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THE RIGHT STUFF: WHAT MAKES 'GOOD' DOCTORS?

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In this last Gresham lecture, I want to look at what makes a good doctor. In my first lecture, I explored the role of emotion and relationship in moral decision making; and in my second lecture, I discussed how that might apply to the use of information in medical practice. In this last lecture, I want to explore the moral expectations on doctors and what it is that we think makes a doctor 'good'. This lecture draws heavily on discussion and collaboration with my colleague Professor Deborah Bowman, whose contribution I acknowledge here. I would also like to acknowledge the valued support of Professor Clare Gerada, and the work of the Practitioner's Health Programme.

I am going to suggest that there are three ways that we think about doctors being 'good'; in terms of their knowledge, their empathy and their virtue. I am going to critically discuss these three domains and conclude with some thoughts about how best to train and support doctors, especially those who work in the NHS.

Knowledge

It seems obvious that we want our doctors to be knowledgeable; and it is true that the backbone of the medical training is the acquisition of information about the human body: its anatomy, physiology, biochemistry and what happens when these are dysfunctional. The earliest years of medical training are not unlike the sixth form exams of 16-18 year olds, where large amounts of information have to be memorized and reproduced under timed conditions as evidence of successful acquisition. First year medical students generally approach medical information just as lay people do; they focus on unusual specialist data but do not have a systemic understanding of how the different systems in the human body work together. They also do not yet understand how to approach uncertainty and complexity because they do not yet know how to ask the right questions and in what order. By year 3, medical students now start to ask questions about the validity of the sources of their information, and enquire about what further information they might need to manage a problem; and by year 5, they are beginning to interpret information in a systemic way; so that they consider information from different standpoints, and are enabled to think about what information may be missing.

In his 2008 book, 'How Doctors think', Jerome Groopman describes how doctors typically organize their thoughts and experience into a set of algorithms and heuristics that allow them to deal with the complex cases that they see every day; especially those cases that seem perplexing or unresponsive to treatment. He argues that doctors often make their minds up fast, based on first impressions of positive signs and symptoms. Although generally these heuristics and algorithms serve doctors well, problems can arise when doctors do not stop to think about what is *not* being mentioned or discussed; or respond to uncertainty by gathering more information. Groopman suggests that the increasing use of tests and scans is a good example of how one can gather information (often in costly and uncomfortable ways for the patient); which may contribute very little without interpretation and reflection, and consideration of what is not there as well as what is.

Groopman suggests that doctors tend to stick with their first diagnostic hunch; and struggle to think of alternatives, or of multiple disorders. He therefore warns that doctors may struggle to change their minds about a diagnosis or treatment because they do not like to admit that they are wrong. Training in medicine encourages

doctors to elide professional success with quickly identifying a single right answer; which is true of medical school exams but rarely applies in real life medical practice.

What I infer from this is medical students and doctors face a classical problem about the nature of knowledge, and even more importantly the acquisition of wisdom. Information is not the same as knowledge: as the comic writer PJ O'Rourke observed, information is when you have a supermodel's phone number; knowledge is when you actually talk to the supermodel. Knowledge implies complexity and perspective taking; and an appreciation that there are relationships between different sets of data that generate new and distinct information. Wisdom in turn builds upon knowledge but adds that crucial element of understanding the gaps in knowledge; and the ability to say 'I don't know' or to ask 'What is missing from this picture?'.

Medical knowledge and wisdom is so much more than just information acquisition; which is why people using Google to self-diagnose is risky. There is no doubt that people can and should be empowered to understand and manage their health and well-being; and if they become ill, they also need to be active in their own illness story. The internet has been, and will continue to be an extremely useful tool for anyone who wants to learn about their illness; who wants to be in touch with other sufferers, or who wants to learn about the latest research. But (as many experts by experience will attest) it takes time to become wise about the nature of morbidity and pathology; and the possibilities for intervention, *or not*.

The wisdom of not acting is one of the hardest things to learn in medicine; as the recent tragic case of baby G attests. In that case, a 9 month old baby is dying of an incurable disease; his doctors want to stop active treatment and support G's death to be painless for him, while his parents want to take him to the USA because doctors there may be able to provide an intervention that will extend G's life even by a little. The wisdom of Solomon is truly needed for such a decision; and the English courts have decided that this is a case for non-action; not the withholding of care or love or support or tenderness; but no further action to delay the inevitable. The parents challenged this view, and any parent can understand why they felt that they had to do so; but the Court of Appeal has determined that there is no ethical justification to cause someone suffering in order to do them good; especially if they are a dying child.

Miranda Fricker (2007) argues that people can be prevented from obtaining knowledge because of lack of access to education, resources or social networks; or can have their knowledge dismissed because of their identified social status or identity. Fricker calls this process 'Epistemic Injustice', describing how people of colour or women can have their knowledge dismissed, especially in terms of the court room testimony. It could be argued that doctors' knowledge has been privileged over people with the lived experience of illness in a way that is unjust; baby G's parents might well feel this now. But there is a counter problem which is that doctors' knowledge includes knowledge of many cases beyond the individual case; and social justice requires examination of multiple perspectives, not just one. Fricker's argument is a good example of what I tried to argue in my other lectures; namely that many medical dilemmas cannot be reduced to an adversarial struggle between one righteous view and one wrong view.

Given that everyone can access basic medical information, the challenge is then what we want medical knowledge to consist of; what we want our doctors to know. The first part of any answer must surely be that we want doctors to engage in a process of life-long learning; to understand that becoming a 'knower' is a process of development, which goes beyond information acquisition. Such an approach is now taken seriously in medicine with an emphasis on continuing professional development and on self-reflective skills. The second aspiration must be to help doctors turn their knowledge and skills into wisdom that can tolerate uncertainty and anxiety about what can't be seen or known. I will discuss emotions and feelings in more detail below; but at this point, I want to suggest that wisdom includes attention to unrecognized emotions, usually uncomfortable ones. Such unrecognized emotions can have a powerful impact on hospital practitioners; as described by Isobel Menzies Lyth (1990) and Danielle Ofri (2013). Ofri describes honestly how doctors can get angry or disgusted by people who are sick or distressed, especially those who don't get better quickly, and she offers some painful and candid examples of how her emotions led her to fail to care for people.

Menzies Lyth's study is even more compelling because it suggests that unconscious emotions can be played out by an *institution*, in the form of policies and procedures. She was invited to consult to a busy hospital, where the senior management had noticed that nurses did not stay after training and there seemed to be high levels of

sickness. What emerged from observing the staff was that they found being close to human distress uncomfortable; and so the services found ways to keep them distant from the work. Further, the most junior staff were given most responsibility, and blamed for things that went wrong. This study suggested that both the personnel and the institution developed defences against distress that were unhelpful, and actually interfered with the primary task of looking after patients. If we think about the collapse of care at north Staffordshire hospital (Francis 2010) it is hard not to think that unconscious fear and distress led to failures of practical wisdom by staff at every level of practice.

Finally, we may want our doctors to become wise by developing their imaginations, which implies a capacity to think something one has not thought before. The arts have always been essential to the process of developing the imagination, and we take this seriously in children; ensuring that they get exposure to creative play as much as data play. In relation to doctors, the study of what has been called 'medical humanities' is a way for doctors to develop wisdom about their emotional experience as doctors, and the experience of being ill. What theatre, poetry, novels and visual arts can do is open a different perspective on experience; especially those dilemmas in medicine that are so painful and inescapable. I include in this list those television dramas about medicine that are so popular worldwide; in this context, it is hard not to think about Dr Gregory House; the fictional doctor who has apparently limitless information and even knowledge, is painfully unwise when it comes to human distress and emotions.

Empathy

Empathy is a 'hot' topic in many academic domains at present, including social science, neuroscience and medical education. Empathy has a variety of definitions, but it is related to that imaginative process that I touched on earlier; namely the capacity to imagine another person's experience to be as real as one's own experience, yet different and distinct. When we express sympathy, we look for points of similarity with our own experience; we say 'I know how that feels', or 'I feel the same'. When we are empathizing, we are recognizing the distinctness and difference of other people's minds and acknowledging that these minds are as real as our own, and that their experience has weight and meaning.

