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EDITORIAL

Medical professionalism in psychiatry

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SUMMARY

The principles of primacy of patient welfare, patient autonomy and social justice are fundamental to medical and psychiatric professionalism. Medical professionalism is also about encouraging and celebrating good practice. As a set of values and behaviours on the one hand, and relationships with patients, carers and other stakeholders on the other, the implicit contract between psychiatry and society needs to be renegotiated regularly. Serious threats to medical professionalism in the past 30 years have led to the demoralisation of professionals. Learned helplessness and a perceived loss of autonomy have been recognised as important factors in the 'loss' of professionalism. Psychiatry as a profession needs to identify its core attributes, skills and competencies. Professionalism should allow individuals to set and maintain their own standards of care.

DECLARATION OF INTEREST

None.

Each profession has its own societal obligations and these contracts with society need to be regularly updated and renegotiated. In any profession, the key components of the professional contract include professional competence, scientifically or technically based knowledge, self-regulation and altruism. But what of the medical profession – and psychiatry in particular? What are the additional parameters defining our contract with society? And is it time that this contract be reconsidered?

How to define medical professionalism?

In 2002, the Medical Professionalism Project published its Charter on Medical Professionalism (American Board of Internal Medicine Foundation 2002). Developed by US and European physicians and published simultaneously in the USA and the UK, this charter is introduced with the following premise: that changes in healthcare delivery systems in high-income countries worldwide threaten the values of medical professionalism. It then sets out three core principles specific to medical professionalism: the primacy of patient welfare (based on dedication and altruism), patient autonomy and social justice. Further to these principles are ten commitments for physicians (Box 1).

The charter was not the end of the debate and medicine continues to grapple with the state of professionalism in its specialties. The Royal College of Physicians (2005) has defined medical professionalism as 'a set of values, behaviours and relationships that underpin the trust the public has in its doctors' (p. xi). It describes medicine as 'a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability' (p. 14).

Irvine (2006) has argued that medical professionalism is 'about both the encouragement and celebration of good practice and the protection of patients and the public from suboptimal practice'. These are indivisible, as public trust depends on both.

Sox (2007), using a historical paradigm, suggests that codes of ethical behaviour have changed in response to changes in the political environment within which medicine is practised. He identifies a set of core attributes across a historical span. These include causing no harm, acknowledging

BOX 1 Outline of the 10 commitments of the Charter on Medical Professionalism

1 Professional competence
2 Honesty with patients
3 Patient confidentiality
4 Maintaining appropriate relations with patients
5 Improving quality of care
6 Improving access to care
7 Just distribution of finite resources
8 Scientific knowledge
9 Maintaining trust by managing conflicts of interest
10 Professional responsibilities (including maximising patient care, self-regulation, remediation, disciplining)

(American Board of Internal Medicine Foundation 2002)

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a patient's right to privacy and not violating the moral codes of society. It is inevitable that changes in mores will affect practice.

Threats to professionalism

In the past three decades, a number of serious threats to professionalism have emerged. Professions such as medicine, education and the law have been challenged by politicians and other stakeholders. These threats might be divided into the external and the internal.

External threats to the medical profession

Erosion of public trust

In the UK, external threats include scandals such as those that led to The Royal Liverpool Children's Inquiry (at Alder Hey Children's Hospital), and the Shipman and Kerr/Haslam inquiries. The public perception was that the medical profession was unable to regulate itself: colleagues who knew about some of the problems engaged in a conspiracy of silence and whistle-blowers were ignored.

Loss of autonomy and changing roles

Increased regulation linked with reduced autonomy further contribute to deprofessionalisation. Prescriptive policies such as community treatment orders in England, which were introduced despite the opposition of a majority of the psychiatric profession, and the increased centralisation of funding mean that the profession is marginalised. Such threats to self-regulation are likely to turn doctors into technicians rather than healers.

In the USA, nurse-prescribing and the agreement that, in at least two states, psychologists can prescribe medication means that further erosion of the profession's responsibilities is likely, especially if these options are seen as cheaper and as effective as interventions by psychiatrists.

The role of the patient is also changing. Patients (and carers) increasingly use the internet to access knowledge on their conditions and treatments. In addition, many policy-makers would like to see patients take control of their own healthcare needs. Thus, many patients enter the therapeutic encounter not only better prepared than ever before, but also expecting to have a say in how their treatment is delivered.

The rise of the economic state

Montgomery (2006) raises concerns about how the law starts to have an impact on healthcare, especially as it is used by campaigning groups. For example, a pressure group can push politicians into agreeing to provide specialist services and pressurise professionals to come up with new clinical diagnoses. Campaigners can then use laws to increase pressure for both resources and processes related to a particular condition. A couple of years ago, the NICE guidelines on anti-Alzheimer drugs were challenged in the courts and the guidance had to be revised (National Institute for Health and Clinical Excellence 2009). In discussing demoralisation among medical professionals, Montgomery observes that various factors, including the law itself, may be to blame. The authority of the nation state, he suggests, is being superseded by that of what Bobbitt (2002) describes as the market state.

