

The  
University  
Of  
Sheffield.

**Medical Professionalism and the Social Contract:  
An Intergenerational Study**

**By:**

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**A thesis submitted in requirement for the degree of**

**Doctor of Education**

**School of Education**

**Faculty of Social Sciences**

**The University of Sheffield**

**Submission Date**

**October 2020**

## **Abstract**

*This thesis investigates the relationship between the changing nature of medical professionalism across three generations of Plastic Surgeons (Baby Boomers, Generation X and Generation Y) and the 'Social Contract'. The research sought to discover, firstly, whether intergenerational differences in medical professionalism are evident, and secondly, if such differences do exist, what impact these may have on the current and future relationships between doctors, government and society within the context of the Social Contract. The study is underpinned by Social Contract theory.*

*A constructivist-interpretivist approach formed the philosophical basis of the research. A single case study of 20 Plastic Surgeons in one hospital at varying career stages was undertaken. Semi-structured interviews were conducted to obtain data relating to the attitudes and experiences of participants on professionalism, being a member of the medical profession, the doctor–patient relationship and the Social Contract. The data acquired was triangulated by means of documentary analysis of relevant government policy documents from the period 1983–2019.*

*Interviews revealed that Baby Boomers and Generation X held a 'nostalgic' view of professionalism whereas Generation Y expressed a 'new' sense of professionalism requiring a better work–life balance. Major factors accounting for these differences in attitudes were found to be (1) the implementation of the European Working Time Regulations (EWTR) with the subsequent loss of teamwork along with (2) the changing demographics of the workforce.*

*Documentary analysis revealed repeated policy implementation that increased the rights of patients whilst simultaneously increasing regulation of the medical profession.*

*Overall, this research revealed concern amongst Plastic Surgeons as to how they are treated by society and government. Social Contract theory would predict 'push back' by the medical profession principally amongst Generation Y doctors as their proportion within the profession increases with time. Intergenerational tension also exists within Plastic Surgery. To dissipate that tension, greater emphasis should be given to bringing the generations back together through enhanced mentoring schemes and other schemes designed to foster better teamwork.*

## **Acknowledgements**

My everlasting gratitude goes to my supervisor, Dr Heather Ellis, for her unwavering support, patience and good grace dealing with such a qualitative novice. She continually challenged my reasoning and provided perpetual and timely guidance. I will be forever grateful.

Thank you to all those who participated in this research. Obviously, it would not have been possible without your assistance. I am indebted for the time you kindly gave in supporting this thesis. I hope I have given you the 'voice' you deserve. To all those on the EdD course, thank you for your warmth, kindness, humour and wisdom which inspired me immeasurably.

To my wife, Lisa. You remain my rock, wise counsel, colleague and love of my life. Not a day goes by without me realising what you have given up for me.

To my children, Niamh and Pierce, thank you for sharing my academic journey over the last decade with your childhoods. I hope one day you will forgive me and realise the value and power of education.

To my mother and father, thank you for the sacrifices you made for me over the years. Whilst you yourselves did not have the educational opportunities you provided me, you had the wisdom to know the value of education.

To everyone above, thank you will never be enough, and I hope I have done you proud.

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# Chapter 1

## Introduction

### ***1.1. Thesis Introduction***

The goal of this thesis is to investigate the relationship between the concept of medical professionalism and the ‘Social Contract’, with the Social Contract being a three-way relationship between government, society and the medical profession. In particular, I wish to explore whether differences in understandings of professionalism exist across the three generations that are currently found within the medical workforce in the UK (Baby Boomers, Generation X and Generation Y) and, if such differences are found, how they might affect the current and future relationships within the Social Contract and its function. The research is underpinned by Social Contract theory as proposed by Rousseau in the 18<sup>th</sup> century and extended to involve specifically Medicine (Starr, 1982; Cruess & Cruess, 2008).

This introduction will offer the context in which the research was performed, its aims and a subsequent outline of the thesis chapters.

### ***1.2. Research Context***

I have been a Plastic Surgery Consultant for 17 years. During that time I have noticed that those trainees struggling to progress at annual appraisal do so, not through lack of knowledge or operative skills, but rather because an aspect of their professional behaviour is at odds with *Good Medical Practice* as set out by the General Medical Council (GMC) (2019a), for example, lack of engagement in the assessment process. This sparked my interest in studying medical professionalism.

This idea of lack of professionalism hindering trainee progression has been noted by other authors (Duff, 2004; Papadakis et al., 2008). However, what becomes immediately apparent on studying the literature is that professionalism is remarkably difficult to define as it is a somewhat abstract theme that changes with time, between societies, across nations and even between and within professions (Dixon et al., 1998; Rowley et al., 2000; Cruess & Cruess, 2008).

Added to this difficulty in defining professionalism has been the changing nature of how a doctor interacts with his or her patients. The relationship has transitioned from one of paternalism where the doctor knew best, held all access to knowledge, and led the patient in their treatment, to one of shared decision-making between doctor and patient. This shift has been brought about since WWII through a combination of consumerism, increased access to knowledge via the internet, social media, repeated medical scandals, as well as recurring government policy interventions that have sought to increase the rights of patients but at the same time increased the regulation of doctors (Burke, 2008). Thus, for doctors, it seems likely that both understandings of 'professionalism' and what it means to be a member of a 'profession' are changing. As such, I wish to explore whether there are any intergenerational differences in these concepts. I have classified the generations as follows: 'Baby Boomers' (born 1946–1964), 'Generation X' (born 1965–1980) and 'Generation Y' (born 1981–1996) (Pew Research Center, 2010; Money et al., 2013).

The existing secondary literature suggests that there has been a significant shift in recent decades from a sense of vocation, where a person puts the needs of those they serve above their own (Baby Boomers & Generation X), to calls for a better work–life balance, where Generation

Y are said to consider their needs as important as those they serve in the public sector or for whom they work. (Moreno-Walton et al., 2009; Eckleberry-Hunt & Tucciarone, 2011). In this research, if there are indeed changes in how medical professionals view themselves in terms of 'professionalism' and the term 'profession', I wish to consider how that may impact upon the dynamics of the relationships within the Social Contract by using Social Contract theory.

### ***1.3. Underpinning Theory***

Social Contract theory came to the fore in 18<sup>th</sup>-century Europe. It concerns how the construction of society relates to the power of the state. Rousseau championed this concept in his book *The Social Contract* (Rousseau, 1762). Rousseau argued that individuals gained benefits by consenting to the need to defend and respect the rights of others, whilst losing some rights and freedoms of their own. In doing so, a civil society could be established for the greater good of all. More recently, the concept of the Social Contract has been extended to consider the tripartite relationship between Government (as the funding source for the health service), Society (i.e. patients who use the health service) and Medicine (i.e. doctors who provide the service) (Starr, 1982; Sullivan & Benner, 2005).

Social Contract theory will be used in this research in two ways: first, deductively, in an a priori manner to help give explanation to the findings of the research and second, inductively, in an a posteriori manner to potentially predict the future trajectory of the relationships within the Social Contract as applied to healthcare.

#### ***1.4. Research Focus & Value***

What then is the focus of this research and what value can it add to the literature?

The focus of the research is to identify whether generational differences in understandings of professionalism within a single Plastic Surgery unit exist or not. If they do, then what impact do these differences have on the relationships within the Social Contract? The hypothesis on which this thesis is based is that when one partner in the Social Contract senses a loss of equipoise within the tripartite relationship, that same partner will react in a manner to rebalance the power distribution within the contract.

The literature on intergenerational differences in professionalism has been written almost entirely from an American perspective and focuses on the specialties of General Surgery and Orthopaedics. I could identify only one paper relating to generational differences within Plastic Surgery (Larson, 2003). This paper was written before Generation Y had even entered the medical workforce as well as being written from an American perspective. The American perspective is important to consider as medical professionalism is different in the USA in that there is a greater focus on financial conduct than in the UK (Sox, 2002; Timmermans & Oh, 2010). Additionally, the medical workforce in the USA continues to work without restrictions placed upon them in terms of hours worked, whereas in the United Kingdom the European Working Time Regulations (EWTR) were introduced in 1998. Furthermore, the general literature suggests that Generation Y places greater weight on seeking a more measured work–life balance, as compared with their predecessors, namely Baby Boomers and Generation X (Howell et al., 2009; Pew Research Center, 2010).

What if generational differences were identified? What would be their significance?

A long-held traditional tenet of being a member of any profession is that the individual must put the wishes, needs and expectations of those they serve above their own (Carr-Saunders & Wilson, 1933; Elliot, 1972; Abbott, 1988; Hensel & Dickey, 1998; Wynia et al., 1999; Evetts, 2006; Cruess & Cruess, 2008). If this research demonstrates that Generation Y trainees do expect to have a greater sense of work–life balance, then this could potentially be at odds with the traditional view of being a member of a profession as outlined above. In turn, one could use Social Contract theory to predict potential consequences for the tripartite relationship within the Social Contract as Generation Y doctors increase in number and proportion within the profession. If Generation Y doctors do indeed have a changing concept of professionalism that may be at odds with their patients’ expectations, then Social Contract theory could be used to predict potential friction within the partnerships of the Social Contract. No such direct correlation between medical professionalism within a specific medical or surgical specialty and its impact on the Social Contract has to my knowledge previously been performed.

The research in this thesis will provide a unique UK perspective on current intergenerational differences in professionalism within Plastic Surgery in the UK that has not been documented previously in the literature particularly with respect to Generation Y trainees (Larson, 2003; Money et al., 2013).

It is hoped that the conclusions of the research will be of interest to a wide audience that would include doctors, patients, NHS institutions, medical educators, policy makers and government.

Indeed, discussion of the conclusions will include the feasibility of drawing generalisations not only on a more widespread basis within Plastic Surgery but also within other medical or surgical specialties.

Before embarking upon the research, I needed to consider my position as a researcher and how that may influence my subsequent approach to answering the primary research question. This was essential as differing ontological and epistemological positioning can result in a single phenomenon being viewed differently by different individuals (Cohen and Manion, 2011).

### ***1.5. Positionality & Personal Context***

I commenced the EdD with the notion that I would study the issue of professionalism in some manner. Initially, I was interested in understanding what drove a trainee to act in an unprofessional manner but realised that issues of anonymity and confidentiality would be difficult to overcome in the ethical process. Whilst considering my options, I realised during the policy module that I enjoyed understanding how changes in society drove policy introduction.

I must declare a significant interest in medical education since becoming a Consultant Plastic Surgeon that has led me, as I have suggested in section 1.2, to consider that trainees who are struggling to progress in their training, do so predominantly as a consequence of an issue in their professional behaviours rather than deficiency in knowledge or operative skills. This, in turn, nurtured the seed, for the research question at the centre of this research.

I have previously been a Regional Training Programme Director (2006-2015) for Plastic Surgery in the East Midlands and Yorkshire Deaneries such that I took the educational lead for training in the units in Bradford, Hull, Leeds, Leicester, Nottingham, Sheffield and Wakefield. This progressed to being Chair of the Specialty Advisory Committee (SAC) in Plastic Surgery (2012 – 2015) on behalf of the four Surgical Colleges such that I was the educational lead for all Plastic Surgery units across the UK and Ireland. This involved maintaining the Plastic Surgery curriculum such that I led on national selection into Plastic Surgery, set the boundaries of the syllabus, put in place an assessment programme and established the exit requirements from the training programmes across the UK and Ireland. Subsequently I became Chair of the Interface Training Oversight Group (2015-2018) on behalf of the four Surgical Colleges that oversaw the training and curriculum requirements for pre-CCT (Certificate of Completion of Training) training fellowships in surgical fields that crossed surgical boundaries such as Cleft Lip & Palate, Hand Surgery, Head and Neck Cancer Surgery, Oncoplastic Breast Surgery and Trauma Surgery. In 2019, I was appointed the incoming Chair of the Education Committee for the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) to lead the educational strategy for the national specialty association in Plastic Surgery. Finally, in 2020, I was appointed the Convenor of Education at the Royal College of Surgeons of Edinburgh to provide a clinical lead within the Education Department of the College to shape and take forward the educational strategy for all its members and fellows whether based in the UK or abroad.

I have therefore had broad access to and been a keen observer of the three generations currently working in the Plastic Surgery workforce in the UK through my clinical role as a Consultant Plastic Surgeon as well as my educational roles particularly with respect to professionalism.

This research tied in with my own changing sense of self-identity over time. I wondered why it was that I felt that during my 35-year career in Medicine my prestige, authority, place in society and financial gain had progressively diminished with time? The EdD has given me the time, space and opportunity to critically analyse and reflect on why I perceived these changes to have occurred.

My concerns when I started out on this research were not only linked to the question of what exactly to study about professionalism, but also the fact that my positioning according to Johari's Window was in the upper right pane (Luft, 1961). This put me in the 'blind' area where I could not 'see' what was otherwise clearly obvious to others from a social sciences background. I come from a medical background where the positivist paradigm is almost exclusively dominant, particularly so in Plastic Surgery. I was used to being an observer who was independent of the 'researched'; in Medicine, theory is made 'a priori' and results are tested statistically for direct cause and effect through experimentation in a quantitative manner. This is my everyday experience of working in the NHS where no drug, equipment or surgical procedure can be introduced into patient care without careful evaluation of cause and effect as part of the mantra of 'evidence-based medicine'. Before embarking on this EdD, the terms ontology and epistemology were foreign to me and I was entirely ignorant of the contribution that an interpretivist position using qualitative data could make when undertaking research.

I grasped that if I was to obtain a rich picture of the attitudes, experiences and perceptions of a group of doctors then this would require a qualitative approach that at the commencement of the EdD was entirely alien to me. Thus, rather than my usual positivist approach to research, I would need to view the participating Plastic Surgeons as existing in particular socially

constructed situations and positions in which I too existed. The data obtained would likewise need to be slowly built up and theory tested following analysis either a priori or a posteriori in an interpretivist manner. As such, I realised that if the research was to be deemed credible by others that I had to be extremely reflexive about my effect on the research and mindful of my own attitudes, values, past experiences and perceptions on the data analysis and subsequent conclusions. I was mindful of the work of Greenbank (2003) which identifies that I as a researcher came to this research with a unique constellation of moral, competency, personal and social values that gave me my own unique lens on how to view and interpret my existence. Greenbank (2003) describes how this set of values that are unique to me could impact upon each phase of this research. I have tried through reflexivity to minimise my personal biases as much as is possible by describing my position throughout this thesis, undertaking a systematic approach, laying open my interpretation of the data for others to review how I came to my conclusions, and inviting feedback on my results from participants.

Thus the research was carried out with a constructivist-interpretivist framework which in turn contributed to the subsequent methodological approach followed and methods used to obtain data for the core research question.

In order to assist focus on the aims of the research described above, a series of research questions were posed.

## **1.6. Research Questions**

The question at the heart of the research to be answered by this thesis is as follows:

*Do generational differences exist in current understandings of medical professionalism which may impact the way the ‘Social Contract’ functions in practice?*

In order to structure and guide the research a series of complementary questions were put forward to assist in answering the core question:

- 1) How do current Plastic Surgeons view ‘professionalism’?
- 2) What does ‘profession’ mean to current Plastic Surgeons?
- 3) Can current Plastic Surgeons use the concept of the ‘Social Contract’ to understand their working environment?
- 4) What are the potential consequences for the Social Contract if there are indeed significant generational differences in how professionalism is viewed?

## **1.7. Methodology & Methods**

Methodology has been described (Wellington, 2015) as the “*business of choosing, reflecting upon, evaluating and justifying the methods you use*” (p.33). To do this, I have considered my own ontological and epistemological position as described previously.

The research used a single case study design to examine the perceptions of 20 Plastic Surgeons, within a single Plastic Surgery unit, at varying points in their career. Semi-structured interviews were used to garner the attitudes, experiences and perceptions of participants on professionalism; what it meant to be a member of the medical profession; the doctor–patient relationship; and the Social Contract. To ensure all three generations involved in the medical

workforce were involved in the research, participants were chosen at various stages of their careers (Cohen & Manion, 2011).

Furthermore, documentary analysis of government White Papers and reports from the period 1983–2019 related to healthcare policy was also undertaken (Denscombe, 2017). Rather than being the sole focus of the research, this forms a complementary arm of my research that helps to triangulate data with that from the interviews and, in so doing, improves the generalisability, reliability and validity of the study. The purpose of the documentary analysis is to go beyond the literal understanding of the words and phrases within the documents, i.e. their denotation, and instead unravel the implications and meanings of the words and phrases used given the context in which they were written, i.e. their connotation (Chandler, 2007).

A further and more detailed discussion of the decision to utilise this methodology and methods is explored in Chapter 3 of this thesis.

An outline of this thesis is presented below.

## ***1.8. Thesis Structure***

The thesis is presented in five chapters.

### *Chapter 1 – Introduction*

This chapter introduces the thesis through a discussion of the aims and focus of the research. It does so by placing the research within the current literature – highlighting previously uncharted areas into which this research fits with respect to identifying new knowledge and the value that

it will bring to the literature. I discuss my own positionality along with my professional context. I identify the core research question and the ancillary questions used to frame the research from which the methodology and methods are proposed.

### *Chapter 2 – Literature Review*

In this chapter, the literature was explored with respect to (i) professionalism, (ii) being a member of a profession, (iii) the doctor–patient relationship, (iv) the sociocultural context post-WWII, (v) healthcare policy introduction and implementation in the UK and (vi) Social Contract theory.

### *Chapter 3 – Methodology & Methods*

Within this chapter, the philosophical basis of the research is laid out in terms of my ontological and epistemological positioning in its undertaking. The influence that this positioning had had is explained and described, and the adoption and use of the subsequent methodology and methods used to obtain the research data is explained and described.

### *Chapter 4 – Data Analysis (Interviews)*

The key findings of the participant interviews are described in this chapter with respect to professionalism, being a member of a profession, and the Social Contract. An in-depth discussion of the results and their implications for the research is undertaken.

### *Chapter 5 – Data Analysis (Documentary Analysis)*

Similarly, the key findings of government White Papers and reports are presented in this chapter along with an in-depth discussion of the findings and their consequences.

## *Chapter 6 – Conclusions*

The final chapter draws out the conclusions from the research and the answer to the core research question. The manner in which this research contributes to new knowledge is discussed. The limitations of the research are discussed along with how this research could be carried forward in the future.

## **Chapter 2**

### **Literature Review**

In this chapter I wish to identify the literature that will enable me to unravel the difference between what is meant by the term ‘professionalism’ as opposed to being a member of a ‘profession’. This is vital in considering how Medicine as a single identified body has previously interacted, does so now, and may do so in the future with Government and Society.

The term ‘professionalism’, as will be explained, consists of the behaviours expected within the profession both by the ‘professionals’ and also by those they serve which in the case of Medicine will be the patients. The one single body being the ‘profession’ and I will explore how this is defined and how it is possibly evolving. I will then discuss the significant changes to the doctor–patient relationship (DPR) as a result of changing patient perceptions and experiences that have occurred even during my career.

I will then introduce the concept of Social Contract theory that will allow an understanding of how the changing doctor–patient relationship may impact on the surprisingly complex tripartite relationship between Medicine, Government and Society.

The chapter will culminate with an analysis of the literature that identifies how healthcare policy has developed since the foundation of the National Health Service. I will use the literature to determine what has driven that process and what methods successive governments

have used to push policy introduction through into everyday practice that in turn may have had an impact upon the Social Contract.

It is only when the above relevant literature is appreciated that the data obtained from this research can be fully understood and put into context, the past and present interactions within the Social Contract can be comprehended, and the future direction of the Social Contract can be assessed.

### ***2.1. Medical Professionalism***

Professionalism is characterised by the attitudes and behaviours expected of a member of a particular profession. The literature suggests it is easier to identify poor behaviours as compared to acceptable behaviours as the concept of professionalism is an ever evolving concept that is multi-factorial.

Duff (2004) suggests examples of unprofessional behaviours in Medicine:

- *Intellectual or personal dishonesty* such as the making up of laboratory or research results, plagiarism, not engaging with assessments and cheating at examinations.
- *Arrogance and disrespectfulness* due to a sense of entitlement.
- *Prejudice* founded on age, disability, gender, race or sexual orientation.
- *Poor relationships with colleagues* as exhibited by awkward exchanges due to an inflated sense of self-worth.

- *Lack of accountability* particularly following medical mishaps when lack of insight, empathy and reflection inhibited learning to prevent such happenings occurring again.
- *Fiscal irresponsibility* whereby inappropriate expensive tests or treatments are undertaken.
- *Poor self-learning* resulting in poor participation in continued professional development.
- *Lack of due diligence* demonstrated by poor punctuality, inadequate note-taking and reluctance to ensure patient management plans are completed in a timely manner.
- *Personal excesses* as seen in alcoholism, substance abuse or gambling.
- *Sexual misconduct* as seen in misguided relationships with patients.

Duff (2004) considers the American sense of professionalism. However, it would be difficult to find any doctor in the UK who would not recognise his list as constituting unprofessional behaviours as such in the UK. From my own surgical perspective, the four Royal Surgical Colleges of the UK have come together in the Intercollegiate Surgical Curriculum Project (ISCP) (2016) in which the curriculum for each of the ten surgical specialties is described. Each of the ten curricula have the same generic list of acceptable attitudes and behaviours listed that are expected of all surgical trainees. The ISCP view on professionalism is based on the GMC guidance *Good Medical Practice*. Published originally in 2006, *Good Medical Practice* sets out a wide-ranging set of standards of conduct required of doctors in the UK. This definitive guidance sets out the rules by which doctors are assessed and judged and, therefore, can be viewed as the core tenets of what it is to uphold professionalism in Medicine as discussed later in this section (General Medical Council, 2019a).

From a UK perspective, the National Association of Clinical Tutors UK (NACT) (2018) have listed “*early warning signs*” suggestive of unprofessional behaviours:

- *The disappearing act* exemplified by not answering bleeps, poor punctuality and repeated sick leave.
- *Low work rate* suggested by the undertaking of clinical decisions and tasks in a long drawn-out manner.
- *Ward rage* when disposed to bursts of anger at the least provocation.
- *Rigidity* implied when an individual sticks to guidelines, an inability to compromise or think outside the norm.
- *Bypass Syndrome* occurs when peers work around and avoid as much contact as possible with the doctor concerned.
- *Career problems* revealed in repeated examination sittings and disenchantment with a career in Medicine.
- *Insight failure* when a doctor becomes very defensive in response to any questioning of their knowledge, skills or behaviours and counter-challenges no matter how inconsequential and counter-arguing aggressively in response.
- *Lack of engagement in educational process as shown in* hesitancy to undertake work-based assessments or annual assessment.
- *Lack of professional engagement when the doctor* simply accepts the actions of others and does not reflect on his or her own practice.
- *Inappropriate attitudes* towards others particularly those of a protected characteristic such as age, disability, race, religion, sex and sexuality.

From my own experience, I would agree that these NACT warning signs are the classic tell-tale signs of a doctor failing to progress in their career. I would suggest that it is uncommon for just one particular warning to be exhibited but, in reality, a varying constellation of warning signs are displayed.

If then, we can identify poor professional behaviours from Duff (2004) and NACT UK (National Association of Clinical Tutors UK, 2018), an attempt must be made to clarify what are regarded as appropriate attitudes and behaviours expected of the medical profession. This is not as easy as it first may seem, and this is described by Rowley et al. (2000, p.90) who summarised the difficulty in defining professionalism thus:

*There is no clear, concise and currently relevant definition of professionalism....  
Nearly everyone has in mind certain qualities or values that exemplify professionalism,  
and some of these achieve a certain consensus.*

Given the difficulty in defining ‘professionalism’, it then becomes apparent that to prescribe the prerequisite attitudes and behaviours expected of doctors that are to be learnt, assessed and examined, becomes particularly problematic when trying to lay them down in a curriculum format.

However, the GMC in 1995, and subsequently in 2019, without explicitly using the term ‘professionalism’ set out four key areas termed ‘domains’ to be regarded as appropriate professional medical behaviour and expanded upon these within their publication *Good Medical Practice* (General Medical Council, 2019a). The domains are (1) *Knowledge, skills*

*and performance; (2) Safety and quality; (3) Communication, partnership and teamwork; and (4) Maintaining trust.*

The need to incorporate professional behaviours into training as standard was highlighted by Harden et al. (1999), Simpson et al. (2002) and De Cossart (2005) who suggested suitable professional behaviours were just as essential in learning outcomes as were the acquisition of knowledge and operative skills. Realising the requirement to integrate professional behaviours into teaching, the Surgical Royal Colleges in 2007 introduced curricula for each of the ten surgical specialties, based upon the above four domains from the GMC, but expanded its remit to cover good clinical care, communication skills, teaching and training, keeping knowledge and skills up to date, managerial responsibilities, promoting good health, and probity and ethics (Intercollegiate Surgical Curriculum Project, 2016).

This difference in approach between the GMC and the Surgical Royal Colleges is perhaps due to the GMC almost entirely basing their guidance *Good Medical Practice* on the Canadian ‘CANMEDS Project 2000’ that investigated how society wanted their doctors to conduct themselves with little mention of the term ‘professionalism’ (Frank et al., 1996). Only in subsequent years did the concept of ‘professionalism’ within Medicine gain a foothold such that by the time the Surgical Royal Colleges came around to develop formal written curricula for the first time in the early 21<sup>st</sup> century it became essential to reflect on the topic.

Despite the difficulty, attempts have been made to define professionalism. Dreyer (2010) describes efforts at defining professionalism through the ages from the Hippocratic Oath in

Ancient Greece to more modern theories. However, he left it to others to summarise it as, for example, Barry et al. (2000), “*a set of values, attitudes and behaviours that results in serving the interests of society before one's own*” (p.136) or DeRosa and Paul (2006), “*doing the right thing... regardless of how one feels*” (p.29).

Van de Camp et al. (2004) listed extensively the values, attitudes and behaviours required of medical professionalism following a study of the medical literature between 1966 and 2003 resulting in an analysis of 57 papers on medical professionalism. This identified 90 characteristics of which the most commonly recurring themes were accountability, altruism, integrity and respect. Others such as Arnold and Stern (2006), De Cossart (2005), Duff (2004), Friedson (1988, 1994; 2001) and Rowley et al. (2000) produced similar lists.

Van de Camp et al. (2004) identified three strands running through these attributes of professionalism:

1) *Interpersonal Professionalism*

This involved appropriate working relationships with both patients and other healthcare workers. This particularly concerned altruism with respect to patients and nurturing working relationships with colleagues.

2) *Public Professionalism*

This related to attributes thought most necessary by society to be expected of members of the medical profession, such as empathy, honesty and integrity.

### 3) *Intrapersonal Professionalism*

This theme was associated with those attributes that a doctor should possess to work well as an individual within the wider medical profession, such as appropriate communication skills, maintaining lifelong learning and the capacity to reflect on past practice.

Adding further to the complexity of attempting to define professionalism is the fact that professionalism is not a 'one size fits all' concept but one that can be understood differently between groups even within the same profession. Cruess and Cruess (2008) stressed the different aspects of professionalism that would be expected of a general practitioner as compared to an anaesthetist. They put these differences down to the context in which the doctors practised. Thus, the relevance and importance of various facets of professionalism would differ between specialties, further hampering attempts at generic teaching of professionalism. A report from the Health and Care Professionals Council (2014) also remarked that the professional behaviour of its members was based on the context within which they worked. One example provided was that of the importance of communication in preserving boundaries between the healthcare professional and patient, so that what would be appropriate for one patient may not be for another.

Brownell and Cote (2001) highlighted that trainee doctors on being asked to define professionalism assigned greater importance to competence in skills as compared to trainers who thought most highly of altruism. Similarly, Ginsberg et al. (2002) revealed that medical students' perceptions of professionalism differed to that of their trainers. They concluded that trainees' concepts of professionalism changed with time as they were subjected to the world of Medicine resulting in them eventually mirroring their trainers.

The concept of professionalism is further complicated as not only is there no uniformity within the professions but also none between the professions.

Interestingly, the literature suggests that the way professionalism is considered in other professions, such as Education and Law, is different – but how so?

### ***2.1.1. Law***

The regulatory body for solicitors, the Solicitors Regulation Authority (SRA), has described how it expects members of the legal profession to behave in a professional manner (Solicitors Regulatory Authority, 2019). Unlike in Medicine, there is acknowledgement of the need to maintain the reputation of the law to maintain public confidence in the legal profession as well as the need to respect the authority of legal statutory bodies. Unlike Medicine, the guidance focuses on the ethical running of a commercial organisation that would be considered irrelevant to the GMC's guidance such as:

- Offer a certain level of assistance to clients.
- Ensure the business is run effectively with proper governance and sound financial risk management.
- To encourage equal opportunity and diversity within the business.
- Protect client money and assets.

Whilst this legal emphasis on financial matters and company governance seems anathema to doctors in the UK, that is not so to our peers elsewhere, for example, in the USA, where the

need for appropriate financial management is part of their daily practice. Indeed, Timmermans and Oh (2010) comment on the loss of trust in the USA between the medical profession and society based on apparent financial opportunism as compared to the UK where the main concern for patients is poor clinical practice. Concerns in the USA raised by patients include those of marked changes in practice within and between regions, abuse of the insurance system for financial gain and collusion with pharmaceutical companies. Likewise, Chiu et al. (2019) comment on the difficulties for professionalism in Plastic Surgery in Taiwan as commercialism related to Cosmetic Surgery has encroached on the traditional reconstructive work in the public sector.

The increasing disconnect between society and the medical profession in the USA has led to all medical and surgical colleges in the USA signing up to a standard of practice entitled *A Patient Charter* (Sox, 2002). This charter, for the first time in Medicine, just as in the legal profession, warned specifically of the risk of financial impropriety:

*Medical professionals...have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal...interactions with for-profit industries including medical equipment manufacturers, insurance companies and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties.*  
(p.245)

### **2.1.2. Education**

Whilst in Medicine and Law, the regulatory bodies are separate in organisation from the government, no such autonomy in Education exists where the regulatory body, the National College for Teaching and Leadership (NCTL), is actually part of the Department for Education. The NCTL has a dual role in that it (1) sets out policy for teacher recruitment and workforce planning as well as (2) regulating the educational sector up to the stage of sixth form. One would therefore have to question its impartiality and question if teachers can ever really be regarded as autonomous and self-regulating.

The NCTL has drawn up guidance as to how it expects teachers to behave and, just like its medical counterpart, it lists a number of similar attitudes and values along with specific teaching attributes such as ensuring timely teaching plans, upholding discipline within classrooms and undertaking proper appraisal of pupils' work. However, the NCTL alone requires the need for teachers to exhibit what are described as 'British' values linked to the Prevent Strategy and anti-terrorism legislation (Department for Education, 2013). Such values are noted as: "*democracy, the rule of law, individual liberty and mutual respect, and tolerance of those with different faiths and beliefs*" (p.14).

In contrast to Medicine and Law, Education has a focus not only on the specific teacher-student relationship but it also emphasises the professional role of the teacher beyond the boundaries of the school into their personal lives when it states, "*teachers uphold public trust in the profession and maintain high standards of ethics and behaviour, within and outside school*" (p.14). No such declaration on social responsibility is present in either Medicine or Law.

Higher education has a voluntary code of practice for lecturers from AdvanceHE. Although not statutory in nature, it is recognised as an advisory body by many organisations in the sector. Its code of practice is called the UK Professional Standards Framework (UKPSF) that sets out a nationally recognised benchmarking framework in the higher education sector. It does this by encouraging individuals to consider three areas of their practice:

- Areas of activity.
- Core knowledge.
- Professional values.

Each of these three sections are stratified into increasingly more complex educational roles attained by being able to correspond with proscribed descriptors for each level. Intriguingly, this code of conduct uses a ‘carrot’ approach rather than the ‘stick’ approach of Medicine and Law. The regulatory bodies in Medicine and Law are quite explicit that failure to adhere to principles as set out by the respective statutory body will result in disciplinary action against that individual. Higher Education, on the other hand, encourages continuing professional development by advancement through the three above sections with the awarding of fellowships of increasing rank (AdvanceHE, 2011).

This ranking of individuals encourages personal development and informs prospective employers when individuals are ready to progress up the academic hierarchy. Given that the fellowships from AdvanceHE are primarily based on teaching and learning support, rather than research output of individuals, such a national framework dovetails with the need for Universities to improve their own standard and quality of teaching as required by the introduction of the Teaching Excellence Framework (TEF) in 2016. This looks at the quality

of teaching provided by higher education institutions rather than individuals and is used to guide the government as to whether or not institutions in the sector can raise tuition fees (Higher Education Funding Council for England, 2016). Institutions are rated on student dropout rates, student satisfaction surveys and subsequent employment rates of graduates along with the measurement of the quality of teaching, the learning environment, student outcomes and learning gain. As a result, the institutions receive an award of ‘gold’, ‘silver’ or ‘bronze’. Thus, Universities have encouraged academic staff to sign up to the UKPSF so that this, in turn, will improve the institutional TEF rating, presumably making the institution more attractive to prospective undergraduates. Once again this reveals the ‘carrot’ approach by government within the education sector, albeit there is a ‘stick’ in that student fees and thus institutional funding is dependent upon the TEF rating.

Given that the concept of professionalism evolves with experience and demonstrates national and cultural differences as well as differences within and between professions, it is perhaps not surprising that for many professionalism is difficult to define and remains simply a gut feeling.

Many, therefore, simply quote US Supreme Court Justice Potter Stewart, who found himself in similar difficulty when asked if the film he was being asked to judge demonstrated evidence of pornography or not in the case of *Jacobellis v Ohio* (1964), stating: “*I know it when I see it*” (p.7). This small phrase deftly sums up for many the elusive nature of exactly what is meant by professionalism and the difficulty in conveying what is meant by the concept.

Having considered what is ‘professionalism’ – what then is a ‘profession’?

## 2.2. *Profession*

A philosophical breakdown of what constitutes a profession was performed by Downie (1990) who concluded that a profession required:

- i) A knowledge base that emerges from more than one discipline culminating in high level skills or knowledge.
- ii) A one-to-one relationship between the 'professional' and 'client'. This relationship can either be looked at as a bond between the two, i.e. doctor and patient, or as an attitude, i.e. respect between doctor and patient. Such relationships need to be governed by a recognised statutory body and legitimised by high public esteem for those within the profession.
- iii) Individual members of a profession have a duty to speak out on matters that affect society related to that particular profession.
- iv) To undertake their duties and responsibilities, members of a profession must be free of government interference.
- v) A distinction was made between members of a profession having to be educated rather than just trained. The difference being that an educated person can situate their expertise into the ever-changing context of policy, politics, society and culture.

The medical literature describes a profession on a more practical everyday basis (Carr-Saunders & Wilson, 1933; Elliot, 1972; Abbott, 1988; Hensel & Dickey, 1998; Wynia et al., 1999; Evetts, 2006; Cruess & Cruess, 2008):

- Individuals within a select group have an exclusive right to practice in an area of specific expertise.

- Members of the group work to an ethical code that is more rigorous than society's legal code.
- The group is allowed to self-regulate its membership.
- Members of the group are obligated to put the needs and wishes of those they serve above their own.

In return, society allows individual members of a profession to be rewarded by means of status, power within society, as well as financial gain.

These membership expectations of a profession seem entirely reasonable at face value, yet professions are not without criticism. In particular, political parties are often distrustful of professions. Those on the political left see professions as “*elitist, class-biased and profiteering*” (Downie, 1990, p.148), which acts as a constraint to those born into working-class families who do not share the same values as the middle-class professionals, preventing entry into the professions. Those on the political right are suspicious of professions maintaining a restrictive monopoly on working practices that inhibits competition and thus maintains inflated fees, inhibits development in the public sector and diminishes political influence over the sphere in which the profession operates (Downie, 1990).

Martimianakis et al. (2009) draw attention to the existence of a ‘murkier’ side to professions as a social construct. Hughes (1994, cited in Martimianakis et al., 2009) stated: “*Professionals profess. They profess to know better than others the nature of certain matters, and to know better than their clients what ails them*” (p.832). This appears to reposition the definition of a

profession away from a simple list of attitudes, behaviours, and values to one instead whereby professions are thought of as deliberately setting out a position to protect their own status, power and standing in society to the disadvantage of their clients. This is despite professions publicly declaring their altruistic nature for the benefit of those they serve when, in fact, they are simply maintained for the benefit of their members. The two positions are, however, not mutually exclusive. This is because professional structures and practices can serve the interests of both their members and those they serve. It could be argued that professionals benefitting from their professional practice (in terms of wealth, status, etc.) do not materially disadvantage their clients who benefit from the professional services provided to them.

This positioning in society by professions was termed 'boundary work' by Gieryn (1983) who stated that at the periphery of each profession's knowledge, skills and expertise was the possibility that they may encroach on to other professions, such as the boundaries between doctors, nurses and pharmacists. Professions were portrayed as continually being involved in a political process to charm, convince, and lobby society and government of their importance in advancing their professional goals. These goals were seen as the maintenance of professional power and career chances for members over those from other professions. Friedson (1970) made the concerning suggestion that the medical profession attempted to indoctrinate their members' minds in order to achieve and maintain its self-interests by requiring of their members designated values, attitudes and professional behaviours that all members were expected to adhere to.

Entry to the professions in the 19<sup>th</sup> and early 20<sup>th</sup> century was considerably restricted to those who were of a certain class, had access to education and demonstrated what were regarded as

appropriate personal characteristics. The result being that professions almost exclusively consisted of middle-class white males to the detriment of all other groups as described in *Medicine, Dentistry and Science* (Witz, 1992; Adams, 2000; Ellis, 2014).

Given what seem like remarkably similar defining requirements to identify a profession in its own right by authors over time despite an ever-changing social milieu since the inception of the NHS in 1948, do the commonly held beliefs of what it means to be a ‘profession’ now, in reality, still stand? (Carr-Saunders & Wilson, 1933; Abbott, 1988; Elliot, 1972; Hensel and Dickey, 1998; Wynia et al., 1999; Evetts, 2006; Burke, 2008; Cruess & Cruess, 2008). To consider this issue requires a critical analysis of the fundamental characteristics of a profession set out in the medical literature.

### ***2.2.1. Exclusive Right to Practice***

Medical professionals certainly no longer have an exclusive right to treat or prescribe for patients. There has been blurring of the boundaries between healthcare professions led by the nursing profession (Salvage, 1988; Ghadirian et al., 2014). Nursing has become increasingly ‘professional’ resulting in an aspiration for continuing professional development leading to not only the creation of new managerial roles but also advanced practitioner roles with titles such as Nurse Consultants or Clinical Nurse Specialists. Such nurses can now prescribe, operate and run out-patient clinics (Daly & Carnwell, 2003; British Broadcasting Company, 2004). This extension of nursing roles was taken as an opportunity by government to deal with a shortage of medical staff following a reduction in junior doctors hours as a result of the implementation of the European Working Time Regulations (EWTR) in the late 1990s. A decade on, another medical employment predicament, but this time in general practice, triggered the government

to look for alternatives to medical staffing to reduce the workload on the remaining GP workforce. Hence, the government looked to pharmacists to commence prescribing any drug from the British National Formulary and to run routine health clinics along with the provision of health travel advice (Gerard et al., 2012; Baqir, 2015).

### **2.2.2. *Autonomy & Self-Regulation***

When looking at issues of autonomy and self-regulation, it can be argued that this is diminishing swiftly for doctors. The General Medical Council (GMC) is the recognised statutory body with legal powers to regulate the medical profession. The government in 1997 introduced the White Paper *The new NHS: modern, dependable*. It endorsed increasing patient involvement in the GMC and thus the regulation of the medical profession (Department of Health, 1997). Until this time, there was a professional majority appointed by the profession itself so that there was a semblance of autonomy and self-regulation. Dyer (2003) describes the subsequent impact on the make-up of the GMC Council with relation to medical and patient/lay representatives. Before 2003, there were 104 GMC Council members of which 24% were lay members. Subsequent restructuring consequent upon the introduction of the General Medical Council (Constitution) Order (2008a) resulted in 24 members on its Council with equal representation of medical and lay representation. The Chief Executive of the GMC is not on the Council but is expected to be a lay member. Additionally, selection on to the Council was made more transparent by making appointments through the Public Appointments Commission against explicit criteria. Moreover, the GMC Council is now accountable directly to Parliament, rather than previously to the Privy Council (Waring et al., 2010).

Accordingly, the medical profession has lost the overall majority vote within its own regulating body. Adding to this loss of medical autonomy is the ever-increasing governance and regulation of the medical profession (Burke, 2008). I see this in my own working practice with the requirement for an annual job planning process that allows absolutely no wriggle room for me to stray from its demands. This ever-expanding regulation can be demoralising, making medical professionals believe that they are now just treated like employees. The sense of bewilderment is concisely summarised by Edwards et al., (2002, p.835):

*The developed world has seen significant reductions in medical autonomy and increases in accountability as a result of the increasing evidence base and a long running attempt to bring medicine under managerial and cost control by governments...This has resulted in the growing use of guidelines, protocols, audit, regulation and inspection that many doctors perceive as eroding their control over their professional lives.*

Access to membership of professions is also controlled from within the membership as part of self-regulation. In the United Kingdom entry to practice Medicine is tightly regulated by the GMC that only allows those that have qualified from recognised medical schools within the UK or abroad to practice in the UK. This control by the GMC continues into doctors' careers with only those who undertake annual appraisal on a rolling 5-year cycle of 'revalidation' being granted a licence to continue practising. Given the increasing patient involvement within the hierarchy of the GMC, patients now have a significant input into the everyday working lives of doctors.

### ***2.2.3. Placing Patients' Needs Above Those of Doctors***

The issue of trust as an indicator of the state of the relationship between the medical profession and society is open to interpretation. Patients now have ready and constant access to all forms of media and the internet, resulting in rapid and widespread notification of any medical misdemeanour. In the UK, recent medical scandals have involved either individual poor practice or institutional failures. Ultimately, this has led to increasing societal anxiety about the professional behaviour of doctors which, interestingly, is more so amongst the younger generations as compared to the elderly who continue to maintain levels of respect for the medical profession (Charles, 2015; Medical Protection Society, 2015). Despite the incidence of criminal medical malpractice being due to the actions of only a few rogue individuals, society appears to have lost faith in the medical profession putting the needs of patients above their own interests, as evidenced by patient surveys (Timmermans & Oh, 2010; Blendon et al., 2014).

The Coronavirus pandemic has brought into stark relief the risks that doctors can face in treating patients. Sheather and Chisholm (2020) argue about the ethics of treating patients in the scenario of inadequate personal protective equipment (PPE) being provided by government. It is argued that if the government has failed in its duty to protect doctors then doctors should not require a duty of obligation to treat Coronavirus patients as they themselves have a duty to their families and the NHS to stay well. I have never before seen open discussion of doctors attempting to reason why they should protect themselves rather than treat patients, and this may in itself represent the evolving nature of what it means to be a member of a profession.

This potential shift in medical thought may alter the doctor–patient relationship, but what other factors are at play in the doctor–patient relationship?

### ***2.3. The Doctor–Patient Relationship***

For the purposes of this thesis, I have referenced the post-war years since the commencement of the NHS as this is the point at which one can state that Medicine, the Government and Society first came together in the UK in a formal relationship to provide healthcare for all citizens.

What, then, are the factors since WWII that have driven the changes in the doctor–patient relationship (DPR) because, as we have seen, both the concepts of ‘profession’ and ‘professionalism’ have evolved with time?

#### ***2.3.1. Patient Engagement***

Burke (2008) has described the increasing role of patients in healthcare policy since the 1970s which has provided patients with a greater say over their own healthcare. Farrell and Gilbert (1996) explain the commissioning of Community Health Councils (CHCs) in 1974, allowing members of the community to directly oversee and comment upon local healthcare services such as GPs and hospitals. CHCs did not achieve their stated aims according to Hogg (1999) as a result of inconsistent action between CHCs across the UK, insufficient authority, inadequate finances and little accountability.

However, the government continued to pursue its plan to give patients an increasing role in decision making in their own healthcare along with their doctors, introducing a series of government White Papers. The first, in 1989, entitled *Working for patients* (Department of Health, 1989), charted the government's strategy to improve healthcare by providing patients with choice as to where they received that healthcare. However, such proposed patient choice faltered as there was no obvious means by which patients could exercise their right to choose (Mold, 2010).

In 1996, the Department of Health introduced the White Paper *Patient partnership: building a collaborative strategy*. This paper introduced the notion of patients, doctors and management working together as a collaborative team. It was hoped that there would be a dual approach. At service level, the hope was to insist healthcare providers provided patients with the knowledge, skills and support to assist and enable local policy-making. At an individual level, the plan was to encourage patients to involve themselves in their own treatment choices. Consequently, the Department of Health (1997) published *The new NHS: modern, dependable* that encouraged increased patient involvement in the planning and running of NHS services. Such patient participation was made compulsory on NHS Trust Boards to reflect the wishes of the local community. For the first time, senior management meetings involving NHS Trust Boards were to be held publicly with production of annual reports to allow scrutiny by those who would use those very healthcare services. An annual patient survey was introduced to appraise patient experience using NHS services. It was this White Paper that pioneered the notion that patients should be involved in the professional regulation of doctors.

The Department of Health (1997) published *The NHS plan* that described the need for a UK-wide consultation process on how both patient and lay opinion could be further harnessed to shape the future direction of NHS strategy. Significant emphasis was placed on empowering patients by encouraging patient and layperson participation at all levels within every organisation that made up the NHS. The paper highlighted the need for focus on patient choice; provision of increased patient information on their own health needs and local healthcare providers; acknowledgement of the results of the national patient survey in representing patient needs, wants and concerns; the requirement for patient and lay participation at all levels of health services; and the setting up in each Trust of a Patient Advocacy and Liaison Service (PALS) to provide an accessible means to allow patients who wished to express concern about their treatment to do so if they wanted.

*Better information, better choices, better health* (Department of Health, 2004) asserted that those patients with greater access to health information made improved decisions about their treatment options specific to their individual needs. It was, however, acknowledged that in order to allow more confident patient participation in decisions made about them with clinicians, better communication skills on the part of both doctors and patients would be required.

