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‘The voice of an oracle’: Little Nell and the art of ‘enacting the persona of the doctor’

Medical humanities have long been promoted as a means for trainees and doctors to gain deeper understanding of patients, illness and professionalism. In practice, teaching on medical humanities – while valuable – struggles to connect such learning to the realities of the clinical workplace and patient encounters. The solution to this shortcoming lies in recognising ‘soft’ – but clinically relevant – concepts that operate within consultations. These concepts are, in fact, best revealed through literary and historic accounts of doctors, patients and illness. Such a vignette is Dicken’s parody of Victorian physicians in the shape of the doctor who visits Little Nell in his book the Old Curiosity shop. By taking prescription and technology out of the encounter, Dicken’s parody lays bare ‘soft’ elements that constitute the art of ‘enacting the persona of the doctor’. Medical humanities in general (and literature in particular) constitute a valuable tool for teaching the place of performance and the power of human qualities in the consultation. This ‘old fashioned’ professionalism should be a foundation to every formation in clinical medicine.

Opening ‘case’:
An orphaned girl lives in the care of her grandfather. Threatened with desperate poverty and forced to travel around England, she falls gravely ill. The doctor is summoned. In the Victorian era, although doctors often possessed outstanding examination and diagnostic skills, effective medical treatments were in their infancy. What is more, the medical profession was preoccupied with protecting lucrative private practice. Medical knowledge was, therefore, perceived by many as a commodity of the privileged few. These limitations ensured that in many interactions with patients, Victorian doctors had to fall back on another key strength: their skill in the art of medicine. Dickens, thus, offers insight into the power of the doctor’s persona by drawing upon a world undistracted by modern science and technology.

Introduction

How a consultation is conducted and the way the doctor is perceived by the patient have an important therapeutic impact over and above any biomedical ingredient. Indeed, the practice of medicine has been described as ‘an art whose magic and creative ability have long been recognised as residing in the interpersonal aspects of the patient-physician relationship’ (Hall et al., 1981). Being the doctor means assuming a persona to fulfil a key social role. Medical students must learn to look, act and undertake clinical examination ‘like a doctor’ (Bird, 2016). The hallmark of this art lies in promoting ‘doctor as drug’ (Balint, 1957), mastering therapeutic
examination (Hodgkin, 1966; Bird, 2016) and adopting a strategic approach to consultation (Cooper et al, 2022a; Cooper et al, 2022b). The application of this art extends far beyond simple reassurance and into everyday clinical encounters (Bird, 2016; Cooper et al, 2022b). Here, ‘doctor as drug’ and therapeutic touch are enhanced by the symbolic power of examination equipment, helping patients take control of their breathing and by ending on a moment of firm pressure (Bird, 2016). Adopting a therapeutic approach to examination also offers the doctor ‘space to think’ (Cooper et al., 2022a), a moment to re-focus that may be facilitated by removing oneself from the patient’s gaze (Cooper et al., 2022b). Finally, placing therapeutic examination at the centre of the consultation permits the doctor-in-training to bring structure and momentum to the encounter, not least by providing a legitimate reason politely to quieten the chatty patient (Cooper et al., 2022b). Embracing these concepts constitutes ‘enacting the persona of the doctor’ and should be the foundation of every formation in clinical medicine.

This art has its roots in the traditional apprenticeship model of learning medicine. Engaging modern medical students motivated by hard facts and success in academic assessments is more challenging. One way forward is through the medical humanities. At Brighton and Sussex Medical School (Cooper et al., 2022a), I have used Dickens’ Old Curiosity Shop for this purpose (Dickens, 1840). Here, a short vignette has served as an entrée to the art of consultation, preparing students for subsequent placements and simulation within a longitudinal module in general practice (Cooper et al., 2022a).

The vignette of Little Nell’s home visit

In the story little Nell ultimately dies but the narrative reveals what - in Dickens’ time - was expected in a doctor and just how expertly that could be enacted. This vignette illuminates clinical wisdom in action by ‘enacting the persona of the doctor’ and its rituals in the form of therapeutic examination. Here Dicken’s doctor is seen creating ‘thinking space’ albeit largely for show. Little Nell’s doctor employs symbolic equipment in the guise a timepiece supplemented by diligent application of physical touch:

“The doctor, who was a red-nosed gentleman with a great bunch of seals dangling below a waistcoat of ribbed black satin, arrived with all speed, and taking his seat by the bedside of poor Nell, drew out his watch, and felt her pulse. Then he looked at her tongue, then he felt her pulse again, and while he did so, he eyed the half-emptied wine-glass as if in profound abstraction”.

