Being a good doctor

A lecture delivered to myself in fragments over many years

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SIR William Osler was once asked if he could recommend a clever doctor. He replied: " There is no such thing as a clever doctor. There are only good ones and bad ones ".

Osler was given to witticisms but not to frivolity. Was this just a witty remark, or was it the distilled essence of great insight?

I first came across this remark of Osler's when I was a student, and only after 20 years of medical practice have I realised the significance of it. In isolated thoughts over all those years, I have worked out for myself some guiding principles on which to base my professional life, and in the hope that others may be stimulated to crystallise their own ethical ideas, I offer this paper as a starting point for thought or discussion.

THE DOCTOR AND HIS PATIENT

Putting the patient at ease

When your patient feels at ease in your presence he will open his heart to you. Your opening words will set the tone of the consultation. No matter how ordinary and meek a patient may seem, you must make him feel that he is important to you. Nobody is ' another case of . . .' You have no cases. You have patients who are human beings with feelings and emotions who often have a greater dignity and self-respect than you possess yourself. Never refer to ' the pneumonia in the third bed '. What do you envisage—grey hepatisation in a display box?

Never ask a patient to enumerate his specific symptoms until first you have shown an interest in the whole person. If your patient is a child, play with him. Time spent playing with children is never wasted. Never examine a child until he is willing to co-operate. There can be nothing worse for an ill child than, kicking and screaming with fright, to have a speculum forced down his ear or a cold spatula rammed down his throat. You cannot be in a hurry and have a successful consultation with a child.

Of all age groups, teenage patients are the most embarrassed in the doctor's presence. They are very conscious of their bodies. They are developing a new awareness of themselves and their surroundings. Handle them with tact.

You need only 30 seconds to find out whether a teenager is a student or an apprentice and what his ambitions are. In that brief time a rapport is established. If you have to examine the genitals of a young man or the chest of a girl, be concerned that you may be embarrassing them. All people, but especially teenagers, respond well when respect is shown for their physical person.

Foster the feeling of dignity in the aged, for they are older and perhaps wiser than you. Above all, impress upon them their continuing usefulness. A confident old person who feels he still has a place in the world will respond to your advice better than those who are depressed.

Your patient will feel at ease when he knows that you are really pleased to see him.

The art of listening

Every patient who goes to the doctor does so for a reason. The doctor may think it a good reason or a bad one—that is the doctor's interpretation. But there is always a reason. Patients never consult their doctors for nothing. A patient may be worried about his own health or the health of a member of his family.

He may deliberately be trying to hoodwink you, but even the malingerer deserves a second thought. Is he inventing his symptoms to escape a task or even a way of life he loathes? Perhaps he could be redirected to something he enjoys from which he would not wish to escape and hence he would have no further need of malingering.

But whatever the reason, the doctor must listen. He must not only listen to what the patient says but also to the way in which he says it. He must listen to what the patient emphasises and remember to reassure the patient on these points even though they may seem trivial to the doctor.

And when all has been listened to, the doctor must decide whether the patient is concealing something he is afraid of or embarrassed to confess. It is a good doctor who, from the patient's seemingly casual conversation, can identify his opening gambit even though the patient fails to make a second move. The doctor understands his patient well when, after the consultation is apparently over, asks, ' Now what did you really want to speak to me about? '

It is a good doctor who, though tired at the end of the day, will sit and listen to the tale of the depressed, to that volcanic eruption of emotions long suppressed in a turmoiled mind. Such a patient may well have been plucking up courage for weeks or months to force himself to the doctor's side and there to lay bare his soul. A brusque, cold or tired reception from the doctor would soon quench the fire of his brief enthusiasm. How many suicides have resulted from the inability to find a listening ear? The listener does not necessarily have to prescribe treatment, nor does he need to understand (though it is better if he does). The emptying volcano releases its own pressure.

Listening is the greatest single function of the physician. We learn much from our patients by listening, not only about their illness but also about their character. And from the attention we pay to them, they learn of our character. If you merely ask questions you will only get answers. If you listen, you will learn of the deep worries which loom black in your patient's mind.

What the symptoms mean to the patient

Children are not interested in their health. Teenagers don't care. Illness is a nuisance to young men but to the middle-aged it is a sword of Damocles. To the healthy aged it is frightening though to the weary sick it is blessed and many pray for death.

