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What would you do, doctor?

Daniel K Sokol

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A novel that helped pave the way for the NHS, p 855

VIEWS & REVIEWS

What would you do, doctor?

PERSONAL VIEW **Daniel K Sokol**

Some ethicists believe that doctors should be like hairdressers. If you ask a hairdresser to shave your head, he or she will most probably do so. Similarly, such ethicists would argue, if a patient asks to have whiskers surgically implanted or his penis enlarged by injecting fat into the shaft (penoplasty), the surgeon should perform the operation once satisfied that this is what the (competent) patient truly wants. Increasingly, medical professionals are involved in procedures that, to most people, are distinctly odd. The principle of respect for autonomy—still gathering moral weight since its modern birth in the 1960s—seems to be constraining doctors' decision making to such an extent that they are no longer sure if they know what is best for patients. When they do know, they wonder whether communicating this is respecting patients' autonomy or violating it.

What does patient centred care—that current buzz term—require? Are doctors wise gatekeepers of medical expertise, adjudicating the reasonableness of patients' requests; or are they unthinking service providers, dishing out medical procedures like the hairdresser does with haircuts? “What would you do, doctor?” is often regarded as an awkward question, because it exposes this current confusion of roles.

Are doctors wise gatekeepers of medical expertise or unthinking service providers?

“What would you do, doctor?” is a recognition of the asymmetry in medical knowledge and experience between doctor and patient. It generally signifies a patient's desire to shift from one model of the doctor-patient relationship—the consumerist model in which the doctor's role is primarily to provide the patient with relevant medical



“If I were you, I wouldn't opt to have a Mohican”

facts—to a conversational model, where both parties are more actively involved in the decision making. Often, it is also a sign of vulnerability and uncertainty, an acknowledgement that the patient is finding the decision difficult and needs help to resolve the problem. Finally, it is a sign of trust—and in particular trust in the value of the doctor's judgment of what is, overall, best in the circumstances.

The question itself is ambiguous. The first meaning relates to what you, another individual, would do if in the patient's shoes. Answering this question requires you to put yourself in the patient's situation: would you have a regional or general anaesthetic for this hip operation? The second relates to what you, the doctor, believe is right for the particular patient: would you say that the best option for me, Daniel Sokol, is a regional or general anaesthetic for my operation? This question requires a deeper knowledge of the patient's values and beliefs than the first, which is mainly concerned with your own preferences.

The first step in answering this question is thus to disambiguate it. To which of the

two meanings does the question refer? Howard Brody, in the *Healer's Power*, suggests that doctors should sometimes “think out loud” when obtaining patients' consent. This suggestion is particularly apposite in this context. The doctor's answer forms part of the informed consent process. It provides the patient with desired information about the various options. The answer, then, could go like this: “Well, if I had to make the decision, I would probably choose general anaesthesia, as I don't like the thought of being awake when it happens, even if this entails a slightly higher risk. But that's just me, and you might have different priorities. If you don't mind seeing and hearing what happens in the operation room—and let me tell you that you'll probably hear the surgeon hammer away when he fixes your bones—then you might choose regional anaesthesia. It's got lower risks, and you'll probably leave the hospital earlier.” If the doctor knows the patient better, he or she may provide a more tailored answer to the second interpretation of the question.

This kind of answer, far from reducing patients' ability to make an informed choice, enhances their autonomy. By showing a willingness to actively engage with the patient's situation and to address the patient's concerns through meaningful personal involvement, it represents good, patient centred care. On the other hand, declining to answer it altogether—“That's a personal decision that only you can make”—is a form of abandonment. Fear not, then, this common question, for it is a trusting invitation to support and advise the patient—who may well be overwhelmed by unfamiliar circumstances—and to fulfil the Hippocratic moral commitment to benefit the sick.

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See also [Head to head](#), p 826

Home alone

FROM THE
FRONTLINE
Des Spence



My brothers and I shared a room throughout our childhood. Not just a room but clothes as well: we had a communal pants and socks drawer. It held family heirlooms of grey cotton and stretched elastic, others were psychedelic polyester, but darker forces were at work—the purple “pants” lurked menacingly at the bottom. My mother swore blind that they weren’t girls “knickers,” but we knew she was lying. Crammed together in one room we fought, teased, wrestled, studied, and laughed together. When I first opened the door of my tiny cell in the university halls of residence I thought myself royalty. One week later I was miserable; I hated being alone.

