

1

THE GOOD
DOCTOR
THE IDEAL

In this part of the book, I seek to describe the ideal situation, in which patient expectations of receiving care from a good doctor are routinely fulfilled. I explain what I mean by a good doctor, based on the views of patients and doctors themselves. I introduce the concept of the ‘good enough’ doctor, who may not be excellent but who fulfils our expectations, in contrast to the ‘problem doctor’, who does not reach this threshold. Finally, I explain how, in an ideal world, patients would be able to rest easy in the assurance that every licensed doctor is a good doctor.

What is a good doctor?

‘Patients need good doctors’, proclaims the General Medical Council (the statutory body that has regulated doctors in the United Kingdom since 1858) in the opening statement of its guidance for doctors, *Good Medical Practice*.¹ ‘Everyone is entitled to a good doctor’, states Donald Irvine, paraphrasing William Osler, the acclaimed scholar and teacher who was said to epitomise a good doctor at the start of the twentieth century.² ‘Most doctors are good doctors in the eyes of most patients’, writes health advocate Angela Coulter.³ The phrase is bandied about in the health policy and sociology literature about doctors, and in the media when individual doctors are praised for their community service, or defended by patients in the face of official sanctions for misdeeds.⁴

In his powerful novel *The Good Doctor*, author Damon Galgut contrasts the characters of two doctors, one deeply cynical yet realistic, the other naively optimistic and seeking to do good, in remote, rural post-apartheid South Africa.⁵ The reader is left to ponder whether either of these flawed men is a good doctor. The word ‘good’ when applied to doctors is ambiguous, speaking both to the motivation and character of the workers, but also to the quality of their work. This ambiguity is reflected in attempts to define the attributes of a good doctor, and to describe the characteristics of good medical practice. Invariably, the desired qualities

relate to both motivation and performance. The duality is also seen in an influential seventeenth-century definition of a physician as *vir bonus medicinae peritus*, a good man expert in medicine.⁶

Governments, insurers and employers, as funders of medical care, are interested in what makes a good doctor. So, too, are the medical schools and colleges that train doctors, the medical professional organisations that seek to promote the interests of doctors, and the regulators charged with overseeing medical practice. The ultimate arbiter, of course, should be the patients on the receiving end of medical care.

Patients’ views

Individual patients form their own views about what to look for in a doctor, influenced by personal experience and the experience of friends and family. With the burgeoning literature about doctors and health, some patients may even be primed in how to get the best out of their doctor, and alert to pitfalls in medical practice.⁷

Patient associations represent patients’ views in advocating for the standards of care and practice they expect of doctors. Health researchers, health policy and advocacy organisations, medical associations, medical regulators, and funders periodically undertake surveys and debate what patients look for in doctors. In the discussion that follows I have drawn on published surveys and literature from such groups. My thinking is also influenced by my observations from reading hundreds of letters from patients about their doctor, in which they praise great care and lament failings.

Technical competence

Patients generally rate technical competence as the most important attribute in a doctor. By ‘technical’ competence I mean the knowledge, training and experience to provide an appropriate level of medical care and the practical skills to do so. Some researchers draw a distinction between ‘competence’ (knowing what to do) and ‘performance’ (doing

it),⁸ but I doubt that the general public makes this distinction. People expect both in their doctor. Competence in communication is obviously an important aspect of broader clinical competence, but patients generally differentiate between ‘bedside manner’ and knowledge or ‘technical’ competence.

Patients understand that doctors are cogs in a complex health system, and that sometimes things go wrong in health care. Public reports and media coverage of ‘serious and sentinel events’ causing harm to hospital patients have become relatively routine.⁹ The public is also used to being told, in the wake of human tragedy in many settings, that the outcome was caused by a ‘systems’ problem. However, in my experience, people are sceptical about the claim that the vast majority of unintended harm to patients is caused by faulty systems, not incompetent individuals – at least when asked to apply that general proposition to a specific case. The public and the media look for an individual practitioner to be held accountable.

