

The
21st doctor

Understanding the doctors of tomorrow

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Royal College
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Setting higher medical standards



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General
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Council

Regulating doctors
Ensuring good medical practice

Ros Levenson
Stephen Atkinson
Susan Shepherd

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Susan Shepherd qualified in medicine at the University of Bristol and worked in child health before joining the Department of Health in 1990. She held the departmental community child health portfolio for four years, moving to smoking policy in 1994. In 1996 she was appointed Private Secretary to the office of the Chief Medical Officer, working there for three years. She was senior adviser to Lord Laming on his inquiry into the death of Victoria Climbié. She joined the Royal College of Physicians on secondment from the Department of Health in 2003, was appointed to the staff in 2006 and made Fellow of the College in 2010.

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Foreword

In their report of the 2008 roadshows with the medical profession, *Understanding Doctors: Harnessing professionalism* (Levenson *et al* 2008), the Royal College of Physicians and The King's Fund described medical professionalism as 'a strong value-based framework within which doctors can shape the improvement of health care and exercise a constructive influence on health policy in the public interest'. Two years on this description remains current but the environment in which health care is provided, and the competing demands placed on those who deliver it, make it more critical than ever. The modern doctor must have a robust reference point against which to measure their capabilities and compare judgements. Doctors need to be able to assess their capacity to meet the obligations of their chosen field of practice. This is at the heart of medical professionalism.

In 2009 and 2010 a new series of events on medical professionalism, '21st Century Doctor: Your future, your choices', was held with medical students. It was a continuation of the work reported in *Understanding Doctors: Harnessing professionalism* and it allowed a comparison between the views and feelings of students and those of qualified doctors.

The findings are encouraging. First, there was an affirmation of the importance of medical professionalism in the personal and professional lives of medical students, although it was clear that the concept evolves and needs to be kept up to date. In order to ensure this, medical students need to engage in the process that defines medical professionalism and how it is taught and assessed. Second, medical students need a fuller understanding of the role of the General Medical Council and the role that it will play in their professional career, especially as, with the introduction of revalidation and other initiatives, all doctors will be engaging with it on a regular basis. Third, in future the role of the doctor will increasingly include significant input to managing and leading health services. To do this effectively, the leaders of the future need education and training in appropriate skills and competences.

The 21st Century Doctor: Understanding the doctors of tomorrow is a glowing testament to the quality and insight of the next generation of young doctors. It should be seen as work in progress. The conclusions set out an agenda to help realise some of the issues discussed in the series. The most important of these is to find ways to utilise the energy and enthusiasm of those who within a short time will be the custodians of medical care and moderators of its delivery.

Chris Ham, Chief Executive, The King's Fund

Sir Richard Thompson, President, Royal College of Physicians

Niall Dickson, Chief Executive, General Medical Council

Helen O'Sullivan, Director, Centre for Excellence in Developing Professionalism,
University of Liverpool

John Clark, Director of Medical Leadership, NHS Institute for Innovation
and Improvement

Fiona Godlee, Editor, British Medical Journal

Summary

This report summarises the discussions of 11 consultation events, '21st Century Doctor: Your future, your choices', run from October 2009 to April 2010. An earlier series of events, 'Do Doctors Have a Future?' ran from May 2006 to April 2007 and looked at the way that doctors viewed the challenges that they face. Since the publication of the report of that first series (Levenson *et al* 2008) the future of doctors has become increasingly uncertain. Professor Sir John Tooke's review of the Medical Training Application Service (MTAS) (Tooke 2007) recommended clarification of the doctor's role. This was done partially through the Medical Schools Council collaborative definition (Academy of Medical Royal Colleges 2008) published after the MTAS final report. Since then it has been elaborated on by the Royal College of Physicians (Royal College of Physicians 2010).

This second series of roadshows was held to involve medical students who were invited to contribute to the debate by sharing their views on one of the underpinning principles of good medical practice – medical professionalism – and on the part that this will play in their future careers.

That medical students are the custodians of medical professionalism and that they will play a key part in the future of medicine are perhaps simplistic statements. But their views and beliefs on certain aspects of professionalism, and how these might shape their behaviour and practice in the future, are unknown. This roadshow series was therefore an attempt to capture and understand medical students' views and beliefs, to understand how they relate to the challenges ahead, and to consider the implications of these as the students enter into practice.

Each section of the report gives a brief context to the key questions, and then moves on to summarise the discussions in the words of those who attended the events. It finishes with issues for the future. Running through all the sections is the issue of how medical students can become more vocal on the issues that most affect them.

Educating for professionalism

Although the emphasis placed on formal professionalism teaching varies between medical schools, it is agreed that professionalism needs to be promoted as a critical and integral part of medical education and training, and is one of the threads running through the whole of a medical career. It is also agreed that one of the most powerful ways of learning professional behaviour and inculcating professional values is through experience of positive role models – although modern team structures, teaching regimes and working patterns may reduce these opportunities somewhat. Mechanistic approaches to teaching and assessing professionalism are

largely rejected by students, but early and explicit definitions of professionalism would allow them to engage more meaningfully in the concept early in their training. With professionalism such a critical part of medical practice, medical educators and senior doctors need to develop and refine their approaches to teaching and assessing professionalism, wherever possible providing opportunities for the students themselves to shape policy in this area in their own schools.

Professional values and personal behaviour

Information for medical students on professional values and behaviour is freely available, but awareness of such material varies. Finding the right way to engage students is a challenge. Medical schools have a crucial role to play in making clear the standards of behaviour expected of their students. But what constitutes acceptable behaviour generated much debate, with the 'grey' areas and the case of the persistent low-level offender being the most contentious. Standards are not static, however, and what might be regarded by one generation as acceptable may change, and vice versa. Medical schools owe it to students to make clear what standards apply and to apply these consistently: they should consider providing mechanisms for students to explore issues of professional behaviour and values in a safe environment, facilitated where possible by senior students or junior doctors to help put behaviour into context.

Engagement with professional regulation

Straw-poll voting among medical students revealed a lack of knowledge about one of the key issues of regulation, namely revalidation. This was backed up in discussion and extended to a generalised lack of awareness of the role and function of the General Medical Council (GMC) across most of its activities. Lack of understanding of revalidation is perhaps unsurprising as the processes of assessment leading to recertification and relicensing are yet to be fully implemented for trained doctors. The GMC might also consider addressing the negative image that medical students often have of it generated by awareness of its fitness-to-practise role. This image would be improved if students became aware as early as possible in their careers of the GMC's well-respected position in relation to guidance and standard setting in the context of education and practice. The forthcoming formal review of its position on student registration is likely to offer opportunities in these areas.

Leading and managing as part of a professional career

Medical students have a range of views on the extent to which all doctors need to be leaders and managers. But they recognise that aspects of management and leadership are likely to be part of the job at various stages of a medical career, although this recognition is clearly an evolving one. Medical students go into medicine with the sole intention of pursuing a clinical career: the recognition that leadership and management skills are increasingly integral to good patient care and organisational excellence comes later. With these aspects ever more important, the critical issue is how to integrate doctors into management and leadership roles, how to equip them with the right skills and at what stage to do this – undergraduate or postgraduate? At the same time it is necessary to ensure that clinical expertise is maintained at levels that protect the interests of patients.

The role of the doctor in the future

Medicine as a profession has always had to move with the times, and will continue to need to do so. The medical profession needs to be able to anticipate as far as possible the changes ahead and ensure that it continues to produce doctors soundly educated and trained in scientific principles, who will be able to respond expertly and appropriately to whatever conditions prevail. The potential to adapt to an unknown future should be put at the heart of medical education and training, underpinned by the ability to practise safely and respond to patient needs.

Introduction

The series of 11 consultation events '21st Century Doctor: Your future, your choices' ran from October 2009 to April 2010. Our aim was to engage medical students and faculty staff in a discussion of medical professionalism in the context of entry into medicine at a time of health system, economic and societal change. The events were based on a pilot series at four medical schools early in 2008, which in turn were based on a successful series of consultation events, 'Do Doctors Have a Future?' This focused mainly on trained doctors and was summarised in *Understanding Doctors: Harnessing professionalism* (Levenson *et al* 2008). The student events were co-hosted by medical schools. Of the 695 people who attended the events 492 (71 per cent) were medical students, 128 (18 per cent) trained doctors, and 75 (11 per cent) were neither medical student nor doctor.

In addition to *Understanding Doctors: Harnessing professionalism* (Levenson *et al* 2008) the starting point of our discussion were two seminal reports from The King's Fund (Rosen and Dewar 2004) and the Royal College of Physicians (2005) on medical professionalism, supplemented by work done by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges (2008, 2009, 2010a, 2010b), GMC publications (GMC and Medical Schools Council 2007; GMC 2009a) and the work of the Centre for Excellence in Developing Professionalism (2010).

How the events were run

The format adopted for the medical student roadshows was similar to that used in the first series of roadshows, adapting the discussion material to a contemporary student audience. The objective was to draw on a large population of medical students and faculty staff in a proportion of 70 per cent students to 30 per cent 'others'.

Each event had four components:

- a series of presentations giving the context for our debate and presenting personal perspectives on medical professionalism
- a number of electronic straw polls on a variety of questions pertinent to the future of medical professionalism
- discussions in groups of eight to ten participants per topic. Discussion was facilitated by a medical student 'table host' who was responsible for introducing the topic using pre-prepared material and leading the debate
- a *Question Time*-style panel session.

Each of the events was conducted in strict accordance with the Chatham House Rule of confidentiality.*

Participants were allocated randomly to tables for in-depth discussion of one of five topics. Topics were selected on the basis of key unresolved issues emanating from the first series of roadshows and on areas relevant to the interests of the organising partners. These were:

- educating for professionalism
- professional values and personal behaviour
- engagement with professional regulation
- leading and managing as part of a professional career
- the role of the doctor in the future.

Topic sheets handed out by each table host provided some background to the issues and some sample questions to promote and facilitate discussion. Transcriptions of more than 100 hours of debate and the answers at the *Question Time* panel session form the basis of this report. The subsequent division of the material and its analysis reflects the weight of opinion of our contributors and the issues that emerged with most frequency and consistency. When analysing the material, what was remarkable was the similarity of view between medical students across the country. The expression of their views is reflected in the many quotations that support our analysis.

* When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speakers(s), nor that of any other participants, may be revealed.

Educating for professionalism

Context and challenges

There are competing definitions of professionalism and many levels of understanding of the term as it applies to the medical profession. For the purposes of the roadshow discussions, the following definition of medical professionalism was used:

A set of values, behaviours and relationships that underpins the trust the public has in doctors. (Royal College of Physicians 2010)

Some people believe an understanding of professionalism should be demonstrated in applicants to medical schools, and that every potential doctor should be able to demonstrate an awareness of professional attributes. However, not everyone takes the view that this is feasible.

Whatever one's views on the feasibility of teaching professionalism, it is clear that it is not taught consistently in the undergraduate curriculum.

It is also clear that at the start of medical careers some students may have little insight into professionalism. A formal induction is one way to address this. In some countries, such as the United States of America, such induction commonly includes a ceremony at the start of the undergraduate course. Students put on their white coats (as an outward sign of their professional status) for the first time, and take an oath binding them to the values of their chosen profession. Variations of these ceremonies have been adopted at some medical schools in the UK, and in Japan.

Discussion about education for professionalism has to be put in the context of the length of undergraduate medical education in the UK, which varies between four and six years and covers a wide range of topics. Every UK student graduating in medicine will have received a broadly similar education, acquired equivalent knowledge and skills, and attained a uniform level of competence to allow them to continue through the postgraduate phase of their medical career.

Because of the broad and diverse nature of medical education, students spend relatively short units of time in each specialty and sub-specialty. Limited topic exposure is sustainable because of the continuing nature of medical education – graduation signals the beginning rather than the end of training. However, there are disadvantages as the relatively short time that students spend with a particular clinical team limits the opportunity both to integrate fully with the work of clinical colleagues and to influence systems and policies, and hence health outcomes, in any meaningful way.

What we heard

Is it possible or desirable to select for professional qualities?

Participants expressed a range of views on whether it was possible to select for medical school on the basis of identifying professional qualities, or at least the potential to develop such qualities. Some were confident that it was possible, believing that a basically sound approach was either innate, or set fairly early.

Perhaps we should start earlier in terms of the selection process. There are a lot of medical students who I don't think are going to make good doctors when they come in, and, when they come out, I still don't think they're going to make good doctors.

Some people judged themselves to have had the appropriate qualities from a tender age, and to have nurtured them with a medical career in mind.

I think I realised that, when I was about 15 or 16, I wanted to be a doctor, and I realised that I had to behave differently and do different things to what my friends were doing. ... I just knew that I shouldn't get in trouble at school.

Well in some ways it already is [part of the selection process]. ... I mean if you've done your A Levels and whatever else you are already part professional because you've got the right attitude ... you can organise your time and whatever else you need to do all these things, so in some ways you already are [a professional].

However, a considerably greater number of both students and others took the opposite view or were doubtful that young people, many of whom are still at school when applying for medical school, could have the maturity to understand or demonstrate the potential for professionalism. As one person with experience of selecting students stated:

For 10 years we pored over our interviews and interviewing techniques and so on and I came to the conclusion that short of doing a biopsy of the soul, as it were, you couldn't catch for either character or professionalism.

Others tended to agree:

Even so, if you're selecting people at 18, by the time they qualify, that's five years later, so someone who may not have displayed professionalism when they were 18 may have developed those things by the time they graduate. So even at that stage I don't know that you should be necessarily looking for those kinds of things because people have still got a lot of developing to do.

There were also concerns that, even if it were possible, attempts to select for professional qualities might produce unwanted consequences, such as a group that was well behaved, but with all its members being similar to each other, and possibly without the range of qualities that a group of students would ideally have. One person worried that:

... there's this attempt to have a one-size-fits-all for medicine when in fact medicine is such a broad profession, you can be a slightly sociopathic pathologist or a very gregarious hospital consultant or a one-to-one person in general practice. ... You need strong manual dexterity for surgery whereas much better communications skills for general practice, so you need this vast range of different types. Is that being threatened?

Another person pointed out that as medicine changes, there was a danger of selecting only for those qualities that were currently highly valued.

