A question of professionalism: leading forward the surgical team

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ABSTRACT

Surgical practice must be driven by wise professional judgements, involving complex deliberation, in the interests of ensuring the safe care of patients. Large amounts of energy are now being concentrated in training doctors in skills (competencies) in the belief that this will reduce risk to patients. Little thought is being given to developing in the young, wise professional judgement which is at the heart of being a good doctor and a good surgeon.

KEYWORDS

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There is a growing feeling abroad that the professional status of doctors and in particular surgeons is being systematically undermined.^{1–5} Surgeons are by nature, doers, enjoying a busy professional life where they are responsible for making complex decisions and treating patients with new and evolving procedures whilst working in a busy and frenetic clinical environment. The deeper and deeper layers of bureaucracy designed to make doctors more accountable are creating demotivation in their failure to recognise the importance of trust.⁴ Surgeons are expressing this demotivation as a loss of professional status but to my mind they have not made clear or considered what they mean by this feeling.

Berkeley George Andrew Moynihan would have had no difficulty understanding his professional status nor would the staff he worked with or even the society in which he lived. Some may not have liked his apparent elitism but they would have respected him, recognising his ability to provide solutions for previously untreatable surgical problems. The details of Moynihan's life and some key contributions which he made to surgery are summarised in Table 1.

Moynihan was a visionary, who learned his craft and professional artistry, as many did at that time, in military service, perhaps an interesting point today as the re-emergence of military surgery is a topic of significance at this meeting. His concern about the professional rivalry between surgeons in London and in the provinces led him to inaugurate the Moynihan Surgical Club, the Association of Surgeons and publish the first copy of the *British Journal of Surgery* with the aim of improving professional respect

and collaboration between surgeons. All these organisations continue to thrive and this week the Association of Surgeons of Great Britain and Ireland (ASGBI) demonstrates its strength as an organisation full of ingenuity and diversity. His vision, at an earlier time of apparent difficulties in surgical practice, has borne fruit.

It is pertinent to reflect that at its start the ASGBI was an exclusive men's club, only agreeing to admit women 16 years after its inception, some 20 years after The Royal College of Surgeons of England (RCSE) had voted, following much

Table 1 Berkeley George Andrew Moynihan

- > Born Malta 1865
- > Died England 1936
- > Qualified at Leeds Medical School
- > 1890 FRCS England
- > Military and abdominal surgeon
- > PRCS England for 6 years
- > Visionary who created:
  - * Moynihan Surgical Club
  - * Association of Surgeons of GBI
  - * *British Journal of Surgery*

Table 2 Development of the Association of Surgeons of Great Britain and Ireland

1920	250 male members
1936	Women members
1953	Limited number of trainees
1970	Open to all consultants
1992	Open to staff-grade associates
2005	Engaging with non-medical members of the team

heated debate, to allow them to sit the Fellowship examination. Efforts to make surgery attractive to women are now a vital part of the agenda of all surgical institutions. The last 50 years has seen enormous growth in the constituency of ASGBI which now welcomes all sections of the surgical team (see Table 2). It mirrors the history of the RCSE, see Table 3.

Being a surgeon demands a complex mix of human characteristics. I have enjoyed a career spanning over 30 years as a doctor most of which time I have spent in surgical practice. Different phases of my career have made different demands and all have shaped the surgeon I am now. I share many of the concerns of my fellow surgeons in our loss of control in both the changing scene of clinical practice and in our very important role of directing and developing surgical education and training. I am particularly concerned that simulated training of surgeons will replace the formative influence of everyday clinical practice as a short-term expediency to train surgeons faster.

There is a considerable body of opinion that surgeons are simple souls who only care about operating on patients in an environment reminiscent of a film set.⁵ Sir Robert Platt summed this up in 1963 when he said:⁶

Surgeons, I suspect, see themselves in a setting of glamour, conquering disease by the bold strokes of sheer technical skill. Physicians quietly remember that they were educated gentlemen centuries ago when surgeons and apothecaries were tradesmen.

Currently, many involved in shaping the practice of surgeons of the future still hold this view. The future generation has given voice to its concerns as expressed in this quotation from the British Orthopaedic Trainees Association Web Site which should not be dismissed:⁷

Trainees of today are the pawns in a game of political chess with forced changes to the healthcare system, as well as the regulation and training of doctors.

I value my ability to think on my feet and not be constrained by overbearing and often illogical rules. Of course, I recognise my responsibilities to practice within my capabilities and the bounds set by my profession. But the core of my practice must be driven by wise professional judgements, involving complex deliberation, in the interests of ensuring the safe care of my patients. Large amounts of energy are now being concentrated in training doctors in skills (competencies) in the belief that this will reduce risk to patients. There is little evidence for this assumption. Little thought is being given to understand, to teach and develop in the young, wise professional judgement which is at the heart of being a good doctor and a good surgeon. It is believed to be immeasurable and, therefore, left unattended to. If we are to avoid the suicide of our profession we should heed McNamara's Fallacy described in Table 4.⁸ I do not see myself as a bundle of competencies trained in a surgical factory to be fit for (unquestioned) purpose to work in a surgical practice driven by targets and profit. I do not see this as the legacy that I wish to leave to the surgeons of the future.

I believe that much of our feeling of loss and powerlessness is born out of our failure to understand professionalism and its importance and to share and nurture this in our younger colleagues. Friedson, the American sociologist, has studied this subject in depth.^{9,10} Over the last 50 years, there has been a gradual 'professionalisation' of the whole work force. The effect of this has been to increase the numbers in work who call themselves 'professionals' but who have no tradition or understanding of the responsibilities that this involves. Being a 'professional' footballer does not imply the same as being a professional surgeon.¹¹ We have moral and ethical responsibilities which demand certain priorities and values as follows.