The doctor goes onto reveal the importance of therapeutic measures in formulating his management plan. He expertly gleams what treatment has already been tried and detects subtle cues to observers’ beliefs about what else may assist Nell’s recovery:

“I should give her,’ said the doctor at length, ‘a tea-spoonful, every now and then, of hot brandy and water.’

‘Why, that’s exactly what we’ve done, sir!’ said the delighted landlady.
‘I should also,’ observed the doctor, who had passed the foot-bath on the stairs, ‘I should also,’ said the doctor, in the voice of an oracle, ‘put her feet in hot water, and wrap them up in flannel. I should likewise,’ said the doctor with increased solemnity, ‘give her something light for supper—the wing of a roasted fowl now—’

‘Why, goodness gracious me, sir, it’s cooking at the kitchen fire this instant!’ cried the landlady. And so indeed it was, for the schoolmaster had ordered it to be put down, and it was getting on so well that the doctor might have smelt it if he had tried; perhaps he did.

‘You may then,’ said the doctor, rising gravely, ‘give her a glass of hot mulled port wine, if she likes wine—’

‘And a toast, Sir?’ suggested the landlady.

‘Ay,’ said the doctor, in the tone of a man who makes a dignified concession. ‘And a toast—of bread. But be very particular to make it of bread, if you please, ma’am.’”

He offers no scientific advice and Dickens is clearly poking fun at the medical profession. It is, however, the doctor’s masterful response to everything he observes that lays bare his clinical wisdom. With students this narrative stimulates discussion about what it means to ‘enact the persona of the doctor’: entrance, attire, being observed, kindling confidence, gravitas, attentive listening, responding only after due consideration and timing one’s departure. It is of note that he leaves no drug or written prescription, an act of commission that too often symbolises the essence of being a doctor. Instead, he bequeaths his wisdom. This is evident in his mastery of the ‘golden minute’ at the consultation’s end (Cooper et al., 2021; Cooper et al., 2022a), departing at the very moment this wisdom has swept away all doubt:

“With which parting injunction, slowly and portentously delivered, the doctor departed, leaving the whole house in admiration of that wisdom which tallied so closely with their own. Everybody said he was a very shrewd doctor indeed, and knew perfectly what people’s constitutions were; which there appears some reason to suppose he did”

Dickens tells us that patients need doctors to convey understanding of their ‘constitution’. His doctor highlights how this personalised approach to consultation is best achieved inside patients’ homes where cues abound. His gift of reading cues and patients’ ‘constitutions’ is woven into his management plan: it is personalised, flexible and starts by building on the patient’s (or guardians’) own beliefs about treatment. Here we witness ‘doctor as drug’ and steps taken to promote the placebo effect. Nell’s doctor is comfortable being observed and accomplished in reading situations. His sense of performance and ritual is palpable.

Discussion

Setting aside Dickens’ fun-poking, the vignette offers insight into the place of consultation skills and the status of general practice, particularly within the undergraduate curriculum. Today most medical school teaching takes place outside
what McWhinney terms the patient’s natural ‘habitat’ (McWhinney, 1981). That means inside the hospital - where patients are sicker, expectation higher, cues absent and technology omnipresent. In 1985 Julian Tudor Hart famously called for primary care to become the core curriculum in medical education and for students to be taught ‘within communities’:

"Our system of medical education is still designed to produce community clinicians only as a by product, an after thought following a core curriculum designed by and for specialists. Its central aim remains the production of specialist excellence, unsullied by prior contact with the society it serves. It is training the wrong people, at the wrong time, in the wrong skills, and in the wrong place…” (Tudor Hart, 1985)

With regard to consultation skills, this conundrum is still writ large in medical school curriculums today. Students are taught consultation according to the ‘hospital’ model, albeit with some consideration of ‘Ideas, Concerns and Expectations’ (Denness, 2013). The latter serves as a ‘bolt on’ to the former, so much so that students may be heard muttering the afterthought: ‘I’d also ‘ICE’ the patient’. Students are increasingly unaware of other philosophies to consultation because the hospital model forms the substance of the assessment that drives all their learning.

