Being a professional general practitioner and using principles of professionalism to consider workforce issues in general practice

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ABSTRACT

Being a professional is different from being an expert. Professionalism demands not just that a group holds particular knowledge and skills and is responsible for their teaching, practice and advancement, but that the profession uses these for the benefit of society. The profession must embrace the values of respect for human worth, of trustworthiness and have a commitment to altruism in its dealings with society. The profession must protect vulnerable people and vulnerable social values. Society and the profession are in mutual relationship. This paper proposes two questions to address problematic issues in a general practice setting, including that of workforce. They are *'What relationships are involved, and what are the responsibilities of each party?'* and, *'How should the problem be addressed from a professional perspective?'* Specifically, doctors and the profession are in relationship with patients, communities and society, and together these parties must decide what to do and where the responsibility for action lies, and be explicit about what underlying values should drive the decision-making process.

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When was the last time you heard a colleague introduce themselves as a 'professional general practitioner'? I'll bet it was some time ago, if ever. And anyway, who cares? Isn't it enough to be an expert, or at least to be competent and not stuff things up too badly, without having some esoteric discussion about what being a professional may or may not be? Well, I say no, it isn't enough. The idea that professionalism transcends mere competency or even being expert is well worth exploring, because it may be that if we as individuals (professionals) or as a group (the profession) start to grasp the implications of the idea, we may find a way through some of the issues that beset the profession, in particular that of the general practice workforce.

The suggestion that I propose in this paper is to use the notions of 'relationship and reciprocity' and 'the professional perspective' to pose two questions for any particular problem as a starting point for considering how they can be resolved without causing adverse unintended consequences. The questions are:

1. *What relationships are involved and what are the responsibilities of each party?* (There are three relationships to consider: the doctor–patient relationship; the relationship between doctors and the community in which they work; and the relationship between the profession and society).
2. *How should the workforce problem be addressed from a professional perspective?*

The issue of workforce problems is huge, and involves many complicated interrelated factors, from selection for medical school training through to retirement planning, and I am not going to attempt to address them all, merely to consider a scenario that raises some workforce problems, and demonstrate how the questions posed above may help consider the issue.

But first, back to the notion of professionalism. Being expert is not the same as being professional (but perhaps a requirement of being a professional is to be expert). Being

expert is simply a case of 'doing' a particular task to a standard that meets the requirements of the circumstances. It is nice if your plumber 'expertly' installs your new toilet, your mechanic 'expertly' replaces the car's worn brake pads, or if the airline pilot 'expertly' lands the plane you're flying in. However, successfully completing a task does not in itself indicate professionalism, and for us as doctors the same rule applies. Successful task completion (and even being paid for one's skill or aptitude) is only part of professionalism. Despite the overuse of the word to include everyone from athletes to hairdressers as being 'a professional whatever', there are underlying notions that make professional practice demanding and quite distinct from simple expertise.

The word 'profession' is derived from the ancient notion of 'to profess',[1] in which an individual or group makes a statement to society in which they *profess* to hold knowledge or skill in some particular area. Until the end of the nineteenth century, three learned professions were recognised – law, divinity, and medicine. However, the twentieth century brought a proliferation of groups claiming professional status, and the idea of what constituted a profession came under academic scrutiny.

Professionalism has been considered from two main vantage points. These are the 'structural-functional' and, more recently, the 'values-based' notions, but I would add the idea that professionalism only exists in relationship, and for general practitioners that means relationship with our patients, communities and the wider society (but more of that later).

The first way academics looked at 'profession' was as a social construct, defining the structure and function of a profession within a society.[2] They saw a profession as holding particular knowledge or skills, self-regulating in terms of determining instruction and certification, and receiving special rights that other members of society would not usually have. Furthermore, the profession was expected to be dedicated to public service, and in the case of medicine, the professional was expected to *'subordinate personal financial gains to the higher value of responsibility to the patient and to public interests'*.[3]

So professionalism was seen as a type of contract between the profession and society, in which the profession had a monopoly over specialised knowledge and skills that are not easily acquired by the average person, was held responsible for its teaching, and was granted sufficient autonomy to establish and maintain standards and quality. Society, in return for this autonomy, expected the knowledge to be used altruistically. In short, and in more modern terms, the professional should embody the intellectual property associated with that profession, and that property should be used for the benefit of society.[4]