Table 3 The Royal College of Surgeons of England

Pre 1450	Barbers
1540	Barbers/surgeons
1745	Surgeons
1800	RCSE (all male)
1900–2005	Women
	Anaesthetists
	Dental surgeons
	Dental general practitioners
	A&E doctors
	SCPs

Table 4 McNamara's Fallacy

The first step is to measure whatever can easily be measured	That's OK as far as it goes
The second step is to ignore that which can't easily be measured or to give it an arbitrary quantitative value	This is artificial and misleading
The third step is to assume that what can't be measured easily really isn't important	This is blindness
The fourth step is to say that which cannot be easily measured doesn't exist	This is suicide

Handy (1994) cited by Broadfoot.⁸

Membership of the profession of surgery

Medicine has long been regarded as a profession. The educationist Mike Golby pinpoints the key characteristics of a professional as:¹²

Professionals are persons who seek a broad understanding of their practice, paying attention not only to their developing competence, but also to the fundamental purposes and values that underpin their work.

Fish and Coles,¹⁵ extrapolating from Friedson's work, say that a profession: (i) is an occupation exercising 'good' in the service of another; (ii) is specialised work in that it cannot entirely be understood by the layman; (iii) is not measured by financial reward alone; (iv) is ethically and morally based; (v) has an esoteric and complex knowledge base; (vi) exercises discretion; and (vii) depends upon professional judgement. They emphasise that it requires the capacity of the professional to retain a fiduciary (trusting) relationship with a client or in the case of the surgeon, a patient.

The nature of professional knowledge that surgeons use in practice is far more than the theoretical knowledge tested by examination.¹¹ It is characterised as:

It is always incomplete

It evolves during collaborative relationship with colleagues and clients

It works with not on clients

It involves professional judgement which opens professionals up to taking risks and thus to risk being wrong

It is characterised by mystery at its heart

It is based more upon uncertainty than upon total expertise

It involves a spiritual dimension

It opens professionals up to moral answerability

It involves theorising about practice during practice

It is about creating new understanding during practice

It espouses moral and ethical approaches to practice and demands from practitioners an endless critical examination of their beliefs.¹²

Professional practice is conceived of, by some, as involving a set of clear-cut routines and behaviours (performances) and a pre-packaged content which requires merely an efficient means of delivery. They argue (value the idea) that this cuts down considerably the risk that professionals might fail to provide a reliable service. In turn, this makes assumptions that practice is a relatively simple interaction in which the practitioner knows what should happen, despite appearing to negotiate with patients.¹¹

I believe that this outsider view that surgery is a masterable practice is what demotivates surgeons, denying them the real character of professionalism on the one hand and the artistry of practice on the other. Surgeons, I believe value, and therefore must argue for the importance of, complex decision-making and elements of professional judgement and practical wisdom guided by moral principles. Good surgeons see this as central to their daily work where absolute rules and routines are impossible.

Schön, described two views of professionalism the Technical Rational (TR) view and the Professional Artistry (PA) view.¹⁴ The TR view characterises professional activities as essentially simple, describable and able to be broken down into their component parts (skills) and finally masterable. The PA view, defines behaving professionally as being concerned with both means and ends. (It is concerned with conduct rather than mere behaviour.) Here, professional activity is more akin to artistry, and practitioners are broadly autonomous, making their own decisions, and, essentially, exercising their professional judgement both about their actions and the moral bases of those actions. In this model, the professional is not less answerable. Here, to be professional is to be morally accountable for all one's conduct (not just the delivery of the service). Conduct, here is concerned with an individual's beliefs, expectations, attitudes, assumptions and values rather than just their visible and measurable performance.^{11,15} Fish and Twinn expand on Schön's ideas and their work is useful when examining our reactions to current practice (Table 5).¹⁵

The practice of surgery will always be complex. Its increasing complexity now also involves a larger number of professionals in the team than ever before. Even Moynihan was aware of this when in 1928 he wrote:

Surgery is nowadays not the work of an individual but of a team in which every member plays an exact part, in which all contribute to the success and in which each may bring about disaster.

Table 5 Two versions of professionalism

Technical Rational View	Professional Artistry View
Follows rules, laws and prescription	Starts where rules fade, sees patterns and frameworks
Uses diagnosis and analysis	Calls on interpretation and appreciation
Wants efficient systems	Wants creativity and room to be wrong
Sees knowledge as graspable and permanent	Sees knowledge as temporary, dynamic and problematic
Applies theory to practice	Allows theory to emerge from practice
Regards the visible performance as central	Sees more to practice than surface features
Regards as vital the setting out and testing for basic competency	Sees more to the practitioner than the sum of the parts
Sees technical expertise as all	Values professional judgement
Sees professional activities as masterable	Sees mystery at the heart of professional activity
Emphasises the known	Embraces uncertainty
Requires standards to be fixed, measurable and controlled	Warns that which is fixed is usually trivial and argues that professionals should be trusted
Emphasises assessment, appraisal, inspection and accreditation	Emphasises investigation, reflection and deliberation
Thinks change must be made from outside	Believes professions can (and should) develop from inside
Believes that quality is really about quantity which is easily measurable	Believes quality comes from deepening insight into one's values, priorities and actions
Requires technical accountability	Requires professional answerability
Requires training	Needs education
Takes the limited instrumental view of the professional	Sees education as necessary for developing the whole professional

From Fish and Twinn.¹⁵

Surgeons must consider carefully what it means to be a member of a profession and must know what they value, must stand by their values and be explicit about them. This is their first step in maintaining the trust of patients, gaining that of managers and perhaps more importantly re-establishing their own self esteem. To keep their professionalism at the centre of their vision for the future, surgeons need strong leaders in these ideas.

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