Chapter 1

Introduction

Experts and expertise

Dinesh Bhugra and Amit Malik

Experts in any field develop their expertise using both their training and experience. One of the key essentials of professionalism is embedded in the nature of the expertise of the profession. Underlying these attributes is the personality of the individual. Not every individual is good at everything, but all individuals have some skills which can lead to them becoming experts. The relationship between professionalism and expertise needs to be revisited, as not all professionals are experts and not all experts are necessarily professionals. The so-called oldest profession in the world is not necessarily related to level of expertise. Other professions, such as medicine, education and law, have different levels of expertise, depending upon a number of factors. The key to understanding professionalism is on two levels: first, what constitutes professionalism, and second, what gaps might highlight what a professional lacks, thus looking at expertise and professionalism both positively and negatively.

Experts are said to reach a level of skills where they can think clearly and rapidly and come to a quick and correct decision. Training to become an expert requires the acquisition of a number of skills. Skills are also linked with aptitude and attitude. Although skills can be learnt, aptitude and attitude may well be innate. The question often asked is whether experts, like good leaders, are born or made. The truth, as ever, is somewhere in the middle, indicating that skills can be learnt and practised, and that one can become proficient in them, but others are innate. The attitudes and components of professionalism are fluid and dynamic and change depending upon the circumstances and needs of society. Professionalism is defined as a socially sanctioned activity whose primary object is the wellbeing of others above the professional's personal gain (Racey 1990). Medicine, law and the ministry are the earliest examples of professionalism. Racey (1990) defines the virtues of a profession as moral links, fidelity to trust, benevolence, intellectual honesty, courage, compassion and truthfulness. The central virtue is said to be practical wisdom which unites moral and intellectual virtues. A considerable amount of learning is by practice, and best practice sometimes is to follow good role models. Embedded within this learning process are the components of skills and knowledge, which lead to personal and professional development. Expertise therefore takes on a new meaning. In craft specialties within medicine, repeated procedures allow individuals to gather experience and expertise. In art specialties such as psychiatry, clinical experience allows for professional development to occur in a different but distinct manner. Within the context of both professionalism and expertise, raising awareness of ethics and values through this learning experience is helpful in understanding subtle issues in an ever-changing complex world.

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Professionalism is a large body of behaviour and beliefs which guide morally grounded physicians in their interactions with patients, their carers and families, other professionals and society at large (Page 2006). It is obvious that personal values such as greed, misrepresentation, abuse of power, breaches of confidentiality and exploitation of the vulnerable patient are totally unacceptable, and there is no justification for any of these behaviours. Physicians are also in danger of forfeiting a sizable portion of their status by ignoring patients' stories of their illnesses (Latham 2002).

Influential values in professionalism include professional autonomy and regulatory autonomy, patient autonomy, consumer sovereignty, patient advocacy, access to care and assurance of quality care (Preister 1992). These essential values are fundamental to the delivery of patient care, where the patient is at the pinnacle of the therapeutic interaction with high quality and efficiency. Instrumental values for the physician include personal responsibility, social solidarity, social advocacy, provider autonomy, consumer sovereignty and personal security. Preister (1992) goes on to define a new generation of essential values including access to care, efficiency and respect for patients. Specifically within mental healthcare, of these, access to care has to be both geographical and emotional access to services. Emotional access in psychiatry means that the services are not seen as stigmatizing and controlling.

As professionals, psychiatrists are experts not only in treating mental illness, but also in managing mental health problems associated with physical conditions and dealing with public mental health. This expertise is related to their roles as clinicians, researchers, teachers, managers and team players, in addition to their professional role as an advocate for their patients and their carers. One of the key skills embedded within this professional role is that of a good communicator. In the core therapeutic relationship, the professional must focus on the patient and the impact the patient's psychopathology is having on their social and personal functioning, exploring both the disease and the illness process with the patient (for a distinction between the two, see Eisenberg 1977). In any therapeutic encounter, an expert will explore the various dimensions that the illness causes for the patient, such as explanation, consequence, fears. The clinician must make every attempt to understand the whole person within the context of their society and culture. This is where the impact of social factors on illness must be explored thoroughly. In understanding the experiences, explanations and expressions of illness from the patient, the expert can engage with the patient, find common ground to explore, agree on goals of treatment and management plans and then keep these under review in regular discussions with the patient. The expert has to deal with the ambiguity of mental illness and also contain the anxiety not only of the patients and their carers but also of the team. These skills do not often come easily, but they can be learnt. Through a sense of vocation, compassion and awareness of the self and others, the expert can manage both simple and complex problems. *Good Psychiatric Practice* (RCPsych 2009) lists the attributes of a good psychiatrist, including providing good clinical care, a trusting relationship, confidentiality, teamwork, teaching and training and clinical governance, among other skills. Critical self-awareness and awareness of issues related to gender, ethnicity and culture, and the legal aspects of psychiatry, are also part of being a good clinician and a good psychiatrist. Therapeutic relationships with patients will produce transference and countertransference, of which the psychiatrist needs to be aware and also work through in order to foster the clinical relationship.

