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How important are role models in making good doctors?

Elisabeth Paice, Shelley Heard, Fiona Moss

The use of teaching staff as role models for professional behaviour has long been an informal part of medical training. The authors consider whether role models can still be an effective means of imparting professional values, attitudes, and behaviours in a health service that is increasingly sensitive to society’s expectations.

Role models—people we can identify with, who have qualities we would like to have, and are in positions we would like to reach—have been shown as a way to inculcate professional values, attitudes, and behaviours in students and young doctors.1,2 Because good role models are seen as important in the making of a good doctor, we need to know more about them. What are the attributes young people look for in role models? Are these the attributes they really emulate? How do they react when they find that seniors lack these attributes? We consider these questions and whether we should rely on role models as a mechanism for developing doctors who are more patient centred and ethically sensitive.

What qualities do students and young doctors look for in role models?

The attributes of medical role models have been the subject of several interesting studies. Wright and colleagues looked at physicians who had been identified as excellent role models by students and residents.3,4 They found that the most important qualities in role models were a positive attitude to junior colleagues, compassion for patients, and integrity. Clinical competence, enthusiasm for their subject, and good relationships in role models were a positive attitude to junior colleagues, compassion for patients, and integrity. Some senior doctors show poor attitudes and unethical behaviour, causing confusion, distress, and anger in young doctors and students under their supervision.

Role models may not be a dependable way to impart professional values, attitudes, and behaviours

Professional behaviour and ethics should be explicitly taught through peer group discussion, exposure to the views of people outside medicine, and access to trained mentors who socialised more with house staff, sharing professional experiences and talking about their personal lives.

A survey of general practitioners and their students identified a positive attitude to teaching and excellent doctor-patient relationships as important in role models.5 Using a different approach, other researchers asked medical students to name one or two role mod-
els among their teachers and list five characteristics that described the role models. The commonly occurring characteristics were grouped under the headings “physician,” “teacher,” and “person.” The role models themselves were then asked which of these characteristics they had. The most commonly identified characteristics were, as physicians, enthusiasm for their specialty, clinical reasoning skills, doctor-patient relationships, and viewing the patient as a whole; as teachers, enthusiasm for teaching, involving students, and communicating effectively with students; and as people, enthusiasm, compassion, and competence. Attributes that did not feature highly on any list were excellence of research, publications, success in raising grants, senior management roles, service development, and professional leadership. Nor did power, status, and high earnings feature highly.

Are these the qualities that students and junior doctors really emulate?

The work of Simon Sinclair, a psychiatrist and anthropologist who spent a year observing a group of medical students, gives contrasting findings to these studies. He saw that the students were drawn to and emulated senior doctors who had responsibility and status. The students were not impressed by doctors who seemed to share their power and responsibility with other professionals. He also observed the students learning an aversion to investigating patients’ social and psychological problems. Their personal idealism waned as they became distanced from their family and non-medical friends and adopted the idealism of the profession. They had little awareness of the internal conflicts that must have been associated with these changes. These observations suggest a divergence between the qualities that students and young doctors say they seek in their role models and the qualities that they actually emulate. The most sought after careers are not necessarily those most associated with a holistic, patient centred approach.

Are these the qualities they find in their teachers?

By no means all doctors with teaching responsibilities have the attributes that students and young doctors say they seek in role models. Over half the students in a Canadian medical school considered their teachers to be insensitive to the anxieties of students and patients and their needs for communication. A study of clinical teachers found that the teachers’ negative attitudes towards the doctor-patient relationship were obstacles to their teaching about the relationship. The teachers were hard pressed to think of occasions when they modelled the doctor-patient relationship for their students, and they expected more of the students than of themselves in this regard. When graduates from a US medical school were invited to write a brief essay on their time in internal medicine, they showed such a high level of dissatisfaction with the teaching staff that the researchers were taken aback.

In some cases students have reported seniors behaving in a way that was frankly unethical and made them feel like accomplices in the wrongdoing. Students who reported witnessing unethical behaviour were more likely to report having done something unethical themselves, and receiving more hours of ethics education made little difference to reported unethical behaviour.

The consultant as role model

Most consultants in the United Kingdom are trainers. Consultants entrusted with the educational supervision of doctors in their first year have a special responsibility for inculcating the principles of good medical practice, and the relationship between trainer and trainee is critical. We recently studied this relationship through a confidential survey of preregistration house officers across the United Kingdom. We asked respondents to describe an exchange with a supervising consultant that seemed important or interesting and to tell us how they felt about it (box).

In 59% of cases the described exchange was positive, with the young doctor describing being praised or thanked, taught, given career advice or support, socialised with, or offered an example of excellent patient care. These house officers admired and respected their consultants. They were likely to feel happy in their choice of medicine as a career and to believe they would make good doctors.
Role models and reform

Medical schools have traditionally depended on good role models as part of an informal curriculum of medical professionalism—a use that may be more or less acknowledged and organised. In this way professional values, attitudes, and behaviours have been handed down from generation to generation. The important question is whether these values, attitudes, and behaviours have been handed down from generation to generation.