The study of empathy has developed and become more extensive over the last twenty years, especially in the field of the neuroscience. A key player in this field is Professor Jean Decety, who has studied empathy for many years and with different paradigms (Decety & Chaminade 2003; Decety, 2013). He argues that a lack of empathy is a key aspect of many mental disorders (Decety & Moriguchi, 2007), which suggests that good mental health is important to the function of empathy. His studies indicate that empathy has a neuroanatomical base; that it is closely linked to an appreciation of self states; and that it involves both thinking (cognitive) and feeling (affective) skills (Decety & Chaminade 2003; Jackson et al 2006; Decety & Yoder, 2016).

Empathy has come to be seen in moral terms of evidence of 'goodness', leading to the assumption that those who lack empathy are 'bad' people. This argument was made forcefully by Professor Simon Baron Cohen (2012) in a book which contrasted people with autism and people who have committed offences or general acts of cruelty. Baron Cohen argues that people who have autism do lack empathy but in a different way to criminal offenders because people with autism lack only the feeling states of empathy but not the thinking aspect, whereas offenders lack both. Further, Baron Cohen argues that in autism, this deficit in empathy is physically caused by a neurobiological problem; whereas there is no evidence that offenders have such a deficit.

Although superficially plausible, there are many problems with Baron Cohen's argument. First, and counter-intuitively perhaps, several meta-analyses of studies have *not* found that offenders lack empathy (Domes et al 2013; Vachon et al 2014; van Langen et al 2014). Those professionals whose job it is to assess offenders often comment that some violent offenders do have empathy, in that they can imagine how others feel, but they use this skill in antisocial ways and for antisocial purposes. Second, there are problems about how we define 'offenders'; if we only focus on those who are convicted of crimes, we will miss all those who are not detected, who may turn out to be the most empathic of all. Nor are all offences the same; it may come as a surprise to readers to learn that those offenders who commit crimes due to strong emotions do not usually show a lack of empathy generally. They may lack empathy in the moment of violence, but do not lack it generally; which is why most domestic homicide perpetrators do not lack empathy and are at high risk of suicide afterwards. Third, there is evidence that people can switch their empathy on and off (Preston et al 2007); in fact, some studies of

historical war crimes suggest that more educated and intelligent people may be better at the flexible use of empathy. Finally, there are real uncertainties about how best to assess empathy: whether it can be assessed by questionnaires, or whether it is best assessed by observing a personal interaction.

This last point is relevant to doctors in training. Doctors have been expected to be empathic towards the suffering of others since classical times, and the capacity for empathy is therefore part of clinical effectiveness (Decety et al 2014). Medical students and doctors in training are rated on their empathy by observers; but there are questions about whether observation can really provide a valid and reliable assessment of empathy. If an observer says that the candidate lacked empathy, there is a suspicion that what they observed was an absence of overt supportiveness and kindliness. Clearly these skills are valuable for medical practice, but are not identical with empathy. Some observers might see agreeing with a person's view point as evidence of empathy, but it could be argued that this is sympathy not empathy, and that really useful empathy includes awareness of a person's experience that they may not be aware of, or may not be explicit. For example, when people are frightened or anxious, they may become irritable or angry. A sympathetic and supportive response would validate the anger but an *empathic* response might be to try and understand what lies behind the anger, and facilitate the expression of the fear or anxiety.

Danielle Ofri (2013) argues that empathy is indeed a crucial skill for doctors to learn because this will enable doctors to understand what really matters to the people they are treating; and so enable them to choose the best treatments in partnership with those whose lives are changed not just by illness and injury but by the treatment itself. Ofri comments on the research that shows that by the third year of medical training, empathy levels have typically dropped in medical students (p30); and she wonders what can be done to change this.

I wonder whether the apparent lack of empathy is actually an improved capacity to switch off the affective response to other peoples' suffering, which is essential for life time's work in medicine. It may be that we want all doctors to maintain their cognitive empathic skills but only judiciously use their affective empathy. This argument is supported by research by Gleichgerrcht & Decety (2011, 2014) who observe that the expression of empathy is costly for health care professionals, and can lead to anxiety and decreases in professional competence. It seems to be important for health care professionals to not get too personally involved when helping others because this generate a threat response in their own stress systems, which is damaging to their own health (Buffone et al 2017).

