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'New' professionalism or professionalism derailed?

The future of the medical workforce and its professional standing in psychiatry continues to be the subject of scrutiny and fierce debate, particularly in the UK. The debate is not simply confined to psychiatry, McCulloch (2006) described how surgery faces the challenge of the 21st century. However, for psychiatry there are additional stressors: the process, outcomes and impact of New Ways of Working; the NHS Employers discussion paper *The Future of the Medical Workforce* (NHS Employers, 2007); the development of new legislation for England and Wales which questions the very nature of the concept of medical responsibility; and the restructuring and remodelling of the medical workforce associated with Modernising Medical Careers and the Medical Training Application Service. The well-known problems of the methodologies for recruitment paint a very different landscape for psychiatrists to that of just a few years ago. In spite of rapid and much needed advances in the sciences and technologies supporting increasingly effective therapeutic interventions, there is considerable pessimism and a sense of foreboding among psychiatrists.

Professionalism

Professionalism is a much bandied and misunderstood word. A charter was developed by a number of organisations to discuss medical professionalism, and this reflects the frustration felt by physicians in high-income countries. The fundamental principle is that professionalism is the basis of medicine's contract with society. Other principles include that of primacy of patient welfare, patient autonomy and social justice, and with these principles comes a set of professional responsibilities (American Board of Internal Medicine Foundation, 2002). These include a commitment to professional competence, honesty with patients, improving quality of and access to care, a just distribution of finite resources, keeping abreast with scientific knowledge and maintaining trust. It is also claimed that professionalism strengthens individuals' professional and managerial skills, helping them to develop as clinical leaders with a national voice for medicine, education, training and evaluation (Wass, 2006).

Rosen & Dewar (2004) ask for a more transparent and accountable approach to patient care by doctors. The question that arises concerns the socio-political environment in which this contact is operational. This contact has increasingly become dominated by mistrust of public services and professionals. There is a suspicion that many policy makers and tax payers believe that professionals are 'in it' for themselves, creating institutions and policies to preserve their position, pomp, power and earnings!

There have been several headline-grabbing cases in the past 10 years related to the practice of medicine. These include paediatric heart surgery at the Bristol Royal Infirmary, organ retention at Alder Hey Hospital, Liverpool, Harold Shipman and Kerr/Haslam, among others. Each highlighted specific problems related to self-regulation by the medical profession. As a consequence, the General Medical Council was seen as a weak and ineffectual body and the medical Royal Colleges as indolent, self-serving and self-absorbed. High-level and clear executive action had to be seen to be taken. With several inquiries costing millions of pounds, along with the recognition that undergraduate teaching did not produce fully 'fit for purpose' doctors, the Modernising Medical Careers team and the Postgraduate Medical Education and Training Board (PMETB) were created. Under the banner of public safety, increasingly draconian 'external' control has been imposed upon doctors. The theme of public safety is the key function of the new Mental Health Act for England and Wales which is currently being debated in Parliament. A cynical interpretation of this control might be that it is to demonstrate to the public (who in surveys continue to trust and support doctors more than they do politicians) that politicians are in charge and know better than doctors about issues of risk and public safety .

Another contribution is the move towards patients becoming consumers and users with doctors as providers. Clark (2005) argues that this is a result of a shift towards greater control of public expenditure. It also represents a shift from a social contract towards a consumerist approach, with greater private sector involvement in care provision. The work environment of welfare professionals is changing as a result of more prescriptive policy, increased regulation and changes in professional roles, with a gradual reduction in autonomy.

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This push to accept unpopular policies with which they do not concur deskills psychiatrists as a profession. Jordan & Jordan (2000) have described this phenomenon as psychiatrists becoming enforcement counsellors. One construct of professionalism is that professionals are accountable for their actions, but when things go wrong increasingly individuals are blamed without the context of their clinical practice being taken into account. Clark (2005) argues that trust, spiritual wisdom, the ability to promote healing and inculcate understanding of having been through a process of experience are important factors in understanding professionalism. 'Deprofessionalisation' denudes individuals of their personal sense of worth and represses autonomy of the professional as well as many of the factors described above. The problem is widespread and the remedy has to be regaining professional control.

