16 Professionalism: Maintaining an ethical approach to practice

This performance area is about practising ethically with integrity and a respect for diversity.

At first sight, this may seem like a relatively small domain within the competence framework. Don't be fooled! Its ramifications are huge because ethics and its associated values and attitudes underpin virtually every action that a doctor takes. Additionally, these attributes are strongly associated with the trust that patients have in us as individual doctors and with the trust they have in the profession.

To understand these attributes, let's think about how they are used in practice.

Ethics and joint decision-making

Ethics sounds theoretical, but it has real practical significance. One way to consider ethics is to look at its major application in medicine, which is its role in improving decision-making. Remember first of all that in general practice, decision-making is not doctor-centred, but is done in partnership with the patient or the patient's representatives. This decision-making has two major strands. One is the need to practice evidence-based medicine and the other is to accompany this by the use of values-based practice (Fulford KWM. *Ten Principles of Values-Based Medicine*. Ch. 14. In: Radden J (ed.). *The Philosophy of Psychiatry: a companion* New York: Oxford University Press, 2004, pp. 205–34)

The relationship between the two is that Evidence-Based Practice is concerned with complex/conflicting evidence, whereas Values-Based Practice is concerned with complex/conflicting values. Let's pause for a moment to think about this.

Values-based practice

Can you recall any episodes in which complex and conflicting values between yourself and the patient influenced decision-making? When decision-making is difficult, have you ever wondered whether the problem might lie in a difference in values? How would you explore this possibility in consultation? Try it next time things are not going well, perhaps by finding out if there is a mismatch between what the *patient* feels they need and what *you* are hoping to achieve.

Joined up?
See p14

The rationale for evidence-based medicine is well known but even where the evidence is good, joint decisions should also take into account the values of those involved in the decision. On the doctor's side, values may be informed (even biased) by the views of the team, practice, profession and local health care system and on the patient's side, by the views of family, carers, employers, teachers etc.

So the first step to using ethics in a practical way is to explore and understand our personal values and to do so openly, i.e. without fear of censure. It can sometimes be difficult for educators to provide these opportunities, but doing so is an important way of valuing the diversity of different people's viewpoints.

Is it appropriate to censure the ethics of others? Because people vary so much, there are very few absolutes in ethics and it is through discussion that we learn what is acceptable to the majority and what might not be.

We have to remember that things change. Evidence-based practice changes in response to science and the expectations of society and the profession. It is therefore not a static body of opinion but more a journey than a destination. The same applies to values, particularly in a multicultural society where values are often surprisingly diverse and society's idea of what is acceptable continually changes. This evolution happens best if opportunities for discussion are created without being unfair to those who express views that are 'challenging'. Part of our role as doctors is to encourage society to have these difficult debates. Think, for example, of the prominent role that doctors play in discussions around human fertility and gene therapy. In our professional lifetimes, science is going to make possible what at present seems impossible and as a result, everyone's ethics (profession and society) will be challenged as never before.

Personal values are therefore not fixed in perpetuity and should be informed by a number of people and organisations as discussed above. For the medical profession, the GMC produces 'Good Medical Practice 'which we can think of as a contemporary description of what is acceptable professional behaviour. This is therefore an important document and we should be familiar with it, referring to what it has to say when discussing our performance as practitioners.

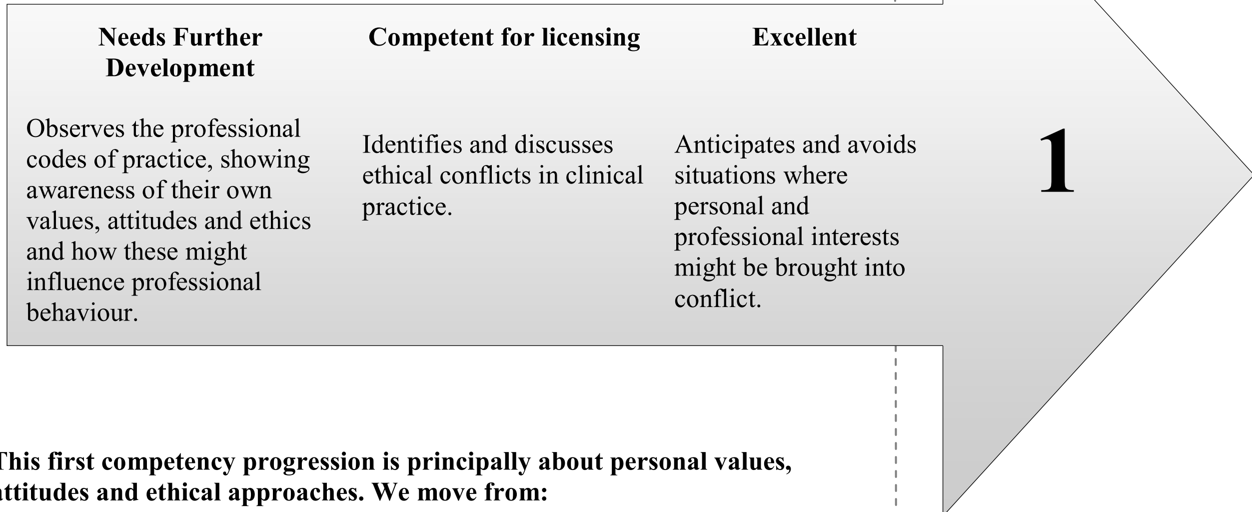
In addition, our values will be tempered by knowledge of the legal framework within which we practise. To illustrate this with practical examples, we may apply our values to common situations such as the following:

