Future Health Worker Project

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Rethinking Professionalism: the first step for patient-focused care?

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Introduction

Health and health care are dominated by the profession of medicine. For many years this was viewed by many people as right, proper and even natural. Although thorough-going critiques were developed of the shortcomings of British health care and of the ways in which traditional medical professionalism contributed to these shortcomings, they were mostly confined to academic and fringe political discourse on both right and left. Most of the public and their elected representatives remained on the whole content with the status quo. Now, however, with health a daily concern, health care high on the political agenda and the quality of care in the NHS perceived to be inadequate on many counts, hitherto unquestioned assumptions and practices are being scrutinised and challenged.

The contribution of medicine to health care and health gain, and the relationship between patient and professional, are two issues under the microscope. They are distinct but deeply intertwined, finding a common root in the attitudes and practices of the medical profession. So deep and wide-ranging is its influence that no radical reform of health services, especially one that claims to put the patient at its heart, can succeed without a sophisticated understanding of medicine, where it succeeds and fails, and how it needs to change.

This is not to underestimate the importance of other health care professions, which include not only nursing, midwifery, dentistry and allied professions such as physiotherapy and speech therapy, but also so-called complementary professions such as osteopathy, and even, latterly, health service management. Furthermore, non-medical professionals such as social workers and opticians may make a significant contribution. Each occupation has its own history, culture and trends, and makes a distinct contribution to health care. Much of the critique of 'old' professionalism to be offered in this paper may also apply to them, but generalisation must be handled with care.

Even the definition of what constitutes a profession is ideologically and politically contested territory. Nursing has been described as a 'semi-profession' while physiotherapy and others were until very recently labelled 'ancillary to medicine'. Any comprehensive discussion of health care professions is also incomplete without a focus on other 'support' workers who give direct patient care, such as health care assistants and nursing auxiliaries.

The role of voluntary workers and lay carers is equally deserving of consideration. Just as voluntarism has become increasingly professionalised, so has the contribution of lay carers such as family and friends, whose knowledge of the patient and their condition is often far more comprehensive than that of the health professional. They are often aided by knowledge, skills, emotional support and problem-solving from myriad self-help groups and specialist charities. The place of these individuals and groups in the health care team and their interrelationship with the professions should be central in the debate about rethinking professionalism.

The purpose of this paper is to provide an analytical foundation and historical reference point for stimulating debate about the key issues, specifically, what needs to change and how if the health professions are to provide genuinely patient-centred services. In its inevitably limited scope, I will focus on the profession of medicine, and its traditional handmaiden nursing, because together they are the most powerful and most numerous grouping in health services. This critique of the practices and perspectives of the traditional professions is also essential to illuminate their interrelationship with 'support workers' and volunteers. Their history, culture and trends are also distinct but remain largely unexamined to date, but their contribution to health services is beyond the scope of this short paper.

Nevertheless this paper attempts to cover a huge amount of ground. Complex arguments are reduced here to a sentence or two, or a reference. Outside academe, the debate is polarised and impoverished: polarised because it concerns sensitive issues of power and politics that arouse passionate feelings, and impoverished because the rich discourses of sociology, history, anthropology, and gender and policy studies only rarely find their way into the mainstream of health policy discussion. My hope is that this paper makes a contribution to bridging those currently yawning gaps, and thus sheds some light on the debate about rethinking professionalism.

Context

Making assumptions explicit

One of the challenges of this topic is that many of its 'givens' seem self-evident. We have all experienced illness and health care, we all have a personal sense of what being healthy means, we all know a health care professional or are one, and we all have our own notion of professionalism. Yet a rethinking of professionalism requires us to move beyond the taken-for-granted attitudes we derive from these experiences.

One of the main 'givens' that needs attention is how we define and understand health, illness and illness behaviour. These assumptions underpin what we think societies, communities and individuals can or should do to improve health, prevent illness, live with disability and deal with death and dying. Yet the debate rarely, if ever, surfaces in health policy circles. Illness seems to Western society to be an organic physical fact, but comparison with other cultures, or with our past, reveals that it is also socially constructed. How, and to what degree, is open to question.

Anglo-American scholarship over the past 50 years has offered a wide variety of interpretations. The leading US medical sociologist Eliot Freidson described illness as a social product of the doctor-patient relationship rather than a feature of the patient's 'organic state' (Freidson 1970). Other famous studies concluded from empirical data that there was a 'clinical iceberg' – most illness lies outside health care provision (Last 1963) - and that people experience symptoms most days of their lives but few visit the doctor (Mechanic and Volkart 1960).

These and many other studies show the inadequacy of the simplistic assumption that you feel ill and therefore seek professional help. Illness behaviour is much more complex and socially defined. The work of functionalist sociologists like Talcott Parsons, who thought that socially responsible people consult a doctor when faced with illness (Parsons 1951), was superseded by an interactionist view that going to the doctor is a last resort when other avenues of advice and assistance have been exhausted, if it is any resort at all for socially excluded groups (Zola 1973).

Recent studies cited in the IPPR report *The Future Patient* (Kendall 2001) suggest that people's attitudes towards health information remain diverse and complex. It may be inferred from this that the decision whether, when and where to seek help continues to be far more complex than the commonsense assumption that when you are ill you go to the doctor.

Another 'given' is the assumption that medicine, and its scientific foundation, exists in order to solve the health problems confronting contemporary society. Clearly that was one of the drivers of the profession's development, but a complex set of social processes was also involved.

Medicine succeeded in redefining health problems and then presenting itself as the solution. According to Friedson, the conflict between the perspectives of doctor and patient is seen to involve the submission of lay concerns about illness to a technical and scientific interpretation of disease. 'Autonomous and self-directing, and supported by the power of the state, the medical profession is able to "recreate the layman's world", defining and constructing illness in terms of its scientific and technical knowledge base' (Friedson 1970).

Although medicine's scientific and professional status has enabled it to extend its authority and influence into new and expanding areas of jurisdiction, this process of medicalisation has not been seen as necessarily enhancing health (Purdy and Banks 2001). This challenges another given, that more medicine means better health, a point to which I will return.

Further, the assumption that medicine's pre-eminence is a just reward for its high standards and successes is only part of the story. The process of an occupation winning acceptance as a profession is also inevitably a power struggle. The professions that succeeded in institutionalising their expertise in 19th century Britain did not emerge autonomously, but were part of the process of state formation (Johnson 1995). However favoured an occupation might be in the division of labour, Johnson argues, 'the creation of a realm of cognitive

exclusiveness as part of *a successful project of market control* depended on the supporting role of the state' (Johnson 1995, my italics).

All these complexities need to be considered in the project to rethink professionalism. How we define professionalism in future will be partly contingent on our underlying assumptions about these issues. They need to be held up to the light if a consensus is to be reached on what health problems should be tackled, how and by whom. Decisions will then flow from such a consensus, not only about the health care team's composition, practice, education, relationships and rewards, but about the broader social policies needed to make the nation healthier. Without exploring these assumptions, and without learning from past mistakes, we are whistling in the dark.

Some history lessons

In thinking about how professionalism needs to change, we need to understand something about medicine's origins and development. As Foucault said, 'the history of the past is the history of the present'. Historical accounts need to be handled with caution, however. The 'histories' of the health care professions written in the first half of the 20th century, still commonly found in royal college libraries or summarised in the popular media, were intended as celebration rather than analysis. Yet their Whiggish descriptions of the battle against ignorance and the triumph of reason were echoed by many more scholarly analyses of the medical profession at least until the 1970s.