Changes in service delivery

Service change over the past 30 years has been widespread and has involved the delivery of services and where services are delivered. A shift from care in asylums to community care opened the doors for ever greater specialisation, especially that based on service delivery (e.g. assertive outreach, crisis resolution). One of the by-products has been that a body such as the Royal College of Psychiatrists has some difficulty in representing all groups within psychiatry, leading to fragmentation of interests. Although the creation of faculties and special interest groups within the College has major advantages for psychiatry as a whole and as a profession, this has also meant that the College (indeed all Royal Medical Colleges) has a fundamental problem because it often cannot take all members with it. However, could increasing specialisation mean greater real expertise albeit within a narrow field and thus preserve professionalism?

The changing picture of service delivery has been associated with the movement away from a system wherein psychiatrists had total responsibility for management of patients (and services) to a position in which responsibility has been diffused and diluted perhaps to the point where psychiatrists are becoming technicians, assessing and prescribing for patients but with reduced skills, reduced power and control by financial decision-makers. The increasing barriers to continuing care whereby the same team is responsible for the care of the patient are becoming the norm. This also has implications for training because trainees will not be able to follow the long-term care of a patient.

The blame culture of investigation into adverse incidents is contemporary and widespread, and in spite of repeated assurances that these investigations will stop, nothing has happened. In contrast, investigations appear to have led to increasingly risk-averse practice constrained by policy and procedure. One may ask which other medical specialty has found other groups taking over critical decisions about the admission of patients to hospital and then required national policy and guidance on how to discharge those same patients.

Training

In line with all medical specialties, psychiatry is moving towards a competency-based model for training and assessment. There are unequivocal advantages with this model because it has a clear focus on clinical skills as well as values and attitudes, maintains a broad knowledge base and has the potential to produce excellent specialists. However, potential disadvantages, which include fragmentation of practice, failure to reflect professional practice and producing technicians rather than professionals, must be recognised and guarded against.

Becoming technicians

Systematic reviews have been used successfully to guide policy and clinical practice but what is their impact on everyday practice? Fundamental questions are posed, including whether we have sufficient 'real' evidence. There is a clear danger in that as 'technicians' we will be expected to follow guidelines faithfully and the possibility that (foundation) trusts and other healthcare providers will demand that psychiatrists and mental healthcare workers simply log on and follow the care protocol, or that algorithms will take away the humanity of the clinician–patient interaction. Another potential problem for healthcare delivery for psychiatric patients is the Payment by Results which needs to be monitored.

Multidisciplinary team-working

The thrust is toward standardising team communication and team-working, indeed this is to be part of annual assessment for all. The data and many of the training programmes are from industry (e.g. the aviation industry), but questions must be asked and answered as to whether they truly and easily translate into mental healthcare. In addition there lurks the issue of which standards should be enforced and what will happen when remedial action is required?

Care outcomes

At present we are in grave danger of measuring the measurable too much. If this trajectory continues then one might ask whether we will slavishly follow league table methods based on morbidity/mortality and if so what the impact will be. On the other hand, if we are truly professionals will we be allowed to develop our own valid and reliable measures? Electronic patient records will add further to the technician aspects of clinical practice, especially in the context of confidentiality and human rights, an area which urgently needs further debate.

Conclusions

These are times of tremendous change with continuing threats to the professionalism of psychiatrists. The shift of power has clearly been toward the employers, with the

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Department of Health/National Health Service as monopolists, and many are concerned that the bullying style of the Medical Training Application Service may be an indication of worse to come.