Others simply did not believe that it was possible to make such fine judgements at the selection stage.

So say five minutes is taken up with introductions and basic questions, how on earth would you assess professionalism in the last 10 minutes of interview?

For some people, the key issue was that attempts to select for particular attitudes and values might result in discrimination on socioeconomic grounds. These views were clearly benevolent in intention, but were sometimes tinged with a little condescension.

I think everybody should be given a chance because some of us come from what we consider very privileged backgrounds. Professionalism and those sort of attitudes are part of everyday life. It's almost ingrained in us. But some of us aren't from such fortunate backgrounds and don't have that as a day-to-day basis.

If you sit with your parents at the dinner table and discuss the ethics of paying for transplants, when you come to an interview you're going to be able to talk about that. ... I think we've got to watch when we make assessment markers, are they really markers of ability and potential or are they markers of background and opportunity?

Finally, one person who was not entirely opposed to a screening process, at least to identify a lack of professionalism, thought that, if someone was intelligent enough to get an interview at medical school, they would probably be intelligent enough to hide their negative qualities too.

The main reason why students and others doubted that it was truly possible to select for professional qualities was that the development of professionalism was often bound up with maturity. Students readily acknowledged that they had changed since the time they were selected for medical school.

I think you change a lot as a person from day one in medical school and I think a lot of people do.

I would say in the first year I was not professional, I was not responsible, I would say in the fourth year I am.

I don't think I knew what professionalism was when I was 16 or 17. I knew I wanted to be a doctor, but I don't think I knew what it involved. I knew that people respected doctors and that they were an important part of society, but I don't think I knew what professionalism meant.

Some felt that students who were slightly older and had worked before going to medical school were more likely to have learned from their experiences and be more able to function well in a working environment and to acquire professional skills earlier on in their courses than others.

Many people also rejected the implicit determinism of selecting for professional qualities, noting that people can change, both for better and for worse. They could also change their fundamental values as they were exposed to new ideas. As one doctor reflected:

I think I used to have quite homophobic views because of my upbringing, but I also am a better doctor because of having worked through those problems.

If I think of myself at 16 or 17, no-one else had done medicine from my family and I would have come with some fairly unacceptable views about people with disability from my parents. They're not reactionary or anything but for example the idea of actually sitting down and talking to someone with a learning disability and giving them the same time, or perhaps more time, to make a decision about complicated treatment, which we now do, would have been anathema to that generation before.

For such reasons, it was often suggested that it was necessary to select people who are willing to learn and reflect, rather than hoping to identify the finished article.

Graduate entry

Discussions about maturity and professionalism led to debate about the impact of graduate entry and whether graduate entry to medical school should become the norm. A number of people were very positive about graduate entry.

I would certainly myself have benefited in all sorts of ways from having done a degree first. I'd have matured more by the time I started in medicine and there are lots of things I wanted to just study for its own sake.

I came into university very late; I'd had my family and I'd kind of faced that. And I think that makes a big difference because I've had some life experience. I've had 20 years working in the City so I come with a brilliant understanding of what I believe professionalism is. ... And that's not belittling people who come in at 18 because that's how they do it. But I think it makes a difference on how you approach the issues and what you need to learn along the way.

Encouraging professionalism in medical students

Regardless of the level of professionalism in new medical students, it was reported that medical schools tried to encourage professionalism in their students in various ways. However, students were often unimpressed with the kinds of conduct that were encouraged and dismayed at what was not mentioned. Some were also concerned that medical schools do not give students responsibility, and this does not encourage their growing professionalism. Typical comments included:

Things like going into hospital and signing in, the undergraduate co-ordinators treat you like you're 17 and you're at school and you have to sign in at night, you have to sign when you leave at five and I think that's when they should be thinking right, we're all professional ... you can make your own decisions when you're training to be a professional.

Teaching and learning professionalism

Medical schools were keen to have formal input into teaching their students professionalism, although this was done in various ways. Many people agreed that there was a difference between teaching professionalism and learning it. Similar concerns to those voiced in the discussions about teaching and learning management and leadership skills were expressed about how and to what extent professionalism could be taught. Are such skills innate? Even if they should be

taught, is there time on a crowded syllabus to do so? (see *Leading and managing as part of a professional career*, p 35).

One student concluded that professionalism could be taught, but was not actually taught in a meaningful way. Most people, however, were optimistic that medical schools could enable students to learn about professionalism. Many of the skills that were taught, such as communication, were thought to be intrinsic to most people's notion of professionalism. If people balked at the teaching of professionalism, it was generally because they wished to emphasise that medicine is an art as well as a science, and it was not just a question of teaching students a set of rules.

It's that age-old argument isn't it, is medicine an art or a science and as a doctor are you practising art or science? I think the time I spent in a GP practice it definitely felt like my general practitioner was practising art and he just had a knack with things. But then I think 'is that just something that we get at the time, can that be taught in medicine?' Does the flexibility of medicine as an art just come with time or is that something that can be taught?

There was a high level of endorsement for the view that modern professionalism required good teamwork as well as high standards of individual behaviour.

How professionalism is taught or learned

As we have seen, a distinction is frequently made between teaching and learning professionalism. One student asserted:

Most of the medical students I know have reported that it couldn't be taught and most of the educators thought it could.

Nevertheless, most people did feel that they could be helped to learn how to be professionals and they wanted to be supported in their learning.

I think initially you are entering into a profession where the public feel they have the most trust in you so I think it's vital that we have that at the start ... because once we enter into practice and stuff, the moment you graduate, this is just going to be a continuous development for us.

One student spoke of a recent session on professionalism in which students had been able to explore various ideas and exchange views with others, so that they could develop their own ideas and also learn what professionalism means to others. The quality of input from tutors was evidently important.

We have an excellent tutor; he's really good at getting the issues out of [the discussion] and encouraging us to discuss how we felt about it. And I found that that's been quite useful. In the future, if I was in a similar situation, just having thought about it once before ... is quite helpful.

One student described how, on arrival at medical school, each student is set certain goals about self-reflection and reflection on critical incidents. They also have an inter-professional learning development course where they interact with students from different health professions in scenarios.

Others described the importance of observation, particularly when they were on placements with GPs. Generally, it was thought to be easier to take in lessons about professionalism when it could be more immediately applied, ie, on clinical rotations. This raises interesting questions about the optimum point in a medical school's

curriculum to learn about professionalism. Quite apart from questions of maturity, students pointed out the importance of relevance.

I think it becomes more relevant as you get closer to qualifying. You really start to think, 'I become a doctor in less than eight months'. So you actually start thinking, 'Is this going to become really relevant?' ... But I think, in the first and second year, you probably won't be thinking about it that much.

Obviously, it's a bit dry, but I feel like I owe it to my patients; in two years' time I'm going actually to be treating them. So I think I owe it to them to know all about it – even if it's common sense things.

How students are taught and the impact on professionalism

Although teaching methods are beyond the scope of this report, it is worth mentioning that the overall approach to delivering the curriculum appeared to have some bearing on how students learned about professionalism.

Some of those in practice wondered if an integrated curriculum made it difficult to learn professionalism. This might be because students were exposed to clinical and ethical complexities before they were mature enough to derive the maximum benefit and to take an appropriate level of responsibility.

Problem-based learning (an instructional method of hands-on, active learning centred on the investigation and resolution of real-world problems) was discussed in some detail (Learning Theories 2010, Wood 2003). Problem-based learning (PBL) in medical schools aims to encourage a group of undergraduates to collaborate in order to provide reasoned possible solutions to a posed question or scenario, to which there may be no single correct answer. Issues tend to be predominantly clinical in nature though many may raise non-clinical (ie ethical, legal or professional) issues.

Theoretically the interactive and self-directed nature of PBL means that this method of learning requires greater student cognitive involvement and thus retention of learning. Additionally the use of open-ended problems should encourage the application of principles rather than factual knowledge, which might be a particular advantage to developing an understanding of professionalism. However, the relative lack of institutional control over what is learned can be an issue as the institution can set the topics but cannot control the work that the students do to complete the task.

Overall discussion at the roadshows seemed to indicate that PBL sessions provide a setting for individuals to learn about aspects of professionalism and in turn have their professionalism assessed, not necessarily so much by trying to address issues that relate to professionalism but more through the actual process that is involved.

However, opinion on PBL was quite polarised. Some students felt that it had gone too far, and this could affect their learning on professionalism and on other aspects of the curriculum.

I know we're supposed to be self-directed but we don't get a huge amount of teaching which I think you really notice when you're in third and fourth year.

I feel like I know quite a lot now but I feel I had to muddle through and I would have liked to have done it in a much more structured way. I feel like I've got where I am despite our curriculum.

But others viewed the PBL approach more positively.

When people say we haven't been taught this or I haven't learned this, it often quite frustrates me ... it's possible to learn yourself, direct your learning, take responsibility for it and learn it out of a book or use whatever resource you choose. Do you think we should perhaps embrace that we should take responsibility for our own learning or do you think that it's gone too far and that a bit of direction would be appropriate?

Learning professionalism from role models

Many people pointed out that whatever learning methods were employed, much of the learning about professionalism came from observing role models. A similar point was made about learning about management and leadership too (see Leading and managing as part of a professional career p 35).

I think that some aspects of professionalism ... you learn by watching other people and, to some extent, by feeling your own way around – not as far as trial and error, but seeing what it's like in practice ... things like confidentiality and how doctors can talk about patients, when it's appropriate and when it's not.

So, when you're shadowing a doctor and you know they're really good – and sometimes it's really hard to say what it is that's really good but you just know that they're good.

I think it has to be learned through experience, so you pretty much have to go on to the wards and see your older doctors and see how they're behaving, and then you get to pick up from them, their professional behaviour, I think that's the way it's mainly learned.

But recognition of what was good, particularly when one was inexperienced, could be a major challenge.

[On recognising good role models] I think that you'd like to think that they're there and that you could differentiate, but in a real-life situation I think it's so hard to do it, because it's ingrained in you that you just respect these people and what they say is gospel.

Assessing professionalism

If the question of how to teach and learn professionalism is challenging, the question of how it can best be assessed is perhaps even more so. In part, this is because professionalism is defined in many different ways and, even within the most commonly accepted definitions, there can still be a wide range of subjective views on what, in practice, constitutes acceptable, professional behaviour.

In our final year one of the sections is on professionalism so I guess that's one way. I have spoken to my friends and nobody has been able to get a six which is the highest mark, or a five. It is generally four or three, so it is quite difficult to actually assess how professionalism exists for doctors and it seems everybody has a different idea.

I think it definitely is based on individual judgements. I know one student was given an unsatisfactory professionalism judgement because he was chewing ... it's definitely quite subjective.

Some were simply doubtful that professionalism could be properly assessed, and felt that one learned throughout one's life and that recognising professional behaviour was a matter of common sense.

Some students felt that assessments were made too quickly and too superficially.

I've been marked on the professional thing on a placement by someone who's spent nearly 20 minutes with me. And it's nice that they've got me as professional within that 20 minutes, but 20 minutes out of my career isn't really going to say whether I'm professional or not.

It varies between attachments because you don't always have a lot of contact with the person that signs you off.

It was suggested that the assessment of professionalism in some schools was 'more of a negative thing' because it was assessed and actually taken seriously only if there was a problem. This was compounded by students in the early part of their courses not necessarily knowing how they should behave as professionals. In one case, it was reported that a fifth year student had been told by her consultant in her last placement that her attitude towards nurses was 'absolutely terrible'. She was reported to be angry that she had progressed so far into her course without anyone making her aware of this problem.

Methods of assessing professionalism

Assessing professionalism was seen as a challenge both by students and by those involved in their education. What is clear is that several different methods are used in assessing students' understanding of professionalism and their ability to put that understanding into practice. The main ways are set out in Table 1.

Advantages and difficulties inherent in all of these methods were noted in discussion, for example:

I think professionalism is really hard to assess formally, because it's not just how you appear, it's also how you behave when you're not in an exam situation, and that's really difficult to assess, because it's how you behave with your medical team, things like that. That's really difficult for an examiner to think 'oh this scenario, when this has happened, so-and-so behaved professionally', because it's too fake. It's too genuine in a real situation and too fake to replicate that in an exam situation.

However, students were aware that professionalism was assessed in a wide variety of ways, and they specifically mentioned many of them (or noted their absence).

As a third year medical student I've noticed that on each placement feedback form there's this box for the assessor or the clinician to tick that says 'Did the student behave professionally? Yes or no?'

I know I've got a friend who's at [name of medical school], who's in the third year and every week they meet and have the opportunity to talk to people about how they're feeling about things they've seen or things that they're having to deal with and I think that's something that is actually really lacking here.

We have a lot of professionalism through all years, starting off with peer assessments. Almost every group and teaching session we have is assessed by

the facilitator or doctor and then we have to self-assess our professionalism with our portfolio analysis so it's quite a core part of our curriculum.

In OSCE [Objective Structured Clinical Examination], a lot of the marks are for the ability to communicate, and that's very important for professionalism.

Many of the comments were neutral or positive but a few were more critical. One student complained that they spent hours on their portfolio and then the tutor only read it when they met, rather than giving it adequate prior consideration.

Another person recalled:

The way it is assessed after every assignment there are a lot of complaints, well not complaints but comments. ... For example there was an elderly person and they had a discussion with the consultant about depression and it was quite relaxed. Filling out the feedback form the doctor said they had to rate me on professionalism. It was the first time I'd met them so it wasn't based on anything other than how I acted in that 10 minute discussion about depression ... it wasn't a great way to assess it.

Those who had genuine opportunities to reflect on their learning found that it helped them to develop and demonstrate their professionalism. Such methods evoked positive comments, although positive attributes of reflective and discursive methods sometimes made sense only as the student progressed through the curriculum.

I think, for me, also, Jigsaw's been just like a really integral part of it. In my first years, I asked 'What's this all about?', 'This is ridiculous', 'Why are we doing this?', 'This is obvious'. But as I've gone through and, also, starting more clinical attachments ... it has really made me feel 'Why didn't we do this?'. And to be able to discuss that with other students made it make more sense to me and also made me form my own opinion about professionalism.*

I think the fact that we have to write an essay about it encourages you to go and look up the documents that explain a bit more specifically about aspects of professionalism that we need to be thinking about. So, I think that can be quite useful if it may seem a bit woolly at the time to be writing.

