A duty to expose: professionalism in a time of crisis

‘I think’, said the then Lord Chancellor Michael Gove on 3 June 2016, ‘people in this country have had enough of experts … saying that they know what is best and getting it consistently wrong.’¹

A tide of anti-professionalism is on the rise. It seems nowadays that to claim any kind of expertise is to invite the scorn of politicians and the suspicion of a disaffected public. I had thought, wrongly, that we had come a long way from the days when Bernard Shaw could write ‘All professions are conspiracies against the laity’, and Frederic Ogden Nash ‘Professional men, they have no cares; whatever happens, they get theirs.’ But no; the hands that clapped during the pandemic seem to have morphed, as the NHS crumbles around us, into pointing fingers.

What does ‘professionalism’ mean to a doctor? Recent decades have produced a flurry of working parties and documents, their executive summaries larded with words like ‘care’ and ‘duty’ and ‘altruism’ and ‘respect’ and ‘partnership’. The grand-daddy of them all was — still is — the General Medical Council’s Good Medical Practice.² Periodically updated since 1995, it remains an excellent thesaurus of synonyms for moral probity. In 2005, the Royal College of Physicians chipped in with its report, Doctors in Society: Medical Professionalism in a Changing World, which defined medical professionalism as ‘a set of values, behaviours, and relationships that underpin the trust the public has in doctors’.³ I reckon that about nails it. Trust is of the essence; professionalism is doing whatever it takes to be trustworthy. The catchphrase ‘Trust me, I’m a doctor’ ought to be the mantra of the 科学, 善行, and 科学 and let the 海洋 be your guide.

And whose fault’s that? Not ours. Every overstretched and overwhelmed GP knows it. Just do the math. Divide growing demand by dwindling supply, and the inevitable result is disappointment. General practice, like everywhere else in the NHS, lacks chiefly one thing — capacity. There simply aren’t enough GPs to do the job expected of us. True, albeit far too late, we now have a workforce plan that, if implemented and funded, in 10 years should deliver substantially more fully qualified doctors, and in the meantime tries to plug the gaps with a variety of cheaper fast-track surrogates.⁵ Whether this prospect is enough to stop thousands of experienced GPs retiring prematurely remains to be seen.

EPIDEMIC OF MORAL DISTRESS

Ultimately more damaging than external opprobrium, however, is the creeping negativity eating away our self-esteem from within. General practice is being ravaged by a new epidemic — an epidemic of moral distress. Moral distress is the soul-destroying angst that arises when our ability to deliver the first-class care we know we’re capable of is frustrated by conditions and policies over which we have no control. It’s a corrosive mixture of fury and impotence, impelling us towards a Charybdian spiral of defensiveness, disillusion, demoralisation, and burnout.

We have three possible responses to moral distress. The first is — give up. Quit. Go part-time, take early retirement, or change career. Emigrate. The second is compromise. Abandon our principles. Lower our standards and expectations so that the narrower gap between aspiration and reality doesn’t hurt so much. This is the approach presently driving the drift towards transactional general practice, where it doesn’t particularly matter who sees the patient, or however impersonally, as long as it gets them in and out the door at the necessary rate. Concentrate on the 科学ia and let the 后卫 go hang.

The third, and I believe the right one, is to stand firm. Hold the relational line against the transactional pressures of the day. Protest and insist. Our expertise is well founded. We know what good general practice looks like and is capable of, and what it takes to deliver it; we should settle for nothing less.

To succeed in this courageous — some would say lost — cause, among other things, for an expansion of what professionalism requires of us. To date, the notion of professionalism has concentrated on how we should conduct ourselves in relation to individual patients: keeping them safe; respecting their confidentiality and autonomy; and maintaining our clinical competence. But these principles, which we can legitimately claim overwhelmingly to honour, apparently are no longer sufficient to underwrite our corporate responsibility to the public at large. We need to borrow

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PROFESSIONALISM AT SCALE

What does professionalism at scale involve?
In short, it consists of adding one more duty to those we already owe to individual patients – a duty to expose.

“Expose” is a nicely nuanced word. Expose is what surgeons do when they open up an operating field so that vital structures can be recognised and protected. To expose oneself, in the non-prurient sense, is to allow others sight of, insight into, one’s own inner workings. These are the senses in which general practice needs to expose itself more fully to public gaze, so that our skills and value can be better appreciated. To the lay person, general practice can look easy, trivial, and humdrum. But we know – and the public needs to better understand – the sophistication underlying such artlessness: the diagnostic and therapeutic power of the doctor–patient relationship; the interplay of fact, probability, and insight that informs our decision making; the clinical value of continuity; the fluency of a well-crafted consultation; and the multiplicity of our roles, such as clinician, advocate, guide, counsellor, and friend.

THE RCGP’S DUTY AT SCALE

I believe the RCGP, as the voice ‘at scale’ of what good general practice stands for, should go onto the front foot with a high-profile campaign of public information, so that our patients – or the electorate, as they will shortly become – are left in no doubt as to what is under threat of extinction from political mismanagement.

We also have a professional duty to expose as whistle-blowers do when, in the public interest, they denounce egregious inequity or maladministration.

It cannot be right for policies that hamstring our ability to meet our professional obligations to patients to be determined by the partisan interests of successive Secretaries of State who are fitted neither by experience nor aptitude to exercise such power. The NHS urgently needs a governance process that is above party politics: one that harnesses the contributions of acknowledged experts who are not enslaved to the short-termism of the electoral cycle. I believe the RCGP, together with other professional bodies, should be actively campaigning for this long-advocated proposal, which for too long has been gathering dust in Parliament’s ‘too difficult’ pile.

To be fair, as the next election approaches, the RCGP has produced its manifesto of seven steps to save general practice, all of them perfectly sensible. But a politely worded bucket list with a hint of cap-in-hand-ness is hardly the kiss of life our discipline needs at this desperate time. This is no time for prissiness; we should join with the British Medical Association and our sister royal colleges and unite in a vociferous clamour for change.

It is often said that where general practice is concerned our politicians just don’t ‘get it’. We need to help them ‘get it’. How? When I had the privilege of being the RCGP’s President I suggested we organise a 1-day seminar to be attended by health ministers and members of the Parliamentary Health Select Committee, in which we would explain to them the inner workings of general practice – its subtleties, processes, and ‘conditions needed to thrive’. At the time, the idea came to nothing, but I put it forward again now.

In my 1986 book, The Inner Consultation: