Personhood, values, and work

Wayne Cunningham

There is an important take-home message to be found in this issue of the Journal. In the study by Mason *et al*., Zara, Chrys and Dawn explore reasons why general practitioners continue to practice obstetrics.[1] Excuse me? Zara, Chrys and Dawn? Surely a respectful editorial should never refer to these authors by their first names, and should instead use the conventional and impersonal 'Mason *et al*. …'? However, consider this: two of these authors have been my colleagues and friends for twenty years. All three are real people and have families, careers, relationships, a perception of future, and all of those other things that as Eric Cassell pointed out, define personhood.[2] That is my point and I think it is the underlying message to take from this research; we need to pay attention to the person, not the 'im-person', of ourselves and our colleagues.

The study indicates that GPs who continue to practice intra-partum obstetrics (GPOs) do so because the work aligns with their personal values. They value continuity of care, teamwork, and collaboration, a sense of personal competency and of meeting community needs (particularly in rural settings). GPO practice aligns with what helps define them as general practitioners. Some respondents allude to a real sense of loss on stopping this aspect of their medical lives. In other words, they are personally, not impersonally, invested in their work. They are also mindful of the costs of delivering such care - to themselves and to their families - of the challenges to running their practices, and of how they have built good relationships with other providers of maternity care to enable them to continue this work. Such issues and concerns are deeply personal.

Does this study imply that those of us (the huge majority) who are not GPOs are somehow lesser doctors? I certainly hope not. For myself, I find intra-partum obstetrics moderately terrifying and it is best for me and my patients that I stay well away! When I first entered general practice in the early 1990s, I provided shared obstetric care with my GPO colleague who provided excellent late antenatal, delivery and postnatal care, and who then returned mother and baby back to me. It worked well. The arrangement was collegial and probably paralleled the sense of relationship that current day GPOs have with their midwife and specialist obstetrician colleagues. Latterly, the majority of my pregnant patients enrolled with a midwife and apart from providing emergency care, I tended not to see them. I felt the loss.

But why is it that the person of the doctor needs to be attended to, to be taken seriously? I think that one answer lies in the importance of the doctor-patient relationship and how it relates to caring for patients. We create and sustain the relationship though listening, exploring the patient's illness experience, having empathy, using emotional intelligence, sharing power and behaving with compassion.[3] To this we add our technical biomedical skills of inquiry, examination, investigation and therapies to achieve good outcomes of care. The doctor of course, forms one half of the doctor-patient relationship. It is important to remember that the various components that constitute the person of the doctor including the doctor's health, their own relationships and their own values and beliefs are, consciously or subconsciously, examined or unexamined, brought into that relationship and have the potential to alter the quality of the patients' care, for better or for worse. In summary, the person of the doctor is integral to caring for patients.

Pursuing this line of thought further, it seems to me that we cannot consider our current models of healthcare delivery and any proposals for change, without considering the impact of these models on the person of the doctor (and for that matter, on other healthcare providers). As Mason *et al*. demonstrate, doctors are not simply biomedical technicians, dispensing healthcare impervious to the complex milieu of their work. It is everything that goes with the work that

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matters. To accurately assess models of healthcare delivery we need to deliberately take account of how that work affects doctors personally. Good healthcare delivery planning demands what our colleagues have done in this research; ask what our work is like, what we think about it and how we feel and respond to what is good and not-so-good. From this we will learn about the values we hold most dear. Ultimately, I would argue, it is our values that drive our behaviours - in this case the types and fields of medical practice that we engage in and those that we avoid.

We are all personally invested in our work. We are not, as Zara, Chrys and Dawn demonstrate, impersonally invested. The message is to consider the values held by doctors that shape how they practice, before making changes to healthcare delivery. If change (or lack of change) is sufficiently out of line with our values, it may not succeed or it may have unintended consequences.

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