What is the good doctor good at?

3.1 Some cases

Consider the following imaginary cases, or vignettes:

3.1.1

Dr D is a GP who was very successful at medical school. He has just seen a patient who complained of sleeping problems. On asking whether she had any worries he was eventually told that she was not happy in her marriage and had fallen in love with another teacher in the school at which she taught. She wanted to explain her problems in more detail, but Dr D felt unable to help and just a little embarrassed. He prescribed sleeping pills, but was worried as to whether he had done the right thing. After some hesitation about confidentiality he asked the advice of his older partner. The partner made a tasteless remark and said 'We're doctors, not marriage counsellors.' Dr D felt a little better, but was still uneasy.

3.1.2

Mr F is a surgeon who has just had a row with a patient's relatives. He has successfully carried out an operation. But the operation involved a number of possible side-effects. He explained these to the patient. The relatives are now alleging that the patient did not understand what was being said.

3.1.3

Dr I is an SHO who did well at Medical School and spent a year as a JHO in top hospitals. The registrar and consultant in his present post have left him with a reasonable amount of responsibility. He makes a decision on one patient, and to his surprise the ward sister tells him that she thinks his decision is the wrong one. Dr I is not accustomed to having his views questioned by nurses, and when he consults the registrar he is told that the sister is very experienced and should be listened to, and that the issues should be raised at the team meeting. Dr I secretly disapproves, because he is firmly of the opinion that nurses totally lack his scientific training.

3.1.4

Dr S is irritated to read in his local newspaper that a health education officer has been appointed to try to improve the health of his neighbourhood, where the rate of smoking-related disease is high. He regards the appointment as a waste of money: 'Health education is my responsibility. All my patients have been warned by me against smoking.'

3.2 Roles, skills, and aims

The problems which we tried to highlight in the foregoing vignettes arise out of confusion in the idea of what a doctor ought, to be doing, at the. Present time. We must therefore consider the concept of a doctor. Such a concept is not an unchanging idea. Whereas there is a historical and cultural continuity in the concept of a doctor, so that we can still recognize the preoccupations of Hippocrates or Galen as those of a doctor in our sense, there is no doubt that there are also historical developments and cultural differences. We shall be concerned with the doctor in Western culture at the end of the twentieth century. How can the job of a doctor be described?

Occupations can be described or classified from three different points of view, or in terms of three different sets of concepts: as role-jobs, skill-jobs, and aim-jobs. For example, the jobs of income tax inspector or mayor are role-jobs, 'role' here being defined in terms of a set of rights and duties. In contrast, the job of musician is defined in terms of a skill, or a set of skills — to be a musician one must logically have certain skills. This is not to say that certain skills are not in fact required for the job of a mayor or an income tax inspector to be carried out successfully; but it is to say that an adequate definition of those jobs need contain no reference to these skills. On the other hand, a reference to the relevant skills is logically required for an adequate definition of the jobs of a musician or a plumber; we can claim that the statement 'Hamish is a musician/plumber' is essentially connected with the statement 'Hamish is skilled at music/plumbing.' In general, the distinction between role-jobs and skill-jobs can be stated as follows: the connection between a skill-job and the possession of an ability is a logic one whereas the connection between a role-job and the possession of an ability is a 'pragmatic one — a person may in practice need certain skills in order to acquire a role-job or to perform it well, but possessing the skills is not part of the definition of the job.

Let us now turn to aim-jobs. It would seem to be the case that a number of occupations are defined in terms of some end or aim. For example, the job of 'farmer' can be said to be an aim-job, in that to be a farmer is to aim at cultivation, milk or beef production, or whatever. Similarly, the job of 'forester' is defined in terms of an aim; and so also is the job of 'gamekeeper'. It is not necessary that the aim should always be attained, and obviously skill in the choosing and implementing of means will have a bearing here; but before people can be described as farmers, foresters, gamekeepers, and so on they must at least see themselves as aiming at certain ends. We would call people bad farmers if they chose the wrong means to those ends, or were unskilful at implementing the means; but if they are not pursuing those ends at all then they are not farmers. The same would hold for all who profess occupations which are aim-jobs. In general, then, to say that A, B, or C is an aim-job, is to say that there exists some purpose, aim, or end which is logically connected with job A, B, or C. It is to say that unless people have the aims in question, they cannot be counted as members of the class of those who have jobs A, B or C.

