How important are role models in making good doctors?

Elisabeth Paice, Shelley Heard and Fiona Moss

BMJ 2002;325;707-710
doi:10.1136/bmj.325.7366.707

and cautious. That way, stakeholders in health care, especially service users, will be able to make informed choices; good care will be identified and rewarded; and safety will be improved. If healthcare regulators are serious about promoting quality then they must ensure that measures of quality are not misapplied and abused,[14] that natural variations in systems are recognised, and that measures are not perceived as capricious tools for shifting responsibility and blame.

Competing interests: MP is the strategic director of Primary Care Information services (PRIMIS) and is a paid adviser to Dr Foster (http://home.drfoster.co.uk), a guide to local NHS and private healthcare services. TW has been paid for talks and workshops on measurement.

1 O'Neill A. Called to account. 2002 Reith lectures. www.bbc.co.uk/radio4/reith2002/ (accessed June 2002).
2 Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the quality chasm*. Washington: National Academy Press, 2001.
3 Grol R. Improving the quality of medical care. *JAMA* 2002;286:2578-85.
4 Grol R. Successes and failures in guideline implementation. *Med Care* 2001;39: S2(II46-54).
5 Marshall M, Shekelle P, Brook R, Leatherman S. *Dying to know: public release of information about quality of health care*. California: Rand, 2000.
6 Kassirer J. Hospitals, heal yourselves. *New Engl J Med* 1999;340:309-10.
7 Davies HT, Marshall M Public disclosure of performance data: does the public get what the public wants? *Lancet* 1999:353;1639-40.
8 Martin N, Marshall M, Shekelle PG, Leatherman S, Brook RH. Public disclosure of performance data: learning from the US experience. *Q Health Care* 2000;9:53-7.
9 Mohammed MA, Cheng KK, Rouse A, Marshall T. Bristol, Shipman, and clinical governance: Shewhart's forgotten lessons. *Lancet* 2001;357:463-7.
10 Berwick D. Looking forward: the NHS: feeling well and thriving at 75. *BMJ* 1998;317: 57-61.
11 Berwick DM. 1989. Continuous improvement as an ideal in health care. *N Engl J Med* 320:53-6.
12 Walshe K. Opportunities for improving the practice of clinical audit. *Q Health Care* 1995;4:231-2.
13 Richards KF. Developments in total quality management in the United States: the intermountain health care perspective. *Q Health Care* 1994;3(suppl):20-4.
14 Scherkenbach WW. The *Deming route to quality and productivity: road maps and roadblocks*. Washington, DC: George Washington University, 1986.

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.

Summary points

- Students and young doctors identify enthusiasm, compassion, openness, integrity, and good relationships with patients as attributes they seek in their role models
- They are also drawn to senior figures who embody responsibility and status
- 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

London Postgraduate Medical and Dental Education, University of London, London WC1N 1DZ
Elisabeth Paice *dean director*
Shelley Heard *postgraduate dean*
Fiona Moss *associate dean*
Correspondence to: E Paice epaice@londondeanery.ac.uk

BMJ 2002;325:707–10

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.[3–5] 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 teaching ability were also important, but research achievement and academic status were much less so. Compared with colleagues, physicians who were identified as excellent role models spent more time teaching and conducting rounds and were more likely to stress the importance of the doctor-patient relationship and psychosocial aspects of medicine. They also 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.[6] 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.[7] The commonly recurring 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 the 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.[8] 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.[9]

House officers' recollections of an exchange they had with a consultant

Consultants as good role models

"Dealing with young patient who was dying of cancer on a Saturday evening and the consultant on call was there throughout the terminal process. I felt sad and helpless. I respected the calm way she handled the situation"

"Once when a particularly aggressive alcoholic patient was admitted, just watching [the consultant] control the situation, make his examination and treat a patient no one else could control"

"A patient died. I thought it was my fault, but consultant came on ward at 8 am to explain to me that it wasn't. I was very grateful. He was extremely kind."

Consultants as poor role models

"Complaint was made about me by senior nurse. Consultant was only willing to listen to my point of view. I was initially pleased that he backed me, but should he not have supported her? He seemed blasé, uninterested."

"Consultant got angry on ward round when I couldn't find the most recent blood tests because the notes were very big—he snatched the top result sheet and complained it was out of date. The correct results were found shortly after, and he put his arms around me. I thought him irritable, unpredictable, and unprofessional."

"My consultant handled a patient with cancer in a way I thought was very bad. She turned to me and said (self satisfied), 'I used to have to run after my consultant when I was a house officer to sort out people he had emotionally upset.' I could only agree!"

Consultants as unethical role models

"Consultant wanting to do an invasive procedure on a cancer patient who would be dead within three days. I refused to fill in the form. I was incredulous. I thought he was disrespectful, incompetent, and mean."

"After an unexpected death surgical consultant tried to take advantage of my inexperience by asking me to write retrospectively in notes."

"While caring for a terminal patient their condition deteriorated and I phoned up the consultant at home who told me to administer a fatal dose of diamorphine. I said I didn't feel this was appropriate as the patient needed to speak to relatives, etc, and he eventually agreed."