The trait approach, which sought to define professionalism by compiling a checklist of attributes and assessing whether an occupation matched up to them, dominated early 20th century medical sociology. Still evident in popular professional discourse, it viewed medicine uncritically as an archetypal profession, noting such characteristics as possession of a unique body of knowledge and control of entry to training. It proclaimed them as the yardstick by which any occupation's claim to be a profession should be judged – a self-fulfilling prophecy. Occupations such as nursing inevitably failed the professional test, and were thereby regarded not only as not worth studying but as 'naturally' inferior to the true professions. These studies reproduced the prevailing professional pecking order and made stereotypical assumptions about the gender division of labour and the inferior knowledge of 'semi-professionals' (for example Simpson and Simpson 1969).

This old, largely self-generated professional ideology dies hard, and still dominates the attitudes of professional bodies. In the 1970s, however, historians and sociologists began to develop more critical insights using empirical evidence, scrutinising actual health care practice and what shapes it. Close attention to such issues as gender and class, and history 'from below' rather than of 'great men', challenged received wisdom. These more diverse interpretations of professionalisation, regarding it not as a static form of work organisation but as a dynamic process, need to be injected into contemporary debate.

The emergence of the health care professions

Friedson argued that the term 'profession' could be reserved for 'that form of occupational organisation which has at once gained for its members a labour monopoly and a place in the division of labour that is free of the authority of others over its work' (Friedson 1970). The key to understanding it was therefore how the work was organised, rather than what the work actually consisted of. I shall return to this absolutely central point later.

The emerging profession of medicine in the 19th century claimed ownership of specific tasks/domains and attempted, usually successfully, either to stop others doing them or to delegate tasks seen as less important or interesting to poorly rewarded subordinates. It constructed a public 'monopoly of credibility' (Larson 1977) that remains central to the creation of a professional commodity. Organised medicine, like the other emerging archetypal professions for the 19th century gentleman, persuaded society that its own particular form of work organisation was better than the alternatives, and even 'natural' rather than socially constructed, a kind of social Darwinism. By defining the problems it claimed to be able to solve and securing ownership of a corresponding occupational territory, it was able to control not only clinical practice and standards but also admission to training (eg excluding women and the working class), the competence and attitudes acquired in training, the regulation of qualified professionals, the acquisition and control of new knowledge and technology, and even the organisation and management of health services. This huge span of control established patterns and norms that persist to this day.

Medicine's definition of and subsequent control of its knowledge base was a crucial ingredient in its rise. In the classical tradition, there were two dominant ideas on health - 'one, associated with the goddess Hygeia, that it could be achieved by a rational way of life; the other personified by the god Asclepius, that it depended largely on the role of the physician as healer of the sick' (McKeown 1976). While both paradigms exist in current medical practice, the Asclepian approach has been predominant since the 17th century. Medicine's close relationship with the 19th century growth of the biomedical sciences, and subsequently with related commercial interests, reinforced this orientation.

The medical profession established itself so successfully that the other emerging health care groups had to work around its template. Victorian attitudes to class and gender, shaping the assumptions of both men and women, also played an important part. Thus Florence Nightingale's decision to model professional nursing on the Victorian household was strategic, but also accorded with the prevailing social order. The doctor/husband/father was wise, firm, yet kindly; the nurse/wife/mother stayed in the background, dutiful, keeping order among the servants and ever watchful of her husband's needs; and the patient/child was obedient, respectful and in awe of father. Many vestiges of this Victorian dispensation remain (Davies 1999).

Medicine's strategy by definition excluded other practitioners (labelling them 'quacks') or reduced them to subordinate roles. Sometimes they belonged to other organised occupations but more often they had no formal training and were local, often female healers. In the struggle for control of childbirth, for example, the new masculine occupation of obstetrician ousted the traditional female midwife in a power battle that still rages. Traditional 'lay' healers usually belonged to the communities they served, and lacked the social, regional or

ethnic distance that often existed between doctor and patient; much doctoring and nursing was carried out by family members, particularly women. The consolidation of hospitals as medicine's power base reinforced the shift of the centre of gravity away from lay healers, carers and communities towards professionals and institutions.

Medicine maintained its monopoly position through social and intellectual control of health care and health services, subordination of other health care disciplines and curtailment of patient power, individual and collective. By the advent of the NHS in 1948, it was so powerful that its assent to government initiatives had to be bought, often literally and at a very high price. Governments dared not face it down, fearing the withdrawal of medical labour. The profession had a positive image as a defender of the public interest against scheming politicians; the medical-industrial complex was too powerful; and government failed to create strong alliances with other stakeholders to outflank it.

Relationships between medicine and patients, other professionals and the state changed relatively little in the decades after 1948. The state, increasingly working through NHS bureaucracy and the emerging profession of health service management, chipped away at its hegemony but with little success. The introduction of general management and the Thatcher reforms tried and failed to bring medicine under tighter managerial control. As late as 1994 analysts were 'wary of claims that the proletarianisation of British medicine is all but complete and that medical power has been successfully harnessed in the advance of managerialism'– though doctors were beginning to have to account for their actions as never before, and the biomedical model was being challenged anew by the revived public health movement (Hunter 1994).

Have the past few years changed all that? Negotiations over doctors' contracts continue to be fierce and protracted, and biomedicine continues to be the dominant health paradigm. Changing social attitudes and the zeal of a reforming government, fuelled by a series of malpractice scandals, may mark the beginning of a sea-change in medicine. Hunter warns, however, that doctors' considerable political skills in 'redirecting or neutralizing attempts by governments and managers to control them' should not be underestimated. 'These skills may serve them well once again as they seek to resist the corporate embrace even if part of the strategy of resistance involves adopting the trappings of corporatism,' he concludes.

According to Abbott (1988), 'the real, the determining history of the professions' lies in competitive struggles between occupations for jurisdiction over realms of expertise. Experts are continuously engaged in making such claims and counter-claims over existing, emergent and vacant areas of expertise. While this account may appear to single medicine out for criticism, every traditional profession has behaved in broadly similar ways. The fact that medicine has done it so successfully and for so long should not exclude it from critical scrutiny.

The position of nursing

It is superficially easy to characterise the nursing profession as driven by the same imperatives as medicine and thus prone to the same failings. It is certainly true that nursing, continually in medicine's shadow, envied its success and sometimes sought to emulate its

methods and behaviours. Yet the process that nursing has followed as a profession, is profoundly different. The basic premise that nurses do what doctors tell them, and practise according to what medicine permits, ignores or neglects; it is still a salient feature of contemporary nursing. In terms of power and policy nursing has always been small fry compared with medicine, despite being by far the largest occupational group in health services.

It may therefore seem paradoxical that nursing has appeared to change almost beyond recognition as it has incorporated new knowledge and practices. However, a misleading picture of professional roles and relationships can be created by advances in health knowledge that are often most visible in hard technology, such as equipment and invasive procedures. To the public, the nurse wielding a stethoscope or conducting a procedure may seem autonomous and powerful. Yet the sphygmomanometer (which measures blood pressure) was once out of bounds to nurses until doctors tired of the novelty and allowed them to use it for routine tasks. The less visible advances in soft technology, such as better understanding of human psychology, may prove more influential in the long run in challenging the predominance of biomedicine and its professional superstructures. These developments may be a matter of evolution rather than revolution, but as yet they have not created a major paradigm shift.