Professionalism allows an individual not only to meet the standards set by others, but also to set standards for themselves. Under these circumstances, self-regulation takes on a

different meaning in that, rather than the profession regulating itself, the individual takes on the responsibility of ensuring that they keep up-to-date and are fully aware of the nuances of clinical practice. This is not always easy. McNair (2005) points out that barriers in developing and maintaining professionalism include arrogance, abuse of power, lack of conscientiousness, conflicts of interest and uni-professionalism (pursuit of a goal for a single discipline to the exclusion of others). The development of professionalism must incorporate core areas of the framework of teaching – values, ethics, knowledge, skills for the process of learning and application (see Diaz 2006). Elcin *et al.* (2006) taught a course on professional identity to medical students and were able to show positive changes in all seven domains: the 'meaning' of being a doctor, expectations of professional identity, patient expectations of their doctors, professional limits of medical students, reactions of patients towards illness and death, reactions of physicians and situations faced in relation to patients. The study shows that attitudes and professional attributes can be changed.

In addition to other professional attributes of experts, knowledge of law, amongst other domains, needs to be looked at as a component of expert decision-making. Climo (1984) notes that in public mental hospitals, doctors must take into account what ordinary, well-meaning and responsible citizens might consider the right thing to do, above the guiding principles of either medicine or law. Under these circumstances, Climo (1984) suggests that the physician must ask two questions: first, what issues need to be resolved, a matter on which the staff should be able to advise; and second, what judgement is defensible if public accountability is demanded. Psychiatric decisions are often scrutinized by the legal system, especially in the context of risk assessment and management. Burstajn *et al.* (1984) point out that decision-making under these circumstances must look at the magnitude of the risk and the values or importance of that which is exposed to risk. A physician's acts must be measured against what other physicians would have done in similar circumstances. Burstajn *et al.* (1984) observe that these acts can founder on the inconsistency of medical knowledge, among other factors. In any analysis, personality and emotional, cognitive and philosophical factors must be taken into account. In collating a theory of clinical expertise, Kassirer *et al.* (1982) describe decision-making using protocols and protocol analysis. They note that physicians must learn thousands of configurations of findings in order to perform as experts. Citing the example of professional chess players who need over 50 000 configurations, these authors argue that talking about the problem changes the decision-making process. Therefore, turning a professional into an expert may require focusing on a different range of competencies. As stated before, not all experts are necessarily professionals, and neither are all professionals experts. The relationship between the two depends upon training and experience. Balint training in groups has been shown to be effective in developing insight into self by the trainees (Adams *et al.* 2006). Developing the students' professional self through the internalization of the values and virtues of medicine as a calling (vocation) and discipline requires a number of value orientations (Hafferty 2006). Personal reflection and self-awareness play an important part in becoming a professional and an expert.

Areas of expertise in psychiatry include culture; the ability to understand, co-ordinate and work co-operatively to provide comprehensive mental healthcare; the ability to understand ethical practice; and effective communication and education (Talbott and Mallott 2006). The concordance between professionalism and expertise needs to be emphasized further. Humanism in professionalism and in being an expert includes caring (defined as being concerned or interested in providing needed assistance or watchful supervision) and compassion (deep awareness of the suffering of another coupled with the will to relieve it) (Stern 2004).

