# BECOMING A DOCTOR

## Re-Membering a Medical Education

Christopher D Ward

# BECOMING A DOCTOR

# BECOMING A DOCTOR

## RE-MEMBERING A MEDICAL EDUCATION

CHRISTOPHER D WARD

FHB | FIRST HILL BOOKS

FIRST HILL BOOKS
An imprint of Wimbledon Publishing Company Limited (WPC)

This edition first published in UK and USA 2026
by FIRST HILL BOOKS
75–76 Blackfriars Road, London SE1 8HA, UK
or PO Box 9779, London SW19 7ZG, UK
and
244 Madison Ave #116, New York, NY 10016, USA



*British Library Cataloguing-in-Publication Data*
A catalogue record for this book is available from the British Library.

*Library of Congress Cataloging-in-Publication Data: 2026937641*
A catalog record for this book has been requested.

ISBN-13: 978-1-83999-705-1 (Hbk)
ISBN-10: 1-83999-705-2 (Hbk)
ISBN-13: 978-1-83999-706-8 (Pbk)
ISBN-10: 1-83999-706-0 (Pbk)

Cover credit: © 2025 The Estate of L.S. Lowry. All Rights Reserved, DACS.

This title is also available as an eBook.

*We are what we pretend to be, so we must be careful what we pretend to be.*

*Kurt Vonnegut*

*Without one's own questions one cannot creatively understand anything*

*Mikhail Bakhtin*

# TABLE OF CONTENTS

# CHAPTER 6

# CREDIBILITY

> A physician that has his tongue well hung, and is master of the art of persuading, fastens, by the mere force of words, such a virtue upon his remedies, and raises the faith and hopes of the patient to that pitch, that sometimes he masters difficult diseases with the silliest of remedies
>
> George Baglivi

The first five chapters of this book have mostly been about theory and the last four will be about practice. This one bridges the two perspectives. It concerns communication, which is a practical skill, but here we look at medical talk from a theoretical as well as a practice point of view. When doctors talk to patients, or to each other, they are inevitably practising the art of persuasion, in other words rhetoric, and rhetoric is a theory-based approach to communication. Aristotle defined it as 'the transformation of spontaneous or habitual persuasion into methodical practice'. There are students in other parts of the world who are taught rhetoric, but I doubt if many are medical. To us, to our teachers and to our future colleagues, the idea of rhetoric was anathema, as it still is to the vast majority of Britons. A word that is still very current, however, is credibility. No student, in fact no person, is given formal lessons in credibility, but we did need to learn how to be believable doctors.

Doesn't a doctor's credibility depend on what she knows? Quite the reverse, I think. What a doctor says only counts as knowledge because the doctor herself is credible. When we students reported our clinical observations to the all-powerful consultant we would only be believed if our language and demeanour were credible, just as our patients would never believe us unless they believed *in* us. Our scientific findings faced the same challenge, which was to practise whatever rhetoric a particular audience required. The skill of being believed seems to me to be at least as basic as the more conventional medical skills that I will come to in subsequent chapters, although how much our education contributed to that skill is a matter for speculation.

## 6.1 Ward Round Rhetoric

> Rhetoric, that powerful instrument of error and deceit
>
> John Locke

> If we loved truth, we should be impatient to make it appear as lovely to everybody else
>
> Bernard Lamy

**In a Paris Hospital, 1910**

(Credit: Wellcome Collection.
Photo Seeberger Frères, ca. 1910)


The moment I started as a clinical student, I was assigned to a medical firm and allocated a patient to be interviewed and examined (clerked). On the firm's ward round we would each present a patient to the consultant, along with a retinue of other doctors, nurses and students who in my memory look like the group pictured in 1910 Paris. In the western world, teaching rounds are enactments of an archetypal drama, played out in a distinctive speech

genre. The required narrative was supposed to be a colourless recitation of specific categories: *Age and Occupation; Presenting Complaint; History of presenting complaint; Past Medical History; Drug History; Family History; Social History; Systems Review; Test Results; Differential Diagnosis; Diagnosis; Treatment*. It was a scientific presentation, like the reports we made of classroom experiments at school: *Aim; Introduction; Materials and Methods; Results*. I now recognise both these as forms of rhetoric. I had learned to make speeches at school, but our debating society's combative atmosphere seemed very different from the clinical objectivity of a hospital. On a ward round the student was expected to relay facts, and nothing but facts; no tricks, no appeals to the audience, no effort to persuade, no personality. And absolutely no rhetoric. But storytelling is a rhetorical task, and presenters of clinical histories are orators of a sort. Whenever I was put on the spot I felt the need to be a credible person. To be credible, we must show a certain amount of diffidence, but not too much; appear confident, but not worryingly so; be aware of shortcomings, without ever revealing fatal ones. The rules we were learning were scarcely ever put into words.

We needed to be on our rhetorical mettle because we were all painfully aware that our clinical teachers must believe in us. Sooner or later they would have the power to either grant or deny us medical jobs. In an interview for a television programme, a beloved fellow student was asked why he wanted to be a doctor. 'To be rich and famous!', he declared, with a hearty laugh. This was an outrageous error in the eyes of our consultants, for whom one of the unspoken rules was to avoid irony. The doctor's manner should be cheerful, as Hippocrates and Galen insisted, but one's deportment must exude high seriousness. These were the rhetorical elements that Aristotle called *ethos*. Such is the subtly false code that people call the bedside manner.



A case presentation's raw material was always a story from everyday life:

> *The doctor told me not to worry but there was a strange pain in my chest and it didn't go away I started to find it hard to sleep lying down my shoes felt tight the wife told me to go back but she didn't come because we can't leave the dog on her own these days so I did go and see him and wrote a letter and I've been feeling worse since I arrived... .*

For the ward round, I would need to translate the patient's colourful story into something like this:

> *Age and occupation*: 'Mr Carter is a 63 year old plumber'
> *Presenting complaint*: 'He complains of what he describes as 'a strange pain in my chest''.
> *History of presenting complaint*: 'He was well until eight days ago when he was lifting some heavy equipment out of his van and noticed a pain in his chest […]'
> *Past medical and surgical history*: 'An inguinal hernia was repaired five years ago. He is being treated for essential hypertension […]'
> *Drug history*: 'Methyldopa 250 mg three times daily and[…]'
> *Family history*: Nothing of note
> *Social history*: 'He smokes 30 cigarettes a day, has no more than two or three pints of beer in an evening, and lives with his wife'

In the desired version, Mr Carter's voice is drowned out by medical vocabulary. Just four of his words, or a rough version of them, are placed at the top of the story, where the presenting complaint 'strange pain in my chest' is recorded as 'Pain in the chest'. Personality is already on the retreat even there: the pain is not 'strange', and it is no longer *my* pain. From that point onwards, the pain will be redescribed as retrosternal; difficulty breathing will be dyspnoea; swollen legs will be ankle oedema. I must play the right language game, in Wittgenstein's terminology, or use the right speech genre, in Bakhtin's (not that these two concepts are identical).