Significantly, the settings and specialties where nurses began to develop more autonomous roles or innovations were those in which medicine had little stake, or where it had a vested interest in nurse empowerment. Medical permission for such innovation was rarely based on an internal challenge to its own prevailing ideology. The nurse practitioner role in the USA (a spur and model for much subsequent nursing development in the USA and UK) emerged as a way of providing primary health care to underserved populations in rural, inner-city or other areas where doctors did not want to work.

More recently in the UK, the greater status and power vested in senior nursing clinicians such as nurse practitioners and clinical nurse specialists springs largely from the need to fill the gaps left by medical labour shortages, specifically to reduce junior doctors' hours. From the 1970s onwards nurses had been advancing new types of initiatives (characterised by a holistic approach involving the patient's active participation) covering many innovations in various settings, such as prescribing, clinical specialist practice, nurse consultations in primary health care, community empowerment, and projects with socially excluded groups. Yet managers and policy-makers mostly gave only lukewarm support until pragmatism forced them to adopt 'new' solutions.

At local level some doctors actively opposed them, as in the notorious closure of the Oxford Nursing Development Unit. This developed an early pioneering model of nurse-led intermediate care for patients who no longer needed intensive attention from medics. Evaluation including a randomised controlled trial showed better outcomes for patients including fewer deaths and greater independence on discharge, but research evidence could not override the opposition of some medical consultants who regarded it as an affront to their power (Salvage 1992).

The very slow roll-out of nurse prescribing, first proposed in the 1980s and lately boosted by the Blair government, also shows how attempts to expand the nurse's role have been hindered by opposition from many quarters of the medical profession (and in this case, from some pharmacists).

Recent research and anecdotal experience reveal that challenges to the dominance of the medical profession may yet be far off. Researchers in a study for the NHS health technology assessment programme, looking at nurses and doctors in three hospitals where nurses had extended roles in preoperative assessment, perceived two relationships: 'the superficial public one in which the team members co-existed in a climate of mutual respect, and the private one, not far under the surface, which was one of a power struggle, disrespect and gender imbalance'. The report says 'power and authority remain vested in senior doctors, most of whom are male' (Meikle 2001).

This may not be the case across all clinical settings. Whether care of the elderly or palliative care are more conducive to egalitarian relationships than the surgical units in this study is an open question. In primary care, nurses are now leading primary medical service schemes and are providing much of the first contact care. There is evidence that this inversion of traditional relationships is leading to a greater focus on the patient and the community (Lewis et al 2001). Many GPs oppose the new arrangements but they are beginning to change the shape and nature of these services – and the roles of the professionals who provide them.

In a classic illustration of how the leverage for major change can come from unexpected quarters, the reduction in junior doctors' hours opened the door to a dramatic and largely unexpected shift in professional relations. In 1996 the government decided to formalise and encourage arrangements often already in place that empowered senior clinical nurses to fill the medical gaps. They were carrying out many tasks that would have been done by the absent junior doctors and were traditionally regarded as medicine's domain. Funds were made available to regions to train nurses in these skills and domains, developing what was to become the first wave of nurse consultants after the role was announced by the prime minister at a nursing awards dinner in 1998.

In summary, the drivers of nursing and medical professional behaviour have probably more differences than similarities. The outcome is an unhealthy relationship that is good for neither - and certainly not for patients – and is overdue for review and regeneration (Davies, Salvage and Smith 2000).

The Current Picture

The limits to medicine

The medical profession achieved much in the course of at least two centuries as an organised profession. At its best, its practitioners display a wonderful blend of skill, knowledge, intellect and compassion. There is a collective and individual commitment to a humanitarian,

altruistic code of ethics. The development and dissemination of a formidable body of knowledge has helped prolong life and improve its quality. Its integration of practice, teaching and research is an all too rare combination. It confers a sense of pride and status that has stood its own with other important power blocs such as industry and the law, and that public service can ill afford to lose. Perhaps most crucially today, it has continued to challenge bureaucratisation, often defending professional/ humanitarian values against cost-controlling bureaucracy and political expediency.

Notwithstanding these substantial achievements, however, it is time to look to the future. The world in which the medical profession functioned so effectively is changing dramatically and health and health care with it. We need to question whether it is now appropriate or desirable that the NHS should still be dominated by doctor-driven structures, processes and reward systems that are not always in the best interests of patients or the service. Examples are the consultant contract and its authorisation of private work, and its regular breach; the independent contractor status of the GP; the organisation of in-patient services around individual consultants and their specialties; the referral system from primary to secondary care, and the GP's gatekeeping role. These impose pointless limitations on competent non-medical professionals not only within the NHS but outside it (eg an optician cannot refer a patient directly to an ophthamologist).

Conceptually, too, health care is dominated by a medical model of health and illness that has limited use in many situations, especially prevention; public health; other conditions or settings where social causation is dominant; chronic and long-term illness and disability; care of the elderly; and social care. How could this happen?

Medicine works hand in hand with the natural sciences, itself often performing or controlling the research. It is a key partner in the medical-industrial complex, an enormously important but barely discussed power nexus that now controls a billion-pound transnational business supplying drugs and equipment. It dominates the research and development agenda, and through this maintains the medicalisation of health and the biomedical domination of health services.

Other ways of interpreting the world and different models of health and illness have been sidelined. The marginalisation of care is one example, embodied in the hierarchical doctor-nurse-carer relationship. Only now is research beginning to demonstrate the validity of the subjective experience that feeling better is intrinsically linked with getting better – and that the psychological wellbeing facilitated by excellent care is as crucial to recovery as the surgeon's knife or the medication.

Scrutiny of medicine's contribution to health gain in the last 150 years reveals a surprisingly equivocal picture. Epidemiologist Thomas McKeown analysed the reduction in deaths associated with infectious diseases, so often claimed as a triumph for medicine, and found the diseases were declining long before effective means were available to combat them. 'The health of man is determined essentially by his behaviour, his food and the nature of the world around him, and is only marginally influenced by personal medical care', he concluded (McKeown 1976). UK government-commissioned inquiries into population health, such as

the Black report (1980) and the Acheson report (1998), point to some similar conclusions. The quality of health care services is a relatively minor determinant in Acheson's socio-economic model of health and its inequalities.

Medicine's status and rewards are greatest in specialties where it appears to have the greatest impact on health, such as surgery, and where the presenting problem appears more amenable to biomedical, physical intervention. These are often settings where a fleeting encounter rather than a long-term relationship with the patient appears to suffice. The Cinderella specialties are seen as less prestigious or interesting, offer few 'merit' awards and little private practice, and attract little research funding or interest from the medical-industrial complex. Yet even these settings are dominated by the biomedical model and the patterns and structures of medical practice that drive the entire health care system regardless of appropriateness. This hierarchy of interest, following the money and the power, reinforces social exclusion and health inequalities, compounded by strong medical influence on resource allocation at local and national policy level.

The predominance of the biomedical model, and its pull towards increasing specialisation, encourages the development of more knowledge in depth but blinds the specialist to the whole picture. While the model can have huge explanatory power, it needs to be used in conjunction with other models in a rounded approach to patient care. There is no logical reason why the team member who practises mainly according to this model should have more say over care decisions than any other member, or indeed than the patient or carer.