Expertise also raises certain expectations from patients, their carers, families and society at large. Such expertise relies on experience gained by managing cases and working with patients. Expertise can be lost through external factors such as changing circumstances or context of clinical practice. It can also be lost as a result of internal or personal factors, e.g. addiction or illness. Gaining expertise is the first step, but retaining it is a major challenge.

The psychiatrist will need to be both an expert and a professional. Skills, knowledge, experience and the world view will all contribute towards this. Such attributes can be gained using different strategies, and the individual's development requires investment and resources.

O'Connor (2005) indicates that clinical practice guidelines articulate clear goals of care and enumerate potentially beneficial therapeutic approaches, which may reduce variations in care. O'Connor (2005) suggests that clinical practice guidelines are variably flawed in terms of conflict of interest, endorsement of newer interventions (which may be unproven) and a focus on a single condition. However, clinical practice guidelines are often difficult to employ in managing co-morbid conditions. Inevitably, all 'evidence-based' recommendations are not of equal clinical benefit to a patient. There need to be additional safeguards, such as looking at gender, age, costs, patient expectations and other factors, as noted by O'Connor (2005). Tinetti *et al.* (2004) point out other pitfalls associated with disease-specific guidelines for patients with multiple conditions. They suggest that medicine-related evidence which underlies the treatment guidelines only addresses the short-term disease-specific benefits of individual medications. They argue that the benefit/harm ratio, patient preferences and types of benefits from various combinations also need to be borne in mind. An awareness of the guidelines, their utility implications and their pitfalls all form part of the expert's portfolio. Ericsson (2004) states that individuals need experience to become professionals but extensive experience does not necessarily make people experts, and also notes that the limits of attainment of expertise are determined by one's basic endowments, such as one's innate and functional abilities, and mental capacities. Deliberate practice is at the heart of both expertise and professionalism. Whereas initial expertise is related to engagement in deliberate practice, continued deliberate practice is essential for maintaining professional performance (Ericsson 2004). It takes up to 10 years of professional development to become an expert. Ericsson (2004) stresses that the principal difference between the acquisition of everyday skills and professional development is related to differences in timescale. Motivation plays an important role, and the sense of purpose and vocation could be linked with motivation.

Expert performers have to be trained to such a level that they can reproduce their superior performance under representative conditions in everyday life whenever it is required during competition and training (Ericsson 2004). According to Ericsson (2004), acquisition of expertise occurs across different domains and at different paces, and deliberate practice is designed to improve specific aspects of performance in such a way that all the changes can be integrated into representative performance. Expert performance in medicine relies on long periods of training and a long time for knowledge and continued professional development. Steps in learning depend upon establishing tasks which define the domains and then learning and practising such tasks to build on existing skills. Ericsson *et al.* (1993) define deliberate practice as highly structured activity aiming to improve performance, to overcome weakness and carefully monitor performance. Of course, deliberate practice requires time, energy and motivation. Introduction to an activity ends with the start of the instruction and deliberate

practice followed by extended periods of preparation and full-time commitment. Bloom (1985) goes on to emphasize that external support is required in all these stages and, as an expert, they go beyond the knowledge of teachers to make major innovative contributions to their domain. Constraints which may influence the development of expertise include poor resources and lack of interest and effort, all of which may occur singly or in combination. As Ericsson *et al.* (1993) note, expert performance is qualitatively different from normal performance, though there may be some commonalities and some differences in level and style. The relationship between training, expertise and professionalism needs to be explored further.

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Chapter 2

Globalization

Norman Sartorius

Editors' introduction

In an increasingly shrinking world, the contacts between cultures and communities are becoming closer. The economic and social impact of the process of globalization can be understood at several levels – that of the individual, the family, culture, society, etc. – and the different systems get influenced at different speeds. For example, the economic system changes and responds to the needs of globalization at a faster pace in comparison with the political systems. With globalization, two additional factors – urbanization and industrialization – may come into play, contributing to additional social stresses. Rapid transition from agrarian societies with perhaps more traditional attitudes and values to industrialized societies competing in the international market-place will change attitudes, beliefs and behaviours. Changes in economic patterns may further add to increasing social disparity and poverty, perhaps in the short run. The impact of two cultures coming into contact with each other will affect the way each one looks at professionalism. Professional standards in one country are therefore likely to affect how services are delivered and social expectations evolve within others. Globalization also encourages trained professionals from low- and middle-income countries to rich countries.

