TALKING ABOUT GOOD PROFESSIONAL PRACTICE

VIEWS ON WHAT IT MEANS TO BE A GOOD DOCTOR
Talking about good professional practice
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This report is based on research conducted with members of the public and members of the medical profession in Ireland between 2011 and 2013. We are grateful to everyone who generously provided their time to share their views with the Medical Council on what they think it means to be a good doctor.

Research with members of the public was conducted in 2011 by Millward Brown and in 2012 and 2013 by Behaviour and Attitudes. Research into the views of doctors was conducted by the Medical Council in 2013. Support was provided by Dr Mary Clarke and Professor Hannah McGee at RCSI for the analysis of the results, and their expertise is gratefully acknowledged.

Professor Martin Roland, CBE, Chair in Health Services Research at the University of Cambridge, kindly shared a questionnaire on doctors’ attitudes to medical professionalism. This questionnaire was the basis to the survey into the views of doctors conducted by the Medical Council in 2013. We are grateful to Professor Roland for generously providing access to this resource and for sharing his experience of using these questions in the UK.

The research was planned and overseen by Ms Lorna Farren, Mr Simon O’Hare and Dr Paul Kavanagh, who also drafted the report. Finally, the assistance of Ms Sarah Lane is gratefully acknowledged in compiling and finalising this report.
While it’s a simple idea, there is no greater accomplishment or accolade than to be recognised by patients and colleagues as “a good doctor.”

Good professional practice describes the knowledge, skills, values and behaviours which enable medical professionals to pursue the goal of being a good doctor.

Technical competence is essential - a command of the ever-expanding body of medical knowledge, a proficiency in completing procedures of increasing diversity, and an ability to deliver care in a healthcare system of growing complexity.

But being a good doctor is more than technical competence. It involves values – putting patients first, safeguarding their interests, being honest, communicating with care and personal attention, and being committed to lifelong learning and continuous improvement. Developing and maintaining values is important; however, it is only through putting values into action that doctors demonstrate the continuing trustworthiness which the public legitimately expect. As public expectations develop, new technologies emerge, and healthcare systems evolve we need to constantly re-evaluate what we understand by a good doctor - and how this is experienced in practice.

This report, which informed the Statement of Strategy for the term of the Medical Council 2014-2018, provides welcome evidence that the public in Ireland have a good experience of doctors and that the patient-doctor relationship is underpinned by trust. It is reassuring that the public report positive experiences in relation to key aspects of good professional practice that demonstrate trustworthiness - most people told us that they experience effective communication, appropriate involvement in decisions about their care, safeguarding of their confidentiality, and their interests being put first. As my fellow Medical Council members and I set out on a new programme of work, this is a good starting point for our challenge of safeguarding the public’s trust in doctors.

However, the findings in this report are not presented as a manifesto for complacency. While most people report positive experiences, a small but significant proportion do not; some doctors reported concern about the practice of a colleague. Their views will not be overlooked, and as a regulator we must take action where standards are not met.

This report has identified some ways in which we can go about addressing this so as to ensure that everyone experiences care from a good doctor. The Medical Council will set standards through defining good professional practice for doctors, working with education and training bodies to foster good professional practice, and taking action to protect the public where these expectations are not met. However, this report also highlights the need for us to look at new ways to build a strong and effective patient-doctor relationship. The Medical Council will engage, inform and work with all the individuals and bodies that shape the professional lives of doctors so as to ensure we collectively build a healthcare system which supports doctors to put professional values into action for the benefit of patients.

The public and the medical professionals share the ambition that every patient is cared for by a good doctor. The Medical Council is committed to providing leadership to make this ambition a reality.

Prof. Freddie Wood
President
I am pleased to introduce this report, which provides a valuable snapshot of the views of the public and the medical profession on what constitutes good professional practice among doctors.

In many instances these views are complementary, and there is broad agreement on the importance of confidentiality, shared decision-making and maintaining competence. There are, however, areas where the public and doctors may have differing expectations.

Our role as regulator is to consider these views and determine a course which enables our effectiveness in enhancing patient safety. The findings in this report have informed and influenced the priorities and directions we have set over the next five-year period in the Medical Council’s Statement of Strategy 2014-2018.

A key finding of the report is the need to sustain the high levels of trust between patients and doctors. Only by listening carefully and acting thoughtfully can we realistically expect to be viewed as a leader by patients and doctors. As a starting point on the five-year journey to implement our strategy, this report highlights the views of the public and medical profession. The challenge now is to agree the best way forward with patients, doctors and other partner organisations.

Through defining good professional practice among doctors and overseeing doctors’ education, training and lifelong learning, we will apply what we have learned. We look forward to working closely with education and training bodies to build on the strong emphasis which is already placed on medical professionalism so we can identify new ways to foster good professional practice among doctors.

Our collective ambition for a strong and effective patient-doctor relationship must continue to be embedded into the systems that educate and train doctors. However, this same ambition must also be part of the fabric of the wider system of healthcare where patients and doctors work together on a day-to-day basis.

In addition to continuing our work in supporting and ensuring good professional practice among doctors and working with education and training bodies, we will seek to better inform and collaborate with individuals and bodies across the wider healthcare system that shape the professional lives of doctors. Individual doctors are responsible and accountable for maintaining trustworthiness through appropriate professional values and behaviours. The environment where doctors and patients work together on a day-to-day basis, national legislation and healthcare policy, and the leadership, culture, systems and processes in the places where medicine is practised must support a strong and effective patient-doctor relationship and should make it easy to put the right professional values into action.

We look forward to continuing to work with the public, doctors and our partner organisations to collectively achieve this aim.

Ms Caroline Spillane
Chief Executive Officer
EXECUTIVE SUMMARY

Background to the report
The Medical Council is a statutory organisation, charged with supporting and ensuring good professional practice among doctors for the benefit of patients. To effectively carry out this role, we must be able to define good professional practice – to know what it means to be a good doctor.

Some elements of good professional practice remain constant – a commitment to putting patients first, good communication skills, compassion, integrity and technical competence will always be fundamental to the delivery of safe, high-quality medical care that responds to patients’ needs and supports the vital relationship of trust between patient and doctor.

However, healthcare systems evolve and patient expectations and priorities change. Doctors’ support needs change, too, in response to developments in healthcare, new technologies and alternative ways of working.

In the face of an ever-changing healthcare landscape, promoting the consistent delivery of safe, high-quality medical care and maintaining the public’s trust in doctors requires an ongoing focus. For this reason, to ensure our oversight of medical education, training and practice fosters ‘good’ doctors, the Medical Council must continually listen to the views, expectations, values and experiences of patients and doctors.

This report presents findings from research we conducted involving members of the public and doctors, which sought to identify their beliefs and experiences regarding good professional practice.

Objectives of the report
• To describe the public’s views on, trust in and experience of doctors;
• To describe doctors’ views on professional values and behaviours;
• To compare and contrast the views of the public and the medical profession so as to identify priorities for the ongoing fostering of good professional practice among doctors in Ireland.

Conducting the research
This report is based on research undertaken by the Medical Council with members of the public and doctors between 2011 and 2013.

Listening to the views of the public
The Medical Council listened to the view of the public through a series of cross-sectional surveys conducted between 2011 and 2013. Each survey involved a nationally representative quota sample of approximately 1,000 people aged 16 years and over.

The surveys were completed through face-to-face interviews. The questions used in the interviews were informed by a review of literature about the public’s views of doctors.

Listening to the views of the medical profession
The Medical Council also listened to the view of the medical profession through a cross-sectional survey in 2013. A random sample of 2,500 doctors was drawn from all registered doctors (n=17,403) with an email address (89%).
An online questionnaire was sent to the sample, which contained questions developed by Roland et al. and shared with permission.1

In total, 696 responses were received (28% response rate) and characteristics of respondents were broadly representative of doctors registered with the Medical Council.

Overview of the findings
Overall, Irish people reported a positive, trusting relationship with their doctor. The public’s reported trust in the medical profession was supported by generally positive views about their interactions with their usual doctors and high levels of satisfaction with the medical care received.

Doctors reported values and practices that promoted patient trust and supported a strong patient-doctor relationship, such as fully informing patients about their treatment, safeguarding confidentiality and taking into account patients’ preferences regarding their care.

Trust and satisfaction with doctors

Public trust in doctors
• Approximately 9 out of 10 people trusted doctors to tell the truth. Compared with other professional and public groups, doctors were highly trusted.

Satisfaction with own doctor
• 94% of people reported a positive experience with their own doctor. In 2013, 63% of people rated as ‘very satisfactory’ the experience they had with the doctor they attended most often, and 31% rated their experience as ‘satisfactory’.
• 89% of people had never experienced anything that would require them to make a complaint about a doctor.

The building blocks of trust

Doctors’ communication skills
• The public had confidence in the quality of their doctors’ communication skills: approximately 9 out of 10 people were confident about their doctor’s skills across four indicators of good patient-doctor communication: effective communication about personal health, explaining diagnosis and treatment, respect and being a good listener, and giving time and attention to the patient.

