What makes good doctors practise bad medicine?

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There is a malaise in the community of general practitioners. Less than half of general practitioners in one survey agreed to recommend general practice to a junior doctor or medical undergraduate (1), supporting previous evidence suggesting that many of this generation of general practitioners regret coming into clinical practice (2), The BMA speculates that most of general practice could be delivered by nurses (3), prompting some experts question whether society needs doctors in primary care (4). General practitioners feel shoved around by government, perceiving, for example, that they are being forced to open their surgeries evenings and weekends, and inviting patients to blog their comments about the surgery onto Department of Health websites. Emile Durkhiem would call this feeling professional anomie – the situation where one's "*accustomed collective consciousness is disrupted by a sweeping set of new regulative influences*" (5).

But why? Doctors still occupy their privileged position in the health service, and still have the privilege of interacting with people at the edge of the human condition, when they are fearful, sick and dying. We are trusted if not respected by society, and, paradoxically, our primary care provision is the envy of the world (6). Recent work from a learning set populated by a mix of professionals with interests in anthropology, sociology and philosophy, as well as medicine has identified four pervasive, but largely un-named forces, which coalesce to create the conditions where, effectively, good doctors end up practicing bad medicine, experiencing this anomie as a result. In this essay, we argue that the combination of these forces results in care based predominantly on transactions (things you can measure and count) rather than relations. To redress the imbalance between transactional and relational care, a new professionalism is needed.

First, the ability to store and retrieve data electronically now permits us to see valuable patterns in data sets, allowing us to understand trends, explore variations and compare performance across groups. This digital revolution has opened up all professional decisions to scrutiny: if comparisons can be made, they should be made. The digital revolution has inevitably spawned the second influence, the audit culture.

The audit culture has helped drive up standards for patients and reduced variation in practice, even, some suggest, helping to diminish health inequality (7). But it measures only what can be measured, thus diminishing the status of interactions which cannot be captured by simple metrics. This focuses attention on second order activities – the measurable processes meant to reflect good practice – rather than on the practice itself, the creative, unpredictable sense making interaction between a sick person and their doctor.

This emphasis on performance measuring is one aspect of a third force which conspires to create uncomfortable conditions for the practice of medicine – a change in the nature of politics. The art of politics now is confined to managing the country's affairs as if it were merely a market within a global economy. Politicians rarely allow themselves to be seen, or even worse heard debating complex issues where opposing views all have some validity. To

some extent the Freedom of Information Act has contributed to this: if a politician thinks that almost everything she says, even informally, may be accessed and quoted what does she end up doing? Saying little or nothing. Thus, debates about allocation of power or resources are left to the market or re-fashioned in the form of science and farmed out to organization like NICE to sort out.

Finally, and complicating the impact of the three forces described, above is the uncertainty inherent in the practice of medicine, and the attendant anxiety engendered in its practitioners. At one to one level, clinical interactions are defined by fear, pain, loss and ultimately death. At another level, there are the sometimes equally painful decisions about allocating resources. These interactions are complex and unpredictable, yet often the impact of the three forces described above result in the simplification of the issues. Complex issues are linearised, in effect, to create only binary outcomes - this is right that is wrong. The outcome: a blame culture, where the inherent uncertainty is re-interpreted retrospectively to create a false impression of certainty, and thus identify failures of the professionals involved. Counting, then, becomes an unhealthy defence against such anxiety. The combination of counting and blaming encourages clinicians to seek the management option which carries the least risk, thus privileging risk inadvertently and disproportionately. A healthier response is to bring the anxiety into awareness in a form of altruism, where the clinician brings together their own anxiety alongside the anxiety of the patient, to co-create an acceptable, shared outcome.

Doctors are just people who happen to have been to medical school: they are not immunized from the fears, or prejudices of the human condition. Society affords much less respect to this generation of doctors, than to previous ones. While this generation of doctors might find that painful, failing to realize that successive generations have to win their spurs with their societal contemporaries, they are regarded and exposed as, well, just people. This however affords a unique opportunity for doctors to debate with society what it expects of their person/clinicians. Practicing medicine is a deeply uncertain activity, particularly in primary care. General practitioners can spend decades looking after and getting to know individuals with serious chronic conditions, which inexorably deteriorate. There is a gradual attrition of fortitude as clinicians spend day after day interacting with people at the limit of their human frailty. If society elects, as is its right, not to afford doctors respect, simply because of their professionalism, then it should accept their human frailty too.

Across the developed world the result of the combination of the four forces outlined above has been to focus on a style of care which is predominantly transactional, in which counting is the currency of judgment, and targets the fuel driving development. This style of care is distinguished from relational care, where the patient is cared about, as well as cared for, and where the professional patient interaction is reciprocal – they give as well as receive, where they share in the suffering of those they care for. Table 1 outlines the key features of each style of care.

We argue that within our health care system it is important that both of these styles of care are offered. We support sensible, carefully evaluated, evidence based activity to promote

effective transactional care. However we believe there is currently an unhealthy imbalance between these two styles of care, which needs to be redressed. This requires not a return to the old paternalism, nor a disregard for the strengths of transactional care. Society needs doctors to co-create a new compact, debating what it is society wants from their doctors, what doctors, in return are able to give, both of their professional, and their personal selves. This is utterly different from a new contract with government, and requires fresh creative thinking about a new professionalism. This new professionalism needs to be complemented by a new managerialism, in which relational care is much more highly regarded, despite the challenges inherent in its elusive accountability. And society needs a new civic-ness, where debates about accountabilities and reciprocal responsibilities are not re-framed in the language of pseudo-science. One can argue that a similar debate needs to take place in education and social care (consider the debate on baby P). Within health care it is doctors, as the highest status profession in the system who have to start the debate, and if they do its ramifications could be extensive.

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Table 1 Key features of transactional and relational care.

Transactional care	Relational care
Patient is cared for	Patient is cared about
Focus on efficiency and effectiveness	Focus on quality of the moment
Predetermined protocols	Emergent creativity
Reflection on facts and figures	Reflection on feelings and ethics

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