The *Patient's Charter* was introduced in 1991 (Department of Health, 1991) and subsequently updated in 1995 (Department of Health, 1995), pledged certain rights for patients within the NHS. This charter was notably criticised by healthcare providers and the medical profession, as noted by Farrell and Gilbert (1996), due to the raising of patient expectations beyond what the NHS could provide at its initiation. In 2009, the *Patient's Charter* was updated and retitled

the *NHS Constitution for England*, which in turn was updated in 2015 (Department of Health, 2015). Despite these updates, the guiding principle remains “*the patient will be at the heart of everything the NHS does*” (para. 4).

In 2010, *Equity and Excellence: liberating the NHS* was published by the Department of Health, stating, “*we will put patients at the heart of the NHS, through an information revolution and greater choice*” (p.3). The paper proposed to increase patients’ access to healthcare information, including their own medical records, at the same time as setting up the new body ‘Health Watch England’ to collect, collate and represent patients’ views and opinions about their NHS experience. Additionally, tendering of healthcare service contracts was opened up beyond the NHS to private providers to increase patient choice.

Given this historical overview, it is evident that successive governments of whatever political persuasion have knowingly focused on increasing patient participation in managing the NHS. Mold (2010) sums up this societal shift from one where patients were passive receivers of healthcare to one where they became active decision-makers in a collaborative manner with doctors in deciding upon their treatment choices.

Alongside this active government attempt to increase patient participation was a series of policy changes with regard to the regulation, governance and accountability of the medical profession.

### ***2.3.2. Professional Monitoring***

Rivett (1997) describes the founding of the NHS in 1948 as positioning the health service in direct government control for the first time. However, initially, the professional autonomy of the medical profession remained unaffected with doctors being allowed to continue to be self-regulated. This was confirmed by Rosenthal (1995) who explained how entry into the medical profession and subsequent regulation was carried out without any public input but solely by doctors for doctors.

The Department of Health and Social Security (1983) brought out the *Griffiths Report* urging the use of direct management of the NHS at every level. This was based on the belief that there was a complete absence of managerial structure both centrally and locally that needed to be corrected. It was advised that a new central NHS management board be set up with managers being placed into every NHS department regionally and locally with the stated aim of freeing up doctors' time to spend more of it with patients. This subsequently led Gorsky (2015) to state “*the existing system of consensus management was replaced with general management*” (p.89) within the NHS.

The White Paper *Working for patients* in 1989 continued this managerial effort of increasing efficiency and accountability. Additionally, this paper introduced fundamental changes to the employment contracts of Consultants that for the first time specifically defined employment roles, monitoring and performance management (Hunter, 1994).

Hughes and McGuire (1992) noted in Burke, (2008, p.30):

*Although none of these developments amounts in itself to a frontal challenge to medical authority, their cumulative effect will be to enhance the power of the manager vis-à-vis the clinician.*

By 1990, it was the turn of general practitioners to receive new employment contracts when a new UK-wide GP contract was enforced upon GPs without their approval (Rivett, 1997).

The White Paper *The new NHS: modern, dependable* published in 1997 concentrated not only on the pre-eminence of the patient but also the perceived requirement to performance manage hospitals in order to improve standards and outcomes for patients (Department of Health, 1997). This was to be carried out via implementation of evidence-based medicine through National Service Frameworks (NSFs) to ensure uniformity in clinical standards across the UK. The NSFs were to be monitored by the National Institute for Clinical Excellence (NICE). NICE in turn would assess the financial implications of commencing new treatments and set the standards to be tracked by the NSFs subject to the latest peer-reviewed research. A Commission for Health Improvement (CHI) was also formed to review the standard of local healthcare providers by monitoring feedback from patients based on a new annual UK-wide patient survey.

The focus on performance management of doctors was further reinforced in the White Paper *A first class service: quality in the new NHS* (Department of Health, 1998) through the formation of the National Framework for Assessing Performance. It was stated “*the Government will ensure there is accountability for both efficiency and quality throughout the NHS*” (Department of Health, 1998, p.6).

The Department of Health (2000b) published *An organisation with a memory*, suggesting the roll out of a mandatory reporting system for serious untoward medical incidents within the NHS. This led in time to the formation of the National Patient Safety Agency (NPSA) whose aim was to minimise patient harm caused by medical error by the systematic collation, scrutiny, audit and dissemination of patient safety data (National Patient Safety Agency, 2005).

The government White Paper in 2007 *Trust, assurance and safety: the regulation of health professionals* introduced proposals to ensure parity in numbers at the GMC at all levels between lay and patient representatives and that of medical members. This was indeed an important milestone where patients were given explicit parity with members of the medical profession in regulating its members. It also proposed in the wake of the Harold Shipman case, the requirement for doctors to secure a licence to practise to remain on the medical register. This licence would be obtained by means of a compulsory annual appraisal culminating every five years in the presentation of a body of evidence to the GMC to enable revalidation. This required doctors for the first time ever to prove to the GMC that they kept up to date with the knowledge, skills and professional behaviours expected of their specialty. The increasing representation of the patient was left in no doubt (Department of Health, 2007):

*For any consideration of the regulation of health professionals, the preservation of that trust has to be the starting point. Professional regulation must create a framework that maintains the justified confidence of patients in those who care for them. (p.1)*

*Its overriding interest should be the safety and quality of the care that patients receive from health professionals. (p.2)*

This notion of overseeing the medical profession was continued by the White Paper *Equity and excellence liberating the NHS* (Department of Health, 2010) which proposed the setting up of ‘Monitor’. This was to be a semi-autonomous body to ensure the money spent by the NHS did so based on best practice and evidence-based medicine. The stated aim being to drive down costs and improve efficiency, but, in reality, it was being used as a tool to ensure medical professionals followed guidelines set out by NICE.

The legal framework by which there could be increased competition from private providers, the setting up of ‘Health Watch England’ and ‘Monitor’ was set out by the *Health and Social Care Act* (Department of Health, 2012). There was wholesale reorganisation of the NHS as Regional Health Authorities (RHAs) and Primary Care Trusts (PCTs) were abolished and replaced by Clinical Commissioning Groups (CCGs). This had the effect of changing those who controlled the health budgets for local communities from faceless bureaucrats at RHAs and PCTs to GPs for whom patients had direct links to discuss their access to care should there be funding issues (Full Fact, 2013).

This shift towards patient dominance was a gradual step-by-step process over several decades as set out in this chapter. The push to listen to patients and society was driven by a series of medical scandals that the government needed to address.

### ***2.3.3. Medical Scandals***

The Medical Protection Society (2015) describes how, from the 1970s onwards, the medical profession and its regulation faced increasing patient and public criticism. This was due to the inability of the medical profession to identify in a timely manner doctors who had harmed patients, and to deal appropriately with them by either remediation or sanction.

Medical scandals involved either inadequate practice by individual doctors or systems failures within hospitals causing patients to be harmed. The government initiated a number of reports steered by high-ranking members of the legal profession into these scandals to learn lessons to ensure the mistakes found would not be repeated. The following are examples of investigations into individual poor practice: Ritchie, (2000) against Rodney Ledward; Matthews, (2004) against Richard Neale; Pauffley, (2004) against Clifford Ayling; and Fleming, (2005) against William Kerr and Michael Haslam.

There have also been investigations into hospital systems failures that have included the Bristol Inquiry led by Kennedy (2001) into avoidable deaths precipitated by inadequate Paediatric Cardiac Surgery, resulting in a dramatic change in the public mood. Smith (2005a) led the inquiry into the GP (and serial murderer) Harold Shipman which subsequently had a deep effect on the public, resulting in the commencement of an annual assessment of doctors. The idea being to make the assessment process of doctors more transparent and more regular on an annual basis, leading to a licence to practise on a five-year rolling summative process called 'revalidation'. Excessive deaths at the Stafford General Hospital led to the Francis Report (2013) that drew attention to issues of lack of care and compassion amongst the doctors, resulting in significant public criticism of the medical profession. More recently, the conviction of Ian Paterson for undertaking grossly negligent breast surgery has prompted a government inquiry that recommended further regulation, but on this occasion in the private sector to bring it up to the same level of oversight as the NHS sector (Alderson, 2020; James, 2020).

The reaction of the public to this constant stream of medical scandals and the subsequent lessons learnt has resulted in the accelerated move away from the autocratic system where the

doctor was in complete control of the DPR to a more patient-centred one where doctors and patients work together in a collaborative partnership.

#### ***2.3.4. Information Technologies***

Rivett (1997) and Lupton (2003) describe how the introduction of new forms of media resulted in the medical profession having to adapt to its ever-changing portrayal. In the immediate post-WWII years there was negligible coverage of either the medical profession or healthcare topics within any form of public media. By the 1960s, newspapers and magazines covered medical topics, but, even then, this was in a deferential manner often referring to the noteworthy achievements that Medicine could provide for patients by doctors who always acted in patients' best interests.

In the 1970s, TV programmes on Medicine changed from programmes in a documentary format providing factual information to more drama-based programmes that started to portray doctors as less than ideal in both a professional and/or private capacity.

The 1990s saw the widespread availability of the internet arrive, resulting in patients gaining access to medical information almost as freely as doctors at a time and place of their choosing (Price and Oliver, 2007; Keengwe et al., 2008). This increasing access to knowledge with which patients could make decisions about their own healthcare in an informed manner without recourse to their doctors fed into other changes that were going on in wider society.

The emergence of the internet and new information technologies extended beyond simple access to knowledge for patients but formed the basis for new learning technologies within all sectors of education that was embraced by the medical profession.

#### ***2.3.4.1. Learning Technologies***

All Consultants are either Baby Boomers or Generation X and as such learnt almost exclusively through the direct passing on of knowledge from their own trainers by means of tutorials, bedside and clinic teaching, lectures, and access to knowledge via journals or textbooks. There was no access to learning technologies such as computers or the internet. Instead they were limited to chalkboards, flip charts, acetate sheets on overhead projectors and carousel slide projectors. Teaching was formal at a prescribed date, time and venue organised by the medical school.

Trainees in this research were all Generation Y and the situation for them is more complex. Whilst all the previous learning techniques remain available to them, they have always had access to computers, the internet and, more recently, social media platforms which are second nature to them as compared to the proceeding generations. As such, Generation Y have a tendency to use a greater number of sources for their knowledge in a less formalised manner in that they have '24/7' hour access to knowledge through the internet, and thus they can choose the date, time and venue for their learning to a much greater degree than previous generations (Mangold, 2007; Keengwe et al., 2008; Eckleberry-Hunt & Tucciarone, 2011). Whilst there has not been a complete change in teaching techniques, the need for direct contact between trainer and trainee has been lessened given the ready availability of learning technologies that allow the use of podcasts, webinars, blogs and virtual learning environments (VLEs).

This difference in learning styles has been recognised within the medical profession with the introduction from the 1990s onwards of problem-based learning into medical school curricula either partially or totally. This resulted in a shift away from the traditional formal lecture and textbook approach to one of problem-based learning (PBL) where the trainee took the lead for their own learning. Key topics from within the curriculum were used as a starting point for students to learn about a topic individually before taking part in group tutorials (Wood, 2003). This learning was facilitated through the use of learning technologies to access knowledge from multiple sites and at a time of trainees' choosing. Wood (2003, p.328) describes PBL through group learning:

*[It] facilitates not only the acquisition of knowledge but also several other desirable attributes, such as communication skills, teamwork, problem solving, independent responsibility for learning, sharing information, and respect for others.*

However, there is no definitive answer about the benefits of PBL and the literature is awash with debate about whether PBL has any advantage over ongoing traditionally taught medical school courses (Wood, 2008). This has resulted in a subsequent re-thinking in the role and dominance of PBL in medical education.

However, learning technologies are one factor amongst many (such as EWTR) that have changed how teaching is undertaken and that consequently have resulted in a potentially more distant relationship between Consultant and trainee as the emphasis from traditional face-to-face learning has shifted to a more distant 'virtual' online relationship. In the context of the hidden curriculum, this is an important factor as discussed in section 2.5. The increased use of learning technologies within Medicine can be viewed through a lens that suggests it is one further factor that has diminished the time spent together for Consultant and trainee resulting

in less impact from the hidden curriculum in its ability to pass on the professional traits that have historically been acquired in this way.

However, to return to Mangold's cautionary note (2007), not everyone born within the confines of Generation Y are such 'digital natives'. This is a particular issue in developing nations. In poorer parts of the world, where access to knowledge and other parts of the world is limited and funding is absent for the latest learning technologies then learning styles are more likely to remain comparable to those of Baby Boomers and Generation X (Wang et al., 2003; Unwin et al., 2017).

### ***2.3.5. Societal Change***

Following WWII, UK society became increasingly disenchanted with what might be termed the 'establishment', such as political parties, the armed services, the civil service, and the professions. This social development could be publicly identified through movements such as the Campaign for Nuclear Disarmament (CND), anti-war protests and hippy culture (Hassan, 2001). This change in societal values reflected to a degree what has become known as 'postmodernism', a philosophical approach that was championed by, amongst others, Foucault who contemplated the relationship between power and knowledge. Foucault examined how government used both knowledge and power to maintain its authority over both individuals and society through the instruments of various government bodies. Foucault (2014) considered the process by which a government changed over time to deliver healthcare to the general population, as occurred in the 18<sup>th</sup> century, during which time improving the health of all individuals would in fact be for the greater good of all in society. The thinking being that as healthier individuals attended to work more reliably, they were more productive and of greater

economic worth to society and that, in turn, had the added benefit of reducing the cost of healthcare.

Foucault (2014, p.114) noted:

*Medicine was no longer simply an important technique in the lives and deaths of individuals...it became...an essential element for the maintenance and development of the collectivity.*

In essence, Foucault described how Medicine changed from being a simple relationship between doctor and patient to one where the process was actively managed through decisions made by groups of doctors and increasingly governments. As we will see later, this tripartite relationship between Government, Society and Medicine is the bedrock of the Social Contract.

The literature summarised by Timmermans and Oh (2010) highlights the rise of consumerism as a crucial social and cultural development in the post-war UK.

### **2.3.6. Consumerism**

The questioning of those previously given authority based on expertise spread to the medical profession, resulting in increasing demands for second opinions especially in the wake of a series of medical scandals as described above. By the 1980s consumerism gathered pace as a result of increased access to media, particularly TV, expanding patients' awareness of their rights, knowledge and ability to litigate. This upsurge in consumerism should not be regarded as unexpected given repeated efforts by successive governments to direct healthcare towards the needs of patients by actively encouraging their participation (Mold, 2010). The

establishment of the internet only served to encourage consumerism further by providing patients with instant knowledge on a boundless range of medical issues, information and feedback about individual doctors, and, once again, healthcare policies that permitted patients to actively manage their own healthcare, rather than being wholly dependent on doctors.

Davison et al. (2000) describe the formation of self-help groups that acted either as a voice for all patients or instead for smaller more specific health groups. This allowed patients to seek advice and support on healthcare issues outside the normal boundaries of Medicine at a time and place of their choosing. Hazelgrove (2002) and Mold (2010) describe how influential one such group, the Patients Association, became following its inauguration in 1963. It was formed following clinical trials carried out at the Hammersmith Hospital on patients without their knowledge or consent. Accordingly, a founding principle of the Patients Association was that patients had the absolute right to self-autonomy and self-determination. This was determined on the premise that a patient's body was their own and that they alone should decide what happened to their body, no matter how a doctor might think otherwise. This mounting need for patient-centred control of their own bodies struck a chord with the postmodernist movements of the time.

The increasing notion of patients' 'rights' along with a greater sense of citizenship was a familiar topic in the post-war era. Following the formation of the NHS in 1948, it was not long before patients felt they had a right over how it was run and how it could serve them, particularly given that they were now paying for the NHS through their hard-earned taxes (Mold, 2010). In fact, the NHS has not discouraged this sense of citizenship in patients given the *Patient's Charter* (Department of Health, 1991) that in time transformed into the *NHS*

*Constitution* (Department of Health, 2015) with their evocative names and lists of patients' rights within.

Whilst patients were being empowered, the practice of Medicine became ever more shackled (Timmermans, 2010).

### ***2.3.7. Evidence-Based Medicine***

Especially in the USA, there was increasing unease about the financial sustainability of health services given the rate of rising costs due to the increased range and availability of drugs, and the ever more novel medical technologies and surgical techniques that could treat conditions not previously thought possible. Insurance companies realised that there were no standardised healthcare costs, and that there were regional differences in practice that led, in turn, to significant variations in clinical practice that weakened public trust in the medical profession. To combat increasing costs, evidence-based medicine (EBM) was pioneered to standardise practice, and this has progressed to become standard everyday practice throughout the world.

The Cochrane Collaboration was set up in 1993 to undertake systematic reviews of randomised controlled trials in particular areas to decide best practice that all clinicians should follow (Bero & Rennie, 1995). Rivett (1997) noted: "*It was one thing for managers to challenge clinical decision-making; now management sometimes dictated it*" (p.383). The use of guidelines for clinical practice in the UK became further established in medical practice by the introduction of the NICE guidelines that determined whether treatments introduced into the NHS were financially sustainable and clinically proven (National Institute for Clinical Excellence, 2017).

Correspondingly, the introduction of evidence-based medicine had the effect of further restricting a doctor's individual practice because to stray from any formal set of guidelines risked disciplinary action, loss of remuneration and litigation.

As we have seen, societal trends triggered the doctor–patient relationship (DPR) to evolve. In the immediate post-war years, the DPR was ‘paternalistic’ whereby the doctor was dominant, the only one who had access to knowledge, and the patient acted in a subservient manner. An extreme example of this relationship would have been what occurred at the Hammersmith Hospital in the 1960s (Hazelgrove, 2002). Yet, it seems that since WWII, the DPR has swung quite the other way. Shared decision-making within a partnership is now the accepted form of DPR, as explored by Stiggelbout et al. (2015), resulting in patient autonomy as the prominent position whereby patients with mental capacity can determine their healthcare based on the knowledge provided to them by their doctor, even if the doctor disagrees.

Dewey (1927) might be argued to be a visionary as he argued in the inter-war years that democracy was in peril due to the increasing struggle of ordinary members of the public to understand their progressively fragmented, technology-driven society that was led by professionals who dominated expertise in their fields. Dewey asked for a change in the dynamic of the relationship between citizen and expert. In so doing, he argued that professionals should better justify their expertise and provide solutions to society's difficulties for which in turn the citizens would ponder and decide the best options to take forward.

Parsons (1951) studied the DPR immediately following WWII. He noted doctors actively used their knowledge in the best interests of their patients. Consequently, doctors were rewarded with social status, autonomy and self-regulation. Equally, patients were passive and were without access to knowledge of how to improve their health, requiring doctors to improve their welfare. Elston (1991) suggested this asymmetrical DPR existed into the 1980s. Rivett (1997) describes the changing attitudes of society in the 1980s that started to question the influence of the medical profession. This would chime with the sentiment of postmodernity and the introduction of government policy as described in this chapter whereby there was a general move in society towards making the professions such as Medicine answerable to the public.

This inequity raised concern with Foucault (1973) who depicted the dehumanising effect doctors had on patients by their examination, diagnosis and treatment based on signs and symptoms of disease. Accordingly, doctors were prone to treating the diseased body part rather than the patient as a defined whole individual. This situation permitted doctors to maintain a professional distance, and thus create a barrier, a situation in which the patient played no active role but accepted what happened to them in a passive manner. Illich (1974) described the paradox that doctors who, while allegedly protecting patients and putting their needs above their own, were in fact institutionalising them in order to preserve their power and status. In so doing, doctors were thought to be inhibiting the ill from helping themselves as individuals, but this was also thought to be to the disadvantage of society as a collective group. Illich (1989) persisted in this criticism of Medicine describing it as self-interested rather than safeguarding its duty of social responsibility.

The changing DPR was recognised by the General Medical Council (2008b), who introduced guidance on obtaining fully informed consent that expressly placed patients on an equal standing with doctors. The guidance signposted for doctors how, in collaboration with patients, both parties could come to a joint agreement on healthcare decisions. The GMC left no doubt that the DPR was a partnership of equals. The role of the doctor being to impart their clinical knowledge, inform the patient of all reasonable treatment choices whilst in turn the patient having received the doctor's expertise, would come to the decision as to what treatment path they would follow in an autonomous manner.

Patient autonomy has subsequently become enshrined in UK law as the legal system responded to societal change. The law legitimised medical autocracy following WWII in the Bolam Test case (*Bolam v Friern Hospital Management Committee*, 1957). This case involved a severely depressed patient treated by means of electroconvulsive therapy. During this therapy, the patient sustained a number of fractures to the limbs leading to a claim of medical negligence. The Court directed: *"a doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art"* (p.1). A doctor in 1957, therefore, was protected from being prosecuted for medical negligence if it could be proved there were other doctors from the same specialty who would have acted in a similar manner. The role and involvement of the patient played no meaningful part in the legal process.

Increasing patient autonomy was finally recognised in a legal sense following the *Montgomery v Lanarkshire Health Board* (2015) legal case. In this case, a patient suffered a delayed labour resulting in the child being born with brain damage. Duffy (2016) explained how the Court

came to the decision that the long-held ‘paternalistic’ DPR did not reflect current social norms in how patients and doctors interacted in 2015 as compared to the Bolam ruling in 1957. The Court decided that patients were well able to assimilate, digest and process the benefits and risks of treatment choices to allow patients themselves to come to a choice that best met their individual needs. The role of the doctor was relegated to one of simply imparting and communicating their medical knowledge to a patient who in turn would make their decision in an autonomous fashion. This, in fact, mirrored guidance already given by the General Medical Council (2008b) on consent.

In one brief statement the Court in its Montgomery ruling (2015) overruled the Bolam Test bringing the law into line with social reality when stating:

*The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it. (para 87)*

From 2015 onwards, the tables have turned in that it is no longer what a doctor thinks is reasonable, but, in fact, it is now what a patient might think reasonable, as to whether medical negligence has occurred or not.

The difficulty for doctors is that there is no definition of a ‘reasonable’ patient to determine at what level consent is obtained. Concerns centre around the pressures on service delivery that provide insufficient time in clinics to appropriately consent patients to all reasonable risks of

every potential treatment option they may have in order to allow patients to come to a state of self-determination as required by the Montgomery v Lanarkshire Health Board (2015) ruling. If patients are not consented in a fully informed manner then this significantly increases the risk of medical litigation (Cooper et al., 2017; Montgomery and Peter, 2017).

How, then, can we explain the changes in the practice of Medicine since the NHS began? Is there some way of explaining the evolution of the terms ‘profession’ and ‘professionalism’ along with the changing DPR within the sociopolitical milieu of the time?

I would suggest that the means by which to consider these issues involves looking at the introduction of healthcare policy during the time of the NHS as well as Social Contract theory.

#### **2.4. *Healthcare Policy***

Government use of policy introduction to mould and guide the direction of all education tiers is acknowledged (Steer et al., 2007). I will seek to explore how the UK government has initiated and progressed policy through repeated introduction of White Papers during the lifespan of the NHS with specific reference to how that has impacted upon the DPR.

To scrutinise policy, it is essential to understand the ‘drivers’ which push the process forward. Policy drivers being the intended aims, outcomes and objectives of a policy. Drivers can be either explicit, as seen in White Papers, government statements or speeches, or may be implicit,

in that policy may lurk in ‘silences’, such as the non-engagement of certain stakeholders in documents, speeches or feedback, about which a researcher must be aware (Hyatt, 2013).

To give warrant to my historical policy analysis from 1948 to this day, it is recognised by academics that policy is indeed a historical process (Taylor, 2007). Moreover, it has been acknowledged that the mounting effect of repeated policies over time can be value-laden and have not only the premeditated, but also unintentional, consequences when put into the sociocultural environment of other policies, institutions and relevant stakeholders both at home and abroad (Ball, 1993). This has led to some suggesting that a historical analysis of policy requires a trajectory-style approach considering its production, implementation, evaluation and repeated consideration of context which I hope to mirror in this research (Hyatt, 2013).

The means by which policy is encouraged are known as the ‘levers’, and these are described as being what “*the state has at its disposal to direct, manage and shape change in public services...functional mechanisms through which government and its agencies seek to implement policies*” (Steer et al., 2007, p.177). Levers used in the public services by the government tend to be appraisal, professional regulation, remuneration, pensions, funding, quotas, inspection and target setting, all of which facilitate the implementation of the policy. Consequently, levers are political in nature used to enforce the political view of the day.

Thus, understanding policy evolution requires consideration of the drivers and levers with respect to the context in which they are introduced and used at a national, regional and local level.

I set the historical parameters for the assessment of healthcare policy to be the years following WWII for two reasons. Firstly, formal control of healthcare services for the general population by the government occurred for the first time with the origin of the NHS in 1948. Secondly, the literature suggests that changes in the sociocultural environment, such as consumerism, took place concurrently and that in turn influenced the DPR. Additionally, I concentrated on those years in which I had a presence in the medical profession after commencing at medical school in 1983. This was a personal decision because, as I have explained, one of the reasons in undertaking this research was to try and understand my increasing conviction that my personal sense of power, authority, prestige and financial well-being has changed during the course of my career.

#### ***2.4.1. Political Context***

In the immediate post-WWII years, the dominant UK government philosophy was Keynesian in nature where supply and demand was closely regulated by fiscal monetary policy. The Oil Crisis of 1973 caused a global economic shock that not even such direct fiscal policy could manage (Ainley, 2004; Newman, 2000). This resulted in a new political ideology known as ‘neoliberalism’ that was embraced by the Thatcher government in 1979, responding to fears that governments could not deal with complex social problems that the free market would manage more efficiently both in terms of time and cost. This resulted in a more laissez-faire approach by governments to intervening in public services such as the NHS and the education sector (Palley, 2004; Higham & Yeomans, 2011). As such, government withdrew from direct hands-on control of the economy leading to privatisation of services and a reduction in bureaucracy. This change in ideology resulted in less government intervention but correspondingly greater contribution from the private sector and individuals.

Neoliberalism advocates the idea of increasing the primacy of individuals' rights as commented upon by Newman (2000) who stated, "*citizens and clients were recast as consumers*" (p.45). This new political doctrine was subsequently termed 'New Public Management' as part of which subsequent successive governments used levers to 'steer' the NHS (Hyatt, 2013).

In 1997, New Labour conceived a 'third way' based on modernisation that continued market reforms. It emphasised the sense of consumerism amongst users of public services by increasing the availability of multiple providers to improve consumer choice as well as increasing accountability of providers to their users if services fell short. This was described by Newman (2000) as "*updating services to match the expectations of modern consumers*"(p.46). This 'third way', introduced by Labour, extended the New Public Management arms-length type of government, introduced by the Conservatives, and achieved policy goals using non-elected 'Quangos' to deliver services, whereupon the government became more distant in nature, simply turning into a "*regulator of services, setter of standards and guarantor of quality*" (Newman, 2001, p.83) rather than providing or regulating public services directly.

Thus, one starts to understand why a shift in the DPR occurred, consequent upon changes in political dogma as individuals were increasingly treated and regarded as active consumers of public services. As consumers, patients became rather more than just passive individuals, but began to actively expect rights when receiving healthcare (Sitzia & Wood, 1997; Ham & Alberti, 2002; Veitch, 2010).

This literature review reveals increasing patient engagement in the use of their healthcare system encouraged by successive governments through repeated policy introduction. Simultaneously, the literature review reveals government also used repeated policy introduction to increasingly regulate the medical profession. Added into this mix of changing political ideologies were changes in society that initiated a shift in the balance within the DPR, such as successive medical scandals, loss of deference and increased patient access to knowledge that ultimately led to changes in the legal arena that bolstered the rights of patients.

Into this political context (as we have seen in sections 2.2.2. and 2.3.1.), successive UK governments introduced healthcare policy that both increased the regulation of the medical workforce as well as increasing the rights and expectations of patients. However, as became clear from the pilot interviews discussed in section 4.1.1. the introduction of European Working Time Regulations (EWTR) must also be considered as part of this political mix. These regulations were aimed at ensuring employees in all employment sectors did not work excessively long hours and had appropriate and spaced-out rest breaks.

Whilst EWTR was introduced in 1998, it was not put into working practice until 2003 with the purpose, over time, of reducing legal working hours and introducing mandatory rest periods. Given that within the medical profession in the late 1990's, junior doctors were routinely contracted with hours well in excess of those required by EWTR, there were consequences for the NHS and in particular junior doctors working hours and their training. Over a number of years, legally permitted weekly working hours were gradually reduced. Subsequently, the 80–90 hours per week that trainees worked prior to 2003 came to an end. Progressively, working

hours were reduced to 72 hours/week in 2004, 56 hours/week in 2006 and finally the current 48 hours/week in 2011 (Royal College of Surgeons of England, 2014).

Such a large reduction in working hours necessitated wholesale changes in working practices that the government required to be (1) cost 'neutral', (2) ensuring rotas were sufficiently staffed 24/7 across the entire week but with (3) no change in the overall number of doctors. These changes were introduced progressively between 2003 and 2011.

Prior to 2003, doctors worked in a hierarchical team structure known as a 'firm' with trainees learning in an apprenticeship-like model. Trainees worked extended daytime 'office hours' as well as a nightly 'on-call' system, on a rolling basis. Following implementation of EWTR, the NHS, in order to fulfil its legal requirements, started to dismantle the 'firm' structure with the slow but steady introduction of shift pattern working that was fully in place by 2011. This meant that, rather than regular office hour working for trainees in conjunction with their Consultant colleagues, junior doctors were made to work in 'packets' of time that would change from week to week (Royal College of Surgeons of England, 2015a). These changes resulted in the loss of the team-like 'firm' working structure which, in turn, meant trainees having less contact with Consultants during regular office hours when Consultants were predominantly present.

This change from the "firm" structure to a shift pattern of working necessitated a change in the provision of teaching which affected all aspects of the curriculum including that of professionalism. As such, training in professionalism shifted from one of role modelling centred on the hidden curriculum that existed prior to 2003 to a greater emphasis on a more formal curriculum requiring a more didactic system of teaching of professionalism since the

introduction of EWTR (Brown et al., 2010; Gilleard et al., 2012; Khan et al., 2012; O’Gallagher et al., 2013).

This slow but steady change in the learning of professionalism impacted the three generations in this study differently.

All Baby Boomers in this study finished their training and became Consultants prior to the introduction of EWTR in 2003. As trainees, they never worked in shift patterns but only ever in the team-like hierarchical ‘firm’ structures with their learning of medical professionalism being driven through role modelling explained by the informal hidden curriculum as described subsequently in section 4.3.1. As there was no curriculum introduced into Plastic Surgery until 2007, Baby Boomers did not receive formal instruction or teaching on medical professionalism (Intercollegiate Surgical Curriculum Project, 2016). Nor did Baby Boomers ever have their hours restricted by EWTR.

Generation X , however, got caught up in the changes brought about by EWTR resulting in a mixed economy. Those in the older half of the generation will have learned professionalism exactly as Baby Boomers had done so via the hidden curriculum. The youngest half of Generation X would have initially commenced their training in the firm structure and then transferred in varying degrees to shift pattern working with those still in training in 2007 being subjected to the new formal Plastic Surgery curriculum requiring didactic teaching in professionalism for the first time in conjunction with the workings of the hidden curriculum. Thus, those in the older half of Generation X would not have been subjected to the changes brought about by EWTR, but those in the younger half will have been restricted in the hours they worked and undertaken shift working to a varying degree.

Generation Y trainees have had little if any access to the hierarchical firm structure but have been subjected to the demands of the EWTR throughout their career with little or no knowledge of the previous team-like structure with working in shifts as the perceived normal working pattern. The emphasis on training in professionalism shifted for Generation Y from role modelling via the hidden curriculum (albeit to a much lesser extent than previously), to one requiring formal teaching through the formal Plastic Surgery curriculum since 2007. This was simply a consequence of trainees and trainers not meeting with each other as often in normal daylight office hours due to trainees increasingly doing evening and weekend hours to maintain medical coverage for hospital services on a rolling 24/7 basis given that there were no additional doctors to add to the shift pattern working.

This literature review reveals the external pressures which have arisen as a result of sociocultural changes and political policy since the commencement of the NHS. These, in turn, have impacted upon medical professionalism and what it meant to be a member of the medical profession. However, the introduction of EWTR caused 'internal' pressure on the medical profession to come up with solutions to maintain the practice and organisation of hospital medicine resulting in fundamental changes in working practices from a focus on teamwork in 'firms' to more independent shift-pattern working. The impact of these changes, in particular on the hidden curriculum, with respect to medical professionalism will now be considered.

## 2.5. *The Hidden Curriculum*

The term 'hidden curriculum' was first coined by Jackson (1990) in 1968 in relation to primary school education. He realised the significant impact of children spending so much time in a classroom on their behaviour. Specifically, he suggested that over time the classroom becomes somewhat uniform for the children as each day follows a similar pattern. Jackson theorised that three behavioural concepts existed in a classroom. First, a child learns to exist amongst a group of children as classroom activities are typically group-orientated. Second, children were repeatedly being assessed both by other children and teachers. Third, children must learn that the teacher's authority is unquestionable and be deferential. Essentially, Jackson describes how children learnt to behave in such a manner so as to make their school lives as easy as possible.

Hafferty (1998) applied the concept of the hidden curriculum to medical education, realising that medical students were similar to schoolchildren in that they rapidly learnt recognisable behavioural traits in order to maximise their training opportunities and thrive at medical school. Hafferty explicitly separated the "*stated, intended, formally offered and endorsed curriculum*" (p.404) which, in Plastic Surgery, is the curriculum offered on the ISCP website, from that of the "*unscripted, predominantly ad hoc, highly interpersonal*" (p.404) form of teaching and learning based on the informal association between medical student and trainer. Hafferty (1998) highlighted the need to understand that many of the learnt professional behaviours in Medicine are formed through relationships between individuals well outside the 'classroom' and that this should be acknowledged by those designing medical education.

The hidden curriculum involves the unintended transfer of attitudes, beliefs and values between trainee and trainer through the use of, amongst other things, informal personal anecdotes, jokes and stories (Hafferty and Franks, 1994; Howieson and Cloke, 2019). The hidden curriculum

works by means of trainees observing and listening to a multitude of both informal and formal interactions between Consultants and both other doctors and patients. The use and passing on of informal vignettes from trainer to trainee accomplishes the net effect of allowing trainees to cope with traumatic experiences that they have never been exposed to in their everyday life prior to their medical career but will encounter regularly in their daily medical practice. This is achieved by altering their emotional responses to extreme situations from that of a 'normal' member of society prior to entry to medical school through to the expected more resilient emotions and attitudes of the medical profession. This passing on of informal teaching, down the years, has a similar effect to the strategies developed among Jackson's schoolchildren as these result in the new medical students and junior doctors learning the unwritten implicit rules, code of conduct and expected norms that allow them to survive within the medical profession without even realising that the process has occurred (Hafferty, 1998).

The role of hierarchy within Medicine is of great significance to the hidden curriculum. Junior doctors rapidly learn helpful career-enhancing behaviours to benefit career progression especially by observing those with power and authority over their careers. Consequently, those deemed to have such influence over a trainee's career such as Consultants are seen as role models to be copied. The more articulate and charming the Consultant, the more likely they will be a role model (Kenny et al., 2003). Indeed, the importance of role models influencing the career choice of medical students to take up Plastic Surgery has been described. Those Plastic Surgeons who appeared happy in their work and declared that they had a rewarding career were particularly influential over medical students (Ibrahim and Asuku, 2016). Whilst it would be hoped that the behaviours of Consultants would always be positive, this unfortunately is not always the case, for just as positive behaviours can be copied so too can less favourable behaviours (Stern, 1998a; 1998b).

Before the introduction of EWTR, Consultants and trainees worked closely together for long periods of time as a result of the 'firm' structure. This was subsequently diminished by the gradual migration towards shift systems of medical cover for patients as a consequence of the EWTR which was fully implemented by 2011 (Goddard, 2016; Rich et al., 2016). Consequently, the opportunities for Consultants, i.e. Baby Boomers and Generation X, to pass on the expected and traditional professional behaviours and attributes of the medical profession to trainees, i.e. Generation Y, were severely diminished by the simple process of the two cohorts of doctors simply not working together as often. EWTR was not fully introduced until 2011 and the new formal curriculum in Plastic Surgery was implemented in 2007. To replace this loss of interaction between Consultants and junior doctors, the new curriculum was expected to bridge this gap by introducing more formalised teaching in professionalism.

In essence, from 2007, the presence in the background of the hidden curriculum in teaching professional behaviours remained present, but its impact upon trainees was diminished because of the reduction in time that Consultants and trainees spent together during their working lives. The hidden curriculum now running alongside the formal curriculum that had not previously existed.

However, this transfer of teaching and learning of 'professionalism' from the informal to the formal curriculum does not appear to have been an easy process for the medical profession. Riley and Kumar (2012) surveyed a group of junior doctors who, despite having undergone formal teaching on professionalism by means of lectures and small group discussions, still believed that clinical experience, observing trainers and role modelling remained the best means by which to learn professionalism. Likewise, the introduction of professionalism into a medical school curriculum found the same continued reliance by medical students on role

modelling via the hidden curriculum rather than formal teaching as this was considered the most beneficial in learning professional behaviours (Goldie et al., 2007).

A possible explanation for this trainee hesitancy to engage with formal professionalism teaching may be provided by Brody and Doukas (2014). They found that trainees provided negative feedback to straightforward classroom professionalism teaching, considering it little more than a list of negative behaviours to avoid in what they termed an ‘*unreflective, mechanical view of professionalism*’ (p.981). However, once trainees realised that professionalism was about assisting patients, developing wisdom and an enhancement of career progression, this subsequently resulted in a more positive response to the teaching.

Whilst the literature suggests that there are differences in how different generations view the world as in the teaching of professionalism, Mangold (2007, p.21) provides a cautionary note against overgeneralising:

*While one must always practice caution in overgeneralizing or categorizing groups of people, certain characteristics are shared by a common generational cohort (i.e., each cohort has shared the same set of life experiences and undergone events in society at approximately the same point in development). This sharing of key life experiences has led to commonalties in values, beliefs, attitudes, behaviors, and perceptions of the world.*

When it comes to healthcare provision and delivery, therefore, we have three sets of actors, (i) government, (ii) patients and (iii) the medical profession. It is apparent from this literature review that the relationship between the three parties has evolved since the birth of the NHS.

However, is it possible to explain how these relationships evolved or even predict how they will evolve further in the future? To do so, I have considered Social Contract theory.

## **2.6. *The Social Contract***

*Social Contract: A basis for legitimate legal and political power in the idea of a contract. Contracts are things that create obligations, hence if we can view society as organized 'as if' a contract had been formed between the citizen and the sovereign power, this will ground the nature of the obligations of each to the other. (Oxford Dictionary of Philosophy, 2016).*

The Social Contract as a theory came to the fore in 17<sup>th</sup>–18<sup>th</sup> century Europe. It concerns how the construction of society relates to the power of the state. Rousseau in 1762 championed the concept, bringing together the ideas of other philosophers in his book *The Social Contract* (Rousseau, 1762). Grotius in 1625 had concluded that individuals had basic human rights which was an unfashionable view at the time given that European monarchs had absolute power over their subjects through the principle of divine right. Hobbes in 1651 noted that whilst it was reasonable to expect individuals to have rights and freedoms, it was wholly unjustified to expect society to allow individuals to do whatever they liked, whenever they wished, such as steal or murder, without society collapsing into a state of anarchy. Hobbes suggested that in order to prevent this lawlessness, individual members of society needed to give up certain rights either implicitly or explicitly to an absolute 'power', preferably an elected group of individuals from within society that would form a government instead of a monarchy, to improve society for the greater good of all. In so doing, this would protect individuals from an anarchic-like

state, requiring not only natural rights but also new legal rights (Crocker, 1968; Harrison, 2003, D'Agostino et al, 2019). Rousseau (1762) maintained that individuals secured rights in exchange for consenting to the need to defend, protect and respect the rights of others, whilst losing some rights and freedoms of their own in doing so. More recently, philosophers such as Harrison (2003) assert that a basic precept of Social Contract theory is that the development of government, a legal code and political systems are not random natural events but deliberately constructed human inventions. It is argued that Social Contract theory imposes reciprocal expectations and rights on behalf of all parties that if not met can dissolve or change the contract (Cruess & Cruess, 2008).

Social Contract theory has been used to hypothesise a contractual relationship between society and Medicine instead of government akin to a social contract that could also transform with time (Starr, 1982; Reid, 2011). Sullivan & Benner (2005) argued that such changes in this new concept of the Social Contract were indeed occurring as society had increased access to medical knowledge, increased workforce flexibility, and increased involvement of outside companies in the provision of healthcare not directly under the control of governments. These changes revealed the difficulty of the medical profession in maintaining its influence over patients and government as well as tardiness in reacting to change with a wish to retain its status quo.

However, some considered the concept of the Social Contract involving Medicine was in fact more complex when introducing a third party, namely, the government (Rosen & Dewar, 2004; Cruess & Cruess, 2008). This tripartite contract can be regarded as both explicit (written regulations and frameworks) and implicit (unwritten expectations, values and behaviours). It was their conclusion that professionalism was the absolute keystone in the relationship between

the medical profession and society forming an essential part of the implicit section of the contract that is more difficult to control, influence and manage.

I would suggest that this tripartite relationship within the Social Contract truly commenced in 1948 when the NHS was inaugurated. This in itself, however, did not significantly alter the autonomy and self-regulation of doctors. Nonetheless, there was an implicit contract (Ham & Alberti, 2002, p.838):

- *The government guaranteeing access to care for all citizens and determining the budget for the NHS.*
- *The medical profession taking responsibility for ensuring clinical standards and delivering care to patients.*
- *The public accepting its healthcare rights from the government, delivered to appropriate standards by the profession, and paying taxes to fund the NHS.*

However, it has been determined that when bonds between society and professions are considered, either party can choose and alter the rights, freedoms, expectations and duties of either side even though there is no recognised legal framework in which to do so. However, when the wishes of one or other party in the Social Contract are not met, this can result in attitudinal and behavioural changes resulting in action by one or both of the parties involved (Rawls, 2003).

Thus, Social Contract theory can help to explain why when the attitudes, behaviours, expectations and norms of society change with time so will the dynamic within the Social Contract between society, government and the medical profession that can result in actions

from the other parties to counteract the original move from another party. This very point was alluded to by Cruess and Cruess (2008) who discussed that as Medicine and society evolved so too did the nature of the Social Contract between the two. They warn against those that adhere to a nostalgic notion of professionalism but instead consider professionalism in terms that reflect the current ethics, morals, values and attitudes of the day. Thus, any attempt at considering professionalism must take into account contemporary societal expectations and the demands of its doctors.

The Social Contract between Medicine and society not only changes with time but across countries as well being swayed by cultural, economic and political influences. Dixon et al. (1998) and Kearney (2000) note that those components of the Social Contract dealing with the 'healer', namely doctors, are relatively uniform across national and societal boundaries but those that relate to how the expertise of the 'healer' are organised, funded and delivered, namely governments, varies across the same boundaries. This leads inevitably to professionalism being seen and expressed in varying ways across different societies.

Starr (1982) raises the issue that the Social Contract is both explicit (written) and implicit (unwritten) in nature. The explicit nature of the Social Contract is demonstrable as government legislation relating to the governance, organisation and regulation of healthcare systems. However, it is within the implicit nature of the Social Contract where doctors demonstrate the behaviours expected of a medical professional. Given the difficulty in defining professionalism this leaves the implicit portion of the Social Contract open to interpretation.

The Social Contract is even more complex in that, as Laugeson and Rice (2003) and Lewis (2006) report, the medical profession is not monolithic. It is in fact made up of a disparate number of individual clinicians who in turn are clubbed together in a myriad of ways through national and specialty societies all of whom may want different ideals and to whom the idea and interpretation of what is meant by professional is different. Thus, there is a constant interplay between individual doctors and the medical institutions that represent them in developing consensus views to be provided to society and government. This, in many ways, explains the difficulty facing Medicine in the working of the Social Contract as there is no one true medical leader through whom society and government can negotiate.

Social Contract theory therefore will be the lens used in this thesis to view not only the actions and behaviours within the tripartite relationship but also to explain the research data obtained and predict how the relationships within the Social Contract may develop.

## **Chapter 3**

### **Methodology & Methods**

#### ***3.1. Methodology***

This chapter will describe the research methodology used during the conducting of the research for this thesis. I will outline my position as well as the philosophy underpinning the research project with reference to the ontological and epistemological framework of the research. I will subsequently focus on the research design based on the philosophical framework. Finally, there will be a description of the research methods and the reasoning behind the methods employed to both gather and analyse the data.

##### ***3.1.1. My Position***

I openly concede my somewhat narrow experience of research, which had been almost entirely quantitative in nature and thus objective and supposedly value-free up until the commencement of this EdD. I had no knowledge or understanding of qualitative research as it does not really exist in Medicine, but is dominant in Education, and is deemed subjective and value-laden. I did not realise I could have a 'position' on how research was carried out, or how values affected the research process. I now recognise that my very presence has the potential to introduce bias in interpreting qualitative data. Thus, from the very outset of this EdD, I needed to get to grips with the basics of educational research from a qualitative perspective before commencing the thesis.

Each researcher has a unique cluster of moral, competency, personal and social values akin to a set of individual fingerprints that shapes how they view reality and thus determines how they approach research (Greenbank, 2003). It is this view of reality that shapes the ontological and epistemological framework of the research which needs to be declared by the researcher. Ultimately, the credibility of this research will be assessed by others who read it. To ensure credibility to readers, I hope to describe how I as a researcher view the world and in a reflexive manner determine what impact that may have upon the undertaking and interpretation of the research.

Indeed, diverging opinions on ontological and epistemological positioning can lead to variable views of the same social phenomena, reflecting the fact that there can be more than one ‘truth’ at any one time to explain such phenomena. Therefore, it is incumbent upon the researcher to be explicit about their own ontological and epistemological positioning (Knorr-Cetina, 1981).

### ***3.1.2. Ontology***

Ontology is the philosophical study of what ‘exists’ by taking a view on the nature of the reality that surrounds us (Wellington, 2015). Bryman (2016) suggests the central tenet of ontology is the question of whether social entities have a reality that is external to the researcher and are objective or whether they are constructions built up internally by the researcher based on past experiences and perceptions and are thus subjective. These positions are accordingly known as ‘objectivism’ or ‘constructionism’. From a social science point of view, Beck (1979, cited in Bracken, 2010) called it the ability “*to understand the social reality as different people see it and to demonstrate how their views shape the action which they take within that reality*” (p.2) which neatly reiterates the need for a researcher to be explicit about their positioning for the research to be credibly received.