Autonomy and shared decision-making
• The public were confident that their doctor would take time to give information to help them understand and make decisions about their care: 84% were confident that their doctor would explain the side-effects of medication he or she recommended and 92% were confident that their doctor would give them information to enable them to make a decision about their care.
• Doctors demonstrated respect and support for patient autonomy: 80% of doctors completely agreed that doctors should fully inform all patients of the benefits and risks of a procedure or course of treatment, and the majority had referred to a specialist (68%) or prescribed a branded drug (57%) in response to a patient’s request.
Confidentiality

- The public had a high degree of confidence that their personal information would remain appropriately safeguarded: 92% of people were confident that their doctor would maintain the confidentiality of their personal information.

- Most doctors reported practices which safeguarded patient information. Doctors strongly held the view that they had a duty to protect patient confidentiality, with 93% agreeing completely that doctors should never disclose confidential health information to an unauthorised individual.

Openness, honesty and transparency

- The public trusted doctors to be honest even when there had been an oversight or mistake in the course of their care: 77% were confident that their doctor would tell them if a mistake had been made.

- However, views of doctors were mixed: 63% completely agreed that doctors should disclose all significant medical errors.

- The Medical Council procedures to inquire into concerns about doctors are increasingly transparent. Public awareness of this, however, is low: 38% of people were aware of fitness to practise inquiries involving doctors, of those who were aware, only 19% were aware that these were held in public. Regarding the impact of transparent procedures, 31% and 49% of people reported that this improved their impressions of doctors and the Medical Council respectively. Most people did not think that media coverage had any impact on their impressions: 5-in-10 and 4-in-10 reported that it had no impact on their impression of doctors and the Medical Council respectively.

Concerns about patient safety

- Approximately 9-in-10 people were confident that their doctor would report child protection or child welfare concerns to the appropriate authorities.

- The public were less confident that concerns about doctors’ performance would be reported: 72% were confident that their doctor would tell his or her employer about problems relating to his/her ability to treat patients, and 71% were confident that their doctor would report concerns about another doctor.

- Doctors’ views on raising concerns about patient safety were mixed. Only 50% of doctors said they completely agreed that doctors should report all instances of significantly impaired or incompetent colleagues to the relevant authorities.

- In practice, of those doctors who had encountered a significantly impaired or incompetent colleague, only 41% reported this colleague, 36% spoke to the doctor concerned themselves and 18% stopped referring their patients to the doctor.

- Reasons given for not reporting an impaired or incompetent colleague were a belief the report would not result in any action (44%), fear of retribution (25%) and a belief that someone else was dealing with the problem (19%).

Maintaining competence and assuring quality of medical practice

- Approximately 9-in-10 people were very or fairly confident that their doctor was keeping his or her knowledge and skills up to date; a lower proportion - 68% - believed that their doctor was subject to external assessment to check they were doing a good job.
• Maintaining standards of medical practice was important to the vast majority of people: 95% of people agreed that doctors should regularly review the standard of their practice and that they should be assessed to ensure they were practising medicine to a high standard.

• Doctors’ views on measures to assess their practice were more mixed. Only 25% agreed completely that doctors should have their continuing fitness to practise periodically re-evaluated and 42% that doctors should peer-review the work of their colleagues.

• Professional development practices reported by doctors varied by type of activity. Only 24% of doctors reported that they had engaged in peer-reviewing a colleague’s work, 55% had taken part in a formal medical error reduction activity, 63% had contributed to the development of clinical practice guidelines and 82% had changed their practice after becoming familiar with a relevant practice guideline.

Conclusions and next steps

The overall picture painted by the report is that the Irish public trust the professionalism of doctors.

Trust is essential for a strong and effective patient-doctor relationship. Given the importance we all place on our health and wellbeing, it is critical that we feel we can trust doctors. Trust improves the experience and outcome of medical care.

However, trust should never be placed blindly. In practice, patients re-affirm or revise their views about placing trust based on their day-to-day experience with doctors. Doctors’ values and actions must consistently demonstrate and maintain trustworthiness.

Importantly, the report indicates that patients’ trust in their doctors is associated with generally positive experiences of medical care. Furthermore, this report also demonstrates that patients’ positive experience of medical care is associated with a system of shared values and behaviours among doctors. These values and behaviours demonstrate trustworthiness through a commitment to putting patients’ interest first, involving patients in care decisions, being honest, safeguarding confidentiality and maintaining competence.

However, we live in a rapidly changing world where new and unexpected challenges can arise for patients and doctors. These changes affect the patient-doctor relationship. While many aspects of the building blocks of public trust in doctors are constant, our collective understanding of good professional practice must be continually re-evaluated if this trust is to be maintained. Gaps between what the public believe and expect, how expectations for good professional practice are defined by the Medical Council, and how these expectations are put into action by doctors in their day-to-day practice can challenge the patient-doctor relationship and the relationship between society and the medical profession generally.

A small but important minority of the public do not trust doctors, report dissatisfaction and report experiences of medical practice which have given them cause for concern. While acknowledging the generally positive views of the public described in this report, the viewpoint of people who do not share this view should not be overlooked. Similarly, almost 1-in-7 doctors reported direct personal knowledge of a doctor who was impaired or incompetent to practise medicine. Is this good enough?

Being honest and open is fundamental to public trust in doctors. Openly disclosing adverse events and communicating honestly with patients and their families is a challenging but critical competency for a good doctor. The report highlights room for development in this area.

Raising concerns about poor professional practice by a colleague is never easy. However, through taking action to deal appropriately with concerns, doctors could play a greater role in safeguarding patients. The report identifies some reasons why this may not currently be a well-established practice.

Finally, approaches to maintaining competence and assuring the quality of medical practice need to be
strengthened and become more consistent. While there have been significant development in doctors’ lifelong learning in Ireland in recent years, there is further work to be undertaken to develop a culture of routine ‘checks and balances’ on medical practice, systematic review of the outcomes of medical care, and feedback and support to doctors to enable them to continually improve care.

A continuing focus on fostering good professional practice among doctors is required to meet the needs of a strong patient-doctor relationship. Ongoing leadership in developing the attitudes and behaviours for good professional practice is necessary. But we must also ensure that the workplace settings where doctors train and practice have leadership, cultures, systems and processes which align with and support what we all expect from a good doctor. Putting the right professional values into action in the place where they practice should be the easy choice for doctors. Our collective ambition for a strong and effective patient-doctor relationship must continue to be embedded into the systems that educate and train future doctors; this same ambition must also be part of the fabric of the wider system of healthcare where patients and doctors work together on a day-to-day basis.

What are the next steps for fostering good professional practice in 21st century Ireland?

For the Medical Council
We have reflected on what we have heard from public and doctors. It has significantly informed the priorities and directions we have set out for ourselves in our Statement of Strategy 2014-18.

*Defining and communicating what it means to be a good doctor*
We will continue to provide leadership through defining and communicating what it means to be a good doctor. This will involve ongoing dialogue with the public, with doctors and with all relevant stakeholders. In this way, we can identify changes in the needs of the patient-doctor relationship and respond appropriately through how we define the expectations for good professional practice among doctors in Ireland. We will ensure that our guidance is clear, and we will also explain how the guidance should be put into action so that professional values are translated into professional behaviours that support a strong and effective doctor-patient relationship.

*Learning environments that foster good professional practice*
We will continue to quality assure the education, training and continuing professional development of doctors in Ireland. In particular, our work will focus on how, through formal learning, professional values and behaviours are developed and maintained at all stages of a doctor’s career. While a focus on formal programmes of medical education and training delivered by universities and postgraduate bodies will remain important, we cannot overlook the role of the workplace as a learning environment and the socialisation of trainee doctors into the culture of medical practice since these are key in shaping future doctors’ identities as professionals. If doctors in training are to develop good professional practice they must experience workplace environments and role models that are consistent with and support expected professional values and behaviours. We will ensure that the workplace environments in which doctors learn have leadership, cultures, systems and processes that are aligned with our expectations about what it means to be a good doctor. For example, at clinical sites where doctors learn the practice of medicine, we will ensure that clinical leadership and systems of clinical governance are in place to prioritise patient safety and support processes for quality assuring medical practice at a local level, such as the measurement and benchmarking of clinical outcomes.
A better understanding of how good professional practice is developed and maintained

We will gain, through research, a better understanding of how good professional practice is developed and maintained by doctors. In particular we will seek to understand how professional values, aligned with our expectations on what it means to be a good doctor, are developed and maintained by doctors. Critically, we will focus on understanding potential barriers to the translation of these values into professional behaviours that demonstrate and maintain trustworthiness. We will collaborate with other bodies in trying to build this better understanding and will develop capacity to address these important questions.

Working with other bodies and individuals who shape good professional practice

Shaping professional practice requires a joined-up and coordinated approach across the health system. The workplace environment and the wider health system in which doctors practise medicine must also foster professional values and make it easy for doctors to put these values into action. For this reason we must continue to work with all bodies and individuals who influence medical professionalism in Ireland - policy makers, healthcare organisations, patient representative groups, and other regulators, for example - so as to ensure that the health system in Ireland is focussed on the needs of individual patients.

