With luck, good doctors make a difference

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SUMMARY
The luckiest general practitioners work in an ideal environment with a perfect patient population, their clinical intuitions are always correct, they face difficulties with total equanimity, and they get on with all their patients. In the real world one needs a lot of luck for things to go right. This paper applies the philosophical concept of 'moral luck' to the world of general practice.
Keywords: *intuition; physician–patient relations; luck; ethics.*

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Submitted: 6 May 2003; Editor's response: 26 June 2003; final acceptance: 3 September 2003.

Introduction

WE are acutely aware of the dangers of demoralisation, burnout, and unhappiness in general practice, and in a very real sense we all need a lot of luck to remain happy in clinical practice. Despite our best efforts and intentions, things sometimes turn out for the worst and not for the best. The basic paradox is that you can do the right thing, but you also need good luck for it to turn out right. Who has not had a bereaved patient say something like 'If only you'd have sent him in earlier', when you know very well that you did everything absolutely right, but that you simply cannot save them all? This paradox is not confined to medical practice alone, but applies to all those areas of life where doing the right thing is involved, and it has been called the paradox of 'moral luck'.[1,2] This article examines some of the implications of moral luck for the practice of clinical medicine, following the recent publication of a book by the bioethicist, Donna Dickenson.[3]

Outcome luck

There are various types of luck. There is the usual type, called 'outcome luck' by philosophers, which is the sort of case just described, where bad luck intervenes to affect the outcome of our actions. When the unlucky factors are quite outside our control, like the severity of an illness, that sort of outcome luck has sometimes been called 'brute bad luck'. Sometimes it is brute bad luck and sometimes it can be brute good luck when things undeservedly turn out right. On other occasions, however, it might be that one is faced with a choice among different management options, two or more of which seem equally reasonable. Given one's level of knowledge and expertise, the choice is a matter of judgement, and it is lucky if you chose the right option and unlucky if you chose the wrong one — for you and for the patient. This second sort of outcome luck has been called 'option luck'.

It may be instructive to look at how the dangers of option luck can be minimised in good general practice. The past 50 years have seen the widespread recognition of the value of comprehensive primary care throughout the world. Comprehensive care combines curative interventions with the origins of disease being controlled by encouraging risk factor reduction, and care for the chronically ill and the dying. The spread of good general practice has developed in parallel with a remarkable lowering of premature mortality.[4] Whereas received wisdom states that premature mortality is reduced by public health improvements rather than by curative medicine, in the case of contemporary affluent societies this no longer seems to be so, and much of the more recent improvement is owing to many of our newer curative interventions becoming truly effective. It is not immediately obvious, then, why the general practitioner (GP) should be the best person to provide curative medicine, for

surely directing patients to the relevant expert specialist should afford them better chances of recovery. The basic counter-claim of general practice is that, although GPs are relatively less knowledgeable in any one field of medicine, they are better equipped to make the right probabilistic choices and to take the right risks. How they manage to do this seems to be related to their lack of constraint by algorithms.

Algorithm-driven medicine relies on relatively predictable and linear relationships between discrete causes and defined effects. But that is not the way the real world works. The real world of general practice is far more complex, with all manner of obvious and not so obvious confounding influences on outcomes. Randomised control trials are designed to cancel out those confounding influences, but in real life they are there the whole time. Slavishly applying algorithms to general practice has been called evidence-burdened medicine, not evidence-based medicine. GPs' decisions are in the domain of what are fashionably called complex responsive processes.[5] A GP's life is not governed by linear processes but by highly complex fields of decisions that are too complex to reduce to a simple series of linear relationships. Much of what a good GP does when making decisions happens at an unconscious and intuitive level. Subtle cues affect the decisions, such as the current behaviour of a familiar patient that contrasts with that patient's behaviour generally. Slight degrees of dissonance and strangeness ring the alarm bells and alert the doctor to imminent dangers, such as a child's meningitis or an impending suicide attempt, even when the questionnaire scores do not add up. The expert and experienced GP combines evidence with intuition to choose the best options.

Circumstantial luck

There are, however, other sorts of luck lurking in the shadows. The link between being a good doctor and successful clinical outcomes is often mediated by the environment of practice, which is also a matter of luck. It is a matter of good circumstantial luck if we work in better environments and bad luck if we have to work in more problematic environments, with more or less pressure or resources. It is not just the circumstances of the contract we hold, such as the conditions of service and our working environment, that are being referred to here, but also the personal, family, and socioeconomic circumstances of our patients, and the culture and the physical amenities of the neighbourhood.

The real question is whether to do anything about one's circumstances. Socially committed doctors have brought about social change. There are some notable examples where good doctors have made a huge difference — most notably in campaigning against smoking. More contentious is the frankly political activity of some doctors in organisations such as International Physicians against Nuclear War, Physicians for Social Responsibility, and Physicians for Human Rights. Is it the GP's job to become politically active, whether it be at a professional, local, national or global level? Is this part of medicine's professional role, or a private role for each individual to choose? GPs are confronted daily with the deleterious health consequences of social inequity.

Professionally, we are committed to providing just and equitable medical care, but our work is embedded in a world that produces and aggravates ill health as a by-product of the unequal distribution of wealth. As the country as a whole becomes more prosperous, the gap between richer and poorer grows wider, and it is perceived poverty — the awareness that you are left behind, rather than absolute levels of income — that has been found to correlate with the worst of health.[6] As their justification for imposing a market model on health care, politicians cite the unlimited demand for limited health resources, but the only model of practice that can relate to the reality of our daily dealings with the victims of the open market is that of service, not of commodity. At the very least, I think a good doctor should be expected to lobby for equality in the distribution of health-care resources.