Some comments on assessment were not restricted to the assessment of professionalism, but also to the wider curriculum. One person felt that examinations could drive learning and could thus distort it, but another student remarked:

[I] have to confess that I do actually sometimes wish for more examinations. ... And I know it's very rare thing for students to be asking for exams but I do find that the exam is something that will make you sit down and go through things if you know it's going to come up ... just having that sense of, you know, you need to learn it.

One group discussed whether the range of professional regulatory bodies, each with their own rules, made it difficult to assess people in teams rather than as individuals.

* Jigsaw is a small group for discussing community placements. Among other things, it is a way for students to get in touch with their feelings about their experiences.

Table 1 Methods of assessing professionalism

Assessment	Description	Uses	Role in assessing professionalism
Case-based discussions (CBDs)	Assessee brings a case in which they have been involved for an in-depth discussion regarding points relating to management. Generally completed with a relatively experienced doctor.	Used in the assessment of medical students (typically more as case presentations) and trainees. Discussion tends to focus on issues relating to medical management and in terms of rating categories for assessment these focus more around clinical judgement than anything else.	There is scope within 'investigation and referrals' and 'ongoing management plan' sections to consider team working. Potentially, dependent upon the case, issues relating to consent could be brought out.
Clinical evaluation exercise (CEX, mini-CEX)	Assessee is observed during the process of a clinical encounter. The encounter is subsequently deconstructed/discussed as part of the assessment process. Generally completed with a relatively experienced doctor.	Used to provide assessment of trainees' behaviour in clinical situations – may be inpatient or outpatient. In some cases encounters within multidisciplinary team meetings may be used as examples for assessment. Initially introduced for postgraduate trainees, it has been extended to undergraduates.	This assessment has an almost 50–50 weighting in terms of categories that have a relevance to professionalism (communication, counselling, professionalism, interviewing skills) and those with a relevance to clinical judgement (at least at trainee level). There is likely to be inter-institutional variability in assessment design at undergraduate level. In reality the completion of the assessment is variable and the interaction is often not even observed.
Directly observed procedural skill (DOPs)	Assessee is observed during the performance of a technical clinical skill (eg, venepuncture, cannula insertion). Can be completed with any health professional competent in the skill in question.	Used to demonstrate proficiency in the completion of a particular clinical skill.	Has a number of categories that relate to professionalism in terms of gaining informed consent, consideration for the patient/professionalism, seeking help where appropriate and communication in the postgraduate trainee version. Clinical skills for medical students tend to be described and progress recorded in log books which tend to have more formulaic descriptions of the clinical skill in terms of steps to follow.
Multi-source feedback (MSF), also known as peer assessment tool (PAT or mini-PAT)	Individual being assessed is required to source feedback from a variety of medical professionals (doctors, nurses, allied health) and potentially other staff (eg, clerical). Typically around 12 responses must be obtained, all anonymously.	Used to gain a good spread of opinion regarding professional behaviour from a multitude of multiprofessional sources.	Very much aimed at assessing team-working ability and professional behaviours.

continued opposite

Table 1 *continued*

Assessment	Description	Uses	Role in assessing professionalism
Objective structured clinical examination (OSCE)	A form of summative assessment typically held at the end of a clinical placement or year. Consists of a series of simulated or 'arranged', fixed duration clinical encounters which may be technical or communication based, forming a 'circuit'. Assessment is made against predetermined criteria deemed to cover important aspects of the skill (but not 100% comprehensive).	Generally used as an end-of-year (or occasionally end-of-attachment) exam for the assessment of ascertainment of key clinical skills.	Number of aspects that relate to professionalism ranging from stations centred around communication skills (including with colleagues) to certain more detailed aspects of the mark scheme such as points on introducing oneself. Some schools allow additional marks to be awarded as part of a 'global rating' which incorporates a number of issues relating to professionalism (eg, dress, manner, confidence).
Record of in-training assessment (RITA), annual review of competence progression (ARCP), end-of-placement review	RITAs and ARCPs are (generally annual) reviews of the progress of postgraduate trainees through training programmes. They require the presentation of a sufficient number of appropriate assessments (pre-specified) along with evidence of completion of a number of pastoral meetings recording fulfilment of a personal development plan (PDP).	Used as a checkpoint system to ensure adequate progression through training scheme at 'high level' within training programme supervision structure (ie deanery). RITAs and ARCPs are not used in undergraduate training.	Relates to the assessments that must be completed in order to progress through the checkpoint.
Portfolio	A collection of various materials that trainees collect to demonstrate a variety of skills and achievements not necessarily covered in other assessments. Typically assessed by trainers/tutors.	A means of formative assessment in terms of a record of reflections upon various clinical (and non-clinical) experiences with an emphasis on how these experiences will shape future clinical behaviour.	Provides important insights into trainees' views of behaviour and responses to professional challenges or significant events. Variability in what trainees understand portfolios should contain and aim to demonstrate.
End-of-placement reviews (clinical supervisor, educational supervisor)	A short meeting (typically very variable duration) with either direct consultant supervisor in a clinical placement (clinical supervisor) or consultant with responsibility for educational development (educational supervisor). Meetings have a predetermined structure with a number of stages to complete and certain checks and/or forms that need signing by both parties. Essentially a form of appraisal.	Used to ensure adequate educational progression through clinical placement or training programme and as an opportunity to address any concerns/issues.	As part of ensuring adequate progression and in terms of setting and reviewing progress in accordance with meeting PDP.
Fitness to practise/ yellow/pink forms	Forms issued by medical schools to be completed and returned in the event of significant concerns being raised regarding an individual student's professional behaviour.	Appears that policy varies on who can complete one of these forms. Used to allow identification of worrying behaviours in terms of professionalism. May form part of a 'card' or 'warning system' which precipitates referral to fitness-to-practise board/dean.	Identifying worrying behaviours.

The 'tick-box' approach

Occasionally, methods of assessment felt rather contrived. For example, one student recounted having to write about bullying in the medical profession. However, they had no experience of bullying and 'had to try and fit an experience that I hadn't had into this framework which had been given to me because it's one of the things that you have to tick off that you can talk about'. Others, too, referred to 'ticking the boxes' and were not convinced of the relevance of the tasks in relation to assessing professionalism.

I'd say it's important that undergraduate education doesn't necessarily become too much like a tick-box culture, which I think maybe it's in danger of sometimes, because we get all these sheets where we have to go through and tick everything off ... it's quite broad and not necessarily focused on learning things that you're going to need on day one as a doctor without actually having a more broad base to it.

The problem was that not everything could be neatly categorised.

I was a simulated patient for the finals and everyone was following a template – some did it really well and others did it very badly. There's a lot more to it than following a sketch, it's how you interpret it.

Further discussion on that point showed that some people thought that following guidelines and filling in forms became more important than, for example, making the patient feel comfortable with news of their condition, or tailoring the consultation to the patient's needs.

I think we're too homogenised, we sit in front of a patient and we do this, that and the other, take a history, examine them, do that, and medicine is far more than that now, and if we're going to add in public health into everything with consultation, every single contact should count towards prevention, then we need to completely change our mindset.

Who can assess professionals?

There was considerable discussion on who could and should be involved in the assessment of professionalism. Many people had experience of peer review in some form, including multi-source feedback (360-degree review). Some approved of peer review by medical students, since they would be required to assess their peers and be assessed by them once they were qualified.

I think you have to appreciate that when you do graduate, when you work, your appraisal and your assessment is peer reviewed so when you're a doctor that's how you will be assessed, so I think it's probably not a bad thing to get into that mindset early.

It was also viewed positively by those who noted that students spend a lot of time with their peers, so peer assessment could be based on a detailed knowledge of the person and it would be unlikely that a poor student could put on a good face over a prolonged period.

I think students, fellow students, are in a position really to assess you because we spend most of our time with other students, not with doctors.

Indeed, students admitted making an effort for the particular occasions when they felt that they were being assessed by consultants.

If I know my consultant has a ward round on a Tuesday and a Friday I dress sharp on a Tuesday and a Friday for that. ... And then, as soon as the consultant turns round, I loosen my tie or put down my hair.

Some students felt that some peer assessment by the junior doctors with whom they worked would be valuable as they knew the students' work and behaviour quite well.

There were also concerns about inconsistencies and a possible lack of objectivity in assessment by one's peers, particularly by friends.

I think in the second year it was almost a popularity contest and the nicest people were rated higher, you could see it, and one person who particularly irritated a lot of members of the group definitely scored very poorly.

I think students assessing other students is open to abuse.

I would have to be completely honest, I would have to say if a good friend of mine was in my tutorial group and I knew he was a nice guy and I had to mark him on whether he speaks too much, I would struggle I think to be honest to give him a bad mark.

However, some schools had a system whereby students could submit concerns about others anonymously, and the validity of what was said would then be assessed. Whether that system was in place or not, a few students were worried about peer assessment being 'a little bit Big Brother'.

But being a peer reviewer (as well as being peer reviewed) was also seen to be positive in so far as it made students consider what professionalism means and what qualities they were looking for in themselves and others.

I think students assessing students in itself is quite a valuable experience ... but I think the experience itself is something that you should practise because ... you are going to have to give constructive criticism to your colleagues and so it's a good practice, it's something to get used to but it just shouldn't be counted towards anything.

The value of student assistantships

However it is taught and learned, professionalism cannot be wholly delivered by lectures and other formal teaching methods. Yet opportunities to learn 'on the job' were sometimes insufficient too, and did not give enough hands-on experience. Some students contrasted their own experiences with that of nursing students, who appeared to have longer placements and to be more part of the team

I always find it amazing, you wander round and you see a nursing student and you say 'are you in your final year?', and it's 'no, second year'. You're doing a full schedule but we're standing in the corner and doing absolutely nothing.

I call it the helicopter approach, because you come in, you drop in for a few minutes and you lift up and drop somewhere else.

Some people felt that students were not with a particular consultant for long enough to maximise learning (although the contrary view was also expressed – that short placements prepared students for whatever they might encounter):

... moving around quite a lot is sometimes a good thing because you change and you have to learn with a new set of people and things that are going

on and you're put in an unfamiliar environment every couple of weeks. That forces you to quickly get used to a new situation and suss it out.

For all of these reasons, a number of people supported the idea of student assistantships (which they sometimes referred to as student apprenticeships – a period during which a student acts as an assistant to a junior doctor, with defined duties under appropriate supervision). These could have a number of advantages in helping students to prepare for their future roles as doctors. Students felt that this would mitigate a perceived lack of hands-on experience.

Issues for the future

It is apparent that medical schools approach education for professionalism as a curriculum topic in different ways. Given that there is little evidence at the present time on whether there is a 'right way' to approach this topic, the diversity of approaches in relation to teaching, learning and assessing professionalism is not, in itself, a negative feature. However, it should be possible to evaluate which approaches are most effective in educating medical students to develop their professionalism. Although there may well be no magic bullet that swiftly delivers the desired effect, there are, at least, some pointers to what students and others regard as most helpful.

What is clear is that professionalism needs to be promoted as a critical and integral part of being a doctor. Indeed, students perceive the development of professionalism as one of the threads that will run right through their career. It follows from this that medical schools should have well-articulated and clearly expressed definitions of professionalism and allow students to engage with these definitions from an early stage in their programmes.

It is also important to ensure that self-directed learning is well supported and does not result – as some fear – in a lack of direction to medical students. Yet at the same time, students are very clear that an over-reliance on formal teaching methods of professionalism is not helpful. Formal teaching must be heavily supplemented by opportunities to learn in realistic working environments, with opportunities to learn from role models and experienced colleagues. However, this raises questions about whether structures are in place to support practical learning about professionalism. For example, if students spend only short periods with a team, does this seriously reduce their opportunities to learn by example?

For this and many other reasons, opportunities to bridge the gap between being a student and being a junior doctor, such as student assistantships, may be very beneficial, and should be encouraged.

There are also concerns that issues that were fully discussed in *Understanding Doctors: Harnessing professionalism* (Levenson *et al* 2008), such as changing working patterns (including shorter hours) and different expectations of work–life balance, may erode professionalism. The challenge, however, is to develop and foster a new and equally robust professionalism that can adapt to the modern world, while still ensuring the high standards that the public expects and the profession aims to deliver.

It is also necessary to develop and refine approaches to the assessment of professionalism and develop robust, valid and authentic ways of assessing professional behaviours to aid development. Medical students should have the opportunity to shape policy around developing and assessing professionalism in their own schools, alongside their teachers and more experienced colleagues. We

have seen from the roadshows that students and young doctors are likely to see professionalism as applying broadly to many aspects of their values and conduct and do not want to limit it to relatively small or bureaucratic aspects of behaviour such as dress or punctuality.

It is essential that the assessment of professionalism develops beyond a mechanistic tick-box approach, so that wider aspects of professionalism can be properly assessed. Educators who support medical students to develop their professionalism and those who assess that learning will need to be properly equipped themselves for these tasks.

Incidentally, it is also possible that, if students are required in future to make greater contributions towards the costs of their undergraduate education, they may well become more demanding of what they expect to be included in their curriculum and how it may be delivered and assessed.

Finally, given that demonstration of professional values and behaviour is seen to improve with maturity, the debate about moving to more graduate entry medical school programmes will continue. Either way, medical students, whatever their level of maturity, need and expect a rounded and systematic approach to nurturing professionalism to be a central part of their medical education.

Professional values and personal behaviour

Context and challenges

Doctors and other health workers continue to be held in high regard by patients and the public. Clearly, this regard can be shaken by poor practice, but what is less evident is whether it is also affected by the behaviour of doctors in their private lives.

The Royal College of Physicians' medical professionalism working party (Royal College of Physicians 2005) considered to what extent a doctor's private behaviour might affect their professional competence and its putative significance. In effect the working party was asking 'Do you need to be a good person to be a good doctor?'

Some people argue that private behaviour can tell us something about the doctor's attitudes, values and relationships with others. Others may contend that a doctor does not always need to be a good person in all realms, both private and public, to warrant their professional status. However, it may be appropriate to take private conduct into account when it tells us something relevant about their approach to society or sections of society, individuals or colleagues.

The medical professionalism working party believed that each doctor is viewed as a role model for other doctors, for colleagues in the health care team and for society in general. However, dilemmas and contradictions – both personal and work based – are commonplace and frequent.

