Letters

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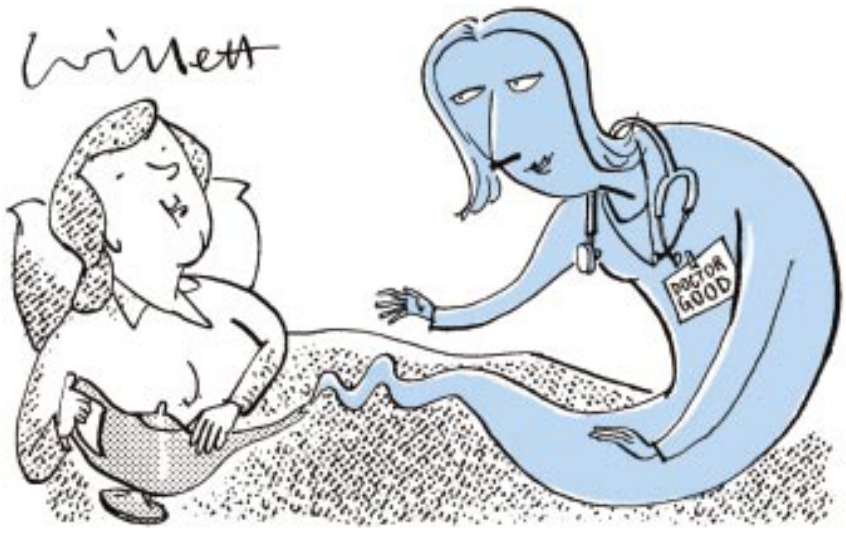
What's a good doctor and how do you make one?



Doctors should be good companions for people

EDITOR—Imagine waking tomorrow to find a magic lamp by your bed, and the genie tells you that there is only one wish left. You decide to devote it to making good doctors. What kind of people would these good doctors be?

We ask this question often among ourselves—a doctor embarking on his career, an active researcher approaching his peak, and a retired clinician needing geriatric care. We sometimes ask other people too. Despite the disparate vantage points, the wish lists are amazingly similar. We all want doctors who will:

- Respect people, healthy or ill, regardless of who they are
- Support patients and their loved ones when and where they are needed
- Promote health as well as treat disease
- Embrace the power of information and communication technologies to support people with the best available information, while respecting their individual values and preferences
- Always ask courteous questions, let people talk, and listen to them carefully
- Give unbiased advice, let people participate actively in all decisions related to their health and health care, assess each situation carefully, and help whatever the situation
- Use evidence as a tool, not as a determinant of practice; humbly accept death as an important part of life; and help people make the best possible arrangements when death is close
- Work cooperatively with other members of the healthcare team
- Be proactive advocates for their patients, mentors for other health professionals, and ready to learn from others, regardless of their age, role, or status

Finally, we want doctors to have a balanced life and to care for themselves and their families as well as for others. In sum, we want doctors to be happy and healthy, caring and competent, and good travel companions for people through the journey we call life.

Unfortunately, we do not have a magic lamp, and there is no genie. We must use our own skills and endeavours to make the good doctors we want and need. It is an awesome responsibility.

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ABC of being a good doctor

EDITOR—I offer some quotations on being a good doctor.

"To be a doctor, then, means much more than to dispense pills or to patch up or repair torn flesh and shattered minds. To be a doctor is to be an intermediary between man and GOD" (Felix Marti-Ibanez in *To Be a Doctor*).

"One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient" (Frances W Peabody in *The Care of the Patient*).

"Being a good doctor means being incredibly compulsive. It has nothing to do with flights of intuition or brilliant diagnoses or even saving lives. It's dealing with a lot of people with chronic diseases that you really can't change or improve. You can help patients. You can make a difference in their lives, but you do that mostly by drudgery—day after day, paying attention to details, seeing patient after patient and complaint after complaint, and being responsive on the phone when you don't feel like being responsive" (John Pekkanen in *MD—Doctors Talk About Themselves*).

"You can't know it all. And even if you knew everything that anyone else knows (which you can't, so stop worrying about it), you still wouldn't know what you need to know to help many patients" (Perri Klass in *A Not Entirely Benign Procedure*).

Some of the qualities that a good doctor should possess are measurable, others are not. A good doctor should be:

A: attentive (to patient's needs), analytical (of self), authoritative, accommodating, adviser, approachable, assuring

B: balanced, believer, bold (yet soft), brave

C: caring, concerned, competent, compassionate, confident, creative, communicative, calm, comforter, conscientious, compliant, cooperative, cultivated

D: detective (a good doctor is like a good detective), a good discussion partner, decisive, delicate (don't play "God")

Advice to authors

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Responses should be under 400 words. They should include up to five references in the Vancouver style, including one to the BMJ article to which they relate. We welcome illustrations.

Please supply each author's current appointment and full address. We ask authors to declare any competing interest and to provide the signed informed consent to publication of any patient whose case they describe.

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E: ethical, empathy, effective, efficient, enduring, energetic, enthusiastic

F: friendly, faithful to his or her patients, flexible

G: a "good person," gracious

H: a "human being," honest, humorous, humanistic, humble, hopeful

I: intellectual, investigative, impartial, informative

J: wise in judgment, jovial, just

K: knowledgeable, kind

L: learner, good listener, loyal

M: mature, modest

N: noble, nurturing

O: open minded, open hearted, optimistic, objective, observant

P: professional, passionate, patient, positive, persuasive, philosopher

Q: qualified, questions self (thoughts, beliefs, decisions, and actions)

R: realistic, respectful (of autonomy), responsible, reliever (of pain and anxiety), reassuring

S: sensitive, selfless, scholarly, skilful, speaker, sympathetic

T: trustworthy, a great thinker (especially lateral thinking), teacher, thorough, thoughtful

U: understanding, unequivocal, up to date (with literature)

V: vigilant, veracious

W: warm, wise, watchful, willingness to listen, learn, and experiment

Y: yearning, yielding

Z: zestful.

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Good doctors abound

EDITOR—It is fairly easy to define in a few words what makes a good lawyer, a good architect, or a good writer, by saying that it is one who wins difficult trials, who builds the best constructions, or who writes moving novels—no more qualities would be absolutely necessary. In contrast, to define what makes a good doctor is a rather difficult task.

A good doctor is not one who cures the most because in many specialties recovery is not a frequent outcome. It is not one who makes the best diagnosis because in many cases of self limited or incurable disorders the precise and timely diagnosis does not make a great difference for the patient. It is not one who knows more scientific facts because in medical science ignorance is still rampant in several diseases. It is not one who is gentle, compassionate, and honest with the patient because these qualities are often insufficient for an effective medical course of action. It is not one who discovers a new fact or treatment because nowadays new information is only a small fraction of knowledge to be inserted in the enormous puzzle of biomedical research.

Other professionals can be judged by their end results, but a doctor can be defined as good only when he or she has as many as possible of the above attributes. A good doctor is simultaneously learned, honest, kind, humble, enthusiastic, optimistic, and efficient. He or she inspires total confidence in patients and daily renews the magical relationship that by itself constitutes good treatment for any kind of ailment and the best starting point for confronting all causes of pain and suffering. Although so many virtues are difficult to find in a single human being, the medical profession is fertile ground for finding such combinations. Fortunately, in our profession good doctors abound.

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Some magic is required

EDITOR—As I think about the past when doctors were soothsayers, astrologers, historians, philosophers, artists, and so on, my feeling is that to be a doctor requires a lot of science but also a little bit of "magic."

Where does this magic come from? Well, it is a result of being a complete, integrated person trying to help other people by being understanding and caring but also knowledgeable, prepared, and ready to give your best—not to save lives but to make them as good as possible.

But why do I consider it a gift, or compare it with magic? There is not a single piece of evidence or the means to measure whether a doctor is good or bad. Patients need knowledge, but that is not all. They need someone who cares about people, not about illnesses.

As a recently qualified doctor, I consider myself ignorant in many ways, but I know my limitations, and I hope to become better for the good of my future patients. A good doctor should always admit that he or she is human and has limits, but these boundaries must not stunt us. Secure in the knowledge that our boundaries make us strong, we may excel, trying always to be better as human beings and doctors.

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We are trying to make doctors too good

EDITOR—We are trying to make doctors too good today, and that is the problem. Medical training demands that doctors master at least the basics of a host of scientific disciplines—anatomy, pharmacology, molecular biology, computer science, epidemiology, nutrition and diet, psychology, and so on. At the same time, they are asked to be insurance specialists, anthropologists, ethicists, marriage counsellors, small business owners, social workers, economists—the range of disciplines we ask our medical students to consider is staggering.

The guilt is poured on as articles appear almost every day in the literature, lamenting how little doctors know about some important issue or another—doctors miss depression, don't ask about sexual behaviours, misunderstand familial abuse, don't know enough about subcultural beliefs,

haven't been brought up to date on the functioning of the (fill in the blank) system, have not read up on drug interactions, ignore patients' spiritual needs, and on and on. Doctors reel under the breadth of expertise they are supposed to master.

As society becomes increasingly medicalised, and more and more social problems that used to be the jurisdiction of law or religion (such as drinking too much alcohol or coping with stress, street violence, or general world weariness) fall under the rubric of medical care, doctors are expected to understand more and more as they heal our social and our physical failings. Doctors simply cannot assimilate so much information, or at least they cannot assimilate it well. The truly good doctor must, of course, be technically proficient and know the craft of medicine. In addition, however, the good doctor must be able to understand patients in enough breadth to call on a community of skilled healers—nurses, social workers, insurance specialists, yoga teachers, psychotherapists, technicians, chaplains, whatever is necessary—to help restore the person to health (or perhaps, to support the person in their journey towards death).

To do that, the doctor must be able to be touched by the patient's life as well as his or her illness. The doctor need not be an anthropologist but must know how to ask about a person's culture; he or she need not be a marriage counsellor but must be able to spot the signs of spousal abuse or the depression that may be the result of a failing union. Good doctors are humble doctors, willing to listen to their patients and gather together the full array of resources—medical, human, social, and spiritual—that will contribute to their patients' healing.

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Tools of the trade must be put to good use

EDITOR—Good doctors must be able to put their tools to good use. With their ears, they must hear all that the patient tells. With their eyes, they must see all that the patient shows. With their hands, they must feel all that is hidden from their eyes. With their mind, they must detect all that is unspoken. When all this information has been assimilated, they must use their mouths to tell patients their thoughts and their body language to reassure. All the time, remembering their duty to the patients.

It must be remembered that as a profession, we have the highest ideals and standards to uphold. We can do this only when we ourselves are well trained, have the appropriate time with the patient, and have patients who remember their duty to us too.

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Medical profession needs input from belief in humanity and ethics

EDITOR—In the developing world with its deficient facilities and patients who need to eat before they need medical care, the medical profession needs input from a belief in humanity and the ethics of the job more than scientific professionalism.

A good doctor needs to develop an abundance of patience; to explain and educate before prescribing drugs; and to think about the proper decision—this does not always have to be what is written in the textbooks. Costly investigations that confirm only what history and examination have discovered have no place, and neither have investigations that would not alter management.

The choice of treatment of a patient who cannot pay immense costs also needs special consideration, as does that of a patient who has to travel long distances to reach appropriate care. Taking time to explain and understand, choosing the language to fit each and every patient, is not taught in medical school. Deciding to wait rather than to interfere, when interfering in a deficient and too short lived manner would only prolong suffering, sharing the sufferings from disease not only in a biological but in a social sense these are skills that a good doctor definitely needs but is not always successful in developing.

Recognising your limits and acting only within them and giving yourself the chance to gain relief and regain energy are sometimes more important than just hanging around helplessly in a busy ward. Honesty and humility—the slogan of my medical school in Khartoum—are easy to write and say but very difficult to practise in an overpressed emergency department where tiredness and nervousness gain the upper hand.

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Being a patient helps

EDITOR—Aside from the obvious benefits of a fine medical school, great teachers, and lots of hands on clinical experience, I think the very best way to produce a good (sympathetic and humane) doctor is to force student doctors or residents to become patients.

I believe every doctor in pupa should have many tubes of blood drawn over a few days by poor phlebotomists, have a nasogastric tube inserted once or twice, undergo a thorough sigmoidoscopy, barium enema, and bowel preparation, and perhaps even be made to spend a night or two confined to a hospital bed, plugged into an intravenous drip, and then be subjected to harried and uncaring staff doctors and nurses while bedridden.

I'll bet a case of wine that this trenchant exercise will produce far more empathetic, sympathetic, and good doctors then multiple lectures on sensitivity and humanism by some medical academic, ethics professor, or member of the cloth. I daresay that I truly believe that my experiences of being a patient as a student sure as hell helped mould me into the caring and sensitive practitioner I am today!

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A nurse speaks

EDITOR—From a nurse's point of view, being a good doctor is not that hard. Good doctors have graduated from medical school so should have a reasonable depth of knowledge to inform their decisions.

