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President of the Ulster Medical Society 2004–05

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Ulster Medical Society
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TO SEE OURSELVES AS OTHERS SEE US[1]

"Oh wad some power the giftie gie us
To see ourselves as others see us!
It wad frae monie a blunder free us,
An' foolish notion.
To a Louse. Robert Burns 1759-1796

DREAMS

We all had dreams, ideals, and aspirations: Caring for the sick, heroic surgery, becoming, perhaps, a world famous medical researcher. Most of us do not achieve the dizzy height of our ambitions, but it is useful to measure ourselves against our hopes and expectations. Margaret Cook put it eloquently "I had a romantic notion of myself in medical research, complete with daydreams of Nobel prizes, reincarnating Marie Curie, winning an immortal reputation." Similarly we have an image of the traditional family doctor that has changed little over the years. Life published a photo essay on Dr Ernest Ceriani, that set America thinking. In June 1990 they returned to Belfast (pop 6500) Maine, to revisit that story and photographed Dr David Loxtercamp at work. "He cares about all the right things—about love and honour and ethics and community. He has faith in himself, in his profession and in those he serves." These are familiar sentiments. But, in the modern world, we must ask ourselves if they are still relevant. Time and medicine have moved on.

Contemporary literature can give us some idea of the changing role of the doctor in society. Nick Hornby shows us a different world in his novel "How to be good". The central figure is a woman, a general practitioner: "Listen: I'm not a bad person. One of the reasons I wanted to become a doctor was because I thought it would be good—as in Good, rather than exciting or well-paid or glamorous thing to do. I'm a GP in a small North London practice. I thought it made me seem just right—professional, kind of brainy, not too flashy, respectable, mature, caring."

The reality is not, however, a glamorous, prestigious and honoured role in society. Nick Hornby portrayed it eloquently through his narrator: "And I'll tell you something for nothing. All my life I've wanted to help people. That's why I wanted to be a doctor. And because of that I work ten hour days and I get threatened by junkies, and I constantly let people down because I promise them hospital appointments that never come and I give them drugs that never work. And having failed at that, I come home and fail at being a wife and mother".

John Diamond, another contemporary commentator, who has since died of cancer of the throat, did not shy away from telling us: "We used to like doctors, of course, or have some respect for them at least, but that was in the days when there was some communal respect for people who knew things that we didn't.... We like nurses, because they don't get paid much, tend to use the same pubs that we do and we know that if we were willing to spend a couple of weeks...we could do the job just as well. But doctors. No".

What is a good doctor? A recent edition of the BMJ tried to help us decide what we valued in the medical profession, and the cover featured some well known faces in medicine ranging from criminal to celebrity. But it is difficult to identify what factors determine the standing of the profession. Recent surveys may give us some insight into public opinion. Trust is important in any professional relationship and, in a recent survey 92% of the public trust their doctors.

This is reassuring and, indeed, doctors polled highest of any profession. But, in another part of this study, the public were more satisfied with nurses than with doctors. In a similar poll, commissioned by the Irish College of General Practitioners, the public were asked who they held in high esteem. Of the professions, 72% held nurses in very high esteem in contrast to 60% who held general practitioners in very high esteem. Perhaps we should ask ourselves why there is such a difference in the public perception of two professions working in a similar caring medical context. Why does the public hold our nursing colleagues in higher esteem? Exploring further we find that the public consider doctors to be helpful, hard-working, committed and patient-focused, but a significant proportion considered doctors to be aloof (16%) inefficient (13%) overpaid (16%) and financially-driven (19%). Figures worth reflection.

[1] *Ulster Medical Society*, 2005, v74(1), p3.

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In the national survey of patients, the public perception of general practitioners was generally very favourable. The vast majority of respondents (around 90%) had positive views of GPs' skills, knowledge, attitude and ability to communicate but their views on nurses were even more positive. Those with less favourable views of doctors were younger people, those living in London and those from minority ethnic groups. The authors warned, however, that to keep that status, doctors will need to measure up to patient's higher expectations of care.