- Situations where consent and confidentiality are issues, such as treating those with learning disabilities or treating young teenagers.
- Rationing decisions (e.g. doing the greatest good for the greatest number, the implications of implementing guidelines such as NICE, which apply in England but not in Scotland).
- The care of the terminally ill (e.g. euthanasia and advance directives).

Just as our personal values are not set in stone, the views that patients hold will not only change from person to person, but may also change in an individual over time, particularly through the course of a chronic disease or in response to significant life events such as bereavement. For example, someone who may never have thought that suicide was an acceptable option, may find themselves changing their mind when having to endure intolerable suffering.

Beyond understanding our values, we apply ethics to practice through our *reasoning* skills, through gaining *knowledge* of the values likely to be involved in different health care scenarios and through our *communication* skills. The latter are particularly important, because as the competence framework shows us, good communication involves the active use of the patient's values for example in:

- Respecting the patient's agenda and preference for involvement.
- Seeking to understand the patient's context and establishing what is important to them.
- Working in partnership to develop a mutually acceptable plan.



This first competency progression is principally about personal values, attitudes and ethical approaches. We move from:

Understanding the basics of Good Medical Practice and discussing how we stand in relation to this.

Correctly identifying situations in which ethical conflicts are an issue and using a framework of ethical principles to clarify our thinking and justify our actions.

Looking ahead and anticipating potential ethical conflicts, preventing these from occurring wherever possible and being open about conflicts where these are avoidable.

Looking at each of the word pictures in turn:

Observes the professional codes of practice, showing awareness of their own values, attitudes and ethics and how these might influence professional behaviour.

The first step in this progression is for us to recognise that professional codes of practice exist and to try to understand the contents of the GMC document 'Good Medical Practice' (GMP).

Why is this important? A lack of awareness of the broad themes within GMP would be of concern, as this document helps us to gauge, challenge and develop our values.

Using moral reasoning: how and where

Values, attitudes and approaches to ethics can be nurtured if we become involved in audit and review meetings, for example when developing practice policies on issues that have ethical implications, such as rationing.

In addition, we often display our understanding of these attributes through case-based discussion and in particular when using 'moral reasoning'.

By this, we mean the ability to problem-solve by applying values and ethics, for example by talking through a case that has an ethical dimension and asking questions about right and wrong, benefit and harm, in relation to those people and groups that might be affected by the decision.
Valuable experience can be gained by attending more formal 'ethics events' such as the local research ethics committee.

Ethical issues are often discussed in the medical press, for example the BMJ publishes the opposing views of two authors on issues that often have ethical underpinnings. In addition, medical matters that have implications for society are discussed in programmes such as the BBC's 'Moral maze'. These are good ways to keep in touch with contemporary thinking.

At this basic level of ability, we may not need to know GMP in detail or be able to skilfully use an ethical framework to argue an ethical problem. However, we should be able to recognise when the problem has attitudinal or ethical dimensions and be able to deduce what these dimensions might be, examples being 'doing the most good' or 'being fair to everyone'. Additionally, we should be able to argue how values, attitudes and ethics, particularly our own, might influence a decision.

The curriculum mentions a number of areas in which personal values may have a bearing on healthcare issues. For example, it states that a doctor should:

- Ensure that personal opinions regarding risk factors for cardiovascular problems (e.g. smoking, obesity, exercise, alcohol, age, race) do not influence management decisions
- Ensure that a patient's weight does not prejudice the information communicated or the doctor's attitude towards the patient.
- Ensure that personal opinion regarding smoking does not influence management decisions for people with respiratory problems.
- Ensure that skin problems are not dismissed as trivial or unimportant by health care professionals.

Identifies and discusses ethical conflicts in clinical practice.

This competency is thought by many educators to be the most important within the ethics domain. The competency requires us to identify situations in which an ethical issue, particularly an ethical conflict, might be an important factor in problem-solving. These might be conflicts between our own values and those of others, principally the patient. More usually, they may involve conflicts between the points of view of individuals and groups that are opposing, but each have merit.

An ethical framework, when applied to these areas of conflict, can greatly help to act as a template for discussion, a means of weighing up various aspects of the argument and of justifying whatever decision is finally taken. The ethical framework most commonly used in medicine utilises the following four bioethical principles. This may sound rather dry, but in practice it is an invaluable tool not only for explaining our thoughts and actions to others, but for helping us to clarify our own reasoning.

