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978-0-521-70967-5 - Learning Medicine: How to Become and Remain a Good Doctor, Eighteenth Edition

Peter Richards, Simon Stockill, Rosalind Foster and Elizabeth Ingall

Excerpt

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Why medicine and why not?

So you are thinking of becoming a doctor? But are you quite sure that you know what you are letting yourself in for? You need to look at yourself and look at the job. Working conditions and the training itself are improving, but medicine remains a harder taskmaster than most occupations. Doctors have also never been under greater pressure nor been more concerned for the future of the National Health Service (NHS).



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Before starting medicine you really do need to think about what lies ahead. The trouble is that it is almost impossible to understand fully what the profession demands, particularly during the early years of postgraduate training, without actually doing it. Becoming a doctor is a calculated risk because it may be at least 5 or 6 years' hard grind before you begin to discover for sure whether or not you suit medicine and it suits you. And you may change; you might like it now, at your present age and in your current frame of mind, but in 6 years' time other pressures and priorities may have crowded into your life.

Medicine is both a university education and a professional training. The first 5 or 6 years lead to a medical degree, which becomes a licence to practise. That is followed by at least as long again in practical postgraduate training. The medical degree course at university is too long, too expensive (about £200,000 in university and NHS costs, quite apart from personal costs), and too scarce an opportunity to be used merely as an education for life.

It might seem odd not to start considering "medicine or not?" by weighing up academic credentials and chances of admission to medical school. Not so; of course academic and other attributes are necessary, but there is a real danger that bright but unsuited people, encouraged by ambitious schools, parents or their own personalities, will go for a high-profile course like medicine without having considered carefully first just where it is leading. A few years later they find themselves on a conveyor belt from which it becomes increasingly difficult to step. Could inappropriate selection of students (most of whom are so gifted that they almost select themselves) account for disillusioned doctors? Think hard about the career first and consider the entry requirements afterwards.

Getting into medical school and even obtaining a degree is only the beginning of a long haul. The university course is a different ball game from the following years of general and specialist postgraduate training. Postgraduate training is physically, emotionally, and socially more demanding than the life of an undergraduate medical student on the one hand and of a settled doctor on the other. With so many uncertainties about tomorrow it is difficult to make secure and sensible decisions today. Be realistic, but do not falter simply for lack of courage; remember the words of Abraham Lincoln: "legs only have to be long enough to reach the ground".

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This is your life; if you get it wrong you could become a square peg in a round hole or join the line of disillusioned dropouts. Like a submaster key, which opens both outer doors and a particular inner room, you need to fit both the necessary academic shape and also the required professional attitudes. In this new edition of *Learning Medicine* we give greater emphasis to the professionalism the public, and patients in particular, expect of their doctors and even of medical students. Finally, you need to dovetail into a particular speciality.

You must have the drive and ability to acquire a medical degree, equipping you to continue to learn on the job after that. Also, you need to be able to inspire trust and to accept that the interests of the patient come before the comfort or convenience of the doctor. It also helps a lot if you are challenged and excited by clinical practice. Personality, ability, and interest, shaped and shaved during the undergraduate course and the early postgraduate years, will fit you in due course, perhaps with a bit of a squeeze, into a particular speciality “hole”. Sir James Paget, a famous London surgeon in the 19th century concluded from his 30 years of experience that the major determinant of students’ success as doctors was “the personal character, the very nature, the will of each student”.

Why do people want to become doctors? Medicine is a popular career choice for reasons perhaps both good and not so good. And who is to say whether the reasons for going in necessarily affect the quality of what comes out?

So, why medicine?

Glamour is not a good reason; television “soaps” and novels paint a false picture. The routine, repetitive, and tiresome aspects do not receive the prominence they deserve. On the other hand, the privilege (even if an inconvenience) of being on the spot when needed, of possessing the skill to make a correct diagnosis, and having the satisfaction of explaining, reassuring, and giving appropriate treatment can be immensely fulfilling even if demanding. Yet others who do not get their kicks that way might prefer a quieter life, and there is nothing wrong with that. It is a matter of horses for courses or, to return to the analogy, well-fitting pegs and holes.