We have tended to speak so far as if there were three types of job, and this is so in the sense that some jobs are to be defined in terms of one or other of the three categories of role, aim, or skill. And it is also so irrespective of the fact that many jobs, while they may be *defined* in one of the three ways, clearly involve the other categories also. In the case of some jobs, however, it is not so obvious that they are to be defined in one category rather than another, and at any rate they certainly involve all three. The job of teacher is one example of this. For 'teacher' cannot be defined exclusively by reference to any one of the three categories, but requires to be placed in all three. Similarly, and importantly for our purposes, the job of 'doctor' cannot be placed in any single one of these categories, but requires to be defined in terms of all three. Note that this is not just making the point that being a doctor happens to be describable in terms of all three characteristics, while belonging mainly to one of the three categories — as being a mayor might involve having aims and skills, but be essentially a role-job. The point is that the job of being a doctor, like that of being a teacher, must be seen in terms of all three categories, or serious distortion or bias in medical education will result. To bring this out let us consider medicine first in terms of its aims. What is the aim of the doctor?

3.3 'Doctor' as an aim-job

It might be objected immediately that there is no one aim of the doctor; different doctors have different aims and one and the same doctor may have many aims. We can make a start in dealing with this complexity by distinguishing, as is done in many medical and other contexts, between aims and objectives. Let us say that an aim of the doctor is to try to promote health. It will follow that the doctor will have many specific objectives which are generated by the broader aim. This distinction helps, but still leaves complexities in need of conceptual tidying. We therefore need to draw a few distinctions in the concept of aim as it applies to a doctor.

In the first place, a person who happens to be a doctor will have various aims which are not necessarily connected with his occupation, although they are furthered by it. Let us call these his 'personal aims'. For example, he might aim at earning his living, at having job security, or at expressing his idealism. These are legitimately regarded as among his aims as a doctor, in that he fulfils them by means of his occupation, but they are not connected with his occupation as such, since they might just as easily be satisfied by other occupations. Hence they can be identified as 'personal aims'. Note that it does not follow from the fact that they are not connected with medicine as such that they are unimportant, or that they should be disregarded in medical education. Indeed, it may be that job satisfaction or dissatisfaction are in fact largely connected with the opportunities of the doctor to fulfil his personal aims through the practice of medicine.

Secondly, and most importantly, there is what we shall call the 'intrinsic aim' of the doctor, the aim which must logically be entertained by the doctor *qua* doctor. We shall state here quite briefly what must later be elaborated: that the intrinsic aim of the doctor is the promotion of health in its broadest sense. We shall later specify the relevant senses of 'health' and of 'promotion'. To say this is not, of course, to say that only doctors have this aim - other occupations, such as nurses and other branches of the 'caring' professions, also entertain this intrinsic aim. But it is to make health, or the relief of suffering, or healing, the intrinsic aim of the doctor.

It may be objected, however, that doctors sometimes have other aims, or other objectives, which cannot easily be put under this heading, such as certifying that someone is suitable for a

certain job, or reporting that a given refuse dump constitutes a health hazard. To reply to this type of objection we require a third category of aim.

The third category of aim we shall call the 'extrinsic aim' of the doctor. To ask about the extrinsic aim of the doctor is to ask not so much about what he might achieve in the practice of medicine but *as a result of it,* meaning by that the indirect or non-medical consequence of it. For example, as a result of his medical practice a doctor might hope to promote health in the community, say by making public statements on the dangers of addictive drugs, or on the need to have adequate facilities for recreation, or on access to public places for the disabled. These are legitimate and desirable aims, which at least some doctors might pursue as a result of their medical education; but they are not the concerns of the doctor *qua* doctor, or so we are asserting.

We are insisting on this to prevent the concept of the doctor's becoming so wide that no education, however intensive or long-lasting, could ever qualify a person to become one. There are many competing and conflicting demands on the time of doctors; but we must distinguish what is intrinsic to their activities from what they can sometimes do as a result of their skills and role in society.