You may never understand fully how patients look upon their own symptoms. A trivial boil or a twinge of myalgia may temporarily upset a patient's whole life. Yet others carry on normally with huge fungating carcinomata, which they can see for themselves, and it appears to affect them not a jot. The triviality of the symptom bears no relation to the worry and fear it causes the patient. It is the doctor who regards the symptom as trivial, not the patient.

Perhaps those most worthy of understanding are the illogical, frightened patients who don't want to be examined or even see the doctor in case he discovers something wrong. The fact that the doctor might effect a cure means nothing to such a patient. He would rather remain in ignorance of what is happening to him.

In trying to understand what the patient's symptoms mean to him, ask if he knows

(or knew) of someone else who had the same symptom—and what happened to that person.

Be wary of the patient who tries to gloss over an obviously important symptom, and though his casual approach may annoy you, invite him to sit down to a relaxed consultation. If you fail to understand him, the failure is usually your own.

The patient's symptoms mean more to him than the immediate effects of ill health. He may be worried about the effects on his job or his marriage. All sorts of private and personal feelings are involved.

If you have no sympathy for the patient who comes to consult you, it is better you should not care for him. You will not help him. You will generate tension within yourself and you will help to destroy the good social image which doctors have earned for themselves over many years.

What the symptoms mean to the doctor

It is no use knowing 30 causes of enlargement of the spleen if you are unable to detect early hypertrophy of the organ, or worse still, fail to examine the abdomen. Knowledge alone is sterile. It is the use to which you put your knowledge that is important.

If a young man comes in to see you with boils, it is not enough to say to yourself—these boils are caused by an invading staphylococcus, therefore I will prescribe flucloxacillin which will kill the organism. Instead, you must ask yourself—why has this otherwise healthy young man suddenly come out in a crop of boils? He must often be in contact with the staphylococcus. What has happened to him at this moment in time that his resistance has become so low?

In the complete diagnosis of boils you may need to know much of the patient's life, his hopes, his ambitions and frustrations, his emotions and his sex life, his work, and the strength of his character in relation to those with whom he mixes.

In every illness the psyche and the soma work hand in glove. You cannot separate them. You must learn to understand your patient in all his complexity, but at the same time, you must also understand yourself. You must recognise your own religious and moral prejudices, even the influence of your own special interest in medicine. Is your advice on contraception coloured by the fact that you receive a fee for fitting an intrauterine device? Do you advise pregnant unmarried girls of 16 on abortion for their own personal good, or for what you judge to be the good of the community, or is your advice a reflection of your own personal standards of morality?

This does not mean that you cannot help your patient with moral advice. It only means that such advice must always be for the patient's benefit. For example, if a girl of 17 requests the contraceptive pill because she intends to have sexual intercourse regardless of your own or her parents' moral standards, you must see she is physically fit to have the prescription, and while you cannot deny her the right to have it, you can tell her that, though the drug will prevent conception, it will not prevent venereal disease. Indeed, because she knows she is protected against pregnancy, she may feel free to have sexual relations on a casual basis and therefore would be more likely to contact a venereal infection. Such advice is good preventive medicine but the moral implications cannot be separated from it. But it is for the patient's good.

Patients come to the doctor for help. It is the doctor's function to find out what kind of help the patient needs.

Do not brush aside the intelligent man who seeks advice about some minor complaint such as a nasal cold. He knows there is no cure. He needs reassurance about something. Perhaps it's another respiratory disease like carcinoma of the bronchus. Likewise do not fob off the unintelligent as nuisances if they come repeatedly for the same

complaint for which you know no treatment. You, the doctor, have to do all the understanding. It is not the patient's function to understand. It is his prerogative to be understood.

The elderly

Treat the elderly with great respect as you would hope to be treated yourself when you grow old. There is no illness more crippling than the loneliness of old age. Physical illnesses are often accompanied by high drama. Everyone rallies round—the family, friends, and an array of medical and paramedical workers.