The GMC's publication *Good Medical Practice* (GMC 2009b) sets out the principles and values on which good practice is founded, and states that:

You must make sure that your conduct at all times justifies your patients' trust in you and public's trust in the profession.

It is in this context that students and others at the roadshows were invited to think about the values and conduct of doctors and medical students and to consider the interrelationship of professional values, personal conduct and professionalism.

What we heard

Are medical students different to other students?

There was lively discussion across all the roadshows about whether medical students were somehow different to other students. Might the trust and expected behaviour that are placed on doctors also be placed on them? Might they feel the weight of public and professional expectations from an early stage? Most people thought that medical students were not able to behave in quite the same way as other students. Even as undergraduates, many people saw medical students as

representatives of the profession and as custodians of a public image that needs to be lived up to. There were particular concerns about the need for good behaviour where a student was identifiable as a medical student.

I think there's also quite a difference, if you're identifiable as being a medical student that also has great bearing in terms of your conduct, whereas if you were just another student on a Friday night you'd feel that inhibition removed.

It was noted that the typical student, on beginning a university course, may have little idea of what is expected of a professional, and they also want to fit in and enjoy student life. There might also be perceived pressures from other students, who might treat medical students differently if they showed relative restraint. Therefore, some thought that it was appropriate that medical schools emphasised the importance of professional conduct from the outset. Indeed, some students were very aware that from their very first week they had been told that they must report even getting a parking ticket. Others spoke of their shock at the expectations that were placed upon them:

We were all really shocked on our first day. They said if you're seen to be doing things like setting off the fire alarm it would be an offence, all the typical things that students do, it was all listed and the distinction was made then that you're different from other students and that was quite difficult for a lot of my colleagues.

In spite of all the warnings, students also felt that the requirements at medical school in relation to professional behaviour are somewhat superficial, including issues such as timekeeping and appearance. A number of students referred to being required by their medical school to sign up to a code of conduct. The idea was generally welcomed, but its content was sometimes thought to be too limited in scope.

Some would welcome a more positive attitude to encouraging professionalism.

I think there's something about professionalism being defined much more broadly than it being about how you dress or how you look ... it's about thinking about the attitudes and the values that they hold ... do they have an understanding of the importance of communication skills and the importance of taking on board patients' views, having respect for their opinions and involving them in decisions?

Many of those who considered that medical students were different from other students rested their case on the early awareness among medical students of the possible consequences to their career of unacceptable behaviour.

I think you're constantly worried about your CRB [Criminal Records Bureau] check – you don't want anything showing up on that.

It is interesting that the discussions about perceived pressures on medical students to behave with restraint were also liberally illustrated with stories about how medical student culture tended towards the flamboyantly uproarious, with alcohol playing a particularly large part in social life.

When you consider that a major part of joining the medical school is actually the scrubs pub crawl and the pyjama pub crawl ... then you come along to something like this and say getting massively hashed isn't a very professional thing when we've all gone and done it.

Clearly there was a poor fit between aspiration and reality for many students, with competing pressures to take part fully in student life, while not overstepping the mark and jeopardising one's standing at medical school and future career. One student told this cautionary tale:

... a girl who I didn't know very well had been slumped in a corner and I offered to take her to A&E because nobody else was going to and we were a bit worried about her. I didn't know very much about her so I asked for her student card to try and get her name and date of birth, and they saw that she was a medical student and one of the things they said was the dean will hear about this ... so she spent the entire rest of the week terrified that someone was going to call her up and bring her to account for this behaviour, when actually it had just been a silly mistake, probably through some immaturity early on in med school.

Another said:

My sister's just started at the graduate course at [name of medical school] and she told me that they've got a three strikes and you're out for all medical students if you turn up to A&E, if you're drunk or disorderly or anything like that. And, on your third one, they'll kick you out of the medical school if there's enough inappropriate conduct.

Some students drew a distinction between illegal behaviour and other behaviour that might be seen as unacceptable or unwise, although it was not illegal.

[Re cannabis smoking] I think, at the moment, as that actually breaks the law, then, no. If it were to be legalised, then I don't see how you could argue that that wouldn't be acceptable. If it was acceptable within society as recreational activity, then how would you then discriminate against doctors and say, 'We're going to be able to say the rest of the community can do this but, actually, we're not going to let you'?

Others felt that the salient factors were social acceptability to patients rather than a question of legality. That raised interesting issues, for example about whether it was acceptable for a medical student to pay her way through medical school by lap-dancing.

Students described how they were immediately aware that others saw them as different in all sorts of contexts, no matter how new they were to medicine. One student reported going to the local pharmacy for a flu jab just a week or two after starting at medical school. When the person giving the jab realised that they were attending to a medical student, they admitted to being nervous. This was perplexing to the student, who was surprised to be treated differently, particularly as the student had claimed absolutely no knowledge of how to give a flu jab.

Some students felt that medical students were somewhat apart from other students for other reasons too:

I don't think we are necessarily like other students. I mean literally we spend our time in medical school, with little or no contact with the campus if we choose not to.

There's extra-curricular things as well like medics don't often get to join in a lot of mainstream activities because we have such busy timetables and so that also separates us a bit more I think.

A few dissenters argued that there was little or no difference between medical students and other students.

... outside of the clinical environment I don't think it makes much difference. There's no difference between a medical student and a history student.

What sort of misdemeanours can be tolerated?

People went on to discuss what kinds of aberrant behaviour could be overlooked, or dismissed as 'high spirits' and what should be seen as serious enough to attract censure. There was, perhaps, a bit of nostalgia for a more forgiving era.

The year ahead of me after their second MB exam had a party that got totally out of hand and 120 in the year were arrested and charged and now have a criminal record. Many of them are now eminent members of the professions. Now there would be a huge public scandal about that. Then, 40 years ago, it was medical students being medical students sort of thing.

... 20 years ago if you got really drunk and did something stupid like moving a traffic cone you might spend the night in the cells and the police would be, like, you're an idiot, go home, and now you get a caution and it would affect your personal rights.

Attitudes to traffic offences such as speeding varied. Some saw them as trivial, while others focused on their life-threatening potential.

How far small misdemeanours can be tolerated might depend on whether they indicate future behaviour and attitudes.

I think you'd probably find, I don't know if there's any evidence of this, but people who are a bit of a chancer at medical school, it will end up that's the way that they practise and that's not exclusive to medicine, that's life isn't it.

I'm involved with Fitness to Practise in my own medical school and I think there are certain things that once a student's demonstrated that they can cross the line and do certain things I've no confidence that that's going to change.

And it was not always major offences that worried people:

When I look back, I'm quite sure, by the end of the first year, we could pick out certain individuals. ... It would start off with 'Can you get a hand-out?' to 'Can I have your notes?'. And I think, yes, a lecture is boring but it's part of your training; you're there for a reason. You're going to be attending conferences one day. Just because it's boring, it doesn't mean you don't show up.

Another person noted that it was not necessarily or solely those who seriously transgressed who posed a potential risk. It was also those who were 'slightly off-message repeatedly'.

Mistakes in personal life

Many people – both students and others – took a sympathetic view of minor lapses in good behaviour, seeing them as part of the process of growing up. Many people felt that most medical students were simply not yet mature enough to

demonstrate that they had the necessary values or behaviours that were to be expected of a doctor.

We've all done things when we were a house officer or just training that ... we wince about and that's through combination of immaturity, fear, lack of support, lack of knowledge.

Many people recognised that maturity was not achieved overnight and students were on a lengthy path. They thought that expectations of students' behaviour should increase gradually, particularly once students had significant contact with patients. The transition between being a pre-clinical and being a clinical student was seen as a watershed. One person said:

If you're a third year medical student and you are entering that profession, patients on the ward view you as a doctor and they will hold you in the same sort of trust as that of a consultant. ... I think you should have the same standards as a third year student as a registrar [or] consultant.

It was suggested that it is very different being in a hospital environment every single day rather than just occasionally. Students tend to go to bed slightly earlier and make sure that they are not late, as part of getting into a routine and preparing for professional life.

One person thought that it may have been easier for students in the past when they had little exposure to patients until they were older and more mature.

I think it was much easier ... when you had two years where you had very little patient contact and you could actually behave like the rest of the university in terms of being an undergraduate, and then third year was the transition year and you were very much on the wards full-time in fourth and fifth year, so it was expected that you behaved much more like a junior doctor and you took on the responsibilities of a junior doctor.

Students recognised that they had matured during their studies, and hoped to continue to do so.

I am a different person when I started at medical school, I've matured and I see things in a very different way and I'm much more careful how I interact with people, so surely in 10 or 20 years time I'll be a completely different person.

Social networking sites

There was much discussion on how early mistakes may come back to haunt people, particularly since social networking on the internet left a near-permanent record of behaviour that a student may not wish to publicise, and certainly would not wish to leave on record for ever. This applied not only to the students' own postings on social networking sites but also to postings made by others over whom the student has no control. Cautionary stories – factual and legendary – abounded to illustrate this.

I remember hearing some story about some girl at [name of medical school]. They have some celebration where they're not meant to throw flour or something and she did and there are photos of it on Facebook, so they had seen that she'd done it and they booted her out.

I think it's been reported that PCTs are looking at people's Facebook accounts.

Some were less concerned and thought the problem was manageable, with a little common sense.

You don't take records out of hospital and leave them on the bus. It's the same thing on Facebook, you don't put things on there that you don't want people to find and you have got to take responsibility for that.

The danger of breaching confidentiality by sharing experiences about patient care or about colleagues on social networking sites was also noted.

There were also concerns that the use of Facebook left students and doctors open to being traced or contacted by patients. On some occasions, people had experience of being invited to be a Facebook friend by patients and others with whom they would not wish to have that kind of relationship.

You wouldn't give your patients your address, you wouldn't want them to be writing to you at home all the time and writing on your Facebook page is even more personal than a letter.

However, not being on Facebook could be difficult for medical students as most other students conducted their lives through such media. Many university student groups disseminated information by such means and not being part of social networks was virtual social death. Some students reported that their professors posted links on Facebook so they were expected to access it for that reason. One who did so was a little surprised to see the professor's holiday photos too!

To a lesser extent (and perhaps with less possibility of control) people noted that aspects of their lives and some personal information about them were available on the internet generally. However, some people pointed out that patients knowing about their doctors' personal lives was not an entirely new phenomenon. One person suggested that 50 years ago, and particularly in smaller towns, people tended to know more about their doctors. That too would have raised issues about how doctors behave outside their work environment. However, the ease with which people can now find out about others highlights the importance of self-awareness in relation to potentially embarrassing or unprofessional behaviour.

The personal behaviour of qualified doctors

It was not just students' behaviour that was under the microscope. There was also discussion about the personal behaviour of qualified doctors and a detailed consideration of the spectrum of behaviours in a doctor's personal life that may impact on their professionalism. In particular, there was a lot of debate about whether doctors need to uphold higher standards of behaviour than other people.

On the whole, it was agreed that doctors did need to have particularly high standards of conduct. This extended to upholding the law and to wider matters of integrity and even to lifestyle choices.

I think the standards for behaviour are a lot higher for doctors than for the general public, even drinking and smoking. People are more tolerant with the general public doing those things compared with a doctor doing the same thing, I think they expect a lot higher behaviour from doctors.

The sense that doctors were never quite 'off-duty' added to the feeling that good behaviour needed to be the norm. However, no-one had any illusions that the desirable was always achievable:

No-one is perfect are they? We can't set down a list of rules of exactly how a doctor should run their life, we are normal people who make mistakes and they have extra-marital affairs and whatever and that happens.

For some, the issue was where the boundaries should lie.

If you saw your doctor at Glastonbury, if she wasn't high on drugs, as you expect she wouldn't be, it wouldn't be a problem for her to be there associating with that kind of situation ... you have to think, okay we're still allowed to be people. But maybe if you want to go for a glass of wine with some friends, you shouldn't be going to the pub next to the hospital as you might see patients.

The question arose whether it was necessary to be a 'good person' in order to be a good professional and a good doctor. One person thought that if people had had 'a normal upbringing' they would have 'all the qualities of being a professional'. However, most people saw the question as more complex.

Those who felt that being a 'good person' was inextricably linked to being a good professional and a good doctor held those views because they felt that it was hypocritical for private values and behaviour and professional behaviour to be at odds. For example, if a doctor held racist views or if a doctor was homophobic, that might impact on how they treated patients.

It was also felt that the public expected doctors to uphold high standards of behaviour and to hold values that supported such behaviour. In other words, it was a matter of trust.

Some drew a distinction between values and behaviour or activities. For example, is a doctor who views pornography violating trust? Some people argued that in so far as viewing pornography was generally thought to be negative, it was something that doctors should steer clear of. Some people warned that 'skeletons in the closet' were liable to become public, so anything that a doctor felt impelled to hide might well be off-limits.

Others felt that it was perhaps desirable, but not strictly necessary, for a doctor to be a good person. One person admitted to being influenced by the portrayal of the eponymous doctor in the television series *House*, in which a mendacious, drug-addicted doctor always diagnoses and treats his patients with greater skill and perspicacity than anyone else.

Some people felt that a separation of private and public behaviour was acceptable, at least to a certain extent.

I think among other professionals they appreciate that you have a professional personality when you're working and you can leave that at least to a certain extent behind when you're not working and they will accept that.

Nevertheless, attitudes varied according to the seriousness of the bad behaviour. Criminal activities were frowned upon, and some conduct, such as domestic violence, was seen as unacceptable irrespective of whether it was also proven to be criminal.

Can medical students raise concerns about colleagues?

Occasionally, students have concerns about the professional behaviour of their colleagues, either fellow students or qualified colleagues from medical or other professions. For the most part, students felt that they could make themselves heard

if they had concerns about poor clinical practice, although they did not necessarily feel that whistle-blowing was sufficiently covered in their education. This was a potential problem since it was suggested that, in the past, students had not wanted to blow the whistle 'in case it gets taken the wrong way'. Discussion at one roadshow suggested that students might be helped to think through how they could raise difficult issues if they had concerns, by discussing realistic scenarios in groups.

I think that's a good idea because you just don't know, until you're faced with something, you don't know how you'd react, what you'd do, what you should be doing.