Cohen and Manion (2011, p.6) explain ontology via a series of questions:

*Is social reality external to individuals – imposing itself on their consciousness from without – or is it the product of individual consciousness? Is reality of an objective nature, or the result of individual cognition? Is it a given “out there” in the world, or is it created by one’s own mind?*

Reality according to Sikes (2004) can be thought of as independent of the observer and objectively real. Such a reality can be observed, assessed and interpreted through the obtainment of quantifiable data by experimentation. Typical of objectivism, this has been the ontological perspective of the physical sciences through which researchers claim to have no impact on the observed as they are ‘outside the reality’ of the research. Likewise, variables are controlled, data gathered is considered to be objective (quantitative) allowing cause and effect to be determined. Thus, an initial hypothesis is either proved or disproved in a value-free environment (Wellington, 2015).

Alternatively, a researcher may regard themselves as living ‘within’ and interacting with their reality, undertaking observations made through interviews and questionnaires that require interpretation. This is the predominant ontological standpoint of the social sciences. The data collected is subjective (qualitative) and descriptive based on how the social world is experienced, perceived and put together by those living within that reality. Emerging theories are formed incrementally as the data is interpreted over time in a value-laden environment consistent with a constructionist approach (O’Leary, 2017).

If the researcher believes their ontological position to be the foundation from which to undertake research, they must then consider how that research will gather ‘new’ knowledge, this being the essence of epistemology.

### ***3.1.3. Epistemology***

Epistemology is the philosophical study of knowledge: what is knowledge, the nature of knowledge, what it is possible to know and the best way of obtaining that knowledge. Knowledge can be obtained a priori by putting theory forwards first and then challenging it with research or acquired a posteriori by developing theory from the data collected initially (Wellington, 2015).

In this vein, Burrell and Morgan (2016, pp.1–2) suggested researchers must decide whether they regarded:

*Knowledge as being hard, real and capable of being transmitted in a tangible form, or whether knowledge is of a softer, more subjective, or spiritual or even transcendental kind, based on experience and insight of a unique and essentially personal nature.*

These differing epistemological standpoints are known correspondingly as ‘positivism’ and ‘interpretivism’.

Depending on whether a researcher is a positivist or interpretivist, this will have an impact on the methodologies and methods used in subsequent research to gather ‘new’ knowledge. As Cohen and Manion (2011, p.6) clarify:

*The view that knowledge is hard, objective and tangible will demand of researchers an observer role, together with an allegiance to the methods of natural science; to see*

*knowledge as personal, subjective and unique, however, imposes on researchers an involvement with their subjects and a rejection of the ways of the natural scientist.*

Thus, understanding the concepts of ontology and epistemology and where one as a researcher positions oneself relative to each is vital in choosing the subsequent research methodology and methods as this influences the topics studied, questions asked, research methods chosen, data analysis undertaken, data interpretation and future research.

Those researchers having an objectivist-positivist viewpoint dominate the natural sciences such as Medicine. They regard themselves as producing the ‘purest’ form of knowledge based on experimentation that determines cause and effect. The knowledge produced is theoretically not contaminated by the physical presence or values of the researcher. Such knowledge is used to test theories and develop new laws of science (Cohen and Manion, 2011; Bryman, 2016).

Alternatively, those researchers having a constructivist-interpretivist viewpoint dominate the social sciences such as Education that I have entered in order to undertake this EdD. Such researchers have an entirely different view of the world from those in Medicine in that they appreciate and accept the effect of the observer on the observed, as Pring (2004, p.9) commented:

*The distinction is drawn between physical things and persons in that the latter, but not the former, interpret, or attach meaning to, themselves and others. To understand other people, therefore, requires understanding the interpretations which they give of what they are doing.*

Researchers who follow the interpretivist paradigm therefore focus on the understanding of subjective meanings of research participants based on their individual experiences, perceptions, attitudes and values. Interpretivism supposes that social reality is constructed through the prior experiences and perceptions of the participants and how these are processed by themselves. In turn, the interpretation of the data collated is that alone of the researcher and is not that of the participants (Pring, 2004). This highlights the need for reflexivity on the part of the researcher of what impact their past experiences, previous perceptions and values may have upon not only the research design but also the interpretation of the results.

Consequently, if given to different researchers, the same set of data is likely to be interpreted differently based on their past experiences and values. Thus, there can be more than a single ‘truth’ or ‘reality’ co-existing simultaneously if one accepts an interpretivist approach to research. As Oakley (2000, p.8) states:

*We live through experiences, rather than in them....we can't live in anyone else's.*

*That's the great puzzle: none of us will ever know what it's like to be anyone else.*

Therefore, I hope to acknowledge my ontological and epistemological position as a lens through which others can view my research and assess its credibility because, as suggested by Kemmis (1995), educational research should be “*tested, justified and sustained through debate in a public sphere*” (p.15).

#### ***3.1.4. Philosophical Position of This Study***

The approach to this thesis was grounded within a constructivist-interpretivist paradigm. I have chosen to look at how potential generational differences in professionalism may impact upon the Social Contract in the context of healthcare. The Social Contract being the combination of

implicit and explicit agreements needed to provide healthcare between three parties, namely the Government (funders of healthcare), Society (users of healthcare) and the profession of Medicine (providers of healthcare). This requires an exploration of the participants' experiences and perceptions of their careers in order to construct a social reality upon which my interpretation would be based.

My approach takes into account both Crotty (1998), who stated that the interpretivist researcher “*looks for culturally derived and historically situated interpretations of the social life-world*” (p.67), and Svennson (1997), who noted that “*knowledge is a question of meaning in a social and cultural context*” (p.163).

I have chosen a case study research design to answer my definitive research question. The case being a group of Plastic Surgeons within a single hospital at varying stages of their careers. As a Plastic Surgeon myself, I am clearly not divorced from this ‘community’ and presumably will have been exposed to a similar sociocultural milieu as the research participants. There is therefore the potential for my values to affect the participants. To counter my effect on the research, I have continually gone back and forth in my research in a reflexive manner to neutralise as much as possible my impact on the participants. For example, I have attempted as far as possible, in the design of the participant interviews that there was no leading or biased questions. Likewise, I have acknowledged my own values based on my past experiences particularly when critically interpreting the document analysis of government records. I am not naïve enough to believe that I have entirely eradicated any personal bias because as Eisner (1993) indicates there is a question as to whether one can “*neutralize ourselves from our work*” (p.50), but I have attempted to do so as best I can by being transparent in describing my philosophical position and research methodology.

I acknowledge that as my career has progressed, I have increasingly felt that my autonomy, power, status, prestige and financial gain associated with Medicine has diminished. As such, my sense of both self-identity and professional identity has changed negatively. What I had hoped to undertake as a Consultant when I started my career in 1983, no longer exists. I am frustrated that my career, requiring significant personal sacrifice, has resulted in a role that had I been offered it in 1983, I would have chosen to follow a different career path. This thesis has been an opportunity to critically reflect on my career, and search for answers that have caused these changes in my personal and professional identities.

Indeed, Carr and Kemmis (1986) suggest reflexivity on the part of the researcher is fundamental to the research process as it has the ability to not only change the perspectives of both the researcher and the participants but also challenge their opinions.

I do not suggest that my research will find the absolute 'truth' in answering the research question. I accept that my 'truth' is based on my interpretation of the data based on my previous experiences but that there are other perfectly valid 'truths' possible when the data is interpreted by others with differing experiences and perspectives that co-exist.

To summarise, this thesis is founded on a constructivist-interpretivist paradigm. Underpinning the ontological and epistemological basis of the thesis is the acknowledgement of my role as a researcher and the attempts that I have made to neutralise that effect. Thus, this thesis should not be regarded as the sole definitive answer to the research question, but it will certainly go some way to shedding light on the function of the Social Contract in the context of Plastic Surgery and possibly also the medical profession more broadly.

### ***3.1.5. Research Design***

Having considered my philosophical position to be constructivist-interpretivist in nature, my next decision was to determine how I would design the qualitative research undertaken in this thesis.

But for me to understand the use of research methodologies and methods from having little experience of qualitative research, I first needed to understand their context in the role of educational research. Educational research developed in the 20<sup>th</sup> century along a path away from the ‘scientific’ method of investigation, as used in the physical sciences, towards an increasing emphasis on qualitative research based on the disciplines of philosophy and sociology from the 1960s that was typical of the social sciences (Nisbet, 2005).

What then is educational research?

Bassey (1990) describes educational research as “*systematic, critical and self-critical inquiry which aims to contribute to the advancement of knowledge*” (p.35). My interpretation of this definition is that the research requires a structured design and implementation of the research process. Once data is obtained, a formal process of analysing and interpreting the data is performed, with the researcher being reflexive to realise the potential effect of their values and biases on the research undertaken.

The fundamental starting point for me was the development of the ‘research question’ to be answered. This was crucial as the research question according to O’Leary (2017) “*defines an investigation, sets boundaries, provides direction and acts as a frame of reference for assessing your work*” (p.116).

One then can design the research around the ‘research question’ that in turn determines the methodology which in this research was qualitative in nature. Denscombe (2017) describes this approach as “*a matter of horses for courses – choosing a strategy that is fit for purpose in relation to the particular thing the research is trying to achieve*” (p.4). This allowed me as the researcher to use the method(s) most appropriate to obtain the data necessary to answer the specific research question (Wellington, 2015; Denscombe, 2017). This, indeed, was the approach that I took as compared to an approach whereby a researcher has a favoured data gathering method that is used to ‘shoehorn’ data in an attempt to answer the research question that may prevent the ideal data being collected to answer the research question (Wellington, 2015; O’Leary, 2017).

As my professional background in Medicine has a dominant positivist paradigm, the decision to follow a path led by the research question rather than a favoured qualitative research method was eased by the fact that, having little experience of qualitative research prior to this EdD, any qualitative method I used to obtain data would be new to me such that I was content to follow whatever method would best serve to answer the research question.

### ***3.1.5.1. Iterative Research Design***

This thesis was performed in an iterative, rather than linear, manner whereby research design, methodology and methods emerged as I passed through the EdD programme. The focus on ‘professionalism’ was always the area of inquiry. The initial focus changed from studying trainees who failed to progress due to a ‘professionalism’ issue to one of looking at differences in views of ‘professionalism’ between the generations. This obviously meant a change in the research question to be answered and in the methodology and methods used to harvest data.

The process of undertaking a research project has been described as linear, passing through a seamless series of recognised steps, namely identifying the broad area of study, selecting the topic to study within that area, deciding on methodological approach, formulating methods to be used, collecting data, analysing the data, and presenting the findings (Sharp et al., 2002). However, such linear descriptions do not appear to reflect real-life experience when there is constant toing and froing in a cyclical fashion between the described stages of research (Medawar, 1981; Wellington, 2015; O’Leary, 2017). Rather, as occurred in this research, there was constant looping back and forwards refocusing on the research question, enhancing interview questions following a pilot study, identifying the need to sample a greater range of experience in Plastic Surgery, deciding whether to analyse the data freehand or by NVIVO, and throughout the research process, the writing up was constantly refined with ongoing reading.

My approach concurred with Maxwell (1996, p.3) who stated:

*The activities of collecting and analysing data, developing and modifying theory, elaborating or refocusing the research questions...are usually all going on more or less simultaneously, each influencing all the others.*

Thus, an iterative approach allowed me to be highly flexible and respond to unexpected findings or challenges. For example, the pilot interviews revealed potentially marked generational differences with respect to self-identity that I felt were important to explore further. I therefore decided to ask more directed questions about the sense of vocation that Plastic Surgeons currently had, how that vied with their sense of work–life balance, and whether they could separate their professional and personal identities. In terms of challenges,

having never coded or themed research critically before, I struggled in deciding how to perform the data analysis so as to ensure credibility for the research.

An iterative approach is more than just a repetitive task but one requiring reflexion (Grix, 2001; Srivastava, 2009). Thus, whilst continually reflecting upon the research design of the process, it was by considering my impact upon the research based on my previous values, experiences and perceptions that I needed to ensure I had as little impact as possible upon the data collected and its interpretation. I attempted to follow the advice of Srivastava (2009, p.77):

*The role of iteration not as a repetitive mechanical task but as a deeply reflexive process, is key to sparking insight and developing meaning. Reflexive iteration is at the heart of visiting and revisiting the data and connecting them with emerging insights, progressively leading to refined focus and understandings.*

Primarily, this thesis is not about me, but about the perceptions, experiences and attitudes of those who have participated. This thesis allowing them a voice through which one can use Social Contract theory to both explain the current and assess the future state of the tripartite relationship within the Social Contract. By using an iterative approach, I hoped to give participants every opportunity to express themselves to achieve as rich a set of data as possible to subsequently analyse.

To give participants that voice in medical research has been recognised as crucial to the process (Taylor, 2019). The World Medical Association's Declaration of Helsinki (2013) states "*all medical research subjects should be given the option of being informed about the general outcome and results of the study*" (para. 26). Given that interviewees had given up their time freely and put on record their personal thoughts with some risk of potential harm, albeit with

the safeguards of anonymity and confidentiality, I felt it only right to allow them access to the findings of the research for their comment, understanding and interest. As Taylor (2019) states “*reporting back to participants is part of the discipline of transparency that keeps researchers honest and accountable*” (p.347).

### **3.1.6. Case Study**

The framework underpinning this research is that of a case study design. Case study research is noted (Thomas, 2011) to be “*one of the principal means by which inquiry is conducted in the social sciences*” (p.511). It has been further used to conduct research in other areas such as Business, Law and Medicine.

Case study can be elusive to define but Simons (2009, p.21) summarises it as an:

*in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a “real life” context. It is research-based, inclusive of different methods and is evidence-led. The primary purpose is to generate in-depth understanding of a specific topic...to generate knowledge and/or inform policy development, professional practice and civil or community action”.*

Case study is not a research method per se but a framework around which other well-recognised methods can be used, as Flyvbjerg (2011, p.301) suggests:

*Not so much a methodological choice as a choice of what is to be studied. The individual unit may be studied in a number of ways, for instance qualitatively or quantitatively, analytically or hermeneutically.*

Case study therefore concentrates on developing a narrative based on the in-depth exploration of complex interactions of many variables within a single or few cases as opposed to looking more superficially at a few variables in a great number of cases (Hammersley & Gomm, 2009; Thomas, 2011). In essence, a rich tableau describing multiple features of a particular social phenomenon can be built up that is not possible by other research means such as questionnaires or surveys (Hammersley & Gomm, 2009). Such research can be illuminating, insightful, accessible to readers, and can lead to further qualitative or quantitative research (Wellington, 2015).

It is the context against which the contemporary social phenomenon is assessed that permits a more in-depth understanding of the case, as Yin (2014, p.2) suggests:

*The distinctive need for case studies arises out of the desire to understand complex social phenomena. In brief, the case study method allows investigators to retain the holistic and meaningful characteristics of real-life events.*

The literature reveals a variety of typologies for how to choose a 'case'. Stake (2011) distinguishes between three types of case:

- a) *The intrinsic case* is chosen for the need to better understand the case that is of interest to the researcher. The case is not chosen because it is either typical or an outlier.
- b) *The instrumental case* is chosen to develop a better understanding of a particular issue or test a hypothesis. The case is a means by which to investigate something else.
- c) *The collective case* is the study of a number of cases simultaneously.

This research study could be said to combine features of the intrinsic and instrumental types of case study research. The *intrinsic* part being that I have had a long-term interest in

‘professionalism’ with respect to training within Plastic Surgery. As such, this allowed me to commence the research having some professional and personal knowledge of the subject. Therefore, I felt ready to explore and probe the case that could be done with relatively straightforward access to research participants for interviews and government White Papers for document analysis. *Instrumentally*, I have used the case study in this research not necessarily to look at Plastic Surgery but to explore the concept and use of Social Contract theory to explain changes that may be occurring within Plastic Surgery and, by extrapolation, what that may mean for the relationships within the Social Contract. I made the decision from the outset that a *collective* approach would not be undertaken due to the need to limit the amount of data obtained to a manageable level that could be analysed and reviewed within the timeframe of this EdD. However, as will be discussed in Chapter 6.4., such an approach would certainly take this research further.

George and Bennett (2005) split the types of case study into two broad areas. Case studies were described as being *illustrative* whereby the complex interactions within the case were richly described only or *theory-dependent* whereby the case was used to test existing theory or allow theory to emerge in a grounded manner through the use of the data obtained. My research set out to do both in providing an in-depth understanding of the feelings, perceptions and understandings of individuals who had worked in Plastic Surgery and interpreting that through the use of Social Contract theory.

The ‘case’ can be considered to consist of two elements. The first is the ‘subject’ of the research that can be regarded as the ‘thing’ to be explained, and the second is the ‘object’ of the research, the ‘thing’ doing the explaining (Thomas, 2011). According to this view, in this research, the subject would be considered the specialty of Plastic Surgery and the object thought of as the

Social Contract which was being used to explain changes in professionalism and in what context this was happening.

In this case study, the use of Social Contract theory assisted in explaining past changes, the current situation and in predicting what may happen to the complex tripartite relationship within the Social Contract. The Social Contract being the combination of implicit and explicit agreements needed to provide healthcare between three parties, namely the Government, Society and Medicine.

This research project relied on a single case study. The ‘case’ being explored was that of the surgical specialty Plastic Surgery. A case is ‘bounded’ and thus restricted in this case to doctors who had at some point in their career worked in Plastic Surgery. The need to define the boundaries for the case was noted by Starman (2013) to be vital as “*outlining the borders of individual units within the survey establishes what counts as a case and what becomes its context*”(p.32). By identifying the context of the case, the researcher is then able to start to develop the research question to be answered, use appropriate methods to answer that question, and ensure the possibility of answering the question within the limits of the case.

The decision to use Plastic Surgery as the ‘case’ was influenced by my own awareness of the specialty for which I already had a number of potential contacts allowing access to participants in a convenient and timely manner and reduced costs by diminishing travel (O’Leary, 2017).

### **3.2. Methods**

Case study research allows the researcher to use a full array of methods, sources of data, and types of data whether qualitative or quantitative in conducting their inquiry (Denscombe,

2017). During this research, data was obtained initially through interviews and subsequently triangulated through the complementary use of document analysis of government documents.

Case study is not without its detractors particularly, as in this case, a single case is studied alone. Such criticism revolves around the concern of applying generalisability to other cases (Bryman, 2016; Yin, 2014). Lincoln and Guba (2009) suggest that in any form of research it is the very context in which it is carried out that inhibits generalisability. They stated that how findings can be extrapolated from case to case is dependent on the similarity of the context between them. It was therefore my responsibility in carrying out this research to provide readers as much context as possible, so that they can judge for themselves in an informed manner if the results are generalisable.

Schofield (2009) baulks at the suggestion of needing to determine generalisability when the researcher should concentrate on the uniqueness of the case rather than trying to provide widespread generalisability stating:

*The goal is not to produce a standardized set of results that any other careful researcher in the same situation or studying the same issue would have produced. Rather it is to produce a coherent and illuminating description of and perspective on a situation that is based on and consistent with detailed study of that situation. (p.71)*

Other researchers when considering the predominant qualitative nature of case study research accept that whilst formal statistical generalisation cannot be obtained, there is opportunity to provide a foundation for generalisation between cases using theory (De Vaus, 2001; Yin, 2014).

In summary, a case study design was embraced to allow an in-depth description and understanding of the case. The intention of the research was not to find statistical significance but rather by studying the complexity of the case to identify emerging themes from which Social Contract theory could be used to understand the past, current and future experiences of participants within the Social Contract.

Whilst case study research allows significant latitude in determining what methods are used to capture data, I needed to ensure that I captured the in-depth thoughts, perceptions and experiences of participants with respect to how they viewed the concepts of professionalism, the medical profession and the Social Contract. To do so, I adopted the use of interviews.

### ***3.2.1. Interviews***

Whilst the method of ‘observation’ allows the study of individual/group behaviour in a particular setting, the use of interviews allows what cannot be observed to be investigated, such as the values, attitudes, reflections and experiences of participants (O’Leary, 2017).

I needed to determine who I was going to interview as I could not interview every doctor in the UK who had spent time in Plastic Surgery, i.e. ‘the population’, as this was not logistically practical. I therefore chose a selection of doctors who had undertaken Plastic Surgery in one hospital unit, i.e. ‘the sample’, who in turn could represent that population.

I undertook ‘non-probability’ sampling, which is widely used in qualitative research, to gain access to interviewees in a convenient manner given the time constraints of the EdD (Woods, 1986). This was particularly prudent given my ethics approval required my access to doctors must not involve the NHS in any manner. Therefore, I contacted interviewees via non-NHS e-

mails, interviewed out of NHS time and in non-NHS facilities. Having identified the Plastic Surgery unit to be involved, I then also used 'probability' sampling whereby I contacted doctors in the unit in a random manner. Whilst 'convenience' in considering how sampling would be undertaken was important, it was not the sole consideration. I was keenly aware of the need to ensure my research could be viewed as credible and hence my attempts at transparency in how the sampling was achieved.

How one determines the means to select samples was summarised by Maykut and Morehouse (1994, p.51):

*The selection of a sampling strategy depends upon the focus of inquiry and the researcher's judgment as to which approach will yield the clearest understanding of the phenomena under study.*

Therefore, I did not attempt to identify individuals who might be known to have extreme opinions (maximum variation sampling), or any doctor with a specialist knowledge in professionalism (critical case sampling), but just sought those who were typical (typical case sampling). Obviously, there was some degree of stratification of those to be interviewed, given that a fundamental issue in the research undertaken was to determine if 'generational differences' existed, so I made a purposive decision to ensure I interviewed doctors from each of the three generations, Baby Boomer, Generation X and Generation Y, in order to ensure that I captured generational differences should indeed they exist.

I accept that the use of non-probability sampling brings up the issue of whether the sample used is actually representative of the whole population and is therefore difficult to analyse

statistically. However, I discuss in Chapter 6.2. how I reflected on the ‘generalisability’ of the data obtained from this research.

I chose one-on-one interviews as the best means to access an in-depth analysis of each participants’ responses in a confidential and anonymous manner that might not have been obtained in a focus group, either from embarrassment or feelings of being upstaged. Given the access that I had to participants, I felt that even with the constraints of the EdD I had sufficient time to interview an appropriate number of participants without needing to resort to focus groups that I did not think would provide the rich detail that I wanted to extract from participants. Furthermore, the transcription of the digital recording of interviews was made easier as there was no need to differentiate between participants.

I was struck by the approach offered by Wellington (2015, p.139) who, when discussing the purpose of interviewing, suggested:

*[The purpose of interviewing is] to give a person, or group of people, a “voice”. It should provide them with a “platform”. A chance to make their viewpoints heard and eventually read...the interviewer should not play the leading role.*

Thus, the interviews I wished to undertake would be neither a two-way unstructured exchange of ideas between myself and the participant nor a rigid structured collection of data. By using semi-structured interviews, I hoped to use my prior experiences and knowledge as a Plastic Surgeon to shape the questions but be flexible enough to explore new avenues if something noteworthy came up in conversation (Bassegy, 1999). However, I was mindful to negate my values, attitudes and beliefs in preparing the interview process in order to minimise as much as possible my influence over the data obtained from participants (Ashworth & Lucas, 2000).

Furthermore, I was acutely aware of the potential power imbalance as a trainer in Plastic Surgery with that of the trainees I was to interview (Elliot, 2005; Wellington, 2015; O’Leary, 2017). This concern was not so acute with my Consultant colleagues who I regard as equals. This power imbalance was negated to some extent by the use of semi-structured interviews so that whilst having certain topics to be covered with set questions designed by myself, the participants were subsequently in control of what and how much they wished to discuss with me. I further attempted to defuse this potential power differential by ‘dressing down’ from a formal workplace suit to a more informal ‘jeans and jumper’ approach.

I also offered all participants the decision as to where to hold the interview which in line with ethical approval had to be outside NHS working time and NHS workplace. All Consultants wished to be interviewed at their home whereas trainees accepted the neutral arena of a quiet corner in a university study area following the end of their day shift, prior to going home, which I also hoped would reduce any perceived ‘power’ differential.

All participants were reassured when approached by e-mail and again before beginning the interviews that there were no wrong answers but only right answers as their responses were based on their past and current values, attitudes and perceptions that were unique to them. All participants were reassured that involvement in this thesis played no part whatsoever in any form of annual appraisal although the signing and keeping a copy of the consent form could be used as proof of evidence of research involvement expected of doctors by the GMC as part of their annual appraisal.

The use of semi-structured interviews allowed me the flexibility to use an interview question schedule to ensure I covered the essential topics of professionalism, Medicine as a profession

and the Social Contract. However, it also allowed the opportunity to explore, probe and ask additional questions if and when interesting, relevant and unexpected responses were made. Consequently, I hoped to gain relevant in-depth qualitative data and the participants would be provided with the opportunity to share their individual and collective ‘voices’ (Cohen and Manion, 2011).

Taking my lead from the research question(s) identified in Chapter 1, as well as my literature review, I developed a structure to the interview process. I first identified my areas of interest and subsequently grouped the questions to be used into three broad areas to be explored: (1) professionalism, (2) Medicine as a profession and (3) the Social Contract. I then decided what I wanted to explore specifically in detail about these areas which for topics (1) professionalism and (2) Medicine as a profession proved to be similar. For example, what is your understanding of these terms? Has it changed through your career? If so, why? Do you believe that differences in these concepts exist between generations?

For topic (3) Social Contract, I asked participants about its meaning to them, its relevance to them and how they saw the tripartite relationship currently and developing in the future.

Questions were designed to be open to elicit the participants’ views and opinions on past and present experiences. Interviews can be daunting, so in order to develop rapport and ease the participant into the interview closed questions were used initially to simply provide basic information without the need for deep initial thought. Such closed questions included the length of their career, what generation did they belong to and for them to describe their career path in outline (Denscombe, 2017).

Careful consideration was given to the crafting of all questions to eradicate any bias I might introduce by avoiding leading questions, questions with emotive language, questions that eliminated certain responses and double-barrelled questions.

The questions were used as a starting off point to ensure essential areas were covered. However, as each participant was unique, the use of some probing was used to explore interesting areas that came up by asking participants for either more detail, further clarification or to explore more their thoughts (Wellington, 2015).

Given that my fundamental ‘research question’ was attempting to determine if there were generational differences in what interviewees thought of the concepts of ‘professionalism’ and ‘profession’ I chose to interview Plastic Surgeons with a range of experience from several years to only a few months. The need to include those with only a few months experience, as will be described later in this chapter became clear following pilot interviews.

I took my lead from the literature as to what were the cut off points for each generation in terms of the year of birth, but I separated out the generations as follows (Pew Research Center, 2010; Money et al, 2013):

Baby Boomers	born 1946–1964
Generation X	born 1965–1980
Generation Y	born 1981–1996

The literature is in general consensus about the cut off points for each generation albeit with minor differences (Howell et al., 2009; Pew Research Center, 2010; Eckleberry-Hunt & Tucciarone, 2011; Espinoza, C. & Ukleja, 2016; Dimock, 2019).

The dates used are a man-made phenomenon as explained by Dimock (2019):

*Generational cut off points aren't an exact science. They should be viewed primarily as tools...but their boundaries are not arbitrary. Generations are often considered by their span, but again there is no agreed upon formula for how long that span should be. (Blog post)*

Dimock (2019) further explained that the span of each generation was dependent on key economic, political and social factors in modern history.

Therefore, when interviewing for this thesis in 2019, Baby Boomers in the general population were aged 73–55, Generation X were aged 54–39 and Generation Y were aged 38–23. As I chose a case study that was Plastic Surgery, this allowed ease of access to interviewees who were practising Plastic Surgeons. Even with the current retirement date of 67 years not being entirely mandatory, I know of no working Plastic Surgeons in the NHS aged 74 years or above nor do they exist according to the British Association of Plastic Reconstructive and Aesthetic Surgeons (2020) in their annual workforce review. At the other end of the scale, medical students tend to enter medical school at the earliest at 18 years and following a five-year course will be 23 years of age at the earliest in qualifying. This meant that Generation Z individuals had not quite entered the medical workforce at the time of interviews.

Before embarking on the interviews, a decision was made to undertake two initial pilot interviews (Wellington, 2015; O'Leary, 2017). The first interview was with a male full-time Baby Boomer Consultant and the second a female trainee working part-time from Generation

Y. It became clear from the pilot interviews that a potential defining moment in attitudes towards the concepts of professionalism and being a member of a profession was the introduction of European Working Time Regulations (EWTR) in 1998. Before EWTR were instigated, doctors worked in hierarchical teams known as 'firms' with trainees learning in an apprentice-like model. Following EWTR, doctors trained in shift patterns with loss of teams in a more meritocratic manner learning less from role models but more from didactic teaching. As the Consultant had trained under the firm model and the trainee under a mixture of both, I felt it appropriate to also have the participation of trainees who had only ever experienced a shift system.

A third pilot interview was undertaken with a female full-time Generation Y trainee who had only experienced employment since the introduction of EWTR. From the answers in response to all three pilot interviews, I realised the importance of access to participants who had a comparable range of experience to the three pilot participants.

An unanticipated pilot interview finding revealed potential generational differences with respect to self-identity that I felt warranted further exploration. It became apparent that the Consultants appeared to have their professional, social and domestic lives intertwined which was accepted, whereas trainees seemed to have a clearer demarcation line between the worlds within and outside Medicine. I, therefore, wished to explore this possible divergence in generations further.

The pilot interviews revealed that participants had not previously encountered the concept of the Social Contract as it was not a theme covered in formal curricula taught at undergraduate or postgraduate level. Therefore, I decided to send each subsequent participant an information

leaflet summarising the Social Contract one week prior to the arranged interview to ensure all participants had a fundamental level of understanding of it as a general concept.

Given that the information leaflet had the ability to influence subsequent responses I attempted to reduce that risk as much as possible by providing an overview of the Social Contract. The leaflet opened with a definition of a 'social contract' from the Oxford Dictionary of Philosophy (2016). I then placed the Social Contract into a historical perspective from its initial understanding in 17<sup>th</sup> century Europe through to its modern-day interpretation (Rousseau, 1762; Crocker, 1968; Harrison, 2003; Williams, 2007). I described how Medicine was first attached to the Social Contract via a relationship with society (Starr, 1982; Sullivan & Benner, 2005) but that this bipartite relationship was subsequently extended to a tripartite relationship including government (Cruess & Cruess 2008). I placed the tripartite relationship of the Social Contract in the context of the NHS in which all interviewees would have had some experience to ensure relevant meaning to them in terms of their everyday working practices (Ham & Alberti, 2002). Finally, I explained that the relationships within the Social Contract are not static but can potentially change over time for sociocultural and political reasons that may or may not have consequences for each party (Rawls, 2003; Cruess & Cruess, 2008).

I asked participants to read the leaflet just once at least a week prior to the interview, absorb it and reflect on the piece for a few days prior to the interview without looking at the leaflet once again. The hope being that this would allow interviewees the time and space to mull over the concept of the Social Contract and reflect on how the interested parties interact. This arrangement allowed for a more thoughtful discussion exploring the workings of the Social Contract subsequently described in this thesis. The information leaflet is viewable in Appendix 1.

The interviews revealed that whilst the term ‘Social Contract’ may not have been previously known to interviewees they readily grasped and recognised the concept of relationships between Medicine, Government and Society shifting over time to the advantage and detriment of one or other party based on their everyday past and present experiences. This was particularly the case for Baby Boomers and Generation X who had a greater length of time within the profession to observe these relationships and what effect these had on them.

Following each of the three pilot interviews, I undertook a feedback session three days after the event to get comments on issues such as my performance, clarity of questions, relevance of questions and how I may improve the interview process.

Following the completion of this feedback, final adjustment of the interview schedule was made to include questions on self-identity, vocation and work–life balance. The formal interviews subsequently took place ranging 26-48 minutes in length. Appendix 2 contains the initial questions used for the pilot interviews and Appendix 3 contains the final questions used at the subsequent interviews demonstrating how the questions had evolved.

Thus, I obtained my own primary data through semi-structured interviews. However, I sought to use secondary data through the analysis of government White Papers and reports as a complementary means to better understand and triangulate my own data. Such an approach is well recognised in case study research (Wellington, 2015).

### ***3.2.2. Interview Quality Assurance***

An essential part of this research is to ensure its credibility for the reader, for it is they who will judge its merit and in particular the validity of the research. By that I mean, I wish to assure

the reader that despite my previous background in quantitative research, all reasonable means were used in the qualitative interview process and its analysis to ensure that the findings of the research reflect as closely as possible the lived experience of participants.

Throughout this thesis, and in particular in section 1.5, I have described my position with respect to my past research experiences, previous educational roles, my current reality and how my attitudes have shifted during the undertaking of the research. In conjunction with advice and support from my experienced supervisor, I hope to have assured the reader that I undertook a systematic and critical approach to both the methodology and methods used in this research.

This involved much reflection on my part resulting in an iterative approach to the research as I went back and forth through the research process as data was collected and analysed along with an ongoing literature review. For example, as described, pilot interviews were undertaken, to ensure questions were appropriately structured, obtain feedback on the questions and my performance as an interviewer. The pilot interviews highlighted emerging themes such as EWTR and work-life balance that required adjustment and addition to the interview schedule. The emerging theme of EWTR made me reconsider my sampling strategy to ensure I captured data from interviewees who had worked exclusively before and after the introduction of EWTR as well as those who worked through its transitional introduction.

Not only did I reflect upon the research process but I was also reflexive and thus mindful of my own impact and effect upon the research process. As will be described, I attempted to ensure I did as much as possible to nullify my impact upon the research process to allow as much as possible the participants' perspectives that I was seeking to come to the fore. I made deliberate attempts as described in section 3.2.1. to make interviewees as comfortable as possible both

before and at the time of the interviews in order to maximise the chances of them providing an honest and open narrative of their current and past attitudes and experiences. To do so, interviewees were provided with a detailed information sheet to make sure consent was informed and reassured that no responses would be deemed ‘incorrect’ as they were based on each individual’s unique values, attitudes and past experiences. Interviews were undertaken at a site that was comfortable and non-threatening to the participants and I dressed down for all interviews to try and get a relaxed informal air to the process to encourage discussion.

Following each interview, almost immediately, I would summarise the interview with respect to themes and overall impressions that came out and appeared significant to me. As noted in my ethics application that was approved without change, I tasked one single secretary who works with me on my medicolegal work to undertake the transcription process of the digitally recorded interviews. This secretary has undergone additional training in GDPR and is fully conversant with its requirements and the need for utmost confidentiality and protection of data. Both my computer and that of the secretary are internally and externally monitored by an IT security firm to minimise hacking, viruses and phishing scams. The level of security being exactly the same as local, regional and national law firms.

I was able to co-ordinate my secretary’s availability to each interview such that as soon as each interview was completed, I could send the digital recording for transcription that was available as a typed document the next day. I realise that this is possibly a unique situation for a doctoral student and that I am fortunate enough to have the logistics, resources and staff to do so. The literature suggests that one should immerse yourself as a researcher in your data, i.e. your transcription, but that is exactly what I did. Having already identified the main themes of the individual interview, I was able the following day to simultaneously listen and read the

interview whilst the actual interview remained fresh in my mind. I admit to being only able to type in a '2-finger' style such that for me to transcribe would have been a lengthy process and a frustrating one that would not have allowed me to get close to the data in the manner I wished as the time from the interview progressed ever further. Instead, I was able to dive deep into the data in an undisturbed manner the following day from the interview through unhindered reading and listening. The method that I used, at least for me, allowed me to immerse myself in the data in a more enjoyable, efficient and timely manner which I believe enhanced the analysis rather than detracted from it.

Furthermore, having an efficient transcription process, allowed me to send the interviewees their transcribed interview in a timely manner, so for them as well the interview was fresh in their mind and could be readily recalled. All interviewees were sent their interview transcription as a typed document for them to check as an accurate representation of their words and allow them to request removal of any sections that they so wished. Only one interviewee requested any changes which was the removal of one sentence which was immediately removed.

Once the thematic analysis had been performed and Chapter 4 (Analysis & Discussion-Interviews) written, in line with the World Medical Association (2013) and Taylor (2019) (as noted and quoted in section 3.1.5.1. above) I sent the entire Chapter 4 to all interviewees for their feedback. No feedback received from interviewees in return suggested I had come to the wrong conclusions or missed out on a vital matter that should have been considered. Six of Generation Y responded with formal feedback, as did four from Generation X and three from the Baby Boomers. However, I was able to informally discuss the findings with all Baby Boomer and Generation X interviewees. The overall consensus was that it was an interesting

read that put into an academic form, the concerns of those who participated in the interviews. The discussion and conclusions drawn in the chapter were considered appropriate and measured. It was felt that this area of research had not been so comprehensively documented all together in one place in the literature.

### ***3.2.3. Documentary Analysis***

The choice of documents to analyse was based on both my literature review and interviews. It was clear from my literature review that healthcare-related policy that was introduced through successive government White Papers had both altered the doctor–patient relationship (DPR) and increased the regulation of the medical profession. As noted in the interview analysis, the influence of the government on the everyday working lives of the interviewees was identified as a significant factor in a number of responses. So, it felt instinctive to me to more closely explore healthcare-related government documents to identify whether interviewee responses were justified.

I chose to analyse government White Papers and reports throughout the period of my career, commencing the year I started medical school (1983) through to the present. I felt that this was a sufficient timeframe to identify any significant impact from these policy interventions. Furthermore, the use of government documents was considered reasonable given that they are written by a public organisation rather than an individual and are freely available to access as such by the general public via the internet without the need for special permission or consent to access (Scott, 1990). I felt such analysis could potentially help to explain my stated position of a sense of loss of power, prestige and autonomy through my medical career.

However, I was appreciative of my own potentially biased position as a medical professional and approached this documentary analysis with an open mind in order to undertake a systematic critical analysis based on what I found rather than on my past experiences. To that end, I hoped that this documentary analysis would further help explain and triangulate the findings of the interviews through which readers of this research could be more assured of its credibility, reliability and validity.

The list of White Papers and reports analysed can be seen at Appendix 4.

### **3.3. *Ethical Issues***

The process of obtaining ethical approval proved more challenging than I was expecting. I naïvely believed it would be straightforward to set up a series of interviews with doctors about their sense of professionalism and belonging to a profession. I did not appreciate the bureaucracy involved in NHS research.

As part of the University of Sheffield Research Ethics Approval Procedure, a researcher must fill out the online application form. One question was whether the NHS might be involved, and I confirmed it was. I was then directed to two ‘toolkits’ run by the NHS Research Health Authority.

The first toolkit (available at: <http://www.hra-decisiontools.org.uk/research>) determined whether my proposed study was research as defined by the UK Policy Framework for Health and Social Care Research. The answer confirmed that it was research. Consequently, I proceeded to the second toolkit (available at: <http://www.hra-decisiontools.org.uk/ethics>) which determined whether I needed NHS Research Ethics Approval. The toolkit revealed that as my

research did not involve the following: patients or relatives, human tissue, any new drug or device, or new procedure then I did not need approval beyond the University.

Additionally, I checked with the NHS Trust ethics committee where I would undertake the research. To access NHS staff, I was informed I would require local Trust research ethics approval. I would also need to apply via the University of Sheffield's Costing Tool even though I was not expecting to use any NHS resources as I fully expected to do this research outside of NHS time and premises both for myself and participants.

I queried whether or not I could ever get this research project off the ground and approached the Secretary of the University of Sheffield Research Ethics Committee. The Secretary suggested that if I approached participants via non-NHS means, undertook the research outside of NHS time and not on NHS premises then I would only need University of Sheffield ethics approval. This came as a great relief. I note that the online ethics approval application form relating to whether the NHS is involved now has the following statement:

## Research involving the NHS

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Research which **only** involves NHS staff or NHS premises may be reviewed via the University procedure. All other NHS research **must be reviewed by an NHS Research Ethics Committee**, and will need to go through the Health Research Authority's HRA approval process (see HRA website for details: <https://www.hra.nhs.uk/research-community/applying-for-approvals/hra-approval/>)

Please note that some types of study that only involve healthy volunteers rather than patients will still require HRA approval (e.g. clinical trials of investigative medicinal products or medical devices).

For full details regarding when review by an NHS Research Ethics Committee is required, refer to the HRA's ethics decision tool: <http://www.hra-decisiontools.org.uk/ethics/>

**Research involving the NHS, or requiring NHS ethics approval, must also follow the Research Governance Procedure.** For further guidance and details of your departmental governance contact see: <https://www.sheffield.ac.uk/rs/ethicsandintegrity/governance>

**Research involving the NHS requires registration on the University's Costing Tool** (accessed via My Research on the My Services MUSE menu. For more information see: <https://www.sheffield.ac.uk/rs/pricing/costingtool>)

*Fig. 1 Current entry on University of Sheffield Research Ethics Approval Form*

I thank the University of Sheffield Research Ethics Committee for taking a pragmatic approach and making their stance explicit to those who follow behind me.

This research was subsequently approved by the University of Sheffield Research Ethics Committee. The approval letter is available at Appendix 6.

When considering the ethics application, I was mindful of the main areas that have been identified as being of ethical concern in relation to interviews, namely (i) informed consent, (ii) confidentiality, and (iii) protection of the participants (Cohen and Manion, 2011; Denscombe, 2017; O'Leary, 2017). I had these three areas in mind as I set about designing and undertaking my research.

I contacted participants through my own contact details having worked previously with them. This allowed ease of access in the most efficient, timely and cost effective manner. Once a participant was contacted, there was an initial meeting to explain the extent and purpose of my research and the extent of their involvement followed up by sending the proof of University of Sheffield ethics approval along with the participant information leaflet. The leaflet was designed to answer frequently asked questions about research projects, and more specifically this project, as well as being written in simple terms without complex educational or research terms. The participant leaflet is available at Appendix 7.

Potential participants were then free to contact me at another point by e-mail or phone to discuss the research project. This discussion included the research aims and objectives; how data would be collected, stored and subsequently deleted; how the results would be disseminated; as well as the advantages and disadvantages of taking part. Following a cooling off period of a week for the potential participant to consider the merits of the research, they were then asked to sign a participant consent form as seen at Appendix 8.

Participants were approached on a private basis outside NHS time and premises so that no impact whatsoever was made on the NHS. All participants were Plastic Surgeons at some stage in their career, having the capacity and competence to achieve fully informed consent. The signing of consent was at the participants' own free will with no financial or other inducements to take part in the research.

Issues of anonymity and confidentiality were considered paramount to protect all participants. I gained access to and recruited participants but did not identify participants of the research project to any others involved. I was the only individual to record the interviews digitally. The

data sent by e-mail to my secretary was done so in both an encrypted and password protected manner. Data was transcribed by my secretary also in a digitally encrypted and password protected format for protection. Files were held within password protected computers at all times that were both internally and externally monitored for hacking and virus corruption. The secretary deleted all computer files relating to the data immediately upon sending the transcribed files to me in a password encrypted fashion. Hard copies of data used during data analysis were held in a locked filing cabinet in a locked basement. On completing the research, hard copies of data were industrially shredded by an external company and encrypted computer files will be deleted three years after completion of the thesis. At no point in the research will names be used, nor workplaces be identified to protect participants given the relatively small number involved from a relatively small geographical area.

The only personal data I collected was the determination of what generation and gender the participant belonged to and a brief description of their career path albeit with no names of hospitals or locations. Given the relatively small community of Plastic Surgery in the UK, it is conceivable that recognition of the voice of the participant may be enough for them to be recognised, hence data being stored securely, and the recorded files ultimately being deleted.

All participants, being practising doctors, would not be considered to be 'vulnerable' individuals. As part of employment processes, all participants will have carried out Disclosure and Barring Service (DBS) checks, as indeed I have, ensuring there are no criminal judgements against them or myself. Such checks are carried out on a regular three-yearly cycle or on commencement of any new employment such that the likelihood of an unlikely individual being involved in this research was extremely small. I personally am already registered with the Information Commissioners Office (ICO) as a data controller for medicolegal practice

outside of this study. However, as such, I am already extremely aware of the needs of data protection and the requirements of General Data Protection Regulations (GDPR).

The disadvantages for participants in taking part in this research I considered to be relatively few. Consisting chiefly of the inconvenience of time involved in meeting with me. However, I ensured as much as possible that interviews were carried out at a time, date and place of as much convenience to the participants as possible.

For the trainees involved, there may have been concerns that a refusal to participate may hinder career progression but as I am not involved in any of their annual appraisals this is not a consideration. Furthermore, it was made clear to all participants that whether they took part or not, it had no impact whatsoever on their annual appraisal. As I was looking at participants' sense of 'professionalism' I was not expecting to uncover any illegal or illicit activities that may have an impact upon any individual participant's safety or career. The participant information leaflet clearly stated lines of communication and contact for participants should they have issue with my personal conduct.

Whilst there were no direct benefits for participants, I hoped that they would view the research as helping to inform the debate on medical professionalism for the greater good of the medical profession, society and the government via dissemination through presentations and journals. A possible advantage for participants is that they can use the participant leaflets and consent forms as proof of active participation in research as part of their annual appraisal. Any direct quotations used in the thesis, papers or presentations will be anonymised to prevent identification of participants. By ensuring safe collection, storage and subsequent destruction

of data, as expected for GDPR, the risk of harm from the loss of research data will be extremely small.

As for the document analysis performed in this research, government White Papers are readily accessible on the internet free of charge for subsequent analysis. Furthermore, as access is unrestricted and readily open to the public, I considered ethical considerations to be negligible as I was not intending to write anything libellous or inflammatory (Wellington, 2015).

### ***3.4. Data Collection***

Knowing when to stop collecting further data proved problematic for me. I came to this research from a positivist background steeped in quantitative analysis. Positivist research requires statistical analysis to achieve significance from a probability point of view and thus a defined sample size. Conversely, the in-depth nature of qualitative analysis looking at the human experience as in this study requires consideration of a ‘saturation point’ following which the collection of further qualitative data is not warranted. This point is neither rigidly defined nor requires such a large sample size as in quantitative analysis (O’Leary, 2017). I was reassured by some authors actually stating the point at which they felt in their experience this saturation point had occurred. Lincoln and Guba (1985) suggested a figure of 12–20 participants achieving saturation whereas Douglas (1985) proposed a figure of 25 participants.

