PERSONAL VIEW

What is a good doctor? The impact of ‘fruitful irrelevance’ in medical education

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Abstract

Medicine is a science and evidence-based profession. Therefore, medical education and training should offer optimal conditions to help students to become a medical expert. However, in order to become a ‘good doctor’ the development of additional skills should also be stimulated. By including subjects like philosophy of science, medical history and sociology, the link between literature and medicine, and other ‘unrelated and irrelevant’ academic subjects, medical education programmes can stimulate that future doctors will broaden their mind. This will contribute to their professional performance.

Medicine is a science and evidence-based profession. Knowledge and innovations in the area of basic science in the clinical context are at the bottom of the adequate practice of future doctors. Consequently, medical education and training should offer optimal conditions to help the students to become a medical expert. But, although such doctors may be clever clogs, this does not mean that they are ‘good doctors’ too. For being a good doctor other additional skills are required. Additional skills that can be considered as academic skills but that deal with more than just being able to give a presentation during a grand round or conference, being able to write a scientific paper or being able to find your way in PubMed. The skills I refer to belong to the so-called Medical Humanities, training programmes that include the development of qualities that broaden students’ and residents’ view of medical profession.

In many countries modernization of medical training programmes occurs by applying the CanMEDS model (The CanMEDS 2005 Physician Competency Framework 2005). Originally this model was designed for postgraduate training, but it appears to be useful also for undergraduate training. The model describes seven roles of the doctor. The medical expert has diagnostic and therapeutic skills for effective and ethical patient care. The communicator establishes therapeutic relationship with patients and their family. The collaborator works effectively together with other physicians and health care professionals. The manager utilizes resources effectively to balance patient care, learning needs and outside activities. The health advocate contributes effectively to improved health of patients and communities, and recognizes and responds adequately to mistakes made in health care. The definition of the scholar is interesting because it refers to the one who learns as well as to the one who teaches others. And finally, the professional delivers highest quality of care with integrity, honesty and compassion, exhibits appropriate personal and interpersonal professional behaviour and is also aware of his/her limitations with consequences for his actions.

Although these roles, if applied integrally, are all part of the concept of a ‘good doctor’, professionalism is the major keystone of the performance as such. In order to teach professionalism convincingly, it is required that learning environments of the academic institutions support students’ and residents’ professional development, that the institutional culture demonstrates that professionalism is important, and that teachers behave as role models by demonstrating the relevance of reflection in daily practice (Whitcomb 2007). Philosophy of science, medical history and sociology, the link between literature and medicine, and other ‘unrelated and irrelevant’ academic subjects may contribute to doctors’ professional performance. Subjects that fit with the meaning of the term ‘academic’ as presented in the Oxford Dictionary: ‘not relevant to practical affairs, of theoretical interest only’ (Hornby 1995).

Medical Humanities deal with training programs that focus on the reflection on one’s own action, reflection on our ‘western’ way of medical practice in comparison with the practice in other cultures, diversity, ethics, philosophy of science and history of medicine. Teaching modules that help students to realize the presence of other, mostly non-western paradigms in medicine that might be complementary to the commonly used models; modules that help students to recognize the responsibilities of doctors towards their patients; modules that focus on the changed cultural and social context in which medicine is practiced with diversity as major characteristic for the perception of disease and for the patient’s expectations towards the doctor.

In this respect we can learn from medical training programmes in many Anglo-Saxon countries. Several universities, in particular those in the United States of America, have implemented teaching modules that focus on a broad and more general education (Dittrich & Farmakidis 2003). Actually, by...
teaching subjects that are not directly related to medicine and that focus on general education, so-called ’fruitful irrelevance’, a term created by Derkse (2004), a concept of teaching has been introduced that had been applied successfully in the universities of Salerno, Bologna, Montpellier and Oxford during the Middle Ages. In that time the ‘artes liberales’ were part of medical training and were considered as essential for the free thinking of the educated individual. In order to analyse and understand medical questions, skills in this area were needed as part of the intellectual baggage of medical doctors (Burns 1984). In most of the universities a degree in liberal arts was required before admittance to the medical studies.

By including Medical Humanities in the medical teaching programmes medical doctors really become experts in the field of medical professionalism. A broad education as human being, not only trained in biomedical and technical aspects of medicine, but also in other areas: looking across borders (literally and metaphorically), reserving time and energy to other issues than only our medical profession, taking responsibility for other tasks we have in society (partner, family, friends). All these issues contribute to that broader vision. Nowadays, this is recognized increasingly as an important role of a good doctor. Possibly, the current spirit of times is helpful in this changing view as there are more signs that broad education is important. Articles and comments of opinion leaders about the relevance of a broad view across traditional and professional borders can be found more and more in scientific journals. The leading journal ‘The Lancet’ devoted its special issue of 2006 to medicine and creativity (Osmond & Pini 2006). In that issue several authors describe that different art forms have not only influenced their work as a doctor but also the life of their patients. Furthermore, it contains articles dealing with the importance of art and culture in the education of future medical doctors. But also outside medicine the urgency for broader education, the medieval liberal arts, becomes clear. Interestingly, already for many years, students of Bachelor programmes of Massachusetts Institute of Technology (United States of America) have to complete a core requirement that is equally divided between science and mathematics, and the humanities, arts and social sciences (MIT facts 2008). Furthermore, the past president of the Royal Netherlands Academy of Arts and Sciences, Professor Frits van Oostrom, stated in his annual speech in 2007 that a broad cultural education is a prerequisite for good leadership (van Oostrom 2007). In his speech he made a plea for a system of education that stimulates the use of other talents than just only those that are required for the development of profession-related knowledge and skills.

There are no prospective controlled studies showing scientific evidence for the added value of Medical Humanities in the medical training programmes. Presumably such evidence-based justification will never occur. However, the reality is that professionals and society urgently ask for ‘humanizing’ medicine (Petersen et al. 2008). Thus, the questions ‘what is a good doctor?’ and ‘how do you make one?’ remain important and intriguing. If one realizes that the concept of a ‘good doctor’ has changed in human history, it is clear that the definition of a ‘good doctor’ is strongly influenced by culture. A couple of years ago the British Medical Journal asked these questions to their readers. Many reactions, from both doctors and patients, followed (Letters 2002). Most of the characteristics that were considered as necessary for doctors fit perfectly with the competencies of the CanMEDS model. Actually, even less predictable qualities such as courage, creativity and optimism fit in this model. One reaction of a reader of the British Medical Journal was very interesting. This reader, a psychiatrist, referred to the famous words at the top of the temple of Apollo in Delphi “ΕΝΤΩΝ ΣΕΑΤΩΝ” (Know thyself). He stated that there is no ‘good doctor’, just like ‘the good man’ does not exist. Every doctor has to deal with contradictory and incoherence of thoughts and feelings. He suggests to speak of ‘good enough doctors’ assuming that they are able to reflect on these aspects of the self with consequences for their behaviour (Holmes 2002).

Nowadays a good doctor should have many qualities. Besides a great knowledge with respect to medical content, these qualities should also include a kind of meta-vision. A broad vision that will benefit both the education of the individual doctor and the well-being of his or her patients.

Notes on contributor

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References