I consider that there are lies, damn lies, statistics, and then surveys. But the Office for National Statistics’ annual report on social trends, released this month, seems to have the ring of truth, for a change. Apparently when we aren’t living with our parents into our 40s we are living alone. Some seven million people in the United Kingdom now live alone, and this number is set to rise. So what? Well, this atomisation of society is a ticking time bomb for healthcare provision.

Having spent more than a decade doing a weekly shift of night-time home visits, I am conscious of the vulnerability of people who live alone, especially elderly people. There may be no one to nurse them or watch over them. Distant relatives are unable to offer practical

support. The phone rings at emergency social work support. There remains the last and lowest common denominator: acute medical receiving. A trolley, unnecessary investigations, and bed blocking; perhaps a hospital acquired infection thrown in for good measure. This is no good for anyone.

Others have family acting as advocates. Crushed against the wall, inflamed by their body heat—so starts the game of family tag wrestling. Round after round of verbal slapping downs and head locks from 15 concerned family members all impossibly squeezed into the consulting rooms. Draining tussles with families are our medical auditors, the quality control. Paid “carers” are simply no substitute for a family.

But also there is the broader issue of loneliness. Gnawing, it inflames introspection, distorts perspective, and leads to deep unhappiness. Television and the media offer false companionship—a selfish acquaintance selling a one way mirror into someone else’s life. I want to write a formal complaint about Margaret Thatcher’s mis-selling of the “culture of the individual.” Nobody seems to have read the small print about the disintegration of community, and I fear that it is too late for compensation. I may not want to wear other people’s underwear, but I will certainly never want to live alone.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk

Doing medicine

OUTSIDE THE BOX
Trisha Greenhalgh



The cuddly yellow doggie in the room that I use for my GP consultations comes in for a lot of attention. If I need to examine a child with earache, we first look in the doggie’s ears with my little light. If the child has a sore bottom, the doggie usually hides under the couch roll because he is embarrassed, but then obediently comes out and allows me to look, ever so gently. He wags his tail to show it didn’t hurt, and then I ask the child if I may examine him or her.

Sometimes it’s easier for a child to say how the doggie would be feeling right now than how they are feeling themselves. The doggie is useful to hold if you are about to get an injection, and afterwards, he can sniff his way to where the Smarties jar is kept. And if you are middle aged and working your way through a complex narrative of sadness and struggle, absent

mindedly stroking the doggie will help the words come out.

Although I have occasionally got through an evening surgery without my stethoscope, I doubt if I could do it without the doggie. Yet in six years at medical school, nobody explained to me how much easier my work as a doctor would be if I recognised the consultation for what it is: a piece of theatre. Like most people reading this article, I completed entire courses at undergraduate and postgraduate level in which both student and examiner were required to sign up to the misconception that the clinical consultation is an exercise in pure deductive logic.

Thirty years since failing an audition with Cambridge Footlights on the grounds that I had no dramatic talent, I was chuffed to the core when a medical student described my double act with the doggie as “awesome.” Recently

plucked from the predictable environment of the lecture theatre and hospital ward, he had quickly discovered that his well thumbed textbook of evidence based general practice did not actually tell him what to do with the fuzzy and multidimensional reality of illness in the community. And the essence of medical skill—in both primary and secondary care—is knowing what to do.

The difference between “knowing medicine” and “doing medicine” is the difference between a logical deduction and an outcome that is relevant to the patient. It is also the reason why all first year medical students should be issued with a soft toy or comparable prop and encouraged to improvise creatively with it in at least 50% of their interactions with patients. Trisha Greenhalgh is professor of primary health care, University College London p.greenhalgh@pcps.ucl.ac.uk

Where are all the blighters?

The world has changed a lot since I was a boy and, I regret to say, not entirely for the better. For example, our language has become coarser, a fact that was brought forcibly home to me recently by reading R Austin Freeman's detective story *The Stoneware Monkey*, first published in 1938.

R Austin Freeman, born in 1863, was the son of a tailor. He became a doctor, travelled as such to Ashantiland (about which he wrote his first book), contracted blackwater fever there, and then became a general practitioner in Graves-

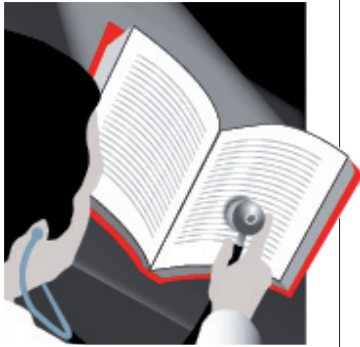
end. It seems that there was something about living on the coast that turned late Victorian general practitioners into writers of detective fiction: Conan Doyle was another. Freeman wrote a book a year for a couple of decades, until his death in 1943, and was a fixed star in the literary firmament.