Autonomy –this concerns respect for individuals and their ability to be self-directed regarding their own health and how they wish to live their lives. Generally, we are expected to recognise, respect and enhance autonomy and actions that diminish autonomy are considered undesirable. As always with ethics, things are not as straightforward as they seem. For example, the rights of the individual have to be balanced with those of society, rationing being a good example. Additionally, there are cultural perspectives with autonomy being much more promoted in the West as a cultural norm than in the East. Neither view is 'right'. Where do *you* stand?

Beneficence - this concept involves making decisions that are best for the patient, without regard to personal gain or the interests of others. No action is wholly good or wholly bad and for GPs, who also have to consider the local community rather than just the individual patient, beneficence is also influenced by utilitarianism, which is the need to ' do the greatest good for the greatest number'.

Non-maleficence - means to 'do no harm'. We must refrain from providing ineffective treatments or acting with malice toward patients and this much seems obvious. However, it isn't quite so straightforward because many beneficial therapies also have significant risks. Beneficence therefore has to be balanced with non- maleficence and this affects key decisions such as whether to investigate, prescribe, refer or 'watch and wait'. Ultimately it is the patient who

assigns weight to the risks and benefits through the process of informed decision-making. However, the potential benefits of any intervention must be believed to outweigh the risks in order for the action to be ethical.

Justice means being fair or just to an individual and the wider community in terms of the consequences of an action. Two notions are encapsulated by this term. The first is equality or '*distributive* justice' which is the principle of treating everyone equally. The second is fairness or '*procedural* justice', which means ensuring that the process of making decisions is fair and that undue bias or prejudice is avoided.

Confidentiality is mentioned here because although it is not a single ethical principle in itself, it is a mixture of several of the ethical principles mentioned above. Confidentiality is a very frequent concern of doctors (see box on this page).

As well as understanding the ethical principles that underpin behaviour, we need to observe the laws of the land, some of which compel us to act in particular ways. For example, in England and Wales confidential information must be shared under particular circumstances such as:

- The notification of births and deaths
- Communicable disease
- Abortion
- Serious accidents covered under the Health and Safety at Work
- Prevention of Terrorism Act

These situations may not seem to be contentious, but as health professionals we sometimes need to question the law on behalf of our patients. Complying with the law should therefore never be a substitute for using moral reasoning.

Finally, here are a few examples from the curriculum that demonstrate the wide range of topics that have ethical implications:

- Be able to balance the autonomy of patients who have visual problems with public safety
- Ensure that the risks of diabetic complications are not over-stated in order to coerce a patient into complying with treatment.
- Describe the ethical principles involved when treating an incompetent patient (e.g. unconscious), and when treating a patient who is unable to communicate (e.g. dysphasic).
- Describe the ethical aspects of managing patients/families with genetic conditions, being aware of the issues involved in genetic testing, such as confidentiality, testing children, and pre-symptomatic testing.
- Be able to identify ethical aspects of clinical practice relating to IM&T e.g. security, confidentiality, use of information for insurance company use etc.

Have you come across these situations? Can you think of examples of your own?

Discussion point: examples of areas of ethical conflict involving confidentiality

Where a doctor has concerns over a patient's fitness to drive, for example an epileptic who is not taking their medication and is posing a risk to the public.

Where a patient threatens serious harm to another individual.

Where a doctor believes a patient to be the victim of abuse and the patient is unable to give or to withhold consent to take this further, for example through immaturity or diminished mental incapacity.

Where a doctor has a patient who is a health professional and has concerns that this person is unfit to practice.

Anticipates and avoids situations where personal and professional interests might be brought into conflict.

At the 'excellent' end of this progression, we are able to show insight and honesty even in the face of temptation to do otherwise. The reason for raising conflict of interest as an issue is that trust between doctors and patients and doctors and colleagues may be damaged by situations in which financial or other personal interests affect, or could be feared to affect, professional judgment.

All doctors will be familiar with the situation where drug companies offer gifts, meals etc. in order to literally 'curry favour' and thereby influence future decision-making. We might think that we are beyond such influence and if we do, we should ask ourselves 'Why do commercially astute companies still continue to use these mechanisms?'

As doctors become more senior, the opportunities for temptation increase, for example chances arise to travel to meetings abroad, give presentations and so on. Especially when couched as 'education' it can be hard to see where the conflict lies, but with writing and presentation, competing interests should be made explicit so that colleagues can decide for themselves whether what is being presented might be influenced by payments, sponsorship or other benefits.

Potential conflicts may also arise with financial dealings, for example when a commercial service is also being offered to patients. Doctors who have a commercial stake in nursing homes or pharmacies used by their patients may find themselves in this situation. Likewise, doctors may have a stake in providing private services such as health checks and should take care not 'recommend' them to their patients. To keep actions above board, the doctor may wish to note on the patient's record when an unavoidable conflict of interest arises.