Even if we accept the key role of safe systems in delivering safe care, the technical competence of individual health practitioners, especially doctors (who are often in the driving seat), remains a crucial factor. As Nancy Berlinger writes: ‘Mistakes are made by individuals, even if these individuals are working within systems.’¹⁰ Patients expect their individual doctor to be skilled and competent, and are wary of experts who glibly invoke the ‘systems’ mantra in the aftermath of disaster.

Public surveys and submissions from patient advocacy groups confirm this expectation. In a 2009 survey of 289 customers of 10 pharmacies in Dunedin, competence was ranked as the number one professional attribute for a doctor.¹¹ In a 2006 submission, the Federation of Women’s Health Councils Aotearoa New Zealand noted that patients expect a ‘[h]igh level of medical competence – good up-to-date medical knowledge and diagnostic skills, sound technique for medical procedures and awareness of limitations’.¹² In a 2010 survey of 502 members of the New Zealand public, 97 per cent agreed with the statement that it is essential that doctors stay up to date with developments in medicine.¹³

(Hardly surprising – indeed it’s intriguing that 100 per cent didn’t agree with such a leading statement, and that 1 per cent ‘strongly disagreed’ with the proposition!)

Of course, most patients have no knowledge of a doctor’s training (at best they may notice a faded degree certificate on the surgery wall), experience, or current skills. Unless a doctor is obviously inept at history taking, examination and diagnosis, it is difficult for patients to judge their competence – though an expert patient may sense that something is amiss. In *A Fortunate Man*, a moving account of an English country doctor in the 1960s, John Berger writes: ‘You have to be a startlingly bad doctor and make many mistakes before the results tell against you. In the eyes of the layman the results always tend to favour the doctor.’¹⁴

As a general rule, in the words of Donald Irvine, ‘although patients can judge a doctor’s personal qualities, they have to take clinical competence on trust because they cannot assess it satisfactorily’.¹⁵ Patients assume that their doctor knows what to do, and can do the job competently. They appreciate that medicine is complex and that sometimes specialist advice is needed. They expect doctors to recognise the limits of their own professional competence and refer to another practitioner if they are out of their depth.

Putting patients first

Technical competence is only part of the equation. Patients also value other professional and personal qualities in a medical practitioner. If asked, members of the public list a wide range of desired non-technical attributes. One key quality is whether the doctor makes the care of the patient his or her first concern. In a survey of 98 members of the public undertaken by the Picker Institute in England in 2006, this was rated as the most important duty of a doctor by 78 per cent of respondents.¹⁶

How are patients to judge whether a doctor places their best interests first? It is something that patients take for granted and are not well placed

to assess. There may be glaring examples of a doctor being distracted and not focusing on the current patient – for example, interrupting the consultation to take a non-urgent cellphone call about a business matter.¹⁷ In the absence of obvious omissions to give primacy to their interests, patients will assume that they are the main focus of the doctor's attention. They *trust* this to be the case.

Patients understand that there are competing demands on doctors' time. They are generally tolerant of having to wait, but if the doctor says a referral letter will be sent, or test results will be reviewed and the patient contacted if there is anything untoward, naturally the patient assumes that this will happen. So, if a doctor is indifferent or lax in these areas of professional responsibility, the patient will feel let down; that their care has not, after all, been the doctor's first concern.

Many instances of failing to give primacy to patients' interests will be covert. If a doctor provides unconventional treatment in pursuance of his own research theory, without his patients' knowledge or consent – as Dr Herbert Green did at National Women's Hospital in the events uncovered in the Cartwright Inquiry¹⁸ – they will feel betrayed when they later learn the true situation, however good his intentions. Similarly, if a surgeon takes an unnecessary biopsy for research purposes, without the patient's informed consent,¹⁹ performs unnecessary stent operations,²⁰ or orders unwarranted tests for extraneous purposes (such as meeting a funder's target), the patient is likely to feel aggrieved. Such behaviour is not consistent with good medical practice, and even if the doctor claims to be well motivated, any avowal to be a good doctor is undermined by their failure to make the care of the patient their first concern.