It should be noted, to avoid confusion, that what we have been contrasting as the intrinsic and extrinsic aims of the doctor can also be expressed in terms of the intrinsic and extrinsic aims of medicine. Using the term 'medicine' we might make the desired contrast by opposing aims in medicine (what medicine essentially consists of) with aims for medicine (the use which might be made of medicine by, for example, insurance companies or other bodies). We shall adopt either terminology as it may be convenient in various contexts.

3.4 Health as an aim

To maintain, as we have done, that the intrinsic aim of medicine is health is uncontroversial, to the extent that it is too vague to quarrel with. What do we mean by health? There has been a large amount of writing on the concept of health in the last ten years, and out of that literature there has emerged a complex view of health in which we can distinguish various elements. The first of these is often called 'negative health', or the absence of ill-health. 'Ill-health' itself is a complex notion, comprising disease, illness, handicap, injury, and other related ideas. These overlapping concepts can be linked if they

are seen on the model of abnormal, unwanted, or incapacitating states of a biological system. Sometimes negative health is called the 'bio-medical model' of health.

Secondly, the idea of 'positive health' has more recently appeared in published reports. The origins of this idea are in the definition of health to be found in the preamble to the Constitution of the World Health Organization (WHO): 'Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.' (WHO 1946).

It follows from this definition that 'well-being' is an important ingredient in positive health. 'Well-being' is a complex concept, and it is important in this context to distinguish well-being as a subjective mood or state from the well-being which is rooted in life-style. In the first sense, a mood of well-being can be induced by drugs or alcohol. This may sometimes be a good thing, and sometimes doctors might prescribe drugs which induce it on a temporary basis to enable someone to recover from a depression. In the second sense, well-being comes from a life-style based on friends, interests, a reasonable diet, and some exercise. The lack of adequate discussion of this, the most important sense of well-being, is a serious omission in many medical courses. There is a third side to well-being, which we shall discuss shortly, but shall mention here for the sake of completeness. This side is often expressed through the concept of 'welfare'. There is no one meaning of well-being in this third sense, but it is convenient to think of a person's welfare as being the aspects of his/her well-being which are affected by such matters as housing, employment, environment, etc.

A third idea in the concept of health is that of 'fitness'. Fitness in its most obvious sense refers to the state of someone's heart and lungs. To be fit in this sense is to have a place on a scale ranging from being able to climb stairs or run for a bus without getting out of breath to being able to run a marathon or climb Mount Everest. Fitness can also be used in a related but broader sense, which we might call the 'sociological' as opposed to the 'heart and lungs' sense. In the sociological sense of fitness a person is fit *for* some occupation or job. This means that people have the necessary health to enable them to perform their job or task adequately without, for example, too many days off work.

It is tempting to think of fitness as standing alongside well-being as a component in positive health. But this is a mistake; fitness can be seen as part of either the negative or the positive

dimensions of health. We are healthy in the negative sense if we are not ill or diseased; analogously we can be fit in the negative sense if we can manage to perform the tasks of daily life — stair-climbing, walking to and fro, luggage-lifting, and so on — without undue physical stress. The analogue to positive well-being is the fitness which enables a person to swim, ride a bicycle, climb a hill, and so on. Fitness, then, is best seen as a component of both negative and positive health rather than as a separate dimension to health.

The WHO definition refers to the 'mental and social' as well as to the physical. Nevertheless, the mental and social components of health are the poor relations of the health services and do not receive adequate attention in published reports, or adequate funding from governments or research institutions. Moreover, to begin with mental health, it is certainly true that mental health is most often taken to be the absence of mental ill-health. A case can be made for the existence of a positive dimension to mental health. The danger of this is that it might encourage conformity or fitting in with prevailing social norms and attitudes; but there are ways of looking at positive mental health which avoid this charge.