"MEDICINE WILL HAVE TO SAY SORRY FOR ITS PAST MISTAKES AND MEAN IT"

Any smug self-satisfaction evaporates after reading a few lines of "Rebuilding Trust in Health Care. Reviewing a catalogue of medical mistakes, hospital mismanagement, misinformation, subterfuge, and murder, the authors show how the medical profession deserves the loss of esteem. Doctors can no longer take respect for granted. If it wasn't all entirely true, we could hide behind excuses. While events surrounding such dramatic medical scandals as Bristol, Shipman, and Alder Hey are familiar, the raw facts make horrific reading. Presenting the case that we have failed our patients, the blunt message that "medicine will have to say it is sorry for past mistakes and mean it" resonates. In Alder Hey, one pathologist erred but many others in the university and health service were complicit by their silence. If ever we doubt the impact of these events we should remind ourselves that the families felt so strongly, they asked doctors and hospital administrators not to attend the church memorial service.

Major scandals like those above make headlines, but there are many smaller issues that should make us think. We speak of the importance of medical confidentiality. Our behaviour may contradict. A small study buried in the BMJ should jar complacency: Medical students listened to casual conversation in the hospital elevators and found that caregivers made 18 comments deemed to compromise a patient's confidentiality on 13 of 113 lift journeys with multiple comments on some journeys. Doctors made the most comments, then allied health professionals, and then a nurse. On two occasions medical students asked that the conversation be continued in another location. Patient confidentiality was compromised on more than one in ten lift journeys. Similarly, we might ask how often medical confidentiality is compromised by lecturers showing illustrations or presenting medical histories without written informed consent, or in hospital canteens or social meetings away from the hospital.

A good doctor or a nice doctor? Harold Shipman was clearly a nice doctor, well liked by his patients and this may be one reason why he remained undetected for so long. But we must ask how we would have reacted if he had been neighbouring colleague. Professor Richard Baker suggested that we each look inwards "…calling for GPs to take responsibility for the killer's legacy and question their trust in each other." We can no longer shirk our responsibility to our patients, just by turning a blind eye to a colleague's errant behaviour, but we must take some collegiate responsibility. In response, Professor Sir Graeme Catto, President of the General Medical Council, reflecting on our individual responsibility suggested that "The doctor-patient relationship must become more open and straightforward and be made less prone to the manipulation and paternalism which featured so strongly in Shipman's practice." And perhaps we are each a little guilty, seduced by the often praised doctor-patient relationship. Liam Farrell, whose satire often finds the profession's weaknesses, wrote about the change in out of hours commitment "…my patients are getting along very well without me, thanks very much: any competent doctor is quite acceptable…I guess most of all I miss being needed."

At the Bristol Royal Infirmary, three doctors were found guilty of serious professional misconduct by doctors' regulatory body, the General Medical Council, for failing to stop heart operations on babies, despite the fact that their death rate was much higher than the national average. Twenty-nine babies died following heart operations at the hospital. The fate of the three doctors has been well documented. But what happened to the whistleblower? The NHS has a long history of treating whistleblowers badly. Many whistleblowers find their career, physical health and mental health all suffer and Stephen Bolsin, of the Bristol Royal Infirmary, claimed that victimisation arising from his actions cost him his career. Surely it is time to put into place a system of honesty, transparency and truth, where the whistleblower is not a victim but respected for his integrity. We know why doctors keep so quiet about incompetent colleagues. They pay a huge price. Is this right?

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OPENNESS AND TRANSPARENCY

Which are the best hospitals or practices? In choosing almost every other service from schools to supermarkets, there is some transparent measure of quality. But, when we try to look at options in measuring the quality of hospital or medical care, there is little available. In contrast, most doctors know to whom they would refer themselves or their family if they were ill. But, it seems, they are reluctant to let it be known to patients. Patients would value such a resource. Claire Rayner, President of the Patients' Association, commenting on publications from the Dr Foster organisation which publishes a number of consumer oriented titles, said "This is a truly remarkable resource. For the first time, I can find out what I want to know about local health services. It's the most authoritative measure of healthcare standards available anywhere in the world".

