

○ Patient-Centred Medical
Professionalism:
Towards an agenda for
research and action

JANET ASKHAM AND ALISON CHISHOLM

MARCH 2006

Introduction

'Patient-centredness' crops up everywhere: in discussions about hospital services, opening hours of surgeries, how health information is given, nursing care, and so on. This paper is about patient-centredness as it concerns the way doctors practise, what they believe or value and how they are organised. It is an attempt to sketch out the various elements, meanings or uses of the concept. There are a number of reasons for doing this. The first is that it is a difficult concept to understand and define. As Stewart (2001) said in the British Medical Journal:

"Patient-centredness is becoming a widely-used but poorly understood concept in medical practice. It may be most commonly understood for what it is not – technology-centred, doctor-centred, hospital-centred, disease-centred" (Stewart, 2004, p 444)

The second reason for the paper is to help towards the setting of a research agenda, by identifying what is problematic in the topic, or in need of further research. The Picker Institute's Patient-Centred Professionalism project is an international research and development programme which aims to bring together evidence about the experiences and expectations of health care service users in order to: (i) help improve patient care by enhancing doctors' understanding of the patient's perspective, and (ii) help the medical profession shape its roles and responsibilities in delivering patient-centred care (See Postscript for further details). This paper will help us – and we hope others – to see where to focus research attention. Our programme, at least to start with, is about patients and doctors, but it could just as easily have been about patients and other health care professionals (as could this paper).

Thirdly, we hope the paper will help those who use or hear the phrase to appreciate the kinds of issues or assumptions which may underlie the statements, for example when it is used in codes of practice or educational syllabuses. Finally, many would argue that although patients' expectations and dissatisfactions have been known for a very long time, their goals have still not been fully met, and we need to know more about why this is so. Thus we hope the paper, as well as the research programme to which it is linked, will show some of the issues for consideration by those for whom 'patient-centred medical professionalism' is an ideal.

Specifically, the key question which the paper addresses is how the two complex concepts of *patient-centredness* and *medical professionalism* can be used together, and whether an examination of what it means to be a doctor and a patient today helps us to see where the two meet.

Patient-centredness and professionalism

For doctors 'patient-centredness' might mean one of four things: that they work in patients' interests; that they practise in accordance with patients' preferences or wishes; that they are in partnership with, or involve, patients; or that they take a person-centred approach.

These are very different notions and all are problematic:

- working in patients' best interests might be thought to smack of paternalism if anyone other than the patient determines 'best interests'. This is especially problematic as patients' interests could be said to lie fundamentally in achieving the best clinical outcomes, a matter on which doctors are trained to know more than patients. However, evidence about best interests now also includes findings which show that the other types of patient-centredness may actually also be in their best interests. For example, involving patients in decisions about their care may affect behaviour (Mead & Bower, 2002). Also we have to remember that improving health status may well depend on patient preferences and values. In addition, much of medical practice is not really concerned with 'improving health status' anyway, but for instance with management of long term conditions, on which patients may know more about their best interests than health care staff. On the other hand, there are many occasions when doctors must take decisions in patients' best interests – even if they cause them real dilemmas; for example, when what patients want may harm others, when their illness affects their ability to take decisions or when they have what doctors see as misguided opinions.
- working in accordance with patients' preferences – or being the kind of doctor patients want – is difficult because patients and circumstances vary, evidence about patients' preferences is limited, and anyway they may not know what they prefer (or may prefer the doctor to decide). There is also an assumption in this suggestion that patients will want what is best for them, or that even if they do not, doctors should respect their wishes. This is all very well, but doctors are trained to give medical care and they may find it hard not to educate, counsel and cajole patients whose preferences do not seem to be in their best interests (Lutfey 2005). However, there is also a growing body of evidence about what patients do and do not want, and doctors cannot afford to ignore this evidence, whether it comes from data about complaints, the choices patients make when they have the chance or research evidence from surveys or more detailed investigations.
- working in partnership with patients, or involving them closely in decisions, treatment or management, is on one level patently more patient-centred. But what does it mean and how far should it go? The term 'partnership' is usually used with reference to people who have similar roles and work in complementary or shared ways to achieve the same ends. But doctors' roles are different from those of patients. Does it mean that patients have to become quasi-doctors?
- Taking a person-centred approach means understanding the patient in a wider context (his or her illness experience, perceptions, values, social and psychological circumstances), and then bringing that understanding to bear on the medical issue. On one level this seems the least contentious of the four meanings, except that it involves a more complex relationship between doctor and patient which may be difficult to develop and sustain, patients may not always want such an approach and for many consultations it may not be necessary.