As demonstrated in the Bristol report (Kennedy 2001) at its extreme the medical monopoly may aggravate, compound or reinforce other attitudes and behaviours instilled or sanctioned by its members that undermine effective health care. These include closing ranks to conceal malpractice; paradoxically for an occupation that claims a scientific knowledge base, a marked failure to heed research findings; social conservatism on issues such as gender, class and race; and deep resistance to change. Furthermore, the patient-professional relationship is too often characterised by control and hierarchy, perhaps underpinned by deep, largely unconscious motivations – the medic's desire to control, instilled throughout training, colludes with the patient's desire for certainty and willingness to be submissive in the face of the threat of illness.

A compelling description of the way the lone, heroic doctor interacts with patients comes from Celia Davies (1996), in her vitally important work on the new professionalism in health care. 'Consider the appearance of the consultant on a hospital ward,' she writes.

> *He (and for the most part it is still he) makes a momentary appearance, quizzes those who have more continuous association with "his" patient, gives an opinion, proposes or confirms a course of action and moves on. His demeanour is cool, calm and collected; his decisions appear to arise rationally from his evaluation of the evidence as marshalled before him. The work is organised according to his convenience. What he does takes on an active and decisive character; he has 'mastery' of relevant knowledge, he is in command. Others offer him deference and respect or, at the very least, rarely offer an overt challenge to his autonomy and authority. Interestingly, it is the work of*

> *others that actually lets him behave in this way…There is a real and unacknowledged sense in which the classic way of being professional – all-knowing, distant and detached – cannot be produced without the support of others: particularly, but not exclusively, nurses* (Davies 1996)

This insight into the dynamic of doctor-patient and doctor-nurse relationships helps us to understand how they exist not in isolation but in interaction. A shift in one part of this micro-system, whatever its source, will destabilize the whole equilibrium. And since growing numbers of patients, nurses and doctors themselves are challenging the old dynamic, something has to give. It begs the question of what new dynamic can be developed to replace traditional professionalism. The last 150 years have seen many shifts in the division of health care labour, but relatively few changes in power relations. Looking only at the content of the work – who-does-what – is misleading. Understanding the power relations is a more meaningful, context-rich and proactive approach. Medicine may be slow to wake up to it, and diehard traditionalists may resist it, but radical changes in professional-patient and professional-professional relationships are inevitable, as well as necessary to improve care delivery and policy decisions - new forms of professionalism genuinely attuned to patients and communities.

Helping forces and hindering forces

The barriers to change cannot be overestimated. Some are evident in any attempted change process, not specific to the health care professions. Their persistence partly reflects the UK's endemic lack of expertise in effective change management: lack of dedicated staff and funds, no goals or unrealistic ones, the lack of a clear vision of the future leading to lack of ownership and commitment, and unrealistic expectations.

Other barriers are compounded by the particular problems of the NHS and its inadequate funding levels. These include lack of resources – staff and time, unstable teams, lack of ownership of goals that are imposed from above, too much leadership vested in positional rather than personal power, apathy, and unequal pay and rewards for the main actors. The constant political pressure for a quick fix means that new ideas are barely tested before being extended nationwide, and there is barely time to consolidate one wave of change before the next innovation is imposed.

Yet other barriers arise from the predominant professional cultures. The culture of medicine, described above, is reinforced by the submissiveness of nursing, based on low self-esteem. Mutual suspicion and territorialism continue, reinforced by separate education, training, socialising, career ladders, institutions, journals and conferences.

There are also barriers related to government itself, despite ministers' impatience with what they see as the slow pace of change. Many relate to the dilemmas inherent in tight political and bureaucratic control of the NHS. Health care reform and therefore professional reform are high on the political agenda, and this subjects the service to intense daily political pressure nationally and locally. The heavy emphasis on targets, standards, regulatory

mechanisms and other norms often conflicts with the ethos of both old and new professionalism, sometimes stifles creativity, and exacerbates the inevitable tension between professional and bureaucratic models of organisation.

That seems like a lot of bad news, but there is also a lot to be positive about.
Utopian thinking about health care professionalism is not new, but there is a better opportunity to revisit and redefine professionalism now than for many years, perhaps one that will not recur soon - a combination of seismic shifts in old domains and significant new factors.

Some of these seismic shifts are occurring in society as a whole, in attitudes to gender, class, age and ethnicity. Traditional professionalism is rooted in a deeply gendered world-view that persists despite the growing proportion of women in medicine and top management and the numerical predominance of women in nursing and allied health professions. The move towards gender equality is generating a growing impatience with that world-view among many men as well as women, and brings with it new processes and relationships. Like gender, class was also decisive in gaining admission to the professions and influenced their attitudes and practices. Deep class divisions are still apparent but are challenged by greater social mobility and declining deference. Similarly, the increasingly diverse ethnic composition of UK society and the health professions brings new assumptions and behaviours to challenge the old order. The recent influx of overseas doctors, nurses and health care students provides a potentially rich source of innovation and opportunities to learn from other health care systems. Finally, changing demographic and employment patterns are bringing a wider span of ages into the workforce; each generation has different work/life expectations.

Partly springing from these broad societal changes, the demands, expectations and attitudes of patients are also shifting. The patient focus has always underpinned professional rhetoric but has had surprisingly little influence on the development of health services or professional practice. That could be set to change, for all the reasons set out in the IPPR report *The Future Patient* (Kendall 2001). As the expert patient/carer becomes a common phenomenon, the professional's role needs to shift. The status of professionals of all types is changing from being the guardians of knowledge to being counsellors and interpreters (Handy 1998). Building relationships with patients and communities and empowering them whenever possible to manage their own health and illness, while continuing to care for those who are unable to help themselves, are at the core of the new professionalism.

The rise of consumerism and the empowered patient, and the social transformations wrought by changing attitudes to gender, class and ethnicity, mean that society is less and less willing to give the professions free rein to conduct their own affairs. This is particularly clear following a string of highly publicised failures by the regulatory bodies to root out or punish malpractice. The traditional contract between professions and laity, with its specific rights and obligations, is wearing thin and professionals are increasingly seen as workers like any other.

Professionals themselves are of course influenced by social change and many support the direction of these trends. The theory and practice of the 'new professionalism' has a significant groundswell of adherents, including many individual medical practitioners, specialty groups and associations who agree with its critique and reflect that in their practice. It receives a sympathetic hearing among groups like nurses and other health professions who not only support its ideology but wish to improve their own position and see it as an opportunity for 'levelling up'.

Pressure for change is coming from other pragmatic quarters. The continuing emphasis on cost containment is reinforcing the strong drive among some professionals towards evidence-based practice. This has already created significant shifts in attitudes towards professional clinical freedom in countries like the USA, whose health care funding mechanisms now oblige practitioners to practise by protocol, and expose frequent failures to base health care practice on research evidence.

A further stimulus is perhaps the most immediately pressing and powerful of all – the huge if not insoluble problems of recruiting, deploying and retaining an adequately trained health care workforce. This is a global phenomenon, particularly in relation to nursing, as well as one that in the UK is linked with the decline of public service as a career choice and paralleled by difficulties in sectors like education. The need to attract new recruits is turning a basic tenet of traditional professionalism – control of the entry gate – on its head, while the challenge of tailoring training programmes to the huge diversity that wide entry gates admit is massive.