How have we come to be a market state? At one time in our nation states, professional guilds controlled not only the means of production, but also trainees and access to training. Capitalism, however, transforms nation states into economic states, which, to gain economic status, start to control training, trainees and the means of production (Krause 1996). This, coupled with increasing globalisation, means that attacks on professionalism may well come from the economic sector. The free movement of goods and people means that multinationals can buy into healthcare provision and training at cheaper rates, influencing 'healthcare tourism'. Also, doctors trained in countries where the cost of training is cheaper migrate to high-income countries, draining valuable resources from the country that trained them. In the present 'credit crunch' times, the profession needs to address this too.

Managerialism and new public management

Reinders (2008) argues that neoliberal managerialism and new public management are further serious challenges to professionalism. Neoliberal managerialism regards the market-led production and distribution of public goods as the prime regulatory instrument in the public domain (Harvey 2005). New public management seeks to improve the performance of the public sector by introducing managerial techniques taken from private enterprise (Pollitt 1993). Reinders holds the view that these approaches fuel consumerist views and values, which in turn contribute to a model in which the market in a society becomes an end in itself.

The combined effect of these managerial approaches is shifting the roles of professionals and adding pressures unrelated to the practice of medicine, such as increased documentation and detailed administration. Managerialism may further add to the deprofessionalising feelings among clinicians.

Internal threats to the medical profession

Threats to a profession will obviously be felt personally by its professionals. A few years ago, psychiatrists attending meetings at the Royal College of Psychiatrists were invited to complete a questionnaire relating to the deprofessionalisation of psychiatry (Bhugra 2008a). Internal factors such as the perceived and real loss of autonomy and self-regulation reported by respondents can produce a sense of rejection, alienation and learned helplessness. Psychiatrists may see other professionals as threats but many social workers and occupational therapists see psychiatrists as valuable (Bhugra 2009). Loss of autonomy and learned helplessness were seen as important factors in loss of professionalism. There is no doubt that changes related to funding both in the USA and in the UK have produced marginalisation of the medical profession (Bhugra 2008b).

Importance of professionalism

Apart from giving a clear sense of identity, higher self-esteem and pride, being a professional is also about belonging to a group with shared and acknowledged aims. Professionalism allows groups of individuals not only to set their own standards of practice but also to maintain them. As a professional group, it may be easier to establish a contract with society. These contracts are implicit and certainly the medical profession as a group can come to an agreement as to what it can and should be doing. The setting of standards allows the professions to own them and deliver services accordingly.

Being part of a profession also brings an element of collegiality and solidarity, thereby giving an opportunity to speak with a unified voice.

Patients expect doctors to have certain standards and to regulate themselves. Autonomy and self-regulation remain key concepts within professionalism. It is inevitable that if professions do not set standards and establish clear criteria for revalidation from within, these will be imposed from without. In the UK, principles of revalidation of doctors have already been identified.† Revalidation is to be related to continuing professional development (continuing medical education) and it is only the profession that can define what the components of this development should be.

The way forward

Holsinger & Beaton (2006) suggest that reduced autonomy, increased scrutiny and criticism, and a gap between patients' expectations and doctors' practice have contributed to dissatisfaction among clinicians. They recommend that professionalism encompass the essential values of quality, efficiency, respect for patients and patient advocacy, along with instrumental values such as integrity, social solidarity, social advocacy, provider autonomy, consumer sovereignty and personal security. They caution quite rightly that with limited resources it is inevitable that pressures on individual doctors will increase, and they suggest that early training in the better management of resources must be part of ongoing personal development. Internalising the values and virtues of medicine is essential (Hafferty 2006). Personal reflection must remain a core element of professionalism, and the Royal College of Psychiatrists' approach to peer-group development and using that time for reflection is a useful start (Royal College of Psychiatrists 2005).

As society and the process of healthcare delivery have changed, it is inevitable that the equilibrium that used to exist between medicine and society needs to be re-set. Hughes (2006) points out that the profession itself – by allowing arrogance, complacency, an inability to self-regulate and poor leadership – has contributed to a sense of demoralisation and deprofessionalisation. Thus, the way forward is to recognise the causes and try to deal with these challenges. For example, professional behaviour of teachers and trainees can be improved by defining professionalism for them and training them in its evaluation (Joyner 2007).

The implications for psychiatry are many. Psychiatry itself can influence professionalism in other branches of medicine. Psychiatrists are particularly skilled in understanding, coordinating and working with the components of a comprehensive healthcare delivery system, in ethical practice, in effective communication and cultural sensitivity, and in working with patients and their families (Talbott 2006).

Just as issues of professionalism are embedded in the curricula of most medical schools (Talbott 2006), so are they in the Royal College of Psychiatrists' MRCPsych curriculum and *Good Psychiatric Practice* (Royal College of Psychiatrists 2009). The next generation of psychiatrists must be aware of the core attributes of professionalism and must be prepared to amend these in response to changing times. As psychiatrists we are trained to deal with ambiguity and change, and we must lead on this.

Conclusions

The practice of psychiatry is vastly different from the way it was even two decades ago. The training of psychiatrists has changed, as have social expectations. Consequently, as psychiatrists we need to renegotiate our contract with society. This is an opportunity to understand the core

†For a discussion in *Advances* see Catto G (2008) Relicensing, recertification and regulation. **14**: 1–2; Mynors-Wallis L (2008) What will revalidation mean for psychiatrists? **14**: 86–8. Ed.

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attributes of professionalism and also to modify these in accordance with changes in society, in societal and patient expectations, in the practice of psychiatry and in the organisation of the National Health Service.

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