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An interest in how the body works in health or in disease sometimes leads to a career in medicine. Such interest might, however, be equally well served by becoming an anatomist or physiologist and undertaking a lifetime study of the structure and function of the body. As for disease itself, many scientists study aspects of disease processes without having medical qualifications.

Many more people are curious about how the body works than either wish to or can become doctors. Nonetheless, for highly able individuals medicine does, as George Eliot wrote in *Middlemarch*, present “the most perfect interchange between science and art: offering the most direct alliance between intellectual conquest and the social good”. Rightly or wrongly, it is not science itself which draws most people to medicine, but the amalgam of science and humanity.

Medical diagnosis is not like attaching a car engine to a computer. Accurate assessment of the outcome of a complex web of interactions of body, mind, and environment, which is the nature of much ill health, is not achieved that way. It is a far more subjective and judgmental process. Similarly, management of ill health is not purely mechanistic. It depends on a relationship of trust, a unique passport to the minds and bodies of all

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kinds and conditions of men, women, and children. In return the doctor has the ethical and practical duty to work uncompromisingly for the patient's interest. That is not always straightforward. One person's best interests may conflict with another's or with the interests of society as a whole – for example, through competition for limited or highly expensive treatment. On the other side of the coin, what is possible may not in fact be in the patient's best interest – for example, resuscitation in a hopeless situation in which the patient is unable to choose for him- or herself – leading to ethical dilemmas for the doctor and perhaps conflict with relatives.

Dedication to the needs of others is often given as a reason for wanting to be a doctor, but how do you either know or show you have it? Medicine has no monopoly on dedication but perhaps it is special because patients come first. As Sir Theodore Fox, for many years editor of the *Lancet*, put it:

What is not negotiable is that our profession exists to serve the patient, whose interests come first. None but a saint could follow this principle all the time; but so many doctors have followed it so much of the time that the profession has been generally held in high regard. Whether its remedies worked or not, the public have seen medicine as a vocation, admirable because of a doctor's dedication.

A similar reason is a wish to help people, but policemen, porters, and plumbers do that too. If a more pastoral role is in mind why not become a priest, a social worker, or a schoolteacher? On the other hand, many are attracted by the special relationship between doctor and patient. This relationship of trust depends on the total honesty of the doctor. It has been said that, "Patients have a unique individual relationship with their doctors not encountered in any other profession and anything which undermines patients' confidence in that relationship will ultimately undermine the doctor's ability to carry out his or her work". A journalist writing in the *Sun* wrote cynically, "In truth there is not a single reason to suppose these days that doctors can be trusted any more than you can trust British Gas, a double glazing salesman, or the man in the pub". We disagree – and you would need to disagree too if you were to become a doctor. If it is of any comfort to the *Sun*, a Mori poll in 1999 asked a random selection of the public which professionals could be trusted to tell the truth. The results were: doctors 91%, judges 77%, scientists 63%, business leaders 28%, politicians 23%, and journalists 15%.

Professionalism includes the expectation that doctors (and medical students) can be relied on to look after their own health before taking

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responsibility for the care of others. Doctors who are heavy drinkers or users of prohibited drugs cannot guarantee the necessary clear and consistent judgement, quite apart from the undermining of trust through lawbreaking. Habits start young, and patients have a right to expect high standards of doctors and doctors in training, higher standards than society may demand of others.

Those not prepared for such personal discipline have an ethical duty not to choose medicine. It has been said that, “Trust is a very fragile thing; it can take years to build up; it takes seconds to destroy”. Sir Thomas (later Lord) Bingham rejected an appeal to the Privy Council against the erasure of a doctor from the medical register, saying, “The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price”. The requirement for a doctor to be honest is stringent: at another Appeal against erasure in 1997, the Lord Justices of Appeal said, “This was a case in which the committee were entitled to take the view that the policy of preserving the public trust in the profession prevailed over strong mitigation; they were entitled to conclude ... that there is no room for dishonest doctors”.