For medical education and training bodies

Fostering professionalism through focus on role models and the “hidden curriculum”

Bodies involved in the education and training of doctors play a central role in the development of doctors’ professional values and behaviours. They should have clear codes, charters, policies and procedures to set expectations for students and trainees regarding professionalism. Formal programmes for teaching and learning, including systems of assessment and the progress decisions these inform, must provide experiences and evaluate outcomes in a way that emphasises the importance of good professional practice. While the content of teaching and learning is important, culture and context impact hugely on developing doctors’ emerging professional identity. Education and training bodies must also consider curricular strategies that take account of the importance of trainers and other doctors as role-models and that seek to address the “hidden curriculum” of deep-seated structures and cultures which powerfully shape developing doctors’ values and future behaviours.

For employers and healthcare organisations

Creating workplace settings that support good professional practice

Employers and healthcare organisations govern the settings where doctors train and work. While the Medical Council and education and training bodies must take a lead in fostering the development of doctors with appropriate professional values, employers and healthcare organisations must take responsibility for ensuring that the governance of workplace settings builds a culture that supports good professional practice among doctors. Employers and healthcare organisations must also ensure robust and effective systems and processes of care which are consistent with what we all expect from good doctors and make it easy to put good professional values into action. In particular, strengthening and ensuring consistency of systems to handle concerns about patient safety and to assure the quality of medical practice must be a focus for employers and healthcare organisations.
For policy-makers and legislators

Building a health system for a strong and patient-doctor relationship
The design and ongoing reform of the wider health system environment must take account of the need to positively shape good professional practice among doctors for the benefit of patients. Healthcare policy and legislation should take account of our collective ambition for a strong and effective patient-doctor relationship. Our health system must be a place where good professional values and behaviours are the easy choice for doctors.
SECTION 1

WHY TALK ABOUT GOOD PROFESSIONAL PRACTICE?
1. **Why talk about good professional practice?**

Good health and well-being enable us to live our lives to their greatest potential. We all place great value on our health and everyone is entitled to receive care from a good doctor. For this reason, good professional practice among doctors is a cornerstone of a strong and effective healthcare system.

The Medical Council is a statutory organisation charged with supporting and ensuring good professional practice among doctors for the benefit of patients. To effectively carry out this role, we must be able to define good professional practice. It is only through talking to the public and to doctors about their values, beliefs, experiences and practices that we can build a shared understanding of what it means to be a good doctor.

1.1 **What does it mean to be a good doctor?**

In many ways, the idea of a good doctor is very easy to define.

As patients, many of us will know a good doctor: someone we trust with our health, who knows us well, who listens carefully and sympathetically, with whom we can talk freely about our concerns and with whom we can easily agree a course of action, integrating their expert advice with our own personal needs and preferences. Most doctors can think of a colleague they believe is an example of a good doctor too: someone who is a positive role-model for younger doctors, who is up-to-date with the latest advances in their field, who is a valued and reliable colleague, and who consistently demonstrates a commitment to putting patients first.

These ideas are reflected in research about what people expect from doctors. A review of studies found that when patients were asked their priorities about doctors, a common set of inter-related ideas were identified: humaneness, competence, patients’ involvement in decisions, making time for care, and exploring patients’ needs.

Most patients want to play an active role in decisions about their health and they should be supported to do so. However, it is also recognised that patients have some vulnerability when they seek care, so being able to trust a doctor’s judgement and advice is central to the public’s ideas about good doctors. In the context of the patient-doctor relationship, trust means “the expectations of the public that those who serve them will perform their responsibilities in a technically proficient way, that they will assume responsibility and not inappropriately defer to others, and that they will make their patients’ welfare their highest priority”.

Trust should never be placed blindly. Doctors have a duty to ensure that they live up to their patients’ expectations and trust; they must demonstrate and maintain trustworthiness at all times.

1.2 **Medical professionalism – the basis for trust in the patient-doctor relationship**

Although many definitions of medical professionalism exist, in general, it is understood to be a set of values, enacted through behaviours and relationships, which underpin the public’s trust in doctors.

Concepts about medical professionalism have a long history and in Western traditions, for example, can be traced back to the principles set out in the Hippocratic Oath. These principles have been reframed over time to better reflect contemporary perspectives on the patient-doctor relationship and on the relationship between citizens and society generally; for example, the emergence of greater patient involvement in decision-making, the new focus on healthcare safety and quality, and an increasing emphasis on doctors’ ongoing demonstration of competence. “New professionalism” is a term sometimes used to describe the subtle but important evolution in the values and responsibilities underpinning what it means to be a good doctor. Fostering good practice among doctors involves acknowledging these contemporary perspectives whilst always upholding and promoting the core values of mutual respect, confidentiality, honesty, responsibility and accountability that remain central to a strong and effective patient-doctor relationship.
1.3 The role of the Medical Council in maintaining trust

Every doctor has a responsibility to ensure that their values and behaviours continually demonstrate trustworthiness to the public. The Medical Council has a key role to play, with doctors and with the public, to ensure that trust is maintained in the patient-doctor relationship. Through our various functions – quality assuring doctors’ education, training and lifelong learning, controlling entry to the practice of medicine, and dealing with concerns about doctors – the Medical Council ensures that doctors demonstrate and maintain trustworthiness so as to support a strong and effective patient-doctor relationship.

An essential foundation to our work is setting expectations about what it means to be a good doctor.

Currently, these expectations are set out in two complementary ways. The “Guide to Professional Conduct and Ethics” informs doctors about how they should act in their patients’ best interest and explains to the public what they can expect from a good doctor (See Box 1). The “Domains of Good Professional Practice” is a set of themes that provide a framework for the outcomes or goals which the Medical Council expects a doctor to achieve through their professional development (see Box 2).

While both the Guide to Professional Conduct and Ethics and the Domains of Good Professional Practice provide an understanding of various elements of good practice (for example, how a doctor should communicate, how a doctor should work in teams, etc), providing good care on a day-to-day basis requires doctors to integrate and apply a range of competencies. It is this integration of the right competencies at the right time in the right situation that makes for a good doctor.

The Medical Council’s expectations about what it means to be a good doctor are embedded in all our functions; for example, when we accredit a medical school, we ensure that future doctors learn the principles of medical ethics and are trained in communication skills; when we admit a doctor to the practice of medicine, we ensure that the doctor is in good standing and has no outstanding concerns raised about their good character; when we receive a complaint against a doctor, we consider this against what we expect from a good doctor and can take action if expectations are not met.

Box 1: Extract from the Medical Council’s Guide to Professional Conduct and Ethics, 7th Edition 2009

“Medical professionalism is a core element of being a good doctor. Good medical practice is based on a relationship of trust between the profession and society, in which doctors are expected to meet the highest standards of professional practice and behaviour. It involves a partnership between patient and doctor that is based on mutual respect, confidentiality, honesty, responsibility and accountability.

In addition to maintaining your clinical competence as a doctor you should also:

• show integrity, compassion and concern for others in your day-to-day practice,
• develop and maintain a sensitive and understanding attitude with patients,
• exercise good judgement and communicate sound clinical advice to patients,
• search for the best evidence to guide your professional practice, and
• be committed to continuous improvement and excellence in the provision of health care, whether you work alone or as part of a team.”
1.4 About this report

The Medical Council has a lead role to play in setting expectations about what it means to be a good doctor. To do this effectively it must listen carefully to the views and experiences of the public and doctors so as to ensure any direction it sets is valid, authentic, relevant and, above all, supports a trusting patient-doctor relationship.

To this end, we undertook research to discover what the public and doctors in Ireland understand by good professional practice: what are their views on various medical professional values and responsibilities; how do doctors bring those values and responsibilities into action; and how are these experienced by patients on a day-to-day basis?

This document collates the findings of the research that informs our strategic direction and priorities and supports our ongoing work to foster good professional practice in Ireland. It also identifies directions that we will take in collaboration with other individuals and bodies involved in shaping the patient-doctor relationship.
The overall aim of this report is to inform the role of the Medical Council in fostering good professional practice in Ireland. The specific objectives of the report are as follows:

- To describe the public’s views on, trust in and experience of doctors;
- To describe doctors’ views on professional values and behaviours;
- To compare and contrast the views of the public and the medical profession so as to identify priorities for the ongoing fostering of good professional practice among doctors in Ireland.

The Technical Annex to this report sets out details of how the research was conducted, including information on the samples and their representativeness. The Technical Annex also appraises some of the limitations of the research.
SECTION 2:

VIEWS ON GOOD PROFESSIONAL PRACTICE
2. **Views on good professional practice**

The results of the different studies are now presented; these have been organised under different themes. Where relevant, views of members of the public and views of members of the medical profession are presented under the same theme and their views are compared and contrasted; we have colour-coded these for easy reading. To place these findings in context, the results of relevant international studies are presented for comparison.

2.1 **Trust and satisfaction with doctors**

Trust is an important basis to the relationship between the public and the medical profession. When a patient places trust in a doctor, they believe that the doctor is working in their best interests. Patients who place trust do so on the basis of assumptions they make about doctors' knowledge, skills and attitudes. A range of factors has been shown to promote patients' trust in doctors; these include: thoroughly evaluating problems, understanding a patient's individual experience, compassion, empathy, advocacy, reliability and dependability, communicating clearly and completely, building a partnership, providing appropriate and effective treatment, and being honest and respectful to the patient. Being able to place trust in a doctor has been shown to increase patients' satisfaction with healthcare, enable patients to follow agreed treatment plans and to maintain continuity of care. Patients' ideas about a 'good doctor' are strongly linked to the idea of trust.

