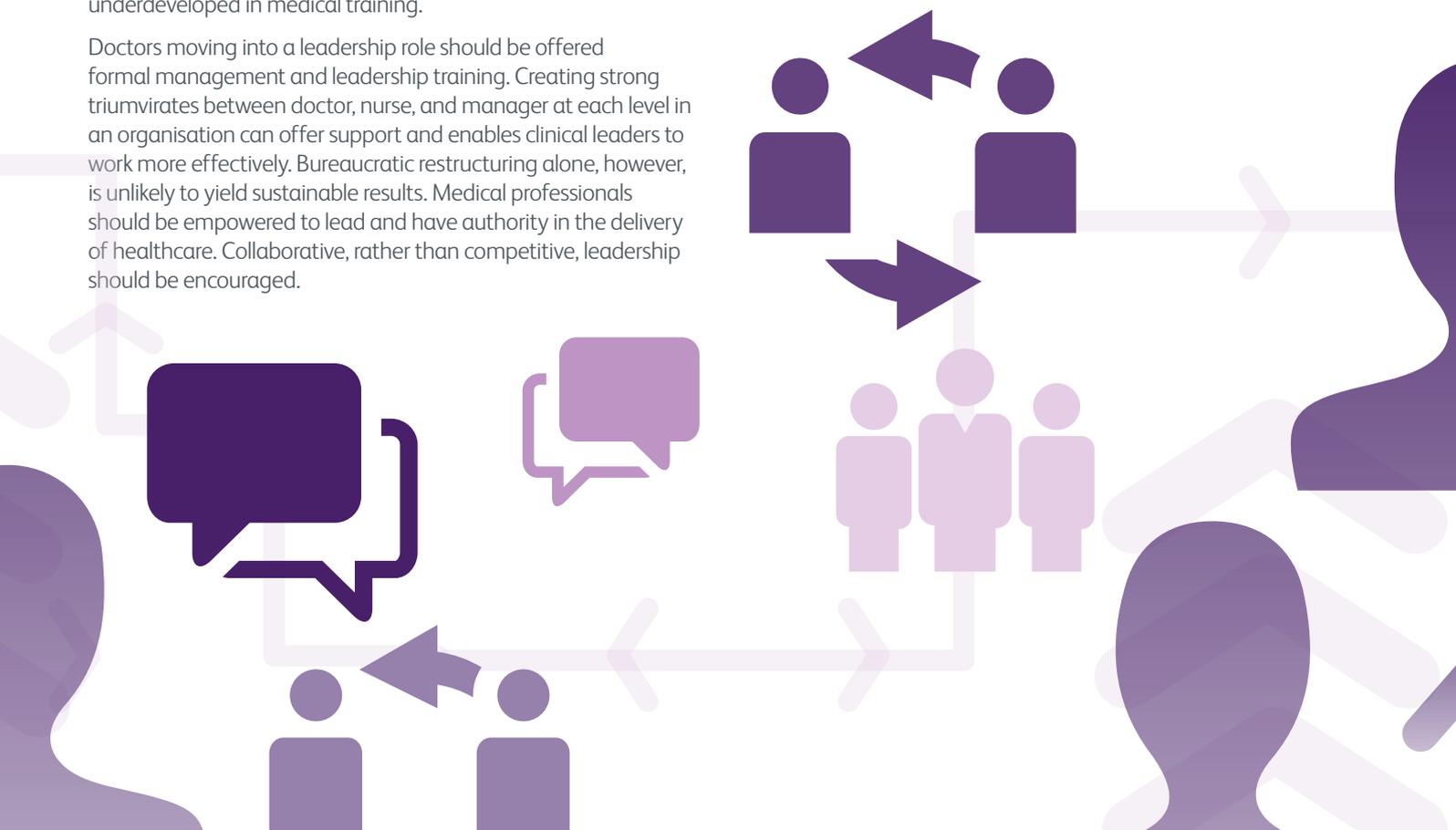
Publish targets that are outcome rather than process driven. Trust in and allow the autonomy of front-line teams. Incentivise clinical lead roles.

### In education

Teach clinical leadership skills to all doctors, and create learning opportunities and support for doctors in formal leadership positions to facilitate a higher level of leadership skill.

### The individual

Ask three of your peers (including at least one junior), to give you feedback on your performance in your role. Take time to reflect on the responses. Commit to doing this at least twice a year. The boxes in the full report can be used to structure the feedback.



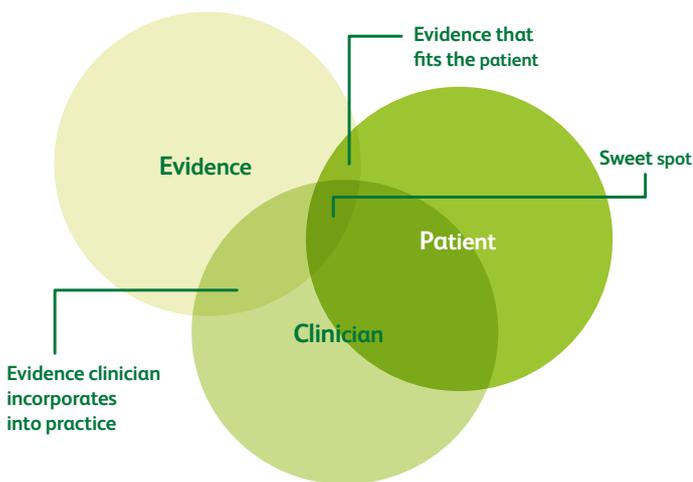
# Doctor as learner and teacher

‘It feels as if people have had lots of clever ideas [about medical education] and, in isolation, they worked but no one goes back and looks at a system as a whole.’

## – Doctor in training

**Lifelong learning** A commitment to lifelong learning underpins the work of all professionals and doctors should seize every opportunity to learn and develop their knowledge, skills and attitudes. Learning should include both the scientific and technical arenas. It should also include the ability to reflect on an event or experience and improve practice, and the understanding that mistakes and errors are an essential part of learning and improving.

Keeping up-to-date with evolving medical practice, including around evidence-based medicine, is vital. Evidence-based practice empowers doctors to deliver the highest quality care and identify questions for future research.



### Box 6.6 Feedback model: Effect, not blame, model

- 1 State the behaviour as neutrally as possible (avoid excessive use of ‘you’)
- 2 Let them know how you are affected (or team/project/organisation)
- 3 What can we do now to move forward

### Box 6.2



#### Personality

- Positive
- Respectful towards patients, families, staff, and colleagues
- Honest
- Shows integrity
- Sense of humour



#### Teaching

- Communication skills, especially listening
- Ability to make difficult topics understood
- Patience
- Non-threatening teaching style
- Adjust to different abilities



#### Clinical skills

- Competent
- Knowledgeable
- Proficiency as a diagnostician
- Enthusiastic in work
- Stresses importance of the patient–doctor relationship
- Awareness of strengths and weaknesses

**Education and training** are also a necessary component of the role of the doctor. Many doctors hold formal teaching positions, and most doctors will teach in consultations, at the bedside, or during operations. Supervision, formal and informal teaching and role modelling are all important for passing wisdom to the next generation and driving up the quality of healthcare.

**Learning and teaching of professionalism** Until the 1980s Doctors used to learn professionalism through apprenticeship to a particular consultant or set of consultants, but it is now a specific part of postgraduate training. Changes to postgraduate medical education in the early 21st century put an emphasis on completing pre-defined competencies; this and other changes (short rotations, loss of team etc) have undermined professionalism education, and appraisal meetings have been described as tick box exercises.

Now rather than focusing on isolated behaviours, there is a call for more emphasis on developing a ‘professional identity’ through mentoring and role modelling. Learners are encouraged to understand themselves, who they are, and what they wish to become. This is based on the belief that medicine is so complex it is impossible to learn correct procedure for every circumstance but that developing professional values will empower clinicians to navigate the complex challenges they face.

## What you can do

### Organisations

Foster a genuine culture of learning that supports all professionals to be lifelong learners and educators. Encourage feedback at all levels and enable employees to act upon it. Adopt the RCP chief registrar programme and flexible training portfolio, which combines apprenticeship-style professional development with competency-based learning.

### In education

Promote learning about professional identity in undergraduate and postgraduate curricula as part of training in professionalism.

### The individual

Consider two people who have been role models in your career. Write down the attributes that you most admired in them. Consider all the people you are a role model to, what attributes would you like them to write down about you, and how you could model these attributes more effectively. See main report for assistance.



# Doctor as advocate

‘The professional is able to escalate concerns about their own and other practice in a way that improves rather than disempowers. These things rarely become evident if people fear retribution.’

– Senior healthcare manager

An advocate can be defined as ‘someone who speaks on behalf of others and helps others speak for themselves’. Professionalism requires that doctors advocate on behalf of their own patients, patients in general, and future patients. This advocacy can be undertaken by both individual doctors and their wider medical organisations.

## Promoting patient safety

Advocacy on patient safety is a professional duty for all doctors and should be given the highest priority. Medical errors arise from both system and personal failures and most are preventable. Raising concerns can be difficult and needs training, practice, and mentorship as well as a ‘just culture’ within which issues can be raised.

### Box 5.2 Reasons doctors don't speak up

- > Lack of clarity: how to report, and to who?
- > Fear of retaliation
- > Futility: nothing will change
- > Not wishing to appear ‘unable to cope’
- > Hierarchical nature of medicine

The gold standard in patient safety culture is when healthcare professionals are held accountable for unprofessional conduct yet are not punished for human mistakes. Such a culture will also recognise and support ‘second victims’ (affected staff) by promoting a genuinely transparent and non-judgemental reporting culture in which staff are allowed adequate time and resources for investigations. Without this, doctors will develop destructive mechanisms such as anger, blame and defensiveness to protect themselves.