These four approaches can be identified with key themes which underlie much of the debates over the past thirty years or so about the changing role of the medical profession, patients, and the organisation of health care in modern societies: *activity and passivity; power and autonomy; conflict and collaboration; emotion and objectivity*. These are big debates, which this paper does not attempt to summarise, but cannot avoid. Although all themes can be linked to all four meanings of patient-centredness, the first most clearly concerns how active or passive patients are, the second who has

control, the third how much collaboration, consensus or conflict there is in the health care process, and the fourth what sort of relationship should develop between a doctor and a patient.

To help clarify some of this complexity we start with a brief description of the terms 'profession', 'professionalism' and 'patient-centred care'.

Forty or fifty years ago there was a tendency to think that one could objectively describe the traits which define '**professions**' (e.g. medicine, law, church, army), identifying in particular their members' specialist skills and an ethic of altruism and service to the community, which – as a kind of contract between the profession and society – was rewarded by autonomy or self-regulation, high social status and income. Later the professions came under heavy scrutiny from social scientists, who queried their altruism and emphasised their power to define their own role, and their ability to promote and defend their own self-interest (Freidson, 1970). More recently, however, and in the light of growing social complexity, accelerating social change and general declines in deference (see below) the professions are thought to have lost some of their power and influence and are as a consequence less likely to be the subject of attack (Freidson, 1994).

'**Professionalism**' is used by some to describe specifically (i) the values or principles of members of professions (such as putting clients' welfare first, acting fairly or objectively), or (ii) the ways in which they engage with their clients (such as treating clients with dignity and respect) rather than their actual skills or ultimate aims; or the term can be used more broadly to refer to (iii) all key aspects of the role of those who are members of professions as opposed to other kinds of occupation. Like 'professions' claims of 'professionalism' have been subject to criticism (Davies, 1996), though some social science researchers have stressed that 'professionalism' defined as the values or moral obligations of service and trustworthiness to which for example doctors adhere could help to "restrain excessive competition and encourage the collaboration which is so important for inter-professional work" (Evetts, 1999).

Each of these perspectives on professionalism is likely to elicit a different response from members of the medical profession when considered in relation to patient-centredness: those who see 'professionalism' as relating mainly to the ethic of service and altruism are likely to assert that the current concern is unnecessary, because 'doctors have always been patient-centred'; those who take the second narrow definition and see professionalism as referring mainly to the way doctors communicate, view the interest in patient-centredness as about improving the way doctors interact with patients. But those who accept the broader definitions see patient-centredness as much more problematic and complex, and it is this view we wish to shed light on here.

'**Patient-centred care**' also has a long history and is a troublesome concept. Of course its meaning depends on the circumstances in which it is used, and there is no need to search for a single definition. Although an oversimplification, the dimensions described at the start of this section encompass the major uses of the terms, with the exception of the first: few nowadays describe patient-centred care as doctors working in patients' best interests (even though it remains one important dimension of their work, and though there are some health professionals who still hold to the view that 'doctor knows best': Coulter, 1999). Taking into account patients' wants and preferences features strongly. For example, Laine & Davidoff (1996) state that patient-centred care is "health care that

is closely congruent with and responsive to patients' wants, needs and preferences." Involvement or partnership is also a common ingredient. Lewin et al (2002) see patient-centred interventions as those where providers share consultation, decision and management with patients. They also include the person-centred approach, stating that in patient-centred care providers focus on the 'whole person' (see also Gerteis et al 1993). In fact, as one would expect, most key exponents or researchers of the concept use a multiple definition. For instance Mead & Bower (2000) see five key dimensions to it: a focus on illness rather than disease; a focus on the specific individual's experience of the illness; sharing power and responsibility so that the patient is an active participant rather than a passive recipient of care; a therapeutic alliance between doctor and patient; and the doctor's, as well as the patient's, emotional responses and experiences being part of that alliance or relationship.