The public should not feel that they have to place trust blindly: doctors have a duty to demonstrate trustworthiness and patients make judicious assessments about when they will place trust and when they will not.

In practice, patients review and update their views in relation to their trust in a doctor based on experience and may sometimes test out their assumptions to ensure that their trust is well placed. While public trust in doctors and satisfaction with doctors are similar ideas, there are differences. Satisfaction is based on patients' past experience of a doctor's actions, whereas trust is concerned with how patients expect that doctors will behave in the future and is based on ideas patients have about doctors' motivations. Where patients are satisfied with their experience of doctors, the relationship of trust is strengthened. Failure to maintain trustworthiness undermines the patient-doctor relationship. These failures not only negatively affect the relationship between individual patients and their doctors; they can also damage public trust in the medical profession generally. Measuring people's satisfaction with doctors helps us understand if trust is well-placed.

**Views of the public**

Figure 1 illustrates that approximately 9 out of 10 people trusted doctors to tell the truth. The relative position of doctors compared with other professional and public groups was favourable, with doctors placed top of the list in terms of public trust. This has been a consistent finding over recent years.

The question posed by the Medical Council to members of the Irish public about whether they would trust professionals to tell the truth has also been posed to members of the public in the UK for three decades. Figure 2 shows that public trust in doctors has been consistently high in the UK for the past 30 years.

Figure 3 shows the trend in the how satisfied people were with the doctor they attended most often. In general, 94% of people rated their experience of the doctor they attended most often as satisfactory or very satisfactory; furthermore, there was a 26% relative increase in the proportion of the public reporting that they were very satisfied (50% in 2011 rising to 63% in 2013). This positive experience is also reflected in the public’s views on the need to make a complaint about a doctor: Approximately 9 out of 10 people had never experienced anything that had required them to make a complaint about a doctor (Figure 4).
Figure 1: For each different type of people, would you tell me whether you generally trust them to tell the truth or not (% “trust to tell the truth”, 2011-2013)?
Figure 2: For each different type of people, would you tell me whether you generally trust them to tell the truth or not (Doctors only, % “trust to tell the truth” – UK trend 1983-2013)?

Source: Ipsos MORI.

Figure 3: How would you rate the experience you have with the doctor that you attend most often, 2011-2013?
Figure 4: In relation to making a complaint about a doctor, which of the following statements best describes your past experience?

<table>
<thead>
<tr>
<th>Statement</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never experienced anything requiring a complaint</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>Made formal written and/or verbal complaint about a doctor</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Thought should have made a complaint but did nothing</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Thought should have made complaint but told neighbours/friends</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Made informal complaint to work colleagues of doctor</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

What does this mean?
Overall, the public reported very high levels of trust in and satisfaction with doctors. These views provide a strong basis to the patient-doctor relationship and to the relationship between doctors and society generally. It is encouraging that the public’s confidence in placing trust in doctors is supported by reports of positive experiences in practice.

A small but important minority of the public do not trust doctors. The views of these individuals on doctors may be aligned with a general scepticism about professional and public groups. However, a small but important minority of the public also report dissatisfaction with their doctors and report experiences of medical practice which have given them cause for concern. While acknowledging the generally positive views reported by the public, the viewpoint of people who do not share this view should not be overlooked.

2.2 The building blocks of trust
To better understand the public’s trust in and satisfaction with doctors, we examined views on specific aspects of good professional practice from the public and from doctors’ perspective. Research has demonstrated that patients’ trust in doctors is composed from a number of inter-related building blocks and their views about these, including:

- Effective communication;
- Respect for autonomy and shared decision-making;
- Maintaining confidentiality;
- Honesty, openness and transparency;
- Raising concerns about patient safety;
- Maintaining competence and assuring quality of medical practice.

Views on these building blocks from the perspective of patients and doctors are now presented and discussed.
2.2.1 Effective communication

Effective communication is fundamental to good professional practice. Communication underpins all patient-doctor interactions and is thus a key competence for doctors. While good clinical knowledge and skills are essential, the way in which a doctor listens to, talks with and relates to patients is integrated with other competencies to ensure safe, personal and good quality care.

Views of the public

Figure 5 illustrates that the public had confidence in their doctor’s communication skills: around 90% of people were confident that their doctor communicated effectively, by providing understandable diagnosis and treatment explanations, listening carefully and providing sufficient care and attention.

Figure 6 illustrates how the Irish public’s experience of doctors’ communication compares with experiences in other health systems. The views of people in the US, New Zealand, Canada, Australia and the UK were captured in studies that examined aspects of communication similar to those examined by the Medical Council in 2013: providing understandable explanations, listening carefully and giving sufficient time. The experience of the Irish public appears similar to that of patients in other health systems. Compared to the Irish public and people in other health systems, however, the US public was less positive about doctors giving sufficient time. This may relate to differences in the way in which healthcare is structured and delivered in different countries, as well as differences in public expectations.

Figure 5: In relation to the doctor you attend most often how confident would you be that … (very confident and fairly confident combined, 2013)?

<table>
<thead>
<tr>
<th>Description</th>
<th>Confident Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor effectively communicates to me about all aspects of my personal health</td>
<td>89%</td>
</tr>
<tr>
<td>My doctor explains diagnosis and treatment in a way that I can understand</td>
<td>90%</td>
</tr>
<tr>
<td>My doctor listens to me and takes me seriously</td>
<td>91%</td>
</tr>
<tr>
<td>My doctor gives me as much time and attention as any other patient</td>
<td>90%</td>
</tr>
</tbody>
</table>
The Irish public, like patients in other health systems, are positive about their doctors’ communication skills. This is important, because having good communication skills is a key element of being a good doctor. The Medical Council has placed greater focus on how doctors relate to patients in our oversight of medical education and training. However, a small but important minority of the public have experiences which appear to fall short of their expectations. This is reflected in complaints which we receive about doctors: poor communication was a leading category of complaint against doctors brought to the Medical Council in 2012, accounting for approximately 1-in-6 complaints.

2.2.2 Respect for autonomy and shared decision-making

It is increasingly recognised that patients want to play an active role in making decisions about their care. This patient involvement is an aspect of medical professionalism that has evolved recently. Respect for autonomy and allowing or enabling patients to make their own decisions about their healthcare can help to strengthen the patient-doctor relationship. For doctors, placing the patient at the centre of care involves putting patient interests first, not undertaking any action which might take advantage of a patient’s vulnerability, and always telling the truth.
Views of the public

As illustrated in Figure 7, in general the Irish public were confident that the doctor they attended most often would provide them with adequate information to enable them to make decisions about their care (92% were confident or very confident), and most were confident that their side-effects would be explained (84%).

As shown in Figure 8, the public in other health systems was less positive than the Irish public about their experience of doctors explaining side-effects. While this may be a real difference, it is also possible that differences reflect changing trends in how patients are informed about and involved in decision-making by doctors, given that the Irish study was conducted a decade later than the international study.

**Figure 7:** In relation to the doctor you attend most often how confident would you be that ... (very confident and fairly confident combined, 2013)?

- My doctor explains the side effects of any recommended medication
  - 84%
- My doctor would provide me with adequate information to enable me to make a decision about my care
  - 92%

**Figure 8:** Public views on doctor explaining side-effects across 5 countries, 2004

Source: Commonwealth Fund, 2004

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Views of doctors

As illustrated in Figure 9, 80% of Irish doctors completely agreed that doctors should fully inform all patients of the benefits and risks of a procedure or course of treatment; these views were comparable to the views of UK doctors.

Irish doctors’ views on the importance of respect for patient autonomy and shared decision-making is also reflected in their reported practices regarding referral to specialists and prescription of branded drugs over generics, when these were patients’ preferences regarding their care. As shown in Figure 10, the majority of doctors were open to modifying their practice in order to take account of patient preferences: in the previous year 57% of Irish doctors reported that they had prescribed a branded drug when a generic was available because the patient requested it; in the previous year 68% had referred to a specialist on the basis of a patient request even when they believed this was not indicated.

Figure 9: Doctors should fully inform all patients of the benefits and risks of a procedure or course of treatment (% completely agree, 2013)

Figure 10: In the last year, how often have you...

- Have you given a referral to a specialist because the patient requested it when you believed it was not indicated? (% Replying Never)
  - Ireland: 13%
  - UK: 32%

- Have you prescribed a brand name drug when a generic was available because the patient requested it? (% Replying Never)
  - Ireland: 21%
  - UK: 43%
What does this mean?

The Irish public’s confidence that doctors will respect their autonomy by explaining side-effects complements the views of Irish doctors. This is an important finding, since greater patient involvement in decision-making about medical care is one of the aspects of good professional practice where expectations have changed in recent times.\textsuperscript{4} It is encouraging to see this development is now well embedded in the patient-doctor relationship in Ireland.

These results, and some of the differences compared with the practices reported by Irish doctors in comparison with their UK counterparts highlight nuances in how good professional practice is understood and put into action on a day-to-day basis. For example, through effective communication, listening to a patient’s concerns and carefully providing understandable explanations, differences in opinion between the doctor and the patient can be managed, while respecting patient autonomy and fully involving the patient in decision-making about his or her care.