The cultural change that is so desperately needed to make doctors more conscious of the patient’s viewpoint has been long in coming. It may be that dependence on role models to deliver the informal curriculum has created a built-in resistance to change. We need to be more open to the views of other professionals, more aware of clinical error, more willing to discuss everyday ethical dilemmas, and more prepared to learn from our patients. Doctors at all levels need to be open about their need to learn. Changing the medical profession from one that is paternalistic to one that is professional group, and the facilitators made a point of exploring the diversity of angles on each of the topics. The opportunity to hear different views and see things from a different perspective was a revelation for many young doctors. However, on their return to the clinical workplace they complained that their seniors did not share these new insights, and it was therefore hard to implement change. Without explicit training for senior doctors, also undertaken in an interprofessional context, it was unlikely that the learning would be sustained.

The values, attitudes, and behaviours that should characterise modern medical professionalism need to be the topic of lifelong learning for all grades of staff.

From role model to mentor

Excellent role models will always inspire, teach by example, and excite admiration and emulation. Role models may have an impact on a large number of people, and individual students and young doctors may emulate different characteristics in a range of role models. However, being a role model is serendipitous: there is no training programme, appointment panel, or certificate. That you have been a role model for a young colleague can come as a surprise, either flattering or alarming, depending on your conscience. To paraphrase John Lennon, being a role model is what happens when you are busy doing other things.

Mentorship differs from role modelling in that the mentor is actively engaged in an explicit two way relationship with the junior colleague—a relationship that evolves and develops over time and can be terminated by either party. A good mentor is a coach, asking questions more often than giving answers. Mentors have an active role in guiding their junior colleagues as they develop their own special attributes. The role is not an easy one and requires training, time, and mutual trust.

Role models, mentors, and the future of medicine

Keeping medicine up to date with society’s changing expectations and values is a continual struggle. We need to be more open to the views of other professionals, more aware of clinical error, more willing to discuss everyday ethical dilemmas, and more prepared to learn from our patients. Doctors at all levels need to be open about their need to learn. Changing the medical profession from one that is paternalistic to one that is self aware and quickly responsive to society’s expectations is a difficult assignment. It won’t happen by chance or through emulating our predecessors. It will require doctors at every level of seniority to be prepared to re-examine their own values, attitudes, and behaviour from the viewpoint of patients. Such reflection doesn’t occur in a vacuum; it is stimulated by colleagues and patients who ask difficult questions and refuse to be put off by easy answers.

A healthy mentoring relationship is likely to provide the mental and moral challenges essential to continuing self improvement. Ideally all doctors—junior and senior—should be in such a relationship and have the opportunity to reflect on performance and how it can be improved.
waiting to be seen by him. On either side more patients are bleeding his patient. This painting of a Greek vase, dating from 480-460 BC, depicts a surgeon medical practice in Western medicine. This early 20th century painting by W R Seton shows how the ideal of the good doctor has changed in the past 200 years. The surgeon now works in the sterile and impersonal environment of the operating theatre. His operation is relayed by means of the latest technology (a periscope) into an adjoining lecture room for the purposes of clinical training. Here, then, are the roots of today’s good doctors. Trained in the clinical procedures of hospital medicine, they care for their patients by means of high tech procedures and the latest findings of medical science.

Throughout the 18th century doctors were lampedooned for their greed and dishonesty and the inefficacy of their cures. But as this drawing by William Small (1898) shows, the ideal of the good doctor as somebody who alleviated the suffering of humanity did survive. It is a sentimental reworking of the doctor as good Samaritan and is notably devoid of any religious imagery. Instead, the picture extols the humanitarian virtue of the good doctor, who provides his services without expectation of remuneration.

Images of the good doctor in Western medicine

Early Greek medicine was based on the notion that health and disease were consequences of divine intervention. In the fifth century BC a new secular, rational approach to medicine emerged, based on investigations of the human body in terms of natural causes operating in rationally discernible ways. These principles subsequently formed the basis of good medical practice in Western medicine. This painting of a Greek vase, dating from 480-460 BC, depicts a surgeon bleeding his patient. On either side more patients are waiting to be seen by him.

In late antiquity, Christianity provided a new ideal for the good doctor. Medicine became a sacred calling in which the doctor practised his art as an expression of Christian charity. This painting, attributed to the Maestro de los Balbases (active around 1484-1500), depicts the martyrs Cosmas and Damian—the patron saints of medicine—removing the cankerous leg of a Christian and transplanting it with the leg of a recently deceased Ethiopian. This miraculous operation presents healing as a gift from God.

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