Most uses of the concept of patient-centredness focus on the relationship between a doctor and an individual patient. Some, however, focus on the social system or patients as a collectivity, for instance describing patient-centred care as care which is fair and equitable to all or as a system of health care based around the patient (Harkness, 2005). Most also see patient-centredness as a characteristic of doctors, with some being more patient-centred than others; though of course it is recognised that the particular circumstances will also influence the behaviour. Patient-centredness may be a characteristic of situations or indeed of patients themselves, some being more patient-centred than others. So the question of whether doctors are becoming more patient-centred is a difficult one to answer, and sometimes even an inappropriate one. Mead & Bower (2000) describe some of the large number of variables which may influence a doctor's propensity to be patient-centred, such as team-working, or time and workload pressures, which may reduce that propensity, or communications training and cultural values, which may increase it.

Pressure toward patient-centredness is increased by the growing body of evidence about its benefits. There is persuasive evidence that patients want a more active, involved role in their healthcare (Picker Institute, 2005), even though not all patients want to play such a role (Arora & McHorney, 2000). Outcomes are notoriously difficult to assess, especially in the field of health care where they may involve: impact on patients' knowledge, patient satisfaction or quality of life, service use and costs, or health behaviour, symptom management or improvement in health status. The other problem is that the many different aspects of patient-centred care need to be studied separately; global measures of the impact of patient-centred approaches being very difficult to interpret. An on-going review of patient-focused interventions by the Picker Institute shows that many interventions designed to enhance patient involvement have some positive impact on outcomes (Coulter & Ellins, forthcoming).

Patient-centredness is therefore – at least in some of its guises – to be advocated. But it is a complex concept, and when linked to the equally complex 'professionalism' needs further exploration. We next examine, therefore, what it means to be a patient and a doctor (as opposed to being another kind of health care worker or lay person) in 21st century Western societies. We look at how these two are, or could be, linked, and most importantly how they have changed. We then return to the above problem areas to set out some parameters for understanding the current emphasis on 'patient-centred medical professionalism' and its use as a concept in policy, research and debate, including how it is or could be reflected in medical education, or codes of medical practice. We also use it

to draw out some key research questions which need addressing on patient-centred professionalism.

We have taken this approach because we believe that the roles of any group of people are partly: a) what they claim them to be (hence the medical profession's recent attempts to define for themselves their professionalism), b) what the state, other regulatory bodies or general societal values accept, accord or allow them, c) the expectations and behaviour of their clients, fellow workers or others whose roles directly impinge on theirs. In outlining patient-centred professionalism therefore it is important first to examine the roles of the two main players in this field.

Being Patients: lay medical roles

Our understanding of what it means to be a patient has changed since the 1950s when the American sociologist Talcott Parsons defined the sick role as involving exemption from normal social duties, and the obligation to seek specialist advice and follow it. In line with the current public debate about what it means to be a doctor it is appropriate to ask what it means to be a patient today – what defines the role and distinguishes it from other roles. In very simplified form, and for heuristic purposes only, we can distinguish five key aspects of the patient role, using evidence from how people themselves define it and from general expectations and values as portrayed in statutes, guidelines, media representations, etc:

1. Being a patient means **seeking specialist advice** or assistance for an experience seen as something to do with health. In other words one is not a patient if a person occupying a formal health care role has not been approached. Lay people may be seen as experts in their own symptoms or experiences, but as amateurs in more complex diagnoses and treatments. It is usually said that health care is demand-led, that is, people have the right to decide for themselves whether or not to seek health care advice. Apart from notifiable diseases, and the need for sickness or disability certificates to obtain state benefits or satisfy employers, this is strictly true in our society, but of course there are social norms about when one should seek advice, with doctors being part of the educative role in this respect. Has this changed in recent years? Have patients or other health care workers become more involved, more powerful and more conflictual? Or has surveillance medicine (Armstrong, 1997) extended its gaze further into the lives of lay people, in the name of public health? The main change in recent years identified by researchers is the increased propensity of patients to seek the advice of alternative therapists, not in opposition to conventional doctors – faith in bio-medicine remains strong – but to supplement them. (Lupton, 1997).

2. Having an **encounter or relationship with a health care** worker. This is a central part of being a patient. In fact much of the research on patient-centred care is almost solely concerned with the doctor-patient relationship. Is this changing? Is it now a more negotiated encounter than used to be the case? Have patients become more active in it than they used to be? Even back in 1956 Szasz & Hollander divided the doctor-patient relationship into the three types of active-passive, guidance-cooperation, mutual participation (Szasz & Hollander 1956). Thus it has for long been recognised as a complex, often – though not necessarily (see Britten et al, 2000) – negotiated encounter, though what is usually argued is that nowadays patients bring more to the encounter in

the way of information or a questioning approach. And they are more likely to make demands or requests as consumers of health care. In this they are encouraged by state policies which promote choice, the well-informed, active and empowered patient, and by the availability of the internet. But illness still remains an experience which may make people vulnerable and dependent, and in need of a 'whole person' approach which acknowledges the emotional aspects of their health experience. As Lupton argues:

"the privileged representation of the patient as the reflexive, autonomous consumer simply fails to recognise the often unconscious, unarticulated dependence that patients may have on doctors." (Lupton 1997)

3. **Having a decision taken** about a course of action for the patient which will assist with the issue for which advice was sought. The traditional model whereby the doctor took the decision is now being replaced with the informed or shared decision-taking model, where the patient's understanding of the issues, and her/his values and preferences, are brought in to the equation and he/she shares in, or takes, the decision.

4. **Undergoing treatment or managing the condition.** Of course there are huge variations in what this means, from those which are usually solely in the hands of the patient (e.g. to take medication while at home), to those which are usually solely in the hands of the health care worker (e.g. to receive an injection or surgical treatment). Both doctors and patients have always expected patients to manage their own care, such as to adhere to prescribed medicine regimens. In the past this tended to be seen as complying (or not complying) with doctors' orders, but would now be seen as involving much more active decision-making by patients and as part of the patient's responsibilities. Again the state is encouraging even more self-care management by patients (e.g. the expert patient programme).

5. Patients are **a collectivity** with an identity as such. Although not an individual role - apart from those members of the public who serve on patient groups - this is an important feature which has gained recognition comparatively recently, as patients have become a more active collectivity or sets of collectivities. These groups can speak for patients and may wield a good deal of influence.

Being Doctors: medical professionalism

Defining the 'new medical professionalism' is a growth industry. For example a recent King's fund enquiry led to a paper called 'On Being a Doctor: redefining medical professionalism for better patient care' (Rosen & Dewar 2004), which although fairly prescriptive in its conceptualisation acknowledged that medical professionalism is "a dynamic concept, rooted in a long tradition of service and high ethical standards, and shaped by public expectations" (p 10). There was also an American-led medical professionalism project which led to a 'Physician's Charter' for doctors. And more recently in the United Kingdom there has been a Working Party led by the Royal College of Physicians (RCP, 2005), which agreed the following definition of medical professionalism:

A set of values, behaviours and relationships that underpins the trust the public has in doctors.

This definition and a more detailed description of it embody the three aspects of: (i) knowledge, clinical skills and judgement, maintained by continued effort towards improvement and excellence (ii) a relationship with patients, as well as other healthcare staff, involving service and partnership and (iii) a set of moral values, involving respect for others, integrity, compassion and altruism. These three aspects together work to further the aim of medicine which is to 'protect and restore human well-being'.

Our concern is also 'on being a doctor'; what it means, or how we conceive of the position and role of doctors. Health care researchers have had a long-standing interest in the roles of doctors and how they have changed over the years, from the Parsonian picture of the paternalistic doctor practising in the interests of the patient and society (Parsons, 1951) to today's much discussed – though not definitively researched – vision of doctor as partner, expert and team member (May et al, 2004).

Again on the basis of evidence from research about medical practice and on social expectations or cultural representations, the following may be seen as key features of a doctor's role, which in themselves are not greatly in dispute, though how they are acquired and maintained and how the relative importance of each might be changing is hotly debated:

1. Doctors have **special medical knowledge and skills**, which they exercise in an encounter or relationship with patients. To acquire this they have undergone lengthy and demanding training, and to retain which they undergo further learning and practising. This is interesting as far as changing relationships with patients are concerned in two main ways: (a) increasingly – through changes in information technology and education – the latter can gain some of this knowledge and sometimes even the skill, and (b) they can consult other health care workers who also increasingly have some of this knowledge and skill. It is no longer – if it ever was – a closed book. Doctors lose power, and patients and other healthcare staff gain it, if doctors do not have exclusive control over medical knowledge and skill. Patients have the potential to become more active in their health care if they have more knowledge. And the potential for both conflict and collaboration is greater, both between the patient and doctor, and the doctor and other health professionals. However, how far doctors' knowledge and skill remains superior to that of either the patient or other health care workers is not well demarcated. Patients can quite understandably argue that they have read the NICE guidelines and therefore know as well as the doctor what to prescribe for their symptoms, or conversely that 'you're the doctor – you're the one who's spent seven years learning how to diagnose my problem, not me'.