2.2.3 Maintaining confidentiality

Maintaining confidentiality means the protection and proper use of sensitive and private patient information. It is another dimension of public trust in doctors. Besides reflecting good professional practice among doctors, safeguards for sensitive and private patient information are defined in legislation.\textsuperscript{25} Maintaining confidentiality means more than protecting information, it also involves judicious sharing of information with other healthcare professionals where this is necessary for care.\textsuperscript{12}

The views of the public

92% of Irish people were either very confident (69%) or fairly confident (23%) that the doctor they attended most often would safeguard the confidentiality of their private information (Figure 11). The public also reported strong views regarding the importance of patient confidentiality being maintained in the age of social media (Figure 12).

Figure 11: In relation to the doctor you attend most often how confident would you be that your doctor safeguards the confidentiality of your personal information (2013)?
The views of doctors

Public confidence in doctors’ approaches to confidentiality is complemented by the views of the medical profession in relation to safeguarding confidentiality. As illustrated in Figure 13, 93% of doctors completely agreed that doctors should never disclose confidential health information to an unauthorised individual. The views of Irish doctors were similar to those of UK doctors on this point. The importance of safeguarding confidentiality is also supported by practices reported by doctors. As shown in Figure 14, in the last year 84% of doctors reported never intentionally or unintentionally disclosing health information about a patient to an unauthorised person.

Figure 13: Doctors should never disclose confidential health information to an unauthorised individual (% completely agree)
What does this mean?

Maintaining confidentiality is a key aspect of the trust between patients and doctors. Discussions with doctors about our health and wellbeing are among the most personal and sensitive interactions we ever have with people outside our immediate family and friends; we expect the content of these discussions to be confidential. Besides being a professional responsibility, the requirements regarding the safeguarding of personal and sensitive information are set out in legislation.²⁵

It is positive that so many doctors value safeguarding patients’ personal information and report practices which are consistent with this value. Patients’ confidence in this building block of trust is generally well placed. However, a small but important minority of doctors had intentionally or unintentionally disclosed health information about a patient to an unauthorised person in the last year. Each of these circumstances was probably unique and the factors around these disclosures were not explored in this study; they may represent lapses in usual safeguards or situations where disclosure was necessary in a given set of circumstances. The volume of information that is now produced in the course of medical care and advances in technology mean that ongoing vigilance is required to maintain confidentiality. This is highlighted by the strong and clear expectations of the public regarding how patient confidentiality should be maintained in the age of social media. It is not enough to leave this to the good intentions of an individual; these intentions must be supported by good systems of care.

2.2.4 Honesty, openness and transparency

Behaving honestly and dealing in an open and truthful way with patients are integral to trustworthiness. Healthcare involves risk, and from time to time things can go wrong. Mistakes can be due to gaps and weakness in systems of care, the actions of individuals or both. Adverse events present a particular challenge to honesty: while patients and their families legitimately expect to be told when something goes wrong, a range of issues are recognised as barriers to open disclosure practices among doctors.²⁶

Recent reform of the functions of the Medical Council have increased the transparency of our procedures and fitness to practise inquiries are now held in public.²⁷ Transparency in regulatory procedures is a common reform trend and is intended to support public trust in the role of professional regulators, like the Medical Council, and in regulated professions such as doctors.²⁸ This transparency also attracts media interest. While efforts to improve public trust through increasing transparency are welcome, it is recognised that these efforts can sometimes have unintended effects which do not support their purpose.⁶
Views of the public

Many members of the Irish public trusted their doctor to tell the truth if there had been a mistake or oversight in the course of their care: Figure 15 illustrates that approximately 8-in-10 people were very confident (48%) or fairly confident (29%) that open disclosure would take place in this case.

As shown in Figure 16, while 38% of people were aware of fitness to practise inquiries involving doctors, of those who were aware, only 19% were aware that these were held in public. In terms of media coverage, 68% of people reported that they had seen or heard anything of this nature in the past year which mentioned a fitness to practise inquiry. Figure 17 shows the reported impact of this media coverage on the public. Of these people, 31% and 49% of people reported that this improved their impressions of doctors and the Medical Council respectively; 5-in-10 and 4-in-10 reported that it had no impact on their impression of doctors and the Medical Council; many people’s impressions were not impacted by media coverage.

*Figure 15: In relation to the doctor you attend most often how confident would you be that your doctor would tell you if there had been a mistake/oversight during the course of your care (2013)?*

*Figure 16: Public awareness of Medical Council fitness to practise inquiries (% yes, 2013)*
Figure 17: Impact of fitness to practise media coverage on impressions of doctors and the Medical Council.

![Chart showing the impact of fitness to practise media coverage on impressions of doctors and the Medical Council.]

**Views of doctors**

Figure 18 shows the views of Irish doctors on the issue of open disclosure: approximately two-thirds of doctors completely agreed that all significant medical errors should be disclosed to patients who have been affected. Their views are similar to UK doctors.

Reasons for non-disclosure were explored and over 8-in-10 Irish doctors reported fear of being sued as a barrier to open disclosure.

Figure 18: Reported attitudes and practices regarding disclosure following adverse events (completely agree %)

![Chart showing attitudes and practices regarding disclosure following adverse events in Ireland and the UK.]

- Doctors should disclose all significant medical errors to patients who have been affected (completely agree %)
  - Ireland: 70%
  - UK: 63%

- Have you not fully disclosed a mistake to a patient because you were afraid of being sued? (% replying never)
  - Ireland: 13%
  - UK: 85%
What does this mean?

Honesty, openness and transparency are fundamental to public trust in doctors.

There are few greater challenges to this principle than when something goes wrong in healthcare. In and of themselves, adverse events challenge the trust which patients and their families place in healthcare providers; however, research illustrates that when the experience of an adverse event is compounded by a poor experience of honesty and openness by doctors the negative impact and outcome for patients and their families is exacerbated.26 Openly disclosing adverse events to patients and communicating honestly with patients and their families is a challenging but critical competency for a good doctor. This is reflected in the World Health Organisation’s Patient Safety Curriculum for healthcare professionals.29 The Medical Council’s Guide to Professional Conduct and Ethics also sets expectations for doctors regarding their approach to communication following an adverse event.27 It is evident, however, from this study that further work is required to develop a more consistently positive attitude to open disclosure among doctors in Ireland. It is also evident that addressing concerns regarding litigation must be a priority if a supportive environment for open disclosure which meets the expectations of patients is to be developed.

While increased transparency in Medical Council regulatory procedures has been a key reform to our work in recent years, it is interesting to note that only a small proportion of the public reported awareness of fitness to practise inquiries being conducted in public. There is, however, awareness of media coverage regarding fitness to practise inquiries. This coverage includes details of situations where individual doctors have not demonstrated good professional practice, and it might reasonably be expected to negatively impact on the public’s impression of doctors. While some members of the public reported that this was the case, almost twice as many reported that this coverage actually improved their impression of doctors. Many people also reported that the coverage improved their impression of the Medical Council. Transparency in regulatory procedures is intended to improve the public’s trust and confidence in regulated professions and in regulatory procedures; the results in this report are consistent with this purpose.

2.2.5 Raising concerns about patient safety

Pursuing the interests of patients and recognising that patients can be vulnerable means that it can be necessary for doctors to raise concerns about patient safety, if trust is to be maintained. Doctors’ commitment to protecting patients in this way is another element that contributes to the relationship of trust between them and their patients.

Views of the public

As illustrated in Figure 19, approximately 9-in-10 members of the Irish public were confident that their usual doctor would report a concern about the protection and welfare of a child to the appropriate authority.

However, while the public had confidence regarding raising a child-safeguarding concern, their views in relation to doctors raising concerns about professional practice issues were different.

Approximately 7-in-10 people were confident that their usual doctor would report problems affecting their own ability to treat patients to their employer or that their usual doctor would report any concerns about another doctor to the appropriate authorities.
**Views of doctors**

Doctors’ views on raising concerns in all instances about a significantly impaired or incompetent colleague to relevant authorities are illustrated in Figure 20. In total, half of the Irish doctors surveyed completely agreed that such a concern should be raised; this compared with 59% of UK doctors.

There were mixed views among Irish doctors regarding the management of a concern about an impaired or incompetent colleague. This theme of raising concerns about patient safety regarding professional practice was pursued through further questions.

It is evident from Figure 21 that a small but significant minority of Irish doctors had, in the last 3 years, had direct personal knowledge of a doctor who was impaired or incompetent to practise medicine. In total, 14% of Irish doctors reported that they had experienced concerns about another doctor’s practice; this compared with 19% of UK doctors.

As shown in Figure 22, however, where a doctor was aware of a doctor who was impaired or incompetent to practise medicine, 41% of Irish doctors raised that concern with the relevant authority. Reported practices were different among UK doctors, where 73% reported that they raised a concern. This difference may relate to differences in professional values between Irish and UK doctors; it is also possible that Irish and UK doctors share similar values on this point but that they behave differently because of differences in how the enactment of values is supported. The health system context is different between the UK and Ireland, with systems of clinical governance, including systems of clinical accountability with defined clinical director roles and systems for clinical performance appraisal, being more established in the UK.

Interestingly, however, there was also a difference between UK and Irish doctors in relation to the raising of these concerns with the doctor whose practice was a cause of concern. Again, as shown in Figure 22 while 36% of Irish doctors said that they had a personal discussion with the impaired or incompetent doctor, 66% of UK doctors reported such a personal discussion.