"Patient with gonococcal arthritis. I was asked to do an HIV screen, but patient refused consent. Consultant got very angry and demanded that we take off some blood and 'just do it.' I refused. Consultant walked off ward round and didn't speak to me for over a week!"

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.[10] 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.[11] 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.[12]

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.[13]

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.[14] 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. Twenty two per

Students seek good role models (Dirk Bogarde (left), as Dr Sparrow in *Doctor in the House*, 1954)

cent of the house officers described a negative exchange, with the consultant behaving badly towards them by making unreasonable demands or being unfairly critical, sexist, or bullying. The words used to describe the consultants—bastard, idiot, fathead, rude, arrogant, selfish, senile, and pompous all recurred—give an idea of the vehement feelings aroused in the young doctors by the behaviour described. In 7% of responses the consultant was portrayed as incompetent, insensitive, or negligent towards patients. House officers recalling these events spoke of their contempt, disbelief, frustration, or anger. These house officers were the most likely to regret their choice of medicine as a career, though whether their disillusionment was caused by the behaviour described or led them to select a negative anecdote can only be speculative. The exchanges included examples of consultant behaviour that was clearly unethical and where the respondent felt pressured to collude in wrongdoing. Students and junior doctors need to feel part of their team and to be assessed favourably by their seniors, but if this is at the price of their ethical values some of them are likely to become confused and distressed. They appreciate the opportunity to discuss in a safe environment the everyday ethical dilemmas they encounter.[15]

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.[1 2] The important question is whether these values, attitudes, and behaviours are the ones that will stand future clinicians in good stead as the health service of the 21st century develops.[16]

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 developed a postgraduate training programme on clinical governance and continuous quality improvement.[17] It was a very successful course, the highest rated feature of which was that it was interprofessional. No more than a third of participants came from any one 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 a 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.[18 19] 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.[20] 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.

1 Swick HM, Szenas P, Danoff D, Whitcomb M. Teaching professionalism in undergraduate medical education. *JAMA* 1999;282:830-2.
2 Wear D. On white coats and professional development: the formal and the hidden curricula. *Ann Intern Med* 1998;129:734-7.
3 Wright S. Examining what residents look for in their role models. *Acad Med* 1996;71:290-2.
4 Wright S, Wong A, Newill C. The impact of role models on medical students. *J Gen Intern Med* 1997;12:53-6.
5 Wright SM, Kern DE, Kolodner K, Howard DM, Brancati FL. Attributes of excellent attending-physician role models. *N Engl J Med* 1998;339:1986-93.
6 Lublin JR. Role modelling: a case study in general practice. *Med Educ* 1992;26:116-22.
7 Ambrozy DM, Irby DM, Bowen JL, Burack JH, Carline JD, Stritter FT. Role models' perceptions of themselves and their influence on students' specialty choices. *Acad Med* 1997;72:1119-21.
8 Sinclair S. *Making doctors: an institutional apprenticeship.* Oxford: Berg, 1997.
9 Whitehouse A. The way I see it: National competition ratios should be available for all HST applicants. *BMJ* 2002;325(suppl):S55.
10 Beaudoin C, Maheux B, Cote L, Des Marchais JE, Jean P, Berkson L. Clinical teachers as humanistic care-givers and educators: perceptions of senior clerks and 2nd year residents. *CMAJ* 1998;159:765-9.
11 Cote L, Leclerc H. How clinical teachers perceive the doctor-patient relationship and themselves as role models. *Acad Med* 2000;75:1117-24.
12 McMurray JE, Schwartz MD, Genero NP, Linzer M. The attractiveness of internal medicine: a qualitative analysis of the experiences of female and male medical students. *Ann Intern Med* 1993;119:812-8.
13 Feudtner C, Christakis DA, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. *Acad Med* 1994;69:670-9.
14 Paice E, Moss F, Heard S, Winder B, McManus IC. The relationship between pre-registration house officers and their consultants. *Med Educ* 2002;36:26-34.
15 Kushner TK, Thomasma DC, eds. *Ward ethics: dilemmas for medical students and doctors in training.* Cambridge: Cambridge University Press, 2001.
16 Allen I. Committed but critical: an examination of young doctors' views of their core values. London: Health Policy and Economic Research Unit, BMA, 1997.
17 Heard SR, Schiller G, Aitken M, Fergie C, McCready Hall L. Continuous quality improvement: educating towards a culture of clinical governance. *Qual Health Care* 2001;10(suppl 2):S70-8.
18 Barondess J. On mentoring. *J R Soc Med* 1997;90:347-9.
19 Sachdeva AK. Preceptorship, mentorship, and the adult learner in medical and health sciences education. *J Cancer Educ* 1996;11:131-6.
20 Christakis N. The similarity and frequency of proposals to reform US medical education. Constant concerns. *JAMA* 1995;274:706-11.

(Accepted 12 August 2002)

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.

Throughout the 18th century doctors were lampooned 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.

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.

PICTURES COURTESY OF WELLCOME LIBRARY, LONDON

Cornelius O'Boyle *adjunct associate professor, University of Notre Dame (London Centre)*