Doctors have never claimed to have knowledge and skill in all areas of health care, and they have always recognised boundaries between their work and that of others, which has necessitated a certain amount of collaboration with other health care workers and with patients. Although some have argued that medical imperialism is strong and that doctors continue to expand their areas of expertise, what appears to be changing is that the areas of knowledge and skill which doctors see as relevant to health care and over which they do not claim mastery are also growing – for example, patients' values and preferences, alternative therapies, pharmaceutical skills – which suggests again a loss of autonomy, more active patients and other health care staff, and more potential for both collaboration and conflict.

2. Doctors are conditionally accorded **privileged access to people's bodies, privileged access to information** about them, and control over dangerous drugs, instruments, or other materials in order that they may work to cure or contain illness, relieve suffering or promote health. Of course they are not alone in this - patients and other health workers are also engaged in this activity and similarly have certain rights of access; but doctors have been traditionally seen as having a greater level of rights, for example in prescription of drugs, or invasion of the body. These privileges too are being somewhat - though perhaps not greatly - diminished; for example prescribing rights are being accorded to other health workers in the UK, and the complementary rights and responsibilities of patients are being emphasised. But on the whole, lay people are expected to go on trusting doctors, having confidence that they are not abusing their privileges, such as using patients for their own ends, making them more sick or killing them off. However, it is widely accepted that the confidence that doctors will not abuse their position is being diminished - or accorded on a more conditional basis - in the less deferential, less hierarchical societies of today, where there is mass communication of information about doctors, more state guidelines and monitoring, and more formal channels for complaining about doctors. This means that the collective medical profession has to work harder to convince the public that they are worthy of trust. More transparency is seen as needed, an openness to scrutiny by patients, the public or their political representatives, and sets of procedures for assuring the public that their confidence is justified. This brings patients, or the public, collectively into greater contact with doctors collectively than used to be the case. This diminishes the autonomy of the medical profession, give patients a more active role, and again enhances the potential for both conflict and collaboration.

3. In order to be able to achieve their health care goals doctors must use **clinical judgement** because of the **uncertainty** and indeterminacy surrounding health care decisions. This has clearly changed in the past thirty years, for although the body of knowledge concerning health and illness has grown vastly, so have the number of treatment options and our understanding of the risks associated with them. In this climate has developed three - not mutually exclusive - ways of handling uncertainty: evidence-based practice; involvement of patients, and their values and preferences, in the decision; multi-professional practice, or team-working. The debate about who has to assume the responsibility or be held accountable for a health care decision in different circumstances is ongoing.

4. Doctors **work within health care systems and organisations** to which they have obligations. This of course varies between doctors and between health care systems. Where there is no NHS, relations between health sectors and with the state are different, but nonetheless operative and there are still rules of clinical governance. There are certain obligations to these other organisations which are unique to doctors and therefore help to define their position and status. For instance in most cases only doctors can sign sickness certificates or death certificates in the UK, and this can be seen as part of a social contract between the state and the profession. This also changes over time, with doctors in the UK now becoming more beholden to statutory clinical governance guidelines (though they are of course also often involved in setting them) and more closely monitored in the outputs and processes of their work. Other aspects of doctors' work within health care systems should also be mentioned, for example, the role they play as commissioners of services, in education, in public health, and policy-making. Particularly as guardians of scarce public resources, doctors may find their role

within the health system sitting uneasily with their role and relationship with individual patients.

5. Doctors have an **ethical code of service** and commitment to healing. Recent attempts to redefine medical professionalism have recognised the need for these to adapt to changing social values. For example, the Royal College of Physicians' 'Doctors in Society' decided that notions of mastery, autonomy and privilege ("in the sense of a special freedom or immunity from, for example, some liability") had no place in "today's properly more egalitarian world."

6. In return for the obligations and service they fulfil doctors are accorded high financial reward and some **rights to control their own members**. By registration with, or membership of, these organisations doctors achieve a sense of identity and their own medical culture, and are defined by others on this basis. The professional organisations in the UK control medical education, entry into the profession and discipline doctors. But we are seeing increasing accountability of the medical profession to users, patients, taxpayers and the government. They now have to involve patients more or at least find out what they want and respond to their demands.

These six defining features, or what follows directly from them, are the basis for codes of medical practice, though what is interesting is the extent to which the codes do or do not reflect the recent changes we have emphasised or the relative importance of each.

Doctors and Patients Together: matching interests and preferences?