A sense of confidence in being able to speak out might be a reflection of the team and environment in which the student worked.

I think it depends on the actual doctor that you're with. Sometimes you can be in a team that is quite open and you can talk, and then other times you wouldn't possibly even bring that subject up.

The problem was that it was possible that teams that made students and others feel confident in raising issues were those that were constantly reviewing their practice and performance anyway, while those that would most benefit from discussion were least likely to encourage or enable it.

Some students were simply not sure that they would know how to raise concerns about colleagues.

Should doctors lead by example on lifestyle issues?

There was no consensus about whether doctors ought to set a good example on lifestyle issues such as drinking or whether they should be seen to make healthy choices as an example to their patients.

Some people felt that doctors should practise what they preach on the use of substances like alcohol and tobacco.

Patients may see you out and expect your behaviour to be acceptable to them as well. It's almost like a politician or an actor, you are on show a lot more of the time so your whole approach to life is judged because people feel if you behave like that outside work, do you really believe what you are saying when you are at work, that's the truth of it. Talking about smoking and alcohol, we spend a lot of time telling our patients to give up smoking and stop drinking alcohol so it is pretty hypocritical to do that if you smoke and get drunk regularly.

I think your personal life and professional life should be separate but if you choose to smoke and drink that could have an impact on your job.

Some took a more nuanced view and suggested that it was rather worse if a doctor working in the field of chronic obstructive pulmonary disease, or engaged in smoking cessation programmes, was seen to be a smoker. At the heart of the argument, once again, was the issue of the trust between a doctor and a patient:

If the patient sees it then that trust has broken down and you can't prescribe advice to a patient and expect them to believe you and take it and run with it if they don't trust you, and I think that's central to what it is like to be a doctor.

It was also a matter of credibility.

I had this conversation with someone, a GP who was very overweight, and actually patients felt very comfortable talking to him about being overweight.

However, not everyone agreed and one student said:

I think it's a bit Big Brother really isn't it? I had a session with my GP a couple of weeks ago, he said he was caught smoking his first cigar in about 20 years by a patient who he'd told the previous week not to smoke, I was kind of like, well yes, it is hypocritical but, I don't know, we're human as well.

Issues for the future

It is important for students to be aware that a great deal of information on professional values and behaviour is given in guidance issued by the General Medical Council, and particularly in *Good Medical Practice* (GMC 2009b). The question is how to make students more aware of the existence of this. It is also not entirely clear which media are most likely to gain the attention of students who need to be aware of and refer to guidance on professional standards and ethics. (This issue is discussed further in *Engagement with professional regulation*, p 28).

All students would benefit from seeing what can seem to be rather abstract principles brought to life. The development of interactive websites such as the GMC's *Good Medical Practice in Action* (GMC 2010) is a positive example that helps to make the links between real-life ethical dilemmas and the standards that are expected of a doctor by the GMC.

Medical schools clearly have a role in making clear what standards of conduct apply to medical students and to the qualified doctors whom they will become. These standards of conduct need to be applied consistently. Medical schools also need to be clear about what is and is not acceptable behaviour. More thought might usefully be given as to how to deal with students who fall short of expected professional standards in ways that may be minor, but persistent. It can often seem difficult to deal with minor transgressions where the whole may amount to more than the sum of its parts. However, the possibility must be considered that minor, repeated lapses in acceptable behaviour may develop into a more serious problem.

In this context, medical schools should enable students to explore issues of professional behaviour and values in a safe environment, perhaps facilitated by senior students or junior doctors to help put behaviour into context. Medical schools should make the possible consequences of early misdemeanours clear to students. In an era where it is so easy to leave an electronic trail of all one's activities, the need for insight into personal behaviour and its consequences is, perhaps, more important than ever. The challenge for the future is how to encourage appropriate standards of professional behaviour, while allowing students to develop, mature and learn from 'youthful indiscretion'.

As students consider professional values and behaviours it is helpful for them to reflect on whether and how medical professionalism differs from professionalism in other contexts. As we have seen, many people at the roadshows thought that doctors and medical students should uphold and demonstrate higher standards than others. While this has a positive side, it is important that what has been termed 'medical exceptionalism' does not encourage an image of members of the medical profession as arrogant or distant from those whom they serve. High

standards are, of course, to be encouraged in all professions, but the argument that such standards are the exclusive preserve of doctors is not so persuasive.

Finally, although most people would accept that there is a core of immutable values and behaviours that are intrinsic to professionalism, it is also accepted that some values, and the weight accorded to them, change over time. All those who are concerned with medical professionalism should consider ways to keep abreast of what patients and the public think are acceptable standards of professionalism for doctors and medical students. The results of surveys of what the public think about medical professionalism can be helpful in ensuring that medical students, doctors and medical educators remain in touch with public expectations of professional behaviour (Chandratilake *et al* 2010).

Engagement with professional regulation

Context and challenges

The General Medical Council (GMC) sets outcomes and curricular requirements for undergraduate medicine in *Tomorrow's Doctors* (GMC 2009a). The outcomes are structured under three headings:

- the doctor as a scholar and scientist
- the doctor as a practitioner
- the doctor as a professional.

These outcomes are mapped to the standards in *Good Medical Practice* (GMC 2009b).

In March 2009, the GMC and the Medical Schools Council (MSC) published revised guidance for medical students and medical schools (General Medical Council and Medical Schools Council 2009). The guidance sets out the professional behaviour expected of medical students and gives advice to medical schools on how to develop fair and consistent fitness-to-practise procedures.

In April 2010 the Postgraduate Medical Education and Training Board (PMETB) merged with the GMC. As a result, one organisation is now responsible for an integrated regulatory framework of standards, education, registration and fitness to practise for all stages of medical education and training, from the point of entry into medical school to retirement, including undergraduate, postgraduate and continued practice. Coupled with the introduction of revalidation, this means that today's medical students will have a much closer, ongoing relationship with the GMC than their predecessors. This relationship will be characterised by the GMC recognising good practice among doctors, rather than censuring bad practice.

One of the new outcomes specified in the 2009 edition of *Tomorrow's Doctors* (GMC 2009a) is that graduates from medical school must be able to demonstrate knowledge of systems of professional regulation.

Formal professional status is dependent upon effective regulation. This needs to be independent and accountable, and command the confidence and support of key interest groups. One issue discussed in the 2007 White Paper, *Trust, Assurance and Safety – The regulation of health professionals in the 21st century* (Department of Health 2007) is whether students and trainees should have closer relationships with their future regulators before qualification.

The GMC has considered the arguments for and against student registration but has not been persuaded that the potential advantages of student registration outweigh the potential disadvantages. This position is kept under review.

What we heard

Understanding of the regulator

Across all the roadshows, it was clear that medical students often had a fairly patchy understanding of the GMC's functions. As students they mostly felt that they did not know what the GMC had to offer them, although several referred to some input during their education.

There was a lecture we had at the end of fourth year where we had pre-registration and they came and spoke to us about getting a bit more information on that, but there's nothing much.

There seemed to be several dimensions to the lack of engagement between students and the GMC. First, students tended to think that, while professional standards and professional regulation were important, these issues were not especially relevant to them as students, particularly at the earlier stages of their studies.

I think you need an awareness of these things to come, their importance. I'm not saying they're not relevant to students, but at the end of the day ... unless they're more specifically applied to students, then it's quite difficult to say anything other than 'Okay, yes, that's great when it becomes relevant to me'.

I'd say on the whole most students would not be concerning themselves greatly with 'Oh gosh, which guidelines should I be looking at'. I think it's just not necessary.

Second, by and large, there was a presumption that the relationship with the GMC should grow as students progress towards qualification. Some felt that there needed to be little or no relationship between students and the regulatory body at the beginning of their studies. That did not necessarily mean that they thought that professional standards were unimportant to students; rather, the relationship was seen as becoming more relevant as medical studies progressed.

I think it's not a matter of being less professional when you're in the earlier stages: more that the professional challenges that you face increase and become more difficult the further you go through the training. So, when you're an undergraduate, perhaps in the first week, you're not going to be confronted with patient challenges around professionalism. What you face isn't going to be quite so tricky and complex, say, as when you're in the fifth year and about to enter practice.

The question of how and when professionalism can be assessed is discussed in *Educating for professionalism*, p 3. Briefly, students and others tended towards the view that young people matured so much during the period of a medical degree that it was not appropriate to expect students to fully appreciate professional standards and professional regulation at the outset, nor to be judged about their level of understanding at too early a stage. As one student said:

I've just started my third year and I've been there for seven weeks and in our second a senior lecturer from the GMC came and spoke to us, and I think that was actually better being there than in the first year because it really doesn't apply that much to the first.

If we were to be given lectures or some kind of information then we would

simply ignore it because in our minds it would be: well what's the point of this, it's not relevant to us at this moment in time.

There's a lot of elements and things that we get taught and told about, but they don't seem relevant. We're told and taught things at the wrong time.

Third, students generally had a low level of awareness of what the GMC actually did. Typically, one student explained that he did not feel in touch with the GMC at his stage. He felt that the GMC 'speaks through the medical school' and his awareness was limited to the GMC being there for 'registration' and 'rules and regulation'. He had not read the GMC guidance, didn't know what the GMC had to offer students and wondered how the GMC could improve its communication with students.

Other students professed similar ignorance of the content of GMC guidance and how to get it, although, when prompted, some admitted that their portfolios were structured around the standards set out in guidance. However, the necessary connections were not always made by students. A number of students admitted receiving guidance, but they had not read (or, in some cases, remembered) it.

The big question in students' minds was how to make the GMC and its guidance more relevant to them. There was a suggestion that the GMC's interactive case studies *Good Medical Practice in Action* (www.gmc-uk.org/guidance/case_studies.asp) could be more geared to medical students.

When students were aware of guidance, they could make better sense of it when it was clearly relevant to their experience. As one student said:

Yes, I think we're supposed to extrapolate the meanings of good medical practice from within the disciplines. You have sections where you reflect [on] an experience ... I think it's quite effective in the sense that it makes you think yourself, rather than just reading a publication from GMC about good medical practice. You read it and half an hour later you've forgotten it.

It's like everything: if you don't have to read it, you won't read it. Whereas, once you do read it, you realise how relevant it actually is.

If current guidance felt somewhat remote to students, the future implications of revalidation seemed even more so. The roadshows seemed to show that medical students are largely unaware of the likely requirements of revalidation and of its implication for their working lives.

Fourth, where students were aware of the GMC, they usually had only a partial understanding of its functions. One student's awareness was restricted to what was described as 'the chuck-off list'. Others knew about registration or standards or fitness to practise. Interestingly, students seemed decidedly hazy about the GMC's role in relation to medical education, and no-one professed to know about the whole span of the GMC's core functions.

Fifth, the image of the GMC among students was generally rather negative and typically associated with fitness-to-practise procedures, as these quotes – all from different medical schools – indicate:

If we don't hear from you, that's good.

I still think there's a very negative connotation with the GMC. It's like, oh if I do one thing wrong then that's my medical career over somehow.

I've always felt mildly intimidated.

This perception of the GMC as exclusively or disproportionately punitive is based on what appears to be a widespread impression of what might happen to misbehaving students. As one person explained:

I think it's quite important for them to have that time at the beginning where they're free of any threat, regulation. You read about these horror stories in the student BMJ magazine about students getting threatened with fitness-to-practise regulations by parking their cars in the wrong place or for having messy rooms in halls and to me that's just totally wrong.

Should students be registered with the GMC?

Opinion was divided on whether medical students should be registered with the GMC before qualifying as doctors. On the one hand, it has been argued that students' perception of their professional status might be enhanced through registration. It could also make it easier to secure consistency in how medical schools consider students' fitness to practise and it would help ensure a good fit between decisions made locally about students and those made by the GMC about graduates seeking provisional registration. However, the counter argument is that medical schools are better placed than the GMC to respond appropriately and speedily to concerns about their students.

Broadly in favour

Some people felt that student registration might make students feel more identified with the profession and its regulator from an early, formative stage.

I think you'd maybe feel like you were part of the profession. You've started medical school and you're registered.

Others were moved by arguments about student registration leading to a greater consistency and openness and transparency in decision-making when students transgressed.

Certain medical schools have had problems with using their fitness to practise as an overbearing way of making examples of certain students. Because it's behind closed doors, there are difficulties with opposing it. You get a minor problem and then you get completely slammed and thrown out of medical school for ... I don't know, it could be anything. And, without that level of control at a national level, it gets quite difficult.

Some of those who broadly favoured student registration saw it as being more appropriate at the latter stages of an undergraduate's course, perhaps in the fourth or fifth year as contact with patients and other professionals increased. As some students suggested:

Surely, we've got exactly the same responsibility, especially when we're in clinical practice. It would be exactly the same.

I actually think that's probably a good idea because, from very early on in our course, we're already setting up a team and we're already having to deal with patients. And if you're already in that position, where you're coming face to face with a healthcare client, then you should be far more aware of the restrictions that would be imposed on you as a doctor than most of my counterparts probably are now.

Arguably, student registration would also ease the transition from student status to foundation year one.

Interestingly, one student argued for early registration as a means of promoting good practice:

I think early registration would work because I do think the GMC's main role is to promote best practice and I think we don't really end up with that at medical school. The medical school has its professional behaviour things but really it seems like they're only checking that you're meeting the standard and they're not trying to encourage you to excel.

Broadly opposed

Those who opposed student registration with the GMC also had many reasons for their views. At the heart of the opposition was frequently a concern that students needed to be free to make their mistakes, and perhaps even to behave badly (within limits) without coming to the notice of the regulator. A prevalent view was that medical schools ought to be able to manage situations where students behaved badly or unprofessionally, and by and large they were able to do so.

It's a very good system that's in place and, if it's not broken, don't fix it.

Those who felt that the current system was working well enough sometimes commended the ability of the medical school to know their students and to weigh up the seriousness of a misdemeanour according to individual circumstances. This is, of course, in contrast to those who proffered greater consistency as a reason for wanting change.

Hopefully the university has more understanding of you as a person and what you might have done wrong.

There was also some generalised mistrust of what one person termed 'a centralised state-run body' and one person expressed their concern about decisions about medical students' behaviour residing with 'a London-based bureaucracy'.