The headlines of a clinical presentation are pre-set, but the story's shape is in the narrator's hands and is part of its *logos*, its argument. I must choose precisely what to quote from among Mr Carter's many words, and what to leave out. Shall I start with the incident at work, where the pain first began to seem like a medical problem? Or shall I track the pain back to the few twinges he had noticed at a funeral a few months previously? If so, do I insert the fact that the funeral was for his 12-year-old grandson? I must decide what negatives to include. It matters from a cardiological point of view that Mr Carter's pain does *not* go into his back, but should I also mention that he has 'no symptoms of anxiety'? If the diagnostic process was being steered towards the heart it would be subversive to complicate it with idle talk about the emotions.

The third element in Aristotle's scheme, along with ethos and logos, is *pathos*, which is emotional engagement with an audience. Science aims for a resolutely unemotional ethos. The author of an experimental report must not describe the

feelings he had when his apparatus exploded (horror, perhaps? or glee?). The same impersonal tone was required on a ward round. In both cases, we would tell the story as if there were no narrator. At school, I would have written that a chemical solution 'was titrated' without any suggestion that the pipette had been held by me or that I longed with all my heart for the solution to turn blue; and now I must describe Mr Carter's oedema without reference to the fact that the diagnosis was made by probing his spongy ankles with my very own fingers, or that I felt for him, and hoped he wasn't seriously ill.

The technical language of our clinical presentations was supposed to capture everything that was truly real. The couple of sentences we called Social History seemed to us to say enough about Mr Carter but what, ultimately, was the point we were supposed to be getting at, if the story of his illness told us so little about how and why he and his wife lived?

Perhaps I sense the word holism coming into your mind. Today, holism functions as a decorative sheen on the essentially mechanistic education that medical students receive. No such term was ever suggested to us, but a well-meaning urologist tried to show us his concept of The Whole Patient. He summoned us to see a man who was lying supine on a bed, under a blanket. The doctor dramatically flung the blanket off, exposing the man's starkly naked body. 'What do you see?' asked the urologist. We were silent, all eyes striving not to look upon the unfortunate patient's genitals. Silence again. 'What do you see?' barked the doctor. Still nothing. 'What you see', he declared dramatically, 'is a PERSON!'. A person who at this very moment must have felt less of a person. The rhetoric of holism is full of holes.



What made teaching rounds so stressful was the fear of losing one's credibility. 'The man in Bed 9 was desperately short of breath when he arrived at the hospital and was thought to be in respiratory failure. What drug would you have given him?', the consultant barked. 'Morphine?', suggested Ed, cheerfully. He was fatally wrong. Morphine was sometimes used for one kind of breathlessness but could have killed this man. We made endless fun of Ed's confusion, and for ever afterwards reminded him of 'Ed's test', a quick though lethal way of diagnosing respiratory failure. Our laughter was nervous, provoked by anxiety. A study of the experience of American students captures the worry that constantly haunted us: 'Missing a single fact or a single practice may cost a life'. But was it the patient's life that most worried me at such moments, or my own? It was glorious to have the right answer, but if you were wrong you would be humiliated.

I remember being asked for an example of an autoimmune condition. My mind had wandered, and instead of rheumatoid arthritis, or lupus, or thyroiditis, or any of the other autoimmune disorders we were supposed to be familiar with, I could only think of a condition I thought I'd read about, which rendered a man allergic to his own sperm. It is easy to see how this arcane possibility might have come into the mind of a medical student who often had sex on his mind. The consultant said nothing, but his withering smile was a blow. I fell back like a stunned boxer, lost for words.

The language of ward rounds is also the language in which doctors officially address one another. In their correspondence, doctors usually present their assessments of a patient as 'findings', making less 'I' statemernts even than a chatbot. Doctors do occasionally lower their guard enough to show a glimmer humanness, however, as when they report what a pleasure it was to meet 'this *attractive* person' – always a man describing a woman. I would sometimes see very well what they meant, but I tried not even to think such a thought about a female patient, let alone put it on paper. A psychiatrist reported in his letter to me that one of my patients was 'not a very nice man'. Reading that letter made me suddenly aware of something I had not dared to think, that the man's sheer unpleasantness was a key to my perplexity, and to his wife's misery. A surgeon upset friends of mine by breezily reporting in a letter that their daughter was rather spoilt. His casual observation was correct, I secretly thought, but not all truths can be uttered in a clinic.

The doctor's personality is supposed to be absent from ward rounds and clinical correspondence, and the narrator must be just as invisible in published case reports as. Today's *BMJ* Style Guide does now encourage authors to say that *we* found X and *we* investigated Y, but reference to a patient's humanity is still scrupulously avoided in medical writing. My very first publication was about a good-humoured, liquorice-loving man, but his character is entirely absent from the way we described him in the *BMJ*: *A 60-year-old Australian became constipated during his journey to Britain, and* […]. A terse letter I co-wrote to *The Lancet* leaves no trace of the anguish we all felt as a young man slowly died amid our frantic efforts to diagnose him. The illness and death of another woman still gives me a sense of loss, 30 years on, but in our published description all that is left of her humanity is a couple of dry sentences under the bleak heading 'Patient 2'.

To betray emotions either in the *Lancet* or in clinical settings would be to show a lack of scientific objectivity. Our teachers constantly encouraged us to *get to the point*, believing that the core of any physical, psychological or social situation

could be expressed in plain English. They imagined they were advocating the kind of talk that the ancient Greeks termed *parrhesia*, which involves 'avoiding any kind of rhetorical form'. They probably thought of themselves as latter day John Lockes – friends of the truth; strangers to deception; enemies of mere rhetoric. The pragmatic realism they flaunted makes me think of a certain Englishman's pronouncement about foreign terms. 'The Germans call it "*eine Brücke*", he is supposed to have said, 'and the French call it "*un pont*". But the English call it a BRIDGE', he bellowed, 'which, when all is said and done, is what it IS'. The British take enormous pride in their simplicity. But according to Foucault, speech is not parrhesia unless it involves risk, and honesty was mostly too dangerous for get-to-the-point doctors to contemplate, either with patients or among themselves.

In Erving Goffman's language, I have been describing how we talked 'front of house'. As Goffman says, the way I spoke often 'knowingly contradicted' the backstage mode. Backstage, perhaps a Mother Theresa will swear like a trooper, and an Oliver Sacks throw his weight around mindlessly. Then there is the more complicated case of Doctor Destouches and Monsieur Céline. Frontstage there was Céline, Destouches's pen name as a celebrated novelist. Backstage was Louise-Ferdinand Destouches himself, as a physician. Among the Parisian literati, Céline was an *enfant terrible* in the same mould as Bardamu, the dissolute, foul-mouthed central character in *Journey to the End of the Night*. Céline's alter ego (or superego), Dr Destouches, was evidently a humane physician and an advocate for the underdog. A journalist who made an incognito appointment with Destouches the physician reported (with some disappointment) that there was no abuse, no swearing. He was respectfully examined and advised to avoid coffee and alcohol. 'Le médecin était resté médecin'.