We now look at where doctors' and patients' roles coincide, and in what senses patient-centredness (in the four meanings discussed above, namely according with patient preferences, patients' best interests, partnership between patients and doctors, taking a whole-person approach) might impact on them, and identify areas where research is needed.

- Seeking, or being available to give, specialist medical advice and help. Doctor and patient roles coincide here in relation to control over access to a doctor. As far as patient preferences are concerned is it more patient-centred to have a demand-led service, or are there circumstances in which patients would like more guidance on when to consult a doctor, or on when to consult other sources of advice and help? Do patients think doctors have too much or too little control over access to their services (for example, by the way they may define something as trivial or not legitimate or conversely may suggest that the patient should have consulted earlier)? Would it be in patients' interests to have more guidance about when to consult, or less/more freedom to choose for themselves? Could doctors and patients work more closely in partnership to decide about and control access? And should access involve greater attempts to allow the development of a continuing relationship between doctors and patient and to explore the patient as a person? All these issues are under-researched and would repay examination.
- Having an encounter or relationship between doctor and patient. This well-researched aspect of doctor/patient roles is generally seen as centrally about the degree of activity/passivity on the part of the patient or the extent to which it is a

negotiated relationship in which each feels respected and at ease with the other. We already know a good deal about patient preferences here, with patients known to want time with their doctor, the opportunity to ask questions, to give and be given information in a courteous and considerate manner (Picker Institute, 2005). But how dependent do patients remain on doctors in differing circumstances? Are their interests in all situations best served by encouraging an active stance? Do they want a 'whole person' approach? And in what circumstances can the encounter be seen as one between partners?

- Bringing specialist medical knowledge and skills to bear on health problems. This is a very interesting area as far as patient-centredness is concerned, involving the relatively new situation where patients may well have access to a good deal of specialist knowledge particularly via the internet, may be encouraged to develop that knowledge so that they can be involved in deciding on their own care or treatment, and may be urged to develop the skills necessary for self-care management. However, we know comparatively little about what patients or doctors want in these respects, whether a little knowledge 'is a dangerous thing', and how far there can be any real partnership in knowledge between doctors and patients.
- Taking a decision about a course of action for the patient (involving the exercise of clinical judgement). Again a good deal of research evidence is available about what patients want, and we know that they do want involvement in the decision and that involvement can be in their interests, in that it can affect the outcome (Coulter & Ellins, forthcoming). But we still need to know more about the extent to which differing kinds of patient in differing situations want to be involved. In circumstances of uncertainty where clinical judgement has to be used it is still necessary for patients to be able to trust their doctors. We need to keep abreast of trends in people's trust in their doctors, and to understand more fully what leads to greater or lesser trust. For example, what impact do clinical guidelines or the involvement of other health professionals have?
- Undergoing treatment, managing a condition (involving doctors' privileged access to bodies, information or potentially dangerous materials). We are beginning to see some research in this field, particularly as patients receive increasing encouragement to manage their own chronic conditions. But there are many questions to answer about how much of their treatment patients can take charge of, what patients want, in what circumstances, and indeed to what extent self-care works. And what balance between self-care and doctor-managed care works best? Doctors retain control over many areas of practice, and we know little about what patients want or whether it would be in patients' interests to have more scrutiny over them (for example by being involved in patient-safety measures in hospitals).
- Having obligations to, and rights under, a health care system. As stated above there are certain contractual arrangements between the state and the medical profession (even though they will differ in details from country to country). We need to ask to what extent the views of patients about these contractual obligations are taken into account, whether the best interests of patients are being served by them, and to what extent patients or lay people could be involved in setting or monitoring them. We also need to know more about the responsibilities of patients themselves.
- Having an ethical code of service and commitment. Patients do not have a code of practice, though they do have obligations as citizens towards the staff who treat them. What patients and members of the public want of their doctors is being investigated. For example, research carried out by the Picker Institute is examining whether they want them to be morally spotless and always on duty. Is it in patients' interests that doctors should for example, have a sense of vocation, compassion and altruism, or

are they just as well served by doctors who see it only as a job like any other? Can and should patients or potential patients be involved as partners in drawing up codes of practice for doctors and appraising them or reviewing their fitness to practise against the codes? And are patients aware of the codes and willing to use them? What sanctions do they have, if any?