Even those who wish to preserve the traditional division of labour and hierarchical relationships have no option but to accept change when there are key long-term vacancies in the medical and nursing workforce and health care team membership is largely temporary. Revisiting the division of labour, or substituting one professional with someone more junior or from a different occupation, is inexorably leading to new roles and accountabilities. Such experimentation, even when forced by necessity rather than sought or welcomed, can create a crucible for innovation, though the negative impact of continuing staff shortages cannot be overemphasised, not least the demoralisation, apathy and resistance to change it generates.

Official policy

The UK has a reforming government with a commitment to patient-centred care as the keystone of its NHS reform programme. Its rhetoric appears to pick up on all these trends, and display an understanding of and commitment to the need for change in traditional professional practice. A radical agenda is implicit or explicit in many policy directives and proposals in the key areas that determine professional power and influence, including education, professional regulation, pay, and practice.

While medical education is being reduced in length and the curriculum updated, the education of nursing and other health care professionals is moving towards, or already at, degree level. This suggests more convergence between the two groupings, a trend enhanced by the growing number of experimental shared learning courses. The Kennedy report

recommends pilot schemes to explore making the first undergraduate year common to 'all those wishing to become health care professionals' (Kennedy et al. 2001). The UKCC walks a careful tightrope in a new report: *'Collaborative working in practice could lead to inter-professional education that maintains the uniqueness of each profession but gives rise to the emergence of shared values that would provide a better experience for patients*' (UKCC 2001).

There is an increasingly strong push from the centre for easier access to professional training for non-registered staff, more flexible curricula and delivery methods, and a commitment to creating lifelong learning opportunities for all staff.

Education and not only professional conduct is a major responsibility of the professional regulatory bodies. Greater convergence of the professions is a possible consequence of the government's challenge to the shibboleth of self-regulation. Its proposals for an overarching Council for the Regulation of Health Professionals will bring the regulatory bodies under one umbrella, though some are reluctant. Professional convergence will be hastened not only by more shared governance but by greater lay involvement in regulation.

There are also signs of convergence in the discussions on the government's *Agenda for Change* proposals for a new NHS pay system, boosted by tribunal rulings such as the Enderby case that award pay parity between doctors and other professionals for work of equal value. The negotiations are slow and tortuous, and the proposals fall short of earlier radical calls for a single pay spine for all NHS staff. Pay may well be the biggest obstacle to the new professionalism, the focal argument between those parties that wish to maintain the current differentials and their implicit reinforcement of existing power relations, and those that want flatter hierarchies and more open and flexible career ladders.

Changes in practice

The ultimate goal of changes in education, regulation, career ladders and even pay scales should be changes in health care practice that create more health gain and greater patient satisfaction. *The NHS Plan* and other recent government directives are built on an expectation that practice will change. 'Shifting the boundaries' or 'breaking down the barriers' between professions is assumed to be the major lever. Yet the absence of any comprehensive vision of a new professionalism, vastly reduces the likelihood of systemic changes occurring in practice.

The NHS plan says 'the old hierarchical ways of working are giving way to more flexible team working between different clinical professionals… The new approach will shatter the old demarcations which have held back staff and slowed down care.' In fact shifting the boundaries may or may not be a valuable thing to do; it is not a good or bad thing per se. It may or may not alter the power relations between the professionals involved. Thus it may or may not contribute to developing the new professionalism.

Each case must be judged on its own merits in its own context. Many of the new proposals can be classified as substitution rather than innovation, though the two often overlap. This

does not make them invalid or pointless, but it is important to be clear about the difference. Substitution of one health worker with another means the same patient need or wish can be met by a different occupation, or the same service provided. It does not require a shift in power relations though it may help to provoke it.

Innovation (excluding the introduction of new drugs or hard technologies) involves a new service development, meeting a new or unmet need, meeting an old need differently, or developing a new care pathway in which the need of the patient (or population) can be met by a different and usually wider configuration of traditional professionals and other service providers, often called 'teamwork'. It usually requires a shift in power relations.

As mentioned earlier, the government has made much of enhancing nurses' roles, including such developments as the nurse consultant, NHS Direct and nurse-led walk-in treatment centres. The 'ten key roles' outlined by the government's chief nursing adviser (see Box 1) have been widely criticised by nurses as representing not so much an enhancement of nursing as an insistence that nurses take on more tasks traditionally done by doctors. Many nurses say they are only willing to undertake these tasks if they are integral to meeting the patient's nursing needs, not if they are simply substitution of a doctor with a nurse (without extra pay to reflect the extra responsibilities).

Box 1: How nurses and therapists will 'shift the boundaries'

From the NHS Plan

'NHS employers will be required to empower appropriately qualified nurses, midwives and therapists to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs…'

Chief Nursing Officer's 'ten key roles for nurses' (England)

- to order diagnostic investigations such as pathology tests and X-rays
- to make and receive referrals direct, say, to a therapist or a pain consultant
- to admit and discharge patients for specified conditions and within agreed protocols
- to manage patient caseloads, say for diabetes or rheumatology
- to run clinics, say, for ophthalmology or dermatology
- to prescribe medicines and treatments
- to carry out a wide range of resuscitation procedures including defibrillation
- to perform minor surgery and outpatient procedures
- to triage patients using the latest IT to the most appropriate health professional
- to take a lead in the way local health services are organised and in the way that they are run.

Chapter 9 of the NHS Plan also says that by 2004 '*the majority of NHS staff will be working under agreed protocols identifying how common conditions should be handled and which staff can best handle them... protocols that make the best use of all the talents of NHS staff and which are flexible enough to take account of patients' individual needs*'. Yet no mention

is made of this in Chapter 8 on 'Changes for NHS doctors'. Practice by protocol is anathema to traditional professionalism's belief in 'clinical freedom'.

The government has actually said remarkably little about how medical practice should change, apart from an even broader role for GPs. Its agenda here seems basically conservative, as though the content of medical practice is held to be acceptable or even beyond dispute, and that it is only medicine's conduct and relationships that need to change. It is, however, central to NHS reform, and the question of how medical practice itself is changing and needs to change requires close attention.

'*Medicine will have to redefine its limits even as it extends its capacities*,' argues Roy Porter at the close of his monumental 'medical history of humanity'.

> *Medicine's finest hour is the dawn of its dilemmas. For centuries medicine was impotent and thus unproblematic… its tasks were simple: to grapple with lethal diseases and gross disabilities, to ensure live births and manage pain. It performed these with meagre success. Today, with "mission accomplished", its triumphs are dissolving in disorientation. Medicine has led to inflated expectations, which the public eagerly swallowed. Yet as those expectations become unlimited, they are unfulfillable'* (Porter 1997).

The government's plans are a series of measures, some long overdue, that often make sense and may incrementally and gradually make major shifts in health care. Yet some of its intentions may be veiled, and it is hard to fathom whether it is working from a strategic framework for transformation of the health professions, let alone a radical vision.

Tinkering with the boundaries while failing to examine the core of what health workers do and how they do it is like rearranging the deckchairs on the *Titanic*. Allocating the tasks differently is the easy bit, and that is hard enough. The division of labour may have changed dramatically over the years, but the core assumptions about how professionals work have remained very largely intact. Now the government needs to show that it has questioned those outdated assumptions and offer a clearer description of the new vision needed to transform professionalism and drive the changes. It may be there, implicitly; it may exist more explicitly in policy-makers' minds; either way, it is not clearly spelled out in public documents.