The key to becoming a good doctor is to gain the confidence not to need support when capable of carrying out a task or making a decision and to ask for help and support when not capable. Remember, the clinical picture is more important in most circumstances than the laboratory results. Look at the patient, not the numbers.

A good doctor also needs to be a team player. Nurses and those in professions allied to medicine can make your life easier or harder. Most house officers and senior house officers have limited practical knowledge of the specialties, whereas nurses often have many years of experience—use this to your advantage. You will not lose your authority by asking for their help but will gain nurses' respect for realising your limits. Nurses often know consultants quite well and can tell you what information they like available on their ward rounds and when they would favour being asked for help and advice.

Remember, most nurses don't envy your responsibilities but do wish to have their concerns heard and answered. We don't mind our advice being overturned. We just want to know you have registered our concerns, have thought about them, and weighed the pros and cons of action or inaction.

Finally, and often hardest to achieve, is good communication with patients. Listen to them, and try to be empathetic. The ultimate responsibility for health decisions is theirs. Remember this. Policies and procedures can be bent to suit the patient, just remember to document that it was the patient's request.

It looks so simple written down like this, but most doctors still find these attributes difficult to acquire.

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A patient speaks

EDITOR—For several years I was registered with a wonderful general practitioner in my home town. I never appreciated him until I moved away to study at university.

I went from being an empowered individual to a patient number. There was no recognition that I had existed before I joined my new practice—the staff never referred to any of my previous doctor's notes. It was upsetting to sit across the desk from the general practitioner, give an account of what had happened, and then find out that the salient points had not been recorded in my notes. My suggestions for what might be happening were treated with,

I felt, derision. After all, what would I know—I'm a mere patient.

It got to the point where I would see my general practitioner only if I had a fair idea of what was going on. If I were concerned or worried I'd return home and see my "real" general practitioner as a temporary resident. So why was one general practitioner wonderful and the other not?

My real general practitioner became my expert best friend. He took an interest in me as a person and not as a set of symptoms. He knew when to speak and, more importantly, when to shut up. My history was my history, not his questions with his answers. I felt empowered and never bullied into taking a course of action that I didn't want to follow. He seemed to realise that I might be better placed to make suggestions about what was going on. My experiences lead me to make the following as a summary of a good consultation.

The doctor asks questions; patients give answers. The doctor uses his or her knowledge and skills to help patients make sense of their answers; patients ultimately decide what they want to do with their doctor's support. My unhappiness arose when the doctor filled in her own answers.

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Eulogy for a good doctor

EDITOR—In June this year I went to the memorial service for an exceptionally good doctor, Phyllis Mortimer. I had been both a colleague and a patient of hers some years ago. An inimitable woman (one of three women in her year of 150 medical students), she had graduated despite having polio as an undergraduate and myriad health problems that continued all her life.

Perhaps this explained something of the compassion she had for her patients and her sheer humanity. Jungians speak of the concept of the wounded healer: that clinicians must be aware of their own woundedness so patients can find the health in themselves. The relationship between the two of them becomes in itself a creative medium unique to that encounter. The protocol is a necessary, but enormously limited, tool, which provides only the beginnings of good care. Real evidence based practice is fluid, ever changing and continually revisable specific knowledge. Some of the necessary knowledge is that which is created in the consulting room itself.

My husband and I had treatment for subfertility for about five years with several clinicians. Phyllis cared for me through many months of it. With her, unlike others, the unpleasant procedure was no more invasive than if she were looking in my ear. This was due to her gentle physical handling of me (despite her own handicap with hand and arm) but especially because of her interpersonal skills, which were nothing short of extraordinary. She was also the only clinician we encountered who was able to work (and work well) with the continual disappointment of treatment failure. As her colleague (at the time I was the regional lead for quality improvement), I knew of Phyllis's reputation for searching to extend the technical quality of care and also of her gifts as writer, dramatist, and director. Phyllis also had her flaws. But it was her capacity for equality and sensitivity of relationship—and at the same time holding her professional boundaries and standards—that made her such an exceptionally good doctor.

She relished the chance to find creative ways of communicating just as well with the patient from a severely deprived background as with the educated patient. Phyllis's consultations were of a dramatically higher standard than most I have witnessed over the years and uniquely tailored to the patient in front of her.

There is no such thing as the perfect doctor. The good doctor is not one type or one thing. He or she is "good enough" in the Winnicottian sense—someone who is truly mindful of her or his own limitations and the profession's limitations. The good doctor has a high tolerance for "not knowing"—an ability to suspend judgment and work with situations of high intractability. He or she is always searching for, moving towards, and finding creative solutions in the moment at hand, able to hold both hope and failure simultaneously, being different things to different patients and thereby meeting myriad needs.