Gifts are a common (although relatively pleasant?) ethical challenge and it would be easy to fool ourselves that the patient is simply being given the opportunity to express thanks. However, gifts may be misinterpreted as a form of payment or inducement and we can prevent conflict arising by not encouraging patients to give, lend or bequeath money or gifts that will directly or indirectly benefit us. The way in which gifts are managed is a good example of the practice's ethical approach, so for example gifts such as donations may be pooled in a practice fund rather than be kept by an individual.

Conflict may also occur at the personal level. For example, it can be difficult to act as a doctor for someone who is also a working colleague such as a partner in practice. Confidentiality will be a constant challenge and dilemmas may occur when medical advice such as a recommendation to take time off sick is in conflict with the interests of the practice.

As we can see, good doctors behave ethically and are seen to be doing so. At this level of performance, doctors will anticipate where problems might arise and discuss with colleagues, take advice (e.g. from a professional or a defence body) and make conflicts clear to others where these are genuinely unavoidable. 'Anticipation' also means using insight to identify a potential problem where this has not previously been recognised. By acting in this way we not only help ourselves, but improve medical care more widely.

Debating points

Although current 'politically correct' thinking dictates that the doctor and patient are partners in diagnosis and treatment, in reality the patient is very dependent and vulnerable.

How does this affect the doctor's wish to promote autonomy?

Should patients who have knowingly contributed to their ill-health be allowed the same access, free of conditions, to NHS services as those who have not?

Ethical approaches

How does your practice deal with gifts from patients? What is your opinion of the approach? Have they identified other areas of ethical conflict for which a joint approach has been developed?

Can you think of any area that should be considered and if so, what would protocol would you devise for the practice on the issue?

Assessor's corner: anticipating ethical conflicts

'Anticipation' is a mechanism by which ethical insight and motivation come together to prevent adverse 'ethical events'. Where does this happen in your practice? Who have you observed doing it? How often have *you* raised an ethical issue?

Ethics is intended to help us make better decisions. As many significant decisions are made in practice meetings, how often is an ethical angle introduced to help problem-solving in these meetings?

The second competency progression concerns our respect for others and our views on fairness, which includes equity, equality of opportunity and access. We move from:

Respecting others and treating them with fairness

Being open and honest about our own prejudice and unfair bias and looking to minimise these in ourselves and our organisation

Influencing the ethos of the organisation so that practical steps are taken to improve equality of opportunity in personal development and service provision.

Looking at each of the word pictures in turn:

Treats patients, colleagues and others equitably and with respect for their beliefs, preferences, dignity and rights.

This competency progression puts an emphasis on *equality* whereas the next concerns *diversity*. The two are related in that they both require us to show appropriate respect toward others and to treat people with fairness. This can't happen without self-awareness coupled with awareness of the life experience, power and degree of control that other people have.

A note on 'status'

There is difference between being seen to be understanding and fair and being perceived as a little 'superior' and the difference lies much more in attitude than appearance.

Although status can be a privilege for those who work in the professions, for doctors it can sometimes be an impediment in relating to patients, which we need to be aware of and manage.

Assessor's corner:treating people with respect

Showing respect is a persistent and consistent behaviour applied to various types of people and personalities.

Good evidence comes from patient and colleague feedback. However, asking about and taking account of the preferences of patients and colleagues is an important early stage of showing respect.

As educators we should listen out for and nurture curiosity and interest of this type. Although respect should be felt in the heart, it can be developed from the head.

Therefore, doctors who have the curiosity to ask about what others are thinking are already developing the mindset of respect.

In this progression, the basic level of performance is to show the fairness and respect that every good citizen would expect to show, and be shown, in British society. You may think that this is easy to do. However, it may be harder for doctors to do than the 'average' citizen because doctors have power and privilege that can act a barrier to understanding the powerlessness and inequity that others in society feel. As a result it can be difficult to appreciate how this gap can lead to fewer options and poorer medical care.

The importance of self-awareness was mentioned above and the curriculum gives us some examples of topic areas in which awareness is particularly important. The doctor should:

- Have a balanced view of benefits and harms of medical treatment
- Discuss their own values, attitudes and approach to ethical issues (e.g. termination of pregnancy, contraception for minors, consent, confidentiality, cosmetic surgery)
- Ensure that their own beliefs, moral or religious reservations about any contraceptive methods or abortion do not adversely affect the management of a patient's sexual health.
- Understand that their own attitudes and feelings are important determinants of how they manage:
    - ⇒ people who self harm
    - ⇒ people who misuse drugs or alcohol
    - ⇒ people who know more about their illnesses than their doctors do
    - ⇒ people who for many reasons engender strong emotions in us.
- Understand the importance of issues for the doctor such as their family of origin and personal prejudices.