But the old person is regarded as a nuisance, a source of distasteful duty to the young. The old person must now be ' disposed of ' in a home to share the company of other unwanted people. I make a plea that the loneliness of old age be regarded as a serious symptom like depression, and treated, not with drugs or a weekly call from the health visitor, but on a broad medicosocial basis necessitating active involvement by the patients. To give antidepressants to the lonely is like giving aspirin for toothache. The pain is partially eased while the tooth continues to decay.

At what point should you feel satisfied with your diagnosis? You can never know everything about your patient. The immediate symptoms form a tiny piece of the large and complicated jig-saw that is the patient's life. The more you know of his life the more easily you will fit that piece into place.

Family doctors and specialists

The family doctor sees the same patient over and over again with different diseases. He therefore gets to know more about the patient than the diseases. The specialist sees the same disease over and over again in different patients. He therefore gets to know more about the disease than the patients.

But the general practitioner's awareness embraces a greater portion of humanity than the individual in isolation. He knows the patient's family, his home, how he chooses to live, the colour of the wallpaper in the hall and the dog's name. While the specialist's diagnosis is specific to the illness the general practitioner's diagnosis is relative to the patient's circumstances, to his family, his employment and his whole way of life.

Be satisfied with your diagnosis when you have returned your patient in good health (if possible) to his normal way of living, but always remember that, though you may succeed in doing this, much of importance has eluded you.

What the symptoms mean to the patient's family

An ill person usually lives at home among others who are well. He cannot compete. If he has a persistent cough or a twitch or is deaf, he may become a nuisance to others. If he is partially disabled he may need their constant help. For a short illness the family will often rally round, but for chronic ailments, the initial enthusiasm wanes and eventually a compromise is reached, often to the patient's disadvantage. The invalid is in no position to dictate terms to the healthy.

The attitude of the family will affect the patient's progress often to a greater degree than the doctor's treatment. A chronically ill patient may see his doctor once a month for ten minutes, but he lives with his family day and night without break. If they sneer at his illness or rebuke him, or if they are compassionate and encouraging, if he is made to feel important or if he is regarded as such a burden that his death will be a blessing to everyone else—all these ' ifs ' will determine the patient's progress more than the doctor's drug therapy. What good is the healing of a fractured neck of femur if the patient's spirit is broken?

In every illness, time spent talking to the family is never wasted. To talk to a mother about her ill baby seems natural. Does the mother care less when she is 60 and her child is 35? Or is her concern no longer important? Teenage children will often respond well when their parent's illness is explained to them, when they are approached as intelligent adults—which is the goal they are striving to attain. Even so it is easier for one mother to look after ten ill children than for ten children to look after one ill mother.

A patient's illness affects the household, its day-to-day running and the time each member has to give to others. When a patient falls ill, you must treat the whole family.

Mutual trust

Patients come to you to lay bare their soul for your inspection. Put yourself in their position. You are now the patient. How would you approach your doctor if you thought you had gonorrhoea? Would you enjoy explaining in detail how you make love because you can't get an erection? What fear would you have if you suspected you had a cancer? And how would you like to be treated if you were an inarticulate hemiplegic?

Whatever trust and faith you hope the patient will have in you, you must equally have trust and faith in him. You are just another human being yourself, and as you see the patient's faults and shortcomings, so will he see yours. He sits in judgment on you as you do on him. And it is upon his judgment that your image in the community rests. No matter how erudite you may think you are or even be, your patients will judge you by your attitude, your friendliness, your humility, your willingness to help, and above all, by your sincerity. Sincerity, when it exists, has the quality of shining from the hardest and sternest face the doctor can present.

Truth

What do you say to the patient dying of cancer? Do you tell him the truth or hoodwink him into believing he will soon be well again? My impression is that dying patients see the doctor's lies for what they are. The processes of nature are too subtle to be outwitted by the words of the physician. What is more important to the dying man is that people should care whether he lives or dies. He should be made to feel that his life has been worthwhile, that he is still loved and wanted even until he takes his last breath, and that his memory will be treasured after his death.

If you judge it desirable to lie to a dying patient, you may find the greatest credibility in being honest about the diagnosis but dishonest in the prognosis so that he believes he has yet two or three years of hope for advances in medical science to find a cure for him.

There will always be times when it is necessary to lie. I did so myself when a patient's beloved husband died suddenly from meningovascular syphilis. From the management of this type of problem the doctor learns the art of medicine.