Trustworthiness is essential for doctor advocates and medical philosophy suggests that it has three components: honesty, competence and reliability. Communicating mistakes to patients shows honesty and suggests trustworthiness. It can seem that admitting errors is incompatible with competency; in fact, apologies for medical errors can reduce the blame attributed to professionals, improve doctor-patient relationships and enhance trust. Communicating errors to patients with respect, integrity and compassion is a skill all doctors need to develop and improves the trustworthiness of the individual.

Doctors’ organisations have a strong track record of advocating on issues such as air pollution, poverty, tobacco, alcohol, diet, physical activity, seat belts, and many other issues affecting health. Climate change is the most significant threat to global health and should be a key concern for doctors. The NHS is a major emitter of greenhouse gases and healthcare leaders and professionals should advocate for action on climate change in organisational strategies and targets.

## What you can do

### Organisations

Use untoward incident responses to build human factors principles into analysis of significant events and identify and mitigate against future risk and support the professionals involved. Systems should be audited against these principles.

### In education

Skills in patient and population health advocacy should be developed across the continuum of undergraduate and postgraduate education, including continuing professional development. Doctors should be educated to both understand and manage clinical risk and raise and manage concerns effectively.

### The individual

During your next clinical shift, note all the systems, practices and events which have real or potential safety risks. Are any of your behaviours contributing to these risks? Is there something you could work with colleagues to improve? How would you start this process and who would you need to involve?



# Doctor as innovator

‘The doctor’s role may increasingly be interpreting machine-obtained data instead of direct interaction with patients.’

## – Advancing Medical Professionalism

Innovation in healthcare has been extensive and rapid, particularly since the Second World War. Innovations may be in technology, health policies, how healthcare is delivered, and much else. Sometimes the innovation is driven by doctors themselves and sometimes from outside medicine.

### Technological development

Artificial Intelligence, machine learning and digital technologies have perhaps the greatest potential to impact on how doctors work. They also raise many questions about the doctor’s role, values, ethics and medical professionalism.

Smartphones are already changing the nature of the patient-clinician relationship, allowing patients to initiate contact with specialists and enabling consultation at a distance. Wearable technology automatically collects physiological and health data from patients, while machine learning is expected to allow more efficient use of laboratory and other investigations.

### The doctor’s changing role

The unique role of the doctor in multidisciplinary teams has traditionally focused on diagnosis, yet automated systems are being found to be better at diagnosis than doctors, particularly in dermatology, radiology and rare diseases. Such systems can also identify appropriate treatment and management options.

In future, the doctor’s role may increasingly be interpreting machine-obtained data and we need to think carefully about what will be lost and gained by such developments. While machine-gathered data and histories may be more reliable, taking a history provides a key opportunity to build relationships with patients. In the same way, gentle and skilled physical examination can mediate compassionate care and reduce anxiety.

In fact, collaboration between doctor and machine is likely to give the best outcome. AI can hold hidden biases and distortions, while experienced doctors can use the expert combination of multiple sources of information and previous experience to form a diagnosis.

## The importance of research and scholarship

To be effective, innovation must build on the skills and attributes the doctors develop as healer, patient partner, team worker, leader and manager, advocate, learner and teacher – with a continued commitment to enquiry, reflection and learning. Research will be a fundamental part of this process and doctors should have a positive attitude to all aspects of research.

### Research opportunities

- > Recruiting patients into trials
- > Publishing papers, including literary reviews and quality improvement outcomes (as leading or contributing author)
- > Leading or assisting audit or quality improvement research
- > Leading or assisting observational research
- > Leading or assisting laboratory work
- > Developing new guidance
- > Leading and assisting clinical research

(Adapted from the RCP report *Research for all*)

Moreover, as innovation in healthcare continues apace, doctors need to see themselves as active scholars, able to explore aspects of literature, philosophy, theology, history and other humanities – to identify what these disciplines can add to understanding of medicine. Humanities research can help address new challenges by throwing light on our ethics and values, and the human aspects of medicine, helping doctors achieve the best blend of innovation and patient care.

## What you can do

### Organisations

Be prepared to reflect critically on the impact of AI, machine learning and digital technologies on medical practice, and ensure traditional practices of physician interpretation, communication and action are supported by them rather than undermined.

### In education

Allow space in the curriculum to learn about AI, machine learning and digital technologies in medical practice. Provide learning opportunities for the exploration of medical humanities which can throw light on the ethical and values-related aspects of technology.

### The individual

Data drives innovation. Choose something to measure in your clinical practice, such as the number of patients who develop a complication from a treatment. Identify patterns and consider whether changes to your practice could improve outcomes. This can also help you identify questions for further research.

***Advancing Medical Professionalism* and the summary document were authored by Dr Jude Tweedie, Professor Joshua Hordern and Professor Dame Jane Dacre. Dr Richard Smith added to, and extensively edited, the report. Louie Fooks edited and contributed to the summary. The Expert Advisory Group gave feedback on the full report as it progressed. Professor Dame Jane Dacre approved the final document.**

For full reading list, references, acknowledgements and methodology please see full *Advancing Medical Professionalism* report.

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