On being a proper doctor

‘My mum’s a doctor’ number one
daughter said to her latest boyfriend,
who seemed more interested in the Sunday
supper Yorkshire puddings than my
career, ‘but my dad’s a proper doctor.’
They were her italics.

The definition of a ‘proper doctor’ has
changed over the centuries to reflect the
progress of medicine from an art form to
a science. Dr William Henry Welch, one of
the founding fathers of medical practice
and education in the US, wrote that his
father, a practitioner in Norfolk,
Connecticut, in the mid-19th century,
was able to make people feel better by simply
entering the room. ‘The art of healing
seemed to surround his physical body
like an aura: it was often not his treatment
but his presence that cured.’ He was
a proper doctor without the benefit of the
20th century pharmaceutical industry and
small group role-play. Nowadays, the
specialities with the highest status within
medicine, where the proper doctors
work, are neurosurgery and thoracic
surgery, specialties associated with
technologically sophisticated, immediate
and invasive procedures in vital organs. What do our patients mean when they talk of wanting a proper doctor? A systematic review of the literature on
patients’ priorities for general practice
(EUROPEP) found that the most highly
rated aspect of care was ‘humaneness’,
closely followed by ‘competence and
accuracy.’ My son reports that at the
Christmas 2007 Medlink course in
Nottingham, thousands of prospective
medical students were told to be sure to
mention that they wanted to be doctors
because they liked science and got on
well with people (science + people = medicine). So future proper doctors may
indeed be just what the patient ordered.

My worry, however, is that in the rush
to train scientists who can string sentences
together, the often-pilloried idealistic reasons for wanting to be a doctor — to
draw a difference and help people —
may become so unfashionable that they disappear altogether. Fifty years ago,
Becker’s classic study of student culture
in medical school in the US found that
87% of students gave idealistic answers
for why they wanted to be and what it
meant to be a doctor, and most
maintained their idealism throughout their
training. Sinclair’s observations of training in
1990s London, by contrast, found a
group of students whose initial idealism
gave way to institutional cynicism. But
should a proper doctor not be idealistic,
want to make a difference, change the
world, even in a small way?

And that, of course, may be the rub. I once
gave a talk at a medical student
conference where most of the 20-
somethings wanted to work in the
developing world as soon as they had
qualified. Other platform speakers had
helped to build drainage systems in
Africa or vaccinated remote tribes. I
presented some data on homelessness in
Birmingham, stories about people who
slept rough within 2 miles of the
college hall, whose average age of
death was 42, who had trench foot and
tuberculosis. I ended by suggesting that
they might want to consider ‘missionary
work’ in their own city. It was not well
received. Being a ‘proper doctor’ to these
idealistic young students meant dramatic
intercessional work in difficult
international circumstances.

To return to Sunday supper, we threw
the notion of a ‘proper doctor’ around a
little and remembered a story from a year
or so ago where a patient that my proper
doctor husband had been caring for had
become suddenly much worse, and
whose last words were ‘Fetch Dr Lester’. He
arrived 10 minutes later and gently
explained to her husband that his wife of
50 years had died. Mr X walked
back two large glasses of whisky with
which they toasted her life and sat down
together for some time to share stories of
her kindness. Mr X’s life changed
unutterably that day but it was made a
little easier by a trusted, kind, and
idealistic doctor. Perhaps changing the
world can start with the patient in front of
you.

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