Céline's biographer doesn't settle the question of what he became when he was not presenting himself either as a doctor or as a cult novelist. Which part of him produced his blatant anti-semitism? Goffman's dichotomy is simplistic. When doctors talk backstage they still censor themselves, but in different ways. You might have to conceal your joys as well as your sorrows there. All through his time as a medical student, the father of a friend of mine was ashamed to admit to a love of opera. I also was careful about what I revealed of myself, never drawing attention, for instance, to my religious beliefs.

Behind even the backstage space, there was the person I could only be on my own. Thinking of Céline's occupied Paris reminds me that in my student days I dreamt that the dermatologist who taught us at St Thomas' was dressed

in a brown shirt, participating in a Nuremberg rally. I was a few rows behind him in the audience. At the time I was reading about the rise of Nazism, a subject that both disturbed and fascinated me. The dermatologist was a bully. He could reduce a patient to tears, and once nearly had that effect on me. There was nevertheless a sense in which I half wanted to *be* this man; I identified with him as an expert physician who could speak with such charming fluency of *acne rosacea*, *lichen sclerosus et atrophicus*, *scrofula* and *systemic lupus erythematosus*. None of us had the courage to stand up to him because, as a study of American medical students says, our desire to become doctors meant that 'those who intimidate[d] and abuse[d]' were at the same 'persons whose respect medical students crave[d]'. Our cosmos was silencing us, just as the military world does in *Catch 22*. It was even invading my dreams. In my dream I was willing to suppress my feelings and allow myself to be recruited. The thought disturbed me. I must have sensed an affinity between our medical cosmos and a totalitarian regime (and also with what Erving Goffman calls a total institution). My ambivalence was alarming because it showed that I wanted to comply with something that felt wrong. If Jewson is right, our cosmos would have been determining what was imaginable and what was not. My dreams were symptoms of an imagination that did not like being squashed.

Powerful figures in our cosmos were training my speech and scaffolding my ethos, and hence must have been changing me as a person. I began by aping them, because I had no alternative model of behaviour. Not that I was altogether happy with what I seemed to be becoming. When I first began talking to patients, my voice sounded to me like a ventriloquist's dummy, and the same feeling of falseness would dog me whenever I caught myself adopting a doctorly tone in later years, in the clinic, or among the members of a patients' self-help group, or once or twice on a radio phone-in. In the jovial culture of backstage medicine, I was less self-aware and less self-critical, but there, again, I was unconsciously adopting the physical demeanour, logical style, language and tone of voice that doctors find persuasive. They were rhetorical devices, but they wormed themselves into my way of being, my habitus. I was busy becoming what I was pretending to be.

## 6.2 Impostures

Huffington Post has collected some lurid headlines about imposture. Phony Doctor Smoked Cigar During Surgery, Flushed Liposuction Fat Down Toilet, for example. Fake Doc Gets A Year In Prison For Door-to-Door Breast Exams; Fake Doctor Misdiagnosed Cancer, Injected Patients, Stole Thousands; Phony

Doctor Busted After Performing Toothpick 'Acupuncture'. The fake doctor I identify with most is Adam Litwin, whose headline reads Man Arrested for Impersonating Doctor Is Now Real Doctor. He looked like a qualified resident, and the medical team took him for one, which probably gave him, in an instant, the sense of belonging that I so much craved when I was a student. Litwin drifted across the no man's land that separates fantasies from realities, and so became what he pretended to be. I quite frequently felt as if that was what I was doing myself. When I read my name on the list of candidates who had passed the Membership examination of the Royal Colleges of Physicians, I wondered if I was perhaps standing in the shoes of another more deserving Dr Ward. Three decades later I was in Beijing, being congratulated on a book I hadn't written. Its author was not Professor CD Ward but Professor AB Ward, a very effective and successful contemporary. Was my flight to China an administrative mistake? Had I walked into someone else's life, like the errant academic in Michael Frayn's novel Skios? Was my magic piano letting me down?

Most of the time I supposed myself to be a doctor, but I wavered between different positions, rather as a shaman does, according to Michel Mauss, when he is so caught up in his cultic rituals that he 'becomes his own dupe, in the same way as an actor when he forgets that he is playing a role'. From time to time I could imagine that I really was the omniscient miracle-worker that my patient's fantasies so much desired. I easily fell into the narcissistic snare of thinking that I could know all, love all, heal all. It gave me a buzz whenever I could make a diagnosis in the blink of an eye, or successfully take the words out of a patient's mouth by predicting a symptom, or pull a therapeutic rabbit out of the hat, or pronounce a rock-solid prognosis. But the illusion never lasted.

I once dreamt that I faced a large and learned audience at the Royal College of Physicians. A sombre figure in a long black gown introduced me: 'Doctor Ward will deliver this year's College Lecture on *The Role of Lymphocytes in the Colon*'. I swallowed hard and woke with a pounding heart, just in time to avoid admitting that I had nothing interesting to say about either colons or lymphocytes.

Sparky's magic piano introduced me to the impostor syndrome at an exceptionally early age. Young Sparky became a world-renowned prodigy because his piano could play itself brilliantly. The magic piano finally refused to play one night, in the Carnegie Hall. I can still hear Sparky's mum on our crackly 78 rpm record, her voice a distant echo at first, then gradually getting louder and drier and more real: 'SPAAARRRRKKKYYYY […] Spaarrkyy […]. Sparky. Wake up'. Nowadays, I still have dreams in which my final medical

examinations are days away, and I have been missing lectures for months. 'Sparky, Sparky […]'.

From the moment I first arrived on the wards as a callow clinical student I lived with the fear of being shown up. Despite the fact that I knew next to nothing about clinical medicine, people began to call me 'doctor'. When I was sent off to speak to my first patient, my magic piano was a crisply laundered white coat and a shiny stethoscope, and I could only hope it would play the right music. A sense of falseness came over me as I sat at an elderly woman's bedside. How was I supposed to speak? Minutes before I had been addressed by an imposing consultant, and his stentorian tones crept into my voice, in spite of myself, because I couldn't find a style of my own. Whatever I was saying is best forgotten, but the words of a nearby ward cleaner will stay with me forever. 'How dare you speak to Mrs Bennet like that?' said the cleaner, sharply. 'She's old enough to be your grandmother'. We must be careful what we pretend to be.