The idea of 'social well-being' is in fact just as obscure as that of mental well-being, although at first sight it does not seem to be a difficult notion. What does it mean? In one sense 'social well-being' refers to the skills and other abilities which enable us to form friendships and relate to other people in conversation and through the many different sorts of contacts which are part of ordinary social life. Sometimes these are called 'lifeskills', and the possession of them helps to create a sense of `self-esteem', which is currently a fashionable concept in the literature of health education. Clearly, like fitness, social well-being in this sense can be graded on a scale from negative to positive. It is a property of individuals and refers to their ability to cope in a social context — hence 'social well-being' is an appropriate term.

But does it make sense to speak of 'social well-being' in a stricter sense — one which makes the well-being a characteristic of society itself, as distinct from the individuals who are in society? One way of making sense of this idea is to think of society not in terms of the individuals who make it up, but in terms of the institutions, practices, customs, political arrangements, social class relationships, and so on, which give structure to the society. From this point of view people are related to each other by the structures of their society, and indeed part of their identity is created by these social structures. We could then evaluate a society in terms of the way in which its social

structures tend to produce well-being in the people who belong to that society. Just as we sometimes praise the 'atmosphere' in a school or hospital as one of well-being, so the social structures of an entire society might be said to make for or detract from well-being.

Some theorists with firm attachments to empiricism might prefer to understand what we have said as referring to health determinants rather than health itself. For example, they might agree that a society with marked social class gradients and corresponding gradients in the distribution of ill-health is one with a tendency to create ill-health in individuals. Thus, in terms of this approach, if we speak of an 'unhealthy society' we are simply speaking metaphorically about the determinants, such as poor housing, diet, and so on, that have helped to produce poor health states in individuals. Other thinkers might maintain that it is not a metaphor to characterize social relationships and structures as being themselves unhealthy. It is perhaps self-indulgent to pursue this theoretical question here.

It is not self-indulgent, however, to examine the relationship between health negatively and health positively conceived. Can we link the absence of ill-health and the presence of well-being in a single concept of health in the manner of the WHO definition? This is not a rarefied question, because it affects the legitimate scope of medicine. If well-being is a component in the concept of health then clearly medicine has a much wider remit than it would otherwise have.

One important factor influencing this question is that ill-health and well-being cannot be related to each other as opposite poles on a linear scale. This approach has been tried by some theorists, but it is not satisfactory, for it is logically possible (and not in fact uncommon) for someone to have poor physical health but a high state of well-being — as in the case of a terminal patient in a hospice who is supported by a caring staff and loving friends — or a good state of physical health but poor well-being — as in the case of someone who has no diseases or illnesses but lacks friends, a job, interests.

The fact that health (the absence of ill-health) and well-being cannot be related on a linear scale must raise the question of whether they are in fact two components of a single concept. It may be preferable and less confusing conceptually to think of them as two overlapping concepts rather than as a single concept with two dimensions. Thus the feeling of well-being that a person has after an invigorating swim can fairly be described as a 'glow of health', but the well-being or satisfaction that a person has after writing a chapter in a book, listening to a piece of music, or just

playing a diverting game is less obviously related to the concept of health, and more obviously related to concepts such as 'enjoyment', 'happiness', etc. Again, the well-being that is created by moving someone to better housing is more obviously related to the concept of 'welfare' than to that of health. The conclusion is that while the concepts of health and well-being overlap they are distinct and cannot be combined into one concept.

It does not of course follow from the fact that well-being is a different concept from health that medicine has no bearing on it. To take analogous cases, a doctor might reasonably be concerned with the processes of aging, or with contraception.
But neither getting older as such nor pregnancy constitutes ill-health. In other words, the legitimate activities of a doctor may be wider than coping with ill-health.

It is helpful here to use the distinction we drew earlier between the intrinsic and the extrinsic aim of the doctor. The intrinsic aim of the doctor is the improvement of health in the negative sense — the removal of ill-health. But a doctor may also have the extrinsic aim of furthering positive health in the sense of the well-being and welfare of his/her patients. As we said, a doctor is well-placed to join social workers, health educationists, and others to further positive health. To see this as a doctor's extrinsic aim is not to undervalue positive health but to assign priorities; a doctor's education cannot fit him/her for every task, and we suggest that the promotion of negative health (the bio-medical model) is the intrinsic aim, and the promotion of positive health is the extrinsic aim.

