Chapter Four: Why Society needs professionals, and the kinds of professional behaviour that allow society to remember that it needs professionals

In this chapter we look at why it is important for all of us that professionals can dance and not always be required to march, and at how professionals should behave if they are to be granted the leeway to do so.

If we are to consider the care that professionals give, and decide on the kind of care we want, we will be wise to stop for a moment and consider the role that professionals fulfil.

The rationale for having professions is that they use their specialist knowledge base in the service of society. More than that, they have a particular role in helping society handle indeterminacy (those situations that are too complex for a clear, correct course of action to be determined in advance).

In this chapter we look at what we mean by this, and then consider the kind of behaviours on the part of our professionals that will allow society to grant them the professional autonomy they need in order to fulfil these roles.

It is helpful to start by distinguishing between four 'domains of knowing',[1] four types of situation in which we ask people to apply their professional knowledge: the known, the knowable, the complex and the chaotic.

There are situations we understand well. We know that if we do X then Y will happen, and that if we want to achieve A then we have a choice of doing B or C but not D. In other words there are clear cause and effect relationships. We can find out more about these relationships by conducting rigorous, quantitative research of the type described and classified by the Cochrane Centre and disseminated under the heading of Evidence Based Medicine, with Randomised Controlled Trials giving the most robust results.

This is the domain of the known and once we KNOW that G is caused by F and better than it is caused by anything else, then if we want to achieve G we can insist on everyone doing F, and indeed all reasonable people will see for themselves the need to do F.

[1] This section draws heavily on the arguments presented in *Mark A Snowden D 2006 Researching Practice or practising research: innovating methods in health care – the contribution of Cynefin in Innovations in Health Car*e. The Cynefin website is also an excellent resource.

The number of situations where we can be this certain are few (compared with the number of decisions each of us takes in a day) but when we come across them we can be 'feudal' in our approach to leadership and insist on certain practices.

There are other situations where these cause and effect relationships are not as clear. This may be because they are separated from each other by time and/or geography. So doing something here and now has an impact over there (out of my sight) or then (much later when we have forgotten about it). This lack of ready association means the cause and effect relationships have been noticed and investigated by far fewer people, people we call experts, and they can be discovered more appropriately by methods such as experiment, fact finding, and scenario planning. In other words they involve more speculation and guess work and multi faceted detective work. In these settings, rather than turning to a set of defined practices supported by RCT evidence, if we want to know what to do next we turn to a group of experts who understand these relationships better than the rest of us. If we are wise we keep an eye on the experts and ensure that they remain constantly open to re-appraisal of the field and that they keep challenging their assumptions. We can call this the domain of the knowable and the style of leadership 'oligarchic'.

There is a third kind of situation which we can call complex. Here the cause and effect relationships are so numerous and they interact with each other so frequently and unpredictably that it is no longer possible to predict what will happen if we do X.

The research methods that are valuable in the first two settings do not work here and, worse, can be actively misleading. They can suggest causality where there isn't any and if we approach a complex situation expecting it to be known or knowable then there is a very real danger of 'spurious retrospective coherence'. This occurs when we look back at a situation and believe we can discern that action A led to outcome B and, if B is undesirable, blame action A or the person taking it. But the individual who did A may have had no way of knowing it would result in B because it often doesn't – since it leads to X, Y and Z which are affected by E, F, G and H, which are themselves influenced by M, N and O etc. So a person choosing to do A was 'muddling through elegantly' which is just the right approach in settings of this kind. Thus an edict that 'to avoid B no-one must do A' would be misguided.

The methods of research needed here are innovative, unconventional and not yet fully accepted - narrative based research being an example. The most effective leadership style here is different too: a combination of a firm foundation of effective administrative procedures and safe governance, with enabling behaviours and an ability to adapt to situations as they arise.