- Belonging to a collectivity/controlling own members. Patients' groups can act collectively to further the interests of patients just as doctors' organisations do for their members. However, whereas the former are mainly campaigning groups, the latter control medical education, entry into the profession and the disciplining of doctors. What would patients and lay people prefer in this regard, and would it be beneficial if their interests were taken more fully into account, or if they were more directly involved in medical education (such as in the selection or assessment of medical students), or in appraisal or assessment of doctors' fitness to practise? Although there is some research on the impact of patient involvement in some of these areas, such as medical education (see our forthcoming report on 'Education For Partnership'), patient preferences still need to be investigated, their interests explored, and the consequences of their involvement examined.

Making Medical Professionalism Patient-Centred

There is some case for arguing the collaborative, contractual nature of the doctor-patient role relationship. Doctors and patients are becoming more open to each others' perceptions and roles. Clearly interests and preferences coincide at points which we can call patient-centred professionalism. In particular:

- Doctors and patients both want patients to be able to trust doctors, but they need to agree about what will create that trust, and where patients come in. We need through research to know more about what kind of regulation or monitoring would make patients nowadays trust doctors and whether doctors would find that acceptable.
- In appropriate circumstances both doctors and patients want patients to share in decision-making, with the doctor bringing the medical information and judgement and the patient bringing his/her values and preferences. But the circumstances for such collaboration still need further examination. We need to know more about where their interests in this do or do not coincide and how doctors can play their part.
- Having accountability or final responsibility for decisions is also an area where there is scope for collaboration or the matching of interests. When would it be appropriate for doctors and patients to share accountability?
- The interests of doctors and patients clearly coincide over self care management again in the appropriate circumstances. But what are these, and can doctors help to foster this more actively?

There may be some potential for collusion between doctors and patients; medical autonomy may be preferable to state control; for example:

- doctors and patients may both agree about a particular course of treatment which the state through its NICE guidelines sees as too expensive, or not of proven effectiveness. We need to know more about these areas of potential for joint action.

There also remain points of potential difficulty, which doctors may want to try to do something about – i.e. accommodate the patient perspective more – in order to retain a position of trust and strength:

- Patients tend to want individualised care; doctors have to routinise the process (Bury 1997). Doctors may also (perhaps increasingly) want to foster equitable division of health care resources; most patients when sick want the best for themselves and their families, though there is a strong strain of altruism in views about the healthcare services, which could do with further exploration..
- In some circumstances doctors may find well-informed patients hard work, even if in others they welcome it.
- Patients may want more liberal outcomes from consultations than doctors; e.g. sickness certificates or prescriptions – because doctors are beholden to state employers, guidelines and limited resources.
- Doctors and patients may have different ideas about the way medical advice should be followed or not followed.
- Patients increasingly look to alternative therapies. How far is the medical profession prepared to go in seeing a place for them?
- It may be in patients' interests for doctors' organisations to give up some of their control over their own members.

Conclusion

So patient-centred professionalism is best understood as doctors fulfilling their changing (and in some cases unchanging) roles in ways which coincide with changing (or unchanging) patient roles, as well as working with patients and others to see whether areas of conflict can be eased. We have indicated some of the research topics which may help with this quest.

Can and should medical professionalism be patient centred? To some this would be silly question. It always has been so, or if not always, it is nowadays. For example, Rosen & Dewar (2004) say that "At the heart of modern professionalism lies a duty to protect patient interests and enhance their experiences of health care" (p 10). Of course. What is interesting is whether the relationship and balance between state, doctors, patients and other health care workers is changing or ought to change. It is hardly surprising that doctors have felt threatened . As Evetts (1999) says:

"The increasing knowledge and empowerment of clients and a heightened awareness of the possibilities of litigation, together with the conspiracy view of professions promulgated by critics and the deregulation policies of governments, have all worked to challenge elements of the intrinsic relations of trust between clients and professionals. Knowledgeable clients are now willing and able to challenge professionals. Radical governments have instigated deregulation and market-based forms of control. Professions have felt threatened and are trying to reclaim aspects of professionalism." (p 124)

It is certainly not the job of researchers to help them reclaim it, but it is a researcher's job to find out more about patient perspectives on this and to investigate the outcomes and implications one way or the other so that doctors – and others – can see where giving patients what they appear to want, or acting in their best interests, or sharing decisions with them or treating the whole person, will lead.