Can you imagine a world where more clinicians, like Phyllis, were able to transform their inherent handicaps into increased effectiveness? That would mean powerful medicine indeed.

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Now I am retired …

EDITOR—What is a good doctor? How do we make one? Now I am retired I know how to be a good doctor. I know how to listen to a patient. I know how to put myself at the patient's disposal. Put down your pen. Turn away from your desk. Face the patient. Sit back. Give him or her your full attention. Only thus will you fully understand the problem.

Before I took up medicine I knew what made a good doctor. I was a mature student. Furthermore, I had had extensive experience of being a patient. I had often had blood taken through an old fashioned, reusable needle, had had barium meals, sigmoidoscopies, nasogastric feeding, intravenous drips, and more than one operation under general anaesthesia. I knew what a good doctor and a good nurse were like.

Once I was qualified things were rather different. Although I was still full of youthful idealism, I became less inclined to sit and listen. I seldom had the chance to sit at all. Still, I loved the work, and, on the whole, I loved the patients. I still felt compassion and fellow feeling for them. But as time went by, things changed. For one thing I was perpetually aware of time's winged chariot hurrying near and most of the time it seemed to be accompanied by the hound of heaven.

Although I had studied art, literature, and philosophy, although I had the gift of tongues and of clear thinking, if not of clairvoyance, I found that the benison of charity, of the milk of human kindness, was leaking out of my soul, squeezed out by the pressures of work, of financial anxiety, of a wife and five children to care for and keep happy, of nights broken by the cries of my own children or the urgent clinical needs of others, of committee work and administrative responsibilities. I became less patient with my patients, less tolerant of the foibles of the human race, less willing to listen, less able to care.

Once I retired, however, things changed again. Suddenly my financial worries were over. I had savings instead of debts. Most of my children had left the nest. I had time once more. Doing locum consultant work here and there when I felt inclined had all the pleasures and little of the pain of full time consultant work. No committee meetings, virtually no administrative duties. Just ward rounds, outpatient clinics, teaching, and on-call duties every three or four nights. The outpatient clinics were generally less heavily booked than I had been used to. I could sit back and listen to patients and their parents, could put myself entirely at their disposal. It made a tremendous difference.

If I had my time again, would I do it any differently? I'm not sure. I hope I would worry less. I hope I would be more patient, with the patients and with myself. But nowadays it would be all different. Whereas in my first preregistration job I was on call for 108 hours a week, nowadays I might at worst be on for 80 hours. In all my 30 years from qualification to retirement, except when I was in the United States, I was always on a one in two rota. Nowadays as a consultant, I would be on a one in four rota at worst. Would that make it easier to love one's patients? I sincerely hope so.

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Teach medical students reality to make good doctors

EDITOR—To make a good doctor we need medical schools to be honest with students and teach them about how things really are. We need to provide medical students with that most powerful and dangerous of life forces—reality.

Some patients can be difficult and dangerous. Most clinical decisions have no evidence base. Pursuing ethical aspects of each case is an activity that needs prohibitively intense resources. Uncertainty looms over all of medicine, and you must be able to cope with the pain and guilt that it brings.

We teach students about a cosy, idealised medical environment that really exists in the minds of the academics. When students experience the real world they do not see the majority of doctors spending a vast amount of time discussing ethics with patients. They find the evidence base to be sorely deficient. They soon realise that many serious illnesses

can present with minimal signs and symptoms, and they must somehow devise a personal way of coping with the pain and guilt that this uncertainty produces.

I believe that we harm our medical students by not being honest about the real medical environment in which they will eventually practise. We need to give them the skills to help them make their patients healthy but we also need to give them the skills to help them remain healthy themselves. Placing students in a real medical environment with deficient skills simply confuses and alienates them and ends up damaging everyone. If we want to make good doctors then we must teach them in the real world.

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How not to do it

EDITOR—First of all, take "raw" medical graduates and place them in a busy medical unit. Write a job description that details their rest periods but not their role, their tasks but not their contribution. Make them work with an ever changing variety of senior colleagues—not for them an old fashioned apprenticeship. Ensure that they never see the same patient twice because compliance with hours is more important than the insights they gain from providing continuity of care.