We can therefore see the importance (great importance) of distinguishing situations that are complex from those that are known or knowable. Behaving as though we are in the

domain of the known or knowable when we are not simply adds tension and does not contribute to an understanding of the situation or to ways forward.[2]

In the fourth domain, settings that are chaotic, there are no perceivable cause and effect relationships. The system is too turbulent, and the time to investigate is not available. An example in medicine might be the accident and emergency specialist dealing with a major incident with many people with critical injuries.

The best leadership style here involves the readiness to act quickly and decisively, and a hierarchy where such decisions can be relayed quickly and acted upon without question. The aim is to deploy authority to "control" the space, trying to move it into the knowable or known, or in some cases into the complex.

In situations that we can think of as 'known' or 'knowable' then protocols and seeking the advice of experts are good ways of proceeding. However in complex or chaotic settings these cannot work and we rely instead on the experience, knowledge and 'practical wisdom'[3] of professionals.

This is so important it is worth saying again: in contexts that are known or knowable we can rely on information from the internet, on algorithms and on statistics. In complex situations we need people with something beyond all that – what Aristotle called phronesis, or Practical Wisdom, an ability to muddle through elegantly[4], drawing on deeply held knowledge, experience, expertise and intuition.

If we understood that better, patients would cease to distrust doctors who look things up when consulting them ('she can't be any good she had to look up the drugs before she prescribed them), clinicians could welcome information patients bring with them from the internet and we could all focus on the *added value* that professionals bring: practical wisdom, seeing ways forward in situations of uncertainty.

So practical wisdom on the part of professionals (of all kinds) is important to society as a whole and we need to ensure they are able to acquire it. We need to help foster it and nurture it, and it is here that we find the greatest danger of a focus on the transactional at the expense of the covenantal – we prevent our young professionals from developing the professional wisdom on which we all depend.

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[2] It can be so frustrating to reflect on a complex situation in which something has gone wrong and not be able to identify someone to blame. Here is one example of that frustration.
http://archive.constantcontact.com/fs065/1102665899193/archive/1103589810918.html

Once we can accept that complex situations are fundamentally different from known or knowable ones we can look for the instead for the full range of contributing factors, with the aim of better understanding the complexity rather than trying to pin the blame on one.

[3] Aristotle argued that we all have need of a master (or executive) virtue that enables us to decide how much of what other virtues, knowledge etc we need to bring to bear in different situations. He called this 'phronesis' or practical wisdom.

[4] The phrase used by systems and complexity theorists

Wisdom is the product of experience. 'One becomes wise by confronting difficult and ambiguous situations, using one's judgement to decide what to do, doing it, and getting feedback. One becomes a wise practitioner by practising being wise'.[5] If we teach our young professionals in ways that do not give them the opportunity to practise being wise then we not only lose the aspects of care we have described in the covenantal column of our chart, but we rob society of its ability to handle situations that are not known or knowable. Situations that are complex or chaotic, indeterminate.

Somehow our approach to risk has reduced our concern about this. The notion that all risks can be quantified seems to give us the illusion that we can get rid of them. We have seen the dangers of this thinking in one sphere – the financial markets - we now need to become aware of other arenas where we are implicitly making this assumption, and we suggest health care, social care, education, policing and many other arenas are in the frame.

This may be a distinctively post enlightenment western approach: the dominance of mythos over logos[6], or science and logic over mystery and meaning. If we were to accord mystery and meaning more attention we would encourage the development of tolerance and generosity and an ability to accept uncertainty, indeterminacy and risk. We would also value anxiety and teach people how to respond with respectful uncertainty to situations in which the way forward is not clear. To achieve this we could remind ourselves that tolerance and generosity are not innate characteristics that people either have or do not but habits that can be actively cultivated and we might look to the contemplative meditation of many Eastern philosophies, (and also of many earlier traditions of Christianity) as ways of doing so.