Integrity and trustworthiness

Patients expect integrity and trustworthiness in their doctor. In the Dunedin survey cited above, being trustworthy and honest with patients scored just below competence as the most highly valued professional attributes. Like competence and putting patients first,

professional integrity is something that patients assume but cannot easily judge for themselves. When a doctor is revealed to have betrayed a patient's trust, both the conduct and the character of the doctor are likely to be criticised.

One obvious type of dishonesty is financial exploitation: the doctor who overcharges, receives an undisclosed kickback from a specialist or private facility to whom they made a referral, or sees the patient for a fee in private without disclosing the option of a free consultation in the public system.²¹ A more common example of untrustworthy behaviour is disclosing only the doctor's preferred treatment intervention, or failing to disclose that an injury or complication resulted from a medical mistake. Breach of confidentiality, such as the doctor who divulges the patient's private confidences outside the consultation room as gossip, rather than for purposes of treatment, is also a breach of trust.

More extreme examples of dishonesty and violation of trust are the physician who undertakes unnecessary procedures to provide cover for prescribing restricted medicines to which the doctor is addicted; the sexual predator who undertakes unnecessary physical examinations for personal gratification or who sexually assaults the patient; and the murderous doctor who kills an unsuspecting patient under the guise of medical treatment.

All of the above examples, to varying degrees, involve a breach of trust in which the doctor's personal interests are advanced at the patient's expense. Doctors who behave in this way, and are caught out, almost invariably face disciplinary process and professional censure, and may incur criminal penalties. Their behaviour is unlawful and unethical, and calls into question their integrity and moral character.

There is some survey evidence that the public is tolerant of misdemeanours in the private lives of doctors, so long as this doesn't spill over into their professional work. This is reflected in modern medical regulation, with statutes removing requirements that relate to the 'good character' of the doctor. However, criminal behaviour in a doctor's

personal life (such as domestic abuse or accessing child pornography) is likely to result in professional discipline, since such conduct reflects on whether the doctor is a ‘fit and proper person’ to practise medicine.

Communication skills

One aspect of clinical competence that matters highly to patients, and that they are well placed to judge, is whether the doctor is a good communicator. Right 5(1) of the New Zealand Code of Health and Disability Services Consumers’ Rights affirms the right ‘to effective communication in a form, language, and manner that enables the consumer to understand the information provided’.²² From my experience, it will often be an aspect of the doctor’s communication or manner, rather than a simple mistake, that will trigger a patient’s complaint. If a doctor ‘talks down’ to a patient, or fails to explain clinical terms or to attempt to answer a patient’s questions, miscommunication is all but guaranteed, and the stage set for a complaint if things go wrong. Research indicates a correlation between good doctor–patient communication and improved patient health outcomes.²³

There are many elements of effective communication between patients and doctors. Patients care about whether their doctor listens, engages with them, provides helpful information and explanations, and spends adequate time with them during the consultation. A European study in 2002 listed top patient priorities in primary care as having enough time in the consultation, and having a general practitioner who listens and provides helpful information about their illness and treatment options, and encourages them to discuss all their problems. Levinson and Pizzo note that patients in Canada and the United States often find their physician ‘too busy to listen and too distant to care’.²⁴

In our early meetings with any new professional advisor – often during the opening moments of a consultation – we generally make a rapid assessment of whether they are a good communicator. Given the intimate nature of the professional relationship between patients and doctors, the

ability to communicate well is especially important. A skilful doctor is able to give the patient enough time to warm up and feel comfortable explaining the reason for the consultation, and then to focus the discussion on key issues and to elicit the information necessary to form a diagnosis or determine next steps. A doctor who is a good communicator will try to ensure that the patient does not leave the surgery with unanswered questions; will explain how to contact the doctor again with any follow-up questions that do not require another face-to-face consultation; will tell the patient about any concerning side effects or changes to watch out for, and what to do; and will provide practical instructions on any next steps (such as getting test results).