Reasons for not reporting the doctors are given in Figure 23. A small but significant proportion of Irish doctors (25%) reported fear of retribution as a reason for not raising concern, while other doctors (19%) thought that someone else was dealing with the issue. However, 44% of Irish doctors did not raise a concern to a relevant body about a doctor who was impaired or incompetent to practise medicine because they believed that nothing would happen as a result; this compared with 14% of UK colleagues.
Figure 20: To what extent do you agree or disagree that doctors should report all instances of significantly impaired or incompetent colleagues to relevant authorities (completely agree %)?

Figure 21: In the last 3 years, have you had direct personal knowledge of a doctor who was impaired or incompetent to practise medicine in your hospital or practice?
Figure 22: If you did have direct personal knowledge of a doctor who was impaired or incompetent to practise medicine in your hospital or practice, in the most recent case did you... (% Yes - respondents could select more than 1 option)

- Did you stop referring your patients to him/her?
  - Ireland: 17%
  - UK: 18%

- Did you have a personal discussion with the doctor about his/her problems?
  - Ireland: 36%
  - UK: 66%

- Did you report that doctor to a relevant body?
  - Ireland: 41%
  - UK: 73%

Figure 23: If you did have direct personal knowledge of a doctor who was impaired or incompetent to practise medicine in your hospital or practice and you did not report the doctor was it because... (% Yes - respondents could select more than one option)

- You thought nothing would happen as a result of the report?
  - Ireland: 14%
  - UK: 44%

- You thought someone else was taking care of the problem?
  - Ireland: 26%
  - UK: 19%

- You were afraid of retribution?
  - Ireland: 34%
  - UK: 25%
What this means

Recognition of the risks associated with healthcare has moved to the forefront of health policy internationally and in Ireland. Ensuring patient safety requires a whole-system response involving the public, health professionals, healthcare managers and organisations, healthcare commissioners and planners, as well as policy makers and legislators. At a local level, on a day-to-day basis, ongoing vigilance is required to monitor issues that could impact on patient safety. Patients and their families must be empowered and supported to speak out if they perceive a potential risk in healthcare. However, it is also important that healthcare professionals who identify a concern for safety are enabled to act appropriately in the interests of patients. The role of doctors in helping to safeguard patients is key, and values and behaviours regarding raising concerns increasingly influence expectations of what it means to be a good doctor.

The public’s trust in doctors is underpinned by confidence that they will recognise the potential vulnerability of patients and act in their best interest. It is evident from these data that the public’s confidence that doctors would raise concerns about patient safety varied depending on the type of concerns; compared with concerns about the protection and welfare of a child, the public was less confident that a concern about professional practice would be raised by a doctor.

This is an important finding and is complemented by the reported views and practices of doctors.

A small but significant proportion of doctors were aware of a colleague whose practice was a cause of concern; however, the reported values and behaviours of doctors did not consistently support patient safety in circumstances where concerns about a colleague’s practice arose.

In any occupational group a small proportion of members will experience difficulties in maintaining good practice; however, poor performance of doctors can have serious implications for the public. It is difficult to estimate the precise frequency of poor performance among doctors. A recent analysis of data from a UK organisation which handles concerns about the performance of doctors found that 5 per 1000 doctors had performance difficulties referred for further evaluation; the rate of referral was greater for doctors whose first medical qualification was gained outside the UK, male doctors and doctors in the late stages of their career. Medical Council data in relation to complaints about doctors illustrate that in 2012, approximately 2.7% of doctors registered with the Medical Council were subject to a complaint; not all of these complaints, however, necessarily indicated a concern about a doctor and in 2012 approximately 1 in 10 complaints went forward for further inquiry.

Raising concerns about poor professional practice by a colleague is never easy in any profession. However, reporting poor practice is particularly important in the medical profession given the key role of doctors in patient care, and yet the report demonstrates that clear barriers exist which prevent doctors from raising concerns. The Medical Council already sets clear expectations for doctors regarding raising concerns for patients safety, including concerns about a colleague’s practice. The report points to some reasons why doctors may not put this guidance into action. Principal among these may be a belief that nothing will happen if a concern is raised. It is critical that the settings where doctors practise medicine have leadership cultures, systems and procedures which make this difficult step easier to take. It is important that doctors feel supported to raise an honest concern about professional practice at a local level without fear of reprimand and have confidence that this concern will be managed in a timely, appropriate and effective manner. The establishment of Clinical Director roles in the Irish health system and the establishment of clinical directorate structures are important enablers of a culture change.
2.2.6 Maintaining competence and assuring quality of medical practice

As discussed in Section 2.2.1, competence, including effective communication, is an essential building block of public trust in doctors.

While the education and training of doctors, and the regulation of doctors by the Medical Council, has traditionally focussed on preparedness to enter the practice of medicine, there is now an increasing emphasis on the importance of maintaining competence across doctors’ professional lives.33 Closely linked to the idea of maintaining competence is engagement in local, practice-based quality-assurance activities, such as peer-review. These activities are an important source of feedback and support for practice-based learning which help doctors to maintain their clinical knowledge and skill.34

Views of the public

As illustrated in Figure 24, approximately 9-in-10 people were confident that their usual doctor kept their knowledge and skills up to date. Although a high proportion of the public were confident that their usual doctor kept their knowledge and skills up to date, a lower proportion (68%) were confident that their usual doctor was being assessed to ensure that they were doing a good job.

However, as shown in Figure 25, 95% of the Irish public agreed that doctors should regularly review their practice to ensure the quality of care provided was of a high standard.

Furthermore, 95% of the Irish public agreed that it was important that all doctors were assessed from time to time to ensure they were practising medicine to a high standard (Figure 26); this is a view also held by a similarly high proportion of the UK public (Figure 27).

Regarding the periodic assessment of doctors, members of the public in Ireland and the UK shared similar views on the relative importance of different assessment methods (Figure 28).

*Figure 24: In relation to the doctor you attend most often how confident would you be that … (very confident and fairly confident combined, 2013)?
Figure 25: To what extent do you agree or disagree with the following statements about doctors in general? “Doctors should regularly review their practice to ensure the quality of care provided is of a high standard.”

Figure 26: To what extent do you agree or disagree with the following statement about doctors in general? “It is important that all doctors are assessed from time to time to ensure they are practising medicine to a high standard.”
**Figure 27:** Could you tell me how strongly you agree or disagree with the following statements? “It is important that all doctors' competence is checked every few years” UK 2005

<table>
<thead>
<tr>
<th>Agree strongly</th>
<th>Agree slightly</th>
<th>Neutral</th>
<th>Disagree slightly</th>
<th>Disagree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>59%</td>
<td>34%</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Ipsos MORI

**Figure 28:** Public attitudes to the relative importance of different methods for periodic assessment of doctors

<table>
<thead>
<tr>
<th>Assessment method</th>
<th>Ireland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence that the doctor is keeping up to date with medical developments</td>
<td>1st</td>
<td>1st</td>
</tr>
<tr>
<td>Receiving high ratings from their patients</td>
<td>2nd</td>
<td>2nd</td>
</tr>
<tr>
<td>Demonstrations of technical skill</td>
<td>2nd</td>
<td>5th</td>
</tr>
<tr>
<td>Monitoring the success rate of the doctor's treatments</td>
<td>4th</td>
<td>3rd</td>
</tr>
<tr>
<td>Passing a written test of medical knowledge from time to time</td>
<td>6th</td>
<td>6th</td>
</tr>
<tr>
<td>Re-checking of doctors' qualifications from time to time</td>
<td>5th</td>
<td>4th</td>
</tr>
<tr>
<td>Receiving high ratings from other doctors</td>
<td>7th</td>
<td>8th</td>
</tr>
<tr>
<td>Receiving high ratings from nurses</td>
<td>8th</td>
<td>7th</td>
</tr>
</tbody>
</table>

Source: UK data from Ipsos MORI
The views of doctors

Periodic recertification is a process to re-assess doctors’ qualifications and to ensure that they are maintaining competence; it may be linked with an assessment of the doctor. Only 1-in-4 Irish doctors completely agreed that doctors should participate in periodic recertification (Figure 29); the views of Irish doctors were similar to the views of UK doctors in this regard. Peer review is a process through which doctors can be assessed and receive feedback on their practice so as to support their maintenance of competence. Both Irish and UK doctors displayed poor support for formal periodic recertification processes, but while approximately 4-in-10 Irish doctors completely agreed that doctors should participate in peer review, approximately 7-in-10 UK doctors agreed with this process (Figure 29).

These differences in views between Irish and UK doctors are accompanied by some differences in reported practices (Figure 30). A high proportion of UK and Irish doctors reported practice change as a consequence of familiarising themselves with a clinical practice guideline. However, across all practices, compared with UK doctors, a lower proportion of Irish doctors reported engaging in different practices to support their maintenance of professional competence. The difference was greatest for the practice of peer review of medical records: 24% of Irish doctors reported engaging in that practice in the last 3 years compared with 55% of UK doctors.

Figure 29: To what extent do you agree or disagree that … (completely agree %)?
What this means

The public expect doctors to have the right knowledge and skills to provide safe and effective care.