Conversely, Bowen (2008) refused to set a figure for interview saturation point as he argued each research project had its own contextualisation. He argued that rather focusing on a specific number, greater emphasis should be placed on the credibility of the research as being more important in terms of transparency, critical analysis, triangulation of data and reflexivity of the researcher.

Certainly, it became clear, in this research, by the time 20 interviews had been conducted that no additional themes and issues were being identified but instead recurring concepts.

### **3.5. *Data Analysis***

Qualitative research can result in voluminous amounts of data, as in this research. It involves the exploration of everyday real-life situations that describes the experiences, perceptions, values and attitudes of the participants. However, not only can humans be studied for deeper critical analysis but so can a host of ‘texts’, such as the government policy documents used in this study. To find meaning in all this data requires a systematic approach. Although, as Coffey and Atkinson (1996) describe, there are several means of doing so, they all essentially come down to the need to break up the data and then piece it back together again in order to allow interpretation, generate new theory a posteriori, confirm or reject theory a priori, or a combination of both to come to conclusions.

Quantitative analysis does a similar job in moving unused data through to meaningful interpretation using statistics on numerical data to find significance. To use such an approach in this research would lose the ‘richness’ of the data and lose the subtle intricacies of the human condition (O’Leary, 2017). Thus, rather than statistical analysis I chose to undertake a thematic analysis requiring a close relationship between the data and the researcher.

I had to decide whether to use pre-established codes to allow Social Contract theory to lead the analysis (a priori) in a deductive manner for potential confirmation of theory, or to allow the data to develop codes from which theory was derived (a posteriori) in an inductive manner, or a combination of the two (Wellington, 2015; O’Leary, 2017).

I used pre-established codes as I was clear that I wanted to cover certain areas, such as ‘professionalism, ‘membership of a profession’ and the ‘Social Contract’, due to these areas being determined by my literature review, the research questions and the wish to use Social Contract theory to underpin my research. However, during the course of the interviews, the issue of ‘professional identity’, ‘self-identity’ and ‘work–life balance’ emerged out of the data, and this required additional coding from which theory could be developed particularly with respect to predicting how the Social Contract may develop in the future. Thus, I used both deductive and inductive logic in the coding process.

The determination of whether a deductive logic proves already existing theory and/or determines what is relevant for inductive coding is subjective and therefore may very well differ from researcher to researcher based on values, attitudes and past experiences. Thus, the same data may produce different ‘truths’ and in choosing my codes I was alive to my own potential biases which I attempted to neuter as much as possible. However, Corbin and Strauss (2008) debate this potential conflict and discuss how it is virtually impossible to eradicate one’s own bias when attempting coding whether one is conscious or not of one’s own bias.

### ***3.5.1. Interview Thematic Analysis***

To undertake this thematic analysis, I decided to follow the guidance offered by Wellington (2015) with analysis being undertaken in a number of stages:

- *Immersion* – This required that immediately following each interview I wrote down what the underlying themes were, and the key points made. It then required the reading and rereading of the transcripts, often at the same time as listening to the audiotapes, while making further notes.

- *Reflection* – I would spend time away from listening or reading the data but would think about the data when often connections between pieces of data and interpretation of the data that I had not previously considered came to light.
- *Breaking Down Data* – The data was initially broken down into broad segments based on professionalism; profession; and the Social Contract. In turn the data within these segments was broken down into smaller codes. Subsequent data was placed in appropriate codes. If no code was suitable, new codes were initiated or codes merged or subdivided apart. Consequently, all data was subsumed into codes.
- *Recombining Data* – The final codes allowed not only the recognition of data that could be grouped together in recurring themes but also the opposite in terms of unexpected inconsistencies and irregularities (Delamont, 1992). Codes were subsequently reduced due to overlap and coalesced into categories and finally themes.

Wellington (2015) describes the stages of his qualitative data analysis as being based on the concept of ‘Constant Comparative Method’ (CCM) based on the work of Glaser and Strauss (1967), Lincoln and Guba (1985), and Maykut and Morehouse (1994). Maykut and Morehouse (1994, p.17) state:

*Words are the way that most people come to understand their situations; we create our world with words; we explain ourselves with words...the task of the researcher is to find patterns within those words and to present those patterns for others to inspect while at the same time staying as close to the construction of the world as the participants originally experienced it.*

CCM analysis is not linear but requires continual toing and froing through the stages of analysis in an iterative manner. Tesch (1990, p.96) summarised the method as follows:

*The main intellectual tool is comparison. The method of comparing and contrasting is used for practically all intellectual tasks during analysis: forming categories, establishing the boundaries of the categories, assigning the segments to categories, summarizing the content of each category, finding negative evidence...the goal is to discern conceptual similarities, to refine the discriminative power of categories, and to discover patterns.*

- *Locating the data* – this involves justifying my research, identifying what new knowledge had been garnered, how that new knowledge was put into place and the connections with other knowledge by adding it to the literature on professionalism. This could only be done on the basis of a thorough literature review and returning constantly to the core research question. The interpretation of the data was done in line with Social Contract theory so that conclusions from the data analysis could be assessed both a priori to help explain the findings and in turn in a posteriori manner to predict possible future occurrences.
- *Dissemination of the data* – this will commence once the thesis has been completed. I will need to determine whom I wish to ‘speak to’ i.e. Plastic Surgeons, the wider medical community, patients, policy makers and/or government. Determining who the audience is will in turn establish what journals to approach and meetings to attend.

### *Constant Comparative Method*

Having determined to use CCM in order to code the data, my reading about the technique made it seem that this type of analysis was predominantly linked with the concept of grounded theory. Grounded theory being synonymous with theory emerging from the data in an inductive manner. However, I also wanted to use the data obtained in a deductive manner to confirm or repudiate the relevance of Social Contract theory. Researchers such as Fram (2013) and Wellington (2015) discussed using CCM in a deductive manner which I believe gave me a warrant to use it both inductively and deductively in this research.

O'Connor et al. (2008, p.41) state:

*[CCM] does not in and of itself constitute a grounded theory design. Nor does the process of constant comparison ensure the grounding of data whether “grounding” is used in a positivistic or interpretive sense...constant comparison assures that all data are systematically compared to all other data in the data set...all data produced will be analysed rather than potentially disregarded on thematic grounds. It is the timing and the process of this constant comparison that determines whether the analysis is deductive and will produce a testable theory or whether the analysis is inductive and will build a theory for a particular context.*

As already described, an advantage of qualitative research is the richness of its data in describing the reality of a social phenomenon under study. The difficulty, therefore, lies in reducing down the vividness in all the data obtained into a more succinct form, as displayed in this thesis, that maintains that diversity of data. I attempted to use quotes from a number of participants but of course that has required personal judgements as to which quotes are worthy and of merit. Such decisions are based on my values and what I regard to be succinct, enlightening and thoughtful that can be used to reinforce and illuminate my interpretations of

the data. Needless to say, such quotes will be my interpretation of the ‘truth’, but inevitably others presented with the same data would choose other quotes to reveal their ‘truth’.

### *Manual or Computer Coding*

Qualitative data can be sorted and analysed into themes and codes either manually or by computer. I found myself being torn in deciding which path to take. The EdD course allowed either way and indeed provided appropriate demonstration of the use of the NVivo software for computer-assisted qualitative data analysis (CAQDAS).

I read the literature on CAQDAS which had its proponents and detractors. The benefits of CAQDAS appeared to me to be the ease by which one can appoint codes, make links between codes, search for specific words or phrases, and demonstrate a trail of how the thematic analysis was performed (Wellington, 2015; O’Leary, 2017; Silverman, 2017). However, it was clear that CAQDAS is a ‘tool’ that helps with the analysis but does not actually do the analysis itself which still has to be done by the researcher (Thomas, 2013; Yin, 2014).

I came down on the side of manual coding. It ultimately felt to me that CAQDAS was simply too systematic and, whilst excellent at producing graphs, tables and charts and to a degree some quantitative data to demonstrate my research, that was not what I was trying to achieve. Instead, I wanted to ‘get under the skin’ of participants and try to understand how they felt about being a Plastic Surgeon. To do that, I deemed it necessary to remain connected with the data. If I was to immerse myself in the data, I felt that this was best done via the manual route. I also felt that being able to view the data globally and get my hands on it readily would be of more help than having to turn from one isolated page to another using CAQDAS.

Strauss and Corbin (2008) described the process of coding as involving three levels, (1) open coding, (2) axial coding, and (3) selective coding, required to gather the whole picture of the data acquired following the data collection process. This pragmatism was designed to help novice researchers such as myself. As Boeijs (2002, p.393) describes:

*The literature does not make clear how one should go about constant comparison, nor does it address such issues as whether different types of comparison can be distinguished.*

Open coding required taking apart line by line the data collected from my interviews. In so doing, identifiable chunks of text varying from single words to a paragraph were identified as relating to a certain idea, view or opinion resulting in themes and then codes. This breaking down of the interview data resulted in lengths of text called ‘incidents’ (Glaser and Strauss, 1967) or ‘units’ (Lincoln & Guba, 1985). Axial coding was the next step whereby data was put back together in novel ways following realisation of connections between codes requiring continual question asking and comparison making. Finally, selective coding was performed by critically connecting categories to other categories (Kolb, 2012).

Indeed, I found the literature extensively described the theoretical framework of CCM and its aims and objectives but there was less clarity on how to practically perform the coding process. Fram (2013) described this as a “*shortcoming of emergence*” (p.3) whereby novice researchers simply did not really understand how to go about the comparing and contrasting of pieces of data from which theory could arise. Fram (2013) also describing a “*shortcoming of theoretical sensitivity*” (p.4) whereby experienced users of CCM undertake no literature review prior to their data analysis relying on their in-built implicit knowledge of how to carry out analysis.

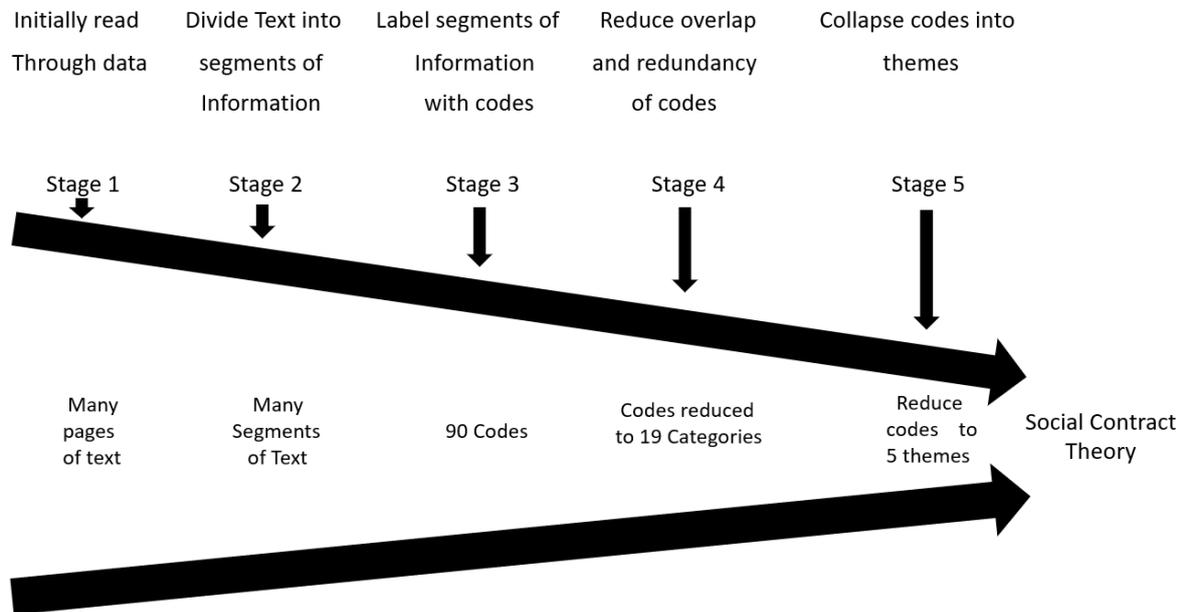
As a practical reference when undertaking my CCM I chose the work of Boeije (2002) which I found to be the clearest description of how to go about the coding process. In particular, there was lucid description of what to code in each of Strauss and Corbin's (2008) coding steps with particular respect to the questions one needed to ask oneself when performing the analysis at various stages. I was also struck by how Boeije (2002) had systematically broken down the analytical process in a way that seamlessly led to the answers that her research questions posed. Following Boeije's (2002) example, I decided that I would in turn perform the following comparisons:

- 1) Comparison within a single interview.
- 2) Comparison between interviews within the same generational group.
- 3) Repeat steps (1) and (2) for each generational group.
- 4) Comparison of interviews between each generational group.

I subsequently spent time reading and rereading individual interview transcripts and highlighted with marker pen sections that related themes. The highlighted section was then cut out and placed on a board in a single pile. This pile was then further analysed into smaller more specific codes related to the research questions using a different highlighter pen. In so doing the data was systematically broken down into codes that did not overlap and left no data outside a code. Thus, it was on my part a subjective exercise as to what constituted themes and codes as well as how these codes were subsequently further subdivided. It was at this point that I was very conscious of my own values and potential biases because as Coffey and Atkinson (1996) suggested "*coding is never a mechanistic activity*" (p.37).

This process was time consuming, but I felt that if I did use NVivo there would be a lengthy learning curve that would take some time to get over, resulting in little time saving nor was I likely to use it again in the future.

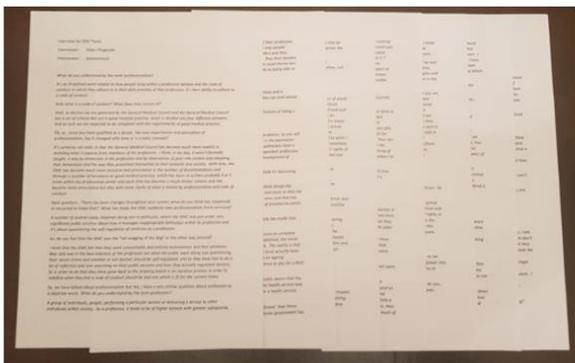
I provide in the following diagrammatic forms the process that I undertook in thematic analysis from taking the raw data from the interviews through to themes that could then be assessed through the lens of Social Contract Theory.



Modified from Creswell, J. (2012)

Fig. 2 Stages in processing interview data

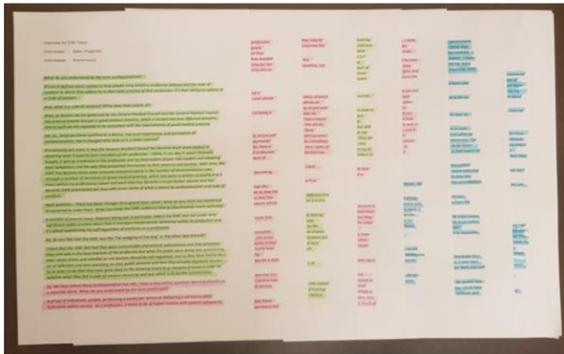
**Stage 1** – Once having obtained the interview data, I immersed myself in the data by repeated reading and listening to the interview data.



Stage 1 Raw Interview Data

Fig. 3 Picture of individual transcribed interview

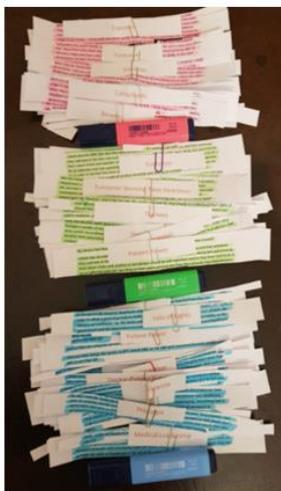
**Stage 2** – The interview data was then divided up into three pre-established segments based on my literature review: (1) Professionalism, (2) Profession and (3) the Social Contract. These segments were highlighted in different colours: (1) Professionalism – green, (2) Profession - pink and (3) the Social Contract – blue.



**Stage 2** Data split into segments with highlighter pens

*Fig. 4 Picture of highlighted segments of text in single interview*

**Stage 3** – Each of the three segments of data were broken down into codes that totalled 90 in number and can be seen in Appendix 5.



**Stage 3** Segments split into smaller codes

*Fig. 5 Picture of highlighted codes from segments of text cut into individual codes*



### Stage 3 Segments split into smaller codes

Fig. 6 Picture of highlighted codes on 'Profession' from single interview

Professionalism	Profession	Social Contract
Code of Conduct	Autonomy	Clarity
Consultants	Benefits	Doctor-Patient Relationship
Curriculum (Formal)	Consultants	Education
Curriculum (Informal)	Evolution	Government
EWTA	General Medical Council	Identity
Evolution	Government	Litigation
General Medical Council	Grouping of Individuals	Loss of Rights
Government	Identity	Medical Leadership
Medical Standards	Regulation	Nostalgia
Nostalgia	Trainees	Patient Knowledge
Patient Power	Vocals	Patient Power
Team	Work-Life Balance	Regulation
Trainees		Tripartite

### Stage 3 Segments split into smaller codes as listed for each interview

Fig. 7 Picture of listed codes from each segment in a single interview



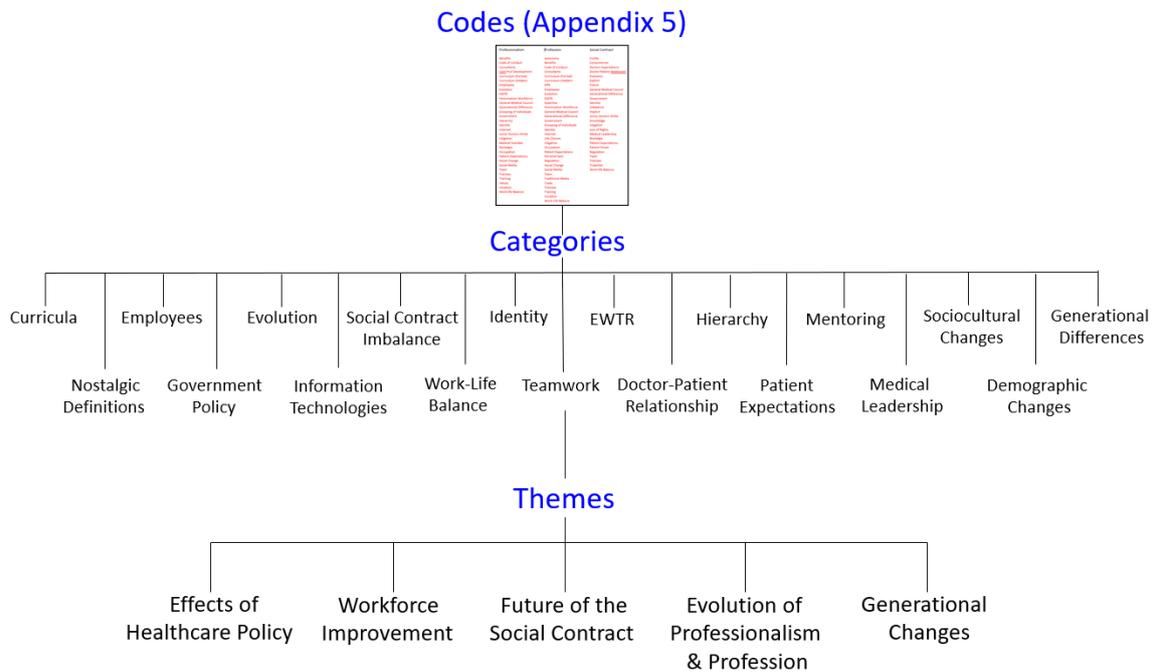
### Stage 3 Steps shown in sequence

Fig. 8 Picture of previous steps laid out in sequence from a single interview

**Stage 4** – The number of codes was reduced given the degree of overlap across the three segments down to a final 57 codes. The codes were then subjected to the Constant Comparative

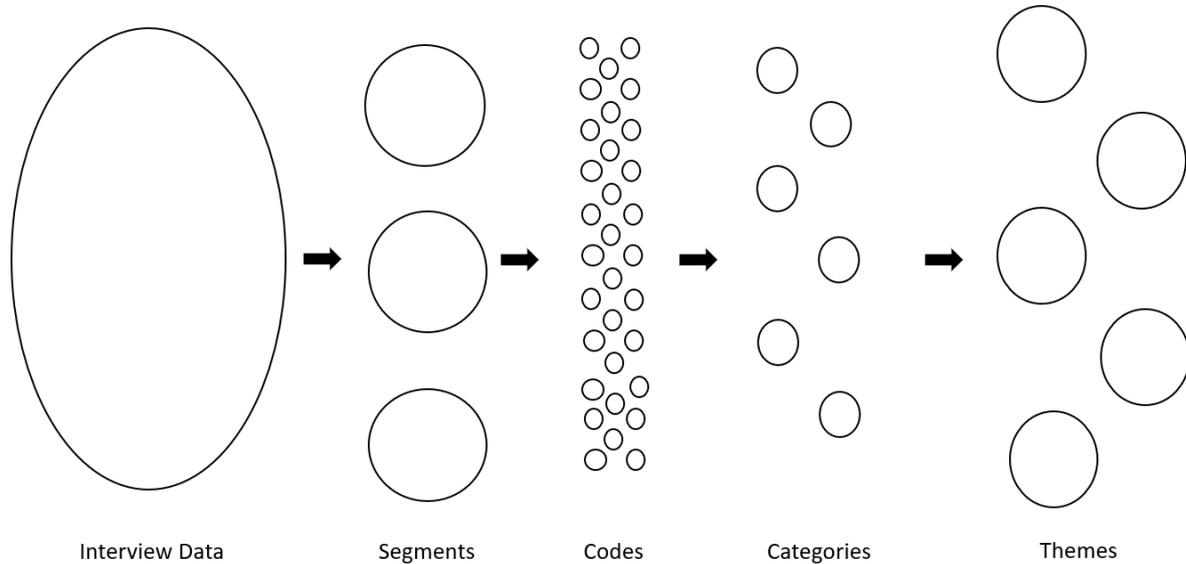
Method particularly based on the technique suggested by Boeije (2002) described in this section above to produce 19 categories.

**Stage 5** – The categories were further reduced down ultimately into 5 themes by further constant comparison and synthesis. The final themes were then viewed through the lens of Social Contract Theory in both a deductive and inductive manner to draw out findings. The findings of this analysis are presented in chapter 4.



*Fig 9. Diagrammatic representation of stages 4 & 5 highlighting sequence of codes through categories to themes*

Whilst the above Fig 2. suggests a funnel-like approach whereby ‘packets’ of information were progressively reduced, the following diagrams provide further clarification of the coding process.

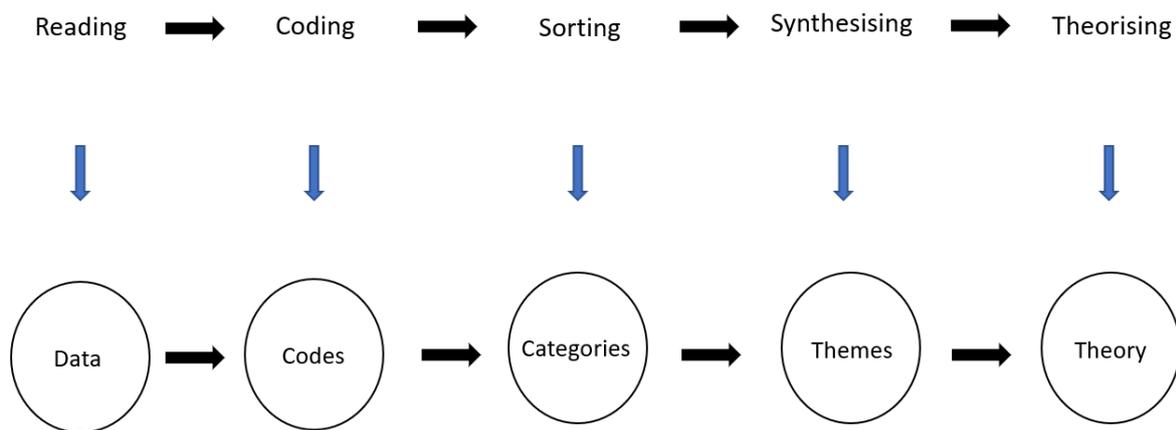


*Fig. 10 Diagram representing initial disassembly and then subsequent reassembly of data*

In reality, what occurred followed the description of Kolb (212), whereby the totality of data from the interviews was progressively broken down into much smaller individual fragments of data, i.e. codes (as can be seen in appendix 5). The total number of codes across the three segments was 90 but there was considerable overlap in codes across the three segments as can be seen in appendix 5. Once this crossover had been taken into account, there were in actual fact 57 different codes before the fragments were pieced back together in new ‘packages’ of data of increasing size, namely 19 categories and ultimately 5 themes as seen in Fig. 9. Piecing the ‘packages’ of data back together did not mean putting it all back from whence it came but required looking for associations both expected from previous reading as well as unexpected associations. Just as important, I also looked to identify where codes did not cut across

segments. As previously stated, the work of Boeije (2002) was instrumental in guiding this process of assimilation and synthesis.

The process of breaking up the original data into smaller pieces and then assimilating it back together in a different form was described by Saldana (2009) and is put in diagrammatic form in Fig. 11 below. The top row represents the actions being taken whilst undertaking the analysis with the bottom row representing the outputs of those actions



Modified from Saldana (2009)

*Fig. 11 Diagram representing actions in the analytic process and their outcomes*

Whilst the diagram suggests a linear process, there was in fact constant movement back and forth along the stages between reading and theorising consistent with the Constant Comparative Method in an iterative manner.

### **3.5.2. Documentary Analysis**

To analyse the government documents, I decided to follow the steps suggested by Plummer (1983). The first step being the ‘exploratory stage’ when documents such as the literature can

be used to open up the field of inquiry to a researcher and in so doing highlight key areas to be followed and commence the development of the research questions. The second step being the ‘complementary stage’ whereby specific documents are analysed, to add to, bolster and triangulate the findings of other research methods. Finally, the third step being the ‘concluding stage’ whereupon the analysis is summarised, made available to a wider audience and its position with respect to already available literature identified.

Having determined the above stages of documentary analysis, I needed to consider how I would assess the documents which I determined I would examine according to parameters proposed by Scott (1990):

- *Authenticity* – reflect on the source of the document and who had written it.
- *Credibility* – establish if the document is free from error and bias and telling the ‘whole’ truth or just part of the truth.
- *Representativeness* – consider the completeness and extent of the evidence provided to account for the conclusions drawn.
- *Meaning* – try to understand what the document is attempting to tell or not tell the audience given the sociocultural and political context in which it was written.

It is the search for ‘meaning’ in a document that is the most controversial aspect of documentary analysis as noted by Wellington (2015, p.215):

*[It] is not some kind of hunt for, or pursuit of, a single inner meaning or essence. It is a matter of interpretation. Documents have multiple meanings. Documentary research starts from the premise that no document should be accepted at face value, but equally that no amount of analysis will discover or decode a hidden, essentialist meaning.*

I needed to go beyond the literal understanding of the words and phrases within the documents, i.e. their denotation, and instead, interpret the words and phrases used given the time and context in which they were written, i.e., their connotation (Chandler, 2007).

Put another way, I needed to consider the points described by Usher and Edwards (1994), as follows:

- a) *The context* – the position of both myself and the author(s).
- b) *The pretext* – consider what documents and social, cultural and political influences existed prior to the document in question.
- c) *The subtext* – determine what has not been included or stated within the document.
- d) *The intertext* – how any document relates to similar literature before and after its production.

I, therefore, used the series of questions recommended by Wellington (2015, pp.216–217) to probe the White Papers as seen in Appendix 9 that consisted of determining authorship, audience, production, intentions, style, content and context. In using these areas of questioning for the documents, I could expect to come to some understanding of the position of these government papers but, in turn, also consider my position based on my past experiences, perceptions and understandings to compare and contrast any difference in the two standpoints (Scott, 1990).

## Chapter 4

### Data Analysis & Discussion – Interviews

In this chapter, I present not only my research data gleaned from semi-structured interviews but also the analysis of that data. I will draw on this analysis to answer the fundamental research question of this dissertation, namely, *‘Do generational differences exist in current understandings of medical professionalism which may impact the way the “Social Contract” functions in practice?’* To assist in answering this core question, further ancillary questions will be addressed alongside as well:

- i) How do current Plastic Surgeons define ‘professionalism’?
- ii) What does ‘profession’ mean to current Plastic Surgeons?
- iii) Can current Plastic Surgeons use the concept of the ‘Social Contract’ to understand their working environment?
- iv) What are the potential consequences for the Social Contract if there are indeed significant generational differences in how professionalism is viewed?

As part of the analysis, the findings will be positioned within both the literature discussed in Chapter 2, and my methodology as described in Chapter 3.

#### ***4.1. Interviews***

As described in Chapter 3, data was obtained by means of interviews with Plastic Surgeons at various stages of their career. The findings from these interviews are presented in this chapter.

The semi-structured interviews centred on three main themes which were identified in my literature review, namely (i) professionalism, (ii) Medicine as a profession and (iii) the Social Contract.

As described in Chapter 3, an initial decision was made to undertake pilot interviews, the findings of which and how they contributed to the research process are subsequently discussed.

#### ***4.1.1. Findings of Pilot Interviews***

The first pilot interview was carried out with a male full-time Baby Boomer Consultant (BB1) and the second with a female part-time Generation Y trainee (GenY1). It became apparent from these two pilot interviews that a potential defining moment in attitudes towards the concept of professionalism and being a member of a profession was the introduction of the European Working Time Regulations (EWTR) in 1998.

When BB1 was asked, “*Do you believe that there are generational differences in the understanding of professionalism?*” the response centred on the effects of EWTR as follows:

*So EWTR had a major impact upon the way that training is delivered...on the whole relationship between seniors and juniors, with juniors seeing that it was their “divine right” to have protected time, whereas in my day, I was completely dedicated to what I was doing and the thought of clocking off at 5pm because that was the time to leave was completely alien. However, now it has become the modus operandi for most people to understand their rights of time off, and they are protected with regard to both their educational time and their protected non-clinical time.*

BB1 seemed to have a disapproving opinion of EWTR given what appeared to be a description of trainees being turned from professionals into nothing more than employees. The use of ‘divine right’ and ‘clocking off’ suggesting to me that BB1 was inferring that trainees did not go the extra mile in their work and that they considered their needs were as important as those of their patients.

GenY1, when asked, “*Have your experience, feelings and your perception of professionalism changed?*” responded similarly with respect to the loss of team working and thus the lost ability to learn through the hidden curriculum (see Chapter 4.3.1. for definition) how to behave. I felt this was a tacit response to the effects of EWTR, although not directly mentioned:

*We worked tightly as a team and there were benefits of being part of that team, financial benefits, social benefits, and so you worked in a very professional manner because you really wanted to please those people above you...I think they just don't feel part of a team...they don't see how the team dynamics work, and how we work as a profession...they don't see how to act.*

Interestingly, although from different generations, both BB1 and GenY1, highlight the significant effect of EWTR on their working practices albeit explicitly by BB1 and implicitly by GenY1. Despite the generational difference, both interviewees communicated what I perceived as almost a ‘sense of loss’ at the breaking up of the model of team working. But how did this come about?

EWTR legislation was introduced in 1998 and put into statute by the UK government in 2003 with the purpose, over time, of reducing legal working hours and introducing mandatory rest periods. In the medical profession, this meant legally permitted weekly working hours were

gradually reduced. Subsequently, the 80–90 hours per week that trainees worked prior to 2003 came to an end. Progressively, working hours were reduced to 72 hours/week in 2004, 56 hours/week in 2006 and finally the current 48 hours/week in 2011 (Royal College of Surgeons of England, 2014).

Before 2003, doctors worked in a hierarchical team structure known as a ‘firm’ with trainees learning in an apprentice-like model working extended daytime ‘office hours’ as well as a nightly ‘on-call’ system on a rolling basis. Following full implementation of EWTR, the NHS, in order to fulfil its legal requirements, dismantled the ‘firm’ structure with doctors subsequently trained in shift patterns similar to a factory worker. This meant that, rather than regular office hour working, junior doctors were made to work in ‘packets’ of time that would change from week to week (Royal College of Surgeons of England, 2015a). The shift pattern was required as this was the only means by which, if the number of trainees was to remain the same, both a reduction in trainee weekly hours could be allowed and total medical coverage for the NHS ensured across all hours. These changes resulted in the loss of the team-like ‘firm’ working structure. This resulted in trainees spending less time in normal office hours when Consultants were predominantly present, such that their professional training shifted from one of role modelling to a more didactic system of teaching and simulation (Brown et al., 2010; Gilleard et al., 2012; Khan et al., 2012; O’Gallagher et al., 2013).

A review at the time (Temple, 2010) on behalf of Medical Education England suggested high quality training could be undertaken in the much reduced hours following EWTR but not if trainees’ time was spent predominantly in out-of-hours service with poor supervision and reduced access to learning opportunities from Consultants. Temple (2010, p.10) commented on what this review specifically referred to:

*The dissolution of the “firm” structure with the work patterns of trainers and trainees not being matched. This has led to the loss of the traditional relationship between a trainee and the trainer.*

As Consultant BB1 had trained under the firm model and the trainee GenY1 under a mixture of both ‘firms’ and a shift system, I thought it prudent to have the participation of trainees in my research who had experienced solely the shift system. I therefore undertook a third pilot interview with a female full-time trainee (GenY2) who had only experienced employment since the introduction of EWTR by means of a shift system. From the answers obtained from these pilot interviews, I recognised that I needed access to interviewees who had a comparable range of experience to the three pilot participants.

An unanticipated finding in the pilot interviews revealed potential generational differences with respect to how work–life balance was perceived and whether sacrifices were deemed necessary to achieve balance. I decided that I wished to explore this further. For example, BB1, when asked “*Do you think there are generational differences in the understanding of what it means to be a member of a profession?*” responded:

*The expectation of the current doctors [trainees] is about ensuring an adequate work–life balance...they are no longer prepared to devote their whole life to delivering care to other people...they want time for themselves, for their family and for other things outside of medicine. I think the older generation who are completely dedicated, perhaps to the exclusion of everything else, to their profession have little interest outside of their professional lives because everything they have wanted was provided within their profession. So, the communication, the adoration, the positive feedback, the enjoyment*

*of their work; that meant a lot to my generation. I am not sure it means quite so much to the next generation.*

Therefore, I decided to adapt the questions in the main interviews based on the findings of the pilot interviews. Specifically, I wanted to test the perceptions of BB1 that trainees wished for a better work–life balance by not making the sacrifices made by their predecessors.

An important issue that surfaced during the pilot interviews was the difficulty in the participants' recognition of the concept of the Social Contract as it was not something any had necessarily heard of previously by name. Therefore, I decided in the subsequent formal interviews rather than introducing the theme by name on the day unannounced to the participants, to send each subsequent participant an information leaflet summarising the Social Contract one week prior to the arranged interview. The rationale behind the information leaflet on the Social Contract has been explained in Chapter 3.

Following feedback from the pilot interviewees, final adjustment of the interview question schedule was made by including additional questions on the themes of the ability of the interviewee to separate work and home pressures, the importance of work–life balance, and what that may mean for the function of the Social Contract.

#### ***4.2. Interviewee Demographics***

Twenty semi-structured interviews were undertaken. The doctors interviewed belong to three generations: Baby Boomers (born 1946–1964), Generation X (born 1965–1980) and Generation Y (born 1981–96). I ensured each generation was interviewed but this almost seemed an artificial classification as all Consultants were either Baby Boomer or Generation

X, and all trainees belonged in Generation Y. I therefore strove to ensure relative equity in terms of Consultants and trainees interviewed. The years in practice reflected the length of service in practice for each corresponding generation.

	<b>Baby Boomer</b>	<b>Generation X</b>	<b>Generation Y</b>
<b>No. Interviewees</b>	<b>5</b>	<b>5</b>	<b>10</b>
<b>Years in Practice</b>	<b>30 – 41</b>	<b>20 – 26</b>	<b>0.75 – 14</b>
<b>M : F Ratio</b>	<b>4 : 1</b>	<b>3 : 2</b>	<b>5 : 5</b>

*Fig. 12 Diagram of demographics of interviewees*

Of particular note, as will become apparent in the subsequent discussion in this chapter, is the potentially important demographic change in the Plastic Surgery workforce with a slow but steady increase in the number of women entering the specialty over the last decade. This reflects the slowly increasing percentage of women registered with the General Medical Council (2018) who state an increase from 43% to 47% between 2012 to 2019. Correspondingly, NHS Digital (2018) suggests an increased proportion of female doctors between 2009 to 2018, rising from 41% of the total workforce to 45% in that time. Plastic Surgery has seen the number of female Consultants rise from 14% in 2010 to 20% in 2019 (British Association of Plastic Reconstructive & Aesthetic Surgeons, 2020). These percentages representing female doctors both in the general workforce and in Plastic Surgery are likely to

increase given that currently 55% of medical school entrants in the UK are women (Bellini et al., 2019).

### **4.3. Professionalism**

All interviewees of whatever generation, when asked what ‘professionalism’ meant to them, considered it a set of attitudes, values and behaviours expected of a member of a particular profession, as described in the literature (Friedson, 1988; 2001; Rowley et al., 2000; Duff, 2004; Van de Camp et al., 2004; De Cossart, 2005; Arnold & Stern, 2006; Dreyer, 2010).

For example, BB4 stated: “*Professionalism is standards of behaviour; the way you dress; the way you speak; integrity; probity and clinical skills.*”

Likewise, GenX2 noted:

*[Professionalism is] a code of conduct...behaving in a polite and respectable manner; respecting the people both that I work with and the patients that I see; doing the best that I can for them within the GMC guidance; confidentiality and me keeping up-to-date”.*

Similarly, GenY1 stated:

*[Professionalism is] a way in which you conduct yourself in society or in the workplace where you respect others, treat others in a manner which I would want to be treated myself and I think it is a code of conduct that, from a medical profession, is stipulated by the GMC.*

I noted that all generations were mindful of professional guidance on what was expected of their professional behaviour by the General Medical Council in their guidance *Good Medical Practice* that was first introduced in 2006 (General Medical Council, 2019a) as summarised here by BB1: “*The GMC has a set of criteria laid out in good medical practice, which is divided into four domains...we are expected to be compliant with these requirements.*”

‘Domains’ refer to the four areas of professional attributes against which the GMC will assess and judge doctors. Domain 1: ‘Knowledge Skills and Performance’ relates to continued professional development, contemporaneous medical record keeping, and applying knowledge and experience to practice. Domain 2: ‘Safety and Quality’ relates to contributing and putting in place systems that improve and maintain patient safety, responding to risks to patient safety, and being transparent about the effect of one’s health on patient care. Domain 3: ‘Communication Partnership and Teamwork’ deals with communicating effectively, working collaboratively with colleagues, getting involved in education and maintaining professional relationships with patients. Domain 4: ‘Maintaining Trust’ requires the need to act with honesty and integrity, avoid discrimination, and demonstrate respect for patients.

On reflection, this familiarity with the GMC’s *Good Medical Practice* is likely to be a result of the mandatory need to consider this document and its guiding principles. Consultants, for example, must undertake a mandatory annual appraisal during which they are instructed to discuss how the information provided demonstrates ongoing commitment to the requirements of *Good Medical Practice* (General Medical Council, 2019a). The annual appraisal documentation for Consultants can be seen in Appendix 10. Trainees follow the Plastic Surgery curriculum as seen at the Intercollegiate Surgical Curriculum Project (2016) in which they have

to be taught and learn prescribed knowledge, skills and professional behaviours. In the curriculum it is noted that from a professional perspective:

*These values and standards are laid down in the General Medical Council's Good Medical Practice...The Professional Behaviour and Leadership skills section of the syllabus is common to all surgical specialties and is based on Good Medical Practice.*  
(p.7)

The concept of professionalism was teased out further by Van de Camp et al. (2004) in their study of intrapersonal, interpersonal and public professionalism as discussed in the literature review. Intrapersonal professionalism is described as encompassing attributes an individual doctor should hold in order to function within the medical profession, such as a desire for ongoing learning throughout their career, the desire to improve communication skills and the aptitude to reflect on past practice. This need for continued professional development was described by BB2 when they stated: “A lot of what I do is driven by a desire to do something useful or difficult or something that other people naturally cannot do.”

GenY7 expanded on this, stating:

*Professionalism comes with a need to be conscientious and the want to strive to be a better doctor and that means continual training, to improve your skills, my skill set, to improve my knowledge.*

Interpersonal professionalism involves looking at how the doctor interacts with their patients and colleagues with a particular focus on attributes underpinning altruism towards patients and developing effective working relationships with colleagues.

Gen Y7 described just this:

*I think it [professionalism] incorporates a set of values...and having a genuine desire to care for other human beings...professionalism incorporates being able to work well with others including people who you may have a personality clash with, but I think it's still possible to work professionally with everyone.*

Public professionalism refers to the behaviours, values and attributes that society demands of the members of the medical profession. Interestingly, BB1 referred to a rise in societal expectations from doctors:

*The general public are no longer prepared to be spoken down to; they want to know what the options are, so the changes in the consent process...but they do mean that you need to spend more time with your patients and make sure they understand the options that they are being offered.*

When interviewees were asked how they learnt their professionalism, there was a stark difference between Consultants (Baby Boomers and Generation X) as compared to trainees (Generation Y). Consultants appeared to learn professionalism by being assimilated into the profession without any formal teaching, as noted by BB1: *“It wasn't formally taught; it was by immersion in the profession and by observation of peer role models and adopting their behaviours.”*

Likewise GenX3 stated:

*I can't remember having formal teaching of professionalism, but certainly as a medical student I had lots of exposure to doctors of all levels to the extent that I was able to observe, this is how I want to be, this is how I don't want to be.*

However, trainees appear to have experienced a sea change in the teaching of professionalism where it has become more structured and formalised in nature rather than relying on assimilation into the profession alone, as seen in these responses.

GenY2: *“We would have lessons on how to talk to patients; how to deal with a patient that is getting angry and we would be told...how we should dress.”*

Similarly, GenY8 noted:

*At medical school they gave us monthly sessions...with Consultants and we would present a case that we thought was evidence of good professionalism or not so good professionalism and would discuss them.*

It is not surprising that only Generation Y have been exposed to formal teaching of professionalism given the introduction of EWTR. It was with the introduction of reduced working hours and shift working patterns for trainees that, in turn, both learning opportunities during office hours and exposure of junior doctors to Consultants were limited. Consequently a need for more didactic teaching and learning of knowledge and surgical skills within Medicine became paramount (Pereira & Dean, 2009). Concurrently, there was increasing awareness of the need to introduce the teaching and learning of professional behaviours into surgical curricula by Harden et al. (1999), Simpson et al. (2002) and De Cossart (2005). These authors were of the opinion that ensuring suitable professional behaviours from doctors was just as important as the acquisition of knowledge and operative skills. Putting this all together resulted in the Surgical Royal Colleges making the teaching of professional behaviours an integral part of all surgical curricula, as seen on the Intercollegiate Surgical Curriculum Project

(ISCP) website when the first ever formal curricula were introduced for each surgical specialty in 2007 (Pereira & Dean, 2009).

The year 2007 was the point at which the first ever Plastic Surgery curriculum in the UK was formalised and all trainees were expected to follow it. Prior to 2007, the learning of 'professionalism' was informal as there was no set structure to follow but with the aid of hindsight it becomes clear that professionalism was taught by means of the 'hidden curriculum' via role modelling. However, from 2007, professionalism has also been taught much more formally through the ISCP Plastic Surgery curriculum (Intercollegiate Surgical Curriculum Project, 2016).

It does seem, from the literature review, that there has been a fundamental educational shift since 2007 in the teaching and learning of professional behaviours from an informal to a formal curriculum. It is worth considering to what extent this may have had an effect on any subsequent generational differences in understandings of professionalism.

#### ***4.3.1 Formal v Informal Curricula***

When analysing the data from this research, I therefore looked for evidence from the interviewees as to whether a shift in professionalism teaching from the informal to a formal curriculum had occurred and whether this shift, if having occurred, had any effect on generational differences in understandings of professionalism.

Baby Boomers appear to have been taught informally through the hidden curriculum by observation and role modelling as evidenced in the following quotes.

BB1:

*In my day, it wasn't formally taught, it was by immersion in the profession and by observation of peer and role models and adopting their behaviours and the way they presented themselves to their patients and society.*

BB4:

*You learned it from the behaviours of your bosses when you're an apprentice.*

Some Baby Boomers suggested that professionalism was taught well before starting their medical careers but once having started it was via the hidden curriculum.

BB3:

*I think from my peers and elders. I think it started at school; respect for others; respect for the teachers and that was inherent and that followed through into university life and then moving into medicine, I learnt from the trainers, seniors and consultants.*

Generation X interviewees essentially concurred with those from the Baby Boomer generation in following the hidden curriculum to learn professionalism.

Gen X1:

*The only way I could learn was by observing my seniors in the way they interacted with patients and staff [So you had no didactic form of teaching]... No. There never was.*

Gen X2:

*I think copying and simulating what I saw my peers do.*

Gen X3:

*I can't remember having formal teaching of professionalism, but certainly as a medical student I had lots of exposure to doctors of all levels to the extent that I was able to observe, this is how I want to be, this is how I don't want to be*

Generation Y interviewees confirmed the shift post-2007 to a mixture of both more formalised teaching of professionalism as well as continued role modelling. In fact in the first quote from GenY1 the loss of learning through teams due to the introduction of EWTR comes through clearly in their words.

Gen Y1:

*I think they just don't feel part of a team and...because they don't see how the team dynamics work, and how we work as a profession because it's been all fragmented with change in how the service is delivered, that they don't see... how to act necessarily.*

Gen Y2:

*We would have lessons or lectures. Like tutorials perhaps on how to talk to patients; how to deal with a patient that is getting angry and we would be told the session before we started placements on how we should dress and appear and stuff like that.*

GenY4:

*I'd like to think that my idea of professionalism is similar to that of senior colleagues...because I would try and emulate the way that they behave and their approach towards professionalism.*

Importantly, it was recognised that if the hope of passing on appropriate behaviours via the hidden curriculum was the intention, then it was just as possible for inappropriate behaviours to be observed.