Studies of emotion in primates (human and non-human) find that emotions are an important aspect of social communication in groups; especially about painful or risky situations. There are a variety of ways that emotions are transmitted between people; sometimes by overt displays and frank communication but sometimes in more inchoate and non-verbal ways. Humans are sensitive to emotional atmospheres and emotions can be induced by sounds, smells and sights: as anyone who has ever been to the theatre will attest. There is a performative aspect to emotions, and humans are adept at reading those performances using what has been called 'mentalising' skills. Mentalising is key to empathy because it treats the other person as having intentions dissimilar to our own; and good mentalising can enable others to mentalise better. Too much emotion and arousal can overwhelm mentalising; so it may be valuable for junior doctors to learn to regulate their emotional responses. Compassionate detachment may be the objective skill for doctors to acquire , not unlimited empathy.

Finally, there are more general doubts about whether any psychological capacity is positive at all times and in all places. Paul Bloom (2017) has recently questioned the high moral value we place on empathy, making the same point that a modulation of empathy may be valuable in certain circumstances. As I suggested above, there are individuals who use their empathic skills to con and manipulate others; and a sub-group of those who stalk their victims are only too aware of the impact on their victims. Perhaps what doctors really need to develop is what Campling & Ballard (2011) call 'intelligent kindness'; kindness and sympathy for pain, distress and fear but an intelligence about how to manage those emotions in others and themselves.

Virtue

The last domain I want to explore is that of virtue; the idea that the good doctor has a virtuous character, because the role of a doctor entails virtue and goodness (Radden & Sadler 2010 p 4). If this idea is true, this means that we must select good people to be doctors and we must train doctors to be good people. Doctors will

be held to a higher moral standard than other people and those that bring the profession into disrepute will be punished; and may lose their identity as doctors. On this analysis, your personal and professional identities are not distinct; one cannot be a good doctor at work and a bad person at home.

There is a tension here between ideals and idols. It is one thing to have high ideals for a professional group; quite another to put them on a moral pedestal, from which the only way is down. Given that people typically apply to medical school at 17, it seems unrealistic to expect that their moral character is fully formed as 'good' at this stage. The development of a moral identity, as a narrative of experience, starts to develop in the teenage years; but that process does not end there, but arguably develops and changes in response to new experiences, especially relational ones. We might expect the years of 17-23 to be crucial periods for the formation of moral identity, which might include making mistakes along the way.

Virtue in medicine has been the subject of extensive study; to some extent as part of the general expansion in the study of medical ethics, but also in response to what happens when doctors do bad actions. The first question is always whether this was incompetence or bad intention; the former is seen as remediable, the latter less so. A good example is the study of sexual boundary violations by doctors i.e. those situations where doctors have consensual sexual relationships with people whom they have met as patients. Typically, what happens is that a doctor (usually but not always male) treats woman for a condition. He then asks her out, or in other ways develops a relationship with her that is personal and not professional. A sexual and intimate relationship begins; but when it ends, the woman reports the doctor to regulatory authorities. In the UK, the GMC nearly always suspend and/or erase doctors from the professional register for this kind of behavior; which is distinct from assaults or inappropriate flirting and contact.

The doctors who get involved with these types of relationship are often older; and work in domains where long term contact is possible with people: general practice, psychiatry and OBGYN. They may be subject to stress at home or at work; and may have a variety of personal problems. Whatever the motivations, the key wrong doing is the exploitation of a person's vulnerability: if someone seeks help for a medical condition, they are vulnerable insofar as they have less knowledge, but they also put themselves in a supplicant position. The medical ideal of virtue includes a commitment never to abuse the vulnerable or helpless; not least because it would be so easy for doctors to do this. We trust doctors with our vulnerability because health care would be impossible without that trust.

How do we ensure that doctors become the kind of people who will never abuse a person's trust when they are vulnerable? At present, we focus heavily on identifying 'bad apples' early; and punishing 'offenders' severely. The regulatory system takes an *ad hominem* approach; if a doctor breaks the rules, this means that they are a bad person, and that means that they may not be able to be a doctor, no matter how good they may be in other ways. One can only assume that deterrence is the key strategy here to ensure that doctors get 'good' and stay 'good'.