Each time I moved up the medical ladder my sense of imposture increased, as though I was being paid in advance for things that I did not yet know how to do. Until 1973 I could hide among a herd of medical students, but on a certain day in July a General Medical Council (GMC) certificate transformed me into someone else, simply because I had the legal status of a doctor. A ward sister would bear down on me, brandishing a medicine chart. I was required to sign, and barely to question why, because all that mattered to the sister was my newly acquired status as a prescriber. Being a pre-registration house officer was a process of gradually acquiring the knowledge I was presumed to have had on Day 1. On another Day 1, as a neurology registrar (intern), I was called to a medical ward to advise the non-specialist physicians about a patient. Only a few days before I had been a jobbing medical registrar with no claim to special neurological knowledge, and yet here I was, an instant expert. For the sake of my credibility I needed to write something clever in the hospital notes.

I often saw other doctors betraying insecurities. One of my bosses felt compelled to raise arcane questions on ward rounds even though he was a brilliant scientist in no need of our admiration. Did we agree that there might be just a little wasting of the thenar eminence? It never mattered what we said, so long as we smiled appreciatively.



Medieval physicians acquired their credibility by memorising books. The content of their learning mattered less than the fact that it took a prodigiously long time to master. What has changed? If people tell me about some medical

TV programme they generally say 'But you would know, of course' (I have a nurse friend who often says this. She should surely know better). Modern doctors are still revered on account of their many years of training. The legendary stature of book learning still boosts doctors' pay, just as it did in premodern times. It was a strange experience to be in a court room as the holder of such knowledge. In those moments I would feel my status weighing down on me like a massive priestly cope, because the court's ritual required me to pronounce *qua* doctor. Barely a year after qualifying I was in court, with no support from my boss, being questioned by a coroner. I drew a shred of comfort from something that Dr Hugh Johnson, our charismatic chief pathologist, had said. 'If you feel intimidated in court', he advised, 'remember that doctors' pronouncements carry weight, whatever they say. "Blood is green, Your Honour"'.

The simplest form of imposture is the barefaced lie. An elderly woman was looking up at me from the trolley as I brought a fine needle carefully towards her twitching eyelid, to inject botulinum toxin. I'd just learned the technique and was still in awe of botulinum toxin's deadly reputation. It had been developed, we understood, in Britain's top-secret biological warfare unit, and I was told that if you put a cupful in the town's reservoir it would kill thousands. The fine needle's tip trembled slightly as I closed in on my patient's upper eyelid.

'Don't move', I whispered, between clenched teeth.
'Have you done this before?' she asked.
'Many times', I said.

Senior doctors encouraged us not to frighten patients with the truth. Cancer would sometimes be described as 'a slight swelling'. MS would often be 'a bit of inflammation'. By imitating senior doctors' lack of frankness, we would deprive a woman of the option of deciding not to have children in view of her uncertain prognosis. We were being taught to play God, as I began to see, but three years of clinical research in the US raised the opposite problem. American clinical research consent forms listed every conceivable risk, as though even a simple blood test might just possibly cause fatal haemorrhage or infection. These strictures were designed to reduce the risk of litigation. This was transparency, a concept that was crossing the Atlantic at about the time I flew back to resume specialist clinical training. Transparency releases doctors from the burden of imposture and replaces it, sometimes, with cruelty. Nor is it ever as transparent as it sounds.

I soon learned that imposture is a trap, but it is sometimes part of a doctor's job, whatever the GMC may say. There were moments when I thought I had a moral duty not to *look* helpless, even when I knew I was. After giving a critically ill patient the best drug we could think of, there would be an obligatory pause while we watched for its effects. The doctors and the patient's family were equally at the mercy of time. We were in the same position as the philosopher Henri Bergson, watching sugar dissolving in a glass of water and realising that this kind of duration 'is no longer something *thought*, it is something *lived*'. We were helpless until the sugar had disappeared into the water, and yet we assumed that the family still wanted us to look as though we were in command of the situation. The temptation was therefore to say something.

It is the function of the doctor to have *something* to say, whether in a courtroom or in a consultation. My students would often clam up when I asked them a question, not because they knew nothing but because they were too embarrassed or too confused to recognise that they did have relevant knowledge. I hated to frighten or humiliate my students in the way several of my own teachers had done, but I needed to remind them that in a few weeks or months they would be faced with their own patients' questions. 'You can say "I don't know" once; you can say it twice; but you can't keep saying it *forever*'.

From the moment I became a junior House Officer I was confronted with impossible questions. The simplest version – 'What is wrong?' – was often a conundrum, as was another, 'Will he live?'. Hippocratic doctors valued the idea of prognosis every bit as much as diagnosis, perhaps because it had the potential to relieve the patient of uncertainty. When someone was diagnosed with MS, the question was sometimes 'Should we have children?'. My boss Bryan Matthews, the person from whom I learned much of my neurology, would look a person in the eye if he was asked what the future might hold, and quietly insist that 'I haven't got a crystal ball'. The most realistic response to a patient's questions is often a guess, but not *anyone's* guess. The Professor's predictions were urgently demanded partly on account of his experience and knowledge of disease but partly, as he well knew, because the burden of uncertainty was so hard to bear.

Ambrose Bierce defines a physician as one on whom we set our hopes when ill and our dogs when well. Uncertainty and disappointment can make us want to unleash our dogs, as in Stalin's savage attack on a group of Jewish doctors, and as in the bursts of shrill hostility towards 'the medical profession' that sometimes escaped from our friends as well as our enemies. Even the most scholarly seeming critiques of medicine sometimes seethe with carefully phrased anger. I was once almost physically pinned to the door by a hostile patient

who demanded 'answers' and insisted that I was withholding the truth about his illness. He reminded me, with a note of triumphant spite, that the Prime Minister had that very week unveiled what the Conservative government of the time grandly described as The Patient's Charter.

Our teachers gave us no inkling of the hatred that doctors can attract, perhaps because their own encounters with uncertainty were too painful to contemplate. Uncertainty about the prognosis and about the possibility of treatment could make me hate myself. Not knowing the patient's future prospects I was sometimes tempted, out of a desire to be kind, to make misleading, meaningless or frankly mendacious pronouncements such as 'I just *know* you are going to be OK'. It may have been my own fear rather than the patient's that was at stake then – the fear of having nothing to say.

The family therapist Barry Mason distinguished two kinds of uncertainty and two kinds of certainty: the safe, and the unsafe. No doctor can be safely certain in our capricious world. Unsafe certainty is a good description for an over-dogmatic doctor. Other doctors burden their patients with more decisions and alternatives than they can bear, which creates unsafe uncertainty for everyone. The position that Mason calls safe uncertainty stays close to reality without pretending to fully understand it. A neurologist is often the helpless witness of events that are difficult for anyone either to understand or to endure. When a patient suffered an attack of MS, the best I could offer her was safe uncertainty: we know what can be done now; we can expect at least some of this to improve over time; we can't say what it means in the long run; we can cross other bridges when we get to them. Many accepted this precarious situation, but those who found it intolerable would go on chasing after safe certainty, of which there is none anywhere in the world.



