Letter from Australia

WHAT QUALITIES MAKE A GOOD DOCTOR?

Each year in December, young medical graduates in Australia are registered as medical practitioners and with eager anticipation, prepare to start their medical careers. As I look back, 41 years after my own graduation and registration, I ask myself: Which personal qualities combine to make someone a good doctor?

In his book, *On Equilibrium: Six qualities of the new humanism*,[1] John Ralston Saul, the great Canadian thinker, novelist and essayist (and husband of the Canadian Governor General), identifies the following as key virtues that can be used to describe an *effective* person: common sense, ethics, imagination, intuition, memory and reason. I find this framework quite helpful and it is interesting to try and structure references for people on them. How well do these 6 qualities relate to what makes someone a good doctor?

In medical practice, common sense is unarguably essential. In specialist examinations, candidates pass or fail depending on their ability to see things in perspective. What is the most likely diagnosis, given the symptoms and signs that have been identified? What is a reasonable number of investigations to order, considering the differential diagnosis, the patient's circumstances and the cost of the tests? What is the safest and most effective treatment? In the bigger picture of the patient's whole being, where does the problem they have presented with fit in? What is the best way to explain something affecting a person's health to them—in medical jargon or in plain language? All of these questions require an answer based on the ability to see things in perspective, which is what common sense is all about. It generally develops with experience, but some people start off with more of it than others, due to their upbringing. Lack of it is usually due to inadequate knowledge (which improves with training), lack of a good role model, or personal insecurity.

The community has a right to expect doctors to behave in an ethical way at all times, which means always putting the best interests of the patient ahead of all other considerations. Love your neighbour (or your patient) as yourself. The best doctors, in my experience, are those who are fully committed and passionate about what they do and whose motivation is the benefit of the patient. There are of course, doctors whose personal ethics are deeply flawed. Hopefully the system identifies them before they have done too much harm and through regulation or other disciplinary action, brings them into line. Medical schools and teachers have a responsibility to teach the ethical basis of medical practice to their students. In Australia, the ethics content of the medical course has fluctuated, but in general, it has been relatively slight. I do not know the situation in Indian medical schools. Hospital and clinic managers also have ethics to consider. First, they must set the ethical standards in their institutions. Second, it is their responsibility to ensure that every young doctor they employ is given the chance to fully develop his or her potential and make the maximum contribution to the welfare of patients that is possible. It is sad if a young doctor's potential cannot be adequately developed due to poor management.

Do doctors need imagination? They certainly do, if they want to pursue a research career. If everyone learned what the lecturers said and what their textbooks contained by heart and never questioned anything, there would be no progress. The best doctors I have known are curious about everything and never lose their curiosity. They are always asking, 'Why is it so?' and 'What is the evidence for that statement?' They are able to imagine that the textbook could be out of date and that there could be another explanation. Teachers who rely on dogmatism can find this confronting. Imagination is the part of intelligence that allows us to dream and to create a vision. It is therefore very necessary for hospital executives and planners to have imagination, assuming they want their institutions to grow and improve.

Intuition is perhaps a more difficult quality to define in relation to medical practice. Do we want doctors to rely on intuition, meaning a 'hunch' or 'instinctive knowledge', rather than on a rational analysis based on a deep understanding of evidence? Sometimes in emergency situations, time doesn't allow all of the alternatives to be systematically identified; a well-trained doctor, acting on her intuition as well as knowledge gained from years of training, will be more effective than one who hesitates. Some people are blessed with reliable intuition, while others may not be.

In the medical course, we have to learn an extraordinary number of facts and commit them to memory. In my day, we learned anatomy using mnemonics—words or phrases that aid memory—most of which were memorable because they were so lewd (and therefore, unprintable). I can still remember the names of the carpal bones and the complex relations of the pterygoid fossa (useless though they be), because of 2 unforgettable mnemonics. I suppose that everything I learned about anatomy, biochemistry and physiology is hidden away somewhere in my memory and perhaps I could never have built on the foundations of my medical education had I not been forced to develop a good memory. In day-to-day practice, we need to be able to remember what happened to a particular patient or family on previous occasions, what confidential disclosures they may have made but which were not written down, and much more. Once memory starts to deteriorate, we can compensate to a certain degree by becoming more systematic in the use of pocket notebooks and asking younger colleagues for assistance, but sooner or later, loss of memory is the thing that will stop us from practicing medicine.

It is often said that law students receive an excellent training in logic or reason. Lawyers are trained to sift through masses of documentary evidence and make sense of it. Doctors also have to do this. We have to be systematic in taking a good history and carrying out a thorough physical examination, analyse what we have learned from that, then test our hypothesis (differential diagnosis) by performing special investigations, the results of which will confirm or disprove our theory. In clinical practice, we are somewhat blessed because there are usually two or three approaches that could be taken to any particular situation and with any luck, none of them will kill the patient! I learned a valuable lesson when I was a research fellow working in a basic science laboratory. It was that in laboratory experiments, there is usually only *one* right way of performing the experiment. Laboratory researchers tend to be more precise than clinicians in their thinking, by and large. I have huge respect for my laboratory research colleagues, as a result of my gaining this insight.

