Professional attitudes: why we should care

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A recent paper in the *British Medical Journal*[1], examining the media portrayal of doctors over the last twenty-one years, shows that more than twice as many negative articles are written as positive ones. Although the ratio remains unchanged over the period of the study, the authors noted that the language used to describe doctors appears to become more negative over time. In the UK the list of clinicians who have been seen to provide substandard care for their patients grows ever longer. Recent examples include a gynaecologist[2], paediatric heart surgeons[3] and a pathologist involved in the retention of organs without consent at Alder Hey[4].

Moral deficiency

So where is the profession going wrong? What the above cases seem to share is either a lack of insight or a failure on the part of the doctors to take seriously the need for a caring approach to their patients[5]; thus they open themselves up to the charge of being arrogant, although this may or may not be true in each case[6]. 'Care' for the patient must, of course, include clinical competency[7] (including the insight to recognise knowledge and skill limitations) but doctors must be able to go beyond this. To be more than a biomedical technician the doctor should have an understanding of his own value systems, an awareness that patients' values may differ from these, the ability to achieve shared understanding with the patient and the ability to share decision making with patients at a level that meets their needs[8]. This concept illustrates an underlying assumption, which appears to be shared by the General Medical Council (GMC) and others[9], that the interactions between a doctor and a patient are moral in nature. Indeed, the lack of ability to see beyond the disease to the person suffering from it has been termed a 'moral deficiency'[10]: far more pervasive than a failure of duty in the legal, negligent sense, this is a failure in the *manner* in which patients are treated.

Patients place great importance on the quality of their interactions with doctors. Papers from the United States[11,12] suggest that over 90% of medical litigation is prompted by a patient's perception that the doctor did not care about them. In addition to the problem of litigation, it would seem reasonable to suppose that the quality of the doctor-patient relationship will have an effect on the health outcome of the doctor-patient encounter and that, within this relationship, the doctor's attitude to the patient is important. Indeed, there are now data indicating a positive association between a patient's satisfaction with a consultation and actual health outcomes[13–15], although not all agree[16,17].

The GMC

These attitudinal problems are not new: doctors have long held the reputation for being arrogant[18]. In 1927 Peabody commented that 'young graduates... are too "scientific" and do not know how to take care of patients'[19]. Similar criticisms of undergraduate curricula can be found in more modern literature: in 1984 the American Association of Medical Colleges stated that:

> *the pace of medical education and of technology's increasing permeation of patient care is such that students need special assistance in perceiving the human dimensions of choices and in developing empathy with their patients*[20].

In recent years the GMC has recognised the potential moral deficiency within the profession and, as a result, has begun to institute changes at both undergraduate and postgraduate levels. In 1993 it published *Tomorrow's doctors*[21], outlining its expectations for the education of medical students in several key areas, including that of attitudes (a new version of *Tomorrow's doctors* is currently in draft form). For qualified doctors the GMC has moved away from a negative emphasis on conduct leading to disciplinary action (the so-called 'blue book'[22]) to 14 positive aspects of the duties of a doctor, in *Good medical practice*[23]. At the top of this list is what some would consider the self-evident edict that doctors must 'make the care of the patient their first concern'. What is interesting about most of these duties is their elementary nature: they are 'the good things which, we hope, would be associated with any upright citizen'[24], and as such are hardly defining of the profession. Such is the current state of affairs, however, that it seems that the profession needs to hear, and to take seriously, aspects that could have been expected to go without saying.

Despite these changes, and the use of disciplinary action in cases of failure of professional conduct, the GMC has not won back popular confidence. A recent

Health Which? report has found that the public believe the GMC does not act in patients' best interests[25].

Beyond the GMC, the profession itself has begun to recognise the potential negative impact of poor attitudes. In the year following the publication of *Tomorrow's doctors*[21] Sir Maurice Shock, former rector of Lincoln College, Oxford, presented a challenge to medical leaders at a summit meeting organised to consider the profession's core values[26]. He said that the medical profession needed to recognise that society is changing, and in particular that society's view of the profession is changing: gone is the 'social contract' and the 'rights of man'; instead we have the 'sales contract' and the 'rights of the consumer'.

The profession needs to consider how best to respond to these changes; lack of response will inevitably bring about the introduction of external control. Perhaps the single most fundamental theme to come from the profession's attempts to define its core values is the importance of being 'patient-centred' both in teaching and practice[26]. Higgs[27] notes that: 'for the doctor, the need to generalise professionally also contains the "same case, different face" trap. It is our moral perspective that supplies the understanding of the unique value of each individual'. He believes that respect for the person in a genuine, if transient, relationship is the key to bringing together the complexities and uncertainties of medicine and ethics.

Medical teaching

Medical teaching fails to recognise this. Work carried out in a US medical school in the 1950s[28] suggested that undergraduate medical education is responsible for the development of cynicism in students (although it appears that this is related only to the period of undergraduate study, and is countered by a return of the students' original idealism towards the end of their time in medical school). This study echoes other research from the 1950s[29] that found medical education to have a de-humanising effect on the students. The source of these unwanted effects seems to be the educational institutions themselves, which encourage students to focus on grades not patients[30]. This is likely to be as true today as it was then: in particular there is a lack of opportunity within formal curricula to spend time with patients, or for reflection[18,30,31]. In addition, the strong culture of scientific positivism and the nature of much hospital medicine is such that clinical teaching tends to have a biomedical, epidemiological and biostatistical focus[32], rather than a psychosocial one. Training tends to neglect the personal aspects of caring for patients, instead overvaluing what is measurable[33] and promoting detachment and equanimity rather than empathy[34]. This tends to foster a disease orientation in which psychosocial issues are seen as secondary, rather than a problem-based, patient orientation.

So what can be done to develop appropriate attitudes within the profession? In this issue of *Clinical Medicine* there is an article on professional medical attitudes. It gives a definition of 'attitudes', considers some of the influences upon the development of professional attitudes and reviews suggestions for encouraging desirable attitudes and behaviours. What becomes clear from this is that the central problem for medical educators, and for all those involved in assessing the attitude of others, is that attitudes are essentially 'internal'. They therefore cannot be measured directly but can only be inferred from what a person says or does.

The profession needs to respond to the challenge of being judged not only on its science, but also on its humanity. The evident priority, and first step to furthering appropriate professional attitudes, is for the development of a method of assessing attitudes that is not only valid and reliable but also feasible (without such a method we cannot know where we are). None of the methods currently published meets all these criteria adequately, necessitating urgent research into this area. Which leads to another important question: who will fund this research?

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