Gen Y8:

*We can always look up to...shining examples of consultants who have excellent work ethics and those are the ones that we remember; we don't remember the ones who go off and play golf! Well, we do but we don't remember them as shining examples of professionalism.*

An unconvinced attitude towards this shift towards formal teaching of professionalism was described by Generation Y interviewees such as GenY8: “*The medical school I went to pushed a very fluffy version of professionalism.*” When GenY8 was pressed as to what they meant by ‘fluffy’, the reply was:

*I guess in the sense that they [the medical school] push it as being very communication [sic], so rather what you say and how you say it rather than what you do and how you do it.*

The use of the term ‘fluffy’ by the trainee to me suggests a sense of scorn in that the trainee was hoping to receive some sense of why professionalism was considered to be important by the medical school. The response as to what ‘fluffy’ meant implies to me that the trainee was more focused on the results of their everyday work rather than the soft skills of communication. Furthermore, it would appear that the teaching simply did not meet their expectations as to

what professionalism meant to them. It seems the attempts by this particular medical school to promote the importance of professionalism were unsuccessful in their objectives.

A tacit acknowledgement that the formal ISCP curriculum, as opposed to informal hidden curriculum, was not entirely successful in the context of surgical training with respect to professionalism has been made by the Royal College of Surgeons of England (2015a, p.24) and is the closest this body has ever come to describing the importance of the hidden curriculum and teamwork:

*This type of apprenticeship model does not solely or primarily depend on explicit instruction. Rather, knowledge is also transmitted through informal learning that relies on time spent together (context, shared language and experiences, observation, implicit rather than direct communication)...The key is that relationships must be allowed and encouraged to form. The current situation, where a consultant may not know their junior trainee's name because of shift patterns that have kept them apart cannot continue if training is to become more effective.*

It is not only the English College that recognises the importance of role modelling in handing over professional behaviours to the next generation, the Royal Australasian College of Surgeons also describes it as fundamental to surgical practice (Tobin & Truskett, 2020).

As will be subsequently discussed, Consultants are critical of junior doctors as a result of their wish for greater work–life balance as well as their lack of resilience. Whilst at first glance this may seem a valid point, Generation Y trainees should not be demonised for being simply born too late to enjoy the benefits of a team-like ‘firm’ structure. Generation Y doctors who have

never experienced the ‘firm’ have lost much of the benefit of the hidden curriculum, as will be discussed later in this chapter.

Interestingly, this desire for a greater work–life balance may well have resulted from the loss of both the ‘desensitising’ effect of the hidden curriculum and the outlets to express their concerns through the ‘team’ that traditionally allowed junior doctors to withstand the rigours of the profession. The wish of Generation Y trainees to seek relief from work-related stress should not be criticised.

What points me in the direction of such a thought is that as one can see from the interviewee demographics there is a wide spread of experience within Generation Y. However, the two most experienced trainees in Generation Y actually worked within a ‘firm’ structure for a couple of years (14 and 13 years’ experience since qualification respectively), and one other Generation Y trainee with seven years’ experience spent six months working for one Consultant only in a firm-like manner. These three Generation Y doctors appeared to align themselves much closer to Generation X interviewees with respect to how they believed ‘professionalism’ had changed during their career with a more negative attitude towards such changes, as compared to their Generation Y peers. This was described by the three Generation Y trainees, as follows:

GenY1 (14 years’ experience) –

*I do think that there has been a shift in the level of professionalism from the junior cohort of doctors...I just think there is a general shift in society, the way we work, the constraints of the NHS, the cut backs, the working day...I think the way younger people behave and conduct themselves and social media like that is very different to how I*

*learnt in the younger years...we used to work for a team, we had the luxury of having our own junior doctors...We worked tightly as a team and there were benefits of being part of that team; financial benefits, social benefits, and so you worked in a very professional manner because you really wanted to please those people above you, and there were rewards from that but I think now there is nothing.*

GenY5 (13 years' experience) –

*Consultants are much more, what I would presume, is how the medical profession is, or should be, or has...they are dedicated to their job, dedicated to helping people with underlying reason for it. [And you have seen changes in the trainees. How do they differ from the Consultant?] I think I noticed it about three to four years ago that really hit me when I saw F1s [year 1 Foundation doctor] who are just very keen on leaving on time and it kind of doesn't matter whether the jobs were done or not. It's like, they need to leave because their contract says they leave at 4 or 5, and they really stuck to the law about that...in contrast to what I thought was acceptable.*

GenY6 (7 years' experience) –

*For the six months I had one Consultant and that was everything, we spoke every day about every patient and I really, really liked that...You didn't have this, you speak to a different person every day to refer the same person or the same issues, you kind of knew what was going on and build that rapport...you know what he was like, how he appreciated things to be done and I thought that was a really good way of looking back and getting good patient continuity; good patient care...they knew where your strengths and weaknesses are and they can help you along with that...whereas I think shift work is very much just completing the hours and getting home.*

These three more experienced Generation Y doctors display a keener awareness of the usual expected sense of professionalism within Medicine than their less-experienced peers within Generation Y. It has been documented that medical students' sense of professionalism differed from that of their trainers (Ginsberg et al., 2002). It has been postulated that as trainees become increasingly entrenched within Medicine, they become familiar with the sense of professionalism expected of them as members of the medical profession. Such a shift in the sense of professionalism as doctors progress through their careers from undergraduate to postgraduate learning was also highlighted by Brownell and Cote (2001) who noted that junior doctors placed greater weight on learning competencies as compared to Consultants who placed more store on altruism. I also just wonder if this is the 'transformation' of these individuals from 'lay people' into 'professionals' that takes a period of time as described by Smith (2005b, p.439) but has not yet occurred with the less experienced members of Generation Y:

*The core of professionalism is the personal transformation of self that takes place in stages during the early years of medical training and practice. Once "lay persons", medical students redefine themselves as physicians, accepting that they now interact with all of society in a new and different manner. Accepting this role colors all of one's perceptions and opinions, setting standards for behavior. Once this transformation occurs, it is impossible to believe being a physician is "just a job".*

Educationally, this 'transformation' described by Smith (2005b) could be explained by the work of Schön (1983; 1987). Schön defined two types of professionalism. The first, Technical Rational (TR) professionalism, divides up complex procedures into smaller components that when learnt and mastered are pieced back together to produce the 'whole' once again. The formal ISCP curriculum uses this approach and it works well for the acquisition of knowledge

and particularly operative skills. However, Schön (1987) acknowledged that the TR approach was not useful when applied to concepts such as professionalism. To deal with professionalism, Schön therefore recommended what he termed Professional Artistry (PA), the second type of professionalism, whereby practitioners pass beyond competence into artistry that is observed in the very best practitioners of a particular field.

Professional artistry requires reflection on one's practice; a novice will start out with 'reflection-ON-practice' after the event whereby the previous experience will be used to shape future experiences. In time, the practitioner passes on to 'reflection-IN-practice' at which point the practitioner can think on their feet at the time of actual practice occurring using prior knowledge, theory and experience to come to an immediate practical decision.

It therefore seems to me that there is something else other than just a generational difference driving changes in behaviour amongst Generation Y doctors. It very much seems that the loss of a team structure that supported junior doctors is contributing to these differences. Criticism of Generation Y doctors would therefore seem unnecessarily harsh and misplaced by Consultants given that Generation Y doctors have never been offered the chance to work within a team through no fault of their own. It is this loss of team with the removal of potential coping mechanisms that may be leading to a loss of resilience and a desire for greater work-life balance among Generation Y doctors (General Medical Council, 2019b).

What appears to be a major difference particularly between Baby Boomers and Generation X as compared to Generation Y is the fact that computer technology and internet access simply did not really take off until the mid-1990s (Price and Oliver, 2007; Keengwe et al., 2008). Consequently, from an educational standpoint there are differences in how these generations

were taught and how they learnt as well as their ongoing general viewpoint on the use of new modern learning technologies (Mangold, 2007).

### ***4.3.2. Learning Technologies***

Thus, the moves made within the medical community to teach ‘professionalism’ via the formal curriculum are fraught with difficulty if medical students/trainees are reluctant to engage with traditional learning methods, if PBL hinders the hidden curriculum, and if there is relatively little recognition of the importance of the hidden curriculum in the teaching of professional behaviours. I would suggest that medical educators should act to ensure educational programmes meet the needs, wishes and expectations of their current trainees and that greater consideration be given to the importance of the hidden curriculum.

My literature review convinced me to see learning technologies and how they deliver training through the lens that it was engendering a situation whereby trainees and medical students were increasingly distanced from Consultants just as indeed EWTR was doing as well simultaneously. In essence, learning technologies and EWTR may be acting in a synergistic manner to deprive Generation Y trainees of opportunities to mix with, observe and learn from Generation X and Baby Boomer Consultants through the hidden curriculum. My concern being that as a consequence, the passing on of expected professional behaviours from one generation to the next could be hampered. This being because if Generation Y trainees rely increasingly upon the formal curriculum through greater emphasis placed on learning through virtual platforms, there would be less transfer of professional behaviour learning than in-person direct face-to-face contact between the generations. There was evidence of this potentially occurring in the following quotes from Consultants.

BB3:

*I think more likely there is a change in the attitudes of universities and medical schools. I see a change in the attitudes of trainees who don't treat their trainers with a degree of courtesy or respect for their age and experience, and if it's not seen in medical school level then it doesn't appear later on in life.*

BB4:

*I'm sort of familiar with the medical school but I know for example they train in terms of a body part...they don't train in terms of system so much anymore. The attachments are very short. Everything is about competencies and the competencies are lip service.*

BB4:

*The trainees and students nowadays are lacking in that ability to take on and follow through and give continuity because they are only around the place intermittently. Or they have exposure to just one aspect of the care. They might see them [patients] in clinic but don't see the operation. Or see an operation but never see the patient in clinic.*

Gen X2:

*There is a feeling that they're spoon fed; that everything should come to them with no effort...it's clear to me that when I go and lecture at the medical school...I get "oh, you haven't put your talk on the system" – "No, you should be taking notes" and they say, "no because it always goes on the system" or "I wasn't there"...Well in my mind if you don't pitch up and make the effort, but it's a very different view, so I think there is a*

*very societal ingrained thing that they don't see it as wrong and may be it isn't because that's my perception from where I come from.*

If then, there has been a shift in teaching of professionalism away from the informal hidden curriculum with the introduction of Learning technologies compounded by EWTR, how does that manifest on a day to basis in the working environment?

### ***4.3.3. Vocation v Lifestyle***

In terms of how interviewees viewed their career, I perceived a greater sense of vocation amongst the Consultants. But what exactly is a 'vocation'? It does seem a rather nebulous concept in nature, just like trying to pin down the definition of professionalism. The Oxford English Dictionary Online (2020) describes 'vocation' as "*a profession, way of life, course of action, etc., which a person feels that it is his or her duty or destiny to follow, or for which he or she feels particularly suited*".

The Cambridge Dictionary Online (2019) makes a subtle but insightful addition to the definition of 'vocation' calling it "*a type of work that you feel you are suited to doing and to which you should give **all your time and energy**, or the feeling that a type of work suits you in this way*". I have added the emphasis but believe it is this demand on one's time and energy that is crucial to understanding potential differences between the generations as I will explain later in this chapter.

In turn, my interpretation of the answers of junior doctors, i.e. Generation Y, was that they now regarded working in Medicine more as a lifestyle rather than a vocation. This is with 'lifestyle' defined as a "*style or way of living (associated with an individual person, a society,*

*etc.); esp. the characteristic manner in which a person lives (or chooses to live) his or her life”*  
(Oxford English Dictionary Online, 2020).

When GenY4 was asked about what had brought about the generational differences in professionalism that they felt were present, they responded:

*It's linked to the government's attempts at changing the power that the medical profession used to have by weakening it and trying to make it less like a vocation, so it's just a job. So, they've brought in the changes of contracts, timings, payments...I think now people are much more likely to see it as purely being a job and not a profession.*

GenY6 explicitly stated they regarded working as a doctor as a lifestyle rather than a career as follows:

*I think the profession...and the role of being a doctor is more of a lifestyle rather than as a career in the past. I think it's moving more towards you attend work and you do this many hours of being a doctor and then you go home to do something completely different.*

GenY7 was dismissive of even the thought of working hours beyond what was allowed by EWTR and seemed content that this was indeed the case: *“Would I be wanting to work in the situations that I've heard described where people worked those crazy hours and then fell asleep in the middle of a ward round? No.”*

My impression was that whilst Consultants continue to value the sense of vocation, placing their work life above all else, that is not mirrored by junior doctors for whom Medicine is

increasingly perceived as if it is becoming a job rather than a career or profession. I state this as there was a diminished sense of duty and certainly not a suggestion from any Generation Y that *all their time and energy* should be put into their work. There appears to have been a shift across the generations from Baby Boomers regarding themselves as ‘professionals’ to Generation Y regarding themselves more as ‘employees’. For example, when GenY6 was asked if there were generational differences in the sense of vocation, they stated:

*I base that on being valued, so this comes down to us as employees of the NHS, how we are valued and again, I was speaking to someone about Google’s employees...they really look after their people...I don’t think we’re looked after anymore, and so people don’t really care. So, the Trust’s values are put ‘patient first’ and I genuinely disagree with that because I think if you don’t put yourself first, you can’t put your patient first. If you look after yourself and you have an employer that looks after you, then you can put your patients at the centre of your focus and give them the best care.*

I got the sense from the trainees that this shift from pursuing a vocation to following a lifestyle was not necessarily deliberate but as a result of how the ‘system’ treated them in making them feel undervalued. Indeed, the above quote from GenY6 is suggestive of a sincere and strong yearning to be valued for the work that they do. Why might this be occurring? I believe the answer may lie in the introduction of EWTR and the subsequent loss of the ‘firm’ structure that allowed doctors to work in tight-knit teams that have now disappeared. This will be discussed in detail later in this chapter.

Interestingly, the current understanding from the Royal Australasian College of Surgeons (Tobin and Truskett, 2020) seems to suggest that it still puts forward the need for a sense of vocation in surgeons in that professional and personal identities are intertwined when stating:

*“The surgeon’s professional identity is related strongly to their specialty and to surgery in general. Professional identity interacts with the individual’s personal identity”* (p.4). The inference being for me that in Australasia both role modelling and vocation appear to be held in high esteem with little consideration for improvement in work–life balance as compared to the UK. Of course, Australasian surgical practice has not been affected by EWTR.

Generation Y trainees may disagree that they are no longer acting as professionals but there is a certain paradox amongst the Generation Y interviewee responses. I would not call it quite being indignant at their sense of professionalism being questioned, but they were keen to state that their professionalism was just as profound as that of colleagues belonging to older generations as suggested by GenY4:

*I’d like to think that my idea of professionalism is similar to that of senior colleagues.*

*I’d like to think it’s very similar because I would try and emulate the way that they behave and their approach towards professionalism.*

The use of the word ‘emulate’ does suggest a desire, most probably unwitting, to use the hidden curriculum to learn professional behaviours rather than formal teaching. This does appear to correlate with the work of Goldie et al. (2007) who noted the preference of trainees in learning professionalism was by means of the hidden rather than the formal curriculum. Furthermore, this trainee echoes the work of Brody and Doukas (2014) who found scepticism in the way in which trainees viewed the formal curriculum in teaching professional behaviours.

A common theme amongst Generation Y was that not only was their professionalism the same as their seniors, but their sense of professionalism had been sharpened with experience over

the years that they had practised, as noted by GenY6: “*I was probably less professional in the first years than compared to now as I feel more responsibility than when newly qualified.*”

However, whilst claiming this increasing professionalism, Generation Y interviewees simultaneously yearned for a greater work–life balance as suggested by GenY3 when asked if there were generational differences in professionalism:

*I think the main one is going to be the hours and being professional about them. I think just keeping going because that is what everyone did and it was just kind of expected of you...it is the idea that we should be taking more of a role in saying when enough is enough in terms of hours and that both because of our own mental health but also realising that doing a 36 hour shift would just be more harmful and creating more problems...I think for the most part senior doctors...they appreciate that things have probably improved, and a lot of people recognise that the previous system was just working and working and was being quite detrimental...I've had doctors talk about it...to kind of train the younger doctors in a negative way in terms of 'back in the day we used to do x,y,z hours' and it is often used and then we compare it to this new generation as being sort of softer or not quite as good.*

The above quote is noteworthy as this trainee certainly does not want to emulate or mimic his trainers in the older generations particularly with respect to hours worked. I would even suggest that there is some degree of criticism of Consultants by GenY3 for working such hours. This sense of criticism gets more acute towards the end of the quote where Consultants are essentially censured for using the hours worked as a marker of professionalism and a tool to demean Generation Y doctors. For example, the suggestion that Generation Y doctors are ‘softer’ than the older generations for not working as hard. The term ‘softer’ does seem to have

a derogatory undertone and highlights for me the separation of the generations by the loss of the ‘firm’ structure resulting in a shortfall of understanding of the others’ position. As I will draw attention to later in this chapter with regard to ‘mentoring’, the generations should be coming back together by talking to each other as hoped for by the Royal College of Surgeons (2015a; 2015b).

GenY5 was quite overt that Medicine was not the ‘be all and end all’ of their existence and that it was a lifestyle rather than a vocation when they acknowledged:

*I wouldn't say never stop being a doctor, I think it's less of a thing now than it used to be... There's more kind of, you finish your shift, and you leave, stop being a doctor and go home. You're a doctor as part of your life but it's not your whole life. It seems to be moving in that direction... I think the profession of being a doctor and the role of being a doctor is more of a lifestyle rather than a career in the past.*

Again, GenY5 raises the issue of needing to restrict hours which presumably then allows this trainee to undertake what they wish to do outside Medicine in their subsequent free time.

Baby Boomers and Generation X had difficulty in separating their professional and personal lives. The following quote from GenY6 was typical of Generation Y who appeared to have much less difficulty in separating their professional and personal lives, as noted: “*I don't know about the old days, but I think my generation care more for how they live outside of their careers...Their professionalism doesn't run into their personal lives.*”

The data obtained from these interviews chimes with the report *The state of medical education and practice in the UK* released by the General Medical Council in December 2019 (General

Medical Council, 2019b) that when considering trainees “*for nearly nine out of 10 (87%) doctors, maintaining a clear boundary between home and work life was important to their satisfaction*” (p.43).

These Generation Y comments do not give a sense of a generation that, whilst claiming to be as ‘professional’ as previous generations, is in actual fact being so if one suggests that they should be putting the rights, expectations and demands of patients above their own. There was to me a decreased sense of ‘duty’ to their patients and given their wish for greater work–life balance, there certainly was not a suggestion that they expected all their time and energy to be expended in their professional life as suggested by the definition of ‘vocation’ (Cambridge Dictionary Online, 2019).

To clarify this point, I considered the apparent loss of altruism and accountability in Generation Y, two attributes that are commonly associated with medical professionalism in the literature (Van de Camp et al., 2004).

#### ***4.3.4 Altruism & Accountability***

Altruism has been defined philosophically as “*selfless concern for the well-being of others*” or zoologically as “*behaviour of an animal that benefits one or more others (typically of its own species), but which carries a cost for the individual concerned*” (Oxford English Dictionary Online, 2020). Whichever way you wish to define altruism the data obtained from this research does not suggest amongst Generation Y the same degree of selfless concern for others, nor are they prepared to accept a ‘cost’ to themselves in doing so as compared to Baby Boomers and Generation X.

Accountability is defined as “*liability to account for and answer for one's conduct, performance of duties*” that is further refined as being “*used commonly in modern times to refer to a liability to the general public*” (Oxford English Dictionary Online, 2020). My interpretation of the data is that Generation Y are less concerned than preceding generations about how they are perceived by the general public (i.e. their patients) as they are no longer putting the wishes, needs and expectations of their patients above their own, particularly given that they wished for a greater work–life balance for themselves.

Thus, this research does seem to suggest a shift in Generation Y doctors’ sense of altruism and accountability. However, this would appear to be at odds with the vast majority of previous literature that suggests a basic tenet of being a member of a profession that should include an obligation amongst members of the group to put the needs and wishes of those they serve above their own (Abbott, 1988; Carr-Saunders & Wilson, 1933; Elliot, 1972; Hensel and Dickey, 1998; Wynia et al., 1999; Van de Camp et al., 2004; Evetts, 2006; Cruess & Cruess, 2008; Brody & Doukas, 2014, Chestnut, 2017). However, as I have seen in the literature review, professionalism is not a static theme. This research may well represent a new developing ‘professionalism’ amongst Generation Y and chimes with the literature that professionalism is in a constant position of change.

The fact that professionalism may be changing, and more specifically with respect to altruism and accountability, should come as no surprise as it changes in accordance with developments in the social, cultural and ethical attitudes and values of the day that doctors are exposed to in their everyday lives, as seen in the literature review (Cruess & Cruess, 2008; Al-Rumayyan et al., 2017). As Cruess and Cruess (2008) warned, doctors should not adhere to a nostalgic sense

of professionalism, but they should move with the sociocultural milieu in which they find themselves.

However, the very concept of altruism as even being relevant to medical professionalism has been questioned, with its persistence being related to the medical profession attempting to retain a moral high ground following recent medical scandals (such as the case of Harold Shipman) in order to reduce disapproval from society (Royal College of Physicians, 2005; Harris, 2018). Harris (2018) warns that clinging to a nostalgic sense of professionalism particularly with respect to altruism risks trainees regarding professionalism as “*patronizing, old-fashioned, outdated and unhealthy*” (p.6).

The King’s Fund (Rosen and Dewar, 2004, pp.12–13) asked whether we need to reconsider what medical professionalism is:

*The traditional image of doctors is of selfless individuals prepared to ‘go the extra mile’ for their patients at all hours of the day or night. But the medical profession should ask itself how far this image remains relevant in today’s conditions. European working-time directives are legally binding and expectations of a better work–life balance are reducing the willingness of doctors to work long hours.*

This changing sense of professionalism is difficult for me to comprehend but the King’s Fund (Rosen and Dewar, 2004, p.6) also specifically questions the requirement for what I perceive to be basic tenets of professionalism – accountability and altruism:

*An increasingly complex system for ensuring accountability can undermine the professionalism it is supposed to safeguard. Doctors may feel less inclined to behave altruistically if they are excessively scrutinised. The profession may need to open a*

*debate about the combined impact of these changes and what other reforms may be necessary.*

The literature review revealed that the government has introduced ever-increasing regulation of the medical profession. One might argue that the King's Fund is suggesting that this regulation is undermining the medical profession and converting 'professionals' into 'employees'. This is certainly a sentiment that was felt amongst interviewees.

Others have objected to the sense of subjugation associated with altruism that was in conflict with the modern-day wish for better work–life balance. Wilkinson et al. (2009) stated that doctors rather than putting others before themselves should “*balance availability to others with care for oneself*” (p.553).

It is further argued that altruism has no place in medical professionalism in any form of commercialism as it cannot truly be present if we are simply being paid for our normal everyday activities as part of our employment. This is particularly so, if, as a result of that job, society allows and provides us with added prestige, power, social status and financial gain over other occupations (Harris, 2018). The Royal College of Physicians of London (2005) singled out and were scathing of a significant section of Plastic Surgery when stating: “*a private doctor carrying out cosmetic surgery is a businessman selling a product and no more altruistic than, say, Giorgio Armani or Estée Lauder*” (p.20). The relevance of this quote lies in the fact that the college did not want to suggest that doctors alone had an exclusive right to altruism over other healthcare professionals.

The most insightful reference I have found that suggests the medical profession is undergoing change from within as Generation Y doctors enter the workforce comes from Fisher (2011) who notes that altruism has been challenged by Yale medical graduates who have replaced the Hippocratic Oath with their own updated version that states:

*I know that I cannot effectively care for patients without also caring for myself. I will maintain perspective by seeking wellness, balance, and happiness in my own life, both within and outside my career.* (Blog post)

This quote reflects others who suggest that altruism should be removed from definitions of professionalism in order to reduce the risk of burnout and work-related stress (Wilkinson et al., 2009).

It is difficult for me and perhaps Consultants in general to accept what we were always taught as being fundamental to professionalism (accountability and altruism) is being turned on its head by younger doctors. I have no doubt that this is adding to the increasing friction that is present between generations within Medicine.

As will be discussed in this chapter, this potential changing landscape in terms of altruism and accountability with respect to Generation Y doctors has implications for not only how ‘professionalism’ and the ‘profession’ may evolve but also what ramifications this may have for the Social Contract in the future.

To counterbalance this potential criticism of Generation Y with respect to their altruism and accountability, it was clear that Baby Boomers and Generation X were not averse to wishing for a greater work–life balance for themselves whether male or female. Amongst these older

generations, the catalyst for considering a change in their work–life balance followed having children, as noted by BB3: *“My priorities have changed, yes. I would say my family come first more than they did when they were younger.”*

GenX3 also commented: *“For me as an individual having a family allowed me to improve my work–life balance and my ability to separate work from home.”* There is a subtle nuance here in that as soon as GenX3 had children this resulted in reflection on work–life balance whereas BB3 had a more gradual dawning of realisation that with family comes the need to alter work–life balance.

There was even a hint of criticism of Baby Boomers from GenX1:

*The previous generation to me...were even accepting of absentee fathers, absentee parents who were constantly at work. We have had to take a view to juggle that more carefully with my partner to make sure it works.*

This represented one of the few occasions when there was some degree of discord between Baby Boomers and Generation X whereby Baby Boomers appeared to be far more accepting of putting their work above their own family. In fact, this sense of placing family above that of patients was strongly argued by GenX2:

*My partner knew marrying a medic meant my absence from home and understood the deal; my child didn't have that choice...but actually I want to have as much fun with my child and I think they should have fun with me, so that's my right.*

So, the data obtained in this research appears to suggest generational differences in attitudes to professionalism although it may be more nuanced than simply being a member of a certain

generation by date of birth. To explore this further, interviewees were asked if they thought there were generational differences in professionalism.

#### ***4.3.5. Generational Differences***

Once again, the data suggests both Baby Boomers and Generation X interviewees were closely aligned in that there were differences between themselves and Generation Y. The older generations' comments tended to be negative in connotation towards Generation Y in terms of changes in behavioural practices and attitudes that related particularly to accountability, as we have already discussed.

What really appeared to unsettle Baby Boomers and Generation X interviewees was Generation Y's perceived lack of commitment with respect to their employee-like mentality to hours worked and finishing work before all tasks were completed. This was exemplified by BB3:

*I see a difference in attitude of more junior doctors. Attitude to work, attitude to their colleagues, attitude to patients. It's changed to more of a clock-in, clock-out and they have a lack of responsibility...so that the aspects of professionalism have eroded.*

GenX2 commented:

*I think my code of conduct is old fashioned to some of them...I stay out of hours; probably do anything I feel I need to; put in extra sessions; everything that goes against their 48hr week...it wasn't like that in my day, and the feeling that I would like them to act as a trainee in the way that I did.*

This apparent loss of respect from Baby Boomers and Generation X Surgeons towards Generation Y trainees is something that has previously been reported by Money et al (2013, p.4) when noted:

*Many Baby Boomers and Generation X members believe that Generation Ys have no work ethic, they're just a bunch of "slackers". They don't want to attend meetings after 4:00 pm, they have "another life", they have other things they want to do.*

The responses from Generation Y were again more nuanced than the older generations. Those more experienced and closer to Generation X (Gen Y1 and GenY5) essentially responded as if they were in Generation X.

GenY1:

*I do think that there has been a shift in the level of professionalism from the junior cohort of doctors... they don't see how to act necessarily...They are not providing us with obs charts or writing in notes or things like that. You know, these things were all part of the job. That was being professional to me.*

This response from Gen Y1 is interesting as they appear to think of themselves as completely separated from other Generation Y doctors.

GenY5 even acknowledges this separation and stratification within Generation Y doctors based on experience when they stated: *"I think people in the earlier end of Generation Y have a very big contrast to what I have. Mine is probably more like Generation X."*

Other members of Generation Y, however, openly admitted that how they behaved professionally differed from that of Consultants. The responses as to why this was, centred

around the change in attitudes in considering their work increasingly as a lifestyle as compared to a vocation, as summarised by GenY6:

*I think the profession of being a doctor and the role of being a doctor is more of a lifestyle rather than a career in the past...you attend work, and you do this many hours of being a doctor and then you go home to do something completely different.*

However, there was not total agreement as Gen Y7 appeared ambivalent about changes in professionalism between generations when stating:

*I think it has changed... the youngsters aren't as professional as the old boys...back a few decades ago, it would be unheard of to turn up looking a bit scruffy with stubble and no tie...but then I'm not a patient, looks aren't important but they care about you, they know their stuff and they are a great doctor, so what if they're a bit scruffy.*

This suggests to me that GenY7 acknowledges that generational differences exist but asks why such differences should matter if the appropriate healthcare for the patient was delivered.

The next stage was to ask what was possibly driving perceived generational changes in professionalism.

A recurring theme that was put forward as driving generational differences in professionalism was the introduction and subsequent impact of EWTR, as explained by BB2:

*As soon as that was brought in, junior doctors that were raised up on this have a sort of a clock-in, clock-out attitude that in my old days, your job finished when the job was finished...that's what you did.*

Similarly, GenX2 noted:

*The breakdown of the system from my point of view, I think being part of a small group was very cohesive...and the lack of continuity. They are unable, working the hours that they work, to offer the continuity even if they want to; they are then working outside the bounds of what they're allowed to do.*

The introduction of the EWTR was designed to protect workers, such as junior doctors, from the exploitation of working excessive hours. It was stated that rested, healthy doctors would be good for patient safety, allow them to provide the highest quality care and allow junior doctors a better work–life balance (House, 2009). However, the responses from interviewees across the three generations towards EWTR were unanimously negative. This negative attitude is perhaps not surprising from Baby Boomers and Generation X as the literature in and around the full implementation of EWTR in 2009 was correspondingly negative. Concerns were raised that EWTR rather than improving patient safety would hinder it given that fewer working hours would be undertaken without any additional workforce; continuity of care would be disrupted; and diminished exposure of trainees to patients and Consultants would hinder training opportunities (House, 2009; Wade and Henderson, 2009; Goddard, 2010; McIntyre, 2010).

Perhaps, what surprised me was that the supposed beneficiaries of EWTR, namely Generation Y doctors, also viewed EWTR negatively even though their work hours had been reduced significantly from that of earlier generations and opportunities for better work–life balance had been provided.

In essence, members of Generation Y, whilst not naming EWTR, were able to state that they were struggling with shift systems as a consequence of having no team structure at their

workplace which was a direct consequence of EWTR. This is noted by GenY1: *“I think they just don’t feel part of a team...they don’t see how the team dynamics work, and how we work as a profession...it’s been all fragmented.”*

It was this loss of teamwork with the decline of the ‘firm’ structure for Generation Y doctors that was primarily causing their dissatisfaction with their everyday working life, as described earlier in this chapter.

It was also argued that generational differences in professionalism were being driven by societal changes in that Generation Y doctors reflected values, behaviours and attitudes of the general population born between 1981 and 1996, as noted by GenX1: *“I think that’s a society issue. [So, our new doctors reflect society?] Yes, reflect society.”* Whilst one has to be careful not to stereotype different generations, particularly as ‘generations’ are an artificial man-made construct, they can be useful as a means of analysing population trends through time and help to explain changing behaviour as it relates to professionalism in doctors (Dimock, 2019).

However, as the literature review showed, the period since the birth of the NHS in the aftermath of WWII, has seen a number of significant societal changes that have affected each successive generation, such as a general reduction in deference to the professions (Hassan, 2001), increasing consumerism that is associated with increased questioning of doctors by members of society (Timmermans and Oh, 2010), increased access to medical knowledge for patients particularly through the internet (Lupton, 2003), and recurring medical scandals (Medical Protection Society, 2015). Added to these changes were ongoing healthcare policy interventions by successive governments of whatever persuasion that concentrated on both (a)

increasing the rights of patients and (b) increasing the regulation of the medical profession (Burke, 2008).

With respect to changes in professionalism, there was comment about the potential effect of the changing demographic of the workforce as a result of the increasing number of women entering the workforce, as noted by BB2:

*When I started, probably the sexes were fairly evenly balanced...maybe there was an excess of men, certainly in surgery, and now that's changing ... [So, you feel that's impacted in some way?] Yeah, family responsibilities. I suppose men were excused sort of from family responsibilities. They'd just work and come home when the work was done but I think for women, it's hard because not only have they got to have a career...how do you have a family and balance that with a career?*

This is an interesting statement in that the interviewee clearly believes that there was relatively equal representation of the sexes at the earlier stage of their career. However, it is recognised that whilst female medical student numbers are increasing, this has still not reached anything near numerical balance when it comes to Consultant level according to the annual workforce surveys carried out by the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) (2020). The latest figures suggest that in 2010 the number of female Consultants as a total proportion of the Consultant workforce was 14% and by 2019 this figure had risen to 20%. That may seem a relatively slow rate of increase and suggests numerical parity between the sexes within Plastic Surgery is still decades away.

However, when one digs a little deeper into the BAPRAS survey results, it is revealed that the total number of Consultants has increased from 413 to 649 in total over nine years, that is a

57% increase in total number of Consultants. However, this increase in the total number of Consultants has been achieved at a differential rate between the sexes. There were 59 female Consultants in 2010 but 128 in 2019, that is a 117% increase in eight years. For men, there were 354 Consultants in 2010 but 521 in 2019, that is a 47% increase in numbers. Given that Baby Boomer Plastic Surgeons are very much male predominant and as a group are likely to retire within a decade, and that the number of women coming through medical school and Plastic Surgery training is increasing, then it seems almost certain that the proportion of women in Plastic Surgery will continue to increase at an accelerated rate above that of men. Therefore, parity in numbers between the sexes may not be as far into the future as one might at first think.

BB2 then goes on to suggest men were 'excused' from undertaking parental responsibilities which could be taken as rather stereotypical and potentially misogynist in nature. I did not get a sense that this was meant in such a manner but that it was rather an impression that female colleagues took on a disproportionate amount of childcare that impacted upon their work-life balance. Such a disproportionate responsibility for not only childcare but also for parental care between the sexes has been documented by authors within the medical profession (Drinkwater et al, 2008; Rich et al, 2016). One might consider that these additional responsibilities outside of work that are shouldered primarily by women may be adding to Generation Y's wish for a greater work-life balance and changes to attitudes towards accountability and altruism.

Having considered the issue of 'professionalism' in the interviews, I now move on to what interviewees thought about being a member of a profession.

#### **4.4. *Medicine as a Profession***

Once again there was consensus across all generations when it came to defining what a 'profession' meant to them; and this was aligned to what was defined within the medical literature (Abbott, 1988; Carr-Saunders & Wilson, 1933; Elliot, 1972; Hensel and Dickey, 1998; Wynia et al., 1999; Evetts, 2006; Cruess & Cruess, 2008).

The sense came across that it was a group of individuals, with a high degree of skill and knowledge as a result of extended periods of learning that whilst providing self-benefit was for the good of patients:

BB1:

*A group of individuals...performing a particular service...to other individuals within society. As a profession, it tends to be of higher esteem with greater rewards, with a number of regulations that will direct the individual and the performance of their profession...it's about regulation of the profession...who wish to be autonomous and a standalone governing body.*

GenX2:

*Profession is a form of employment that has, usually, a particular series of skills and knowledge set that needs to be learnt in order to be accepted as a professional in that skill.*

GenY5:

*A profession is someone that has had higher training and a dedicated amount of time to learn a subject, to be able to provide the service beyond what the common man would know about that subject.*

However, what was detectable, just as when considering ‘professionalism’, there was a greater sense of ‘vocation’ amongst Baby Boomers and Generation X interviewees than among their Generation Y counterparts:

BB4: *“You pass on your knowledge, you’re compassionate to patients, you act in their best interests at all times.”*

GenX1:

*What we do is a vocational subject and as a professional...You’ve got to live, breathe and make it work for you...It goes beyond normal hours. You never really switch off. You are a doctor first and foremost and it’s a job for life.*

Thus, a sense of altruism and accountability was evident from the interviews involving Baby Boomers and Generation X but, just as when analysing the data about ‘professionalism’ for Generation Y, on this occasion even amongst the more experienced members of this generation there was little sense coming out of the data of the interviewees going over and beyond the normal expectations of patient care as might be expected from the ‘nostalgic’ definition of what a profession is, i.e. putting the needs of those you serve above your own.

For example, GenY4 stated: *“I feel that my peers see medicine as just a job and outside of medicine there is a lot of life in terms of, it [medicine] doesn’t necessarily dictate your life choices.”*

These quotes offer the sense from Generation Y that they had an increased sense over older generations of simply being employees that came to work, did their expected hours and subsequently went home when expected at the end of their shift, i.e. they did what was required and expected of them by their employers but did not stay to go over and beyond. To be fair to trainees, the opportunity to go over and beyond their normal hours is simply not allowed, so to do so would put them in breach of their contract as their hours are regularly monitored. Excessive hours worked by trainees can result in financial penalties for the Trust. Thus, again there is a perverse situation whereby we want our trainees to be professional and go the extra mile for our patients but the very system in which they work is designed to prevent them from doing so.

Thus to reiterate, my interpretation of the data obtained suggested to me a shift in Generation Y interviewees in general terms away from having a sense of vocation that if required trumped their commitments in their personal lives to a situation whereby they suggest that Medicine is an interesting and worthy form of employment, but that it no longer usurps necessarily the wishes, demands and expectations of Generation Y in their personal lives. As can be seen with respect to loss of teamwork disrupting the harmonious working of the various generations, we have a further example of the system in which all generations are working in a manner that prevents these working relationships between the generations from flourishing

I would argue that the same contentions pertain for how interviewees from the different generations perceive a 'profession' as they do for 'professionalism' as regards vocation, lifestyle, altruism and accountability. This perhaps is not surprising as I got the sense from the interviews that interviewees regarded the two topics as somewhat intertwined.

Having identified EWTR, societal changes with respect to Generation Y, and demographic changes as important drivers of intergenerational differences in professionalism and being a member of a profession, I decided these themes were worthy of further consideration.

#### ***4.5. European Working Time Regulation (EWTR)***

It appeared from these interviews that all generations had concerns about the effects of the EWTR on their everyday working practices. Baby Boomers and Generation X lamented the loss of teamwork that had resulted in trainees acting more like employees than professionals. In turn, Generation Y trainees felt isolated, bereft of leadership and had no sense of belonging that did not result in a desirable working environment, as demonstrated in the following quotes.

BB1:

*I think for senior people, part of the joy of working in medicine is being part of a team and sharing that responsibility, but if your junior members of that team are never there and do not accept responsibility for their ongoing care, then ultimately that responsibility always falls back on the senior clinician.*

BB2:

*You can't really have rigid teams now, you have to be flexible...I think it's a much looser and ill-defined relationship and its easy for people to walk away now whereas*

*in the days gone by, when the team was much more defined, you couldn't walk away...I think now you can sort of pass the buck quite easily.*

BB4:

*When you have a firm, you have a chain of responsibility, and you have someone you can go up to, they are not sure who to go to next; the decision-making process has been eroded.*

GenX2:

*I think being part of a small group was very cohesive and it felt very personal too. Your patients became people who were looked after by your team...and the lack of continuity. They are unable, working the hours that they work, to offer the continuity.*

Gen X3:

*It is less enjoyable and satisfying not being part of a family, knowing you are all working together for a common aim, whether you are very junior or very senior and I think that is a shame that that relationship has gone...I think the shift system has resulted in a little bit of a sort of clock-on, clock-off mentality with the shift system...when I started out, there was never any question of not staying until the job was done and leaving anything for your colleagues.*

Baby Boomers and Generation X, i.e. Consultants, consider Generation Y, i.e. trainees, to be working in a clock-on clock-off manner more akin to an employee rather than a professional. As such, Consultants seem to question whether trainees, i.e. Generation Y, have as much commitment to their professional lives as they had done at the same point earlier in their own

careers. This resulted in Baby Boomers and Generation X accusing Generation Y of demonstrating less professional behaviour than they felt they had offered their patients.

In contrast, Generation Y doctors felt isolated, not part of a team, demoralised and found it difficult to know who to turn to in times of crisis which is as a result of the system that they have been forced to work in (Royal College of Surgeons of England, 2015a).

GenY3:

*I guess when you've had a really close-knit team...that's felt like the best way to do medicine. I think it's consistency. I think you also get a bit of camaraderie between colleagues, so often you find that you're just doing patchy on-call shifts covering lots of different wards, so you don't know the patients, you don't know who you're working with, and then you go home, you come back and then you don't know them again. Whereas the old firm system...you knew who you were working with and there was a lot more sort of togetherness than there is now.*

A symptom of this demoralisation in Generation Y doctors may be found in the work of Goddard (2010) who found a higher sickness rate in early career Generation Y doctors than all other career grades within Medicine, intimating that this “*may reflect loss of team working and a sense of belonging in doctors a year into their career*” (p.334).

Could it be possible that in fact all generations are correct in their experiences and perceptions of other generations and rather than it simply being a generational difference, it is instead the current working pattern for Generation Y doctors that is broken?

It is apparent that there is a disconnect between Consultants and trainees in terms of communication and time being spent together at work. However, when members of a team have a keen sense of bonding, they tend to be more committed to the greater cause and in particular the team's goals (De Cremer, 2002a; De Cremer & van Knippenberg, 2002b; De Cremer & Van Vugt, 2002c). Indeed, attempts at enhancing behaviours that encourage cooperation between team members resulted in greater group well-being. Furthermore, the greater the cohesiveness and well-being of the group, the better the performance of tasks (Jehn & Shah, 1997). Performance of the group and individuals can be further enhanced by developing trust, intimacy and social exchange between members that in turn results in greater cooperation between members of the group (McAllister, 1995; Seppänen et al., 2007; Ohtsubo et al., 2014).

It therefore seems to me that the introduction of the EWTR, resulting in loss of the team-like 'firm' structure has brought about an inability of the generations to foster and nurture appropriate working relationships that enhances team performance. This has resulted in the breakdown of working relationships between Consultants and trainees with each blaming the other, when in fact it is the system in which all generations are working that is inhibiting the fostering of good working practices. This was acknowledged as happening by Temple (2010) even before the full implementation of EWTR in 2011.

If we consider Consultants as leaders trying to inculcate good practice, and thus professionalism, into their followers (i.e. trainees), then there is evidence within management and psychological literature as to how and why the new shift-pattern style of working is negatively impacting upon the working relationships between the medical generations.

Evidence suggests that leaders who improve both their communication and their access to team members enhance inter-working relationships and in so doing improve team performance (Das & Teng, 1998; Seppänen et al., 2007; De Jong & Elfring, 2010). Thus, if the post-EWTR shift patterns are preventing access of Consultants to trainees, it is now understandable as to why this has resulted in a breakdown in the relationship between the generations.

The significance of these non-technical skills such as communication and teamworking has been recognised in other occupations, the most publicised of which is the airline industry. Following a number of fatal crashes it was realised that such incidents could be reduced if the teamwork of crews could be enhanced. Subsequently, Crew Resource Management (CRM) methods were introduced. A vital factor of the CRM process was a system by which pilots' non-technical (cognitive and social) skills (NOTECHS) were observed (Flin et al., 2002; Flin et al., 2003). Features that are assessed include conduct, communication skills, decision making, leadership and teamwork as part of an overview in managing crews whilst flying.

CRM was subsequently introduced into other industries such as air traffic control, the nuclear industry, offshore oil and gas industries, and the emergency services (Flin et al., 2002; Flin & Yuke, 2004). In the area of Medicine, anaesthetists were the first to introduce non-technical skills (ANTS) based on the NOTECHS system (Flin et al., 2012). The NOTECHS system comprises four skill categories – task management, team working, situational awareness and decision making.

Recognising the importance of non-technical skills, the Royal College of Surgeons in Edinburgh subsequently introduced similar non-technical skills for surgeons (NOTSS). This was adopted for all trainees to undertake in 2014 via the ISCP website. The four components

being situational awareness, decision making, communication, teamwork and leadership. No direct assessment is made of an individual's professionalism but is simply inferred from the components of the assessment system (Yule et al., 2006). The importance of these non-technical skills in improving both patient safety and patient care and thus outcomes has been documented (Weaver et al., 2013; Agha et al., 2015).

We therefore have a perverse situation within Medicine in the UK; at the very time when non-technical skills were being recognised for their importance in enhancing team performance, a means of shift-pattern working for trainees was put into place as a result of EWTR that would do the exact opposite. In so doing, patient safety and outcomes have been put at risk. It is this loss of non-technical skills – the ability to work as a team – which is, I would suggest, vital in understanding the difficulties that the generations have in working with each other.

The Royal College of Surgeons of England (2015a) have acknowledged poor teamworking was having an adverse effect on surgical training and suggested a ‘new’ pilot scheme for surgical training entitled *Improving Surgical Training* (IST) whereby an emphasis would be placed on returning surgical trainees to a team-like structure with a reduction in out-of-hours work which was exactly what Temple (2010) recommended.

IST (Royal College of Surgeons of England, 2015a, p.18) has made a number of recommendations including the following:

*Recommendation 1: To maximise training during daylight hours and to ensure that the time spent on-call is of educational benefit, trainees on a full shift rota should have a minimum of 10 staff in that rota.*

I would suggest that IST is an attempt to return to pre-EWTR working patterns by getting trainees to work with Consultants who are present mainly during office hours by restricting the frequency of shift patterns.