Freeman's hero was Dr John Evelyn Thorndyke, a forensic pathologist and barrister of enormous intellect. He was a bachelor, lived in the Inns of Court in great comfort, and lectured at St Margaret's Hospital. His knowledge, from archaeology to toxicology, was unnaturally encyclopaedic.

The first part of *The Stoneware Monkey* is narrated by a Dr Watson figure, one James Oldfield MD. He starts with a few general observations about the nature of medical practice: "The profession of medicine has a good many drawbacks in the way of interrupted meals, disturbed nights and strenuous working hours."

Well, as Sganarelle put it in Molière's *Le Médecin Malgré Lui* with regard to the heart being on the left side and the liver on the right, "Nous avons changé tout cela." The "we" in question is, of course, the European working time directive. No more interrupted meals for doctors, at least without compensatory rest.

BETWEEN
THE LINES
Theodore Dalrymple



There used to be some blighters still around when I was a boy, but now they are all something far, far worse

But let us return to the question of language. Early in the book, a policeman is struck a tremendous blow to the head by his own truncheon by a man who has wrested it from him. Dr Oldfield is the first on the scene and describes what must have happened to another policeman who arrives a little later on the scene. The policeman's response is, by today's standards, somewhat muted.

"Blighter!" muttered the constable.

It seems to me that a police officer of today might use

rather stronger language, even for a car wrongly parked. This raises an interesting question: where have all the blighters gone? There used to be some still around when I was a boy, but now they are all something far, far worse.

A little later in the story a potter of the name of Peter Gannet discovers that he is being poisoned with arsenic. Dr Oldfield is a little slow to diagnose the case, and calls in Dr Thorndyke, one of his teachers from medical school, who diagnoses it immediately. On being told that his drink has been poisoned, and that it can only have been done by someone in his household, Gannet says with admirable sangfroid: "Ha! So it was the barley-water. I thought there was something wrong with that stuff. But arsenic! This is a regular facer!"

Genteel as I am, I doubt that I should use that expression if I discovered that I were being poisoned by one of my nearest and dearest.

Some things don't change, though. Dr Thorndyke was the most popular lecturer at St Margaret's Hospital: but then forensic pathologists always have been, always are, and always will be the most popular lecturers. Why should this be so? Now *there* is a question.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

The Citadel By AJ Cronin

First published 1937

The Citadel is a semiautobiographical story about a young doctor and his journey through his medical career. A bestseller when it was first published in 1937, it was reprinted more than 12 times in its year of publication. As well as providing an insight into medicine at the time, it was influential in setting up and increasing public acceptance of the National Health Service in the years that followed.

The novel's protagonist is Andrew Manson, a young idealistic medical graduate who chooses to work in a Welsh mining town to pay off his medical school debts. *The Citadel* charts the progress of his personal and professional life, from the hardships of starting out and taking exams, to moving to a bureaucratic government job in London and then on to lucrative private practice. Material success leads to numerous problems for Dr Manson both at home and work, and the story ends with a dramatic turn of events.

The context in which it is written is particularly relevant in the current climate of reform in the NHS. It is set in the late 1920s and early 1930s when there were no specialists and practices varied greatly. It highlighted inequalities between public and private health care and shortfalls within the system. There were public hospitals, and the doctors who worked in them earned greater respect, but if patients could afford to they chose to be treated privately. *The Citadel* covers many issues that are still evolving today—for example, the use of the "scientific method" (evidence based medicine) in clinicians' practice and "compulsory postgraduate classes" (continuing professional development).

My grandmother (a retired paediatrician) gave me her copy of *The Citadel* when I graduated. I read it at two different stages in my career: as a house officer and later in my surgical training. Initially it helped me see how life as a doctor could be different from the theory learnt at medical school, an extreme example being when Dr Manson and his colleague blow up



Robert Donat as Manson in the 1938 film version

the local sewers during a typhoid outbreak to get the council to repair them. The second time I read it, what caught my attention was the relationship between Dr Manson and his wife. Her ongoing support of him throughout exams, research, and the stresses of everyday work is something that I (and my wife!) can now relate to. I am sure if I read it again in five to 10 years' time it would shed light on a different aspect of my job. The fact that it appeals to doctors at all stages of their career makes it a classic.