Sartorius observes that the introduction of a free market economy into healthcare systems had led to the destruction of previously well-established primary care systems. It is likely that public mental health will be seen to be less important in largely private healthcare systems. Changes in the middle class, with expansions in numbers and altered expectations, will influence changes at multiple levels. Commoditification of healthcare provides a further sense of alienation among the poor. Globalization also reduces social capital, which has previously promoted interdependence, survival and mutual trust. Migration, changing relations between countries and socio-demographic changes will influence training and standards of expertise. Changes in value systems are likely to occur. Clinicians and trainers need to be aware of the impact (both overt and covert) of globalization.

Introduction

Globalization was experienced as a possible beautiful dream in the early 1960s. After the horrors of the Second World War and the momentous developments – such as decolonization – that followed it, nothing seemed more attractive than living in a world with open borders and with a free circulation of ideas, wares, people, objects of art and culture. The osmosis

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of ideologies that would lessen the strengths of reasons for conflicts in the future appeared possible.

As time went on, however, the dark side of globalization gained the upper hand. The borders were open within groups of countries, not across the world. The ideologies and value systems of the economically most powerful were imposed on those less fortunate. The free circulation of ideas was replaced by a mono-directional flow of soap operas and news about events in a small number of countries. The productivity of agriculture and industry continued to grow in the First World, suppressing the economic and industrial development in the developing countries.

This chapter will examine some of the components of globalization which, in recent years, became somewhat more useful to all, possibly because of the realization that a variety of the world's problems can only be resolved jointly, by all countries facing the world's challenges together.

Decivilization

Civilization can be measured by the amount of attention that a society pays to its feeble members – children, the elderly, the disabled and others who need support in order to live a life of acceptable quality or to survive (Sartorius 2009a). An indicator of the state of civilization might be a comparison of the gross national product and child mortality or the purchasing power of the retirement pension of the elderly in comparison with the purchasing power of those employed. Accessibility and quality of healthcare to the majority of the population could also be used to assess how civilized a society has become.

Recent years have unfortunately shown that some of the countries that had previously succeeded in reducing child mortality – such as most of the countries of Eastern Europe and of the Community of Independent States assembling previous parts of the USSR – are no longer maintaining their respectably low level reached in the years before and after the Second World War. In other countries that are achieving prodigious economic growth, the level of support for public health measures and in particular the support for those disabled – not infrequently by consequences of unprotected labour – are remaining low or non-existent. The introduction of market economy in a country such as Mongolia (which had previously established a well-functioning primary healthcare system) led to the development of private healthcare facilities and a significant weakening of the peripheral health services. In other countries, rapid industrial development led to an increase in environmental pollution, with consequent health problems and none or almost no improvement of coverage by healthcare of the non-employed part of the population. What is worse is that much of the environmental deterioration happens in countries which have a poorly developed health service. Indeed, of the seven most polluted sites in the world, five are in developing countries (Mexico City, Mexico: air pollution; Niger Delta, Nigeria: crude oil pollution; Dhaka, Bangladesh: waste water pollution; Linfen, China: coal mining and air pollution; Mumbai, India: air, water and waste pollution), and two are in Eastern Europe (Norilsk, Russia: heavy metal and air pollution; Chernobyl, Ukraine: radioactive pollution).[1]

[1] Source: www.groundreport.com, Blacksmith Institute, Green Cross International, cited in China Post, 8 November 2009.

The changes of the middle class

The changes of the middle class have had a profound impact on healthcare and on the social fabric of societies. The size of the middle class in developing countries has grown and led to a variety of consequences. Although the middle-class proportion of the population in developing countries is still small, the total numbers of middle-class citizens became very large. Thus, India has more middle-class citizens than the United States, and in Africa there are by the latest counts some 80 000 millionaires (Sartorius 2009b). Moreover, in many Third World countries, 10 to 15% of the population have incomes that are comparable to those in the Western European countries. This, of course, does not mean that the numbers of poor people became smaller; they have also grown, although in terms of percentage they have somewhat diminished.