Students, thus, may graduate understanding consultations in a linear way: symptom and risk factor tick boxes, textbook clinical signs, diagnosis, and treatment. The outcome will typically lie in the form of an intervention: prescription, investigation, onward referral or all three. ‘Progress’ in the form of tomorrow’s Medical Licensing Assessment may ultimately only serve to cement Tudor-Hart’s observation in 1985:

‘the definition of what good doctoring is remains in the hands of hospital-based specialists’ (Tudor Hart, 1985)

Dicken’s story, conversely, takes Tudor-Hart’s conundrum to its logical conclusion in the opposite direction: students must commence learning consultation skills not just ‘in the community’ but, specifically, inside patients’ homes. This is particularly important for students’ ‘first forays’ into general practice that constitute critical formative moments (Cooper et al, 2022c). In patients’ homes, students become aware that the consultation is so much more than a transactional exchange of fact for pharmacy. Insight acquired in this milieu helps students to understand their patients and to distinguish the clinically ‘normal’ from ‘abnormal’ (Heath et al., 2022)

Dicken’s caricature is male and clearly differs from today’s expectations of a doctor in many ways. His art, however, must continue to be promoted among students, in particular within the homes of patients of diverse backgrounds and identities. Without this formation, positive steps towards expanding and diversifying the workforce may flounder. That is because the patient’s own home constitutes a unique context where students must explore and test their personal vocation to medicine.

Evidence for the power of a doctor’s persona

The power of the doctor’s persona is not fanciful. Indeed, there is research evidence to support the impact of doctors’ soft skills in the consultation. First, evidence exists
of positive association between clinical empathy and improved therapeutic outcomes in various clinical settings (Jani et al., 2012). Second is patient satisfaction: this is associated with increased adhesion to clinical advice (Fong Ha et al., 2010). Third, is a positive consultation style. Thomas (1987) undertook a small randomised controlled trial of being positive in the consultation with patients. His study is presented at length below for its methodological elegance and findings about both positivity and patient satisfaction:

“A group of 200 patients who presented in general practice with symptoms but no abnormal physical signs and in whom no definite diagnosis was made were randomly selected for one of four consultations: a consultation conducted in a "positive manner," with and without treatment, and a consultation conducted in a "non-positive manner," called a negative consultation, with and without treatment. Two weeks after consultation there was a significant difference in patient satisfaction between the positive and negative groups but not between the treated and untreated groups. Similarly, 64% of those receiving a positive consultation got better, compared with 39% of those who received a negative consultation (p = 0.001) and 53% of those treated got better compared with 50% of those not treated (p = 0.5).” (Thomas, 1987)

Dickens’ doctor suggests a further line of future enquiry: gravitas. That is to say the power of patients having their misfortune acknowledged by a professional authority figure, especially one with a solemn disposition. If such a phenomenon indeed exists, its historical echoes might be found in the primacy of confession advocated for the treatment of patients in the medieval monastic hospital.

Recognising divergent challenges between teaching undergraduate and postgraduate general practice

Teaching through Dickens’ vignette also sheds light on the divergent challenges that face teachers of general practice in the undergraduate and postgraduate domains. That is because the former must first seek ways to engage and inspire students, including through medical humanities. Undergraduate teachers must also persuade students of the value of general practice: providing high quality care at an appropriate level (thus, reducing cost and unnecessary tests) and tackling health inequalities by widening access. Furthermore, undergraduate teachers must nurture students towards ‘thinking like a GP’ (Cooper et al., 2022a). For medical students that often means learning to ‘think differently’, specifically to ‘unlearn’ the specialist approach to consultation style adopted and assessed in medical school. This journey of ‘unlearning’ calls for students to return to their natural inquisitive and empathic selves, valuing patients’ stories and supporting people on their journey towards better health, sometimes just one step at a time (Cooper et al., 2022b). Part of this ‘unlearning’ includes recognising that clinical medicine more widely - and general practice in particular – constitute something of a performance art. All together these endeavours comprise what might be called the ‘missionary function’ of undergraduate general practice teaching. Missionary activity, conversely, is largely absent in the postgraduate sphere where trainees’ eyes are already open to the world - and enormous potential - of general practice, a deduction writ large in
their choice of career. There exists, however, one further difference: ‘serious tensions’ with hospital specialists (Wass et al., 2016). This is part and parcel of undergraduate teaching in general practice and emerges wherever calls are advanced for teaching in the art of medicine and the ‘old fashioned’ professionalism described here. Such teaching, as a result, may ultimately find itself being delivered opportunistically or ‘under the radar’, for example in student selected components of the curriculum. These tensions exist for the very same reasons described by Tudor-Hart in 1985: because curriculum content is nearly exclusively determined by medical school leaders who are hospital specialists. Tensions of this type are less evident in the postgraduate sphere where professional identities and terms of engagement are more clearly demarcated, albeit sometimes in the form of entrenched silos.