If we saw uncertainty as inevitable and anxiety as valuable we would respond differently. If we allowed more emphasis on 'inner knowing', an Eastern concept borne out by current neuroscience, we would realise that courageous soul-searching for the best response to an unclear situation (which is surely what we want) is dangerously jeopardised by the 'spurious retrospective coherence' of those whose mindset is solely the domain of the known.

This suggests that when we are patients we need to have two different kinds of mind, one that is appropriately demanding about the transactions of care when these are not effected well, and one that includes tolerance and acceptance when care options are not straightforward and involve risk and trust. If we encourage patients to be only demanding then again we will prevent professionals from developing and using their practical wisdom.

If we are indeed to encourage the development of practical wisdom then we need to help society understand the inevitability of uncertainty and risk and to understand too that people who work with these will inevitably, on occasions, make decisions that do not have successful outcomes.

[5] As described by Barry Schwartz and Kenneth Sharpe in 2005 in the Journal of Happiness Studies
[6] Karen Armstrong, cited in Vernon M, After Atheism.

Of course we must be mindful of the large literature cautioning us against professional power and privilege and be particularly aware of the concept of professional capture – when a profession claims for itself power over decisions that belong more properly to a wider (or other) group. So we must subject all claims by professions to special expertise (and therefore to additional forms of power) to scrutiny – and the professions themselves must welcome that scrutiny and take thoughtful part in the ensuing debate.

How, then, can we persuade society that pleas for professional judgement are not self indulgent and self interested?

We have said before that professionals have not engaged in sensible debate about the current emphasis on transactional care and that many professionals and their negotiating bodies resist pressures from patients for better access and service. So we need to consider ways in which professionals can be persuaded to take these seriously.

We can suppose that some of the resistance on the part of professionals to targets and to systematization is a result of an implicit recognition that a focus on good transactional care undervalues the covenant of care: that their concern for the latter leads to their resenting pressure for only the former. But we can also note that in countries where politicians are no longer involved in championing the patient's interest by setting targets and other requirements, the services offered quickly meet the needs of providers more than those of patients. In other words we can observe a large element of self interest (in addition to professional altruism) that needs to be challenged, and challenged effectively.

Professional behaviours

Let us remind ourselves that professions have a specialist expertise of value to society, so that in return for investing the time and energy in developing that expertise in the interests of society, society confers on professionals a status that allows them certain privileges. Thus, for example, health care professionals routinely touch patients in ways that would be considered assault in other circumstances and they earn rather more than people in other roles who have not made this investment of time and energy. Professionals, knowing more about their field than the rest of society, are granted a degree of professional autonomy.

Along with autonomy, rights and income comes a status – status that is conferred by society and enjoyed by the professions, and which differs from profession to profession. Just what determines the status accorded to a profession has been the subject of discussion among sociologists for some decades and the work of Jamous and Pelouille is probably not the last word on the subject but does seem to have some descriptive and predictive value. They suggest that it depends on what they call the technicality indeterminacy ratio. That if the knowledge base of a profession or specialty is highly technical and definitive and its members can give clear, closed answers to questions (yes /no/ 3.95%) then it is likely to

hold higher status then a profession or specialty that gives more contingent answers (it depends, it could be this or that, let's try it and see). However if the knowledge base is too technical then the people using it could be replaced by a computer protocol or an algorithm, so status will be protected only if the knowledge needs to be interpreted differently in each of the cases to which it is applied.

Status is valuable when it is used wisely and well, for example it allows professionals to resist demands for them to practice in ways that do not benefit patients and society, but it can also be used self-interestedly and then it skews decisions against the interest of others and society as a whole. Unfortunately once a high status has been conferred there are very few mechanisms to challenge its misuse, except in the most egregious instances or in cases where other factors such as racial discrimination come into play.

When status is used wisely it draws on the experience, expertise, specialist knowledge base and practical wisdom that is the reason the status has been awarded, and it is used in the service of society or its members. So when a consultant surgeon argues for a particular surgical practice in theatre, having thought clearly and deeply about alternatives, discussed it with others and decided that this is the way the best outcomes will be achieved for patients, then we are wise to listen to them carefully, and often defer to their judgement. When the same surgeon argues for a particular car parking scheme and especially if it is a scheme that makes life easier for him or her at the expense of others, then we should make sure that view is heard no more loudly than the views of everyone else involved[7].