Many of the matters discussed under the rubric of communication are pivotal to whether a patient feels fully involved in their own care, and able to play a full part in a ‘therapeutic partnership’ with the doctor. Patient involvement and engagement has been a major theme in the patient–doctor literature in the past decade.²⁵ The twenty-first century has been called ‘the century of the patient’, and the hallmark of the evolving patient–doctor relationship is said to be shared decision-making. As Martin Marshall notes, this involves a ‘re-conceptualisation of the role and responsibilities of patients and health professionals in improving health’, with the interaction ‘increasingly being framed as a meeting between two experts’, something that runs counter to the traditional culture of medicine.²⁶ Not all patients will want this level of involvement, but most will appreciate being asked how much input they want to have into their own medical care, so that the ground rules for the relationship are clear.

The General Medical Council’s guidance on consent endorses shared decision-making as the norm for most medical decisions:

Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing, you must:

- a. listen to patients and respect their views about their health
- b. discuss with patients what their diagnosis, prognosis, treatment and care involve
- c. share with patients the information they want or need in order to make decisions
- d. maximise patients' opportunities, and their ability, to make decisions for themselves
- e. respect patients' decisions.²⁷

Finally, an important but less visible element of a doctor's communication skills is how effectively he or she maintains patient records, makes referrals to other practitioners, and communicates with professional colleagues. Most patients never see their own records or, if they do, lack the clinical knowledge and the familiarity necessary to interpret them and make comparisons with other clinical records. Any medico-legal inquirer soon learns that accurate and meaningful records are an essential part of the patient's story, helping to guide future care. Records are a vital aspect of good care, as well as enabling audit and research. Poor records are often a pointer to other problems in a doctor's practice.

When a doctor's referral letters or order forms for tests and procedures are unclear or omit key clinical information, the poor communication is a potential barrier to quality care. So, too, if a doctor is rude or uncommunicative with colleagues, or unwilling to pick up the phone and find out why a referral is delayed, or what's happening with a patient's care, the stage will be set for problems. Patients need their doctors to be effective advocates, and that entails being a good communicator with all the other practitioners involved in their care.

New Zealand's Code of Health and Disability Services Consumers' Rights contains a curiously worded provision, right 4(5), which states that '[e]very consumer has the right to co-operation among providers to ensure quality and continuity of services'. The wording is inapt, since although co-operation among providers (particularly between different

professional groups, such as doctors and midwives) is important, co-ordination of the care provided by multiple providers is also essential. In practice, right 4(5) has proved invaluable in highlighting problems in care co-ordination.²⁸ For care to be co-ordinated, the left hand needs to know what the right hand is doing. A doctor who fails to communicate effectively with colleagues provides fertile ground for discontinuity of care, and falls short on an important indicator of being a good doctor.

Respect and caring

Patients also highly value 'humaneness' in their doctor – qualities such as respect and caring. It is no accident that the right to be treated with respect is the first of the 10 rights affirmed in New Zealand's Code. During consultations in 1995 on the draft Code, community groups highlighted the importance of respectful treatment of patients. The final Code provision covers basic respect, respect for privacy, and respect for the needs, values and beliefs of different cultural, religious, social and ethnic groups.²⁹ Provision of services in a manner that respects individual dignity and independence is also a legal right under the New Zealand Code.³⁰ The new Constitution of the National Health Service in England similarly states that patients are legally entitled to be treated with dignity and respect.³¹

If respect is the bottom line, caring – kindness, courtesy and compassion – is what many patients yearn for. They are frequently disappointed. Whether for reasons of work pressure, bureaucratic demands, changing patterns of healthcare delivery, or endemic culture, the absence of compassion in the health system is a concern commonly expressed by patients and their families – and by stressed health practitioners working in the system.³² It is a concern being voiced in health systems all around the world.