Dickens offers insight into the power of the doctor’s persona undistracted by modern science and technology. His vignette can serve as a persuasive tool in the undergraduate missionary endeavour described above. It also makes an appeal for curriculum leaders to value the art of medicine, ‘old fashioned’ professionalism and the traditional role of the physician. Learning to enact the persona of the doctor, sadly, been lost in repeated curriculum reforms of recent years. That indeed was the fate in September 2021 of the BSMS general practice module (Cooper et al., 2022a).

Conclusion

The hospital model of consulting is inadequate in many clinical situations, not least the majority of encounters in general practice. Medical humanities offer a unique tool towards ‘unlearning’ the hospital model and re-membering students’ natural consultation styles that are oriented towards patients, their lives and their stories. Reading patients' 'constitution', understandably, is not a learning outcome in the forthcoming Medical Licensing Assessment. Nevertheless, the ‘old fashioned’ professionalism inherent in rehearsing the persona of the doctor should be. Without it, students may leave medical school unaware of – or, worse still, suspicious of – the GP perspective on illness, consultation and management (Johnston et al., 2019). The soft formation described here must commence inside patients’ homes. It is this unique environment that offers privileged insight for students and doctors: understanding the world of the patient, testing a vocation to medicine and affirming that a key strength of general practice is its ‘shoe leather’ function (Ashton, 2021), i.e. extending care from the clinic into patients’ homes.

Nurturing this art in medical students and trainees remains the province of the GP teacher. It's foundation belongs right at the start of medical school but its application in increasingly challenging settings should be a theme across the whole curriculum. Once acquired, the art of enacting the persona of the doctor is transferable across all specialities. It may have a critical function for learners undertaking ‘first forays’ into general practice, especially those already imbued in the hospital model of medicine. Supporting learners at critical moments in their training may be important for preventing moral injury among future generalist doctors (Cooper et al., 2022c). A medical humanities approach offers an entrée to discussing with students the importance of ‘enacting the persona of the doctor’. This phrase captures the art of
medicine: entrance, attire, being observed, detecting cues, kindling confidence, gravitas, attentive listening, responding only after due consideration, constructing a personalised management plan and timing one’s departure. By removing prescription and technology from the encounter, Dickens parody lays bare the power of human qualities at play in the consultation. Learning to recognise and enact this art should be the first function of medical education. Perhaps most of all, Dicken’s doctor serves to help students value the consultation for its sense of theatre.

Finally, Dickens’ vignette stands as an important reminder that patient-centred consulting skills peddled in the absence of sound clinical management amount to chicanery and humbug. Worse still, as in the case of Little Nell, it can be fatal. Playing the persona of the ‘good doctor’ can be no substitute for critical thinking, sound judgement and evidence-based practice.

Key points

- Students and trainees must learn to ‘enact the persona of the doctor’
- This phrase captures the art of medicine: entrance, attire, being observed, detecting cues, kindling confidence, gravitas, attentive listening, responding only after due consideration, constructing a personalised management plan and timing one’s departure.
- This concept encapsulates the ‘art of medicine’ and is best learnt inside patients’ homes, where cues abound and technology absent
- This approach emphasizes the ‘human qualities’ of the consultation, in particular ‘doctor as drug’, therapeutic examination and personalised management plans
- Trainees should recognise and value consultations for their sense of theatre

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