The Hippocratic oath is essentially a commitment to absolute honesty, professional integrity, and being a good professional colleague. Many people feel that this spirit is so integral to being a doctor and should be so central to medical education and training that it does not need formal recitation on qualification, especially in the paternalistic phraseology of even modern versions of the Hippocratic oath. On the other hand is there not a place for a formal public declaration by new doctors of their explicit commitment to ethical conduct? Certainly the graduating medical students at many universities now make their own public statement affirming the principles of Good Medical Practice.

The General Medical Council (GMC) is not only responsible for maintaining a register of all doctors licensed to practise medicine in the UK but also for ensuring that doctors are trained to practise and do practise to a high standard. The GMC accepts that the public want to be looked after by doctors who are knowledgeable, skilful, honest, kind, and respectful of patients, and who do everything in their power to help them. Above all, that patients want a doctor they can trust. Explicit duties, responsibilities, values, and standards have been clearly set out on behalf of the profession by the

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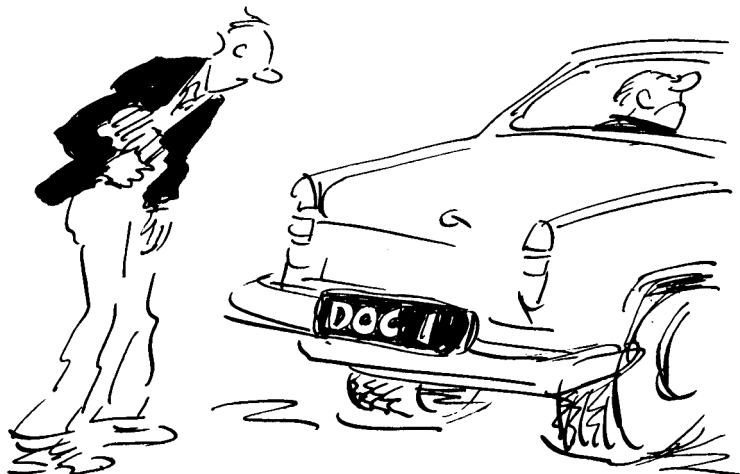
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GMC in *Good Medical Practice*, which medical students now receive soon after arriving at medical school. (see Appendix 3) Now that contact with patients generally starts early in the course, so does the responsibility of medical students to be professional.

Medicine is an attractive career to good communicators and a difficult one for those who are not. The ability to develop empathy and understanding with all sorts of people in all sorts of situations is an important part of a doctor's art. It is part of medical training, but it helps greatly if it comes naturally in both speaking and writing. A sense of humour and broad interests also assist communication besides helping the doctor to survive as a person. Not all careers in medicine require face-to-face encounters with patients, but most require good teamwork with other doctors and health workers.

Arrogance, not unknown in the medical profession, hinders both good communication and teamwork. It is not justified: few doctors do things that others with similar training might not do as well, or better. Confidence based on competence and the ability to understand and cope is quite another matter; it is appreciated by patients and colleagues alike. Respect for others and an interest in and concern for their needs is essential. One applicant was getting near the point when she said at interview, "I like people", then paused and continued, "Well, I don't like them all, but I find them interesting". Patients can of course sometimes seem extremely demanding, difficult, unreasonable, and even hostile, particularly when you are exhausted.



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Many people consider medicine because they want to heal. Helping is more common than healing because much human illness is either incurable or will get better anyway. If curing is your main interest, better perhaps become a research pharmacologist developing new drugs. Also, bear in mind that the cost of attempting to cure, whether by drugs or by knife, is sometimes to make matters worse. A doctor must accept and honestly admit uncertainty and fallibility, inescapable parts of many occupations but harder to bear in matters of life and death.