A large number of people with a middle-class status and income meant that the countries in which they live became interesting markets for both home and foreign industry. This is also true for the health industry, and in many developing countries private healthcare (and private mental healthcare) has grown in size and in quality. Middle-class citizens are no longer interested in or relying on primary healthcare services that the governments in most of the Third World countries tried to build up. Primary healthcare remained important for the poorer portion of the population, which grows disenchanted with it, not least also because they can see that their more fortunate brothers are benefiting from much better care in the same country.

The situation is worsened even further by the fact that the 'brain drain' that was previously due mainly to emigration to other, richer countries has now become stronger for two reasons: first, because some of the highly developed countries such as the UK actively encouraged 'brain drain' by offering attractive conditions of work to immigrant experts; and second, because the private healthcare system siphoned out many of the best young graduates, who flocked to private institutions rather than accepting to serve with a lower salary and worse working conditions in government services.

The middle class did not change only in the developing world. In many industrialized countries the middle class has diminished in size and influence. The middle class was at all times the protector of the morale it created: as it became weaker, so did adherence to moral rules and values, leading to uncertainty and dissatisfaction among the population and to the worsening of indicators of social malaise and disruption such as the increase in violence (e.g. in schools), suicide and criminality.

Commoditification

Commoditification is a new word indicating the gradual conversion of all interactions and activity into economic terms. Thus, healthcare is handled as a commodity in a similar way to sugar, cotton or other commodities. The consequent emphasis on reducing the cost of healthcare in order to make it cost-effective has unfortunately often been accompanied by a worsening of the quality of healthcare. The savings on health calculated year by year sound good to the decision-makers, who often do not see or do not want to remember the fact that at a later date these savings will result in dangerous consequences. The part of the healthcare budget that was to be used for preventive activities has been diminished in most countries. Those who are not likely to fully recover from their ailments are less likely to receive good care. Return to employment of those who have received

treatment is often the main criterion of effectiveness, such that the treatment of diseases likely to result in some form of long-lasting impairment (e.g. severe mental illness) receives very little attention. Government regulations (or regulations of insurance companies and HMOs), for example, have replaced the physician's choice of medications, which are often selected on the basis of their low cost rather than on the basis of a judicious consideration of all of their characteristics, including their side effects and the patients' experience.

Commoditification of the health system contributes to the dissatisfaction of the population with their healthcare and to a renewed growth of alternative medicine, which is experienced as being less dehumanized than the exclusively economically minded health system that is supposedly based on scientific evidence. The magic wand of traditional and alternative medicine had been torn in the late decades of the twentieth century, but it has been gaining new strength in recent years, often to the detriment of the health of those who sought healthcare outside of the health system, which they experienced as disagreeable and excessively commercialized.

Reduction of the social capital

The capital of a society is composed of three elements: the economic capital, including all material goods that a society possesses; the human capital, referring to the productivity of a society; and the social capital, equal to the sum of actions that citizens do to help each other (Sartorius 2003). One of the chief measures of social capital is the trust that members of society have in each other, and one of the main characteristics of societies with high levels of social capital is the interdependence of its members. Social capital is often the main protector of survival in societies with little economic capital and with poor productivity.[2] The increase in the economic capital of a society – through input of material resources (e.g. donations from other countries or of the discovery of natural resources) or through a growth of human capital – usually decreases the social capital. The material wealth makes members of society replace support that they owe to others by money. In the beginning this practice hides the disappearance of social capital; soon, however, the purchase of social support (e.g. domestic help) becomes too expensive, and a number of tasks that are necessary for the survival of well-functioning societies remain undone. The increase in the cost of healthcare seen and lamented in most developed countries is to a large extent due to the fact that family members are no longer able or willing to care for their mentally or physically impaired members. In the developing countries the notion that families are strong and will remain strong is still an article of faith for most decision-makers; the trend of decreasing family size and the failure of healthcare models relying on continuing strong support of extended families, which can be seen in some of the countries that have succeeded in speeding up their economic growth, are unfortunately not influencing this notion.

Social capital is decreasing in most societies, particularly in those that have experienced the fastest economic growth and achieved some prosperity. The consequences of this change for healthcare and for other pursuits that, to a large extent, depend on high levels of social capital (e.g. survival of the elderly with functional impairments) are vast and unpleasant.

[2] The economic miracle of Japan's recovery and growth after the Second World War was in part due to the emphasis on *amae*, interdependence highly regarded by traditional Japanese culture.