IST has recognised the previous importance of an apprenticeship-style of learning through role modelling and the hidden curriculum rather than the formal ISCP curriculum (Royal College of Surgeons of England, 2015a, p.23):

*Traditionally trainees learnt through apprenticeship systems...Nowadays, the curriculum sets out what to teach and how to do it in a much more systematic way. However, curricula are remote documents that need to be translated at a local level to reflect local opportunities. They should not interfere with the idea that as training opportunities arise...We need to reintroduce the positive aspects of apprenticeship by taking the trainee surgeon from a reasonably competent craftsman to a confident, comfortable, self-motivated individual. We need to do this...by re-establishing the relationship between the trainer and trainee.*

To encourage role modelling IST (Royal College of Surgeons of England, 2015a) recommended:

*Trainees should have a consistent relationship with a trained educational supervisor...Each period of training should be of an adequate time to allow trainers and trainee to develop a mutually helpful relationship. (p.23)*

These recommendations were based on the following:

*The old surgical “firm” structure encouraged the consultant trainer to invest time and effort into the emerging surgeon. It provided a sense of belonging that is often now*

*absent...The firm denoted a form of inter-generational cooperation and learning. It brought together novices who were being taught on the 'shop floor' not only by Consultants, but also by nurses and more senior trainees...This consultant took responsibility for the quality of care and the quality of education and training delivered to those within the firm/team. (pp.23–24)*

These pilot training programmes commenced in 2018 in General Surgery and have rolled out in 2019 to other surgical specialties, i.e. Urology and Vascular Surgery, but there are currently no plans to do so within Plastic Surgery (Royal College of Surgeons of England, 2019). It will be interesting in due course to see how these pilot training schemes impact on the training of Generation Y doctors and what they themselves regard about these 'new' pilot schemes which seem to be returning to pre-EWTR training models.

#### ***4.5.1. Hierarchy***

However, one concept that came out of the discussions that I had with interviewees on 'profession' rather than 'professionalism' was the concept of hierarchy. All generations commented upon this issue. Baby Boomers and Generation X interviewees both described a sense of loss at the passing of a formalised working practice that required deference to those higher up the command structure.

BB3 said, "*a profession has to have a structure and a **hierarchy** and a guided moral compass to make it a profession and that compass is professionalism.*"

GenX3 commented:

*The old system, prior to European Working Time Directive was quite **hierarchical** because there were Consultants and registrars, and today the shift system is more of a meritocracy and that's what the new generation like... all the time that I was a junior I have thought medicine was disruptively **hierarchical**...actually one of the really nice things of becoming a Consultant...it doesn't feel **hierarchical** anymore...I think if anything the new sort of shift based system is worse because the juniors don't get any kind of relationship with their Consultants.*

The impression I got from the Consultants was that they 'grieved' the loss of a working structure that they felt worked well for them, which perhaps is not surprising as they would have been at the pinnacle of the hierarchy with the power, prestige and authority to make things happen, and this has now been lost.

What really surprised me was the fact that the trainees, i.e. Generation Y, clamoured for the return of a greater sense of teamwork that had a structured hierarchy as expressed in the following quotes:

GenY2:

*I think that varies a lot between the job that you're on as to whether it feels like there is a team around you working together. I think often it does feel like you are part of a team but there is a big **hierarchy** unavailable to you...I think the hierarchy is probably necessary in some ways because you need, I think, the respect that you have for someone that's in charge of everyone is different. I don't think you can be seen as all equals in a team. I don't think teams really work in that way. There has to be like, a leader in the team which is going to be the Consultant.*

GenY5:

*I think they've now got to the point where they [trainees] talk to Consultants like they are in a school yard and I think it's really disrespectful...there should be a **hierarchy** that should be retained, and I think it's to appreciate the other person's significant experience in what they are trying to do for the patients and they have no understanding of that.*

Why this surprised me was that there is a significant amount of literature suggesting that Generation Y prefer not to work in hierarchies but instead seek the flattening of such structures into a meritocracy (Eckleberry-Hunt & Tucciarone, 2011; Espinoza & Ukleja, 2016; Tulgan, 2016).

This alleged move towards meritocracy needs to be taken with some caution given my finding of some degree of craving for hierarchy amongst Generation Y doctors albeit in the particular setting of post-EWTR working practices. Similarly, stereotyping of Generation Y behaviours needs to be viewed with caution given the diversity of cultures, societies and nations from which Generation Y doctors are recruited. However, the move towards meritocracy seems to be driven by Generation Y's social connectedness by means of the use of social media that allows immediate and direct access to 'experts' in a field or 'managers' much higher up a company. This direct access to expertise is something that they have come to expect and is recognised particularly in new start-up entrepreneurial companies that place a high premium on innovation (Moore, 2011; Stillman, 2012).

A hierarchy is defined by Greer et al. (2018) as "*vertical differences between members in their possession of socially valued resources*" (p.591). The literature suggests that the impact of a

hierarchy within a team on its ability to carry out its tasks can have either a positive or negative effect dependent upon the specific circumstances of the team (Greer et al., 2018).

Those that suggest that a hierarchy promotes team effectiveness state that it does so by means of developing a welcoming psychological space in which to work; it incentivises those lower down the ranks to work hard to climb the ranks for reward whether financial or non-financial such as prestige, authority and power. Likewise, it encourages division of work and diminishes conflict (Halevy et al., 2011). However, there are others that state that the presence of a hierarchy inhibits the effectiveness of a team by rationing resources to individuals within the team, increasing competition within the team to move up the ranking, and encouraging internecine practices for the benefit of the individual rather than the team (van Bunderen et al., 2018).

What, then, determines if an existing hierarchy will display harmony or discord? When members of the team align their knowledge, skills and behaviours for a common goal it is likely to be a well-functioning team (Rico et al., 2008; Anderson & Brown, 2010). This would be the case for the 'medical firm' as there should be a clear goal of improving the health of their patients in the shortest possible time.

This focusing down on achieving a common goal amongst the team is dependent upon three variables (Greer et al., 2018). The first is 'task interdependence' which is the extent to which team members are required to count on and align with one another to complete a task (Saavedra et al., 1993). When interdependence is high this results in greater communication between colleagues, actions become coordinated and decision making is eased. The second is 'task ambiguity' that describes the level to which defined roles and responsibilities are defined so

that all team members know what is expected of them within the team as part of their role (Valentine & Edmondson, 2014). The third is ‘task complexity’ such that if there is more than one pathway to achieve a goal or multiple potential outcomes then this can inhibit team performance within a hierarchy (Zhou, 2013). Thus, for a hierarchy to work well for a team requires high interdependence, low ambiguity and low complexity and vice versa for poor teamwork.

My perception of the interviewees’ responses with respect to hierarchy is that the wish for a hierarchy is a proxy request to return to a more structured way of working such as in a team. In turn, this would allow Generation Y doctors to have a clear line of management to whom they can turn in times of need to ensure their safety and that of patients.

Instead, the current situation for Generation Y doctors is that they no longer work as a team but in shift patterns, and as such it is now plausible to view and understand why they might hanker for the ‘good old days’ of the team-like ‘firm’. Currently, they are working in the worst possible circumstances whereby shift patterns result in loss of communication amongst doctors within a department, poor coordination of effort, and hesitant decision making in bringing together a plan for treatment of patients that has become unnecessarily complex and convoluted that results in low interdependence. Given that Generation Y doctors have no real membership of any team they are ‘out on a limb’ with no ‘leader’ to whom they know they can turn to on a daily basis for assistance, resulting in high ambiguity. Lastly, patients are getting older with more and more co-morbidities as Medicine keeps patients alive for longer, although additional years may not be healthy ones. Thus, the patients that they are seeing at this stage in their early careers are more challenging and complex than doctors in preceding generations at the same stage in their careers, so that Generation Y doctors are subjected to high complexity just in

terms of the clinical difficulty of the patients. Additionally, as they are not part of a team just getting to a decision about the patient's care is proving more complex to arrange.

As Moore (2011) states:

*In times of crisis most of us find comfort in the long-in-the-tooth older person who has been through this before and knows what we should do. Or when safety is paramount, few of us would argue about excessive hierarchy.* (para. 12)

Undoubtedly, Generation Y doctors reflect their peers in society, sharing a similar set of values, given the circumstances and age in which they have been brought up that are different to those of Baby Boomers and Generation X, particularly their wish for better work–life balance. But yet, what I am learning from this research is that my position has shifted as a result of being reflexive and attempting as best I can to set aside my own values in analysing the data. As a Consultant, I previously had concerns about the professional behaviour of trainees.

The more I have considered the research data, the further my position has shifted towards an understanding of what is causing the 'friction' between the generations within the medical workforce, and in so doing this has significantly tempered my previous opinions.

I will now move on to the second issue that may be a factor in understanding generational difference, that is, are the attitudes and identities of Generation Y doctors different in some way to their predecessors as a result of societal changes already discussed in this chapter?

#### ***4.6. Generation Y & Societal Change***

The research data from this study does suggest that there is some discord between Generation Y and their predecessors which has previously been acknowledged as existing in the general population (Eckleberry-Hunt & Tucciarone, 2011).

Doctors now entering the profession belong to Generation Y. As such, they are likely to reflect the values, attributes and aspirations of the generation to which they belong. The literature on Generation Y comes predominantly from western culture, particularly the USA, where the recognition of characteristics of generations are used significantly in marketing by large organisations (Pew Research Center, 2010). Generation Y is characterised as having been watched over closely by their parents and had what is described as an overscheduled timetable i.e. multiple in-school and after-school activities and clubs with little in the way of downtime after homework is considered. Whilst this may indeed characterise some members of Generation Y, it is probably only those (and not even all of those) from the middle and upper classes – those whose parents could afford to pay for multiple in- and out-of-school activities. While the medical profession may draw predominantly on people from these backgrounds, it does not do so exclusively. Consequently, it would be wrong to assume all Generation Y doctors come from this background and hence share these characteristics.

Likewise, it has been claimed that Generation Y have been raised by parents who provide them with constant praise (Eckleberry-Hunt & Tucciarone, 2011; Money et al, 2013; Espinoza & Ukleja, 2016). They are the latest generation to enter the medical workforce and place great importance on online social connectedness, the adeptness to work in a team, the capacity to speak their mind, the preference for close professional relationships with their seniors, and the wish to have a better work–life balance than their predecessors (Howell et al., 2009; Pew Research Center, 2010). It seems more likely, given the ubiquity of internet access and the use

of smart devices, that this social connectedness most probably applies across all social classes making up Generation Y and includes those who enter the medical profession.

Immediately, one can see how discord could arise between members of Generation Y and previous generations due to their preference for social connectedness, their ability to work in a team having been lost as a result of EWTR, their appearing less deferential to older generations who expect some degree of respect, and their wish for a flattened hierarchical structure rather than the regimented managerial structures preferred by Baby Boomers and Generation X. The following quotes suggest these changes occurring and I refer back to section 4.5.1. with respect to quotes on changes in hierarchy.

Gen Y1:

*I think the way younger people behave and conduct themselves and social media and things like that is very different...and so I think that makes them more casual...there's less boundaries between them [Consultants] and us.*

Gen Y2:

*When I started medical school...being on your mobile phone seemed to be, like not allowed. Now as a doctor I see that doctors use them all the time to talk to colleagues...So it's like a behaviour that's kind of changing*

Gen Y7:

*I think there has been a disbanding in those teams not only at the firm level but also at the hospital level...they had housing that they had for all their junior staff and those who were on-call; that was somewhere where communities sprang up and so*

*then people would be able to do 7 days on the trot or 72hrs on-call because their homes were just a minute's walk away...but then there is the big push to sell off all assets...and there isn't that sense of community anymore.*

Gen X4:

*I think it started as a breakdown of hierarchy in society...people are less deferential, people feel more able to question and to find out things, but I think along with that comes with a lack of respect for the role; a lack of understanding of the role that you do.*

Educationally, Generation Y, as already discussed in this chapter, have a far more complex and sophisticated array of learning methods and technologies available to them than previous generations, allowing them virtually unlimited access to learning opportunities in terms of time, place and venue (Mangold, 2007; Keengwe et al., 2008). However, it does seem that Generation Y enjoy learning with technology and social media rather than relying solely on lectures and textbooks as did previous generations (Mangold, 2007). This may explain why Generation Y have found attempts at learning 'professionalism', as described in the literature and evidenced in my data (GenY8 – "*a fluffy sense of professionalism*"), problematic when presented in the standard didactic method expected of older generations (Goldie et al., 2007; Riley & Kumar, 2012). It cannot, therefore, be a surprise if there are concerns about Generation Y's professionalism when neither the informal curriculum is working due to the loss of 'firms' and what is being taught through the formal curriculum is to some extent at least delivered in a style that is not suited to their learning needs.

It is therefore the responsibility of medical educators from preceding generations to alter and update teaching programmes to match the learning needs of Generation Y trainees if the professional attributes, values and behaviours expected of them are to be communicated and learnt successfully (Mangold, 2007; Eckleberry-Hunt & Tucciarone, 2011).

There has been growing discussion in the medical literature that there is an increasingly poor degree of professionalism within Medicine centred on those more recently entering the profession. Smith (2005b, p.439) summarised this as follows:

*A generally accepted consensus that professionalism is decreasing in medicine due to a failure to satisfy patient and societal expectations as well as a loss of the medical profession's dedication to its core values.*

Medicine is not alone in this as there is much literature from the business world also describing a loss of work ethic and an aspiration for greater work–life balance to the detriment of their employers (Tulgan, 2016).

The following quotes from Consultants illustrate their concern.

BB2:

*I think there are some things that have impacted heavily on behaviour. One of the most noticeable ones, I think it was the European Working Time Directive. As soon as that was brought in, junior doctors that were raised up on this have a sort of a clock in, clock out attitude that in my old days, your job finished when the job was finished; you know, it might have meant going on until past 5 o'clock, you might have finished at 7 or 8 o'clock at night and that's what you did.*

BB3:

*It's changed to more of a clock-in, clock-out and they have a lack of responsibility...I feel there isn't the follow through and caring of patients and the commitment that there used to be, and therefore if I, as a team leader, expect work to be done, I don't find it always is, and I have to check up on things to make sure that it is carried out...I see a change in the attitudes of trainees who don't treat their trainers with a degree of courtesy or respect for their age and experience.*

BB4:

*people are increasingly seeing medicine as a job; a job in which you do 9-5; you just do what's asked of you 9-5 and then you go home and then you close the door on that. ... and do a job you feel fulfils, but also do all the things outside of life that are there. I think that's increasingly so; people are looking for a job that allows you to do both rather than 20 years ago you were a surgeon and that was all you did in life at the detriment of family; everything. So, often you would just be in hospital making things better at the hospital to the detriment of your family.*

Gen X5:

*When I started in medicine...we were officially employed from 8 o'clock until 4 o'clock but we never ever... actually went home before kind of 9 o'clock...We would never have dreamed of submitting a claim for additional hours or to get the time back...that was accepted because that was what our colleagues had done and we worked much more closely within a firm kind of organisation so we had a lot more contact with a group of people and you just accepted that if you wanted to do what the people at the next stage did, you just did it and you were only doing it for a finite period of time, but I think there*

*has been a move towards shift working...and with that has come a loss of continuity of care and a loss of ownership and that fundamentally has changed professional values.*

I have to say that, prior to commencing this research, I was minded to agree with this sentiment, but the EdD has allowed me the time and space to sit back, think through issues in a systematic and critical manner and realise that the issue of generational differences in work performance is far more complex than hearsay and anecdotal tales would suggest and that all generations are in some way at fault. This research has highlighted that rather than arguing between the generations, the generations should be starting to talk to each other to cross the divide that has opened up particularly in UK medical practice since the full introduction of EWTR in 2011.

It is clear from the data obtained in this research that Generation Y increasingly regard a career in Medicine as one requiring greater work–life balance that is at odds with the nostalgic sense of vocation, altruism and accountability:

Gen Y3:

*Hospitals are still quite a barrier to work-life because if you're working lots of different shifts... and trying to have a life or relationship outside of work, it is quite tricky.*

Gen Y4:

*I feel that they almost sort of see it as just medicine is a job and outside of medicine there is a lot of life in terms of, it doesn't necessarily dictate your life choices.*

Gen Y5:

*I think now people are much more likely to see it as purely being a job and not a profession.*

Gen Y7:

*I think my generation have less care for how they live outside of their careers...Their professionalism doesn't run into their personal lives.*

The literature corroborates this finding (Smith, 2005b; Mangold, 2007; Eckleberry-Hunt & Tucciarone, 2011; Money et al, 2013) and is summed up pithily by Eckleberry-Hunt & Tucciarone (2011) when describing Generation Y individuals that “*do not look at an organization to see how they will fit into it; rather, they look at how that organization will fit into their lives*” (p.459).

Of note, in the USA, medical students applying to Plastic Surgery training programmes preferentially give a higher ranking to those training programmes where the existing trainees express the greatest sense of contentment in their work (Mahabir and Gray, 2015). This contentment may well be a surrogate marker for the training programme directors putting in place an environment that suits the need of Generation Y trainees i.e. an improved work–life balance.

This increased requirement for work–life balance is a challenge for those from the older generations such as myself, but the wish for younger doctors to have a greater work–life balance must be respected. The real challenge in my mind is how in the future it will be possible

to square doctors' wishes for greater work–life balance with (a) the expense to the government of requiring additional doctors to be trained to allow for flexible and/or part-time working, and (b) the ever-increasing demands of patients who may not be interested in doctors' work–life balance. This brings into stark relief the central question in this thesis: *'Do generational differences exist in current understandings of medical professionalism which may impact the way the "Social Contract" functions in practice?'*

I would argue that if we are to achieve the 'transformation' of an individual from an ordinary member of the public to a doctor, as described by Smith (2005b), the older generations need to do more than simply complain but instead consider another approach that is constructive. This would be my justification for the consideration of mentoring of Generation Y doctors to allow for that 'transformation' to occur.

In many ways, what mentoring may do is replace to a degree the apprenticeship-like model of training whereby a trusted senior takes interest in the development of the trainees under their tutelage. However, mentoring does not alter the fact that a shift-pattern style of working would persist as opposed to the tight-knit 'firm' structure that allowed teamwork to blossom.

However, as previously discussed, the Royal College of Surgeons of England (2015a) are seeking to re-establish a 'firm' structure along with mentoring. To coin a phrase *'plus ça change'* – the more it changes, the more it stays the same. Thus, I believe we have come full circle, it is almost as if EWTR has forced a giant experiment to change the working patterns of the medical profession from the apprenticeship model to one of shift patterns with a loss of teamwork. It seems to me that mounting evidence, including from this research, suggests that experiment has failed (Royal College of Surgeons of England, 2015a).

The position of mentor is defined by the Oxford English Dictionary Online (2020):

*A person who acts as guide and adviser to another person, esp. one who is younger and less experienced...a person who offers support and guidance to another; an experienced and trusted counsellor or friend.*

Generation Y have been described as having a close relationship with their parents and wishing for instant feedback. Yet, one must accept this is stereotypical given the socially limited nature of this characteristic as this may not apply to those in Generation Y from lower income backgrounds or single-parent families. However, the use of a mentor could potentially play the role of a proxy-parent in the workplace to provide support and guidance in the early years of a career (Mangold, 2007; Eckleberry-Hunt & Tucciarone, 2011). Tulgan (2016) discusses this concept of ‘parenting’ those from Generation Y, arguing that to achieve the best from Generation Y requires that their seniors in the business world need to develop a parent-like style to which Generation Y have become accustomed.

Indeed, this notion is gaining traction within the surgical community whereby an empathetic, more experienced doctor helps the newer doctor to the profession reflect on their experiences to smooth their personal and professional development (Royal College of Surgeons of England, 2015a; 2015b). The call for mentoring is aspirational from the college who suggest that it should initially be targeted at certain groups of doctors such as newly appointed Consultants, refugee doctors, doctors in difficulty and those doctors returning after a period of absence.

The college, whilst not expressly commenting about generational differences, does state the following:

*Surgeons in training may find that being trained within shorter hours under EWTR and within a streamlined training programme...particularly stressful.*

*Newly appointed Consultants may find the transition from SpR (trainee) to first consultant appointment challenging. (Royal College of Surgeons of England, 2015b, Why do surgeons need mentoring, paras. 1 & 2)*

Certainly, requests for mentoring are also coming from surgical trainees themselves who wish mentoring to be not merely aspirational but mandatory (Sinclair et al., 2015). Interestingly, if one considers Consultants as acting ‘*in loco parentis*’, Sinclair et al. (2015, p.310) note the issues that trainees wish to discuss with their Consultants:

*[Issues that are] outside the immediate clinical arena, including working with colleagues, pastoral issues, and life decisions such as moving regions or having a family. These issues clearly affect a trainee’s ability to perform to their maximum potential.*

The same paper confirms that trainees wish that mentor to be more experienced and senior and to act in a parent-like fashion (Sinclair et al., 2015, p.311):

*Most trainees felt that a consultant would be the ideal mentor...Current perceptions of an ideal mentor appear to be based on seniority and the directive advice that they can give based purely on personal experiences.*

The literature studying Generation Y appears to be remarkably pessimistic. One has to question if there is some form of bias on the part of authors or if there is a more generational bias against Generation Y. The literature suggests that Generation Y tend to seek immediate feedback on

their actions, find negative feedback difficult to handle, and, indeed, as a result of how they were parented, have difficulties with problem solving, coping with failure and having unreasonable expectations (Eckleberry-Hunt & Tucciarone, 2011; Espinoza & Ukleja, 2016; Tulgan, 2016). I wished to keep an open mind and avoid stereotyping the interviewees from each generation so that I could analyse the data without any preconceived ideas. For example, the general description of Generation Y immediately above cannot be said to represent all such individuals within that group. I was mindful that not all trainees come from a stereotypical Western college-educated background when most of the work on classifying generations has been undertaken in the USA.

It is only on unravelling what is going on between the generations that one starts to understand that Consultants (Baby Boomers and Generation X) and trainees (Generation Y) see the world through different lenses. Rather than concentrating on the differences, however, as much of the literature has done, the medical profession should be taking the concept of mentoring much more seriously as a means by which the generations can be brought together for a better appreciation of each other's world view so that the 'transformation' from lay person to doctor can be made as smoothly as possible. Whilst increasing the 'bond' and sense of belonging between Consultant and trainee through mentoring is crucial, it still does not replace the old 'firm' structure. As this research has demonstrated, the isolation suffered by trainees as a result of alternative shift-pattern working must also be addressed. The Royal College of Surgeons of England's (2015a) initiative *Improving Surgical Training* does exactly this by suggesting a return to a firm-like structure, but this has been so far restricted to pilot studies within specified specialties such as General Surgery and Urology. I am in little doubt now that Plastic Surgery should actively seek to become part of these pilot training programmes or at the very least keep a close eye on the results of this initiative.

The third factor obtained from the data in the research that was driving generational change appeared to be the changing demographic of increasing equality of the sexes for those entering the profession which will now be discussed.

#### ***4.7. Demographic Changes***

It has already been discussed in this chapter how the number of women entering the workforce generally within the UK and more specifically in Plastic Surgery has increased in recent years and is likely to continue to increase further (British Association of Plastic Reconstructive and Aesthetic Surgeons, 2018; NHS Digital, 2018; Bellini et al., 2019).

The numerical base from which this growth in the number of women started has been low given that women compared to their male counterparts have had additional sociocultural pressures to overcome. This starts long before medical school when female students can be steered away from STEM (Science, Technology, Engineering, Mathematics) subjects maybe as a result of conscious or unconscious biases within the teaching profession (Lavy & Sand, 2017).

If successful, after admission to medical school, then the absence of female role models within certain groups, such as the surgical specialties, has not encouraged women to consider such specialties (Goldacre et al., 2010). Once in a surgical specialty, the attrition rate for women has been higher than males. Reasons cited are marriage, relocating with partner, childcare, parental care, being unable to work flexibly, and once again lack of role models (Nadeem et al., 2014; Hampton et al., 2016). Underpinning all of these factors appears to be that women still carry out a vastly disproportionate amount of household and caring responsibilities when compared with men. Until such time as there is wholesale change in societal attitudes towards such an

imbalance, it seems entirely reasonable and understandable for women to place great significance on their work–life balance as illustrated in these quotes.

Gen Y2:

*I think if the woman has a job and she is working full time, I think she is still expected to deal with the children at home as the main carer... they are often thinking about family responsibilities.*

Gen Y5:

*I think even just having a family and stuff changed my perception of how much you can give and should give versus what other people used to give... Having a family now...I've realised that there should be a bit of a balance...I am trying to learn to have a balance, but I find that very, very difficult to be honest.*

However, there was an appreciation of the difficulties faced by younger female colleagues.

BB1:

*I think for women, it's hard because not only have they got to have a career, but they have to have the option of a family and how do you have a family and balance that with a career?*

BB5:

*I think some things have got harder, so National Selection makes their life very hard because they could be separated from partners without any control by themselves, which we didn't have because if we didn't want a job in Scotland, we just didn't apply for it, whereas now, they are sent there. I think that's very difficult for them.*

*I think they are not told where they are going until 6 weeks before they are due to move and I think that's a really bad thing, which again, we didn't have.*

Likewise, burnout in surgical specialties has been noted to be higher than in non-surgical specialties and disproportionately affects women as a result of outside commitments and a lack of work–life balance. This contributes to an increased dropout rate from surgical training for women (Walsh, 2013; Amofo et al., 2015; Elmore et al., 2016).

There is evidence within the medical literature to suggest that a disproportionate amount of domestic responsibilities have been taken on by women within the medical profession as compared to their male counterparts which has added to the difficulty in women obtaining a proportionate work–life balance. This has been noted specifically in Plastic Surgery in the USA and among female medical students contemplating a career in Plastic Surgery in Nigeria (Streu et al., 2011; Ibrahim and Asuku, 2016). In such cases, women were much more likely to drop out of their training programme than male trainees (Drinkwater et al., 2008).

The situation for training across all specialties in the UK was summed up by a study by Rich et al. (2016). They found that trainees regarded their training as deficient in access to flexible and/or part-time working that negatively impacted upon their work-life balance. Consequently, working in a pressurised environment on a daily basis inhibited their access to learning and this was exacerbated by serial examinations. Trainees felt pressurised to prioritise work over their own domestic or personal needs resulting in what leisure time they had being spent undertaking training requirements such as revision for examinations and filling out portfolios, all to the detriment of their families and loved ones, resulting in poor morale. This situation was compounded by regular rotation between regional hospitals requiring time away from home

and/or long commutes, resulting in even further disruption to the personal lives of trainees. It was found that for those with caring responsibilities for children, who were predominantly women, the difficulty in finding an appropriate work–life balance was more acute, leading to reconsideration of future career plans.

It is clear that the drive for a better work–life balance in Generation Y trainees is not only a reflection of the society from which they come, but also of the fact that the increasing numerical equality between the sexes in the medical workforce is placing increasing pressure on the NHS to provide flexible and part-time working to allow increased work–life balance. This is as a consequence of the disproportionate expectation of women within the profession to take the lead on domestic and family responsibilities.

The issue of demographic changes within the medical workforce is potentially a sensitive subject to grapple with. However, those who consider workforce planning, such as the surgical specialty associations, policy makers and government, should not be afraid of considering difficult choices particularly with respect to cost as additional workforce may be necessary. However, such decisions must be made within the law and there must be no discrimination on the basis of sex or pregnancy status. Furthermore, as seen in the data I have gathered, the call for a better work–life balance is coming increasingly from men as well. This needs to be addressed, for if Generation Y, as a whole, seeks a greater work–life balance and this is reflected in doctors, then additional doctors will need to be trained at additional cost to the public purse to make up for the shortfall in the number of doctors working full-time. This is an issue that has been raised by Jefferson et al. (2015). An estimate of the sorts of numbers involved was made in a study by Goldacre et al., (2001) who noted that, following allowance for those leaving the profession and less than full-time working, the actual whole-time

equivalent doctors available to the NHS 15 years after graduation was 60% of women and 80% of men. This is a topic relevant to this research, as it is a debate that needs to be held within the remit of the Social Contract. If, as seems likely, doctors seek improved work–life balance, government needs to ensure the means to allow that to happen and the public needs to be aware that additional money will need to be raised through taxes to allow this to occur. Otherwise some other health provision will need to be rationed.

The interviewees' responses to their perception of 'professionalism' and 'profession' has made me realise the loss of morale within the medical profession not only stems from undoubted intergenerational differences but also as a result of the working patterns forced upon the profession by EWTR. The loss of the 'team' as a result of trainees undertaking shift systems and attempting to learn through a formal curriculum rather than the hidden curriculum has been a mistake that is now being recognised by the Surgical Colleges. The loss of teamwork occurring at the same time as demographic changes to the workforce resulting in increasing parity between the sexes has increased the wish for greater work–life balance.

I must be mindful of my audience when writing this dissertation. Needless to say, it has been written as a piece of systematic critical research that can withstand academic rigour from the educational perspective. However, an eye has also remained on a more widespread audience amongst policymakers and government, but it also must make sense to the surgical community and patients, i.e. it needs to be relevant to each party within the Social Contract.

The reason for multiple audiences is that this research should make the case ultimately that the best possibly trained doctors will deliver the optimum health results for patients. Likewise, the

need to ensure the best possible morale amongst the surgical workforce will not only be good for patient care but also for retention of staff, all of which is relevant to the Social Contract.

With that in mind, interviewees were questioned about the concept of the Social Contract in terms of what it meant to them and how they saw it developing in the future.

#### **4.8. *Social Contract***

It was clear from the pilot interviews that the term ‘Social Contract’ was new to all the participants. However, the sense that I got from the interviewees was that they already had a notion of a relationship between Medicine, the Government and Society but only recognised it as a formal concept once having read the information leaflet which can be seen at Appendix 1. Interviewees, particularly Baby Boomers and Generation X, were readily able then to discuss their personal experiences in the context of this tripartite relationship although Generation Y were less so. I would argue that this generational difference was simply down to the length of experience and exposure to patients and the working environment but not as a result of Generation Y doctors being less thoughtful or not wishing to engage in the interviews. Put another way, Generation Y simply had less ‘life’ experience to illustrate their answers.

I made every attempt to ensure that the information leaflet on the Social Contract was as neutral as possible to ensure that it in no way influenced (and thus myself) their subsequent answers. I used it simply in hindsight to make them realise what they thought informally actually had some formal academic substance through which they could share and explain their experiences, behaviours and perceptions of the complex relationship between Medicine, the Government and Society.

Subsequently, all interviewees understood the tripartite nature of the Social Contract and the issue of giving up some individual rights for the greater good of the collective society which can be seen in the following comments:

BB1:

*The idea of a Social Contract is that there is a tacit understanding between society...the government and medical practitioners with regard to the delivery of a service...whereby society gives up some of its individuality and rights in order to allow a governing body to make decisions, laws and look after them...So, the Social Contract is basically people hand over responsibility to the government and the government ensures delivery of services like law, order, fire and healthcare.*

GenX3:

*Within the medical profession, you as a doctor will agree to have your duty of care to your patient, be trained appropriately, not do work that you're not capable of doing, and the patient will agree to pay their taxes for the NHS. Then there's a third party in our healthcare system because it is government funded.*

When interviewees were asked who led the medical profession, there was no consensus of opinion from across all three generations.

Baby Boomers and Generation X simply stated there was no leadership.

BB3 stated: *“As a group, medics very rarely speak together and because it is a very large and disparate group.”*

GenX2 noted, *“in all honesty, nobody really represents us”*.

Generation Y also stated there was no leadership, but this group had a tendency to list potential leadership sources only to discount them, as GenY1 stated:

*I honestly don't know. I mean the BMA [British Medical Association]...but loads of us lost faith in the BMA after the strike...we have got our Royal Colleges that we are all sort of affiliated to but...I don't know.*

Generation Y trainees stated a range of potential leaders that might include the Chief Medical Officer, the British Medical Association, Presidents of the Royal Colleges, the Care Quality Commission (CQC) and the General Medical Council.

All generations were in agreement that the balance within the Social Contract had shifted and this was explained in more detail and confidence the longer the interviewee had been in practice. Presumably, this simply reflected length of experience and exposure to events over time.

BB1 stated:

*Every part of the Social Contract has changed and evolved. So, doctors as a profession have changed; their regulation has changed; the governments funding and interference with healthcare delivery has changed; bring in CQC, having inspections, micromanaging, everything that is done, all that has an impact on the Social Contract and society itself has overall increased its demands upon healthcare delivery.*

GenX1 commented:

*I think that the doctor-patient relationship has shifted. Patient's charters; their rights and they are now more than ready to challenge the knowledge of doctor especially with*

*the internet and so on...I have said that I feel the micromanagement from Whitehall and with overregulation by the zealous GMC have made the balance of being a doctor in this social context a lot worse.*

GenY4 stated:

*We are being put into a position where we are sort of at the mercy of patients and the government as...like the new junior doctors' contract and the sort of ever-increasing demands on the health service placed by patients...I would say it is imbalanced...it should be in equilibrium but at the moment it is probably weighted towards the expectations of the government and the patient.*

Given, as described above, that all three generations felt that the relationships between the three parties within the Social Contract were not in balance, there appeared to be no consensus as to exactly how Medicine as a profession could renegotiate its position within the Social Contract or who could lead such negotiations given that there was no obvious leader who represented the whole of the medical profession.

#### ***4.8.1. Shifting Relationships Within the Social Contract***

Whilst all interviewees considered that there had been a shift in power within the tripartite relationship of the Social Contract towards the government away from Medicine, there was some difference in the generations as to why that had occurred. Baby Boomers and Generation X put the blame on the government as a result of their continued introduction of health service management and increasing regulation of everyday practice. In turn, Generation Y put the shift in power away from Medicine primarily down to increasing patient expectations. I would argue that this difference in generations simply reflected length of experience and for Generation Y

the limited exposure to the organisational and regulatory changes that are seen by those with a longer time working within the NHS.

As noted in the literature review, any changes within the power distribution of the tripartite relationship to one particular group within the Social Contract can result in changes in attitudes and behaviours in the other parties, particularly if they deem the power shift as detrimental to them (Rawls, 2003; Cruess & Cruess, 2008).

However, if there is no effective medical leadership, it is difficult to see how Medicine as a profession can renegotiate its terms within the Social Contract. This was reflected in a comment by GenX4 who stated: “*Unfortunately, we are just open to abuse. We don't have a Voice.*” It is clear that the government is led in any negotiations between society and Medicine by the Secretary of State for Health and Social Care and likewise patients are represented by ‘global’ organisations such as the Patients Association. Such uniformity of leadership and representation does not exist within the medical profession. It does beg the question how the medical profession has allowed itself to be effectively devoid of any meaningful leadership. This difficulty in developing medical leadership has been identified by the General Medical Council (2019b) as an issue for the profession. Its research suggests that those who develop leadership roles within Medicine do so by default rather than by design. Even when gaining such positions, individual doctors neither receive training to develop those roles nor are they suitably supported by the organisations that they represent.

An explanation may be found in the increasing specialisation of the medical profession that commenced during the 19<sup>th</sup> century and accelerated into the 20<sup>th</sup> century. Weisz (2006) puts into historical perspective the inevitable splitting up of the profession during this period due to

the massive explosion in medical knowledge with scientific advances such that no one individual could keep up with this pace of advancement. Added to this was the 19<sup>th</sup> century scientific vogue following Darwin's 'theory of evolution' to put knowledge into classified units; the increasing authority, prestige and wealth of specialists over generalists; and the urbanisation of the population as they moved away from rural areas combined with increasing education, which resulted in patients seeking out specialists rather than generalists.

However, Weisz (2006, p.xi) explains that as specialisation occurred with the blessing of the medical community, there was simultaneously increasing government oversight of healthcare provision:

*State authorities are now involved in medical affairs to a far greater degree than ever before and significantly encroach on the autonomy of medical professions. Everywhere nations struggle to balance a traditional free-market approach to health care with one based on administrative regulation...Health insurance provided by the state or private carriers has affected the conditions of medical practice in most nations.*

A degree of political distrust exists towards all professions no matter the political persuasion of the government of the day. Parties on the left view professions as “*elitist, class-biased and profiteering*” (Downie, 1990, p.148) acting as a deterrent to entry from those of a working-class background. Similarly, those parties on the right are distrustful of professions sustaining a restrictive monopoly on working practices for their own benefit that in so doing reduces politicians influence over the sphere in which the particular profession operates (Downie, 1990).

There is a cogent argument for suggesting that whilst governments were not responsible for the setting up of specialties that resulted in a loss of ‘leadership’ within the profession, it is certainly in their interest to preserve the present circumstances by using the technique of ‘divide and conquer’ particularly towards the medical profession within the context of the Social Contract.

#### ***4.8.2. Divide & Conquer***

Indeed, the concept of ‘divide and conquer’ was referenced across the generations in the interviews. For example, GenX1, when asked about their perceived lack of medical leadership, stated:

*Over the last 20 years, Medicine has been getting denigrated by political parties and used really as a way to de-professionalise us and basically **divide and conquer** and to be able to rule over the profession.*

GenY5, when asked the same question, said,

*I think it's a bit of **divide and conquer** from the government's point of view. They've got so many splinter groups with their own personal agendas...I think they won't allow them to amalgamate into a useful force.*

The success of human groups is based upon cooperation and social cohesion such that, typically, successful leaders work towards enhancing the social bonds within the group by ensuring appropriate communication and coordination of group activities. In so doing, the

safeguarding and well-being of the members of the group are put as a priority over and above the needs and wishes of the leader (Tyler & DeGoey, 1995; De Cremer et al., 2010). This echoes one of the key tenets of a profession – to place the needs, wishes and expectations of those that a member of a profession serves above their own (Abbott, 1988; Carr-Saunders & Wilson, 1933; Elliot, 1972; Hensel and Dickey, 1998; Wynia et al., 1999; Evetts, 2006; Cruess & Cruess, 2008).

However, on occasion, leaders may instead deploy the tactic of ‘divide and conquer’ in a deliberate attempt to disrupt the harmony of the group to protect and maintain their own authority and power within the hierarchy of the group (Case & Maner, 2014). This authority and power can come with significant personal gain leading to some leaders becoming more interested in maintaining their power instead of seeking to ensure the greater good of the group (Maner & Mead, 2010). When such scenarios occur, this can result in significant conflict between parties (Kipnis, 1972). This authority afforded to leaders provides them with the capacity to influence their followers by the provision of ‘gifts’ or the administration of ‘punishments’ (Posner et al., 2012).

In hierarchical group structures, the gap in power between the leader and subordinates is not fixed but alters with time in order to prevent abuse of power by the leader or exploitation of subordinates (Case & Maner, 2014). However, leaders can attempt to minimise the erosion of the power gap within their group (Van Vugt et al., 2008; Mead & Maner, 2012). The issue for leaders is that certain subordinates can possess and display traits that command respect and admiration from peers that in turn can threaten the leader. Whilst open hostility from a leader to a subordinate is possible, a leader will more likely use subtle tactics to control the

subordinate by monitoring them, putting them in certain positions or separating them from the group. The reason being to prevent subordinates developing alliances that act synergistically to challenge the power of the leader (Georgeson & Harris, 2006; Van Vugt et al., 2008; Mead & Maner, 2012; Case & Maner, 2014).

One can interpret the relationship between government and Medicine within the Social Contract with respect to the above literature, if we consider the work of Posner et al. (2012, p.419) who considered the fundamental principles of 'divide and conquer' as follows:

*(4) A unitary actor bargains with or competes against a set of multiple actors. (2) The unitary actor follows an intentional strategy of exploiting problems of coordination...among the multiple actors.*

Posner et al. (2012, p.419) explain that a unitary actor is not necessarily an individual but state who else this can be:

*Any group that has itself overcome its internal collective action problems...where it is capable of pursuing a unified strategy vis-a`-vis an external competitor, can be treated as a unitary actor.*

Therefore, one can consider a political party in government as a unified group with a single collective opinion on healthcare acting as a unitary actor due to the party whip. However, behind this apparent solidarity there will be a range of opinions on a topic such as healthcare delivery. Political parties will seek advantage over those whom they regard as competitors and that would include the medical profession. A more circumspect approach from government towards patients is likely given the regular re-election cycle.

If one regards the government as a unitary actor, it would certainly have competing interests with respect to the medical profession. Furthermore, as seen in the literature review, there has been remarkable consistency in healthcare policy by successive governments suggestive of an intentional strategy (Pollitt, 2000; Higham & Yeomans, 2011; Posner et al., 2012). This has resulted in increasing regulation of the medical profession along with the expansion of patient rights, expectations and involvement within the NHS (Burke, 2008).

Given the description of a shift in the power balance within the Social Contract that was deemed detrimental by all three generations of doctors, interviewees were asked what this might mean for the future of the Social Contract.

#### ***4.8.3. Future of the Social Contract***

There were no positive responses from any generation about the future of the Social Contract, as reflected in the following quotes:

BB3:

*I have to view with some degree of dismay the way things are developing, the financial constraints, the pressures put on individual doctors, to some extent the government...want someone who is experienced, skilled, intelligent and compassionate but on the other hand they want to be able to tell them what to do, when to work and how to work.*

GenX1:

*I see a generation of young doctors who have seen less because of their limited hours and want more in terms of their personal lives. It is going to be an interesting sociology*

*experiment to see what happens...the enjoyment of being a professional will be no longer there.*

GenY5:

*I think it's heavily skewed in the general population's favour...the young generation are almost fighting back against it. I think there is going to be a big breakdown of the Social Contract.*

The research data obtained from these interviews with regard to Plastic Surgeons and its subsequent analysis correlates with the work of Burke (2008) more than a decade ago who, looking at ENT surgeons, suggested that recurring healthcare policy resulted in a two-pronged approach. The first to increase the rights and expectations of patients, the second to increasingly regulate the medical profession.

Reference in the interviews was made directly to government or political interference by four out of five Baby Boomers, three out of four Generation X and two out of ten Generation Y interviewees. Looking specifically at Generation Y, five out of ten interviewees referred to the Junior Doctors Strike of 2016 which might be considered as the first real signs of discontent within Generation Y doctors as to how they were treated within the Social Contract.

Despite the length of time since the dispute, Generation Y doctors still had a sense of injustice with the government, summarised by GenY1: *"I still don't think that junior doctors feel like they're listened to or heard in any way by the government."*

I sensed that Generation Y doctors were less likely to simply accept what was imposed upon them by government, as stated by Gen Y3: *“Since the strike...my colleagues have been more demanding with the government in this relationship.”*

Indeed, the research data obtained suggests that the everyday experiences of interviewees also dovetailed and triangulated with my literature review with respect to the causes of the changing doctor–patient relationship.

### *Professional Regulation*

Gorsky (2015) describes the introduction of management into every level of the NHS. Indeed, Baby Boomer and Generation X interviewees were critical of how inflexible this had made their professional lives:

BB4:

*The change within the working arrangements, introduction of Multi-Disciplinary Teams, revalidation; all of these things...they erode that powerbase that used to be there, and it interferes with the autonomy that we used to have.*

GenX1:

*I feel the micromanagement from Whitehall and with overregulation by the zealous GMC have made the balance of being a doctor in this social context a lot worse.*

### *Medical Scandals*

The issue of harm to the medical profession cropped up on occasion particularly with one Generation Y interviewee when asked why patients appeared to have increasing influence over the GMC:

GenY5: *“I think it’s the changes with all the different medical scandals that happened and the regulation that it needed to protect patients, but I think it’s gone too far.”*

Increasing numbers of medical scandals caused public concern and backlash that needed to be responded to by government. They did so in the form of increasing regulation on doctors via the GMC (Waring et al., 2010).

### *Information Technologies*

Once again it was Baby Boomers and Generation X who were able to justify from experience why the Social Contract was important particularly with respect to the doctor–patient relationship.

BB3:

*They [patients] are far more informed than they were when I started; the internet; information is far more freely available, and patients use it. They come to see the doctor armed frequently with information and that’s another reason why I think the powerbase in the medical profession has deteriorated.*

GenX1:

*The doctor–patient relationship has shifted. Patient’s charters; their rights and they are now more than ready to challenge the knowledge of doctor especially with the internet.*

However, Generation Y felt at ease with this increased access to ‘knowledge’ for patients. This may be explained by the work of Rivett (1997) and Lupton (2003) who describe the effect of evolving media sources on the relationship between the medical profession and its patients as

a consequence of increasing patient knowledge. Whilst doctors from the Baby Boomer and Generation Y groups have had to learn to cope with the introduction of the internet as initial ‘digital foreigners’, those doctors from Generation Y have grown up and been educated by use of the internet as ‘digital natives’. As such they know nothing else and view ‘open’ access to knowledge for all as the norm as compared to Baby Boomers and Generation X who can recall a time before the internet existed.

### *Loss of Deference*

The numerous quotes from the interviews of all three generations reveals the willingness of patients to challenge doctors consistent with a mood change in society since the 1970s whereby society no longer hold the elite professions in high esteem (Hassan, 2001). This process of patient challenge accelerating within the NHS follows organisational changes particularly from the 1970s onwards. These changes were in part brought about by the introduction of neoliberalism of New Public Management into the NHS. This resulted in internal markets being created between hospitals, whereby funding for services followed the patient for the first time (Dent, 1995). This gained traction with patients who could now decide for themselves where they wished to be treated in a consumer-like manner.

### *Consumerism*

Consumerism is defined as “*advocacy of the rights and interests of consumers*” (Oxford English Dictionary Online, 2020). There was only one interviewee from Generation Y that directly used this term in a related manner:

GenY4:

*We are quite a consumerous society from what people see in the private sector and in other sort of consumerous environments that what the service they get there is the same as what they should be getting in the health service.*

However, I was struck by the concern within Baby Boomers and Generation X about the question of litigation. I would consider litigation as an extreme version of consumerism whereby patients pursue legal redress when they perceive that their rights have been overridden, that what they had expected has not occurred, or that they perceive they have suffered avoidable harm. However, such litigation places great strain on those implicated:

BB1:

*The other thing that has become really difficult is the amount of litigation within...Plastic Surgery...the public have become far more informed and much more aware of their "rights". If anyone deviates from what was expected, then they are becoming more prone to sue or seek legal redress for what in the past would have been considered a normal outcome.*

BB4:

*The GMC's motto is that patients are always right, so they investigate doctors to the n'th degree once they get the complaint and sometimes...unfairly as well, because once you have an investigation, you have a record...even if you haven't done anything wrong.*

GenX1:

*I think you are only one mistake away from having your professional reputation in tatters whether to be sued and to be the victim of a lawsuit is extremely stressful...I wouldn't wish it on anyone.*

It is perhaps not surprising that as none of the Generation Y interviewees were Consultants that they had little personal experience of litigation. Within the NHS, at all times, the named Consultant is the responsible physician for the patient, including being responsible for the actions of trainees. Similarly, trainees do not undertake private practice that is a common source of litigation.