To address these issues the psychiatric profession must speak with one voice. Differences with other medical colleagues should not be minimised but should be acknowledged. First and foremost we are doctors and the core function of doctoring is to care for our patients and their families. The doctor should also be an advocate for the patient, for social policy and for future generations of doctors. The psychiatric profession must continue to work with other interested organisations such as Mental Health Alliance to raise concerns. We need to take our patients and their carers with us, simply because it is their needs which must be met and they not the politicians are our paymasters. In order to return professionalism to the hands of professionals, we must stand up to any perceived bullying tactics. The medical profession in general, and psychiatry in particular, has to closely analyse the demands of the Department of Health and to provide alternatives.

At an institutional level, the Royal College of Psychiatrists has already taken the lead in seeking to establish networks for medical directors, postgraduate school leads and directors of medical education networks to ensure better communication. The College must have further discussions about New Ways of Working. Some suspect that many trusts are using New Ways of Working to get rid of doctors so that the same services can be provided more cheaply. Such suggestions must be examined and if proven exposed and resisted.

In conjunction with other medical Royal Colleges we need to respond robustly to consultation exercises such as those that surround proposals to reorder relicensing, revalidation and reaccreditation in order that the core values of professionalism endure. It is the duty of all individuals to be fully aware of policy changes at national level and implementation processes and problems at local levels. We must effectively communicate with each other so that we can learn where changes have been successful and where they have failed.

Psychiatry is one medical discipline which is able to deal with ambiguity, but the procedural changes that are being thrown at us all the time have the potential for a cumulative destructive effect on the medical profession. It is high time we took a step back to reflect and respond in a sensible pragmatic way to improve clinical services. As a first step, the Royal College of Psychiatrists is planning to hold a series of seminars later this year to discuss the definitions of professionalism in relation to psychiatry. These will take the shape of groups of individuals meeting to explore and discuss what professionalism means, how it can be achieved and how it is retained and developed.

Declaration of interest

N.B. is Associate Dean and D.B. is Dean of the Royal College of Psychiatrists.

References

AMERICAN BOARD OF INTERNAL MEDICINE FOUNDATION (2002) Medical professionalism in the new millennium: a physician charter. *Annals of Internal Medicine*, **136**, 234–246.

CLARK, C. (2005) The deprofessionalism thesis, accountability and professional character. *Social Work and Society*, **3**, 182–190.

JORDAN, B & JORDAN, C. (2000) *Social Work and the Third Way: Tough Love as Social Policy*. Sage.

McCULLOCH, P. (2006) Surgical professionalism in the 21st century. *Lancet*, **367**, 177–181.

NHS EMPLOYERS (2007) *The Future of the Medical Workforce*. http://www.nhsemployers.org/workforce/workforce-2193.cfm

ROSEN, R. & DEWAR, S. (2004) *On Being A Doctor*. King's Fund.

WASS, V. (2006) Doctors in society: medical professionalism in a changing world. *Clinical Medicine*, **6**, 109–113.

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Governance, strategy and innovation in mental health

There is a contemporary move in the National Health Service (NHS) to adopt commercial-style governance for provider trusts. Clinical governance has been developing toward 'integrated healthcare governance', and there is now an intense focus on corporate responsibility for healthcare activity, especially in NHS foundation trusts.

Any form of governance requires systems to manage risk and to provide information on performance, which are surely essential tools for all senior healthcare staff. However, governance initiatives may fail if they are overly bureaucratic, and this may be a particular risk in the complex world of mental health. Good governance is therefore of great importance to psychiatry. Successful governance depends on innovation and integration at a strategic level. This should begin with the culture of the senior staff and directors, and a simple reporting system, such as the balanced scorecard. These must embody a clear vision of future success, based on 'what really matters' for patients.

Governance may sound a very dry concept, of limited relevance to psychiatrists. However, in order that large healthcare organisations deliver good services for patients, there must be good governance arrangements of some form. For organisations which are not well run, real innovation in governance is essential for effective clinical practice to develop and flourish. Understanding good governance is therefore crucial to all clinicians, including psychiatrists.