'You're the doctor!'. I often sensed an ironic sting in those words. Sometimes a patient would wait silently, if not sullenly, for me to conjure up a nugget of certainty. Doctors do sometimes 'play God' arrogantly, but there are moments when they are positioned by others to be shamans, if not gods. When I was a consultant, the nurses, junior doctors, therapists, psychologists and social workers I worked with were usually vocal and assertive, but they would fall silent when we were faced with certain difficult decisions. Their unspoken words were 'You're the doctor', which took me back to those first few weeks as a house physician when I was happy to prescribe whatever drug the Ward Sister requested, knowing that all she wanted from me was my signature. I was

reminded then that I must accept the heaviest burden, not least because I was paid more than anyone else in the room.

Critiques of medicine and confessional books like this one are constantly cutting doctors down to the size, showing them to be riddled with base motives, just like everyone else. I would have been happy for my patients to see me that way, but was that what they desired? Anatole Broyard wants his doctor to have magic as well as medical ability. He confesses that his cancer is pushing him towards irrationality. What he needs is a lucky doctor, and looking round the waiting room's prosperous-looking furnishings and pictures he thinks he has found one.

## 6.3 Platform Rhetoric – or How Doctors Talk to Each Other

**Charcot teaching at the Salpêtrière Hospital, Paris**
(Credit: André Brouillet 1887. Wikimedia Commons. Public domain)

After qualifying, the next stage in my rhetorical education was hospital-based clinical meetings. Like ward rounds, these occasions have an archetypal quality, for which Charcot's demonstrations are a model. Brouillet's famous painting shows a crowd of studious male doctors peering at a helpless woman called

Blanche (Marie) Wittman. Charcot worked hard to convince his audiences, among whom was the young Sigmund Freud, that people like Blanche suffered from a disease called hysteria. There was an element of persuasion whenever I presented cases (as we called them) at a medical meeting. I would appeal to the glittering authority of science, citing analogies from the medical literature and appealing to the audience's memory of similar cases. A favourite rhetorical ploy was to draw attention to one or two atypical aspects of the case, so that critically minded doctors had something to feast on before I disposed of their objections. I had neither the motive nor the desire to be untruthful, but a patient's symptoms and signs can usually be interpreted in more than one way, and I wanted to win listeners over to my point of view. Presenting a clinical case gives you a pleasing sense of privilege when it raises questions that others have not thought to ask, and it is fun to feel an audience bending towards a new and, you think, better point of view.

It was a short step from these local exercises to national and international scientific meetings, where data must be communicated in 10 or 15 minutes and defended from comments in a further five. My first efforts in such arenas were so frightening that my voice trembled and my hand shook, so that the laser pointer wandered drunkenly across the screen, but I soon gained the confidence of an athlete who knows he can reach a certain standard and might, with effort, achieve a personal best. Things could go horribly wrong, of course, as when the formidable Dame Sheila Sherlock cut me spectacularly down to size during a hospital meeting because I had not presented any slides, but the fighter in me always came back for more. A favourite forum was the Association of British Neurologists Conference, where I presented papers on my field of expertise at the time, which was Parkinson's disease, but also on a range of other topics that now strike me as too diverse to be taken seriously.

What was I doing? Hospital case presentations and conference papers were performances. I rather enjoyed the entertainment side of performing, which was why I was eager for parts in school plays, but ambition was a more compelling motive for my medical performances. From at least the age of 10 my educational progress had depended on verbal contests in the form of essays, oral exams and interviews, and these turned out to be rehearsals for the medical life. The competitiveness of medicine has a long history. Religious festivals in second-century Ephesus included music and dancing contests, one of which was a medical competition, called an *agon*, in which doctors such as Galen exhibited their prowess. One man with gout was reported to have been invited on to the Ephesian stage, as in a pantomime, so that a doctor's remedy could be publicly

tested. The unfortunate patient had a bad night, and next day he was unable to walk.

For me, being a medical student and then an aspiring neurologist was an agonistic form of life. As students we were sometimes jostling for advantage, although I don't recall the intensity of competition that medical trainees were apparently experiencing across the Atlantic. Junior doctors competed in various ways. The constant shortage of hospital beds forced us to engage in the kinds of contests that give rhetoric a bad name. When a patient was no longer of neurological interest we would try to 'sell' her to another department by describing the case in terms that we hoped would be attractive. We would emphasise Mrs Oakley's arrhythmia to the cardiologists, but the surgeons would be told about her unexplained abdominal pain, always hoping that one or other of these departments would take the patient off our hands. At the same time, we had to be on our guard lest colleagues mis-sold referrals to us. A GP who phoned to report a sick patient needed to be carefully questioned in case he was trying to dump a time-consuming patient on us before the weekend. While I was a house physician, my colleagues were constantly hatching schemes to secure out-of-hours training or to position themselves for coveted training posts where examination success was said to be guaranteed. Instead of nearby Taunton, I took the high road to Wick, near John O'Groats.

Consultant neurology posts were in short supply, and we had to pass through a selective process from which most would be rejected. Everything we did was an exhibition of competence or of incompetence that could have fateful consequences for our future prospects. In my experience, the nearest thing to an Ephesian *agon* was the weekly clinical meeting or 'demonstration' at the National Hospital for Nervous Diseases in London's Queen Square. Two silent observers from the Royal Free Hospital, myself and another registrar, were placed at the very back of the room. The seats immediately in front of us were reserved for doctors who had been appointed to the junior staff posts we so much coveted ourselves. In the front row sat a distinguished array of neurologists, with Professor Roger Gilliatt as ringmaster. A patient draped in a green hospital dressing-gown was wheeled into the room to face this almost exclusively male audience and to be cross-examined by one of the senior registrars. Gilliatt would often test the presenter's credibility to destruction, before administering the same treatment to someone in the middle rows. The victim was often a recent arrival who could be trusted to say the wrong thing. There then followed a genteel conversation among the consultants in the front row. Gilliatt was a stylish tyrant. He had been best man at Princess Margaret's first wedding, and we in the back row felt like footmen, mutely witnessing royal disputes.

The Queen Square ethos was threatening and in some ways absurd, but I nevertheless longed to be part of it. We two Royal Free observers were both queuing eagerly for a post at Queen Square so that we could have the privilege of being thrown to the lions every Wednesday. Gilliatt disturbed me more even than the heartless dermatologist I mentioned earlier, because I so much wanted to cross the draw-bridge and gain admittance to the neurological fortress he commanded. I had an urge to belong, to be a neurologist myself. This was why I returned to ABN conferences again and again. Each speaking role, and each publication, was an opportunity to display my personal qualities and clinical skills to an audience that could make or break a career. The historian Michael Brown describes how the development of a more distinctive professional medical identity in the early nineteenth century gave doctors a sense of 'deep, horizontal comradeship'. He borrows a political idea to explain this: doctors were entering into an imagined community where professional identities were being forged through 'the interplay between public and private, between the accessible and the inaccessible, the knowable and the unknowable'. Two centuries later we were competing for the attention of an imagined community of academic neurologists. Neurology was a game of musical chairs, because opportunities for promotion were very scarce at that time: you needed to move quickly to be in the right place at the right time, and there was an urgent need to publish.