Fashions in sociomedical thinking allow at different times some diseases to be discussed openly and others to be hushed. Fifty years ago tuberculosis was a dirty word. No one dared say it. It had to be called consumption. In Victorian times even the word ' birth ' was dirty. It was referred to as ' the happy event ' and by other euphemisms. In our day, cancer is a hush-hush word, and it is the current vogue to lie about it. With venereal disease and girls of 16 taking the contraceptive pill, it is customary to be truthful to the patient but to avoid telling the truth to the patient's family. This is usually the patient's wish and must be respected.

You would be well advised always to be truthful to your patients, and on those occasions when you deem a lie to be desirable, make the lie as small as possible, make

it totally credible and be prepared to revert to the truth if and when the truth becomes obvious to the patient.

Being involved

If you do not like your patient, ask him to seek advice from another doctor. You must care for your patient. You must be interested in him. You must like him sufficiently to want to help him. You must become involved with him. Involved enough to understand him. Involved enough to be moved to compassion. But not involved enough to be personally affected in your daily life.

You are incomplete if, in addition to physician, you are not also marriage guidance counsellor and family philosopher. The concern you show for your patients will be reflected in their willingness to trust you and be guided by you. Your patient must look upon you as a friend but you must remain detached from him. You are a friend to share his intimacies but he never shares yours. Therefore always insist on your professional title and never allow a patient to call you by your Christian name. Avoid social contact with your patients and never make a patient of an existing friend.

Never reprimand your patient or shout at him—you will only lose your dignity. Never belittle a patient's mistakes—educate him. Never tell a patient to stop crying—show concern and hand her a tissue but let her sob out her worries. And never use technical terms in order to impress upon others the extent of your knowledge. All these things will widen the gap between you and your patient.

Treatment

The drugs you give your patients may help them, but the best treatment is with words—the patient's words. Let your patient talk. To listen is to cure. The tide of his own words washes clear the patient's mind. It is like a confession. And when you do advise and prescribe, do so as if you were treating your own kith and kin. If it is an old lady, do for her as you would do for your own mother. Move heaven and earth for someone else's child as you would for your own. But even then, remember that, while you try to effect a cure, your treatment may be ineffectual or even harmful. Many with drug-induced illness lie in hospital beds.

After you have tried your best and all has failed, follow your patient to the cemetery where your heart should cry for a lost friend and your brain yearn for greater knowledge to help others.

Making mistakes

Scientific truth is a fashion, and today's fashion is tomorrow's absurdity. Witness the swing in the treatment of diverticulitis from a low residue to a high residue diet and the change from a long postpartum lying-in period to rapid mobilisation. These are the communal mistakes of our profession from which the individual doctor may be exonerated from blame. But of our personal mistakes only some are excusable.

We make errors of forgetfulness when we prescribe offending drugs to those whom we know are allergic. Errors of omission when we fail to examine the rectum. Errors of diagnosis when we do not give our full attention. Errors of treatment when our recent education is wanting. We make errors of judgment when we lie to cover our ignorance or in revealing a patient's confidence.

You do not know your own mistakes at the time you make them for you would not make an error deliberately. And it is very likely that the number of mistakes you make is greater than you would wish to recognise. If you are ever to know your own mistakes, they must be discovered at a later date either by yourself or by another person. Whoever that other person is, you must be thankful to him for otherwise you would never have known it and never been able to learn from it. If he is a colleague, be pleased that

knowledge of your error is kept within the compass of the profession. If your patient discovers your mistake, then your reaction is the test of your own humility, your honesty and the strength of your mutual understanding and respect.

What the symptoms mean to society

Patient's illnesses are frequently the mirror reflection of the society in which they live. As cholera and typhoid reflected the insanitary society, so depression, road traffic accidents and diseases of cornucopia reflect our present way of life. Will we be good or better doctors when our records are stored in computers? That will depend on the doctors, not on the computers!

The doctor's high social position correlates more closely with the length and expense of his training than with his usefulness to society. Would society be better off without its doctors or without its dustmen?

Society can best learn how to direct itself for the benefit of humanity by looking at the current pattern of disease and suffering.