The interviewee responses reveal potential worrying consequences for the relationships within the Social Contract. Interviewees (as doctors) appear to regard the government as instigator of active changes within the Social Contract for which patients have been the passive beneficiaries. As such, much of the interviewee ire is directed at the government. This sentiment seems justified given the review of the literature that clearly reveals deliberate and repeated healthcare policy introductions that have increasingly restricted and regulated medical practice.

There is a sense of nostalgia for when life was less regulated particularly from Baby Boomers:

BB1: *"I rue the good old days. I do think that things were better in the past."*

BB2:

*When I was a boy as it were, the doctor was omnipotent pretty much...he decided what happened in his unit and what he said went. Now, we are pretty much told what we're going to do.*

I need to be clear on my ontological and epistemological position for readers of this research, and indeed I have commented that part of the reason to undertake this research was to understand why during my career in Medicine I felt an increasing sense of loss in prestige, authority, control of my own destiny and financial well-being. This research has shown a light on others in a similar position and whilst it is disheartening to hear their stories, paradoxically, I am reassured that it is not me alone that has this sense of loss.

This sense of loss was summarised by one Baby Boomer when asked about the balance within the Social Contract:

BB2:

*It might be that emasculating doctors is the right thing to do for the public because you get more out of us for less. If you've got a workforce that don't feel happy, it threatens people's professionalism...People will behave well if they are treated well...How you, you know, the amount of time you put into your job. People that are well cared for will put the extra mile in won't they.*

Yet, there was evidence within these interviews that trainees' attitudes were hardening with respect to the Social Contract in that they (i) do not accept the current status quo within the Social Contract (9 out of 10), (ii) expect patients to take more responsibility for their own

healthcare (3 out of 10), (iii) have a greater sense of work–life balance (9 out of 10), (iv) demonstrate increasing militancy to achieve their goals (3 out of 10) and (v) no longer see their seniors in older generations as their role models (2 out of 10).

GenY2:

*I do think that if people took their health into their own hands a bit more and actually took some responsibility, things would probably work better...the patient just wants everything to be fixed for them with them not having to do anything or have any input.*

GenY3: *“A lot of the registrars look and sound like they’ve had enough and that’s not good long term.”*

GenY4: *“It may make the other two groups to stand up and listen and think well actually...it’s an entitlement to be allowed a family life.”*

GenY5:

*I think colleagues are now just becoming a lot more selfish about it and they kind of say “well, it’s my life, I need to live a good life”...and I think doctors, especially the young generation are almost fighting back against it.*

These findings do appear to reveal a significant shift in attitudes within Generation Y when compared with their predecessors. This is reflected in the assessment of those Baby Boomers and Generation X interviewed who believe that members of the medical profession within Generation Y have a different sense of professionalism and now act in a manner little different from being employees doing a job rather than professionals pursuing a career.

I would argue that further evidence of this shift in attitude and behaviour of Generation Y can be seen in the Junior Doctors Strike of 2016. Put simply, the government wished to increase medical staffing levels at night-time and weekends to deal with a perceived increased patient mortality rate at these times, albeit with no additional doctors to staff such rotas on what needed to be a cost neutral basis. This required junior doctors of the time, i.e. Generation Y, to undertake an increased proportion of their working hours at anti-social times away from their normal training daytime hours in return for reduced financial supplements for working such anti-social hours. Further frustration to these Generation Y doctors was caused by a government imposition of the new contract when negotiations floundered (Goddard, 2016).

The new contract has put further pressure on Generation Y doctors' work-life balance that is clearly of keen importance to them as noted by Spooner et al. (2017) who concluded that Generation Y doctors in choosing their career specialty put great measure on work intensity and work-life balance. Such a conclusion was corroborated by Rich et al. (2016) who noted that since the Junior Doctors' Strike, there was increasing concern amongst junior doctors about increasing work intensity that disrupted work-life balance in turn leading to increased risk of mental health issues (McMurray et al., 2000)

My concerns over the lasting effects of the 2016 Junior Doctors' Strike on Generation Y doctors are echoed by Goddard (2016, p.1446):

*The damaging effects of these events on morale and the psychological contract between physicians and the state cannot be understated and will take a generation to repair. Unhappy and demotivated doctors have poorer patient outcomes.*

## Chapter 5

### Analysis & Discussion – Documentary Analysis

We have seen in the literature review that successive governments, no matter their persuasion since the 1980s, have (i) increased the expectation and rights of patients and (ii) increasingly regulated the medical profession. I, therefore, propose to take the reader through a series of government documents that may or may not support the above two suppositions.

The election of Margaret Thatcher in 1979 hailed a new dawn in political science and a move away from direct government control in a Keynesian manner to one where the free market was allowed to dominate that was termed ‘neoliberalism’ (Ainley, 2004; Newman, 2000).

#### 5.1. *Griffiths Report (1983)*

As such, the government in 1983 asked Sir Roy Griffiths, the Chairman of Sainsburys plc, to undertake a review of the NHS, particularly its management structure. Griffiths responded in a letter format to the then Secretary of State for Health (Department of Health and Social Security, 1983). The response by Griffiths within the *NHS Management Enquiry (Griffiths Report)* was a defining moment in the future of the NHS. He acknowledged that there were no clear managerial roles or functions but simply consensus management that inhibited decision making. He recommended a strictly hierarchical management structure from the top down with the need for “*a small strong general management body...at the centre...to ensure responsibility is pushed as far down the line as possible*” (p.1). Griffiths appears to compare his experience of running a large corporate business to that of the NHS. Griffiths was critical of a lack of performance management, an inability to define outcomes and lack of financial controls as, for example, when he stated that the NHS must “*relate workload and service objectives to financial*

*and manpower allocations, so as to sharpen up the questioning of overhead costs” (p.4). This notion of performance management was important to Griffiths at both the macro level in terms of the NHS as a whole but also right down to the micro level for individuals when he noted there must be “some measurement of output in terms of patient care” (p.4) and that the NHS must “ensure with line management that a policy for performance appraisal and career development operates...to meet the expectations of staff and the management needs of the service” (p5).*

This report was a defining moment as it was the start of the rise of the power of the ‘manager’ within the NHS at the expense of the medical staff who previously ran hospitals. Just as important was the recognition that patients ultimately had primacy over the NHS when the report stated:

*Nor can the NHS display a ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves...the NHS is about delivering services to people. (p.8)*

This notion of needs and expectations was taken further with Griffiths’ business background when patients started to be considered as procurers of a service. Thus, the report noted “*the desire to secure the best possible services for the patient. At present consumers’ interests are principally in the hands of the lay members of Health Authorities” (p.17).*

I would suggest the Griffiths Report was the moment when the previously balanced relationships within the tripartite Social Contract started to shift given that the government and patients would be the beneficiaries whereas Medicine would lose control over the NHS and its members would require performance management.

## 5.2. *Working for Patients (1989)*

The changes proposed by the *Griffiths Report* (Department of Health and Social Security, 1983) were subsequently enacted by the government White Paper *Working for patients* in 1989 (Department of Health, 1989). This brought in the new hierarchical management structure but additionally split the primary sector, i.e. GPs as purchasers of healthcare on behalf of their patients, from the secondary sector, i.e. hospitals who provided services. This allowed hospitals to compete for patients for the first time from outside their normal catchment area to supposedly increase patient choice, reduce costs and encourage best practice. Throughout *Working for patients* it is clear that patients were the stated beneficiaries time and again particularly as the seven key changes had stated aims of improving healthcare in various ways for patients. Indeed, it was noted that “*the purpose of all the reforms in this White Paper is to provide a better service for patients*” (p.6).

The portents for the medical profession were more ominous from *Working for patients* (Department of Health, 1989). For the first time it was suggested that doctors should be monitored under the guise of audit as the government wished “*to see all hospital doctors taking part in what doctors themselves have come to call ‘medical audit’ – a systematic, critical analysis of the quality of medical care*” (p.39). Likewise doctors were to have a more defined contract setting out their responsibilities when it stated “*every consultant should have a fuller job description than is commonly the case at present. This will need to cover their responsibility for the quality of their work, their use of resources, the extent of the services they provide for NHS patients and the time they devote to the NHS*” (p.42). One might even suggest there were thinly veiled threats against doctors with respect to these job descriptions when it stated, “*these job descriptions, which will be reviewable annually, will be an essential tool for managing all consultants' contracts...and enable district management to monitor whether consultants are*

*fulfilling their contracted obligations*” (p.42) as well as giving NHS managers “*greater flexibility to determine the conditions of service of NHS staff*” (p.17).+

### **5.3. *The Patient’s Charter (1991)***

The rights and expectations of patients were reinforced further in 1991 with the publication of the *Patient’s Charter* (Department of Health, 1995) when it was explicitly recorded what patients should expect from the NHS. The charter is markedly asymmetrical in emphasis in favour of the patient. There are ten pages of described patient benefits but only two lines as to what is expected of patients in return when asserting “*you can help the NHS – and all other patients – by keeping to your appointment time or giving the hospital early warning if this is not possible, so that others can be seen sooner*” (p.4). It is made clear how to complain about any service that they receive when suggested “*you have a right to have your complaint investigated and to receive a full and prompt written reply*” (p.9). The concept of consumerism is taken even further when noted that patients could be “*referred to a Consultant that is acceptable to you*” (p.1). On the other hand, there is nothing in this document for doctors if they are subjected to poor patient behaviour or what the consequences are for patients if they do so. This document is written entirely with patients in mind and in reality is a set of regulations and standards to which doctors will be held accountable.

### **5.4. *Local Voices (1992)***

Subsequently, in 1992 came the document *Local voices: The views of local people in purchasing for health* (Department of Health, 1992). This described the government’s intentions to extend its acquisition of patients’ opinions about the NHS from standalone consultations to a process of ongoing patient involvement through various techniques such as interviews and focus groups, questionnaires and surveys. The document is quite transparent in

how the government wished to shift the balance of influence in favour of patients, for example, when stating:

*If health authorities are to establish a champion of the people role, their decisions should reflect...what people want, their preferences, concerns and values. Being responsive to local views will enhance the credibility of health authorities.” (p.3)*

Undoubtedly, this document must be taken in the context that public trust, confidence and credibility are important to governments.

It might be considered that canvassing patient opinion was carried out to determine what it was that patients wanted as it was not known previously, at least not in any great detail.

This government quest for patient consultation was similarly emphasised in the document when it stated that if health authorities wished to alter services, they would be “*more persuasive and successful in their negotiations with providers, if they secure public support*” (p.3). Whilst an obvious objective would have been, as stated, to obtain the views of patients, there may well have been other implicit objectives in garnering public support with respect to making the medical profession increasingly accountable and subject to the wishes of the public, as well as moving forward their plans for a health service based on a market model with a more defined consumer and producer.

### ***5.5. Hospital & Ambulance Services (1994)***

The drive for competition between healthcare providers and the provision of information for patients to decide where they would have their healthcare provided was furthered by the publication of ‘league tables’. This allowed direct comparison between healthcare providers

across the UK. An early example of such data was *Hospital and ambulance services: comparative performance guide 1993-1994* (Department of Health, 1994). This document refers on multiple occasions to the *Patient's Charter* first published in 1991 (Department of Health, 1995) which, as we have seen, put patients in the ascendancy, and this comparative guide was designed to maintain that position by the government, as it stated:

*The Citizen's Charter emphasises that the public has the right to know how all public services perform. The publication of these tables and the commitment to their continuing publication and expansion, shows the government's determination to put this objective into practice.”* (p.4)

## **5.6 Patient Partnership (1996)**

The Department of Health (1996) introduced the White Paper *Patient partnership: building a collaborative strategy*. This paper introduced the wish for patients, doctors and management to work together as a team in a collective manner. This being a concerted effort on the part of the government to shift the doctor–patient relationship from one of medical authority to one of shared decision-making between patient and doctor that I believe had the intended consequence of diminishing the power, authority and prestige of the medical profession. *Patient partnership* made it abundantly clear that those working in the NHS required “*acceptance and understanding of the need to put patients first*” (p.1) and that NHS staff needed to give “*greater voice and influence to users*” (p.2).

Throughout *Patient partnership* patients are referred to as users and consumers which rather grates with doctors such as myself but reflects the increasing consumerism in society at that time. In fact, my difficulties with the term ‘consumer’ are matched by other doctors as well as patients (Deber et al., 2005; Costa et al., 2019). Indeed a similar debate exists within Higher

Education, exacerbated by the introduction of student fees, as to how students see themselves increasingly as consumers and how that places pressure on academic institutions as well as individual academics (Molesworth et al., 2009; Tomlinson, 2017).

### **5.7. *The New NHS (1997)***

New Labour came to power in 1997 and introduced *The new NHS: modern, dependable* (Department of Health, 1997). It was stated that competition between healthcare providers had resulted in the acquisition of short-term contracts rather than long-term planning. The hoped for spread of best practice had not occurred due to secrecy in contract negotiations with ‘*wasted resources administering competition between hospitals*’ (para 1.3). Changes in organisation were introduced but still patients were placed centre stage by the government. As the document noted, “*the needs of patients will be central to the new system*” (para. 1.4) with the need to “*rebuild public confidence in the NHS as a public service accountable to patients, open to the public and shaped by their views*” (para. 2.4). I interpret this as whilst doctors placed the needs of patients first and foremost given a nostalgic sense of professionalism, there was now the need to put first and foremost patients’ actual views and opinions. Simultaneously, decisions were made to increase the regulation of doctors by the setting up of a system of ‘*clinical governance*’ (para. 6.12) so that each individual doctor’s practice would be assessed by means of audit, and the requirement to follow evidence-based practice and undertake continued professional development (CPD). At a national level, the National Institute for Clinical Excellence (NICE) was set up to ensure any new procedure, treatment or drug introduced into the NHS was based on evidence and would be costed to ensure financial viability for the NHS. This further continued the gradual erosion of doctor’s control over traditional areas of practice and decision making that in turn started to restrict the practice of doctors.

## **5.8. A First Class Service (1998)**

This idea of regulating the medical profession under the guise of clinical governance and evidence-based medicine was taken further by the document *A first class service: quality in the new NHS* (Department of Health, 1998). Once again, it is clear that the government wanted to answer to patients first rather than doctors when noting, “*Government is committed to ensuring that standards of professional self-regulation are rigorous and in line with the valid expectations of patients*” (p.3). To reduce further ‘quality’ variation (i.e. varying clinical practice) on top of NICE being introduced, the National Service Frameworks (NSFs) for common conditions would be introduced for clinicians to follow that would be policed by the Commission for Health Improvement (CHI) that would do spot checks and visits of hospitals to ensure NSFs were being followed. This determination to regulate the medical profession by the government was clear when it stated the need to ensure:

*professional standards developed nationally continue to be responsive to changing needs and to legitimate public expectations. The Government will continue to work...and strengthen existing systems of professional self-regulation by ensuring they are open, responsive and publicly accountable.”* (para. 3.42)

## **5.9. The New NHS Plan (2000)**

*The new NHS plan. A plan for investment. A plan for reform* (Department of Health, 2000a) brought a large financial injection into the NHS to increase staff numbers, reduce waiting times and allow large infrastructure projects to proceed. However, the document reveals a recurring sense of asymmetry in that patients are at the heart of the process with little emphasis on the expectations of the medical profession. The document contained constant reminders of the equality of patients with their doctors or in fact the primacy of patients when it noted, “*patients and citizens will have a greater say in the NHS and the provision of services will be centred on*

*patients' needs*" (p.4); *"the patients voice does not sufficiently influence the provision of services"* (p.30); and *"patients are the most important people in the health service. It doesn't always appear that way"* (p.88).

This latter quote to me suggests primacy of the patient although up to this point the tone of the document was that of collaboration and partnership that would be more indicative of equality in the doctor–patient relationship. Furthermore, the dominance of the medical profession within the doctor–patient relationship was significantly challenged when it was stated: *"the relationship between service and patient is too hierarchical and paternalistic"* (p.30).

The *New NHS plan* (2000) made it easier for patients to complain by setting up a national Patient Advocacy and Liaison Service (PALS) whereby an independent arbiter would deal with a patient complaint on their behalf. Patients were provided with additional rights to redress if operations or clinics were cancelled or delayed. A continued push was maintained to provide patients with as much information as possible so that they could make decisions about their own healthcare.

Likewise, there was continued impetus to increase medical regulation with a determination to further consolidate the need for audit of doctors, as noted when stated, *"the regulation of the clinical professions and individual clinicians also needs to be strengthened"* (p.90). This was extended to include the need for an annual appraisal and the need to revalidate with the GMC on a rolling five-year cycle. The tone of the document is intimidating when it noted that when considering the actions of doctors referred to the GMC, it *"should explore introducing a civil burden of proof. Government and parliament will have to judge whether the reforms proposed by the GMC will indeed protect patients and restore public confidence"* (p.91). Thus, the

government was proposing that doctors could be found guilty of poor professional practice more easily under the civil burden of proof rather than the criminal burden. It would seem that the government was reacting to societal pressure in the wake of medical scandals that were occurring at the time, such as the Bristol scandal into paediatric heart surgery (Kennedy, 2001) and the Alder Hey scandal with the retention of paediatric body parts (Redfern, 2001).

### ***5.10. Better Information, Better Choices, Better Health (2004)***

The empowerment of patients continued with the introduction of *Better information, better choices, better health* (Department of Health, 2004). The purpose of the paper was two-fold. The first was for health organisations to provide information about their services to patients more readily in comparison with similar NHS bodies. The second was for clinicians to provide appropriate information for patients to come to their own self-determination when deciding which treatment was best for them, i.e. doctors needed to provide fully informed consent. This was indicated by the document stating, “*partnership is at its strongest – when both patient and health professional share in making decisions about treatment*” (p.1). It is clear that the government felt that the previous paternalistic doctor–patient relationship was an anachronism with shared decision-making between patient and doctor the new expected norm. This shift was subsequently recognised by the legal system, as described in the literature review, when the issue of primacy in the doctor–patient relationship shifted from the doctor to the patient as illustrated by a comparison between the Bolam Test case (Bolam v Friern Hospital Management Committee, 1957) and the Montgomery Ruling (Montgomery v Lanarkshire Health Board, 2015).

### ***5.11. Trust, Assurance & Safety (2007)***

The government's desire for even further regulation of the NHS professions persisted, and in 2007, the Labour government published *Trust, assurance and safety: the regulation of health professionals* (Department of Health, 2007). Key to this document was to ensure public confidence in the professional regulators. As such it was felt that membership of any committee belonging to the regulators should demonstrate “*parity of membership between lay and professional members to ensure that purely professional concerns are not thought to dominate their work*” (p.5). This feeds back into the ‘nostalgic’ sense of being a member of a profession as clearly Medicine would no longer be autonomous or self-regulating. To further ensure scrutiny of regulators and negate suspicion of self-protection the document noted it was necessary “*to ensure all Councils [of regulators] become more accountable to Parliament*” (p.5) as well as “*Council members will be independently appointed*” (p.5).

### ***5.12. Equity & Excellence (2010)***

The advent of the Coalition in 2010 brought the White Paper *Equity and excellence: liberating the NHS* (Department of Health, 2010). The document predominantly dealt with another restructuring of the NHS with an emphasis on allowing ‘private providers’ to bid for services. However, just like previous governments there was a focus on putting the experience of the patient first:

*Healthcare systems are in their infancy in putting the experience of the user first and have barely started to realise the potential of patients as joint providers of their own care and recovery. Progress has been limited in making the NHS truly patient led. We intend to put that right.”* (p.13)

I would question the use of the word ‘infancy’ here as the move to put patients centre stage and regulate doctors commenced more than a quarter of a century previously with the *Griffiths Report* in 1983. However, one could argue that the government was referring to progress in putting patients centre stage rather than the existence of the idea itself.

Thus, there was consistency over a prolonged period to push forward patients’ rights that would change the dynamic within the doctor–patient relationship by ensuring constant focus on patients’ needs, continuing improvement in patient access to knowledge about services and their conditions, increasing provider choice for patients, focusing on personalised care and gathering patient intelligence.

Interestingly, it stated that “*healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients*” (p.1). That is certainly not my personal perception of how the NHS has ever run nor did interviewees suggest that their voice was valued. The attitude displayed in the responses garnered from interviewees revealed widespread frustration (all five Baby Boomers; four of five Generation X interviewees; and six of ten Generation Y interviewees) with government at how they are not being listened to nor do they have any control over how the NHS is run. There is an increasing sense that doctors are merely employees who are passive rather than actively engaged professionals. It was my impression that the longer the experience of working in the NHS, the greater the frustration with the government rather than it being a difference in generational attitudes.

### **5.13. NHS Constitution (2015)**

The *Patient’s Charter* (Department of Health, 1995) expanded into the *NHS Constitution for England* (Department of Health, 2015). This set out the guiding principles and values upon

which the NHS would provide services for patients. The principles include the fact that the “*the patient will be at the heart of everything the NHS does*” (p.4), “*the NHS works across organisational boundaries [...] in the interest of patients*” (p.5), and “*the NHS is accountable to the [...] patients that it serves*” (p.5). The document details five pages of ‘rights’ and expectations that patients should be able to receive and have met by the NHS. There is only half a page devoted to the responsibilities on the part of patients which are little more than to turn up for appointments on time, keep their personal details up to date, register with a GP and behave reasonably towards NHS staff. There is no question of sanction if the patient does not follow their responsibilities. However, in practice, NHS staff are perfectly at liberty to call the police if they are threatened.

Whereas patients have ‘rights’ to be met, NHS staff have two pages of ‘duties’ they must follow including “*to view the services you provide from the standpoint of a patient*” (p.15). The sense of ‘duty’ to my mind has an implicit undertone of sanction if these duties are not followed.

#### ***5.14. The NHS Long Term Plan (2019)***

However, given what appears to have been successive healthcare policy implementation promoting patients and restricting doctors, there may have been some relief as a doctor with the publication of *The NHS long term plan* (Department of Health, 2019). This document describes a ten year strategy for the NHS. Once again, organisational changes are made that essentially decrease the opportunities for outside companies to bid for contracts for NHS services. However, the main thrust was to (1) push patients away from hospital care back into the community with associated increased cooperation between the NHS and social services; (2) a focus on improving services in chronic conditions, such as diabetes; and (3) continued improvements in cancer care. However, in relation to this research, for the first time

considerable emphasis was placed on patients becoming responsible for their own care with “*shared responsibility for health, over the next five years the NHS will ramp up support for people to manage their own health*” (p.25).

There was even a nod for the first time towards improving working lives for NHS staff. In fact, I would suggest that it is likely the recent influx of Generation Y workers into the NHS resulted in this statement:

*Inflexible and unpredictable working patterns make it harder for people to balance their work and personal life obligations [...] we will seek to shape a modern employment culture for the NHS promoting flexibility.”* (p.86)

As was clear from the analysis of interview responses, the importance of work–life balance to Generation Y should not be underestimated and it appears that the government is listening.

At every turn, I have tried to acknowledge my own position when analysing and interpreting these government documents, in order to come to a neutral dispassionate interpretation as best I can. However, at least to me, there does appear to have been a distinct trajectory in healthcare policy, no matter the political persuasion of governments, with respect to increasing the power of patients vis-à-vis doctors. What then is happening and how can this be explained?

### **5.15. Policy Amnesia & Memory**

Higham & Yeomans (2011) proposed the concept of both policy amnesia and policy memory. The authors were troubled by policy makers ‘losing’ the ability to learn from the lessons of the past when introducing and implementing new policy into the educational sector which they labelled ‘policy amnesia’. They argued that this loss of ‘memory’ was remarkable given that

past policy was well within the living memory and, thus, working lives of current policy makers who, as experts in the field, should have been cognisant of the historical context of their area of expertise. Thus:

*[Policy decisions] embodied diagnoses of perceived problems and proposed solutions that bore strong similarities to those which had gone before...the justifications which were offered included no acknowledgements of earlier reforms. (Higham & Yeomans, 2011, p.35)*

Explanations as to why policy amnesia existed in public services, in particular, were proposed by Pollitt (2000) and included:

- Continual organisational restructuring leading to the body disengaging with staff.
- Repeated change in documentary storage with each change causing data loss.
- The loss of attractiveness in a long-term career in the public services as working becomes increasingly transitory.
- Managerial trend in the public sector whereby service design intentionally disregards the past and remodels from the ground up.

Higham and Yeomans (2011) additionally imply that policy amnesia was further worsened by repeated changes of senior policy makers such as the Secretary of State for Education. They suggested the role of Secretary of State for Education was simply a career move for those seeking even higher office within government requiring postholders to “*accomplish some highly personal, high profile, innovative and ‘successful’ policy-making*” (p.51).

This analysis of healthcare policy documents, however, has not demonstrated the ‘policy amnesia’ one might expect with regard to a public service such as the NHS. In reality,

consecutive governments with respect to the NHS have maintained a remarkable level of policy memory despite all the factors that Higham and Yeomans (2011) and Pollitt (2000) have suggested would encourage policy amnesia to occur. This ‘memory’ occurred despite all the changes introduced by the White Papers assessed here and the ensuing Acts of Parliament that should result in policy amnesia, namely frequent NHS reorganisations, the setting up of semi-autonomous bodies to oversee various aspects of the NHS, changes in documentary storage, doctors more likely to have a portfolio career, repeated attempts at drives for innovation and efficiency, and constant changes in the Secretary of State for Health.

Analysis of the healthcare policy documents in actual fact clearly reveals a sustained effort with each successive White Paper to ‘remember’ that patients must be put front and centre of healthcare policy, that patient opinion must be sought and listened to, that patients will participate in NHS restructuring, and that patients must be free to make decisions on their own healthcare. Concurrently, White Papers have been introduced that ‘remember’ the need for ever growing scrutiny and regulation of the medical profession and the restriction of practice by means of tools such as guidelines, annual appraisals and evidence-based medicine. This has happened no matter the political persuasion of the day.

This does seem to be a sustained two-pronged attack on the medical profession to reduce its level of influence over the NHS. Undoubtedly, successive governments since Margaret Thatcher in the 1980s have pursued a ‘neoliberalist’ approach that gives individuals rather than the elite increasing influence over public services just as the synergistic effects of loss of deference, consumerism, medical scandals and increased access to knowledge also made their impact on society.

It is perhaps not surprising that any government would want control of the NHS, even if done in a covert manner, given that the UK government spent 9.6% of its gross domestic product (GDP) on the NHS in 2017, over which any government would presumably wish some jurisdiction (Great Britain: Office of National Statistics, 2019). Furthermore, the press often uses the refrain “*The NHS is our religion*” in an increasingly atheist UK society (Toynbee, 2018). The UK public is particularly protective of the NHS and with this in mind it will always be a fundamental electoral consideration for politicians, as identified by Veitch (2010). It is this need to control expenditure and win elections that are some of the key ‘drivers’ of policy.

Patients expect certain standards, and it is they who are now, as well as the government, exerting pressure on doctors especially in the way the doctor–patient relationship has evolved. This weight of patient expectation and increasing medical regulation are in reality the ‘levers’ by which the government has forced the medical profession to change. I have identified this evolution in the doctor–patient relationship in the literature review. It is also visible from the analysis of interviews where many participants commented upon increasingly onerous government regulation and the raising of patient expectations on their everyday working practice.

The fact that government has not been ‘friendly’ towards Medicine should come as no shock. We have seen in the literature review that politicians on the right tend to oppose professions due to their stranglehold on their field of practice that inhibits politicians from effecting change, whereas politicians on the left may regard professions as class-based elites that prevent those from working-class backgrounds entering their ranks (Downie, 1990). Thus all political persuasions seek to control professions such as Medicine in some way.

My position comes from my working within the confines of the NHS throughout the period covered by the documents analysed and being subjected to the introduction and subsequent effects of successive healthcare policy changes. I have, therefore, been subject to the wholesale change in the doctor–patient relationship from one of autocracy to shared decision-making brought about by the ‘drivers’ and ‘levers’ of policy.

My interpretation of the government documents analysed here suggests that there are multiple audiences for each of the documents. In general terms, these audiences would include politicians, policy makers, academics, NHS managers and the medical profession. However, there is still an explicit message to patients that at all times it is their wishes, needs and expectations that will be put first as this is repeatedly stated in clear terms in sequential government documents.

The government, on the other hand, has been less open about its underlying aim to remain electable and to use the issue of patient expectations to dampen down the influence of the medical profession apart from in its rather candid statements in *Local voices: The views of local people in purchasing for health* (Department of Health, 1992).

Most remarkable to me through this data analysis has been how consistently all political parties have sought to exert control over Medicine through covert ‘silences’ in healthcare policy. Policy development has been explicit in consistently putting the needs of patients as its primary focus to the almost complete exclusion of doctors. Whilst there has been a focus on garnering the perceptions, thoughts and experiences of patients, little corresponding attempts have been made for doctors. Indeed, any policy produced aimed at doctors has been to restrict their practice using levers such as increased regulation and evidence-based medicine. Thus, I would

argue that the beneficiaries of healthcare policy have been directly the patients and indirectly the government, with the medical profession losing out.

As a doctor, I have lived in something of a social and economic ‘bubble’ since going to medical school, whereby, without realising, just about all my needs have been provided by my medical community. I have, therefore, been quite isolated from others in alternative walks of life. Completing the research for this thesis has given me a better understanding of other public services and those who work in them, particularly in Education. It has been both illuminating and depressing that those whom I have met on the EdD programme from all sectors in Education are subjected to the same pressures at work. This is perhaps not surprising as governments will attempt to subject all professionals within public services to the same accountability measures.

In considering Education, one could readily swap ‘patient’ choice for ‘parent’ choice. Indeed, my interpretation of the educational literature reveals remarkable similarities between the health and educational sectors in terms of policy design, implementation and evaluation. However, there is very little in the mainstream medical literature about such policy issues, nor the recognition that there is an implicit ‘silence’ in government policy to overlook the medical profession in favour of patients. I would argue that this reflects the general ignorance of the medical profession regarding ‘policy’ as it is not something considered in medical curricula even though it affects all aspects of our working lives.

There is, therefore, much to learn in Medicine from policy analysis in the educational literature. I would suggest now is the time for the medical profession to become alert to the question of government policy ‘silence’ and for its voice to be heard and considered if the relationships

within the Social Contract are to remain stable without further conflict. Accordingly, the medical profession also needs to become shrewder and more knowledgeable about policy analysis in the future in order to be able to alter the relationships within the Social Contract. This could be done through requiring the study of 'policy' as part of the professionalism sections of each specialty curriculum , but more likely through ensuring interested individuals in each specialty take the time to research and study policy implementation in order to lead their specialty in this field.

An appropriate place to start justifying the need for Medicine to be more involved in policy development is the work by Coffield et al. (2007) that describes, lists and puts into context policy development in education, noting this as “*an unending and heavy stream of policy and structural changes[that] has continued to affect those who learn, teach and manage provision*” (p.725). This description mirrors a surprisingly similar process of policy development in the NHS documented in this research that started with the *Griffiths Report* (Department of Health, 1983) where the role of top down management was instigated. Even the stated aim of *Equity and excellence* (Department of Health, 2010) to allow bottom up feedback from doctors has clearly not worked, either from my personal experience or according to the responses of interviewees.

My interpretation is that the negative effect of repeated and cumulative policy implementation on teachers in the classroom is akin to doctors in the consulting room. The medical profession has found it difficult to cope with changes in their working environment that may be explained by the work of Coffield et al. (2007) who describe policy as being developed within a closed system. By that they mean, policy is introduced 'top down' and those whom the policy is designed to affect (i.e. NHS staff) have no subsequent means of feeding back their perceptions,

experiences and ideas in turn to the policy makers. Indeed, one should recall the determined aim of the *Griffiths Report* (Department of Health and Social Security, 1983) to introduce ‘top down’ management into the NHS which still chimes through the years to this day.

Given the stated aims of improving efficiency and innovation, to not have feedback from doctors seems nonsensical as many solutions that exist for the NHS will come from those not only who use it (patients) but also from those who provide that care (doctors). Coffield et al. (2007, p.738) summarise the position for teachers and how they are treated by the government:

*[They are treated] as another lever to be pulled rather than as creative and socially committed professionals who should be involved in the formation, enactment, evaluation, and redesign of policy...professionals in the Learning and Skills sector are neither equal nor full partners in reform, they are the target of reform.*

This sense that those at the ‘coalface’ have little if any impact on policy-making, results in doctors, just like teachers, having the sense that they exist within a system that regards the workforce as a barrier to change rather than as those who should be looked upon as real partners from whom solutions to problems can be sought. This is reflected in issues of burnout which have generated calls to change the environment within which doctors work and have also been identified as a risk in the interviews in this research (Lemaire & Wallace, 2017). Similarities exist again with Education, where there has been a difficult relationship between teachers and government in recent times with the past Education Secretary, Michael Gove. Gove imposed on education the need to concentrate on pure academic excellence and the pursuit of knowledge. Teachers, on the other hand, realise the extended role of a school, such as being a bedrock institution within a community and a provider of vocational qualifications, as well as performing a safeguarding role (Millar, 2020).

In what seems to doctors as an increasingly hostile working environment where patients are far more ready and willing to complain about their doctors, there has been between 2006/07 and 2017/18 an increase in reported legal claims from 5,400 to 10,600 with the cost of such claims to the NHS rising from £0.4 billion in 2006/07 to £1.6 billion in 2017/18 (NHS Resolution, 2018; NHS Improvement, 2019). This increase in legal claims corresponds with the interview responses from Consultants, where the increase appeared to cause significant angst that may be increasing discord in the relationship between patients and doctors.

But what may be driving this litigious behaviour? Perhaps we need to look at the language of the government documents analysed with respect to particular words that are oft repeated. The government instituted a ‘charter’ that transformed into a ‘constitution’. Such naming of documents gives a sense of entitlement to those to whom the documents are directed, to a set of social, ethical or legal rights. Indeed, within these documents, patients are told to expect ‘rights’ and ‘expectations’. Patients are increasingly termed ‘users’ of a service and the term ‘consumerism’ has crept in. Given that patients have been so encouraged to think of themselves as having such rights, it is no surprise that they may consider themselves as ‘consumers’. A consumer has been described as “*a person who uses up a commodity; a purchaser of goods or services, a customer*” (Oxford English Dictionary Online, 2020). If patients are encouraged by the government to increasingly regard themselves as purchasers of a product, it is no surprise that they will complain about the NHS if it does not meet their satisfaction just like any other product they purchase.

This increasing consumerism displayed by patients within the NHS has previously been discussed (Mold, 2010; 2015; Downie, 2017). These authors put this phenomenon down to government policy that has in particular increased patient choice, increased access to

information and improved access to complaint procedures. However, that still does not explain why I and other doctors find it hard to use any other term than ‘patient’ for those we serve?

Many doctors such as myself are extremely proud to work for the NHS where the ability to undergo medical treatment is not restricted by the patient’s capacity to pay for it. I have worked in both Australia and Canada where the universal access to healthcare does not exist and it made me uncomfortable. Consumerism supposes that as a buyer of a good – if one can afford it – one can buy a medical service, i.e. private medicine. It remains uneasy to me that any one person should have greater access to vital healthcare over someone else based on the ability to pay. It appears that consumerism places the rights of the individual over that of the greater good of society (Mold, 2010; 2015; Downie, 2017). The problem with such a stance is that whilst the government, on the one hand, is encouraging individuals to achieve what is best for themselves, on the other hand, it cannot fund the NHS for every want and need for every individual as there is a finite pot of money. Put another way, successive governments have been irresponsible and not open with society in admitting that they cannot afford to allow every individual what they want in the NHS and, hence, that there is a need to ration treatments and drugs by the likes of NICE as they are introduced.

Consumerism gives the sense of choice, but is that choice in the NHS a ‘real’ choice? If a patient gets acutely ill, is a patient really able to make a choice to go further from their home? This seems unlikely. Even those suffering long-term illness are few and far between who have the resources to travel outside the normal catchment area of their district general hospital. *The new NHS: modern, dependable* (Department of Health, 1997) essentially describes competition within the NHS as a failed experiment. We therefore have a situation once again where there

is disingenuousness by the government that promotes choice when in reality the NHS cannot provide that choice nor do the vast majority of patients have the means to follow that choice.

Perhaps, as Mold (2015) and Downie (2017) suggest, there is a fundamental struggle for the medical profession in coming to terms with the idea of patients being consumers that puts the rights of the individual over the greater good of everyone. That is, the medical profession is programmed to act as one bloc (or rather as large groups) rather than individuals. All doctors have to follow the same guidance from our regulator, the GMC, such as *Good Medical Practice* (General Medical Council, 2019a) that tells us how to behave professionally. Large groups of doctors, i.e. specialties, all follow and train to the same curriculum and increasingly we have to follow guidelines en masse as set down by NICE. This all ensures that there are no significant outliers in terms of practice, i.e. it is the opposite of consumerism whereby individualism is frowned upon so that everyone acts in the best interests of the profession and society.

It is this clash between the patient's wish to be regarded as an individual and for their needs to be prioritised and the doctors' wish to act for the greater good of every patient and of society at large that is causing discord in the doctor–patient relationship.

One might conclude from the literature review and data analysis in this research that policy introduction by government has encouraged this to happen which brings us back to the Social Contract and its future. The relationships within the Social Contract appear to be increasingly strained with the medical profession becoming ever more isolated. Social Contract theory suggests that if one party senses its position has been diminished then it will take steps to push back and regain its position of strength. Or, put another way, there will be increasing conflict

between Medicine and its partners within the Social Contract until such time as the medical profession finds that a new reasonable equilibrium has been re-established.

The medical profession, I would argue, is not without blame in allowing this situation to develop. It has been complicit with the ‘silences’ in healthcare policy in not resisting changes introduced by successive governments due perhaps to its innate conservatism. It may be that this wish to be seen to avoid confrontation within Medicine is already starting to change as those with an old ‘nostalgic’ sense of professionalism start to retire, to be replaced by those doctors qualified in the 21<sup>st</sup> century as seen by the recent junior doctors’ strike of 2016. Indeed, there is every justification for suggesting that Baby Boomers and Generation X (within the medical profession) rather than vilifying their younger peers in Generation Y, should instead be applauding them for standing up to patients and government in order to reset the relationships within the Social Contract that they themselves allowed to become so imbalanced during their own careers.

## **Chapter 6**

### **Conclusions**

This research aimed to look at the interplay between the concept of ‘professionalism’ within Medicine and that of the ‘Social Contract’ – a tripartite relationship between government, society and the medical profession. More specifically, I wished to determine if there were differences in the concept of ‘professionalism’ between the different current generations within Plastic Surgery, and that if they existed, whether this would in turn potentially impact upon the working of the Social Contract.

The study was underpinned by the theory of the Social Contract as proposed by Rousseau in the 18<sup>th</sup> century and extended to involve specifically Medicine by Cruess and Cruess (2008). Social Contract theory was based on the need for individuals within society to give up certain individual rights in order to allow a civil society for all to be built. Contracts are both explicit and implicit between two or more parties and place obligations on involved parties. When one party senses a loss of equilibrium within the contract, that same party will act in a manner to rebalance the power equation within the contract.

Data was interpreted in line with Social Contract theory. The conclusions from the analysis were determined by two means. The first, deductively led by antecedent theory and literature in an a priori cumulative manner to help explain the findings of the research. The second, in turn, in an a posteriori inductive manner to predict possible future outcomes for the relationships within the Social Contract that emerge given present circumstances found within the research.

The primary question to be asked by this piece of research was: *Do generational differences exist in current understandings of medical professionalism which may impact the way the 'Social Contract' functions in practice?*

In order to frame and guide the research a series of supplementary questions were put forward:

- 1) How do current Plastic Surgeons view 'professionalism'?
- 2) What does 'profession' mean to current Plastic Surgeons?
- 3) Can current Plastic Surgeons use the concept of the 'Social Contract' to understand their working environment?
- 4) What are the potential consequences for the Social Contract if there are indeed significant generational differences in how professionalism is viewed?

A constructivist-interpretivist framework was the philosophical basis for the study. I believe a career path in Plastic Surgery to be a 'social construct' that both myself, as the researcher, and participants have built up. To therefore understand how others felt in their pursuit of a career in Plastic Surgery, I focused on trying to interpret the subjective meanings of participants' responses based on their own individual experiences, perceptions, attitudes and values. This research giving me an opportunity to consider my own position (reflection) but also its potential effect on the research (reflexivity) that I have considered and documented throughout the research. In summary, I have shifted from having an almost entirely positivist approach to research that is the norm in Medicine to that of an interpretivist paradigm to undertake this research. This has allowed me to change my own views on Generation Y doctors from a sense of frustration to one of understanding.

A single case study design was used as the methodological basis for the research. This allowed me to develop an illuminating narrative based on the in-depth exploration of complex interactions of many variables within a single real-life context. The use of a case study design providing me with the latitude to use research methods that would best allow me to answer my research question by delving deeply into the past and current experiences of participants.

The case study in question comprised 20 Plastic Surgeons in a single hospital unit belonging to different generations as follows:

BABY BOOMERS	BORN 1946 – 1964
GENERATION X	BORN 1965 – 1980
GENERATION Y	BORN 1981 – 1996

A literature review based around the topics of professionalism, profession, the doctor–patient relationship and the Social Contract was undertaken that steered the subsequent research.

Participants took part in semi-structured interviews which required no use of NHS resources due to ethical concerns. Data analysis of interviews was subsequently coded manually.

To further triangulate the data obtained from the interviews and demonstrate that the results were concordant with the literature review and interviews, documentary analysis was

performed on government documents related to healthcare policy over a period from 1983 to 2019 consistent with the period of my medical career.

Whilst this description may appear linear, in actual fact, the research was carried out in an iterative manner with constant looping back and forwards refocusing on the research question, fine-tuning interview questions following pilot interviews, identifying the need to sample a greater range of experience in Plastic Surgery than first thought, deciding whether to analyse the data freehand or by NVivo analysis, along with an ongoing literature review.

## **6.1. Key Findings**

The following sub-sections highlight the central findings of this research.

### **6.1.1. Literature Review**

The literature review revealed the difficulty in defining ‘professionalism’. Although it is regarded as a set of attitudes, behaviours and values, these evolve with time and vary across nations and cultures but also even within and between professions.

The idea of a ‘profession’ was explored and found to evolve with time as well. It was regarded as a group of individuals with specialist knowledge due to an extended period of learning that came with responsibility to those they served but which, in turn, came with benefits of authority, prestige and financial gain.

The doctor–patient relationship has evolved from one of medical autocracy to that of shared decision-making due to changes in society that included diminished deference to authorities, the increasing ability of patients to challenge doctors or complain about healthcare

(consumerism), increased access to knowledge through the internet and social media for patients, and increasing societal concern following repeated medical scandals. Healthcare policy implementation revealed significant policy memory rather than the expected policy amnesia. This resulted in repeated policy introduction that championed the rights and expectation of patients at the same time as the medical profession being increasingly regulated.

### ***6.1.2. Interviews***

Interviewees from all generations concurred with the literature review as to the meaning of professionalism and what it meant to be in a profession.

Baby Boomers and Generation X answered as if one cohort with all being Consultants. All Generation Y participants were trainees.

Consultants had learnt their professionalism informally through the hidden curriculum whereas trainees had done so through a mixture of the hidden curriculum as well as more formal teaching. Trainees were sceptical of the formal teaching of professionalism.

Responses to questions on professionalism and profession revealed marked overlap by the generations. Baby Boomers and Generation X were more likely to describe changes in professionalism and what it meant to be in a profession as well as why these changes occurred, although this is likely linked to their length of service and exposure to social, cultural and political changes in that time. The reason most commonly cited as being responsible for these changes was government interventions but loss of patient deference, consumerism, increased patient knowledge and medical scandals were all mentioned as other contributory factors.

Baby Boomers and Generation X were critical of Generation Y as being less professional and, in particular, not going the extra mile for their patients. Further investigation revealed a stronger sense of vocation in Baby Boomers and Generation X, whereas Generation Y increasingly regarded their career as a job and themselves as employees rather than professionals. Baby Boomers and Generation X tended to put the wishes and needs of their patients above their own, whereas Generation Y expected a better work–life balance than their predecessors. This was most marked when considering altruism and accountability when Generation Y were more reluctant to allow their careers to come at a significant cost to them or their families and did not accept as much a liability to be held to account to the general public as doctors from the preceding generations.

The principal driver causing this intergenerational difference appears to have been the EWTR, introduced in 1998 but not fully implemented until 2011. This resulted in a loss of teamwork and distancing between Consultants and trainees as trainees moved from the traditional on-call rota to a shift system. This change in working patterns resulted in a loss of opportunity for the hidden curriculum to allow the expected norms, attitudes and behaviours to pass down from one generation to the next. The shift pattern of working has increasingly resulted in an isolated and demoralised trainee workforce that has had the unexpected effect of trainees wishing for a distinct hierarchy so that they know where and who to go to for assistance. This was unexpected given that Generation Y is typically said to baulk at hierarchies, preferring meritocracy (Eckleberry-Hunt & Tucciarone, 2011; Espinoza & Ukleja, 2016).

It may be that the Generation Y trainees' wish for a better work–life balance reflects the society from which they are chosen where such balance is now in demand from Generation Y as a whole according to the literature (Howell et al., 2009; Pew Research Center, 2010). Generation

Y trainees are isolated as a result of changes in working practices and the loss of the team structure. The team environment provided both a significant coping mechanism to deal with a stressful working environment and the ability to be resilient in the face of that work. Therefore, it can be understood why Generation Y doctors may in turn request a better work–life balance. This situation is compounded by the changing demographics of the Plastic Surgery workforce as increasing numbers of women enter medical school, undertake Plastic Surgery training and become Consultants. Society and the medical profession still place an excessive burden of domestic and childcare responsibilities on to women that in turn results in a wish for greater work–life balance among the female workforce (Nadeem et al., 2014; Hampton et al., 2016). However, the request for greater work–life balance is coming from the male Generation Y trainees as well. As Generation Y trainees percolate up into the Consultant ranks, this wish for increased work–life balance may well come to represent a new sense of medical ‘professionalism’.