Respecting other people's preferences, dignity and rights requires us to show an interest in patients' thoughts and try to accommodate these as far as we can. It's easy to hide behind our professional position and not actually go very far; tokenism is pretty widespread. Try asking: suppose you were a doctor who believed in patients as partners, rather than just believing that this was a politically correct slogan that had little importance. How much further would you go in accommodating patients' preferences?

Respect is therefore not a passive act but requires interest, communication and good negotiation both to elicit preferences and to negotiate their place in a management plan. Preferences arise from a number of sources including personal, societal and cultural factors and can cause conflict when they leads to risk, conflict or both. For instance, a patient may refuse an intimate examination where this has been recommended and this will raise an ethical dilemma and possibly, depending on the perceived risk, conflict between the patient and their doctor or their family.

Recognises and takes action to address prejudice, oppression and unfair discrimination within the self, other individuals and within systems.

<u>Being fair</u>

Many educators regard this as being one of the most important competencies in this area. To demonstrate this competence, we move from simply giving respect to recognising the threats to fairness and respect that might occur, and then preventing these from taking place or from having a deleterious influence.

This complex competency is the bedrock of becoming, and continuing to be, a fair person as well as a fair doctor. The wording 'prejudice, oppression and unfair discrimination' may be off-putting. For example, although many of us would admit to the possibility of being prejudiced, how many of us recognize ourselves

as being capable of oppression or unfair discrimination? Although these attributes may not be visible at work, perhaps they show themselves in our private lives? Ask your partner or family! If it is genuine, the ability to be fair should apply as much to our lives outside patient care as within it.

Beyond observing the laws and codes of practice as described earlier, we need self-awareness, openness and the opportunity to talk in a protected environment about our personal feelings and experiences of 'prejudice, oppression and unfair discrimination'. The minute we begin to open up about these issues from a personal viewpoint we are already en route to becoming a fairer practitioner. It would be impossible (and inappropriate) to attempt to bring our personal biases into line with our peers, as these biases are important sources of our diversity. Diversity as we will soon discuss, is valuable and necessary to teams and to society. However, we need to identify, explore and understand our personal set of values, biases and prejudices so that these can be taken into account when making judgements. This applies especially to prejudices, which are biases that have no basis in reason or legitimacy but are nevertheless ubiquitous.

Dealing with personal issues is not a 'once and for all' event as prejudice changes with, for example, the expectations of society and personal experience. It needs to be kept under review so that we don't simply become more inflexible or intolerant as we become more experienced. Dialogue is important because what is 'fair' is partly governed by the views of society as well as our own ethical principles.

We cannot maintain fairness simply through self-reflection. Discussion is also important partly because this is how we get the feedback that keeps our excesses in check. Additionally, we have to feel okay about ourselves before commenting on other people and discussion with people we respect is a good way of achieving this.

This competence describes three levels (self, other individuals, systems) but these are not the elements of a hierarchy. Without self-awareness and personal action, what we have to say about the other levels may lack insight, conviction and validity. It is neither necessary nor possible to be blameless in order to comment on others. Nevertheless, we should be humble enough to recognise the weaknesses of our own position when making such comments.

It may seem presumptuous to comment on other people, but it is a facet of positions of authority and leadership. For doctors, there is a need to do so because of our role in delivering a service whose quality depends on the performance of many individuals and systems. Although we may think of ourselves as being independent practitioners, in reality we are inter-dependent.

Constructive comments with the aim of keeping the system fair for those who work within it and for the patients we work for, are therefore necessary. However, taken beyond a certain point this can become oppression, which is unacceptable. The dividing line is not static and to be competent, we need to know what to look for that may alert us that the dividing line is being crossed.

Discrimination

Discrimination is the ability to separate people or items on the basis of some marker of quality. We shouldn't be afraid of being discriminating because it is a necessary part of making judgements. Of course, a balance is needed and the important thing is to ensure that discrimination remains fair. We should not be so undiscriminating that *no* judgement is made, nor so unfairly discriminating (which means positively as well as negatively) that our judgments may not be sound. Discrimination is therefore not only appropriate, but also vital both in clinical practice and in dealing with colleagues and employees.

Equal opportunities

Doctors also select people to positions of responsibility, which may range from opportunities to lead a particular task to being formally employed. A condition,

How important is 'acting fairly' to you?

How do we feel about fairness? Is it important but not central to our lives, or is it part of our integrity as human beings? Remember that integrity is that sense of being 'whole' that we protect from being violated.

Ask yourself whether you feel that fairness is part of your integrity and whether it is something that you would protect in a situation where it was under threat. Such threats are commonplace.

It is all too easy to treat people less well because they are older, junior in hierarchy, because we don't warm to them, because we are stressed or tired and so on. When do you behave less fairly than you should?? How can you prevent this?

Assessor's corner: is the doctor becoming oppressive and unfair?