The distinction, between the intrinsic and the extrinsic aim of the doctor, or between the aims of the doctor and those of the health education officer, or between negative and positive health, is sufficiently important to be worth taking further. We can develop the distinction by comparing medicine with health education. What is the function of health education?

At a very general level we can answer the question by a broad statement of aim: *Health education is an activity aimed at restoring, maintaining, or enhancing the health of individuals and communities.* This definition is not adequate, however, for it provides at best a necessary and not a sufficient definition of health education. The definition as stated could apply to the work of the doctor. Doctors of course see themselves as health

educators; but in their characteristic work in pursuing their intrinsic aim, they are concerned not with education but with treatment. How then can we distinguish the work of the health educator from that of the doctor?

There are various important differences in assumption and approach. To state these is not necessarily to state a preference for one or the other. The activities are complementary and overlap and, as has already been said, the doctor can at times act as a health educator. Nevertheless, there are differences. But before listing these we must first dispel one confusion.

It is sometimes suggested that medicine deals with scientific fact whereas health education deals with advice and exhortation; one deals with the 'is' and the other with the 'ought'. This is not true. Medicine is based on the sciences, but it also deals with advice and with prescriptions. Health education likewise advises and counsels; but it is also based on the biological and social sciences. What then are the genuine differences?

First, medicine characteristically bypasses our rational minds and treats us as causal mechanisms. This is mainly so even if the doctor also listens to the patient's 'stories'. In other words, characteristic medical treatments are biochemical or surgical, whereas health education attempts to get us to understand our bodies and their environment. Secondly, medicine typically (but again by no means exclusively) stresses the curative or palliative, whereas health education stresses the preventive. Going along with the second distinction we might say, thirdly, that medicine stresses the doctor–patient or one-to-one relationship, whereas health education tends to have a broader societal perspective. Fourthly, and perhaps most fundamentally, medicine tends to be reductivist in its assumptions — this follows from the scientific study of disease processes on which it is based — whereas health education tends to be holistic in its assumptions.

Does it follow from the distinctions, if they contain at least some truth, that health education is in some way ethically superior to medicine? This by no means follows. If I break a leg I do not want advice but treatment! In other words, there is a place for both approaches. Moreover, as we have said, some doctors may also pursue health education, and this is a legitimate aim: but it is an extrinsic aim.

It is worth noting here, what we shall shortly develop at some length, that although

the intrinsic aim of the doctor is health negatively and narrowly conceived, that aim can be pursued within the broader perspective of 'whole-person understanding'. The theme of 'whole-person understanding' needs and will receive considerable analysis; but we mention it here to prevent misunderstanding. Even although the intrinsic aim of the doctor is to be seen in terms of the 'bio-medical' model of health, that aim can be successfully pursued only through whole-person care.

3.5 'Doctor' as a role-job

Medicine, in common with other professions, is a role-job, and an account of this role must be included in any adequate description of what it is to be a doctor, and hence of how doctors should be educated. Professions must be seen as role-jobs because they provide a service for other persons. Now many occupations, such as those involved in transport or public health, provide a service; but in the professions the service is provided specially via a *relationship* between the professional and his clients. What is here meant by a 'relationship'?

We can use the word 'relationship' in two ways; to stand for the bond which links two or more people, or to stand for the attitudes which bonded people have to each other. As examples of the first kind of relationship we might mention kinship, marriage, business association, or the teacher–pupil relationship. As examples of the second kind we might mention fear, pride, respect, envy, contempt, etc. Thus someone seeing an adult with a child might ask 'What is the relationship between those two?', and receive an answer in terms of the first kind of relationship: 'teacher and pupil', 'father and son', etc. Or the question might be 'What sort of relationship do Jones and his son have?', and receive an answer in terms of the second kind of relationship: 'Jones loves his son, but his son can't stand him.'

The two kinds of relationship are connected in various complex ways. For example, if the situation is a business transaction then the attitude of the parties would not characteristically be one, say, of affection or friendship. There is of course no logical impediment to such an attitude's developing out of the business transaction, and indeed it is material for romantic comedy when the attitude in the relationship is inappropriate for the bond. What, then, are the special characteristics of the doctor–patient relationship?