Character luck

The third and final sort of luck that affects the success of our good doctor is 'constitutive' or 'character' luck — it is lucky if you have the right sort of constitution to cope with the problems that beset you. People who are looking for a good doctor are often looking for characteristics that are quite different from the obvious signs of expertise (high examination marks, qualifications, knowledge, skill). They are looking for somebody to trust. They want a personal doctor, with a name and a personality, who will care for them as people with names and personalities. It makes a lot of difference to the patient if their own doctor is available or if they are going to have to see someone else.

We all know that there are some patients we just cannot get on with, and when patients discuss among themselves who is a good doctor, some will swear by one and others by another. Character luck requires some degree of matching between the temperament of the doctor and that of the patient.

One of the main differences among patients is the degree to which they want to share or distribute power within the doctor–patient relationship.[7] A group from the Oxford Centre for Ethics and Communications in Health Care Practice (ETHOX) recently asked a series of lay people and professionals about their preferred model of decision making and found a wide range, from those favouring an informed choice model to those who held the view that decision making should be shared equally.[8] This was a purposive sample of currently healthy people, and not a representative one of sick patients, although personal experience would indicate that there are plenty of patients who want their doctor to make the decisions for them.

Colluding with such wishes may be seen negatively — as helping the patient to avoid an opportunity for personal growth in coping with adversity. However, insisting that patients make their own decisions is a parody of patients' rights and autonomy, and may deprive sick people of the support they need just at the time they are most regressed and vulnerable. It may also impose a specifically Western scheme of values on patients from other cultures where, for example, the family may be far more important in the lives of individuals than it is in our own culture. Some patients want to retain control and others want just as much to relinquish

control, just as some doctors find it easier to take responsibility and others find it easier to share responsibility. A good doctor, then, means good for that particular patient.

A truer virtue than respect for the principle of patients' rights is respect for the individual patient. This is less judgmental about the wishes that the patient should have about their own rights, and it shows more humility than slavishly hitting the ball back into the patient's court. Insisting on the patient's fully informed consent to every management decision is a means of getting off the moral and legal hook, effectively neutralising the dangers of option luck for the doctor by transferring all of the options for the patient to decide.[1] However, this exposes the unprotected patient to the full force of the responsibility for the outcome, even if they do not want it. True respect for the patient is demonstrated by sharing responsibility and power with them in a way that they can best tolerate, allowing them to examine their options but expressing one's own opinion honestly when it is asked for. John Launer has described this collaborative process as helping the patient to rewrite a healthier version of their story.[9] This sort of cooperative relationship is covenantal rather than contractual. Whereas a contract only binds people to their obligations, a covenant engages the parties in a personal relationship with mutual responsibilities. This is not very fashionable terminology in a world dominated by the market paradigm.

Responsiveness to the needs of patients as individuals is at the core of humane and ethical personal doctoring. It is what the Canadians term 'patient centeredness': actively finding out what a particular patient wants and needs now, or, as they put it, revealing the patient's agenda and negotiating on it. There is some empirical evidence to support the notion that more patient centeredness leads to better medicine,[10-12] or at least to increased patient satisfaction.

The patient-centred method was designed and taught as a contribution to the improvement of doctor–patient communications, but it seems that merely following the formal rules of the technique without subscribing to its underlying moral philosophy cannot form the basis of a relationship of trust. Patients will only truly trust a good doctor in the moral sense that the doctor is one who will truly respect them as individuals.

Conclusion

When doctors are under stress at work, those with a depressive tendency may blame themselves excessively when things go wrong, and those with a more angry temperament may find the causes in external factors — both would be wise to reflect on the role of luck. How far can we really take the credit for good outcomes, and how far are we really responsible for worse outcomes if luck — be it brute, option, circumstantial or character — is a ubiquitous part of the scene? The philosopher Bernard Williams advises us to look inwardly at our own psychological responses when things do not turn out as well as we expected. Where bad luck plays an important part we are more likely to feel regret, whereas if something really is owing to our own shortcomings, what we feel is remorse. 'Although a project may fail', says Williams, 'this does not mean that a doctor is always a failure'.[1]

The practice of medicine in the community is an ethical endeavour. If we fulfil our various ethical obligations we can make a difference. Scientific virtue requires us to maintain a safe level of knowledge and to develop our critical facilities, moral virtue requires us to respect the dignity of each of our patients as individual human beings, and social virtue requires each of us to take seriously our responsibilities for the state of the world we practice in. Although by definition there is nothing that we can do that will make a difference at the level of brute luck — that is, at the level of those aspects of disease that are still incurable or uncontrollable — a good doctor can minimise the potentially damaging effects of luck in its other three forms of option luck, circumstantial luck and character luck. This way we can hope to make a difference to our patients' health, improve the quality of the lives of the people who entrust themselves to our care, and contribute towards the development of a more just society to live in.

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Acknowledgements

I am grateful to Tel-Aviv University and Clalit Health Services for allowing me to go on sabbatical leave for a year, and to the Department of Primary Health Care, Oxford University, for hospitality during the year this work was carried out. Helpful suggestions came from an anonymous reviewer and the Editor of the *BJGP*, many of which were incorporated in the final version. This paper was first presented as a Primary Care Lecture of the Department of Primary Health Care, University of Oxford, in conjunction with Kellogg College, Oxford, on 10 April 2003.