There are a number of ways of looking at this, for example, how authoritarian is the doctor as a team member? How rigid are his/her views and how does the doctor deal with pressure points e.g. seeing patients who come late/DNA/ ask for emergency or late visits?

What does MSF/informal feedback/SEA say about the doctor's attitudes and actions?

Looking at this from another angle, does the doctor show the ability to detect prejudice and oppression in others? How good is their judgement on these matters? Would they act appropriately and sensitively?

Insights into performance might be gained through actual or hypothetical examples and scenarios.

requirement, or practice that has the effect of unjustifiably excluding or having an adverse impact on a group is covered by equal opportunities legislation that helps to guide the appropriate mindset, for example:

- The Race Relations Act
- The Sexual Discrimination
- The Disability Discrimination Act
- The Employment Equality (Age, Sexual Orientation Religion or Belief) Regulations

What are the key 'people' factors that are subject to unfair discrimination?

Gender
Race
Colour
Nationality
Ethnic or National Origin
Religion or Religious Belief
Disability
Sexuality ('Sexual orientation')
Transgender
Age

Taking action

Doctors may witness prejudice etc. in colleagues and systems and discuss these with those involved. To demonstrate competence, doctors need to know how to recognise prejudice, oppression and unfair discrimination, be vigilant for the signs of these and raise concerns appropriately and sensitively when they occur or discuss how they might do so.

The risks are high, because no person and indeed no organisation, likes to imagine that they have been unfair. Therefore, doctors should seek out the facts, clarify misunderstandings, take advice from colleagues and only then take personal action. This sequence reflects how doctors might address performance issues more broadly and this is discussed in greater detail in the next chapter.

On the equal opportunities front, there are a number of positive actions that can be taken such as:

- Having targets and quotas for disadvantaged and under-represented groups (positive discrimination).
- Monitoring to make sure that unfair discrimination is not taking place, for example with appointments to new posts.
- Looking for and acting on harassment and victimization.
- Having a genuine occupational qualification requirement when making appointments, rather than some spurious one that may indirectly discriminate.
- Monitoring.
- Offering flexible working for employees and flexible service provision for patients.

Unfair positive discrimination

We all have 'forceful features' which can subconsciously (and therefore without our awareness) influence our opinion in a positive or negative direction. For example on the positive side, we can be drawn towards people who are physically attractive or well spoken and also toward people who are like ourselves or remind us of someone we feel positively toward etc. Can you think of any such examples? What are your own forceful features? In which situations would you try to raise your awareness of them? How?

Actively promotes equality of opportunity for patients to access health care and for individuals to achieve their potential.

At the 'excellent' end of the competency progression, we apply our understanding of fairness and equality more widely. 'Equality' is partly to do with the ethical principle of equity and fairness for all. It also overlaps with the law about equal opportunities as discussed earlier. Through personal example and discussion, we can help others including the organisation to understand the importance of these principles and to incorporate them as part of our core values.

What action might we take? We might, for example identify the issue of opportunity and fairness as it relates to management and leadership in primary health care e.g.

- The approaches to the use of resources / rationing.
- Approaches to involving the public and patients in decision-making.
- Appointments to a post or task.
- Patient services and whether a new service might be unfair to some in terms of availability and accessibility.
- Rules governing the access to services. For example, mandatory weight loss or smoking cessation prior to NHS surgery.

The curriculum has some examples that relate to equality of opportunity in patient care. It suggests:

- Ensure that a patient's hearing impairment or deafness does not prejudice the information communicated or doctor's attitude towards the patient.
- Recognise that male circumcision is important for several religious groups.
- All citizens should have equal rights to health and equitable access to health and health information according to their needs.
- Integration is not simply a matter of acquiring skills but of showing commitment. Inclusion begins with commitment to the development of fully accessible services.
- Patients with learning difficulties are more prone to the effects of prejudice and unfair discrimination and doctor's have a duty to recognise this within themselves, other individuals and within systems and to take remedial action.

The underlying principle at work in this competency is that we promote equality of opportunity in the development of team members and, for patients, equality of opportunity to access services.

We also have a role as leaders, which is why the competency refers to the doctor not just providing opportunities, but also actively trying to help individuals to 'achieve their potential'.

Assessor's corner: is the doctor discriminating and doing so fairly?

Does the doctor discriminate between different levels of quality e.g. in their own work or regarding the performance of others?

Is the basis of this discrimination fair, or are irrelevant or unjustified factors brought in? Does the justification lack insight?

Look at the degree of insight that the doctor shows when discussing the ratings that are given by assessors and by *themselves* to structured assessments, especially CbD and COT.