Experience of illness near at hand, in oneself, friends, or family, may reinforce the desire to become a doctor. Having said that, the day-to-day detail of good care depends more on nurses than doctors and good career opportunities lie there too. In any event, the emotional impact of illness should be taken together with a broader perspective of the realities of the training and the opportunities and obligations of the career. Dr F. J. Inglefinger, editor of the *New England Journal of Medicine* wrote, when seriously ill himself:

In medical school, students are told about the perplexity, anxiety and misapprehension that may affect the patient ... and in the clinical years the fortunate and sensitive student may learn much from talking to those assigned to his supervision. But the effects of lectures and conversations are ephemeral and are no substitute for actual experience. One might suggest, of course, that only those who have been hospitalised during their adolescent or adult years be admitted to medical school. Such a practice would not only increase the number of empathic doctors; it would also permit the whole elaborate system of medical school admissions to be jettisoned.

He had his tongue in his cheek, of course, but he also had his heart in his mouth.

Personal experience of the work and life of doctors, first and second hand, preferably in more than one of the different settings of general practice, hospital, or public health, is in any event formative and valuable in getting the feel of whether such work would suit. This can be difficult to arrange while you are still at school, not least because of the confidential nature of the doctor–patient relationship. Observation by a young person who may or may not eventually become a medical student is intrusive and requires great tact from the observer and good will from both doctor and patient. Doctors' children may have an advantage here (the only advantage they do have in the selection process) and could well be expected to know better than others what medical practice is all about. Most applicants have to make do with

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seeing medicine from another side by helping in hospital, nursing home, or general practitioner's (GP's) surgery, each situation giving different insights.

And, why not?

Learning medicine involves an education and training longer and more disruptive of personal life than in any other profession. And medicine is moving so fast that doctors can never stop learning. To be trained, it is said, is to have arrived; to be educated is still to be travelling.

Unsocial hours of work are almost inevitable for students and junior doctors, and are a continuing obligation in many specialities. If this really is not how you are prepared to spend your life, better not to start than to complain or drop out later. That does not, however, mean that the profession and public has any excuse for failing to press for improvements in working conditions of all doctors, especially for those in training. Exhausted doctors are neither good nor safe, and it becomes difficult for them to profit fully from the lessons of their experience.



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What about medicine for a good salary, security, social position, and a job which can in theory be done anywhere? Doctors in the UK are paid poorly in comparison with other doctors in Western Europe, North America, and Australasia, unless they supplement their income with a busy private practice, but, having said that, the pay is not bad. It became clear over the millennium that the UK had for many years been training fewer doctors than it needed. As a result there has recently been a substantial increase in the number of medical students in the UK but, almost simultaneously, the NHS has been reducing the number of posts for trained doctors. Suddenly, and we hope temporarily, medicine has become a less secure profession.

Social advancement would also be a poor motive for entering medicine, unlikely to achieve its aim. The profession has largely been knocked off its traditional pedestal. Much of the mystery of medicine has been dispelled by good scientific writing and television. Public confidence has been eroded by critical reports of error and incompetence, not to mention a rising tide of litigation against doctors. In the words of Sir Donald Irvine, Former President of the GMC: “The public expectation of doctors is changing. Today’s patients are better informed. They expect their doctors to behave properly and to perform consistently well, and are less tolerant of poor practice”. Such respect that doctors still enjoy has to be continually earned by high standards of professionalism.

The freedom of doctors to practise in other countries is no longer what it was. Most developed countries have restrictions on doctors trained elsewhere. European Union countries are open to UK doctors but none is short of doctors, and language barriers have to be overcome. Need and opportunity still exist in developing countries. All in all, there are less demanding ways than medicine of making a good living and having the opportunity to work abroad.

Making your own decision

It would be pompous and old fashioned to insist that all medical students should have a vocation but they do need to be prepared to put themselves out, to *earn* respect, to impose self-discipline, and to take the rough with the smooth in their training and career; they also need to be excited and challenged intellectually and emotionally by some if not all aspects of medicine.