The difficulty about this approach is that it does not fit with what we know about rule breakers more generally. Although there are criminal offenders who are 'bad' in every domain of their lives, and seem committed to an antisocial world view, they are the minority. Most offenders have strengths as well as vices; and it is only by addressing those strengths that rehabilitation is possible. Deterrence does not work well as a way of reducing offending; what works best is understanding how offenders came to make poor choices and lose sight of their moral values. If we apply this to doctors, it would make sense to do therapeutic work with those who have broken the rules and offer more rehabilitation. We can also try and help develop moral identities during training, and allow trainees to talk about those times and situations when they don't feel like being virtuous, brave or kind.

At present, much is expected of doctors, especially those working in the NHS; and they are expected to provide an excellent service with resources that feel fragile and under threat. It has been argued that there has been a decrease in deference to professionals of all kinds, which is welcome in terms of social equality and justice. However, the unforeseen consequence may be that without deference, it is hard to feel that you are doing anything specially valuable. It is said that Aneurin Bevan 'stuffed [the doctors'] mouths with gold' to entice them to work in the NHS (Sheard, 2011); but what kept them there was the respect and sense that they were contributing to a common purpose, and that their contribution was seen as rich, valuable and a vocational

choice. There has been little sense from the current government that doctors are seen as anything other than a self-serving group, who just want more money; which is hardly the description of a virtuous person.
The study of psychological defences mechanisms tells us that where there is idealization in mind, denigration is not far behind. Studies of relationships using attachment theory show that a relationship where there is global idealization is an unstable one which is likely to become toxic and denigratory in an oscillating fashion. Such a pattern is probably operative in sexual boundary violations; but may well operate in other situations in medicine where emotions are running high. Idealisation is (by definition) not rational, and doctors are likely to feel uncomfortable in situations where rationality is not operating. Highly stressed doctors may respond to idealisation with more stress and anxiety about how they can meet impossible demands. I am thinking here of the examples given by Ray Tallis (2005) of the fury he has tolerated from relatives when he does not support extending the life of a dying elderly person with active treatment. In those moments, he is refusing to take on the role of a god who exerts control over life and death; but embraces the role of a healer who takes suffering seriously. Doctors are often accused of 'playing god'; but they are also often treated as entities with both omniscience and limitless power over life and death.

The current employment structures in the NHS are also problematic for high quality moral reasoning in medicine, as doctors find themselves trying to internalise two conflicting standards of medical care: the doctor as functionary workman/ salaried employee, who does what she is told by their employer and the doctor as altruistic saint who makes sacrifices for the good of others. Neither of these formulations address the complexity of medical relationships, nor do they offer a framework in which doctors can maintain wisdom, mentalising skills and a working moral narrative of professional identity.

Conclusion

The language of the "good" is the language of values. Values are judgements about feelings, and arguably the spine of our ethical backbone and structure in medicine. When we say that we want a good doctor, we want one who is technically skilled, but we also want doctors who are humanly good, and who want the best for us, from our perspective and with our experience in mind. We want doctors not to take advantage of our vulnerability; we want doctors to understand what it is like to be us with our condition. Good quality relationships take time and attention; and if we want these in medicine then they will have to be paid for, both in emotional and financial terms. At present, it seems that people want bespoke relationships in health care but won't pay for them: and don't want to pay for others to have them either.

The perfect doctor is a unicorn; a beautiful and fabulous idea. In the real world, we need to help doctors develop and maintain a virtuous attitude across a professional life span. It is relevant here to consider that one aspect of virtue is the capacity to admit one's mistakes and failings, and to learn for them. What this means is that there needs to be spaces in the professional day for honest and authentic exploration of human failings in medical practitioners; and opportunities to rehabilitate and do better.

The observant reader will have noticed that I have barely used the word 'patient' in this essay. I have done this because I do not believe that doctors and patients are different, separate and distinct groups of people; but rather that everyone is a potential patient, and everyone is sometimes a care giver. However, doctors and other health care professionals spend nearly all their human time as care givers; and it is the professional nature of that role that is at issue here. But if we suggest that doctors are not patients, and can never understand what it is to be a patient, we contribute to an idealization process that makes illness and suffering worse, and stops doctors from learning. I conclude that we need to enable doctors to treat their normal frailties with compassion so that they can be the carers we need them to be.

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