One person suggested a compromise position whereby the medical school should be able to cope with their own students to a certain level, beyond which they should be able to refer to the GMC.

One or two people were undecided. In one instance that was because of a question about whether student registration would mean students had to pay a fee to the GMC.

Increasing the engagement of students with regulation

Although the current level of student engagement with regulation was not always as developed as it could be, there was generally enthusiasm for improving it. One student said:

From my point of view I just don't see any bad things about it. I mean a close relationship with the GMC ... I think that ultimately that's best for the patients.

So the pressing question was not whether to bring that about, but how. In terms of knowing more about the GMC and its guidance, some suggested that it would be helpful to reinforce guidance with lectures. As one student explained:

If you had a lecture on it I'd be more likely to go to that and listen to it than someone just giving me a leaflet that will join my folder. I think from that sort of angle I'd find that if you had a more interactive basis on that sort of thing you'd have a better understanding.

Another student made the point that engagement was not a one-way process and students could fruitfully be more involved in discussions and responses to the GMC.

Issues for the future

It is clear that students do not know as much as they could about the role of the GMC. Where they do have an impression of its role and functions, the image that they have is often somewhat negative. Students rarely appreciate the totality of the GMC's remit across registration, fitness to practise, standards and ethics, and education. That deficit may, to some extent, be shared by more senior members of the medical profession. Clearly, there is a need to combat the persisting negative image of the GMC, but that begs the question of the source of the misapprehension about the totality of the GMC's role, and whether there is a 'hidden curriculum' that feeds into a negative image of the regulator, or at least fails to promote the more positive aspects of regulation. There appears to be insufficient emphasis on how the GMC supports professionalism across the whole profession, as well as dealing appropriately with the relatively few who do not observe high standards. This is something that the GMC needs to address.

Most importantly, how can medical students' perceptions of the GMC be changed? As their careers progress, they will probably become more aware of the positive role of the GMC in publishing guidance and setting standards in both practice and education. But it would be greatly preferable to redress the balance in how the GMC is perceived at an early stage, not least so that medical students and young doctors can engage more fully with it. This is both a challenge and an opportunity as the role of the GMC changes and consolidates its work. The merger of PMETB and GMC, mentioned above, provides the opportunity for a more integrated approach across the whole span of medical education.

The introduction of revalidation will also have important implications for doctors. The purpose of revalidation is to assure patients, the public, employers and other health care professionals that licensed doctors are up to date and fit to practise in the UK. All doctors are currently under a professional duty, set out in *Good Medical Practice* (GMC 2009b), to keep up to date and to regularly take part in educational activities that maintain and develop competence and performance. Once revalidation is introduced, doctors will be required to demonstrate to the GMC that they have met this obligation by maintaining a portfolio of evidence which is reviewed annually by the doctor's appraiser.

With such developments in the role of the GMC, it is increasingly important that there is an understanding of the connections between the various functions of the GMC. These are not isolated, but relate to each other. Awareness of these connections appears to be under-developed in the minds of many medical students at the moment.

It is important that the GMC continues – and increases – its promotion of the positive, supportive role that is intrinsic to its purpose. This should provide a more balanced view than the current, somewhat punitive image that persists.

One of the key questions as identified in the roadshows is when is the best time to develop the relationship between GMC and medical students. Too early, and students are unable to relate it to their experience; too late, and opportunities have been missed to nurture a lifelong and positive relationship with the regulator. It is clear from students that the most fruitful approach will be incremental, beginning early with some information about the GMC and opportunities to engage wherever possible, but developing as students have more clinical involvement. That, of course, is not as simple as it sounds, given the varying approaches to clinical exposure at different schools. However it is done, the challenge is to make the relationship real and relevant to the student's future career and not just something to be learned for an exam.

The GMC might also usefully consider producing guidance that is phased and presented with students in mind. For example, guidance on plagiarism and attendance is relevant from the first day in medical school, while other guidance might become relevant only later on.

Clearly, medical schools have a role to play and they might facilitate more meaningful engagement with the GMC and its regulations by building references to GMC standards into the curriculum, for example by including them in problem-based learning scenarios.

Finally, as we have seen, the debate about possible student registration with the GMC continues, with significant points made on both sides. What is plain is that it is time to re-open the debate. The GMC will start a formal review of student registration in 2011, and that debate will provide an excellent opportunity for medical students and others to engage with the GMC on a very important issue that is obviously relevant to students and to the development of professionalism.

Leading and managing as part of a professional career

Context and challenges

The primary focus for doctors is on their professional practice, but all doctors work within organisations and their systems. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes. Doctors have a legal duty broader than any other health professional and therefore have an intrinsic leadership role within health care services. They have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. The development of leadership skills needs to be an integral part of a doctor's training and learning.

Leadership is a key part of all doctors' professional work. It is a requirement as laid out in *Good Medical Practice* (GMC 2009a), *Management for Doctors* (GMC 2006) and *Tomorrow's Doctors* (GMC 2009b).

High Quality Care for All: NHS next stage review final report (Darzi 2008) highlighted the need for all doctors to be practitioners, partners and leaders. The government document *The Coalition: Our programme for change* (Cabinet Office 2010) emphasised the importance of doctors in leading change, both in commissioning services and in having more control of their working environment. This has been further articulated in the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010).

While many doctors are enthusiastic about leadership and management, their views are not shared by all. Some doctors see management as a diversion from patient care, and compromising their commitment to putting the patient first. Yet in practice, few, if any, doctors can lead professional lives without being leaders and, to some extent, managers.

The concept of shared leadership is the basis for the Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges 2010a, 2010b). Under this, leadership is not restricted to people who hold designated leadership roles (positional leadership). Everyone has a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation at different times and are focused on the achievement of the group rather than of an individual. Therefore shared leadership actively supports effective teamwork. The notion of a hierarchy of leadership responsibility is further reinforced in the RCP's publication *Doctors in Society* (RCP 2005).

Teamwork and new ways of working that have a greater emphasis on the contribution of the multidisciplinary team pose new challenges. While being leaders in some contexts, doctors also need the skills to be part of a team in which they may not be the designated team leader.

What we heard

Do all doctors need to be leaders and managers?

Although there was general agreement that the medical profession has a significant role to play in both leadership and management, opinions varied on whether it was necessary or desirable for all doctors to be actively involved in such activities. Given the many ways in which both terms are used in everyday parlance, it is unsurprising that some people were a little unsure what 'management' and 'leadership' actually meant. To some extent, it seemed that people's views were affected by their understanding of the terms.

I have trouble visualising when they talk about management in medicine what that really means for a potential future role for me. These words 'leaders' and 'managers' are bandied around a lot and I have trouble actually seeing what that would really mean for a doctor. I can see what NHS managers do but I'm not sure if that means a doctor taking on a role of an NHS manager or just managing a medical team or what exactly it does mean.

We have to decide, when looking at the question about managing and leading, what exactly is it about? Is it managing and leading money or managing and leading people? As you work your way up in the medical profession there are others who are following you and you need to lead and teach them and that is one of the reasons that a lot of us got into medicine.

Some people pointed out the importance of distinguishing between the two terms.

I think in terms of professionalism, you should be able to separate the terms management and leadership to an extent. Obviously leadership is part of management but every doctor is a leader ... even the junior doctors are leaders in respect to medical students, a fourth year is leader in respect to a third year, they're all teachers but managers are leaders in an organisational sense whereas all doctors are leaders.

I would say there was a difference between 'leadership' and 'management'. ... There are lots of managers; there are very few leaders. And leaders aren't necessarily people who know everything or can do everything; they are people who know how to lead people and to get the best performance from them and inspire them, build their confidence, get things done. There's a big difference between being that sort of a leader and being a manager.

Broadly in favour

Some of those who thought that doctors should generally be involved in leadership and management did so because they saw leadership, at least, as being an intrinsic part of what doctors do. For some, this derived from the commitment to teaching and supporting those more junior than themselves, or from the inevitability of having to manage people and resources.

I think it's difficult to think of any definitive role as a doctor that doesn't involve leadership and if you're that timid and unable to take control then you're going to struggle with it.

It's hard to imagine being a doctor and not having any management work.

Indeed, management is so intrinsic to doctors' roles (perhaps especially for GPs as independent contractors) that it was suggested that many doctors do not actually

realise they are also managing; they simply get on with everyday activities such as managing diaries, looking after trainees and so on. It was also suggested that it was beneficial for doctors to be involved in management as they had actual knowledge of the realities of the workplace and the impact of management on patient care.

Some people felt that leadership sat naturally on the shoulders of students and younger members of the profession too. One person construed leadership as:

Deciding what it is that you think is best and then articulating what it is that needs to be done to achieve that best option – and that can't wait until foundation year one.

Another person felt that medical students often led in other contexts too, for example as captains of sports teams at university, and they tended to be natural leaders. By contrast, one student said that she could not yet imagine leading the profession as she still had so much work ahead to become a doctor.

For others, leadership was an inevitability because the public saw doctors 'as the ones who are ultimately responsible'.

Another person suggested that things had changed and the hierarchy with doctors at the top had broken down. This meant that whoever led teams, including doctors, would need to be good leaders as others were always going to be able to challenge the leader's authority.

Among those who broadly saw management and leadership as part of what doctors do, there were some who nevertheless felt that this did not imply that all doctors needed to be involved to the same extent or in the same way.

A more pragmatic – and more unusual – reason for supporting the involvement of doctors in management was proffered by one person who suggested that, as nurse practitioners were 'taking over' aspects of the doctor's clinical role, a lot of doctors would need to go into management in order to stay in employment.

Less in favour

Those who were less keen on doctors being leaders or managers mostly spoke about their reservations in relation to management rather than leadership. Some of those who showed less enthusiasm for doctors taking on such duties were clearly no longer students and were reflecting back on what had brought them into medicine. This led to some comments about not having gone into medicine to handle budgets or decide how to spend taxpayers' money. A few people remarked that if they had wanted to go into management they would have chosen to study business management rather than medicine.

There was also concern that when doctors become managers they may lose contact with the clinical side of their work. However, some recognised that there was a dilemma: the more experience a doctor had, the more relevant was their clinical experience to management, but once in management, it was all too easy to become remote from the very experience that made one suited to taking on a major role in the first place.

A number of people expressed mixed feelings or ambivalence about taking on these roles. For some, it was a question of how far to become involved.

I think we have to be able to manage a team, but that doesn't necessarily mean that we have to go and sit and meet the executive board of a hospital. I think a lot of people see management as that rather than just a skill.

Others pointed out that, even if it was agreed that doctors needed to be leaders and managers, there should be some flexibility so that people could play to their strengths and follow career paths in accordance with their own preferences and aptitudes.

Management as a career option for doctors

Although many people accepted that management was part of a doctor's job, a number of people were less convinced of the desirability of management as a career option, although some saw it as a possibility later on in a medical career.

A certain person at a certain point in their life would want to take more of a managerial role.

However, there was some evident suspicion of career medical managers, with talk of them 'having gone over to the other side' and concerns that their management ambitions might affect their values.

Several people wanted to have a toe in the water without having to leave clinical practice behind. As one person said:

I'd be quite happy to be a doctor manager and not be the boss of the whole place but nevertheless still be on that management board and influence. You wouldn't necessarily have to be the chief executive which maybe is 100 per cent management. I'd certainly be happy as long as I could influence decisions.

Doctor- and non-doctor managers

Many participants discussed how they saw the role of the doctor as manager in relation to others in management positions. Some people felt that doctors could and should be involved in all aspects of management. They saw this as adding expert knowledge and understanding which might mitigate the pressures to meet targets irrespective of patients' needs.

Others felt that sometimes doctors were best suited to manage and sometimes non-doctors were best suited.

In a clinical context you'd want the leader to be the one with the most medical knowledge and in a managerial setting you'd want the one with the best people management skills.

What I believe is we should not be allowed to manage the money part. That's why the managers are there so let the managers look after the money, the budgets, but let the doctors have a say in how the resources are allocated.

I think [doctors] can appreciate the clinical side of organising care, but maybe they don't quite take into consideration everything else that you need to run a hospital, like laundry services, the refuse services, there's a lot of other things you have to think about in running the hospital other than just delivering the absolute medical care. So maybe it is a good idea to have somebody else there who can think about everything.

For the most part, there seemed to be a respectful appreciation that both doctor and non-doctor managers brought different perspectives and different strengths and that what was needed was 'teamwork between two professionals'.

I think it's important in terms of talking about leadership and responsibility as a team working together; in the same sense you can't have an administrator or a manager working alone, you need to have input from everybody.

I think there should be a good mix between doctors and managers because different professions look at the same thing from different angles. To see the whole the picture, I would say there'd be a good mix rather than one or the other.

Are good leaders and managers born?

The discussion about educating students to lead and manage was often against a backdrop of whether leadership and management skills are innate or whether they are the product of educational input and relevant experience. Some students took the view that those who made it through to medical school were very competitive and were high achievers with a track record of leadership, even at school.

I know that I sort of naturally often become the leader of a group because I want to get things done right away and so you do take charge.

I think it's inherent, because even before you get to medical school you're expected to demonstrate leadership, and within medical school you're expected to demonstrate leadership, so therefore it must be inherent, just part and parcel.

Those who thought that certain qualities were innate were sceptical of what they saw as current management training techniques, which they caricatured as 'where you have to send people off on courses to cross bridges with barrels'.

Others suspected that relevant skills might be innate, but that they could be nurtured and improved. Even those who tended towards thinking that good leaders and managers are born felt that it was unsafe to rely on those with inherent skills and that all doctors needed to acquire a certain level of skill in those fields.

There was an equally powerful body of opinion supporting the view that management and leadership skills could be acquired through a mixture of teaching and experience.

I guess you learn that on the job anyway don't you, I mean, you have five or six years at medical school, and I guess you learn that from day one when you start at a hospital or you've been working somewhere.

I don't think it's a question of being born a leader, you have a certain energy depending on how important you find that issue and that may not be when you are 21, it may be when you are 37 or much later in life.

I think it's taught by experience really isn't it? There's things like once you've established yourself as a leader then you can sort of work at it.

Is training helpful?