Vision: Towards a New Professionalism

Every successful project begins by enabling its stakeholders to dream – and produce a shared vision of where they would like to end up. People not in jobs that regularly encourage them to be visionary find this very difficult, bogged down as they usually are in the daily grind and its apparently insoluble problems. Health professionals feel they have too often been on the receiving end of reform rather than in the driving seat, expected to welcome it without being given the means to achieve it or the rewards for doing it. And there are so many barriers to change that the reform project is indeed daunting.

Simple techniques can, however, free them to dream. Commentators suggest that it is time to put Utopia back on our political map (Taylor 2001) and I would add, on our professional map. Taylor argues that this is not an intellectual game describing a perfect world, but 'a process of "practical imagining"… the concrete and challenging task of defining the kind of society' (also health care system) that might be possible. The energy and commitment this releases then enables us to recognise and analyse the obstacles to progress, so that the action steps to be identified and implemented are realistic and properly planned.

Old-style professionalism, for all its achievements, now needs to change. There are formidable interacting internal and external structural, cultural, political and attitudinal barriers to overcome, and the professions cannot nor should not do this unaided: they need to write a new contract with society. Critique of what is wrong is easier than creating a vision of what the new professionalism might look like, but without such a vision change will be piecemeal and possibly superficial.

Fragments of a vision appear in many of the innovative projects already referred to, and in the academic and professional literature. Davies, building on her finely tuned historical and sociological analysis of health care professionals, has devised an appealing and stimulating framework. She draws on the work of Meg Stacey, eminent sociologist and former lay member of the General Medical Council, whose trenchant 1992 critique argued that doctors should set aside their 'collective illusions', including the outmoded idea that theirs is a one-to-one relationship with the patient. They must recognise the contribution of others (including the patient) to health and healing, and make consequential adjustments to notions of clinical autonomy, of control over allied professions and of the exclusive right of doctors to sit in judgement over others doctors (Davies 1995). (If Stacey's recommendations on GMC reform had been heeded, today's NHS landscape might look rather different).

'Recognising the contribution of others to health and healing' means much more than doctors acknowledging that nurses or physiotherapists do a good job. It requires fundamental redefinition of the knowledge base of health care. Valuing the contribution of all means expanding an understanding of health care's boundaries far beyond the traditional confines of scientific medicine and its mastery, which usually constitutes medical expertise. Davies suggests a fresh approach to health care knowledge that 'sees it confirmed in use, that values things other than the formal and abstract, copes with uncertainty, acknowledges the intuitive

and accepts the importance of experience…. as something that grows and develops from the fusion of expertise and experience and the formal and the intuitive' (Davies 1996).

Many nurses, doctors and patients work this way, perhaps without consciously realising it, and it is demonstrable in absolutely any patient episode, however simple or complex. Davies cites the example in Box 2 below, which captures the reality of daily health care and decision processes, and that fusion of expertise, experience, the formal and the intuitive. Knowledge of anatomy, physiology, orthopaedics, traumatology, therapeutics, psychology, intuition, experience, social context, leadership, emotional literacy, compassion and commitment all played a part in this patient's care. None would have been particularly useful in isolation; it is the combination that was so effective. '*Formal knowledge is put alongside other knowledges, leaving a considerable place for adjustment and negotiation in the light of a carefully acquired and detailed knowledge of persons and situations,*' says Davies.

If this plurality of knowledges is accepted, the traditional definition of a profession as an occupation possessing a unique body of knowledge is open to question. The type of multidisciplinary case conference commonly used in mental health settings and elsewhere offers a taste of how it might work, with a representative of each occupation providing input according to their special expertise – social worker, nurse, doctor, psychologist and so on, as well as the patient and representative. It can only really work, though, if the patient has the final say, the doctor is not the first among equals and someone provides impartial leadership of a process designed to reach consensus. This is perhaps impractical for daily micro-decision processes, though it helps establish working relationships that point in the right direction. It is also inadequate if we accept that much of the power of plurality of knowledges lies in their fusion.

Box 2: A plurality of knowledges

'We had a drunk in one night who was shouting and howling in pain. He was a biker who had come off his bike when it had hit a wall. You know how sometimes you feel about drunks – he was making all this row while the quiet ones lie still and bleed to death – nevertheless there was something about the abrasions on his face that made me think he must have had a real bump on the head, so I held his head and neck still while the other staff got the clothes off him and splinted the broken legs. Even in X-ray he was cursing and trying to sit up. We put on the lead aprons and held him down. He was known locally as a drug abuser and we wondered if he really only wanted some pethidine. I made sure he had some anyway. The relief was instantaneous, too quick, still I'm glad we got it for him. It quietened him down and it turned out that he had fractured his neck; one sudden false move would have paralysed him' – Charge nurse, A&E (quoted in Royal College of Nursing 1992).

Perhaps, then, all health care practitioners should aspire to this plurality – but what of the notion of mastery of their own domain? Even in one closely defined field, this is already impossible with the explosion of information and its accessibility via various media including the Internet. That explosion is also itself breaking down barriers between domains and emphasizing interconnections rather than narrow specialisation. The best a professional

can do is learn at the outset how to learn, and commit to a lifelong learning process. Their domain or area of specialisation might change with time, as they become interested in a new challenge or develop new insights and skills, so the work setting needs to encourage and support this flexibility.

At the very least all professionals need to be aware of the importance of the plurality of knowledges, and confident enough of their own contribution and its limitations to allow for 'adjustment and negotiation'.

There are also some basic skills and knowledge nearly all should possess regardless, such as communication skills, basic life support and nutrition. This points to an education structure and process built around a common core, so that everyone understands and values the different knowledges before choosing their own area of specialisation and developing their own particular strengths. It also points to a novice-to-expert ladder that is not profession-specific, so the apprentice doctor can learn from the physiotherapist or the medical consultant mentor the nursing student – if indeed those old professional roles will continue to be viable or desirable.

Once knowledge has been reconceptualised, Davies argues, 'surrounding social relations can be transformed'. Decision-making becomes interdependent, with what the patient, carer, nurse and others know and understand of the patient's condition and context ascribed as much value as what the doctor knows. Today, what is called teamwork is often no more than a group of individuals working harmoniously but independently alongside each other. This vision regenerates teamwork as a truly collective endeavour. The A&E incident above focuses on one nurse's contribution, but implicit in it is the team ('we') and a sense of democracy and respect, even for this troublesome, abusive and possibly manipulative patient. There is no sense of demarcations or hierarchies but of different people and disciplines coming together to solve a problem.

This calls to mind the deceptively simple proposal of US clinical leader Marie Manthey, that the nurse or other key worker should spend a few minutes with the patient at the beginning of every shift, or community appointment, and ask one question: 'What needs to happen today for you to feel your day was successful?' When the response guides the care plan for the day, the patient is in the driving seat and determines the priorities, whether it is pain control, ending constipation or making sure their cat is being fed (not a trivial issue if you live alone) (Manthey 2000).