Being clear about when it is wise to defer and when to insist when dealing with people of high status (and *as* a person of high status) is important. It not only makes for better decisions but happier professionals. Even so the high status of some groups in health care means that health care organisations are not hierarchical in the way that many organisations are, they are what Henry Mintzberg terms 'disconnected hierarchies'. In other words status protects professionals from being managed.

Status is little talked about and yet pervades day to day life in health care settings. Its impact on behaviours, decisions and working practices is constantly apparent to those working within health care. How is it that this is not discussed more openly? Somehow we have allowed a political correctness to dictate that we pretend there are no differences in status between different healthcare professions, nor between specializations within them, nor between professionals and patients. And this political correctness prevents us reflecting on the complex set of actions and reactions between the high status professions and society, and between these professions and government, that are jeopardising our ability to offer good affordable care.

[7] And of course many issues in healthcare fall somewhere between these clear examples

Let us look briefly at some of the ways in which the relationship between the medical profession and society has changed.

The young people going into medicine are some of the best qualified teenagers in the country and the training they embark on is arduous and long. Some feel called to a life in medicine (although vocation as a term is frowned upon) and most believe their chosen career is of great value to others and see their established seniors as figures of standing and moral authority. Once qualified though, although no longer expected to embody the role 24 hours a day, as their professional forebears did, they find they are dealing with a public less deferential and more ready to call upon medical services for help at unsocial times of day and night, than they would have done 20 years ago.

They find too that the expanding roles of other professions have encroached on the medical one and at the same time many different groups have reacted against what they have perceived as inappropriate superiority assumed by the medical profession. For example some patient groups have protested at medical paternalism, and altruism and self sacrifice have had a bad press from quarters as diverse as the feminist movement and public choice economists. Simultaneously other health care professionals have resisted doctors assuming leadership roles in multidisciplinary teams.[8]

These behaviours and others like them have felt like 'doctor bashing' to those on the receiving end.

The contexts in which doctors work have also changed. Organisations have become bigger and more complex, and management (as described in Chapter Two) has become a specialist role, divorced from the professions where it previously lay, exercising control over resources previously under the purview of senior professionals. Concern for clinical care and financial accountability have tended to be held separately: professions focusing on clinical matters and managers on finances. The battles that have ensued have left both camps lamenting the power and intransigence of the other.

So the relationship between the medical profession and society has been a complex set of actions, reactions and interactions from which have emerged the current behaviours and attitudes. These include:

- An attitude of entitlement and grievance on the part of doctors that manifests all too often in a refusal to engage with agenda set by politicians and enacted by managers, even where their aims could be said to coincide, e.g. over access, waiting times etc. For example a consultant surgeon is infuriated at requests that patients about to breach a

[8] Instead of constructive dialogue to resolve these tensions the situation has all too often been allowed to degenerate into long term dysfunctional team behaviours. Observing this younger doctors, especially in specialties such as psychiatry, have learned the lesson that they should not assume the lead. Since this is again not discussed teams and services are left effectively leaderless.

target are given priority over more urgent cases – and yet makes no constructive attempts to improve processes so that no patient has to wait an unacceptable length of time. [9]

- A frustration on the part of policy makers at their inability to influence the behaviours of clinicians and deliver more or better care, that has led them to wield blunt instruments of coercion – the bluntest of all being the quasi market.

So we have a situation where society needs its professionals to be able to develop and use their professional judgement (practical wisdom) if it is to deal with uncertainty. However the professional autonomy it accords to its highest status health professionals, doctors, has led to a set of dynamics which is manifested in a deep seated lack of trust between policy makers and doctors. They then each use their power in ways that increase the lack of trust.