Any patient, at any moment, might produce something that could be written up. In *The Mutations*, Mexican novelist Jorge Comensal perfectly captures our hunger for recognition. Ramón has a rare type of tongue cancer. Its exotic histology greatly interests Ramón's melancholy oncologist Dr Joaquín Aldama. While tragedy looms for Ramón and his wife, Dr Aldama is excited at the prospect of 'seeing [his] name in print in prestigious magazines, being invited to deliver keynotes and seminars in Boston, London, and Paris'. I often had the same fantasy. A patient with an uncommon complication of cancer told me his muscle weakness worsened when his body got warmer. I could imagine a neat physiological explanation for this strange symptom, and I was determined to test my hypothesis. There was certainly the joy of an intellectual chase, but at the same time I saw a chance to give keynote speeches and seminars all over the world. When one of my competitors on the neurological ladder tried to take credit for my idea as though it was his own, I was spurred into action, instantly arranging to bring the patient into the neurophysiological laboratory the following Saturday morning to be tested. I proved my point, with a lot of help from a neurophysiologist, and got my publication. Dr Almada's dreams of glory were snatched from him, and so were mine. When our paper appeared,

a professor from Berlin sent me a publication of his own, in which he had reported the same finding. I am sad to say that Google could not locate my German colleague's paper but found mine immediately. It adorned my CV and helped in the advancement of my career.

Today's medical job interview is a test of rhetorical skill that involves PowerPoint rather than patients. Self-presentation went to another level at the National Institutes of Health in the US. My boss was too lazy to write a recommendation for me to be promoted. He insisted I write my own, a prospect that so repelled me that I asked my wife to draft it. The American way soon crossed the Atlantic. NHS consultants, including myself, gained uplifts in pay partly by completing an elaborate form in which I described myself in glowing terms. I will say a little more about this process shortly.



The medical world was like a Russian doll: it contained doctors, who contained physicians, who contained neurologists. I see my career less as a ladder than as a tunnel into which I was burrowing, with only vague conceptions of what lay ahead. I've described a balance between ambition and fear. It's impossible to know precisely what kinds of imagined communities I thought I was joining, but I can reconstruct how those communities imagined themselves.

The Royal College of Physicians had medicine's usual masculine ethos when I became a Fellow, with an added aura of exclusiveness. Fellows were elected by other Fellows, and I have a painful memory of the meetings where physicians in our hospital nominated potential candidates for Fellowship. We were crowded into a metaphorically smoke-filled room (for smoke read pheromones). A succession of suggested nominees was read out by the Chair. A few were carried forward *cum laude*, ('hear hear', 'good chap', 'of course') but when some names were mentioned the room fell into silence. 'Should we consider Doctor A from Y [a neighbouring town] this year?' Influential voices were murmuring 'Probably not'. I suspected that racism or some other group prejudice was at work, but no-one could be sure.

Neurologists imagined themselves as more exclusive even than physicians. They were privately confident of being a cut above the neurosurgeons, and only the ophthalmologists could rival their air of aristocratic distinction. At international conferences the neurologists basked in their Britishness. They looked askance at countries where so-called neurologists were two a penny, because their trivial forms of neurology encompassed psychiatry, physical disability, backache and other subjects of no concern to *British* neurology.

The senior neurologists' sense of superiority stemmed from a glorious period half a century previously, when British neurology was more competitive, internationally, than it has ever been since.

Gordon Holmes, mentioned in Chapter 3, was an icon of level-headed Britishness during the First World War.. The Second World War defined our neurologists' character in a different way. The very first paragraph of a web-page commemorating Professor Roger Gilliatt memorialises him as a soldier. 'His war record was distinguished', we read. 'Near Kloppenburg, he went forward alone on foot and rescued the crew of a burning tank, despite being subjected to heavy small-arms fire'. No wonder he organised his ward round with what the website describes as military precision. Two of the ABN's largest personalities, Henry Miller (the neurologist, not the much-banned novelist), and Denis Williams, had served in the RAF during the Second World War and a third, Reggie Kelly, had been a naval officer. Military rhetoric came naturally to them, as it did even to my mild, reflective boss Bryan Matthews. As we strolled along the corridor, thinking about the outpatient clinic that awaited us he would cheerfully mutter: 'Over the top!'

In my memory, I always see the ABN as a crowd looking towards a stage. 'The spectators turn their backs to the city. They have been lifted out of its walls and streets and, for the duration of their time in the arena, they do not care about anything that happens there […] There is no break in the crowd which sits like this, exhibiting itself to itself. It forms a closed ring from which nothing can escape'. Elias Canetti, whose words these are, describes the crowd's power well but omits one vital element, which is humour. The neurological crowd had the same masculine-British joviality as the House of Commons. American doctors are rarely amusing in public, but at ABN meetings you could expect devastating wit from the likes of Miller, Williams and Kelly (which was perhaps why Gilliatt, who lacked those skills, rarely appeared at the ABN). Attuning myself to this audience required me to be focused, but not earnest; gentlemanly and yet deferential; good-humoured, although never flip. I now see what a blurry line there was, at ABN conferences, between instruction and entertainment. Our hospital's senior neurologist took the trouble to congratulate me the day after a presentation I had made at one of those meetings. When I asked if he had encountered cases like the one I had described he looked at me blankly. All he could remember was that I began with a flippant story.

It is difficult to maintain critical distance from a game you are striving to win. An intense desire to persuade had a powerful bending effect on my language, on my perspectives and even, I think, on my character. I wanted to be 'the right stuff' and therefore hoped to be credible, to be approved of, and to be selected in

due course for whatever promotion I needed at the time. I know how painful the shaping process was, because I occasionally re-experience it in dreams. I may find myself anxiously threading through a crowd in desperate search of the stage where I am supposed to be standing, or addressing a darkened auditorium and making no sense.

I don't see my various rhetorical performances as inherently bad. Medicine was a practice, and those were my work clothes. Clinical experience, as it was called, created insights that I enjoyed communicating to others. Teaching should delight the audience, says Augustine, but it can also delight the teacher (the same is true of preaching, as my clergyman dad knew). A desire to profess, in its literal sense, went hand in hand with a willingness to compete in the *agon*. A high point in my medico-athletic career was an invitation to present a clinic-pathological conference at an advanced neurology course in Edinburgh. The CPC is a format that would have made sense to Galen. The presenter's task is to make a diagnostic hypothesis based on the patient's clinical history and test results. Once the differential and final diagnosis have been proposed the results of a post-mortem examination, and hence the true diagnosis, are revealed. From a sporting perspective a CPC is a spectacle, an *agon*, in which a doctor may either win laurels by making the correct diagnosis or else fall ignominiously on The Sword of Truth. My final diagnosis was incorrect, and the person who had invited me gave my shoulder a malicious prod afterwards, to make sure I knew I had been vanquished.