Let us begin by anatomizing the attitude aspect of the relationship. To understand an attitude

we must consider its object. The object of the professional attitude is the patient or client conceived in terms of vulnerability; typically there is inequality of power. This is obviously the case in a doctor–patient or teacher–pupil relationship. It can be argued that because of the dominant position which doctors occupy in the relationship with their patients, and because as doctors they must supply a service, and often assess its success as well, they must be governed more than many other people by principles of ethics; in particular in this context they must be governed by a desire to be of assistance to their patients — an attitude that is often called 'beneficence'.

The inequality of the professional relationship not only requires a special attitude, it also requires a special 'bond', which usually takes the form of an institutional role-relationship. The need for a formal bond in addition to an appropriate attitude is evident if we consider the significant interventions which doctors can make in the lives of their patients. We can approach this point in another way. We have already characterized the doctor as someone who aims at health. It follows that the doctor's activities intimately bear on human good and harm, and therefore the State will take an interest in them. For example, the State will lay down broad conditions for the qualifications of doctors, or specify when a patient has a legal right to medical care, to hospitalization, and so on. There may even be cases, perhaps of certain infectious disorders or psychiatric disorders, where the doctor has a duty to commit the patient to care against his wishes. In the latter case, the authority by which a person may be compulsorily detained in a hospital in Britain is legally derived from an Act of Parliament.

The professional bond is constituted, secondly, by rather vaguer sets of rules, or even of expectations, which doctors and patients have of each other. Doctors often refer to this as the 'ethics' of their professions. There are many different facets to this. For example, a patient has the assurance that a doctor will not take advantage of him with respect to any information about his private life which emerges; and there will be no gossip about medical conditions, social predicaments, and so on. The medical profession is very strict about enforcing its own discipline on these matters.

It is important that the doctor-patient relationship should be constituted, at least partly, by these legal and quasi-legal institutional bonds, for at least the following reasons. Firstly, because doctors and all health and welfare workers, by the nature of their jobs, intervene in existentially crucial ways in the lives of others. This is a serious matter, and its consequences for a patient can be

enormous. It is therefore in the interests of patients that there should be some sort of professional entitlement to intervene. In other words, if he is not simply to be a busybody, a doctor must have the *right to intervene*, and if he has the right to intervene he must have duties and responsibilities; the concept of an institution encapsulates these ideals of rights, duties, and responsibilities.

A second reason is that doctors must ask about many intimate details of people's lives, for example, about their marriages; and they also may conduct examinations of people's bodies. Questioning of this sort, and even more so physical examination, can create situations in which people can be exploited, or which could be embarrassing even to doctors themselves. The fact that it is an institutional bond which brings doctors together with their patients provides *emotional insulation* for both parties in such situations. Moreover, there must be some assurance that no untoward use will be made of the information, that it will not be passed on to neighbours, etc. But the idea of an institution entails that of rules; and the rules can, thirdly, impose *confidentiality* on the doctor, and thus provide security for the patient.

Fourthly, doctors are given a measure of *security* by virtue of the fact that they work inside an institutional framework. There are various aspects to this. For instance, it is good for all professions to have ways and means whereby new skills and knowledge can be shared, and in general whereby members of a profession can support and encourage each other. Again, doctors require legal or similar professional protection from exploitation, unfair criticism, or legal action against them by their patients. Reciprocally, there must be some institutional mechanism whereby the professions can criticize themselves and look for ways of improving their services to the public. These, then, are some of the reasons for which a complex legal and institutional structure has grown up governing directly and indirectly the relationships between health and welfare workers and their patients.

There are various desirable and undesirable aspects to this; but the relevant point for present purposes is that when the doctor, nurse, or other health worker appears to be acting as an individual he/she is also acting as a *representative* of his/her profession, and to a lesser extent also his/her State. In other words, the individual action of a doctor or other health worker expresses also the collective values of his/her profession; individual responsibility becomes collective responsibility, since it is through the individuals that

their professions are represented. We might say that individual health workers represent their professions in two senses. First, they are its ascriptive representatives, in that the profession authorizes their actions, having sanctioned their training. Second, they represent the values of the profession in so far as they act in terms of its ethics, and its ethics are all-pervasive in the actions and attitudes of the individual health worker.

