strated in the process of gaining a primary medical qualification.[13] When it comes to doctoring, the term "good" increasingly functions as a descriptive label that denotes having met certain tests of competency.

A poor doctor is generally credited with good intentions but inadequate knowledge or skills required for the job, and there seems little doubt that some poorly performing doctors will be picked out by performance monitoring procedures. But what about bad doctors? A bad doctor, however skilled, is one with bad intentions, undesirable values, suspect—occasionally evil—motives. Judging someone a bad doctor implies serious defects of moral agency, even though these may coexist with commendable aspects of medical practice, as the above statement from the son of one of Harold Shipman's victims makes plain. Although the death rate of Shipman's patient list turned out to be high when examined retrospectively, performance outcome measures cannot detect bad doctors in all possible circumstances.

The varieties of good, poor, and bad doctors are diverse and may sometimes coexist in the same individual. This does not make becoming a good doctor an unattainable ideal. Medical education today should be aiming to marry the skills and sensitivities of the applied scientist to the reflective capabilities of the medical humanist.

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Patients' views of the good doctor

Doctors have to earn patients' trust

Most doctors are good doctors in the eyes of most patients. Despite the media's fixation with medical errors and damaged patients, doctors come high in the popularity stakes in almost any poll, compared with other professions or trades.[1] Furthermore, familiarity tends to breed contentment, not contempt. Patients who have recent experience of medical care tend to give higher, less critical ratings than patients whose experience is less current.[2] The medical profession does, however, attract criticism from patients—sometimes deservedly so.

Since the 1970s patients' groups, and women's health groups in particular, have drawn attention to the deficiencies of the traditional medical model and its tendency to demean and disempower patients.[3] The reaction of the early antipaternalists was to emphasise self education and self help as a way of redressing the power imbalance between doctors and patients and avoiding dependence on orthodox medicine. It is often forgotten that most healthcare is self care,[4] but too often the manner of healthcare delivery serves to increase dependency and undermine coping skills. Nevertheless, despite the feminist critique, the practitioners of orthodox medicine remain as firmly on their pedestals as ever.

What do patients want? Both interpersonal relations and technical skill are rated highly. A systematic review of the literature on patients' priorities for general practice care was conducted as part of a project by the European Task Force on Patient Evaluations of General Practice (EUROPEP).[5] The most highly rated aspect of care was "humaneness." This was followed by "competence/accuracy," "patients' involvement in decisions," and "time for care." Similar themes have been identified in other studies that used different methods to derive patients' priorities. For example, patients in Scotland placed greatest importance on having a "doctor who listens and does not hurry me,"[6] and provision of information and opportunities for participation feature highly in most studies of patient satisfaction or dissatisfaction.[7] Patients increasingly expect to participate in decisions about their care, but these aspirations are rarely met.[8] Failures in communication and incorrect assumptions about patients' preferences are surprisingly common.[9]

Doctors and patients don't always agree on priorities. A study from the Netherlands found that patients gave much higher priority to sufficient consultation time, availability of appointments at short notice, and being given detailed information about their illness, whereas doctors tended to place greater emphasis on coordination of care, home visits, and continuity.[10] Perhaps this insistence by doctors on the primary importance of continuity—the central tenet of the ethos of the family doctor—is just another example of medical paternalism. The patient wants to be an informed and empowered consumer, but the doctor prefers a long term relationship with a docile patient.

Patients' ratings of doctors' interpersonal skills are strongly related to trust. Most patients want to be able to trust the health professionals they consult, but this does not mean they want to be deceived about the

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nature of their illness or the risks and potential harms of medical intervention. Mechanic and Meyer asked American patients about what trust meant to them.[11] Themes that were most commonly mentioned included honesty, openness, responsiveness, having one's best interests at heart, and willingness to be vulnerable without fear of being harmed. Trust is very important, but it does not equate to blind faith. Sick people need empathy, support, and reassurance, all essential features of a therapeutic relationship, but they also need honest information about their condition, options for treatment, and clinicians who listen to their concerns and preferences.

If doctors find it difficult to listen to patients, understand their preferences, and involve them in decisions about their care, they may need training in the competencies for shared decision making. A recent systematic review found 17 trials of training interventions designed to promote a more patient centred approach in clinical consultations.[12] Most of these led to notable improvements in consultation processes and patient satisfaction. Those responsible for medical education would do well to take note.

Doctors who are concerned that more empowerment for patients might mean greater burdens on their time should consider ways of sharing the load. Giving information, helping patients to think through their preferences, or training them in active self management can be done by nurses, counsellors, information officers, or fellow patients. Information materials and educational packages are available to help in this task.

Despite challenges to medical authority, doctors' skills and advice are still held in very high regard by the public. But doctors' lack of inclination or time, or both, means that patients' desire for information, education, and empowerment is inadequately provided for in modern medical practice. Patients want to trust their doctors, but trust has to be earned by treating people as grown ups, answering their questions clearly and honestly, listening to their views, and involving them in decisions. This cannot be an optional extra. Failure to accommodate patients' needs for involvement will diminish doctors' standing in the long run.

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How can good performance among doctors be maintained?

Department of Health's proposals are wise but need to be implemented with care

See also p 704

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The Royal College of Physicians, the BMA, the Patients' Association, and the Institute of Health Care Management (among others) have backed the Department of Health's call for doctors to have annual appraisals, for continuing professional development, and for the revalidation of doctors.[1] The collective concern of these bodies is to ensure that doctors continue to develop their competence and provide a high standard of care for patients. What evidence is there that these strategies make a difference?

Feedback on performance and objective setting are the two fundamental components of appraisal. The evidence is strong that feedback on individuals' job performance is associated with improvements in performance and reductions in error rates across all employment sectors.[2] Moreover, setting goals is associated with improved performance, particularly where the goals are set collaboratively with professionals and where they are specific and challenging (rather than vague or "do your best" goals).[2] Training (or continuing professional development) has been shown to improve job performance, quality, and organisational performance and service across employment sectors, and to reduce costs.[3] In health care, one study of 600 consultations before and after training of general practitioners found that improved consultation skills and medical knowledge were associated with the quality of medical performance, as judged by adherence to protocols.[4]

Evidence of the effectiveness of these practices in the health sector is limited. However, in a study of the link between such people management practices and hospital performance, the findings showed strong negative associations between these practices and patient mortality.[5] Controlling for a variety of possible third factors (including number of doctors per 100 beds and prior levels of patient mortality) showed that the extent and sophistication of appraisal in hospitals predicted substantial mortality of patients over a three year period. The greater the extent and the more sophisticated the level of appraisals across all staff groups, the lower the patient mortality. Links were also