And yet I enjoyed myself in that CPC. I was exercising skills that were important to me, and the CPC was an opportunity to demonstrate what I thought was the right way to approach a clinical problem. For once in my life I did feel like an athlete, and I reckoned I had made a good throw even though it fell short. I could reasonably hope that future medical athletes, and their patients, might gain a little from my efforts; and as always on these occasions, I learned something for myself.

## 6.4 Bedside Rhetoric Or: Two Cheers for Synthetic Personalisation

Doctor–patient communication was never part of our formal education, and hardly existed as a distinct topic when I was a student. Its first appearance in the *Proceedings of the Royal Society of Medicine* was a report of a symposium, published

in 1967. The meeting's speakers took an intuitive approach to the principles of communication. A senior doctor writes:

> […] under the apprenticeship system one saw how other people did it and one learnt that way. While I expect most patients got the right amount of information, I remember some who got too much and many who got too little.

For this doctor, communication was not a skill you had to be taught, and nor was it for us. It was a knack. Having watched a few experienced doctors in action, we were sent off to work the same kind of magic as best we could. Those who had the knack could establish the kind of rapport that brought back the diagnostic information they required.

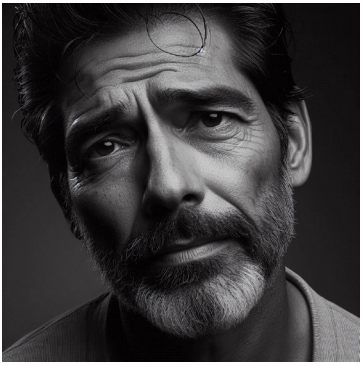
Whilst we were students, a number of writers were giving medicine a more human face. Among the Americans, we knew of Lewis Thomas, but there was also Engel, promoter of biopsychosocial medicine, along with the two Arthurs, Frank and Kleinman, the apostles of narrative. The writers we talked about most were British: Michael Balint, whose psychoanalytically oriented conception of the doctor–patient encounter attracted me, and Richard Asher, whose *Talking Sense* shone a wonderfully ironic light on medical practice. None of these doctors provided rules for communication. As Mark Lipkin says in his historical survey of doctor–patient communication training, our luminaries made a charismatic appeal to 'do as I do and you will be as good as I am'. Good communicators had charm, which in our eyes made them good people. A good person would be a good doctor, we thought. I lived by that assumption.

Communication found its way into the formal medical curriculum in the 1980s, amidst a flurry of academic soul-searching on both sides of the Atlantic. Unbeknown to us, we were on our way towards *late* modernity, which according to linguist Deborah Cameron was when western culture became focused on communication. Presumably the RSM writers, like our teachers, were middle moderns, although no-one uses the term. For them, communication was largely a matter of grammar, politeness and personal commitment, but by the time we ourselves were becoming doctors, communication had become a form of technical expertise that could, and must, be taught. Late modernity coincides with late capitalism. Formulaic communication skills can be put to productive use in call centres and supermarkets in a form that sociologist Norman Fairclough calls synthetic personalisation. A McDonalds training manager is reported by Cameron to have explained to his trainees that 'we want to treat every customer

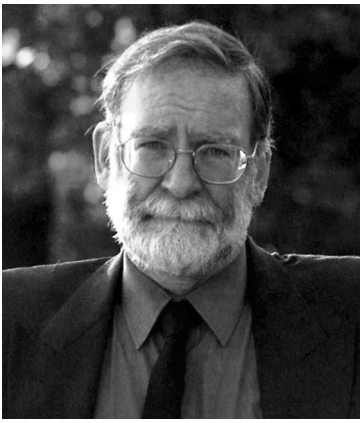
as an individual in 60 seconds or less'. A GP must do the same for every patient but can often luxuriate is as many as 10 minutes.

Modernity and capitalism are still later now, and elaborate regimes for the development and appraisal of personal skills have been imposed on students and trainees. Medical students are taught to '*show* empathy'. Accordingly, in today's final examinations, students demonstrate their communication skills in consultations where they must respond to an actor's sham pain with displays of sham empathy. In the words of one of Peter Nádas's young characters, performative empathy is nothing but a 'pathetic attempt learned from adults to wade into other people's suffering without feeling the suffering itself'. I have seen one or two trainee doctors with very limited ability to relate to patients emerge unscathed from communication skills training. Harold Shipman, the murderous GP, must often have 'shown' empathy. He presumably had plenty of synthetic sincerity and could have written an excellent course on communication skills. As Bob Monkhouse (or was it Frankie Howard?) said: 'The public love sincerity. If you can fake that, you've got it made'.

**An empathic facial expression, according to Wikimedia**
(Credit: Wikimedia Commons CC-SA-BY-4.0 Author: DALL-E)



**Doctor Harold Shipman**
(Credit: EPA Images)



We were never explicitly tested on communication; we were merely conscious of being appraised from a distance by our bosses. They would silently categorise you as a good person or a less-good person. We attended no courses, but we

did learn a model of synthetic personalisation. Adeline Goss, as a neurology resident, describes a recent version of it:

> Our bedside manner expressed human concern, even though much of the doctor's essential humanness had been withheld. We were expected to be brisk and business-like rather than be diverted by casual conversation or by the delicate, time-consuming and compromising task of making personal relationships.

As I feel my way back to what it was like to be with a patient I re-Member, almost physically, a whole set of expressions playing out across my face – non-verbal concern, non-verbal gentleness, non-verbal regret. These could be construed as ruses to facilitate clinical assessment, which is not a dialogue between persons, but almost the opposite. To make a diagnosis I must control the type and volume of information being received, asking more closed questions than open ones, and often interrupting. I must not be diverted by emotions. The doctor can be warm, but never fluffy; yielding but in the end authoritative.

A doctor who expresses too much feeling will not be taken seriously. Within weeks of my final day as a doctor I was on a ward, looking for a patient who had been referred to me. As I riffled through the notes trolley in search of the patient's file, a healthcare assistant very properly asked what I was up to. When I explained who I was and what I was doing she was covered in confusion. 'Sorry', she said, 'you looked too lovely to be a consultant'. Lovely? Medical students are invariably lovely young persons, eager to please everyone, but consultants are not like that. Medical education is supposed to suppress youthful traits. Perhaps mine were beginning to show through. In the next chapter I will think again about the way my body sometimes betrayed me when I was with patients. In her poem *The Specialist*, UA Fanthorpe depicts a master of bedside rhetoric. He 'modulates so touchingly his loud-hailer' but has 'no private words for private chat'. I had been taught by such people. They were unattractive, but I still thought it my duty to be like them. The doctorly habitus had kept me safe for many years, but now it was evidently wearing thin. It was obviously time to hang up my hard hat and my safety boots and leave the building site before anyone else accused me of looking lovely.