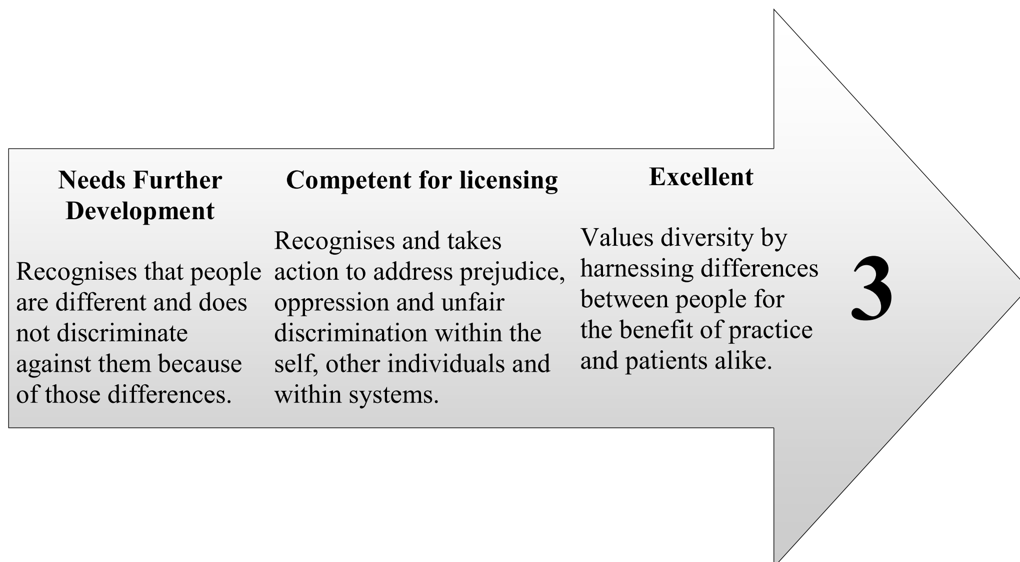
This mindset transposes to patient care in that the best doctors don't just deal with current problems, but try to encourage patients to improve i.e. to achieve *their* potential of being healthy in physical and psychological terms.

Assessor's corner: is the doctor addressing prejudice?

To address the issues, the doctor must first recognize them. Evidence may come through events or through the discussion of hypothetical cases.

Does the doctor admit to having prejudices? (we all have them!). What changes has s/he made or proposed?

Where the doctor recognizes a personal issue, evidence of appropriate action to address prejudice etc. may come through the learning cycle, i.e. raising aspects of personal behaviour as issues for discussion with clinical/non-clinical colleagues and then taking steps to identify needs and attend to them.



The third competency progression builds on the previous one by considering the challenges and benefits of diversity. We move from:

Recognizing the ways in which people are different from each other and avoiding personal prejudice related to this.

Having identified prejudice within ourselves or within others, taking appropriate action to address the issue.

Valuing diversity by understanding the practical uses to which it can be put and being instrumental in doing so.

Looking at each of the word pictures in turn:

Recognises that people are different and does not discriminate against them because of those differences.

Diversity, meaning the differences between people is valuable, but because it is often misunderstood it is insufficiently applied. A radio broadcaster exhorted us by saying 'We are given diversity; let us not turn this into division.'

When diversity is appropriately used, it:

- Builds on the mindset of promoting equality and avoiding unfair bias and prejudice
- Assumes pluralism, which is the belief that the numerous distinct ethnic, religious, or cultural groups present in society are desirable and socially beneficial. On this basis, diversity is pro-active
- Is proactive, recognizing talent, celebrating and harnessing individual differences
- Is inclusive and internally initiated
- Means each person is treated and valued as unique; including background, heritage, economic class, personality and experience

Assessor's corner: 'taking action to promote equality and access'

How well does the doctor feel that equality fairness and respect are shown within the practice? What suggestions does s/he have to improve matters?

What subject area could the doctor audit to investigate a discrimination issue? For example modification of call systems for the deaf, disabled access to the surgery and service access for commuters.

Do the membership of the team and the way the service is provided suggest that equal opportunity is being practised?

What does the doctor think about: the practice development plan, how much personal development is promoted within the team, how accessible training courses are, staff turnover? What does MSF say about the doctor?

What is diversity?

If diversity means differences between people, then the differences that we can define include gender, sexuality, disability, ethnicity, religion and social class. As we can see, the range of differences is broad but discussions on diversity often get no further than discussions about cultural differences. For us to achieve this baseline competency, we need to understand diversity more broadly. In addition, we need to understand diversity in terms of its *purpose* rather than just its knowledge base.

To expand on this, we often get bogged down by learning about *factual* differences between cultural groups. This is not a useful approach because unlike scientific subjects, say biochemistry, diversity is not entirely knowable. That is not to say that knowledge is useless. For example, it can be helpful to know what, in broad terms, the health beliefs and expectations of different ethnic groups might be. However, even these 'facts' are not stable but change in relation to factors such as the process of acclimatisation to a new culture and changes in society itself.

Try thinking of diversity *not as a subject, but as an attitude*. Doctors who really understand diversity show sensibility and cultural humility toward people, rather than just a knowledge of facts. Why humility? Because they do not presume to know the patient's thoughts and do not make assumptions that people, by virtue of their background, will behave or think in particular ways. Instead of treating people as stereotypes (which is so easily done), they encourage people to talk about their perspective and then seek to learn from this.