In referring to doctors we consider outstanding we usually use words such as 'brilliant', 'reliable', 'compassionate', 'hard-working', 'an excellent team member' and 'a good communicator'.

An additional quality that I value in a person is whether or not he or she is a good finisher—do they finish the jobs they start? I regard John Ralston Saul's 6 qualities as very important and they encourage us to think more deeply about how to describe a person's effectiveness, but perhaps they are not the whole story when it comes to defining a good doctor's qualities.

Some medical schools conduct pre-selection interviews that try to screen out the students who are plainly not suited to a medical career or who are not really willing to commit to it. This kind of screening is controversial and opponents of the interview system argue that examination results should be a sufficient indication of quality. In my view, however, the person who is destined to become a good doctor needs humanitarian qualities in addition to the intellectual gifts that lead to good examination results. Not everyone has them.

REFERENCE

1 Saul JR. *On equilibrium: Six qualities of the new humanism.* India:Four Walls Eight Windows; 2003.

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Letter from Glasgow

MENTAL HEALTH AND WELL-BEING

Many patients with mental illness face difficulties in making others understand their problems. There is a stigma about mental health and patients may experience prejudice and discrimination. Even at a personal level, I know friends who will happily discuss all manners of signs, symptoms and other details about physical illnesses and diseases, but they find it difficult to talk about mental health.

Mental health and well-being is an important concept in public health but often public health is (mistakenly) thought to be interested only in physical health. *Stedman's Concise Medical Dictionary*[1] defines mental health as 'emotional, behavioural, and social maturity or normality; the absence of a mental or behavioural disorder; a state of psychological well-being in which the individual has achieved a satisfactory integration of instinctual drives acceptable to both self and social milieu; an appropriate balance of love, work and leisure pursuits'. I particularly like the last definition as one which the 'punter' (i.e. the average person) on the street can identify with. Of course some people think about mental health and well-being and believe it is about mental illness. It isn't—and mental health and well-being is also just like other aspects of health because it is influenced by factors such as employment, social circumstances, lifestyle, housing and the built environment in which we live, work and play.

It is a paradox that to demonstrate health, we generally use mortality and morbidity data. For example, to compare differences in 'heart health' in populations, we look at coronary heart disease (CHD) mortality and morbidity rates and the lower the rates the better the 'heart health'. Mental health and well-being is no different and imperfect though that may be, it gives an indication of the scale of the problem. In Lanarkshire (where I work and which has a population of 560 000 people) it is estimated that 1 in 4 adults will need some form of mental healthcare during their lifetime, that 16% of adults will experience a neurotic disorder such as anxiety or depression in the previous 7 days, and 1% of adults are living with a severe and/or enduring mental healthcare need.[2] We also know that in Scotland and Lanarkshire there are health inequalities in relation to mental health with people in lower socioeconomic groups suffering more mental health problems and having poorer mental health and well-being than people in higher socioeconomic groups.

In Scotland and Lanarkshire, we have a reasonable history of tackling this issue. In 2003, the Scottish Executive produced its National Programme for Improving Mental Health and Well-being Action Plan.[3] The action plan had 4 aims:

- Raising awareness and promoting mental health and well-being;
- Eliminating stigma and discrimination;
- Preventing suicide; and
- Promoting and supporting recovery.

When the Scottish National Party (SNP) became the largest party in the Scottish Parliament elections in May 2007, it formed a minority Scottish Government. While this was different from the previous Labour–Liberal Democrat coalition administration, there was continuity in terms of some policies. So when the SNP Scottish Government produced its policy on the National Health Service (NHS)[4] in December 2007, it referred to 'an enabling health service' in which mental health and well-being was a priority area consistent with the importance accorded to it by the previous administration.

As work on the topic has developed, so the strategy for mental health and well-being within Scotland has evolved. Earlier this year, the Scottish Government published its mental health improvement policy entitled 'Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009–2011'.[5] It notes the responsibility of the Scottish Government in mental health improvement through promoting mental health, reducing mental health problems, and improving the quality of life of people with mental health problems. It goes on to state that the roles of the NHS in Scotland are to lead and embed mental health improvement in its work, but also highlights the roles of local government and the voluntary sector. Towards a Mentally Flourishing Scotland (TMFS) has set 6 priority areas:

- mentally healthy infants, children and young people
- mentally healthy later life
- mentally healthy communities
- mentally healthy employment and working life
- reducing the prevalence of suicide, self-harm and common mental health problems, and