Maintenance of competence can be pursued through engaging in learning activities on a self-directed basis. However, periodic assessment and feedback can help guide doctors in their efforts to keep their knowledge and skills up to date and can provide some additional assurance that competence is being maintained.34

While the public were generally confident that doctors were maintaining their knowledge and skills, they were less confident that doctors were subject to regular checks, albeit that this is a process which would be supported by the public. In general, the public wanted checks to ensure that doctors were keeping up to date; in fact, such checks are already in place through the work of the Medical Council in overseeing doctors’ maintenance of competence. The public also want to play a role in giving feedback to doctors. The Medical Council has piloted patient feedback processes in the Irish context and is closely monitoring the experience of similar processes in other health systems, where formal patient feedback is becoming more established.

Maintenance of professional competence is an evolving area in Ireland; there has been much development in recent years and it is likely that there will be further change. While there have been significant developments in doctors’ lifelong learning processes in Ireland in recent years, there is further work to be undertaken to develop a culture of ongoing checks and balances on medical practice, with feedback to doctors to inform and support their maintenance of competence. The attitudes and practices of Irish doctors regarding peer review lag behind their UK counterparts. Again, this is an area where the Medical Council’s Guide to Professional Conduct and Ethics sets expectations; however, as systems that support maintenance of competence mature, greater elaboration on our expectations may be required.22
SECTION 3

FOSTERING GOOD PROFESSIONAL PRACTICE IN 21ST CENTURY IRELAND
3. Fostering good professional practice in 21st century Ireland

What can we conclude from what we have heard from the public and the medical profession about their views on what it means to be a good doctor in today’s Ireland?

3.1 A strong foundation for the patient-doctor relationship

The views we heard across a range of issues consistently point to a strong foundation for the patient-doctor relationship in Ireland, which fits well with the expectations for good doctors as defined by the Medical Council.12

Public trust in doctors was strong. This trust does not appear to be blindly placed since it was complemented by generally satisfactory experiences with doctors. Furthermore, the public had positive views in relation to many of the building blocks of trust, such as effective communication, safeguarding confidentiality, respect for autonomy and shared decision-making. In addition, some aspects of the experience reported by the Irish public are consistent with emerging ideas about “new professionalism”, which take account of more contemporary perspectives on the patient-doctor relationship and on the relationship between citizens and society generally.

The views and experiences of the public are not accidental. This report provides evidence that the public benefits from a system of shared values and behaviours among doctors in Ireland, which provides a strong basis of trust; for example, Irish doctors placed a strong emphasis on discussing the risks and benefits of treatment with patients and on handling sensitive information appropriately.

3.2 Maintaining trust in a changing world

The evidence in this report of a strong foundation for the patient-doctor relationship, however, is not a manifesto for complacency. The public trust and satisfaction which is experienced by Irish doctors brings with it a responsibility to demonstrate and maintain trustworthiness and professionalism in their practice.

We live in a rapidly changing world where new and unexpected challenges can arise for patients and doctors. These changes affect the patient-doctor relationship. What is more, while many aspects of the building blocks of public trust in doctors are constant, our collective understanding of the essential elements of good professional practice must be continually re-evaluated if this trust is to be maintained. Gaps between what the public believe and expect, how expectations for good professional practice are defined by the Medical Council, and how these expectations are put into action by doctors in their day-to-day practice can challenge the patient-doctor relationship and the relationship between society and the medical profession generally.2

While this report identifies much that is positive, it also points to potential gaps in how our understanding of a good doctor is constructed and put into practice in Ireland.

Variations in professional standards

A small but important minority of the public did not trust doctors, reported dissatisfaction and had experiences of medical practice which gave them cause for concern. While acknowledging the generally positive views of the public described in this report, the viewpoint of people who did not share this view should not be overlooked. Similarly, almost 1-in-7 doctors reported direct personal knowledge of a doctor who was impaired or incompetent to practise medicine. Is this good enough?

Responding to new questions about what it means to be a good doctor

Through highlighting potential gaps between public expectations and professional values and behaviours, the results in this report raise new questions about what it means to be a good doctor.
Being honest and open is fundamental to public trust in doctors. Openly disclosing adverse events and communicating honestly with patients and their families is a challenging but critical competency for a good doctor. It is clear that the public expect this competency; however, it is also evident that the practice of open disclosure is a challenge for doctors. The report highlights room for development in this area.

Raising concerns about poor professional practice by a colleague is never easy. However, through taking action to deal appropriately with concerns, doctors could play a greater role in safeguarding patients. The report identifies some reasons why this may not be current practice. There is a need to address the public’s expectation that doctors will put patient safety first.

Approaches to maintaining competence and assuring the quality of medical practice need to be strengthened and become more consistent. The Irish public – like people in other health systems – base their trust in doctors on assumptions that competency to provide safe and effective medical care has been achieved, is being maintained and is regularly reviewed. While there have been significant developments in doctors’ lifelong learning in Ireland in recent years, there is further work to be undertaken to develop a culture of ongoing checks and balances on medical practice, routine review of the outcomes of medical care, and feedback and support to doctors to enable them to continually improve care.

**A continuing focus on good professional practice**

To meet the needs of a strong and effective patient-doctor relationship into the future, a continuing focus on fostering good professional practice among doctors is required.

The Medical Council has a lead role to play in ensuring that the expectations set for doctors are clear, up-to-date and reflective of the needs of the patient-doctor relationship.

Through our oversight of doctors’ education, training and lifelong learning, we must continue to ensure that professional values are at the heart of doctors’ professional development. We know that professionalism is now an important theme in the delivery of medical education and training in Ireland. This is welcome, and we must continue to work with education and training bodies to find new and better ways to support doctors to develop and maintain appropriate professional identities. Curricular strategies must continue to focus on setting clear expectations for students and training regarding professional values and behaviours and providing teaching and learning experiences, including systems of assessment and the progress decisions these inform, that emphasises the importance of good professional practice.

While the content of teaching and learning is important, we must also find ways to work with education and training bodies to address culture and context since these impact hugely on developing doctors’ emerging professional identity. For example, through demonstrating the importance of putting professional values in action, trainers and other doctors plays a vital role in shaping the professional identity of doctors in training; negative role-modelling powerfully undermines and counteracts formal learning about what it means to be a good doctor. Similarly, doctors in training need to experience professional values deeply embedded in the structures and cultures of the contexts where they learn the practice of medicine. If this so-called “hidden curriculum” is not aligned with what we expect from a good doctor, doctors in training become cynical about the perceived rhetoric of the formally taught ethics since the moral training of cultural norms is the most critical determinant of identity formation for any professional.

Education and training bodies must therefore also consider curricular strategies that take account of the importance of trainers and other doctors as role-models and that seek to address the “hidden curriculum” which powerfully shapes developing doctors’ values and future behaviours.

**Can we make good professional values and behaviours the easy choice for doctors?**

While it is important to maintain a focus on developing professional values, there is also a need to consider how easily doctors can translate values into day-to-day actions which meet the needs of a strong and effective
patient-doctor relationship. Putting the right professional values into action in the place where they practise should be the easy choice for doctors. We must ensure that the workplaces where doctors train and practise have leadership, cultures, systems and procedures which align with and support the values and behaviours we all expect from a good doctor.

Developments like the new National Policy on Open Disclosure and the support for this by the State Claims Agency are welcome, given that fear of litigation is identified by doctors as a barrier to being honest and open in the aftermath of an adverse event. Legislators can go further in building an environment which removes potential barriers to open disclosure; for example, countries like Sweden, Denmark, Finland and New Zealand have long histories of successfully operating administrative systems which deal with the aftermath of error on a no-fault basis and avoid medical malpractice litigation.

Collecting information to quality assure medical practice helps ensure patient safety and supports doctors’ lifelong learning. There are important initiatives underway in Ireland; for example, the National Office of Clinical Audit (NOCA) was established in 2012 as a result of collaboration between the HSE Quality and Patient Safety Directorate and the Royal College of Surgeons in Ireland to establish sustainable clinical audit programmes at national level which will ultimately improve outcomes for Irish patients. However, concerns regarding access to information can stifle these efforts. Protecting information produced through activities like peer review and clinical audit from misuse through special legislative provisions can help promote the quality assurance of medical practice. This was a recommendation from the report of the Commission on Patient Safety and Quality Assurance, and it is important that it is not overlooked in continuing work to develop a legislative framework for health information in Ireland.

The emergence of clinical directorate structures and systems of clinical governance to support patient safety and healthcare quality are also potentially important enablers of good professional practice. These structures must place a priority on positively supporting the ongoing assurance of medical practice at a local level as well as enabling doctors to confidently bring forward concerns about patient safety - in particular concerns about the performance of other doctors. While national-level regulation of doctors by the Medical Council is important, our systems should complement and never be expected to replace local systems to oversee the practice of medicine. Ensuring good practice among doctors is a responsibility which we share with other individuals and bodies involved in the practice of medicine in Ireland. Critically, it is a responsibility which must be shared with all practising doctors.

In summary, while our collective ambition for a strong and effective patient-doctor relationship must be embedded in the systems that educate and train future doctors, it must also be part of the fabric of the wider healthcare system where patients and doctors work together on a day-to-day basis.