There are many enduring themes in this novel that make it interesting to a doctor, such as ethical issues and the work-life balance; but above all *The Citadel* is an easy to read, enjoyable book.

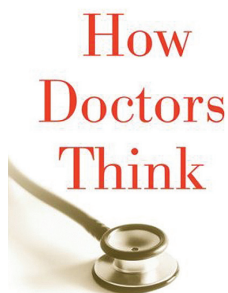
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REVIEW OF THE WEEK

Living in a box

Rigid reliance on evidence based medicine and highly sophisticated technology has taken doctors away from the patient's story, claims a new book, as **David Woods** discovers

"A funny, important, and wonderful book... You'll never look at your own doctor in the same way again."
—Steven Levitt and Stephen Dubner, authors of *Freakonomics*



JEROME GROOPMAN, M.D.
How Doctors Think
 Jerome Groopman
 Houghton Mifflin, \$26,
 pp 320
www.houghtonmifflinbooks.com
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 Rating: ★★☆☆

Doctors need to think “outside the box” much more often, says the noted oncologist and haematologist Jerome Groopman. Failure to do so starts early in the medical training cycle, he says, as medical students and junior doctors all too rarely question cogently, listen carefully, or observe keenly.

What’s partly to blame for this, Groopman contends, is today’s rigid reliance on evidence based medicine and even, to an increasing extent, on highly sophisticated technology that “has taken us away from the patient’s story.” To support this notion he points to the sobering statistic that between 1998 and 2002 the number of computed tomography investigations in the United States increased by 59%, magnetic resonance imaging by 51%, and ultrasonography by 50%.

But it’s the sensitivity to language and emotion, he believes, that makes for a superior clinician. In fact, he says, technical errors account for only a small fraction of incorrect diagnoses and treatments. Most errors are mistakes in thinking. Among these are so called “attribution errors,” in which thinking is guided by stereotype and shuts out possibilities that might contradict that preconception. Groopman’s main prescription to remedy this is a heavy dose of heuristics: stimulating interest as a means of furthering investigation.

Then there’s “availability thinking”—the tendency to judge the likelihood of an event by the ease with which relevant examples come to mind. “Anchoring” is another shortcut in thinking where a doctor doesn’t consider multiple possibilities but quickly and firmly latches on to a single one.

Much of this book focuses on what Groopman sees as the vital importance of doctor-patient communication and of the patient’s role as a partner in diagnosis

and treatment. This is not easy, he says, as doctors must increasingly juggle cell phones, test results, referrals, beepers, and, yes, patient satisfaction surveys. These superhuman demands could “morph us into steely eyed combatants or reduce us to blithering, overwhelmed, white coated globs of jelly.” No wonder it’s estimated that doctors interrupt patients on average within 12 seconds of when they begin telling their story.

Groopman doesn’t shy away from attributing a measure of arrogance and hubris to his fellow professionals’ thinking processes, noting that these traits may persuade them that they are always right just because they usually are. And a defence against uncertainty, he believes, is a culture of conformity and orthodoxy that begins in medical school and something he calls “diagnosis momentum”: when an authoritative senior doctor has fixed a label to a problem it usually stays firmly attached.

The author devotes a chapter to his own experience of received medical wisdom. In a sort of “blind men and elephant” scenario he goes to several doctors in an effort to treat a hand immobilised by too much taping. The first clinician showed what is called “commission bias”—the tendency towards action rather than inaction. The second made a cognitive error called “search satisfaction”—the tendency to stop searching for a diagnosis once you find something. Finally, Groopman settled on a doctor who kept searching for a cause and avoided another error called “vertical line thinking”—the hackneyed “inside the box” variety.

Groopman says that after writing this book he realised that he has a vital partner who helps improve his thinking, a partner who may, with a few pertinent and focused questions, protect him from the cascade of cognitive pitfalls that can result in misguided care. That partner, he says, is the patient, who seeks to know what is in his mind and how he is thinking. “By opening my mind I can more clearly recognize its reach and its limits, its understanding of my patient’s physical problems and emotional needs. There is no better way to care for those who need my caring.”

Throughout the book Groopman relies on many case histories and vignettes. The fact that he seems to be a novelist manqué, describing, for instance, one subject as “a compact woman with a round face, alert eyes and a lilting, almost musical voice that often breaks into laughter,” need not detract from the book’s essential value in helping doctors and patients gain a better understanding of how doctors think.

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Groopman says that the superhuman demands placed on doctors could morph them into steely eyed combatants or reduce them to blithering, overwhelmed, white coated globs of jelly