Who are the best doctors? For a start, we are unsure who the good ones are. Appraisal is the proposed quality mark of professional competence and already some branches of the profession are well advanced. The quality of training and appraisal of doctors is sometimes compared to airline pilots although some mischievously suggest that doctors only use this when it suits them. A letter to the BMJ puts this comparison into perspective. Imagine two airlines—in the first, Airline A, 'pilots undergo regular flight simulator skills tests, including rarely met but crucial challenges and a thorough medical examination. Airline B, in contrast, has informal personal development plans agreed privately with a colleague, maybe of their choice, supported by cabin crew and passenger surveys of the gentleness of their landings and the clarity of their communications together with a self declaration of sobriety, health, and honesty. With whom would you fly?

The relationship between doctors and the drug industry is complex and difficult. No-one would argue that we need a vibrant drug research programme to maintain progress in therapeutics. But we must question the close, and sometimes too close, relationship between the drug industry and the profession. It is difficult to defend a wealthy profession that seems unwilling to fund its own medical education without considerable financial support from the pharmaceutical industry, where influential consultants are funded to attend medical meetings in exotic foreign locations, and that doctors are wined and dined by representatives almost every night of the week. This complex relationship was the subject of an entire issue of the British Medical Journal. As Ray Moynihan, one of the key authors, observed "Food flattery and friendship are all powerful tools of persuasion".

"No free lunch" is an organisation that campaigns against this cosy relationship. A presentation accessible on their website points out that gifts from the pharmaceutical industry are not without strings, carry entitlement, and are demeaning to the profession. They include examples of this pervasive persuasion. In contention, the drug industry will argue that they invest heavily in research, and they do, with 22% of their workforce employed in research. But 39% are employed in marketing. Marcia Angell, former editor of the New England Journal of Medicine addresses the topic in her book: "The truth about drug companies. How they deceive us and what to do about it." Next time you are invited to a drug sponsored event in a luxury location and offered good food and wine, imagine what the restaurant staff might think of you. They are your patients.

CARING FOR EACH OTHER

In this caring profession, do we care for each other? The British Medical Association, in their report "Racism in the medical profession. The experience UK graduates" tells it as it is. Racism is manifest in access to training and careers, and in norms of acceptable behaviour. The system is sustained by the reluctance of trainees to complain and the widely held view within the profession that problems encountered by trainees from an ethnic minority are due to valid reasons such as 'not understanding English culture'. But, surely, the medical profession is not deliberately racist. The report19 of the Department of Health [2003] Medical and dental workforce census England illustrates the pattern of employment. White doctors are over-represented in the consultant grades and non-white doctors are over-represented in the staff grades and associate specialists. Esmail points out, in a BMJ editorial, that he has rarely met doctors who are obviously bigoted, but many who deny the problem of racism but act in ways that result in certain groups of people being disadvantaged. His quotation from "A suitable boy" by Vikram Seth is apt: "If it is only bad people who are prejudiced, that would not have such a strong effect.... It is the prejudices of good people that are so dangerous." "What people

think is not what matters—what they do is what matters and in that respect the medical profession in the United Kingdom has a long way to go." In Northern Ireland, we have had relatively fewer doctors from ethnic minorities than in other areas in the UK but we should still ask ourselves if there has ever been discrimination on race or, indeed, on grounds of religion.

We aim to give the best medical care to all patients. But it seems we have different standards in dealing with our colleagues. A qualitative study of general practitioners in Northern Ireland, highlighted the problem. The authors described a perceived need to portray a healthy image to both patients and colleagues, that there was embarrassment in adopting the role of a patient, and that this attitude impeded access to healthcare for ourselves, families and our colleagues. There was an expectation that we would work through illness and that we would expect our colleagues to do likewise. The strength of the message was in the quotations: "unless you're unable to get out of bed you'll crawl in and work" and "a terrible sense of duty of letting your partners down if you don't go in" and that "doctors feel they shouldn't be sick…you don't want to go and see your local psychiatrist in case one of your patients is sitting beside you".