As for the Social Contract, all interviewees regarded the Social Contract as a valuable and interesting concept to consider. Unanimously, it was felt that during their careers, the power dynamics within the Social Contract had shifted away from Medicine in favour of patients and the government. Once again, all participants felt that if the Social Contract was not recalibrated then there was an increasing likelihood of conflict between the three parties. Concerns were raised as to how Medicine could renegotiate the Social Contract given that there is no sole recognised leader that represents Medicine.

### ***6.1.3. Documentary Analysis***

An analysis of government documents covering the period of my career, 1983–2019, was undertaken, as seen in Appendix 4. I went beyond the literal sense of the words and phrases

within the White Papers, i.e. their denotation, and sought to interpret the meaning of the words and phrases used given the time and context in which they were written, i.e., their connotation (Chandler, 2007). To do so, I considered the context, pretext, subtext and intertext of the documents using the questions seen in Appendix 9. (Usher and Edwards, 1994; Wellington, 2015).

The analysis marks out the *Griffiths Report* (Department of Health & Social Security, 1983) as the point at which patients started to be considered as consumers and the government commenced wresting managerial control from the medical profession. This resulted in the slow but steadily progressive championing of patients as demonstrated in the *Patient's Charter* (Department of Health, 1991) that morphed with time into the *NHS Constitution* (Department of Health, 2015) which extended the rights, demands and expectations of patients. Simultaneously, healthcare policy implementation resulted in the increasing regulation and restriction of medical practice through the progressive introduction of clinical governance, audit, evidence-based medicine, job planning, annual appraisal, five-yearly revalidation, Consultant contracts, funding of services and rationing of services.

The documentary analysis was used to complement and triangulate the findings of the literature review and semi-structured interviews. Indeed, the documentary analysis allowed insight into the evolving nature of professionalism, what it meant to be a member of the medical profession as well as the doctor–patient relationship. Likewise, the documentary analysis chimes with the responses of the interviewees who expressed the view that continual government interventions had made their working lives more challenging and, in so doing, contributed to the changing nature of professionalism, what it means to be in a profession, the doctor–patient relationship and the negative impact upon the Social Contract.

## **6.2. *Limitations of Research***

I have to consider the ‘internal validity’, the extent to which my methodology and methods have accurately studied and measured what I intended to study and measure by ensuring I had as little effect on the research as possible based on my past experiences, attitudes and values. Ultimately, I was trying to determine changes in professionalism across the generations in Plastic Surgery, but as we have seen in the literature, the concept of professionalism is not static but evolves. Furthermore, professionalism is considered differently across nations, cultures and societies so it is a remarkably difficult concept to pin down; hence the difficulty in defining exactly what it is. Given the relatively small sample from one Plastic Surgery unit in the UK, I cannot guarantee that the internal validity is 100%.

I accept that my conclusions are my ‘truth’ based on my past experiences and perceptions and that others, given the opportunity to assess exactly the same data, may come to a ‘different’ truth that would be justifiably valid as well. However, I hope to convince the reader that the contents of this thesis are authentic, credible and trustworthy. I do so by stating that I believe the research to have been systematically carried out, the analysis of the data obtained to have been critically appraised and my positionality to have been open and honestly acknowledged in a reflexive manner throughout. Furthermore, I have shared my conclusions with participants for their feedback to ensure my conclusions are not out of step with their own reality.

The next step is to consider ‘external validity’, otherwise known as ‘generalisability’, that needs to be addressed. This is a major concern particularly in the use of single case study research, as already discussed in Chapter 3, as to how the findings and lessons learnt can be meaningfully extrapolated to other ‘cases’ (Lincoln & Guba, 2009; Yin, 2014; Bryman, 2016). To reassure the reader the boundaries for the ‘case’ in this research were well demarcated, that

is, a group of doctors working in a single Plastic Surgery unit in the UK in a city setting. This is the typical means by which Plastic Surgery services are delivered, predominantly in a central city teaching hospital with less specialised services delivered at peripheral district general hospitals in a ‘hub and spoke’ type manner. Furthermore, the responses from the current participants should be taken in light of the fact that they follow a ‘national’ curriculum that sets the standards for entry to training, the syllabus to follow, the assessments to be undertaken and requirements for exit from the training programme. These are followed by all Plastic Surgery trainees who in turn become Consultants. Likewise, all Plastic Surgeons work for a ‘National’ Health Service in Trusts that follow nationally agreed rules set down by government and work in proscribed work-patterns. Finally, all Plastic Surgeons are expected to follow the ‘national’ guidelines as set out by the regulator, the GMC, in terms of its advice in *Good Medical Practice*, regarding expected professional behaviours (General Medical Council, 2019a). Thus given the number of ‘national’ frameworks within Medicine to ensure consistency of practice across the UK, and that all doctors within the UK are exposed to a similar changing sociocultural milieu, I would expect some degree of ‘transferability’ of key findings learnt in this research to assist with other cases especially within the UK. I will allude to possible ways of enhancing this concept later in this chapter when considering further research.

In essence, whilst the Plastic Surgery unit examined in this research is to some degree unique, it is likely to be just a single example of a larger series of such Plastic Surgery units within the UK with similarities as explained above. If one were to undertake no further case study research, then generalisability should be considered potentially possible given similar locations in urban environments, the same working practices, comparable age and gender mix. Additionally, I hope I have provided sufficient detail in my research design as well as

explaining my own position for the reader so that they can make an informed judgement for themselves as to whether what I have discovered is relevant or not to other similar cases.

I acknowledge that the reliability of the research will be less than 100% given that, when dealing with humans, it will be almost impossible to achieve exactly the same data (in terms of data verbatim in interviews) from one day to the next. However, the reader can be given reassurance that a saturation point was achieved in relatively small numbers and the comments from interviewees were consistent with and triangulated with my findings both from the literature review and the documentary analysis. Likewise, given that Plastic Surgeons throughout the UK, no matter their unit, as well as doctors from all surgical specialties follow mandatory national standards and again are exposed to the same evolving sociocultural milieu to that of the Plastic Surgeons in this case study, I would expect some degree of ‘replicability’ if the same literature review, interview methods and documentary analysis were applied to other contexts, i.e. other surgical units, when studied by either myself or other researchers. This will be discussed later in this chapter in the section on future research. Adding to this sense of replicability was the means by which I chose the sample that was a combination of probability sampling to ensure I had representation from each of the generations but also non-probability sampling that allowed ease of access to potential participants. The non-probability nature of the sampling was further enhanced by it being ‘purposive’ so that no attempt was made to engage with those with extreme views or specialist knowledge in professionalism. This is something further that could be replicated.

### ***6.3. Contributions to Knowledge***

This research highlights generational differences in professionalism within Plastic Surgery for the first time in the UK and across three generations (Baby Boomers, Generation X and Generation Y). Only one paper (Larson, 2003) was found describing previous research on generational differences in professionalism within Plastic Surgery; this was carried out in the USA but only considered two generations (Baby Boomers and Generation X). Furthermore, medical professionalism in the USA has a greater emphasis on financial considerations given the difference in healthcare delivery between the USA and the UK. Thus, this research provides a unique UK perspective as well as considering Generation Y that had not entered the medical workforce at the time of the paper by Larson (2003).

#### *Theoretical Contribution*

I could find no previous literature linking the specialty of Plastic Surgery (or any specialty within the whole of Medicine) to the concept of the Social Contract. It is the first piece of research to formally consider how the Social Contract will develop in the future with respect to Plastic Surgery.

This research suggests, at least within Plastic Surgery, that there is disharmony amongst the medical profession as to how they are treated and perceived by society and government. Using Social Contract theory, one can predict ‘push back’ by the medical profession particularly amongst the Generation Y doctors who in particular wish for a greater degree of flexibility in how they work. Other suggestions that this push back has commenced are the 2016 Junior Doctors’ Strike and the recent outrage amongst more senior clinicians with respect to tax charges on pensions that has been ameliorated in the March 2020 budget. Social Contract theory can be thought of as similar to Newton’s third law of motion where for every action

there is a reaction. Whilst Newton's law calls for an immediate reaction, I would suggest Social Contract theory results in a 'slow-burn' reaction to events if one party is aggrieved in order to re-establish what that party considers a new equilibrium which, unlike Newton's law, may be set at a different point than previously. Until such time as doctors sense that the relationships within the Social Contract have reached a new equilibrium, there is likely to be continued tension within the Social Contract.

The results of this research should matter not only to doctors but also to academics, policy makers, government and ultimately patients. There should be realisation that Social Contract theory is a means by which to consider the smooth operation of the NHS as well as a predictor of conflict. Furthermore, it should now be recognised that any more onerous regulation of the medical profession should not be carried out without due canvassing of medical opinion. The key relationship in any clinical setting is that between doctor and patient – it is in no one's interests to have that doctor aggrieved by the system in which they work.

### *Methodological Contribution*

Whilst a case study approach and the use of methods such as interviews and documentary analysis are commonplace in qualitative research, they are not so in the field of Medicine where quantitative research rules supreme. In the Plastic Surgery literature, any qualitative techniques, such as interviews or surveys, ordinarily will have an analysis performed that contorts the data into some form of quantitative statistical analysis as without such meaning, the data and research is deemed or thought meaningless and valueless. I, personally, have taken a national educational lead in Plastic Surgery and I am not aware of another Plastic Surgeon having achieved a PhD or EdD in Education. I hope to publish and present this research in due course to prove to the Plastic Surgery and wider surgical community that pure qualitative

research, without resort to statistics, can withstand, support and uphold academic rigour. Not only that, but I also wish to reveal to the Plastic Surgery community that qualitative research is capable of producing data and conclusions that can make a significant difference to clinical practice. By doing so, I would like to establish a foothold in Plastic Surgery research that will take this methodological approach on in the future by my peers who follow on behind me.

### *Empirical Contribution*

I am wary of being stereotypical, but this research suggests that there is difficulty between Consultants (Baby Boomers & Generation X) and trainees (Generation Y) in understanding each other's concerns. Consultants find it difficult that trainees wish for a better work-life balance with trainees, in turn, finding it difficult to take on the sacrifices that Consultants have made for their careers. Consequently, the two sets of doctors increasingly appear to be drifting apart with persisting antagonism between them. This research suggests consideration should be given to reversing that trend by bringing the generations back together by changing current working practices. This could be undertaken by means of mentoring between the generations and more specifically within the hospital environment with the re-introduction of some form of teamwork structure even if we cannot go back to the days of the 'firm'.

### *Conceptual Contribution*

I have to admit that prior to my research I had concerns about the professionalism of trainees, just like many of my Consultant peers. However, this research has made me realise I have been considering the difference in professionalism between Consultants and trainees in entirely the wrong way. Undoubtedly, both the literature and this research suggests Generation Y have a different outlook on their lives in and out of work as compared to the preceding generations. The literature review also identified that 'professionalism' is not static but evolves with time.

It seems to me that the process of evolution has speeded up recently as a consequence of the introduction of EWTR that resulted in loss of the team-like ‘firm’ structure. The subsequent transfer to shift-pattern working for trainees resulted in a reduction in time that the generations spent together, inhibiting observation and communication between generations, i.e. the action of the hidden curriculum. Generation Y trainees are now increasingly isolated and demoralised. This has resulted in the loss of harmonious working relationships between Consultants and trainees with a re-evaluation on the part of Generation Y trainees as to their work–life balance. Consequently, how Generation Y view their own professionalism as compared to preceding generations has changed. We, therefore, currently and simultaneously have two types of ‘professionalism’ within the medical workforce. Baby Boomers and Generation X demonstrate the ‘nostalgic’ sense of professionalism with accountability and altruism. In turn, Generation Y demonstrate the ‘new’ version of professionalism that places the needs, wishes and expectations of patients on a par with their own. With time, as Generation Y start to enter the Consultant workforce this ‘new’ sense of professionalism may come to the fore. However, it will be interesting to see if Generation Y’s sense of professionalism changes as they shift from being trainees to Consultants. If this shifting sense of professionalism prevails, it can be predicted that this will have an effect on the power dynamics within the Social Contract.

#### *Workforce Planning Contribution*

The final contribution relates to workforce planning. The literature suggests already that Generation Y prefer a better work–life balance and have a desire for flexible working. This research contributes to this body of knowledge in that it can predict that with specific reference to Plastic Surgery, Generation Y trainees will also request flexible training. Planning for the future, the specialty associations, NHS Employers, policymakers and government must be made aware that the expected whole-time equivalents in terms of Plastic Surgery Consultant

numbers may not be achieved if this wish for flexible working comes to fruition over the next decade. This research should make stakeholders aware that as Generation Y become the Consultants of the future, it cannot be assumed they will work whole-time. Workplace changes designed to accommodate flexible working will be required and workforce planning altered accordingly to avoid the risk of a future workforce shortage.

#### **6.4. *Future Research***

As suggested, there are obvious concerns when undertaking case study research that the results obtained are idiographic, that is, conclusions drawn are considered difficult to be generalised to other cases and theory cannot be generated. To counterbalance that argument, it is recognised that quantitative research improves generalisability by increasing replication of experiments that results in statistical generalisation as the sample size increases and gets closer to the population as a whole, resulting in statistical significance. However, in qualitative case study research it is proposed that instead of statistical generalisation, ‘analytical’ or logical generalisation can be achieved (Yin, 2014). Rather than looking at representative sampling, the researcher needs to regard the single case as a contributor to the opening up and development of knowledge and theory. On this basis the researcher can in case study research extrapolate on the basis of theory that can be tested rather than on the representativeness of a sample.

Verschuren (2003) champions the generalisability of case study research another way by comparing statistical and analytical generalisation. It was suggested that in statistical research, the number of experiments performed was based on the population. If the population was highly uniform then the sample to achieve statistical significance would be small, but if the population had numerous variables then the sample would need to be larger to gain statistical significance. Turning to case study research, a case was described as highly complex if having

multiple variables. It was noted by Verschuren (2003) that “*complex issues in general have a much lower variability than separate variables*” (p.137). It was surmised, therefore, that to achieve generalisability required relatively few case studies as each case study was self-contained and contained within itself all the complexity that existed and which was, in reality, similar to another case’s internal complexity. It is put another way by Cohen and Manion (2011, p.295) whereby:

*Multivariable phenomena are characterized by homogeneity rather than high variability; therefore if the researcher can identify case studies that catch the range of variability then external validity – generalizability – can be demonstrated.*

The means to assuage fears on generalisability would be to carry out multiple case study research to produce a cumulative effect that can enhance generalisability (Yin, 2014; Wellington, 2015).

If I was to carry on this research, I would certainly wish to study further cases within Plastic Surgery throughout the UK to consolidate any new ‘knowledge’ gained in Plastic Surgery. Such new case studies would, it could be argued, increase generalisability as the ‘complexity’ within each of these cases is, on the balance of probabilities, likely to be similar to that carried out in this research, although this could only be confirmed by subsequent research. If a consensus opinion from Plastic Surgery could be obtained, then the research could be rolled out to consider investigating cases within the other nine surgical specialties. Much of what holds true for Plastic Surgery relates to the other surgical specialties, i.e. the same series of national frameworks are also in place: curricula, work within the NHS and following GMC guidance on professional behaviours. There is a similar case to be argued for examining cases within the medical specialties. This research may be more difficult to extrapolate to General

Practice given that there has never been a firm-like team approach with working patterns outside of hospital in small practices with no wards and much work out in the community. However, GPs of varying ages may have a similar sense of professionalism across the ages as they will have been exposed to the same political and sociocultural milieu as hospital doctors. Finally, I would suggest examination of cases, say starting with Plastic Surgery, in other nations, for example, in Europe, North America and Asia. The literature suggests that professionalism changes across national boundaries and each nation organises its healthcare system differently but, likewise, many of the sociocultural changes that have happened during my career in the UK have occurred on a global scale.

This research has centred on medical professionals but as there are in fact three parties involved within the Social Contract, it is imperative to place a lens on the opinions of both patients and government officials/policy makers on the working of the Social Contract if one, as a researcher, is to find a more complete picture of the Social Contract. Only with this full picture, can one really start to fully understand the dynamics within the Social Contract. With such information to hand, the medical profession could in turn gain a better understanding of the Social Contract in order to determine how to alter the dynamics within it. Furthermore, finding out the opinions of the two parties would provide useful further information to help predict the future of the relationships within the Social Contract as to whether a period of stability lies ahead or whether disharmony can be expected.

Of course, it seems trite, having undertaken this thesis during the Coronavirus pandemic, not to mention its potential effect on the Social Contract in the future that undoubtedly will be studied. It could be reasonably argued that this is the most significant political and sociocultural event of the 21<sup>st</sup> century thus far. It seems likely that it will leave its mark on each of the three

parties within the Social Contract. Anyone in the UK, when out in public or looking at the media, would find it hard not to have noticed the widespread public support for key workers and in particular those who work in the NHS during the pandemic. How long will this goodwill persist from the public as waiting times for out-patient appointments, investigations and surgical procedures lengthen? What damage has been done to trust between Medicine and the government as a result of the perceived lack of personal protective equipment (PPE) during the crisis? For how long will the government persist in doing whatever is necessary to ensure the current level of function of the NHS? It will be fascinating to observe in the coming months and years what impact these and other questions will have on the relationships within the Social Contract.

### ***6.5. Impact of the Research***

From a personal point of view, my position as regards how I view trainees has developed from one of a sense of frustration to one of understanding, in that the system in which all generations within Plastic Surgery are currently working does not encourage or enhance intergenerational working.

Academically, I have journeyed from only having an entirely positivist and quantitative approach to research to one where I can appreciate and understand as well the benefits of interpretivist and qualitative research. I have particularly appreciated my increasing ability to critically analyse documents looking for the strengths and weaknesses within them as well as now never taking any document at face value. Perhaps, even more importantly, is my understanding that more than one truth can exist within one set of data dependent on the researchers' past experiences, values and attitudes. This has helped me in all aspects of my

personal and professional life to comprehend others' views and opinions particularly as to how they have been shaped.

Undoubtedly, this thesis was undertaken for career purposes as it is a professional doctorate, but it has also been a deeply personal piece of work simply done for the love of learning and as a challenge to achieve the highest pinnacle that can be obtained educationally. It has been a labour of love as the concept was mine, it has been entirely self-funded, and I have enjoyed the challenge of bringing together a systematic piece of research with a common thread running throughout the work in a coherent manner. This thesis is my legacy and almost a culmination of a lifetime's work in Medicine. It will survive long after me, but I hope it will continue to contribute to knowledge in the future and my family will be proud.

Professionally, the findings of this research are being put to practical use in my national roles that I have documented in section 1.5. for both the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) and the Royal College of Surgeons of Edinburgh (RCSEd). This thesis has helped to increase my authority on educational and training matters and a position from which I can argue a case backed by knowledge of the literature, research findings and experience.

As the Chair of the Education Committee, I have encouraged the Council of BAPRAS to set up a mentoring programme for all Plastic Surgery trainees in the UK and Ireland with fully trained mentors coming from the Consultant body. It is hoped that this will be introduced formally in the Summer of 2021. This will go some way in starting to bring back together the varying generations as recommended in this thesis. Added to that, I have encouraged the Specialty Advisory Committee (SAC) in Plastic Surgery that oversees Plastic Surgery training

to become a pilot partner in ‘Improving Surgical Training’ (IST) as described in section 4.5. so that a return to a more hierarchical team-like approach to training could be instigated given the effects of the loss of both hierarchy and team structure on trainees described in this thesis.

Finally, the importance of virtual learning environments (VLE’s) will also be put to practical use in my national roles at BAPRAS and the RCSEd. In using Blackboard for myself during this thesis as a student; reading of the use of learning technologies; and the changing ways in which generations use and engage with learning technologies made me realise just how vital it was to introduce VLE’s into BAPRAS and the RCSEd for the benefit of all their members and fellows. This position being further encouraged by the devastating impact of Covid on face-to-face learning and training in 2020. Following my urging and persuasion to do so, both organisations have agreed to introduce VLEs for the benefit of members and fellows. It is now my role to choose the most appropriate VLE and ensure their continued financing for both organisations. The advantage for the RCSEd is that this will increase the scope to engage with their foreign membership which has been a clear factor in their decision-making.

## **6.6. *Research Question***

What then, is the answer to the core research question of this research – *‘Do generational differences exist in current understandings of medical professionalism which may impact the way the “Social Contract” functions in practice?’*.

This research suggests that there are indeed generational differences in current understandings of medical professionalism. Consultants belonging to both the Baby Boomer generation and Generation X continued with a nostalgic sense of professionalism, whereas trainees who were exclusively Generation Y had a greater sense of work–life balance and an altered sense of

altruism and accountability as compared with their predecessors. Given widespread concern amongst participants with respect to the balance of the relationships within the Social Contract, Social Contract theory can predict future challenges in the function of the Social Contract as the proportion of Generation Y doctors increases within the workforce in the years ahead.

Ultimately, why should we care about the functioning of the Social Contract?

Fitzpatrick (2004, p.795) identified what he perceived to be the means by which government dealt with doctors:

*The assumption that doctors are untrustworthy, nurtured by a series of scandals, has encouraged a process of political interference in medicine that is likely to prove wasteful, corrosive and destructive.*

This quote suggests a divisive distrust between Medicine and the government and indeed, this research has identified concern amongst participants as to the relationship between Medicine and the government. A fractured relationship between Medicine and the government cannot be good for an efficient running of the NHS and patients will suffer. Concurrently, difficulties in running the NHS will be compounded by rising expectations from patients, set in place by government regulation, that results in increasing litigation and costs to the NHS. This, according to observers, has resulted in the defensive practice of Medicine, resulting in over investigation and excessive treatment of patients (Tallis, 2004).

Thus, discord within the Social Contract benefits no party.

This research has identified serious disquiet amongst doctors with respect to their working environment and my concern is whether doctors, particularly Generation Y, will even want to

continue to work in such an environment where pressure continues to build from government and society.

Social Contract theory should be used as an early warning system that all is not well in the administration of the NHS and that the three parties rather than attempting to trump each other, should in fact, work more closely together for the benefit of all.

All parties to the Social Contract should consider whether or at what point the Social Contract between Medicine, Government and Society may fracture because, as Tallis (2004) ominously states, "*societies get the doctors they deserve*" (p.245).

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**Yule, S., Flin, R., Paterson-Brown, S., Maran, N., Rowley, D. & Youngson, G.** (2006). Development of a rating system for surgeons' nontechnical skills. *Medical Education*, 40, 1098–1104.

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# Appendices

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# Appendix 1

## *Social Contract theory participant information leaflet*

### **Social Contract Theory**

*Social Contract: A basis for legitimate legal and political power in the idea of a contract. Contracts are things that create obligations, hence if we can view society as organized 'as if' a contract had been formed between the citizen and the sovereign power, this will ground the nature of the obligations of each to the other. (Oxford Dictionary of Philosophy, 2016)*

The Social Contract is a theory that came to the fore in 17–18<sup>th</sup> century Europe. It concerns how the construction of society relates to the power of the state. Rousseau in 1762 championed the concept, taking forward the ideas of other philosophers in his book *The Social Contract* (Rousseau, 1762). Grotius in 1625 determined that individuals had natural rights which was at odds with the time when monarchs had absolute power over their subjects through the theory of divine right. Hobbes in 1651 noted that whilst it was reasonable to expect individuals to have rights and freedoms, it was unreasonable to expect society to allow individuals to do whatever they liked or whenever they wished, such as steal or murder, without society heading into a state of anarchy. Hobbes suggested that individuals needed to give up rights either implicitly or explicitly to an absolute 'power', preferably an elected group of individuals from within society, to civilise society and allow all individuals to be protected from an anarchic-like state, requiring not only natural rights but also legal rights (Crocker, 1968; Harrison, 2003). Rousseau (1762) argued that individuals gained rights in exchange for consenting to the need to defend and respect the rights of others, whilst losing some rights and freedoms in doing so.

Furthermore, Harrison (2003) asserts that a basic tenet of Social Contract theory is that the development of government, law and political order are not random natural occurrences but constructed deliberate human innovations. More recently, it has been argued that Social Contract theory imposes reciprocal rights and expectations on both parties that if not met can dissolve or change the contract (Field, n.d.).

Starr (1982) suggested a contractual relationship between Medicine and society akin to a social contract that could also change with time. Indeed, Sullivan and Benner (2005) argued that such change in this contract was occurring as society had increasing access to medical knowledge, increasing flexibility in the workforce, and increasing involvement of external companies in the provision of healthcare that went against the rigidity of the professions and their desire to maintain the status quo.

Cruess and Cruess (2008) went one step further with the concept of the Social Contract involving Medicine, suggesting it was more complex and introducing a third party, namely, the government. This contract is both explicit (written regulations and frameworks) and implicit (unwritten expectations, values and behaviours). It was their conclusion that professionalism was the keystone in Medicine's relationship with society that forms part of the implicit section of the contract and is thus more difficult to control, manage and influence.

The tripartite relationship within this Social Contract could be considered to have truly commenced in 1948 when the NHS was inaugurated. This did not, however, alter the autonomy

and self-regulation of doctors. Nevertheless, there was an implicit contract (Ham & Alberti, 2003, p. 838):

- *The government guaranteeing access to care for all citizens and determining the budget for the NHS.*
- *The medical profession taking responsibility for ensuring clinical standards and delivering care to patients.*
- *The public accepting its healthcare rights from the government, delivered to appropriate standards by the profession, and paying taxes to fund the NHS.*

More recently, when relationships between society and professions were considered, it was concluded that either party could choose and alter the rights, freedoms, expectations and duties of either side although there is no formal legal basis. However, when wants were not met by either party, this could result in attitudinal changes resulting in action by the other (Rawls, 2003).

Thus, Social Contract theory can help to explain why when the attitudes, behaviours and norms of society change with time so will the dynamic within the Social Contract between society and the medical profession that can result in opposing actions from the other parties. Social Contract theory allows us to see the tripartite relationship in action as well as to predict what may happen in the future given the ongoing evolution of professionalism, what it means to be a profession and the changing doctor–patient relationship (Williams, 2007).

## Appendix 2

### *Schedule of initial pilot interview questions*

- How long have you been a doctor?
- Could you summarise for me your career path in Medicine?
- What generation do you belong to?  
Baby Boomer (1946–1964); Generation X (1965–1980); Generation Y (1981–2000)
  
- What do you understand by the term ‘professionalism’?
- Since you qualified as a doctor, has your experience and perception of ‘professionalism’ changed with time?
- If so, what has happened or occurred to make that happen?
  
- What do you understand by the term ‘profession’?
- Since you qualified as a doctor, has your experience and perception of what it is to be a member of a ‘profession’ changed with time?
- If so, what has happened or occurred to make that happen?
  
- Do you believe that there are generational differences in the understanding of ‘professionalism’?
- If so, what experience do you have of such generational differences?
- In your opinion, what has brought about these generational differences?

- Do you believe that there are generational differences in the understanding of what it means to be a member of a ‘profession’?
- If so, what experience do you have of such generational differences?
- In your opinion, what has brought about these generational differences?
  
- What do you understand by the term ‘Social Contract’? (may need to explain concept)
- Do you think this is a meaningful way to look at the relationship between Medicine, Government and Society?
- How do you see yourself within the Social Contract?
- Since you qualified as a doctor, does your experience in professionalism suggest any changes in the Social Contract?
- Since you qualified as a doctor, does your sense of a profession suggest any changes in the Social Contract?
- If you have experienced change in the Social Contract – how do you view those changes, i.e. have they helped, hindered or had little effect on your professional practice as a doctor?
- What effect do you think will these changes, if any, may have on the Social Contract?

## Appendix 3

### *Schedule of final interview questions after pilot interviews*

- How long have you been a doctor?
- Could you summarise for me your career path so far in Medicine?
- What generation do you belong to?  
Baby Boomer (1946–1964); Generation X (1965–1980); Generation Y (1981–2000)
  
- What do you understand by the term ‘professionalism’?
- Since you qualified as a doctor, has your experience and perception of ‘professionalism’ changed with time?
- If so, what has happened or occurred to make that happen?
  
- What do you understand by the term ‘profession’?
- Since you qualified as a doctor, has your experience and perception of what it is to be a member of a ‘profession’ changed with time?
- If so, what has happened or occurred to make that happen?
  
- Do you believe that there are generational differences in the understanding of ‘professionalism’?
- If so, what experience do you have of such generational differences?
- In your opinion, what has brought about these generational differences?
- Do you feel you are able to separate your professional and personal lives?

- Do you think the relationship between your professional and personal life has changed during your career?
- Would you say that being a member of the medical profession has had an impact on your self-identity?
- If so, what has happened to cause these changes to how you identify yourself?
  
- Do you believe that there are generational differences in the understanding of what it means to be a member of a ‘profession’?
- If so, what experience do you have of such generational differences?
- In your opinion, what has brought about these generational differences?
  
- What do you understand by the term ‘Social Contract’? (may need to explain concept)
- Do you think this is a meaningful way to look at the relationship between Medicine, Government and Society?
- How do you see yourself within the Social Contract?
- Since you qualified as a doctor, does your experience in professionalism suggest any changes in the Social Contract?
- Since you qualified as a doctor, does your sense of a profession suggest any changes in the Social Contract?
- If you have experienced change in the Social Contract – how do you view those changes, i.e. have they helped, hindered or had little effect on your professional practice as a doctor?
- Is the ideal of medical professionals putting the rights and expectations of those they serve, i.e. patients, being put at risk?

- What do you feel are the expectations of your patients with respect to your work–life balance?
- How might changes in work–life balance for doctors affect the relationships within the Social Contract?
- Does the medical profession get appropriate representation within the Social Contract?
- What effect do you think will these changes, if any, have on the Social Contract?

## Appendix 4

### *List of government documents reviewed in documentary analysis*

**Department of Health and Social Security.** (1983). *NHS management enquiry report (Griffiths Report)*. London: DHSS.

**Department of Health.** (1989). *Working for patients*. London: HMSO. Available at <https://www.publicinformationonline.com/download/94091>

**Department of Health.** (1991). *Patient's Charter*. London: HMSO.

**Department of Health.** (1992). *Local voices: The views of local people in purchasing for health*. London: Department of Health.

**Department of Health.** (1994). *Hospital and ambulance services: comparative performance guide 1993–1994*. London: Department of Health.

**Department of Health.** (1996). *Patient partnership: building a collaborative partnership*. London: HMSO.

**Department of Health.** (1997). *The new NHS: modern, dependable*. London: HMSO.

**Department of Health.** (1998). *A first class service: quality in the new NHS*. London: HMSO.

**Department of Health.** (2000a). *The new NHS plan. A plan for investment. A plan for reform.* London: HMSO.

**Department of Health.** (2000b) *An organisation with a memory.* London: HMSO.

**Department of Health.** (2004). *Better information, better choices, better health.* London: HMSO.

**Department of Health.** (2007). *Trust, assurance and safety: the regulation of health professionals.* London: HMSO.

**Department of Health.** (2010). *Equity and excellence: liberating the NHS.* London: HMSO.  
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**Department of Health.** (2012). *Health and Social Care Act.* London: HMSO.

**Department of Health.** (2015). *NHS Constitution for England.* London: HMSO.

**Department of Health.** (2019). *The NHS long term plan.* London: HMSO.

## Appendix 5

List of initial codes across the three segments of interview data

### Professionalism

Benefits  
Code of Conduct  
Consultants  
Cont Prof Development  
Curriculum (Formal)  
Curriculum (Hidden)  
Employees  
Evolution  
EWTR  
Feminisation Workforce  
General Medical Council  
Generational Difference  
Grouping of Individuals  
Government  
Hierarchy  
Identity  
Internet  
Junior Doctors Strike  
Litigation  
Medical Scandals  
Nostalgia  
Occupation  
Patient Expectations  
Social Change  
Social Media  
Team  
Trainees  
Training  
Values  
Vocation  
Work-life Balance

### Profession

Autonomy  
Benefits  
Code of Conduct  
Consultants  
Curriculum (Formal)  
Curriculum (Hidden)  
DPR  
Employees  
Evolution  
EWTR  
Expertise  
Feminisation Workforce  
General Medical Council  
Generational Difference  
Government  
Grouping of Individuals  
Identity  
Internet  
Life Choices  
Litigation  
Occupation  
Patient Expectations  
Personal Gain  
Regulation  
Social Change  
Social Media  
Team  
Traditional Media  
Trade  
Trainees  
Training  
Vocation  
Work-Life Balance

### Social Contract

Civility  
Consumerism  
Doctors Expectations  
DPR  
Evolution  
Explicit  
Future  
General Medical Council  
Generational Difference  
Government  
Identity  
Imbalance  
Implicit  
Junior Doctors Strike  
Knowledge  
Litigation  
Loss of Rights  
Medical Leadership  
Nostalgia  
Patient Expectations  
Patient Power  
Regulation  
Team  
Trainees  
Tripartite  
Work-life Balance

## Appendix 6

### *Approval letter from University of Sheffield Research Ethics Committee*



Downloaded: 23/06/2020  
Approved: 10/12/2018

Aiden Fitzgerald  
Registration number: 160210390  
School of Education  
Programme: Higher Education (EdD/Higher Education (DL) 4-8yr)

Dear Aiden

**PROJECT TITLE:** The Impact of Medical Professionalism on the Function of the Social Contract  
**APPLICATION:** Reference Number 023569

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 10/12/2018 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 023569 (form submission date: 13/11/2018); (expected project end date: 30/09/2020).
- Participant information sheet 1052664 version 1 (03/11/2018).
- Participant consent form 1052665 version 1 (03/11/2018).

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

David Hyatt  
Ethics Administrator  
School of Education

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: <https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/approval-procedure>
- The project must abide by the University's Good Research & Innovation Practices Policy: [https://www.sheffield.ac.uk/polopoly\\_fs/1.671066!/file/GRIPPpolicy.pdf](https://www.sheffield.ac.uk/polopoly_fs/1.671066!/file/GRIPPpolicy.pdf)
- The researcher must inform their supervisor (in the case of a student) or Ethics Administrator (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

## Appendix 7

### *Participant research information leaflet*



## Participant Information Leaflet

### **The Impact of Medical Professionalism on the Function of the Social Contract**

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

#### **What is the project's purpose?**

I wish to investigate whether there are generational differences in what is meant by 'professionalism'; and what it means to be a member of a 'profession' amongst a group of Plastic Surgeons at varying stages of their career. In turn, if differences are apparent, I wish to explore how that may impact upon the future of the 'social contract'. The social contract being a three-way interacting relationship between government; society (i.e. patients) and Medicine (i.e. doctors such as yourself). In essence, the government might be regarded as the funding body for health services; society existing as a group of individuals who use the health services: and medicine acting as a group of individuals who provide health services.

I intend to undertake interviews in May–July 2019 with a view to submitting my thesis for a Doctorate in Education (EdD) in September 2020.

### **Why have I been chosen?**

It is recognised that within Medicine there are differences in the concept of what is meant by 'professionalism' between specialties. To reduce as much as possible any response bias that may be as a result of inter-specialty differences, I have restricted participants to one specialty. The specialty chosen is Plastic Surgery.

You have been chosen as a member of that specialty, Plastic Surgery.

The research being undertaken is of a qualitative nature and thus subjective. I will be looking for themes to emerge from the interviews undertaken. I would expect that this would be in the order of 30–40 interviews.

### **Do I have to take part?**

It is up to you to decide whether or not to take part as it is entirely voluntary to do so. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form). You can withdraw at any time without any penalty or it affecting any benefits that you are entitled to in any way. You do not have to give a reason.

### **What will happen to me if I take part?**

I would expect there to be one interview between us at a location of your convenience lasting 45–60 minutes such that travel expenses should not be incurred on your part to assist with this research. The discussion will follow a semi-structured format whereby there will be some specific questions asked of all participants but there will be opportunity to allow us to explore more deeply any answers relevant to the research topic during the course of the interview.

### **Will I be recorded, and how will the recorded media be used?**

The interviews will be recorded onto a digital recorder so that they can be subsequently transcribed by my secretary for analysis and possible direct anonymised quotations in my thesis and subsequent papers, presentations and book. The audio recordings of your activities made during this research will be used only for analysis. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings. All transfer of data will be done so by encryption to ensure protection of data and maintain your anonymity and confidentiality.

### **What do I have to do?**

I would simply ask that you answer the questions honestly and to the best of your abilities. I bring to your attention that there are no wrong or right answers to any of the questions asked. The answers should rely on your ideas, perceptions and past experiences of your sense of 'professionalism' and what it means to be a member of the medical 'profession' which are indeed unique to you.

### **What are the possible disadvantages and risks of taking part?**

As a consequence of undertaking interviews, I need to provide proper informed consent; ensure confidentiality and anonymity of participants; and consideration of the consequences for those participating. All participants will be provided with a consent form to complete once they have read an information sheet about the research explaining why the research is being carried out, its aims and objectives. Participants will be made aware that they can pull out of the research at any point and their data removed from the study. Anonymity and confidentiality will be assured to protect all participants. Data will be transcribed by my secretaries but in a digitally encrypted format for protection. These files will be held within password protected computers at all times. The secretaries will delete all computer files in turn immediately upon sending them to me. I will be the only person to store the data but in an anonymised format with no personal details. Hard copies of data will be held in a locked filing cabinet in a locked basement. On completion of the research, hard copies of data will be kept for 3 years before being industrially shredded to allow any further research to be undertaken using the data. Direct quotations will be used in the final form of written thesis but at no point will names and/or gender specific prefixes be used, nor workplaces be identified to protect participants given the relatively small number of participants involved from a relatively small surgical specialty.

The disadvantages of taking part are relatively few being confined to all in terms of the inconvenience of time involved in meeting with me. For trainees involved, there may be concerns that a refusal to take part may hinder their career progression but as I am not involved in any of their annual appraisals known as Annual Recognition of Competency Progression (ARCP) this will not be the case.

### **What are the possible advantages and risks of taking part?**

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will help inform the debate on medical professionalism for the greater good of the medical profession, society and the government via dissemination at presentations, journals and possible book.

It may be that those involved in interviews can use the participant leaflets and consent forms as proof of active participation in research during their annual appraisal.

### **What happens if the research study stops earlier than expected?**

If the research study stops earlier than expected, then the reasons for this will be explained to you as will what will happen to the data derived from your interview in terms of its destruction.

### **What if something goes wrong?**

If you are dissatisfied by my conduct then you should first contact my supervisor:

Dr Heather Ellis, via [h.l.ellis@sheffield.ac.uk](mailto:h.l.ellis@sheffield.ac.uk) who can be contacted at:

Dr Heather Ellis

School of Education

University of Sheffield

Edgar Allen House

Sheffield S10 2GE

01142223627

Should you feel following contact with my supervisor that your concerns have not been addressed to your satisfaction then you should Contact Prof. Elizabeth Wood, Head of School of Education, University of Sheffield at [e.a.wood@sheffield.ac.uk](mailto:e.a.wood@sheffield.ac.uk) who will then escalate the complaint through the appropriate channels by means of the University's 'Registrar and Secretary'. Prof. Wood can also be contacted at:

Professor Elizabeth Wood  
School of Education  
University of Sheffield  
Edgar Allen House  
241 Glossop Road  
Sheffield S10 2GE  
01142228177

All the information that we collect about you during the course of the research will be kept strictly confidential and anonymised. You will not be able to be identified in any reports or publications. If following participation in the interview you feel that your data has been breached or some other adverse event has taken place then you should contact Prof. Dan Goodley, Director of Research, School of Education, University of Sheffield at [d.goodley@sheffield.ac.uk](mailto:d.goodley@sheffield.ac.uk). Prof. Goodley can also be contacted at:

Professor Goodley  
School of Education  
University of Sheffield  
Edgar Allen House  
241 Glossop Road  
Sheffield S10 2GW  
01142228177

### **Will my taking part in this project be kept confidential?**

All the information that I collect about you during the course of the research will be kept strictly confidential. You will not be identified in any presentations, reports, papers or book. Participants will not be told the identities of other participants.

### **What will happen to the results of the research project?**

The data gathered from all interviews will be analysed to identify any recurrent themes to determine if there are indeed intergenerational differences in the sense of professionalism, what it means to be a professional and how that may impact upon the social contract. Ultimately, it is hoped a thesis will be produced for submission for

an EdD doctorate through the School of Education, University of Sheffield in September 2020. Approximately 3–4 months later, a viva will be held for me to defend my thesis from both an internal and external examiner of the University of Sheffield. Subsequent to hopeful success, it is envisaged that peer-reviewed publications will be published, presentations made at medical meetings as well as a potential book being published. If successful, the thesis will be available through either the White Rose collaboration between the Universities of Leeds, Sheffield and York at <http://etheses.whiterose.a.uk> or via the British Library at <https://ethos.bl.uk>

The data collected during the course of the project may be further used in subsequent or additional research.

### **Who is organising and funding the research?**

There is no external agency or funding associated with this research project. The work is being carried out through the School of Education, University of Sheffield. I am entirely self-funding my EdD research project.

### **Who has ethically reviewed the project?**

This research project has been ethically approved by the School of Education, University of Sheffield via its ethics review procedures. In turn, the University of Sheffield's Research Ethics Committee monitors the application and delivery of the University's Ethics Review Procedure across all University departments.

**Contact for further information about any aspects of the project:**

**Aiden Fitzgerald (Researcher)**

Consultant Plastic Surgeon

Dept of Plastic Surgery

Royal Hallamshire Hospital

4 Claremont Place

Sheffield S10 2TB

Tel: 01142712438

**Dr Heather Ellis (Supervisor)**

Vice-Chancellor's Fellow

School of Education

University of Sheffield

Edgar Allen House

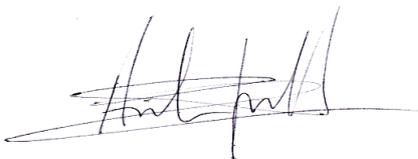
241 Glossop Road

Sheffield S10 2GE

01142223627

Each participant will be given a copy of the information sheet and a signed consent form to keep.

Your participation in this research project is much appreciated by myself for which I am extremely grateful for your time and help.

A handwritten signature in black ink, appearing to read 'Aiden Fitzgerald', with a long horizontal flourish extending to the right.

Aiden Fitzgerald

Consultant Plastic Surgeon & EdD student

# Appendix 8

## Participant research consent form



### The Impact of Medical Professionalism on the Function of the Social Contract Participant Consent Form

<i>Please tick the appropriate boxes</i>	Yes	No
<b>Taking Part in the Project</b>		
I have read and understood the project information sheet dated 28.10.2018 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)	<input type="checkbox"/>	<input type="checkbox"/>
I have been given the opportunity to ask questions about the project.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in the project. I understand that taking part in the project will include a digitally recorded interview by the researcher.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.	<input type="checkbox"/>	<input type="checkbox"/>
<b>How my information will be used during and after the project</b>		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	<input type="checkbox"/>	<input type="checkbox"/>
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	<input type="checkbox"/>	<input type="checkbox"/>
I give permission for the interview data that I provide to be stored securely and anonymously for 3 years before being industrially shredded to allow any further research to be undertaken using the data.	<input type="checkbox"/>	<input type="checkbox"/>
<b>So that the information you provide can be used legally by the researchers</b>		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.	<input type="checkbox"/>	<input type="checkbox"/>

Name of participant [printed]

Signature

Date

Name of Researcher [printed]

Signature

Date

The template of this consent form has been approved by the University of Sheffield Research Ethics Committee and is available to view here: <https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/further-guidance/homepage>



**Project contact details for further information:**

**Lead Researcher: Aidan Fitzgerald, School of Education, University of Sheffield**

[afitzgerald1@sheffield.ac.uk](mailto:afitzgerald1@sheffield.ac.uk)

01142712438

**Supervisor: Dr Heather Ellis, School of Education, University of Sheffield**

[h.j.ellis@sheffield.ac.uk](mailto:h.j.ellis@sheffield.ac.uk)

01142223627

**If concerns are raised by the conduct of the research then Contact:-**

**Professor Elizabeth Woods, Head of School of Education, University of Sheffield**

**Edgar Allen House, 241 Glossop Road, Sheffield, S10 2G**

[e.a.wood@sheffield.ac.uk](mailto:e.a.wood@sheffield.ac.uk)

01142228177

## Appendix 9

### *Schedule of questions used in documentary analysis*

**Authorship:** Who wrote it? Who are they? What is their position and their bias?

**Audience:** Who was it written for? Why them? What assumptions does it make, including assumptions about its audience?

**Production:** Where was it produced and when? By whom? What were the social, political and cultural conditions in which it was produced?

**Intentions:** Why was it written? With what purpose in mind?

**Style, Function, Genre:** In what style is it written? How direct is the language? Is it written to inform, to persuade, to convince, to sell, to cajole or to provoke? How clever is the language?

**Content:** Which words, terms or buzzwords are commonly used? What rhetoric is used? Are values conveyed, explicitly or implicitly? What metaphors and analogies does it contain? What is not in it?

**Context/ Frame of Reference:** When was it written? What came before it and after it? How does it relate to previous documents and later ones?

# Appendix 10

## Annual appraisal documentation for Consultants

« Back to my appraisalsDownload

### November 2020 Appraisal

Revalidation: 9 Aug 2021

OVERVIEW

**1 APPRAISAL INPUTS**

Personal details

Scope of work

Record of annual appraisals

PDPs and their review

CPD

Quality improvement activity

Significant events

Colleague & patient feedback

Complaints & compliments

Medical educator

Achievements

Probity & health statements

Additional information

PDP proposals

Summary of supporting info

Pre-appraisal preparation

#### Continuing professional development (CPD) More info

This is the first type of supporting information doctors will use to demonstrate that they are continuing to meet the principles and values set out in Good Medical Practice. Please use the 'More info' button above to access more information on what you should be providing in this section.

Continuing professional development (CPD) is an essential part of a doctor's career. Your participation in CPD should reflect your entire scope of work, although it is not limited to this. This section allows you to document the CPD that you have participated since your last appraisal.

##### Supporting information

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###### Royal College or Faculty CPD Certificate

If you have a certificate to show you have participated in Royal College or Faculty CPD, please add it below.

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###### Other CPD activity

If you have a diary, summary or list of other CPD activity that you have participated in, please add it below.

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###### Other CPD records

Instead of, or in support of, the above attachments you can also record your CPD below. There is no need to duplicate what is written in your attachments.

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##### Activities

Please use the box below to provide a commentary on how your CPD activities have supported the areas described in your scope of work. You should also reflect on how this information demonstrates that you are continuing to meet the requirements of Good Medical Practice.