Empowering people to communicate is important because those who are culturally or socially different often feel reticent to communicate their views for fear of being ridiculed or misunderstood.

Valuing diversity is therefore of practical use, in helping us to feel confident and competent in dealing with people from different backgrounds, different sociological groups and different cultures. We need to remember that 'people' includes our colleagues as well as our patients.

How to understand diversity

Understanding diversity means understanding and *valuing* the differences between people. To do this, we first need to know what those differences are and then judge, in our terms as well as in terms of the other person, what value these differences bring. We shouldn't assume that differences are *always* valuable, but at least we should be open to the possibility.

A parallel example is with team development, where experience teaches us that functional teams are diverse in that they comprise a *variety* of personalities rather than being made up of just one personality type. Therefore, a team might have someone who is good on the theoretical aspects of a problem and another who hates the theory but likes the practicalities of putting things into action. Both are needed

if the team is to work well.

Theorists help to justify what the team seeks to do, but without completer-finishers nothing ever gets done! These different types may in personal terms initially find it difficult to get on, but are likely to do so when they value what the other can do.

Assessor's corner: does the doctor understand the value of diversity?

What does the doctor value about people who are different or about ideas that are different from his/her own?

Try suggesting examples and evaluating the response. Which types of people/ positions/values does the doctor find particularly *hard* to value? Is this appropriate or does the doctor have a point?

Likewise with diversity, a group of people who have different perspectives can greatly enhance joint endeavours. How does this help us in practice life? One significant example is that understanding and valuing a different perspective from our own can improve shared decision-making both in the consultation with patients and with colleagues.

To understand differences we need to continually explore and compare the viewpoints and values of others with our own attitudes and dispositions. This is a lifelong process of discovery, which will not be entirely joyous as there will be frequent challenges to our mindset and periodic conflict between different perspectives and values.

As the word picture indicates, to demonstrate this competency we have to show that we understand diversity. In terms of behaviour, we may not be able to apply our understanding of diversity to practice, but our behaviour should show that we do not discriminate against people because of, for example, cultural or social differences.

Recognises and takes action to address prejudice, oppression and unfair discrimination within the self, other individuals and within systems.

This competency is common to equality and fairness (as discussed in the previous competency progression) and to diversity. It has been covered in depth on page 190. In addition to what has already been said, we should look at our own behaviour and at the behaviour of those we work with and address prejudice that is based on differences.

Values diversity by harnessing differences between people for the benefit of practice and patients alike.

Remember that differences do not just relate to the obvious, such as racial prejudice, but to factors that are more subtle. For example, we may be intolerant of people who have different upbringings such as different schooling (e.g. private versus state sector), have different political or cultural values, who dress differently or are difficult to understand because of language or accent. Prejudice, which may simply start with irritation, seriously impairs our willingness to recognize and learn from what others have to contribute.

The approach taken to achieving this competency is similar to the approach described for 'actively promoting equality of opportunity' (see page 193) . In addition to promoting an appropriate culture within the organization, we need to understand how diversity can be applied to useful effect. Making use of diversity is not a matter of being politically correct. It should be done because it is *useful* to do so.

A group with diverse perspectives better reflects the multicultural nature of British society and will be more representative of what society needs and wants.

What does 'harnessing differences' mean? Sometimes, diversity can be harnessed in relation to a specific problem. For example, a sizeable ethnic minority community may need targeted attention from healthcare workers with a particular understanding of the needs and concerns of that community. Remember that

diversity is not just about differences in culture. For instance, the diverse perspectives of the patient population could be used to advise on practice development. However, how prevalent is this? For example, how many practices discuss the development of an adolescent health clinic with teenagers in the community?

In our leadership role, we can demonstrate this competency by being proactive in seeking out talent and in putting people together who are different, but potentially complementary. Of course, differences can be irritating or even frightening and we should not assume that such people will automatically communicate well or get on. If diversity is to be made use of, the problems as well as the potential must be recognized and discussed so that individuals can work fruitfully together.

If diversity is already understood by the organisation, we may wish to perform a diversity audit looking at such criteria as: are opportunities being given so that the talent within the team is recognized and rewarded? Does the profile of people in positions of responsibility reflect the diversity of the team? If not, why might this be and what action needs to be taken?

In the end, equality and diversity are steppingstones to seeing people as individuals rather than as categories or stereotypes. No-one wants to be selected because of the requirement for organisations to comply with 'equal opportunities' or with 'diversity awareness'. People need to be understood, valued and promoted on the basis of who they are as individuals and what they have to offer. The attention given to equality and diversity reflects the fact that misunderstanding and prejudice are widespread and need to be overcome. British society has moved a great deal in recent years in the direction of valuing its multiculturalism and the example that doctors set as role models is as important to society as it is to the profession.