Doctors with disabilities describe a similar experience. A piece in the jobs supplement of the BMJ describing career barriers in medicine highlighted how doctors with disabilities felt that "It is difficult to talk about your weaknesses…. We are expected to conform to a certain standard and I think if you have a weakness you keep it hidden, you don't want to talk about it." More alarming: "[You] would expect tolerance from doctors, but this is the worst group when dealing with their own…most people don't want to know…medicine has a 'survival of the fittest' style."

Not all doctors remain in the profession. In their study of doctors leaving the profession, Mike Goldacre and colleagues found that 15% of graduates were not working in the NHS two years after graduation, 18% after 5 years, 19% after 15 years and 23% after 20 years. And their feelings: "Those who left felt dispensable and that no-one cared what happened to them. Their treatment in the NHS contrasted starkly with their experience of working as doctors in other countries and in the private sector". This year we see the introduction of the European Working Time Directive which has greatly changed medical training. Some senior consultants feel that 58 hours each week is too little for adequate training and hospital administrators worry about staffing the hospital. Few seem to consider that 58 hours of work each week is so much more than we would expect of any other profession. And, on top of this we expect junior doctors to undertake additional study and prepare for postgraduate examinations. "What is the role of doctors in the future? A lot of people who are burning out are some of the most sensitive, thoughtful and caring people, We want a sensitive, caring, thoughtful organisation, yet we are driving people like that out".

CHANGING FACE OF MEDICINE

General practice is undergoing some major changes with a new contract in 2004 and a recruitment crisis. Many general practitioners have their own stories to tell, but recent quotations from the BMA Junior members forum might make us think: "one hospital consultant said to me that the MRCGP was given away with cheese and crackers", "this attitude that GPs are second-rate doctors is dissuading people from entering general practice", "why do you want to be a GP? That will be the end of your life". Similarly, medical students from Dundee and Leicester universities at a BMA conference on recruitment: "lecturers often gave the impression that GPs spent their whole day referring patients to secondary care…medical students do generally listen to their exciting cardiology lecturer". If we wish to see a monetary reflection of the importance attached to general practice research within the wider medical research community, we need only look at the tiny funding allocation to general practice research in Northern Ireland compared to overall medical funding.

"My son the doctor" are famously the four favourite words of Jewish immigrants to America. This headlined an article in The Times discussing the findings of a study by Goldacre showing that of UK-domiciled, UK trained graduates, the percentage of non-whites increased from 1.6% of graduates in 1974 to 21.5% in 2000 and will approach 30% by 2005. White men comprise little more than a quarter of all UK medical students. It seems that the male white doctor is endangered, soon to be extinct. Carol Black President of the Royal College of Physicians courted controversy in stating: "Women did better than men at medical school but there was no female dean of a medical school, no female head of a department of surgery, and no female head of a department of medicine in

the UK." "Family commitments made it more difficult for them to rise to the top of the profession".

PUBLIC PROFILE

The medical community has another skeleton lurking: Research misconduct. Various shades of research misdemeanour include duplicate publication, salami publication, authorship (order, gift, and ghost), plagiarism, fraud, conflict of interest. Some cases have made national and international news. The case of Malcolm Pearce is probably the best known. But Peter Wilmshurst, an indefatigable detective of medial research has described what he considered to be institutional corruption in medicine.

Doctors may claim that the media is responsible for the bad press. One study of the national press found that numbers of negative, positive and neutral articles has increased significantly. The ratio of negative to positive was 2.33 with no change over the period of the study. The number of lines in each article and the median ratio of the number of lines portraying negative to positive was 2.98 with no significant change over time. Data suggest that newspapers respond to incidents rather than deliberately hounding doctors. There were not unexpected peaks in negative reports in 1986-7 and in 1996-2000.

CONCLUSION

Medicine is not all that we might hope. There are problems, and problem doctors, that we cannot ignore. Richard Smith, editor of the BMJ for 13 years was never afraid to address the controversial issues and pointed out: "Medical systems and doctors are measured not by how they manage the grateful patient brings whisky but by how they care for terrorists, monsters and the marginal". In a world that neglects the poor, where the greatest epidemiological risk factor is social inequality and where we read of doctors' complicity in torture, we do need to ask some serious questions.