Table 1: Old and new concepts of professionalism (Davies 1996)

Old professionalism	*New professionalism*
Mastery of knowledge	Reflective practice
Unilateral decision process (patient as dependent) (colleagues as deferential)	Interdependent decision process (patient as empowered) (colleagues involved)
Autonomy and self-management	Supported practice
Individual accountability	Collective responsibility

Detachment	Engagement
Interchangeability of practitioners	Specificity of practitioners' strengths

Davies' comparison of old and new concepts of professionalism (Table 1) implies radical shifts flowing from this reconceptualisation of knowledge. Education, regulation and other forms of accountability, decision-making, reward systems, performance measurement, the nature of patient and carer/family involvement, even the very content of practice must be rethought. The transformation of social relations between professionals and patient, and between professionals, simultaneously underpins, accompanies and stimulates this rethinking, and gives it meaning; without it, reforms in education or regulation or any other subsystem, useful as they might be, amount to little more than tinkering with the 19th century model.

Each strand in these intertwined reforms is highly complex. The issue of education and training is fundamental, with the development of a common core of key competencies for all health professionals now emerging as a strong strand in government policy, after many years in the wilderness. Box 3 offers my own thoughts about learning and changing together, a way of working towards the plurality of knowledges.

Box 3: Learning and changing together

A common core or generic foundation programme for all health professionals has much appeal. Many of the skills, knowledges and attitudes displayed by every excellent practitioner cut across professional boundaries; for example, all need some knowledge of applied anatomy and physiology, good communication skills, and emotional literacy. Learning these together at the outset makes sense, not least in creating a shared, holistic understanding of health, health care, individuals and communities, and laying a foundation of mutual respect for each specific contribution.

The curriculum would need to cover at least five main domains:

- Models of health and illness: learning the different ways of understanding the meaning of health and illness and their implications for care and treatment.
- Technical content: not only the biomedical sciences, that currently dominate medical and to a lesser extent nursing curricula, but also social science – epidemiology, health and illness behaviour, health promotion, public health; with a strong focus on psychology and mental health.
- Functional competencies: acquiring manual skills; communication; leadership skills.
- Development of self: emotional literacy, beginning with self-exploration; leadership; learning how to learn.
- Understanding processes: especially building a team/community, understanding consensus and valuing diversity – experiential, working with the group's own diversity to break down social, race, gender etc barriers within it, and thus learn how to do it in work life. Also walking in others' shoes, the only way to appreciate fully the roles of all team members, from patient to porter.

Then what? Generic training begs the question of generic roles. Some specialisation is inevitable but that might be provided on a consultancy basis while a team of highly trained, continually developing generic workers provide the daily care and treatment. The focus would be on specificity of individual practitioners' strengths rather than interchangeability of specialist practitioners.

Numerous projects and experiments on these lines are already under way – 'letting a hundred flowers blossom and a hundred schools of thought contend'. Although it is early days in terms of their outcomes, university professional departments such as nursing, midwifery and radiography are already being merged into supposedly multidisciplinary groups such as community care or women's health. It is notable that, as yet, academic medicine is largely unaffected and continues to control its teaching and maintain the integrity of its discipline.

Action: Some Recommendations

What needs to happen next to foster the new professionalism – cherishing the achievements and public service values of the traditional professions while encouraging them to move towards a future-oriented, patient-centred vision?

Policy often follows rather than leads innovation in the field. Most 'new' practices are actually an extension, amalgam or adaptation of something that has been tried somewhere else. Earlier exemplars can be found in health services of nearly all the developments now hailed as innovative, including some that demonstrate new forms of professionalism. This brief paper cannot begin to do justice to the innumerable range, even if they were documented, which many are not. Innovation is happening everywhere. There have been many attempts to change practice and make it more patient-centred, many barely recorded and poorly disseminated. They have often been isolated, and hard to mainstream. Many innovative projects are undermined from without and within, and have little lasting impact within and beyond their own sphere.

The factors ensuring successful innovation are well researched but not known or poorly heeded by policy-makers or, often, the innovators themselves. Government and health service leaders need to be much clearer about how they can intervene to accelerate and mainstream innovation, and legitimate what is already happening. They need to work at closing the policy-practice loop so that policy and practice interact in a mutually reinforcing, iterative process.

Given the complexity of the issues, change will be incremental and traditional and new professionalism will continue to coexist. Important changes are already being made or planned on many fronts; whether they can together create a synergistic, unstoppable wave of professional reform is hard to predict. Many previous attempts have been sabotaged by medical opposition. The medical establishment, driven by enlightened self-interest and itself more diverse, may now be more open to innovation. Policy-makers must act with more determination and focus than hitherto in insisting that the profession moves forward rather than blocking change, while simultaneously reviving and building neglected alliances with progressive groups within medicine, other professionals, service users and other stakeholders.

Policy, practice, education, research, regulation and labour relations are all areas where change is needed – and is already happening. What makes health services so fascinating but so difficult to analyse and change is the interconnectedness of all these domains. Policy directives are meaningless without incentives to implement them in practice; education reforms may prepare practitioners differently but fall on stony ground if they are then unable to use what they have learned; and so on. None of it can work well unless there are enough staff and funds.

With those caveats in mind, the following are suggested as major areas for reform. What follows is not a list of final recommendations, but a preliminary attempt to sketch the huge

range of issues implicated in rethinking professionalism. Many if not most of these areas are already the subject of detailed experiment and analysis – motivated by a range hypotheses and concerns. Here it is hoped that the initial question of how to create a new form of professionalism allows us to draw a range of ideas that are often disconnected together in new ways and with a new type of cohesion. Learning the numerous lessons and insights into these ideas from what is already 'out there' will be one part of the wider work of ippr's *Future Health Worker* project.

Area	Proposals
Education	• A common entry gate for all health care professionals • Open up entry to far more diverse groups • Identification of core competencies for all health workers • Encourage and evaluate shared learning • Hasten the paradigm shift (see Table 4)
Practice	• Encourage, fund and evaluate innovation • Disseminate learning from innovative projects • Teamwork in practice • Individual transformation through continuing professional development of all kinds – requires time out • Empower patients and carers to drive practice decision processes • Resource the recording and sharing of good practice • Value and empower bottom-up change
Career progression and rewards	• Common currency of professional/academic accreditation • Unified, flexible career ladder for all professions • Single pay spine • Equal pay and other financial rewards for work of equal value
Research	• Explore the implications of the plurality of professional knowledge and expertise in relation to the current focus on evidence-based practice • Encourage and fund more multidisciplinary research with a practice focus, but not at the expense of research into phenomena such as caring, comfort and self-esteem that is often conducted under the nursing research umbrella • Ensure that state funding supplements commercially-driven research by supporting research that does not necessarily have commercial implications
Regulation	• Continue moving towards joint professional regulation with greater non-professional involvement and more focus on the public interest • Deregulation of professional practice in a shift to accountability based on competence, not role or professional label
Organisation	• Encourage better dialogue and more joint action by professional representative organisations • Encourage more organisations and networks, temporary and permanent, based on community of interest, eg Royal College of Cancer Care (some of the National Service Framework working

	groups provide a model) • Encourage more debate within professional bodies on their current scope and purpose: some conduct regulatory, educational, professional and trade union activities, and their obligations to subscription-paying members may sometimes conflict with the broader public interest
Government	• Move towards facilitation rather than control – with the aim of fostering democratic process and pluralistic debate to create a shared commitment to implementation of realistic policy goals • Corresponding to recommendations from the World Health Organisation (WHO 2000) and the King's Fund proposing a role for government as steward rather than operational controller of health services (Bell and Reynolds, 2001) • Explore 'health parliament' or 'NHS forum', bringing together politicians, civil servants, managers, educationalists, professional organisations, trade unions, regulatory bodies, consumer groups and other opinion-formers, from the public, commercial and voluntary sectors. Well facilitated, vigorous debate would encourage openness and expression of diverse opinion, leading to consensus on key issues and agreement on the way forward.