**The listening posture**
(Credit: Wikimedia Images
CC-Zero. Source Pixabay)

When we go to a doctor, this is the sort of conversation we might want:

*Doctor*: [a pleasant young woman seated sideways-on to her computer as the patient takes a seat]: Hello. Julie Thomas?

*Julie*: Yeah

*Doctor*: Hello there, my name's Dr Beddi, I'm one of the new GPs in the practice and I'm seeing you instead of Dr Jones who's your usual GP

*Julie*: Yeah [meekly] usually it's Dr jones

*Doctor*: First of all what would you like me to call you?

*Julie*: Julie's fine. Yeah

*Doctor*: Ok so Julie, what is it that's brought you to see me today?

*Julie*: It's the same thing I've seen Dr Jones a few times for, it's my heart.

*Doctor*: Yes [glancing at the records] I see that. Would you mind if I ask you to go over your problem again perhaps in your own words so that I get an understanding of it?

*Julie*: No not at all […]. I keep getting these situations where my heart starts to really really race […]. It's making me feel funny talking to you about it […] I get very afraid that I'm going to have a heart attack

*Doctor*: Right, right. And […] and […] you're feeling a little bit anxious just here with me

*Julie*: I am, just talking about it I can feel it starting to come on

*Doctor*: Right. Take your time [with a smile and a welcoming hand gesture]. So, your heart starts to race, it beats rally fast, and you feel like you can't catch your breath, is that right?

*Julie*: Yes […]

[pause]

What do you think it is, doctor?

*Doctor* [tentatively]: Well Julia [*sic*], I think I'd agree with Dr Jones, I don't think there's anything wrong with your heart. The reason I say that is […]. I guess I'm more thinking about what Dr Jones thought, whether this might be the anxiety that's giving you a lot of these symptoms. Have you ever thought that it might be that rather than a heart problem?

*Julie*: My friend has panic attacks and she said it sounds just like that. But what I can't understand is how my brain […]

*Doctor*: [softly] Right, right

*Julie:* […] starts the heart racing the way it is

*Doctor*: That's right. Has anyone explained to you about anxiety and panic attacks

Dr Beddi is just the sort of friendly, considerate, knowledgeable person you would look for if you were ill, and even now I envy her consummate skill. She is the very model of the perfect doctor and that, in fact, is precisely what she is, a model. The script comes from a training video in which an actor, who may or may not be a doctor, *models* communication skills for an audience of medical trainees. Synthetic personalisation is being put to good use here.

Bedside manner is synthetic. The very phrase implies as much, and yet it is a performance that most of us value. The doctor who leans in, tilts the head and sighs reassuringly creates an appearance of empathy, and this may be as much as some medical situations require. A doctor who is in fact empathic, inwardly joining you in your suffering, will not be helpful if at that moment she seems cold and unfeeling. You would perhaps be better talking to a skilled illusionist or a personable chatbot.

I recently stumbled on a scientific publication with the sort of title that brightens up academic life: 'Creepy, but Persuasive: in a Virtual Consultation, Physician Bedside Manner, rather than the Uncanny Valley, Predicts Adherence'. The authors, Zhengyan Dai and Karl MacDorman, are virtual reality specialists. They asked a horde of American psychology students, the ones who supply so much data in experimental and social psychology, to watch videos of cartoonish avatars and one human that had either a positive or a negative bedside manner, and then assess their credibility. What concerns us here is not the paper's argument so much as its method. The characteristics of a positive bedside manner were that the avatar 'treated the patient with care, empathy, and patience, responded to questions positively, provided reassurance and emotional support, and expressed a willingness to be available'. Since the caring, empathic avatar necessarily knew nothing about health, illness or anything else, reassurance must have been of the bland variety that, as a living doctor, I too often provided myself ('you will be OK'). The authors' description of a poor bedside manner makes delightful reading. The avatar 'was rude and impatient, joked about the patient's diagnosis, and tried to end the consultation early' He [*sic*] 'showed [*sic*] little empathy for the patient, interacted paternalistically, and implied that the patient's questions were ill-informed'. Not surprisingly, these contrasting forms of bedside manner significantly influenced the participants' attitudes to health.

I wonder whether my patients found me at all eerie and, if they did, whether this was beneficial. Comedy aside, the tenor of this experiment may strike you as sinister since it looks like a step towards the creation of virtual humanness. Deborah Cameron's agenda, I think, is to expose the pernicious effects of falseness in contemporary communications, and we would probably all be on her side. Synthetic is bad. Natural is good. An impersonal doctor will be bad for you, I have usually assumed, and so I have joined Kleinman, Frank, and many more recent writers in resisting the depersonalising effects of medicine. Adeline Goss, the neurology trainee I quoted earlier, is distressed by the impersonal position her work forces her to adopt.

I find Dai and MacDorman's experiment interesting because it gives us synthetic personalisation's limiting case. No doctor, and not even the most compliant of McDonald's employees, could be as synthetic as these digital representations, and none could be more impersonal. In the experiment, a warm avatar influenced the participants' ideas about healthy behaviours more than a cold one. If this is true, it challenges the assumption that synthetic personalisation is *de facto* a bad thing, and suggests we should be interested in its effects.

In any case, is synthetic personalisation avoidable in medicine, or indeed in life? A doctor's sincerity is as inconsistent as a shaman's belief in his practices. The problem in both cases is that the working environment makes rigid demands, regardless of the worker's feelings. One's personal investment in any human interaction tends to fluctuate from moment to moment. More than once, just as a patient released a harrowing torrent of symptoms and distresses, my pen dropped to the floor under my desk. I would hold the patient in a concerned-looking gaze while surreptitiously seeking out the pen with my foot. Imagine the eighth patient entering my consulting room during a busy clinic. I am instantly aware that I know her well, but I haven't yet got my hand on her file and in that moment I cannot remember even her diagnosis, let alone her name. The woman whose hand I am shaking clearly sees me as someone who knows her case intimately and trusts me to understand what is uppermost in her mind. Her trust is precious to me, because without it I will lose face, but it is also precious to her, since mistrust is bad for your health. Trust is fundamental to all forms of therapy, as evidence on the benefits of placebo treatments demonstrates. To preserve this person's trust I must greet her now as though I know a great deal more than is in my head. I must put on an act. Once I get a glimpse of her notes, an avalanche of associations will be triggered in my memory and I will have some chance of recovering a more authentic relationship.

I see communicative skills, including synthetic personalisation and all forms of rhetoric, as techniques that doctors must use to do their various jobs, but a catalogue of communicative skills can never fully describe what a clinical encounter amounts to in practice. If a therapeutic relationship is to be truly *useful* there surely has to be something true about it, and truthfulness must somehow be embodied. Theorists of method acting claim to project a paradoxical kind of sincerity. But I smile at the prospect of trying to teach medical students to 'be' anything other than what they think they already are.