The structural-functional approach is good in theory, but it is not hard to imagine that some members of a profession might not be entirely altruistic, or that the profession itself could act to monopolise trade and be overly rewarded for doing work that only it was allowed to do. Indeed, this is exactly the criticism of professions (and medicine in particular) that emerged in the late 1960s and early 1970s.[5,6] In response to such (probably well-founded) criticism, the idea of values-based professionalism developed in the latter part of the twentieth century. There are two ways of looking at values-based professionalism – from the values of the person of the professional, and from the values and behaviours of the profession as a whole. I think that these have merit when it comes to examining how doctors should behave in society.

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The person of the professional must:

1. conform to the technical and ethical standards of the profession,
2. exhibit particular types of behaviour in the workplace, and
3. respect patients' human worth with a sense of trustworthiness and protection of values.

These values include a sense of commitment, of non-exploitation and of not abandoning patients. The doctor will protect confidentiality and act with compassion, integrity and inter-professional respect.[3] A professional values the well-being of others above their own personal gain, and practises to do 'the right thing' not 'because of how they feel, but regardless of how they feel'.[7] Essentially, the professional must be capable of holding these values at a personal level, and if they are incapable of doing so, then they cease to be truly professional.

As it is for the individual professional, the profession must also embrace the values of respect for human worth and of trustworthiness, and have a commitment to altruism in its dealings with society. In addition the profession must act as a morally protective force in society, protecting both vulnerable people and vulnerable social values.[8] This is an extraordinarily important point, and one only has to consider the abject failures of medical professionalism with human experimentation in Nazi Germany, in the misuse of psychiatry for political gain in the former USSR, and the misappropriation of medical resources in apartheid South Africa, to demonstrate how fragile people and social values can really be. Dr Charlotte Paul, commenting on the Cartwright Inquiry into practices at National Women's Hospital, draws attention to the idea of 'internal morality' in medical professionalism, exhibited by the whistle-blowers in that particular case, and by the majority of doctors in their day-to-day practice. She notes that *'trust-*

worthiness [of the medical profession] *is enhanced by the self-respect accompanying ownership of professional standards'*, reinforcing the link between values held by individual doctors and the collective values held by the profession.[9]

More recently, the notion of 'civic professionalism' has arisen, largely as a response to a mismatch between how the profession behaves in the managed care context and the actual needs of people and communities, especially in disadvantaged situations in the United States. The very survival of medical professionalism is seen as being under threat from a commercialised health care market.[10] Civic professionalism highlights the obligation of the profession to care for the financially disadvantaged and to protect core health values and remain accountable to public need.[11]

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To fulfil the professional responsibilities of doctors, a working medical–societal alliance must be created and sustained.[12] Neither the notion that the profession trades its commodity of knowledge with society in return for some privilege, nor that it uses its values for the benefit of society encompasses the idea that each party may impact on the other in a reciprocal manner. We do know from looking at the impact of complaints, that doctors sometimes respond to society's interventions by practising poorly; practising defensively in a way that does not benefit either individual patients or society. Both the structural-functional and the values-based approaches to good professional practice can be eroded by the current complaints process, demonstrating that the profession and society are not distinctly separate, but rather in relationship, so that changes in how one party behaves can impact on the other.[13]

If the profession sees itself as being in relationship with society rather than sitting separate from society, it has licence to advocate not just for its members but for patients and communities as well. The profession is actually obligated to work for the public good (it is not an option), and society in turn is obligated to consider the needs of the profession and to work collaboratively to preserve the ability of the profession to perform its tasks (and that is not an option either). This becomes quite challenging!

Doctors may need to consider whether they even want to be professionals, given the call for altruism, reduced self-interest and the responsibility for protecting fragile persons and values that the word professional defines. And society may need to consider if it wants to be in relationship with the profession if it has the responsibility to seriously look after it.

So how might these ideas about being a professional help us think about important issues facing the medical profession in New Zealand, and the general practice workforce in particular?