In sum then, the doctor-patient relationship requires the doctor to have a certain attitude — beneficence towards the vulnerability of patients; but it also requires the institutional bonds which we have described by means of the concept of a role.

We have so far used the concept of a role as a way of linking a profession as an institution with the interests of *specific* patients; but it also enables us to refer to a broader social function, which involves the duty to speak out with authority on matters of social justice and social utility. Previously we have been concerned with the duty of the doctor to help and to be fair and honest to individuals, but now we are concerned with these duties in a wider social context. A good example of this from another profession is that provided by judges when in giving judgement they also comment on the need for changes in or additions to the law, or they comment on the practices of bureaucrats or the social services. Again, doctors have a duty to speak out on broad issues of health, as for example, they might speak out against cigarette advertising. Doctors are here pursuing what we have called the 'extrinsic' aim of medicine. In this kind of way the professions can be seen to have the important social function of regulators in the interest of general utility and justice. This is another aspect of a doctor's role. The existence of this function is recognized by the practice of including doctors on some government inquiries or arbitration panels. To some extent they are invited for their expertise; but it is also because they are recognized as having this wider function as public commentators. In exercising this wider function they are pursuing what we called the 'extrinsic' aim of medicine.

Professions are legitimized by the law. Yet legal legitimacy does not fully explain the social status of a professional role; for this we must also employ the idea of 'moral legitimacy'. If a profession is to have credibility in the eyes of the general public it must be widely recognized as being independent, disciplined by its professional association, actively expanding its knowledge-base, and concerned with the education of its members. If it is widely recognized as satisfying

such conditions then it will possess moral as well as legal legitimacy, and its pronouncements will be listened to with respect; it will have legitimized the authority of its role.

3.6 'Doctor' as a skill-job

The most obvious feature of medicine is its knowledge-base and its resultant skills. Indeed, the professions generally have traditionally been thought to be the custodians of special accumulations of esoteric knowledge. This does not mean that a profession is based exclusively on one discipline — on the contrary, professions tend to be eclectic, and to draw from various disciplines. This condition, a base of knowledge and resultant skills, is clearly no more than a necessary condition for being a profession, for there are many occupations which have a solid knowledge-base but which are not professions. For example, a systems analyst, or a film director, and many others, have considerable knowledge and skills — more than many professionals are likely to have; but their occupations are not professions. On the other hand the condition does rule out some occupations which are claiming professional status. For example, the knowledge and skills involved in, say, estate agency or advertising do not seem sufficient to qualify these occupations for entry into the professions through that route, although they may have other attributes in common with some of the professions.

Let us now look in more detail at the knowledge and skills involved in medicine.

Each one within the broad range of the health care professions will have its own particular knowledge-base, although there will be a large amount of overlap. For example, whereas a medical student requires a fairly comprehensive and general knowledge of anatomy and physiology, a speech therapist or a dentist needs a far more detailed knowledge of the anatomy and physiology of the mouth and related areas. It would also be prudent for all health care workers to acquire some knowledge of the law to the extent that it bears on their professional work.

In clinical terms examples of the factual knowledge of doctors would include such pieces of information as:

The blood is pumped by the heart to the arteries, the arterioles, and the capillaries and returns in the venous system to be oxygenated in the lungs.

Cimetidine is an H, receptor antagonist and reduces gastric acid secretion.

These are simple clinical facts. Yet in a historical sense it is important to note that such information was not always available, and that in the future new answers and facts will inevitably come to light which may change our whole concept of a particular disease or illness.

It is important to recognize that changing the factual knowledge may change the kinds of decision that have to be made. Take the introduction of cimetidine for example. Prior to this the management of chronic duodenal ulceration was by simple symptomatic measures such as bed rest or antacids, or by a surgical procedure. The decision as to when to operate was a difficult one. The introduction of cimetidine as an effective non-operative technique for controlling the disease changed the balance of decisions, and introduced a wider choice for the patient and the doctor.