Patients in New Zealand value care and attentiveness from their doctor. The Nationwide Health & Disability Consumer Advocacy Service from 2006 onwards asked people to send in accounts of great

care. The resulting publication, *The Art of Great Care: Stories from people who have experienced great care*,³³ is revealing. Often, it is the small signs of caring that really make a difference. A partially sighted woman describes her general practitioner as a ‘doctor who really cares’.³⁴ Her doctor is attentive to her needs: ‘waits for me in the reception area, to make sure I have heard her call, and can find my way to her room’. Her GP is respectful: ‘doesn’t focus on my disability unless it is relevant to the health issue I am facing right then’. Most of all, her doctor shows that she cares: ‘although very busy, she has taken the trouble to put herself in my shoes, and to treat me as a whole human being, with courtesy and imagination’.

Caring is a quality that many patients especially appreciate in times of illness and worry. Essayist Anatole Broyard, facing metastatic prostatic cancer, wrote: ‘I’d like my doctor to scan me, to grope for my spirit as well as my prostate. Without some recognition, I am nothing but my illness.’³⁵ Broyard wished that his doctor would ‘give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh’.³⁶

The qualities of kindness and caring are relevant not only to the good deeds that a doctor performs, but also to the attitude that accompanies the acts. A doctor who is competent, patient-centred, trustworthy and an effective communicator is, from an objective viewpoint, a good doctor. Yet if that same doctor displays these qualities while maintaining clinical detachment and brisk efficiency, some patients may feel that something is missing: the fellow feeling and caring approach that many patients describe when recalling a good doctor. Physician and writer Rafael Campo describes a remarkable AIDS patient, Gary, who in ‘the availability of his suffering’ helps Campo ‘remove the mask’ he wears in hospital and brings him closer to the suffering of his patients.³⁷

Patients may understand the reasons for a doctor’s detachment, and may even find it more comfortable to keep the relationship on an entirely professional footing. Yet many patients hold on to the ideal of a healing relationship, and draw comfort and reassurance from small

signs that the doctor has the moral character and imagination to stand in their shoes for a moment. John Sassall, the country doctor observed in *A Fortunate Man*, is acknowledged by his patients ‘as a good doctor because he meets the deep but unformulated expectation of the sick for a sense of fraternity’.³⁸

Doctors’ views

It’s hardly surprising that the views of patients are echoed in the opinions of doctors themselves. As health professionals, doctors observe the qualities to be found in a well-rounded doctor – and appreciate that good doctors come in different guises. In addition to their professional perspective, many doctors have insights from being a patient, especially as they age.³⁹

Doctors know that both technical competence and humanistic qualities are essential attributes of the complete doctor. Bioethicist and medical historian Albert Jonsen describes competence as ‘the essential, the comprehensive virtue’ of modern medicine, noting that writings from the sixteenth and seventeenth centuries on the duties of physicians repeat as the first imperative: ‘Let the physician be competent.’⁴⁰ A book published in 1684 claimed that the first mortal sin of physicians is ‘practising medicine without being thoroughly competent in the art’.⁴¹

By the early twentieth century, in response to the growing emphasis on clinical competence and the scientific basis of medicine, some voices within the medical profession reminded colleagues of the need for humanity as well as technical skill. Harvard physician Francis Peabody famously declared: ‘[T]he secret of the care of the patient is in caring for the patient.’⁴² Compassion has long been identified, in eastern and western medicine, as a virtue in a doctor. The seventh-century Chinese physician Sun Simiao described the Ideal Physician as one who develops ‘a heart of great mercy and compassion’.⁴³ The twelfth-century Jewish philosopher-physician Maimonides also identified the need for fellow feeling in the medical practitioner. He prayed: ‘May I never forget that