As they move into specialist training, require them to collect and collate precise details of everything except the quality of doctoring they are learning to provide. Teach them that they too can profit from the drug industry through its necessary supplementation of study leave budgets. Make sure that resources in your institution go where they are really needed—the only computer doctors need is between their ears.

When the time comes for research, use this opportunity to reinforce the importance of numerous competing regulatory frameworks in providing the bureaucratic framework essential to employment in NHS management and its support industries, and to deforestation.

As with all healthcare providers, ensure that their salary, once trained, is sufficiently modest to attract only those who are (or should be) committed.

When issues of professional practice arise, it is better to get someone who isn't involved in providing health care to take it on—they aren't constrained by their understanding of the system they have been asked to change, and the system will cope with all the rogue recommendations—we always have.

The fundamental principle underlying this approach is attention to detail. If we collect all information available, write detailed job plans, and provide coherent written justifications for everything, then all will be well. Good doctoring is nothing more than the sum of these individual parts, and those who argue that there is some higher value system, some "professionalism" which should be involved, belong in the past. Count everything and value nothing.

Not.

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Summary of responses

EDITOR—Altogether 102 people wrote in response to our questions "what makes a good doctor?" and "how can we make one?"[1] They were clearer on the first question than the second, listing more than 70 qualities a good doctor should have. Among the usual—compassion, understanding, empathy, honesty, competence, commitment, humanity—were the less predictable: courage, creativity, a sense of justice, respect, optimism, grace.

Responses came in from 24 countries all over the world, and almost all of the respondents had something different to say, indicating, as one respondent put it, that "a good doctor will be different things to different people at different times." For some, the notion was very simple: a doctor who satisfies his or her patients; a doctor you would trust yourself; a doctor who likes people and likes the job; even "a doctor who feels for himself the sorrow of human kind."

For others, it was more difficult. Like describing a good car, a good play, or good weather it all depends on your perspective. A member of the library faculty at a New York university described a good doctor as one who "reads and reads and reads." A professor of bioethics (with an interest in medical history) argued that good doctors are also good historians, adding that medical history should take up at least a quarter of the undergraduate curriculum. Educators gave a high priority to being a good teacher, coach, and mentor. And a quality improvement specialist thought a good doctor was one who critically examined what he or she did and tried to improve on it.

Patients, however, wanted little more than a doctor who listened to them.

From this great diversity a few common themes emerged.

Firstly, there are plenty of good doctors around and we should nurture them better.

Secondly, to be a good doctor, you first have to be a good human being: "a good spouse, a good colleague, a good customer at the supermarket, a good driver on the road."

Thirdly, it's easier to be a good doctor if you like people and genuinely want to help them. A general practitioner from Wolverhampton wrote: "To like other people, from this all else follows. Liking your patients will get you through the grind and tedium of your working day, and patient contact will be a source of strength and renewal. You may even do some good."

Finally, good doctors, unlike good engineers, good accountants, or good firemen, are not just better than average at their job. They are special in some other way too. Extra dedicated, extra humane, or extra selfless. More traditional contributors wanted doctors to sacrifice themselves for the good of their patients. Others said doctors must look after themselves first—or they wouldn't be able to help anyone. Doctors are patients too.

Few respondents had anything to say about what makes a good doctor in specialties with little patient contact. Pathology, for example, or epidemiology. There wasn't much either on what makes a good surgeon. One of only eight contributing surgeons (a urologist from Saudi Arabia) wrote that good surgeons are "good doctors with extras." Another surgeon said that it was important for doctors to find medicine fun, fascinating, and stimulating.

Making a good doctor seemed a greater challenge than defining one. There was general agreement, though, that we aren't very good at it. To paraphrase 13 responses: all we can hope to do is select students with the right gifts (not the right exam results) and somehow stop them from going rotten through overload cynicism and neglect during their training and early career.

One first year intern from Israel echoed several others when she suggested bad societies were unlikely to produce good doctors: "Whilst doctors are overworked, underpaid, and abused, the debate on defining a good doctor will remain academic," she wrote. "Our society undervalues doctors yet expects and will accept nothing short of perfection … Even with perfect risk management mistakes will be 'made' … people will die young or decline with age, and not all pregnancies will have a good outcome. Unfortunately doctors are more easily sued than God, and moreover … pay cash."

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1 Theme issue: What is a good doctor and how can we make one? bmj.com 2002. bmj.com/cgi/content/full/324/7353/DC1 (accessed 31 July 2002).

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Rapid responses

Correspondence submitted electronically is available on our website