### 3.3 Future directions for medical professionalism in Ireland

What does this report mean for the future of medical professionalism in Ireland? How can we all ensure that every patient’s entitlement to care from a good doctor becomes a reality?

The research described in this report has informed our strategic direction and priorities and will support our ongoing work to foster good professional practice in Ireland. It also identifies directions that we will take in collaboration with other individuals and bodies involved in shaping the patient-doctor relationship.
For the Medical Council

We have reflected on what we have heard from the public and doctors. It has significantly informed the priorities and directions we have set out for ourselves in our Statement of Strategy 2014-18.

**Defining and communicating what it means to be a good doctor**

We will continue to provide leadership through defining and communicating what it means to be a good doctor. This will involve ongoing dialogue with the public, with doctors and with all relevant stakeholders. In this way, we can identify changes in the needs of the patient-doctor relationship and respond appropriately through how we define the expectations for good professional practice among doctors in Ireland. We will ensure that our guidance is clear, and we will also explain how the guidance should be put into action so that professional values are translated into professional behaviours that support a strong and effective doctor-patient relationship.

**Learning environments that foster good professional practice**

We will continue to quality assure the education, training and continuing professional development of doctors in Ireland. In particular, our work will focus on how, through formal learning, professional values and behaviours are developed and maintained at all stages of a doctor's career. While a focus on formal programmes of medical education and training delivered by universities and postgraduate bodies will remain important, we cannot overlook the role of the workplace as a learning environment and the socialisation of trainee doctors into the culture of medical practice since these are key in shaping future doctors' identities as professionals. If doctors in training are to develop good professional practice they must experience workplace environments and role models that are consistent with and support expected professional values and behaviours. We will ensure that the workplace environments in which doctors learn have leadership, cultures, systems and processes that are aligned with our expectations about what it means to be a good doctor. For example, at clinical sites where doctors learn the practice of medicine, we will ensure that clinical leadership and systems of clinical governance are in place to prioritise patient safety and support processes for quality assuring medical practice at a local level, such as the measurement and benchmarking of clinical outcomes.

**A better understanding of how good professional practice is developed and maintained**

We will gain, through research, a better understanding of how good professional practice is developed and maintained by doctors. In particular, we will seek to understand how professional values, aligned with our expectations on what it means to be a good doctor, are developed and maintained by doctors. Critically, we will focus on understanding potential barriers to the translation of these values into professional behaviours that demonstrate and maintain trustworthiness. We will collaborate with other bodies in trying to build this better understanding and will develop capacity to address these important questions.

**Working with other bodies and individuals who shape good professional practice**

Shaping professional practice requires a joined-up and coordinated approach across the health system. The workplace environment and the wider health system in which doctors practise medicine must also foster professional values and make it easy for doctors to put these values into action. For this reason we must continue to work with all bodies and individuals who influence medical professionalism in Ireland – policy makers, healthcare organisations, patient representative groups, and other regulators, for example, so as to ensure that the health system in Ireland is focussed on the needs of individual patients.
For education and training bodies

*Fostering professionalism through focus on role models and the “hidden curriculum”*

Bodies involved in the education and training of doctors play a central role in the development of doctors’ professional values and behaviours. They should have clear codes, charters, policies and procedures to set expectations for students and trainees regarding professionalism. Formal programmes for teaching and learning, including systems of assessment and the progress decisions these inform, must provide experiences and evaluate outcomes in a way that emphasises the importance of good professional practice. While the content of teaching and learning is important, culture and context impact hugely on developing doctors’ emerging professional identity. Education and training bodies must also consider curricular strategies that take account of the importance of trainers – and other doctors – as role-models and that seek to address the “hidden curriculum” of deep-seated structures and cultures which powerfully shape developing doctors’ values and future behaviours.

For employers and healthcare organisations

*Creating workplace settings that support good professional practice*

Employers and healthcare organisations govern the settings where doctors train and work. While the Medical Council and education and training bodies must take a lead in fostering the development of doctors with appropriate professional values, employers and healthcare organisations must take responsibility for ensuring that the governance of workplace settings builds a culture that supports good professional practice among doctors. Employers and healthcare organisations must also ensure robust and effective systems and processes of care which are consistent with what we all expect from good doctors and make it easy to put good professional values into action. In particular, strengthening and ensuring consistency of systems to handle concerns about patient safety and to assure the quality of medical practice must be a focus for employers and healthcare organisations.

For policy-makers and legislators

*Building a health system for a strong and patient-doctor relationship*

The design and ongoing reform of the wider health system environment must take account of the need to positively shape good professional practice among doctors for the benefit of patients. Healthcare policy and legislation should take account of our collective ambition for a strong and effective patient-doctor relationship. Our health system must be a place where good professional values and behaviours are the easy choice for doctors.
Technical Annex

This report is based on research undertaken by the Medical Council with members of the public and doctors during the period from 2011 to 2013. Cross-sectional surveys were used with both the public and the medical profession.

Listening to the views of the public

The Medical Council listened to the view of the public through a series of cross-sectional surveys conducted in 2011-2013.

The surveys were conducted in 2011 by Millward Brown and in 2012 and 2013 by Behaviour and Attitudes. All surveys involved a nationally representative quota sample of approximately 1,000 adults (aged 16 years and over). Quota controls were based on the most recent Census statistics of the national population and respondents were selected across a large range of sampling points in different regions so as to ensure representativeness based on gender, age and social class in each region. The survey was completed through face-to-face interviews by trained and experienced interviewers in respondents’ homes and included questions commissioned by a range of clients, with responses confidential to each. Survey interviewing took place in February-March 2011, September-October 2012, and September-October 2013. Table 1 provides an overview of the characteristics of survey participants. The content of the questions used to hear the public’s views was informed by a series of focus groups conducted by Millward Brown in 2011 and a review of literature about the public’s views of doctors.

Table 1: Characteristics of survey participants 2011-2013

<table>
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<th>2013</th>
<th>2012</th>
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<tr>
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<tr>
<td>Connaught/Ulster</td>
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</table>
Talking about good professional practice

The Medical Council also listened to the views of the medical profession through a cross-sectional survey in 2013.

On the 17th June 2013, the Medical Council conducted a survey of all registered doctors. A simple random sample of 2,500 doctors was drawn from all registered doctors (n=17,403) with an email address (89%). An online questionnaire was administered, which contained questions developed by Roland et al. and shared with permission. The questions were reviewed by the Medical Council to ensure they were applicable to the Irish context. The survey was open for a two-week, and one reminder was provided. In total, 696 responses were received (28% response rate). Table 2 describes the characteristics of respondents and compares these to the characteristics of doctors who retained registration in 2012 so as to illustrate representativeness.

Table 2: Characteristics of respondents to doctors’ survey 2013

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Survey responses</th>
<th>Annual retention 2012</th>
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<tbody>
<tr>
<td>Male</td>
<td>61.5%</td>
<td>60.3%</td>
</tr>
<tr>
<td>Female</td>
<td>38.5%</td>
<td>39.7%</td>
</tr>
<tr>
<td>Mean age (standard deviation)</td>
<td>44.5 years (11.5 years)</td>
<td>45.1 years (12.7 years)</td>
</tr>
<tr>
<td>Irish graduates</td>
<td>65.8%</td>
<td>65.1%</td>
</tr>
<tr>
<td>Working full-time</td>
<td>80.9%</td>
<td>83.1%</td>
</tr>
<tr>
<td>Practising in Ireland only</td>
<td>80.6%</td>
<td>74.7%</td>
</tr>
<tr>
<td>Specialist Division</td>
<td>49.1%</td>
<td>44.3%</td>
</tr>
<tr>
<td>General Division</td>
<td>36.1%</td>
<td>42.0%</td>
</tr>
<tr>
<td>Trainee Specialist Division</td>
<td>13.8%</td>
<td>12.2%</td>
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<tr>
<td>Working in general practice</td>
<td>26.1%</td>
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</table>

Understanding study findings and limitations

While reasonable efforts were made to ensure that the samples selected for the study were representative of the public and of doctors in Ireland, some caution is always required in generalising from samples. The response rate for the doctors’ survey in 2013 was 28%, and while Table 2 shows that the respondents were broadly similar to the general population of doctors in respect of a number of key characteristics, the views of respondents may be different to those of non-respondents in subtle but important ways.

The views of the public and doctors were elicited through questions where respondents were asked to select from pre-assigned responses (e.g. strongly agree, agree, neutral, disagree, strongly disagree). Given the complex nature of the ideas explored in the survey, this way of eliciting views has some limitations, since respondents may interpret the questions differently or may not find that the pre-assigned responses fit well with their view.

To provide context for the findings in relation to the views of members of the public and members of the profession in Ireland, some comparisons are made with international research findings. In some cases these comparisons are based on identical questions (e.g. doctors’ survey 2013 and the results of Roland et al.); however, in some cases the comparisons are based on questions which examine similar concepts but are phrased differently. In addition, the composition of samples may be different in relation to factors which
might reasonably affect responses (for example, 81.4% of the UK respondents in the study by Roland et al. were graduates of UK medical schools, while only 65% of respondents to the doctors’ survey in 2013 were graduates of Irish medical schools). Nevertheless, comparisons are presented to provide some useful international context to the reported findings.
REFERENCES


Talking about good professional practice