Table 4: Paradigm shift in education		
Training	>>>	Learning
In a classroom	>>>	Anywhere, on demand
Upgrade technical skills	>>>	Build core workplace competencies
Learn by listening	>>>	Action learning

Conclusion

While acknowledging how much the patterns and practices of traditional professionalism owe to the dominant ideologies of the 19th century, reform needs to find a way of honouring its many achievements and cherishing its humanitarian values but helping them find expression in more contemporary, productive, socially integrated and egalitarian ways.

Health professional roles have never been fixed in stone and the division of labour has constantly shifted. However, more rapid, dramatic changes could take place in the current decade than in the preceding century. The 19th century 'lone hero model of masculinity' on which the medical profession was built is increasingly unacceptable to patients, who want more equality and openness, and to fellow professionals as well as many doctors. Nurses, physiotherapists and others, becoming more confident and independent, do not want to be subordinate to doctors, and many younger doctors and those working in Cinderella areas support teamwork and other forms of the new professionalism. This focus on collaboration and teamwork, along with profound changes in the age structure, gender and ethnicity of the professions and different expectations and demands from the public, give traditional professionalism no choice but to evolve.

The government, playing a more interventionist role in order to hasten the professional changes it believes will help deliver its promises, is kicking at a partly open door with its moves to break down professional boundaries and encourage a focus on delivering what the patient wants and needs rather than on worrying about who does what. Scandals like Shipman, Bristol and Alder Hey have undermined medicine's reputation and its leaders face a stark choice: to defend its long-held power and privileges, which could be a bloody and unproductive battle for all concerned, or to relinquish some of what it has cherished in favour of a largely unknown but potentially more exciting and creative future.

Nursing and the other allied health professions must also scrutinise their own attitudes and practices, especially those, which, in the understandable drive for recognition and parity with medicine, have mimicked some undesirable features of traditional professionalism. They too may have something to lose, but a lot more to gain. There is a window of opportunity to re-evaluate the potential of these traditionally subordinate occupations, and to encourage a long

overdue focus on the neglected contribution and potential of non-registered health workers, as well as integration of lay carers into the health care team. While the window remains open, there is everything to play for.

References

Abbott A (1988) *The System of Professions: an essay on the division of expert labor* University of Chicago Press

Acheson D (1998) *Independent Inquiry into Inequalities in Health Report* The Stationery Office: London

Allen I (2001) *Stress among ward leaders and charge nurses.* Policy Studies Institute: London

Bell A and Reynolds D (2001) *The Future of the NHS*. Discussion paper. King's Fund: London

Black Report (1980) *Inequalities in Health – report of a research working group.* HMSO: London

Buchan J and Edwards N (2000) *Nursing and New Labour* (unpublished draft paper)

Davies C (1995) *Gender and the Professional Predicament in Nursing* Open University Press: Buckingham

Davies C (1996) 'Cloaked in a tattered illusion' *Nursing Times* 92:45, 44-46 November 6

Davies C (1996) 'A new vision of professionalism' *Nursing Times* 92:46, 54 - 56, November 13

Davies C (1999) Doctors and Nurses: changing family values? *BMJ* 319, 463-464

Department of Health (2000) *The NHS Plan* The Stationery Office: London

Department of Health (2001) *Investment and Reform for NHS Staff – taking forward the NHS Plan* The Stationery Office: London

Department of Health (2001) *Modernising Regulation in the Health Professions.* www.doh.gov.uk/modernisingregulation

Friedson E (1970) *Profession of Medicine: a study of the sociology of applied knowledge* University of Chicago Press

Gillam S (2001) *What has New Labour done for primary health care?* King's Fund: London

Hall S (1998) 'The Great Moving Nowhere Show' *Marxism Today* Nov/Dec

Handy C (1998) *The Hungry Spirit* Arrow Books: London

Hunter D (1994) 'From tribalism to corporatism' in Gabe J, Kelleher D and Williams G (eds.) *Challenging Medicine* Routledge: London

Johnson T (1995) Governmentality and the institutionalisation of expertise, in Johnson T, Larkin G and Saks M (eds.) *Health Professions and the State in Europe* Routledge: London

Kendall E (2001) *The Future Patient* Institute for Public Policy Research: London

Kennedy et al. (2001) *Bristol Royal Infirmary Inquiry. Final Report* Department of Health: London

Larson M (1977) *The Rise of Professionalism: a sociological analysis* University of California Press: Berkeley

Last J (1963) 'The clinical iceberg' *Lancet* 2, 28-30

Lewis R, Gillam S & Jenkins C (eds.) (2001) *Personal Medical Services Pilots: modernising primary care?* King's Fund: London

Light D (1999) *Future Challenges for the NHS* The Nuffield Trust: London

McKeown T (1976) *The Modern Rise of Population* Edward Arnold: London

Manthey M (2000) *Changing the Staffing Mindset* Audiotape, Creative Healthcare Management: Minneapolis www.chcm.com

Mechanic D and Volkart E (1960) 'Illness behaviour and medical diagnoses' *Journal of Health and Human Behaviour* 1, 86-90

Meikle J (2001) 'Doctor and nurse rivalries 'undermine NHS reforms'' *The Guardian* July 31

Parsons T (1951) *The Social System* The Free Press: New York

Peck E and Perri 6 (2001) *Making sense of the second term for the NHS* HSJ/LGC Social Policy Forum www.hsj.co.uk/socialpolicy/making_sense.htm

Porter R (1997) *The Greatest Benefit to Mankind: a medical history of humanity from antiquity to the present* Harper Collins: London

Purdy M and Banks D (eds.) (2001) *The Sociology and Politics of Health* Routledge: London

Royal College of Nursing (1992) *The Value of Nursing* RCN: London

Salvage J (1992) 'The New Nursing: empowering patients or empowering nurses?' in Robinson J, Gray A & Elkan R (eds.) *Policy Issues in Nursing* Open University Press: Buckingham

Salvage J (1995) 'Greenhouses, flagships and umbrellas' in Salvage J and Wright S (eds.) *Nursing Development Units: a force for change* Scutari Press: London

Salvage J and Smith R (2000) 'Who wears the trousers?' *Nursing Times*, 96, 15, 24, April 13

Salvage J and Smith R (2000) 'Doctors and Nurses: doing it differently' *BMJ* 320, 1019-1020

Simpson R and Simpson I (1969) 'Women and bureaucracy in the semi-professions' in Etzioni A (ed.) *The Semi-professions and their Organizations* Free Press: New York

Stacey M (1992) *Regulating British Medicine* Wiley: Chichester

Taylor, M. (2001) Next stop Utopia…but it'll cost us. *The Observer*, 19 August, p24.

UKCC (2001) *Fitness for Practice and Purpose* Report of the Post-Commission Development Group, UKCC: London

World Health Organization (2000) *The World Health Report 2000 – Health Systems: Improving Performance* WHO: Geneva

Zola I (1973) 'Pathways to the doctor – from person to patient' *Social Science and Medicine*, 7, 677-689