There was a broad consensus that, although doctors may be leaders and managers in different ways and to varying degrees, it was generally helpful to expose medical students to the principles of management at an early stage in order to equip them to manage effectively. This need not be a module in management, but could be

integrated into other aspects of the syllabus. Indeed, this happens already, as one student explained:

We are taught time management and how to manage patients and how to manage paperwork and then as you go up the system there are different sorts of management that become necessary.

Others felt that they did not receive enough management training, and some felt that they also needed to learn how to work in teams whether or not they were acting as team managers.

I think we have a responsibility to work within a team framework to produce the best care and the best management of each patient, as opposed to grand gestures and one-off occasions. It's in the day to day that you really see the impact of good management and good teamwork.

I think that the science we learn is never going to change but the environment is going to change so I think that being a team player would equip you for a lifetime because, whatever changes, they're just going to bring more people in to do different jobs, more people in your team, which means you have to be a team player.

Some saw multiprofessional education and working together as a route to better management and better teamwork.

One student felt that, just as no-one would be expected to practise medicine without training, management is different but equally important and the necessary skills should be taught. Another person remarked:

You'll never learn how to be a good leader – or a good manager, for that matter – without understanding how teams work.

It was suggested that exposure to leadership and management should be incremental. A student spoke, for example, about the value of being involved in clinical audit.

Several people noted the benefits of early exposure to management principles, including skills such as budget management. This was thought to reduce the anxiety that some doctors felt when they were suddenly confronted with having to deal with financial issues.

Finally, some people pointed out that learning about leadership and management was not a totally separate entity from learning about more obviously clinical subjects.

I think another thing is that many of the good clinical skills overlap terrifically with good management skills.

How students learn about management and leadership

The key message is that students felt that they learned best about management and leadership (and, indeed, professionalism) by methods other than lectures. Therefore opportunities for placements, shadowing and observation were all welcomed.

If you had a session on budget management, that's going to turn loads of people off. But if you can actually integrate it as part of your clinical placements or whatever, and actually demonstrate not only the clinical

procedural side of actually doing something with the patient but also saying 'Well the decision you took there with prescribing the generic drug as opposed to the brand name one has a knock-on effect so you're actually saving the NHS money there'. So if it's integrated in a way as part of the day-to-day clinical practice it's much more relevant and a lot more interesting than sitting in a lecture about how to manage people.

And, as with learning about professionalism, timing was important: too soon, and students failed to understand the relevance of what they were exposed to; too late and it left them ill-prepared for the realities of the workplace.

Training in leadership and management could perhaps be more beneficial when you've acquired some clinical experience, you know how a hospital works a little bit better at least, and perhaps an aspect of it would be maturity as well.

Some students mentioned the opportunities afforded by problem-based learning (PBL) particularly in learning about management and how teams work.

Basically every week a different person has to take the lead, and that's very much teamwork. ... I've done a group project which collapsed because no-one took the lead, and you can see how it works in teams. It's actually when they don't work and don't click and I think medical students are quite good at teaching you that. Tutors aren't always brilliant, so you do have to learn to just take that on as a group.

Role models were seen as important to the development of management skills and the ability to lead.

I think if they want us to be managers then we need good doctor role models to look up to – that will hopefully encourage us to do the same thing when we're older.

Conversely, some also recognised that there was much to be learned from poor role models. Some students had learned how not to manage by observing bullying. However, other than at the extremes of bad behaviour, this begs the question of how students learn to judge who is a positive role model and who is a negative role model.

Pressures on the syllabus

Although few, if any, people were opposed to preparing students for management, there was a high level of concern about what would need to be omitted if other, non-clinical, subjects were to be given more time.

I mean they cut out embryology, all we have is one lecture on embryology now; you know, to this day that's all I've had but I don't know anything about it. And, you know, anatomy is kind of being squeezed out, so if they were going to fit this in, they'd squeeze out something else.

This concern was exacerbated by a number of students feeling that they had not adequately been taught 'the basics'.

There is a lot on the basics that I feel we've missed out on, our generation of doctors, and I feel there is a gap in my knowledge in key topics. ... I'm not saying that I need to know every enzyme in the body, but I definitely feel that that's a gap.

I think we're being taught to be really good communicators and really nice people but we might not actually have that underlying knowledge that makes you a good doctor.

I think making a diagnosis, having the clinical knowledge, has always come first. Otherwise without that you're not a doctor, no matter how good a leader you are or all the rest of it; you can't call yourself a doctor if you can't cure a patient.

Some students also expressed concern about the pressures that they experienced as 'more is being ploughed into the course'. However, some people acknowledged that to be an effective manager or leader it was essential to have knowledge of 'the hierarchy and hospital, different systems and structures and the way in which you become part of the overall team'.

Management and prioritisation

Most people accepted that as doctors they would have to be involved in considering priorities and taking management decisions about the best use of resources. This seemed to be accepted as a fact of life by students to a greater extent than was the case in the previous roadshows with doctors.

I think that patients understand that there's only a certain amount of money from the government, and I think they understand that you have to ration it to different places. I think if we're really open about what we're doing and why we're doing it people are less critical of you than if you keep it all secret, and then people will think 'Why aren't you doing that?'.

Some students felt that the doctor's primary focus should be on the patient, rather than on costs, but even so there was support for knowing the price of the top 10 drugs to increase awareness of costs. One student suggested that students were very much focused on getting things right for the patient in front of them, but as they developed they took on a wider perspective. One student saw this as part of the development of professionalism:

I think that's part of the professionalism: not just the interaction with the patient but the interaction with the organisation, the interaction with society. There are lots of different levels. And I think we'll think about that differently as we move on.

Some positively welcomed the opportunity to be involved in making hard decisions about priorities.

In fact we're going to have to make cuts and I think we're probably in a better position to show where savings can be made than a manager – so in a way I think I'd quite like to be a manager because I don't want to be managed by somebody that I don't respect.

Well if you knew that next month you wouldn't be able to treat any patients, because you've spent the budget, then I would imagine you'd have a very different perspective to it with an entirely patient-centred role with no concern at all for management issues.

Promoting change

Discussions about leadership addressed the question of how far doctors and medical students had a responsibility to speak out on topics of public interest where they had particular knowledge and to promote change.

Those who expressed an opinion tended towards the view that doctors and medical students could be more vocal in society. Issues of interest to the profession were often in the media and were often discussed within the profession, but there was a feeling that the profession did not always speak out. The range of topics on which they might speak out ranged from matters about the profession itself to wider issues such as climate change. One person noted:

One of the things that's happened recently is the whole climate change discussions that are happening in Copenhagen ... but there hasn't been a lot as far as I can tell in the media about the link between the impact on health that climate change actually has.

Dissenting from the view that doctors could speak out more was one person who felt that the media would misrepresent what was said.

I think the media would twist it really well if we were to stand up and say 'well actually we object'. Like when the GPs tried to stand up for keeping their wages, it was all twisted as GPs' greed. ... I think, yes, we need to develop and improve health services, but we need to be careful about how we vocalise it, because we could just end up becoming public enemy number one.

Issues for the future

Many of the issues identified in *Understanding Doctors: Harnessing professionalism* (Levenson *et al* 2008) were echoed in the student roadshows. From medical students, just as from experienced doctors, there was a range of views on the extent to which all doctors need to be leaders and managers, with considerable recognition that management and leadership are likely to be part of the job for doctors. There was also recognition that the profession has had to embrace leading and managing and to assume some responsibility for creating a culture within which medicine can be practised to best effect.

It is encouraging that there was relatively little evidence that medical management was seen by students as 'being seduced by the dark side', as had been expressed in earlier roadshows for doctors. There was, however, still a residual view that clinical practice and medical management were not necessarily on the same side. More to the point, students were not always able to think beyond their immediate courses and consider their future careers in terms of possible management and leadership roles, so what we heard was a lack of imagination about what the future might hold, rather than a rejection of management and leadership as part of their future careers.

Yet acquiring management responsibilities and assuming leadership roles is not, and should not be, a watershed moment that a doctor suddenly reaches on becoming a consultant or a GP principal; preparation for these roles should be incremental, starting at an early stage.

Among the challenges associated with doctors being more integrated into management roles throughout their career is the question of how to make use of

their specific clinical skills, while not losing touch with the very experience that gave them those skills. Lessons may be learned from the United States of America where doctors are more fully and visibly involved in managing services.

However, no-one can expect doctors to launch themselves into management roles without suitable education and ongoing support to do so. Medical education has an important part to play in fostering students' understanding of the roles that lie ahead as part of a medical career. There is a need to de-mystify and clarify the terms 'leadership' and 'management', and to emphasise the responsibility of all doctors in these areas. Medical schools and those who mentor and support junior doctors can make it clear at the outset of a medical career that most doctors will find that their roles encompass both management and leadership to some extent. Alongside this, there could be a greater clarity around leadership and management within the concept of professionalism, and it would be helpful to discuss with medical students, doctors and medical educators the extent to which leadership and management are core elements of professionalism.

So, if most doctors will lead and manage in some way at some time in their careers, the challenge is how to prepare medical students for that. Although few people would argue for heavy additional modules to be inserted into the curriculum, there is scope for medical schools to provide opportunities for students to develop leadership and teamworking. Medical schools can and should give consideration to how students can reflect on these activities and make their development explicit. Medical schools might also like to consider how they can give students recognition for leadership activities that students take part in outside the formal curriculum.

More radically, the profession would do well to consider whether it would be helpful to encourage some students to enter medical school with an explicit aim of becoming medical managers. Whether or not that is the way to go, medical schools might consider offering additional separately accredited qualifications in management and leadership to those who show an aptitude and interest in such areas.

Arguably, the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010), with its emphasis on doctors managing resources and taking commissioning decisions, will strengthen the impetus for preparing doctors for management as part of their careers. If so, many questions follow from that. Will minimum standards need to be set in this area? How can management and leadership be integrated into the curriculum and not become an add-on? How should competence in these areas be assessed? If it is accepted that leadership and management are essential parts of undergraduate learning, what should happen if a student is unsatisfactory in those areas while demonstrating competence in others?

It will also be important to take stock of what materials need to be developed and to use the material that has recently been produced to support doctors in management and leadership roles and those who are still training for their future careers (NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges 2008, 2009, 2010a, 2010b).

The role of the doctor in the future

Context and challenges

Changes in medicine, the medical profession, and public and professional expectations

Medicine and the role of the doctor does not stand still. This is due to a number of factors.

The development of science and advances in medicine

Scientific knowledge has developed rapidly. It is hard to remember an era without antibiotics, joint replacements, minimally invasive surgery or modern imaging, but these were all developments of the 20th century, while newer 21st century developments, such as the increasing understanding of the human genome, are just beginning to make us realise the equally enormous changes that lie ahead. As Sir Cyril Chantler noted in his much quoted description of how medicine had changed: 'Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous' (Chantler 1999).

These changes in what medicine offers, and what doctors can do, have major implications for the future of the profession. Many aspects of medicine are becoming increasingly specialised and it is difficult to keep up to date over the wider field. This degree of specialisation may be wholly desirable from the point of view of safety and effectiveness, but there may be a price to pay in terms of a holistic approach to patient care, and the relationship between doctor and patient may change accordingly.

Changes in expectations of the doctor's role

Building on work done by the Medical Schools Council (Academy of Medical Royal Colleges 2008), a Royal College of Physicians' working party set out to:

- define the contours of society within which health care will be delivered over a generation
- identify the influence on the roles and responsibilities of doctors of substantial demographic change, technological advance, economic trends and greater patient involvement – with doctors as part of a complex team at the heart of the health care system (Royal College of Physicians 2010).

RCP consultation identified a role for doctors as managers of resources, leaders in the public understanding of difficult and contentious issues, and innovators and integrators of new knowledge. As the health agenda moves away from one focused on the treatment of illness to one of disease prevention and the promotion of well-being, doctors will need to establish a better alignment between themselves and the public on what constitutes a 'good' outcome. In order to achieve this both

doctors and the public will need better education on the management of risk and the understanding of probabilities.

Increased access by patients to information on the internet and other publicly available sources may also accelerate such changes. Patients still want their doctors to be sources of expert advice, but although they may be the most trusted source of medical advice they may not be the only source. Twenty-first century doctors will need to hone their skills in evaluating evidence and develop their communication and facilitation skills in order to help patients make decisions in complex situations, where both risks and benefits may be substantial, but not guaranteed. In an increasingly complex health system, doctors will increasingly become mediators of the system, acting on behalf of patients, working through a variety of carers, providers, and health care agencies, as well as delivering hands-on care.

Changes in the workplace

The environment in which doctors work is also changing. Requirements such as the European Working Time Regulations and formerly the European Working Time Directive (every worker is entitled to an 11-hour break in every 24 hours, and doctors in training must work no more than an average of 48 hours per week) have affected how junior doctors work and their opportunities to learn from experienced colleagues in traditional ways (Royal College of Physicians 2009).

The expectations of doctors may be changing too. The focus has tended to be on the impact of the rapidly increasing proportion of women doctors in what was once a male-dominated field, but the expectations of both genders for a different work–life balance are changing (Royal College of Physicians 2009).

Other changes are present too, as doctors are increasingly recognising their role as managers of people and managers of resources and as leaders of change in health care systems. (These changes are discussed in *Leading and managing as part of a professional career*, p 35).

The influence of students

Today's medical students may have different views and expectations to those of the past as to how much influence they want and expect over the undergraduate curriculum and in relation to matters of wider professional interest. The extent to which students can make their views known may influence debates about the role of the doctor in future.

What we heard

Anticipating change

Students and others at the roadshows were well aware of the potential complexity of the doctor's role and the relatively new aspects to being a doctor that they expected to be part of their future. Some embraced the direction in which the profession seemed to be heading, while others feared that increasing specialisation might diminish opportunities to use a range of skills and that they might tend towards becoming 'technicians' and lose their clinical skills and judgement.

Some students felt that the hands-on role and other roles were equally important, but there was some ambivalence about what this might mean for them.

I think it would be a pity if the two jobs [delivering clinical care and being a mediator or interpreter of care to patients] were completely separated

but I can see why it's becoming more and more important ... having done oncology and trying to deal with setting up radiotherapy for patients, explaining to them what the options are. And as medicine heads further and further down that path I can see that there may actually be a role for a completely separate person who does that kind of explaining of what the options are and I think it's a pity.