POSTSCRIPT

The Picker Institute's Patient-Centred Professionalism programme has the following objectives:

- To learn more about what patients and the public expect of doctors, their training, professional standards and regulation, for example by examining existing evidence on patient and public views on doctors' training, practice, professional standards and regulation; carrying out original research to fill gaps in knowledge about patient and public views and experiences of doctors and the way they practise;
- To collaborate with researchers in North America and elsewhere to facilitate comparative studies on patient and public views on, and potential contribution to, medical education, standards and regulation;
- To disseminate research results to inform and influence principles and, most importantly, attitudes and practice;
- To share experiences and ideas of good practice widely amongst an international network of interested individuals, and thereby encourage debate and policy recommendations.

There are two arms to the project:

The Evidence Base: a programme of research that will identify more clearly and precisely patients' expectations, show how they are or are not already being accommodated in different contexts of medical practice, and identify important factors that ease or impede a patient-centred approach. The research programme includes conceptual reviews, evidence reviews, documentary analysis, and primary studies.

The Forum: a web-based information exchange to help our network of partners learn about our research findings and share knowledge, experiences and good practice ideas. Forum membership is free and open to everyone with an interest in medical practice, standards, education and regulation, especially members of professional and patient organisations.

The project is funded by a generous core grant from the Picker Institute Inc, an international non-profit-making organization based in Massachusetts which supports research in the field of patient-centred care.

REFERENCES

Armstrong D (1997) 'The rise of surveillance medicine' *Sociology of Health and Illness*, 17, 3, 343-404

Arora N & McHorney C (2000) 'Patient preferences for medical decision making: who really wants to participate?', *Medical Care*, 38, 335-341

Bury M (1997) *Health and Illness in a Changing Society*, London, Routledge

Coulter A (1999) 'Paternalism or partnership? Patients have grown up—and there's no going back' *British Medical Journal*, 319, 719-720.

- Coulter & Ellins (forthcoming) 'The quality enhancing interventions project: patient focused interventions'.
- Davies C (1996) 'The sociology of professions and the profession of gender', *Sociology*, 30, 4, 661-678
- Evetts J (1999) 'Professionalisation and professionalism: issues for interprofessional care', *Journal of Interprofessional Care*, 13, 2, 119-128
- Freidson E (1970) *The Profession of Medicine*, New York, Atherton Press.
- Freidson E (1994) *Professionalism Reborn: theory, prophecy and policy*, Cambridge, Polity Press
- Gerteis M, Edgman-Levitan S, Daley J & Delbanco T (1993) *Through the patient's eyes: understanding and promoting patient-centred care*, San Francisco, Jossey-Bass.
- Harkness J (2005) *What is Patient-Centred Healthcare? A review of definitions and principles*, London, International Alliance of Patients' Organisations
- Laine C & Davidoff F (1996) 'Patient-centred medicine: a professional evolution', *Journal of the American Medical Association*, 275, 152-156
- Lewin S, Skea Z, Entwistle V, Zwarenstein M & Dick J (2002) Interventions for providers to promote a patient-centred approach in clinical consultations, *Cochrane Review*, Cochrane Library, Oxford
- Lutfey K (2005) 'On practices of 'good doctoring': reconsidering the relationship between provider roles and patient adherence', *Sociology of Health & Illness*, 27, 4, 448-467
- May C, Allison G, Chapple A, Chew-Graham C, Dixon C, Gask L, Graham R, Rogers A & Roland M (2004) 'Framing the doctor-patient relationship in chronic illness: a comparative study of general practitioners' accounts', *Sociology of Health & Illness*, 26, 2, 135-158
- Mead N & Bower P (2000) 'Patient-centredness: a conceptual framework and review of the empirical literature', *Social Science & Medicine*, 51, 1087-1110
- Parsons T (1951) *The Social System*, Glencoe, Free Press
- Picker Institute (2005) *Is the NHS getting better or worse? An in-depth look at the views of nearly a million patients between 1998 and 2004*, Oxford, Picker Institute Europe.
- Picker Institute (forthcoming) 'Education for Partnership' Oxford, Picker Institute
- Rosen R & Dewar S (2004) *On Being a Doctor: redefining medical professionalism for better patient care*, King's Fund Discussion Paper, London, King's Fund
- Royal College of Physicians (2005) *Doctors in Society: medical professionalism in a changing world*, London, RCP
- Stewart M (2001) 'Towards a global definition of patient-centred care', *British Medical Journal*, 322, 444-5

Picker Institute Europe

King's Mead House

Oxpens Road

Oxford OX1 1RX

Tel: +44 (0)1865 208100

Fax: +44 (0)1865 208101

Email: info@pickereurope.ac.uk

Website: www.pickereurope.org

Charity Registration no: 1081688