Here is a scenario to consider:

A small town practice has three general practitioners, two in their late 40s and one aged 62. They share a 1:4 on-call roster by using PRIME trained nurses, live locally and the practice is functioning well. Unfortunately, the senior doctor is found to have a cancer in the pancreas, and shortly afterwards, a husband of one of the younger doctors has a serious tractor injury, reducing her ability to work from 8/10ths to 3/10ths. A workforce crisis is looming! What to do?

Let's use the questions to explore some of the issues raised.

1. *What relationships are involved and what are the responsibilities of each party?*
2. *How should the problem be addressed from a professional perspective?*

The relationship here is between the doctors and their community, and to a lesser extent between individual doctors and their patients, should an unsustainable workload impact on their ability to practise safe and effective medicine.

What then are the responsibilities of each party, if one accepts the premise that professionalism is based on a mutually responsible relationship? The responsibility of each party is to determine the extent to which it can contribute to a solution, and to not leave the responsibility to the other. Both parties are responsible, and the principle of reciprocity suggests that the actions of either will impact on both.

Using a values-based perspective, the question is *'what do we actually value?'* The doctors should consider the segments of the community to whom they have the greatest responsibility of care and who would suffer most from being abandoned. The doctors' values should reflect those of being a medical professional. The community however, must assess how much it actually values having the doctors there. If it does not act collaboratively with the doctors to find a satisfactory solution, then it is abdicating its reciprocal responsibility to both 'care for the carers', and to value the resource that the professionals provide.

From the structural-functional perspective, a question is 'what should be done?' Arguably, the doctors' responsibility is to deliver general practice care to the community. They should not abdicate that responsibility. They should continue to practise, but consider themselves to be a resource that needs to be protected and rationed to take care of patients; prioritising care to those in highest needs. This may involve delegating tasks to other carers and even pro-

viding no care to some patients, but it will preserve their ability to function. The doctors have responsibility to signal to the community that there is a problem, and to engage with the community to seek resolution. The community has a reciprocal responsibility to engage with the doctors and seek practical solutions to restore the resource that they provide to levels that meet the community's needs.

Underpinning the questions and responses is an assumption that both parties actually want a 'professional' relationship. In this scenario, it is possible that the remaining doctors just quit and walk away. If they did so, even though they take with them their qualifications and skills (in essence, their expertise), they have ceased to be truly professional. Uncomfortable isn't it? This is why both parties in a relationship must bear responsibility for resolving problems, because placing an unsustainable burden on one party alone will lead to systems failure and breakdown of true professionalism.

But what of the relationship between the profession and society? If this hypothetical small town scenario is a metaphor for medical workforce problems facing New Zealand society, then the questions become 'What are the responsibilities of the profession and society?' and 'What are the professional perspectives involved?' Actually, the question becomes even more complex, because New Zealand is part of a global community where medical migration impacts not just the country of destination, but on the resources of the society from which the doctors originate. New Zealand now has overseas trained doctors (OTDs) comprising 38% of its medical workforce. Although OTDs contribute to the country's need for a trained medical workforce, there is potential for doctor migration to deplete the medical workforce in societies that are unable to compensate for such depletion, leaving their population vulnerable to the effects of diminished medical care.[14] Is permitting such migration a failure of professional responsibility to preserve care to those most vulnerable? I believe that these issues need to be debated by the New Zealand medical profession and society, as failure to do so is a failure of shared responsibility to take a global professional perspective.

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Conclusion

This essay introduces the notion that the principles of professionalism may be a useful starting point for discussions between doctors, their communities and society on important topics that impact health care delivery. In it, I have used a small localised workforce crisis as an example, but the concept could apply to issues as diverse as critiquing a specific consultation through to considering a large scale public health care initiative or the impact of health care reform. Problems can be considered using the questions of *'What relationships are we dealing with and what are the responsibilities of each party?'* and *'How should the problem be addressed from a professional perspective'*. I suggest that using these questions will contribute clarity as to where the responsibility lies for problem resolution.

Grasping the notion of the *structure and function* of professional practice is not all that difficult, but embracing the *values* that separate experts from professionals and that define the responsibilities of the profession is much more challenging. However, the challenge is made manageable if members of the profession are seen as being in relationship with patients, communities and society, and can only function if that care is reciprocated, and the profession is cared for by the society for whose benefit it exists.

Competing interests

None declared.

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