Some felt that, while roles such as mediator, arbiter and advocate were needed, it was not clear why doctors had to perform these roles rather than other colleagues. One person felt that 'it was changing the very nature' of what it meant to be a doctor. In contrast, another person felt that doctors needed a range of skills in order to meet patients' needs.

Preparing for change

Participants at the roadshows were keenly aware of recent changes in the NHS and appreciated that the doctor's role was likely to change even more in the future. The implications of this were sometimes summarised as a need for flexibility, but in fact it was often adaptability to circumstances as yet unknown that was at issue.

There's an element of flexibility ... in that no two patients want the same health care, very few patients want identical health care. ... You have to be flexible in the idea that you provide different care to different people and you have to be flexible because the job might change.

Students were particularly aware of the impact of demographic changes – particularly an increase in the number of older people – which might necessitate an increase in the number of doctors in certain specialties.

With an ageing population there will be changes in which specialties will be more in demand so I think there must be ways to make specialties that require more doctors, to make them more attractive ... something that will draw people towards those specialties.

However, for some students, the promotion during their training of the ability to change as circumstances required was experienced as a sense of 'muddling through' and they were not always convinced of the coherence of their educational experience. For others, while they had no wish for 'a module in flexibility', they felt warmly about their early exposure to different people from different backgrounds, and the emphasis on communication skills, as a result of which they felt that they were equipped for a wide range of professional challenges.

One person suggested that, as the number of medical graduates increases and the number of posts available stabilises, there will be increasing competition for posts. They thought that medical unemployment was being introduced into the system to increase the willingness of individuals to demonstrate their flexibility and adaptability.

Some felt that they needed to understand more about how the NHS had developed and how it was run in order to enhance their understanding of the future role of the doctor. Others, while not disagreeing with this sentiment, were concerned that the syllabus was already too full.

There was some discussion about the boundaries between the roles of doctors, and the roles of nurses and other health professionals.

What I've learned at my GP placement is that nurses are doing more and more jobs that doctors would usually do to free up more time for the doctors. I suppose that would give doctors time to do more.

Tensions between current trends and future needs

A recurring theme across the roadshows was the possible tension between the need for flexibility and the ability to adapt, on the one hand, and the apparent tendency towards early specialisation within a more specialised profession on the other. Even within the same medical school, perceptions of this dilemma varied. For one student, the key issue was that it had seemingly become necessary to determine a career path sooner than ever before, while another added:

... but if you think in terms of day-to-day training, the way that our course is structured with the moving between departments every week and even moving localities every year, it is kind of programming in you a sense of flexibility in that you're never comfortable in your environment, not in a bad way.

One person from a different medical school wished that there could be a third year of foundation training to give additional opportunities to try out more specialties before applying for specialist training.

There was some speculation about whether the medical profession would continue to become more and more specialised. One person surmised:

I think it will go through peaks and troughs. I think for the next 15, 20 years it'll be super specialised and then there will be a lack of general physicians and general surgeons, it will go back to being a requirement for more general practice and general surgery and all these sort of things.

Meanwhile, some students lamented the manifestations of specialisation as they saw it. One student described a personal experience:

At the hospital each department's actually in a separate building. We had a lady on the ward who was a few days post-op [and] said 'Oh, I think one of my eyes has gone, the vision's gone a bit funny'. ... There was no history-taking, nothing, no further exploration of that, just that a note would be sent to the Department of Ophthalmology and somebody would be over in the next two or three days to talk about it.

The evolving role of the doctor was seen to have implications for medical education. In preparing to take on the role of the doctor, many people felt that there may be more need to acquire, while training, a range of generic skills rather than a high level of detail that may soon be forgotten or never used.

Some felt that it was very important to be taught the skills necessary for continued learning. Others noted that a balance was required so that core clinical knowledge and skills were complemented by more general skills such as team building and management.

However, a broad approach should not be at the expense of what was seen as the core of medical education. As one student put it:

The core or generic skills, the key skills have to be the patient care. ... That's what we are in business for. ... I think ultimately our raw material is our patients and obviously if we cannot deal with our patients right then I think we cannot take on any other roles in the organisation.

Others noted the importance of core skills such as history-taking because:

It's the same across every single specialty that you do from the day that you're 20 and you have your first history-taking session to when you're 50.

Many people also spoke of concerns about what they did not know. As much as there was an understanding of the need for generic skills that would be durable as roles changed, there was also a wish to ensure that the basics of what doctors needed to know were not overlooked.

Sometimes I think it's scary how much we actually don't know and how much we have missed on the curriculum.

I think in some ways it could be taken a bit more back to basics because we're loaded with all the little extras and a lot of it is very specialist stuff in quite a lot of detail. Maybe that's to challenge you intellectually and get you thinking but I think there is some room there for maybe reducing that slightly and putting a little bit more time into the basics, the anatomy and a few of the other basic aspects.

Some felt that it would be helpful to broaden exposure to a range of specialisms. One student said:

For example, in cardiology we had a cardiovascular module in the second year, the first year and then we had another one last year then we're doing three this year which is cardio again while on the flipside you get no training or any exposure to anything such as ENT or plastics or any of the new specialties except in an SSC [Student Selected Component] where you get four weeks to choose what you want to do.

How students are taught

(See also Educating for professionalism, p 3)

Discussions on what medical students were taught were inextricably bound up with how they were taught. Problem-based learning (PBL) was embraced to a different extent across medical schools. Attitudes about how well it prepared students with knowledge and skills varied within and across medical schools. Some students felt that a PBL approach had gone too far and there was room for a more didactic approach.

I think there's definitely an equilibrium, you can't expect to go through your entire medical career and expect to be told exactly what you need to know, but at the same time when you're starting out there has to be some form of direction to make you feel confident that you're going in the right direction.

There was some discussion about the relationship of learning styles and methods of assessment, with particular reference to the Advanced Medical Knowledge test. (This is an assessment carried out via a progress test – a cumulative study administered 20 times over the five-year course at regular intervals and pitched at the level of the pre-registration house officer.)

One student described having 'random bits of knowledge' yet struggling to talk about the basic physiology of asthma.

Secondments outside medicine

There was some support for enabling students and new doctors to gain experience outside medicine. This was seen as an opportunity to broaden horizons and to learn different ways of interacting with others – all potentially useful in preparing for the role of doctor.

Can students make their voices heard?

It was evident at all the roadshows that medical students, and indeed junior doctors, enjoyed having the opportunity to discuss issues related to their training and to their chosen profession. Although many had discussed such issues as part of their education, it was not uncommon to feel that students, in particular, do not find it easy to have a voice on issues that concern them. In so far as that perception is accurate – and some exceptions were noted in discussion – it is relevant to the discussion of the future role of the doctor in a range of ways, as the voice of students is also the voice of the next generation of doctors.

One of the most common concerns was that students were part of teams for short periods, so they rarely reached the point where they felt that they could change things, or that they would be trusted if they made suggestions. It was not so much that they felt ignored; rather, they did not know how to ensure that their contributions would be heard and valued.

One student raised the possibility that students could make a significant contribution to patient safety, even before they qualified as doctors, for example by prompting the use of surgical checklists. Some students also felt that they could lead by example in demonstrating safe practice.

I know how many clinics I've been in [with another doctor] and I will go and wash my hands and then they go 'Oh' and go and wash their hands. It's clearly something that is drummed into us 24/7, but it's not something that's always done by them, or maybe they forget. Yes, you can lead by example even to the consultant on the ward.

Where the issues were of a different nature, for example concerns about how students were treated, or the quality of teaching, some students reported that they felt able to make their concerns known. However, one student noted:

People are fond of complaining about it but are not willing to actually put themselves out to get it changed.

It was also acknowledged that some students were more interested than others in trying to have an influence and make their voices heard.

... some people will be so keen to get involved and would love to be able to potentially influence decisions, whereas others just want to get through their course and do whatever they have to do.

Formalising opportunities to make students' voices heard

Given the difficulties that individual students often had in having a voice, some felt that the answer might be found in a more formalised approach.

You might be a single student thinking that you've got no voice in the firm or the team but this vision popped into my head which is probably completely unrealistic but ... there ought to be student representation at the highest level of the management of the hospital. I mean it's a bit difficult when you are on placement, on really short attachments, but there is no reason why there shouldn't be student representation on the board of management of [the] hospital trust ... is there?

This was seen to be a radical step as NHS boards tend not to include membership from trainees let alone students. Nevertheless, since students and junior doctors had such a large stake in the future, increasing their influence was seen as very positive.

Issues for the future

Some of the discussion at the roadshows seemed to suggest that we are on the brink of an era of unprecedented change which might impact on how doctors are trained and on their future career paths in radical new ways. However, this is not a self-evident truth. Medicine, as a profession, has always had to move with the times, and will continue to need to do so. No doubt, doctors who trained just as antibiotics or modern anaesthesia became available, or those who practised at the dawn of the NHS, would have spoken equally persuasively about the impact of impending medical and organisational changes. Perhaps the issue now is that the need to adapt is perceived to be accelerating as a consequence of our greater appreciation of diverse factors including rapid technological advance, changing public expectations, worldwide economic change and globalisation.

In the absence of a crystal ball, the medical profession needs to be able to anticipate change as far as possible, to evaluate the impact of change and to accept the professional obligation to keep up to date and accommodate change. That would seem to be the key to enabling future doctors to practise to high standards in a context that they cannot fully anticipate. The ability to adapt will surely be necessary both because of demographic changes and because of changes in how clinical care is configured.

Some of the knowledge and skills that doctors will need may be remarkably constant. Human needs, in all their complexity, arguably change very little, although our views on how they may best be met change all the time.

It is unlikely that we will ever see a time when doctors do not need a good, scientific education and sound, basic knowledge of such subjects as anatomy and physiology. Nor can doctors do without an awareness of social factors, the principles of effective communication and many other skills. This is not simply a matter for the undergraduate curriculum; it is a challenge for all doctors at all stages of their working lives. Medical schools can – and should – put this potential to adapt to an unknown future at the heart of their teaching. But it should not be, and need not be, at the expense of providing an excellent education that enables doctors to practise safely and effectively and to communicate with their patients and the increasingly important multidisciplinary team.

The pressures on the undergraduate curriculum cannot be underestimated, but it is hard to see how any medical student (or doctor) can have an effective voice on their future role if they are not equipped to understand the basics of how the NHS (as the main provider of health care in the UK) is run, and the context within which it operates.

Clearly, debates about the future role of the doctor will continue for as long as there is a medical profession. Given the interest and enthusiasm of students at the roadshows, bodies such as the Royal College of Physicians, The King's Fund, the General Medical Council and the NHS Institute for Innovation and Improvement should consider further ways of involving students and junior doctors in policy debates. It will also be appropriate to look at informal and formal ways of enabling students to make their voices heard.

Conclusions

The opinions expressed during the 11 roadshows can be grouped into the following themes:

- the timing, emphasis, assessment and function of professionalism in undergraduate medical education
- engaging medical students in debates about professional values and standards of professional behaviour
- introducing the role of regulation into the undergraduate curriculum and the establishment of a positive relationship with the regulator
- how much and by when doctors should engage in management and leadership: how to equip them to be effective managers and leaders
- the best way to prepare medical students for the challenges of a professional career.

The following issues emerged as important and ripe for action. They are targeted particularly at those engaged in medical education and training, and those with responsibility for professional regulation.

- Professionalism needs to be promoted as an integral part of medical education and training:
 - mechanisms need to be devised to help medical students to engage with the topic
 - appropriate ways need to be found to assess it.
- Medical schools should have well-articulated and clearly expressed definitions of professionalism, and should allow students to engage with these definitions from an early stage in their careers. Across all schools the following would be helpful:
 - consistent standards
 - clear expectations of conduct and behaviour
 - robust and relevant assessment methods
 - methods of remediation.
- Positive role models remain one of the most powerful ways of demonstrating excellence in medical professionalism. Ways need to be sought within busy modern practice to preserve this.
- While ensuring the maintenance of the high standards that the public expects, medical professionalism needs to evolve and adapt to the modern world.

- Medical students need clarification of the role and function of the medical regulator:
 - the optimum stage at which to engage students in professional regulation needs to be determined
 - the medical student voice should be included in the GMC's forthcoming review of the position on student registration.
- The terms 'management' and 'leadership' are often confused in the minds of medical students. The expectations of many are that the specialist role is predominantly limited to that of clinician. They are seemingly unaware of what it is that fully qualified general practitioners and hospital consultants actually do.
- Educating students on the current and shifting nature of the roles and responsibilities of fully trained doctors may help to manage expectations, increase individual adaptability and resilience, and help guard against the disappointment and disillusionment that sometimes result when these are not matched by reality
- How to integrate doctors into leadership and management, and how to equip them to do this effectively, is unclear and requires further discussion. Specific issues to address are:
 - the place of management and leadership in the undergraduate curriculum, and its assessment
 - the development of management and leadership skills and competences in doctors, and accredited qualifications
 - a stocktake of what materials currently exist to support doctors in management and leadership roles
 - providing secondments out of medicine as a way of enhancing management and leadership capability, and formalising this as part of medical education and training.
- The sound scientific underpinning of medical education and training should be preserved because this is perhaps the best way to ensure adaptability as the role of the doctor evolves in the future.

The aim of this work was to introduce medical students to the concepts of professionalism in a 'safe' environment and to make them aware of some of the facets of this concept that might then be drawn upon to sustain them in their future careers. By reporting this debate the roadshow partners hope to help deans of medical schools, medical educators, the professional regulator and young doctors to consider how medical professionalism can become a powerful force in raising standards and supporting continuous improvement – both personal and in practice. As stated in *Understanding Doctors: Harnessing professionalism* (Levenson *et al* 2008), professionalism offers 'a strong value-based framework within which doctors can shape the improvement of health care and exercise a constructive influence on health policy in the public interest'. It can be argued that the earlier in a medical career one understands and adopts this framework the better – and the medical student roadshow series certainly demonstrated that today's medical students are well up for the challenge.

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At a time of profound change in the NHS, this work introduces medical students to medical professionalism and makes them aware of some of the facets of this concept that can be drawn upon to sustain them in their future careers. Through this report the road show partners hope to assist deans of medical schools, medical educators, the professional regulator, and young doctors themselves to consider how medical professionalism can become a powerful force in raising standards, and in supporting continuous improvement – both personal and in practise.

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