One governmental reaction has been to try and reduce professional autonomy and status by increasing the numbers of doctors (increasing the number of places at medical schools), paying them for piece work (GPs) or for defined periods of time (hospital consultants) rather than a professional salary, systematizing as much as possible of the care process and treating them as impersonal units of production.

But, as we have seen, a flourishing set of professions is important to our collective wellbeing so it is in all our interests to try and develop a new set of dynamics.

Sociologist Celia Davies,[10] a long-time student of the relations between doctors and nurses, argues that the 'emotions work' that nurses so often do, can serve to split off the caring role, enabling doctors to develop and maintain a classic professional identity with many of the features described in this chapter.[11] She has articulated a new sense of professional identity[12] that may be needed, as summarized in Table 4.1.

Conclusion

So if we look back over the thinking presented in this chapter its argument is as follows.

Society needs professionals to develop and use practical wisdom (professional judgement) in situations where it is needed, and to standardise and systematise in situations where it is not. It accords professionals the status and autonomy to be able to exercise this judgement and then because of that status and autonomy finds it difficult to challenge individuals and groups of these professionals when they use them in ways that are not in the best interest of society. Often this involves professionals refusing to recognise when standardisation is

[9] The response of management is to pay for an additional surgical list at a weekend, something they would not consider doing when a lower status profession attempts to refuse to play ball.

[10] Professor Emerita of Health Care at the Open University

[11] Gender and the Professional Predicament in Nursing, Open Univ Press 1995

[12] Celia Davies: Workers, Professions and Identity in Henderson J and Atkinson D eds Managing Care in Context London Routledge 2002.

appropriate. This is understandable because standardisation feels like a loss of professional status and is bound, almost always, to be resisted. Expecting this resistance and influenced by the attitudes and behaviours that result from the five winds, managers and governments choose to use transactional methods of interacting with (and trying to control) doctors rather than constructive covenantal approaches.

These methods are unhelpful, however professions have a responsibility to ensure their members keep the interests of society foremost, and to help them see that it is by accepting and initiating sensible standardisation that they demonstrate their trustworthiness to retain the autonomy to use professional judgement in cases that require it. However unless this responsibility to society is explicitly taught it becomes confused among the acrimonious relations between a profession and the government, and the professions forget their wider responsibility to society, and forget too that society is so much more than the government. They need to help protect society from the inadequacies of government by rising above their squabbles with it.

In other words professions need to redevelop a rich understanding that Government is only one part of society, as are patients, the population, journalists and very much more. Society needs to be seen as something dynamic and changing that involves people, technology, history, different realities, opportunities, risks, single lives, collective relationships, different states of physical and mental health, and the different meanings brought to events by different people. Of course it would help if governments understood this too, but professions can and should rise above their frustrations with governments and find ways of honouring their deal with a wider society. We explore this further in Chapter Seven.

Table 4.1

Classic Professional Identity	***Towards a new professional identity***
A strongly bounded individual -a sense of self apart from others	A strongly connected individual – a sense of self in connection with others
Mastery of knowledge – expertise as hard won personal acquisition	Reflective application of knowledge – blending knowledge and experience in a specific context
Detachment – emotionally controlled and self referential	Engagement – explicit use of self and acknowledgement of emotions
Autonomous practice – a unilateral, personally accountable decision maker	Team practice – welcoming and valuing the contributions of others

Interchangeability – a company of equals with presumed equal competence	Specificity – acknowledging unique expertise/experience of all
A singular identity – professional identity outweighs /transcends all others	Multiple identities – calling on the specificity of team member experience as a resource for clients.
Concern for individual	Concern for individual and society

We might also add:

Working hard for patients despite the organisational context	Helping the organisation to help them succeed, through a good understanding of how organisations work
Concern for and audit of own practice	Continuous reflection on and improvement of service as a whole, using rich data, and their understanding of statistical process control and improvement technologies