Since doctors are practical people, their primary aim is doing rather than knowing. But practical skills or *knowledge how* require a factual substrate or knowledge-base which is essential for the development of practical skills. Arising from a broad factual knowledge-base there will be a huge range of professional skills, from the simple knowing how to take blood to the more complex knowing how to bypass coronary arteries.

In addition to the practical skills originating in their factual knowledge-bases all health care professions require skills in communicating effectively with their patients or clients. Most training programmes now include some explicit study of and practice in communications skills, which traditionally have been learned by apprenticeship.

Like factual knowledge, practical skills are constantly changing and improving. One has only to look at recent developments in health care, transplantation, *in vitro* fertilization, coronary artery bypass procedures, bone marrow transplantation, vaccination against hepatitis, to see how these practical skills may change our views on life expectancy and challenge our traditional values. New procedures and skills will continually evolve, and the doctor, nurse, or other health care professional must constantly be updating skills in diagnosis, prevention, screening, and treatment.

3.7 Teams

Traditionally doctors have thought of themselves as working on their own, with perhaps support from some others, especially nurses. This is increasingly an unrealistic idea. Health-

care is now delivered by teams, and this is true in general practice as well as in hospitals. The concept of a team is one which combines the concepts in terms of which we have been characterizing the profession of a doctor. Thus teams in health care have an overall aim — such as caring for the health of their patients. It may seem bland and pointless to state the obvious, but unless there is some 'mission statement' the point of the team activities may be forgotten in the pursuit of details. Again, the members of the team will each have a different role within it. Consider the following case.

A 65-year-old man, who two months ago had a stroke, has returned to the hospital for a follow-up visit. He has made good progress and is now mobile, but still has a slight speech defect. During his initial admission he was noted to be hypertensive, and was started on drug treatment for this, and was put on a weight-reducing diet. He asks the following questions:

Will my treatment be changed today?

Do I need to continue with my speech therapy and physiotherapy? Can I have a home help?

Should I continue with my diet?

It is obvious from a consideration of the questions that working in teams means being able to recognize one's own limitations and the strengths of others. Too strict a definition of roles, however, may set limitations for the team. Sometimes a centre forward has to play full back. It is necessary, however, if teams are to function properly, that members are able to practise together, and become aware of each other's strengths and weaknesses and share problems. There are interesting questions arising here, which we shall not discuss, about whether the doctor is always the appropriate team leader.

Finally, communication problems are important in teams. It is easy to think of communication as being patient-directed; but there is also the problem of communication within teams. This is a particularly common type of problem. One member of the team has made a decision, and perhaps even discussed it with the patient, but has not communicated it to the rest of the team. Often it is the junior nurse or doctor who is face-to-face with the patient asking the awkward or sensitive question. Unless each member of the team is involved then responses cannot be appropriate. We are here assuming that a decision has been made but not communicated within the team. There is, however, the other side of the coin — sometimes no decision has been made. Once again, confronted by a patient, what does the doctor or nurse do if a question is asked? This is a special

problem when it has been decided (for good or ill) that a patient should not be told of the diagnosis. It may be that others in the team feel that this is not the way to proceed, and wish the patient to be informed.

3.8 Conclusions

1. There are three linked aspects to being a doctor: the aim, the role, and the skills; and it is important for an adequate account of the concept of a doctor that all three should be discussed.

2. In discussing the aims of medicine it is helpful to distinguish the *personal* aims a doctor might hope to fulfil through medical practice from both the *intrinsic* aims of medicine as such, and its *extrinsic* aims — those which can be fulfilled as a result of medical skills or knowledge.

3. The intrinsic aim of medicine is the pursuit of health narrowly conceived, although medical education may also assist doctors to pursue wider community health aims.

4. Doctors act in roles understood in terms of institutional rights and duties which give support of many kinds to both doctor and patient.

5. Medical skills derive from the intrinsic aim of medicine, but it is important to remember that health care is now delivered by teams.

6. Dr D in the opening vignette is worried about widening his scope to include what we are calling the extrinsic aims of medicine, whereas Dr S is too ambitious for the scope of medicine. Mr F lacks the communication skills which medical education should cultivate, and Dr I's education has not stressed the importance of teamwork.

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