THE DOCTOR AND HIS COLLEAGUES

Your relationship with your patients is guided by the ethics of your profession. Your relationship with your colleagues is guided by etiquette. Over the former looms the shadow of the disciplinary committee, but the latter is unencumbered.

Regard all your colleagues as equals whether they are consultants, family doctors or professors. Treat their mistakes with the same generosity you hope they will look upon yours. You must practise in harmony and not try to outdo another in order to enjoy the smug satisfaction of pseudo-cleverness. The enmity of cleverness is achieved at the expense of the patient.

Never belittle another doctor's treatment in front of the patient. You may alter such therapy if you think it necessary, but always with praise for your colleague whose prescription was issued at an earlier stage of the disease. Discuss patients together but never argue in the patient's presence, and always explain to the patient afterwards the result of your deliberations.

Doctors collectively have an image in the community. When talking of them, people from all social classes do not differentiate between the Queen's physician and a family doctor in the poor quarters of an industrial town. And this is the way we would wish it. The community bestows upon us the privileges of status and financial reward. Such privileges can be lost in the course of time. Therefore do not disgrace your colleagues, for the behaviour of the individual reflects upon the whole profession. To deride a colleague is to deride yourself.

Patients expect us to have differences of opinion but also to be tolerant of such differences. Patients expect our methods to be different but the end result, the promotion of good health, to be the same.

The cardinal qualities of medical etiquette are tolerance, dignity and a sense of brotherhood.

THE DOCTOR AND HIS STUDENTS

Senility begins when you stop learning. You learn from the greatness of others and from your own mistakes. Do not blind yourself with your successes. You learn nothing from them. Success is achieved from past learning.

Treat your students with respect and do not mock the gaps in their knowledge, for the holes in your own form a greater embarrassment. Your students bring with them a

freshness of thought unencumbered with old-fashioned theories. Therefore, if you are prepared to teach, also be prepared to learn, for the roles of teacher and student are constantly interchanging.

Things stored at the back of the mind are liable to fall asleep there. Keep taking them out for re-appraisal, perhaps they are no longer worth storing. Measure your old ideas against current thinking and be willing to exchange your pet belief for a less attractive alternative. For yesterday's truism is today's falsehood.

A good teacher does not teach facts—he inspires his pupil with the desire to learn. He lights the fire of his pupil's eagerness with the flame of his own. To the half-hearted, the greatest wisdom is merely an unsolved anagram.

THE QUALITIES OF A GOOD DOCTOR

Each doctor fills an individual place in the medical and social life of which he forms a part. Each doctor is unique. The professor of medicine, the neurosurgeon and the family doctor all have different attitudes of mind towards their work and their patients. No doctor is the poor relation of another. But they should all share qualities of professionalism and humanitarianism.

The good doctor should have the ability to put his patient at ease and help him retain his individuality among all those who are ill. He must have the ability to obtain information from his patient rapidly and accurately and to understand its significance. He must have the technique of physical examination brought to a fine art like the daily practice of professional musicians.

The good doctor must learn how to select the minimum number of investigations in order to arrive at a correct diagnosis, for all investigations are unpleasant to the patient and time-consuming. And he must recognise that the ingredients of prognosis are but two—medical knowledge and a deep concern for the patient's welfare.

The good doctor must be erudite and compassionate and both these qualities must be tempered by discernment. He must be understanding but recognise that understanding alone is sterile without also being effective. He must be willing to recognise his own limitations and his mistakes yet retain the enthusiasm to learn more. He must have the ability to select the best of medical teachings from the contributions of doctors of all ages, for each age has produced something of value worthy of perennial awareness. The good doctor must have the keenness to face the future as a student no matter how distinguished he may be. He must treat his colleagues and his patients with dignity and respect and carry these qualities into his everyday life.

And while striving to achieve these ends he must remember that, though he is never capable of perfection, he always has the ability of self-improvement.

There is no such thing as a clever doctor, said Osler. *The Shorter Oxford Dictionary* defines ' clever ' as ' possessing skill, dexterous, adroit '.

There are only good ones and bad ones. ' Good ' is defined as ' commendable, agreeable, useful, efficient in a function, reliable for a purpose, adequate, morally excellent '.

Osler was right.