The art of medicine

Cynicism as a strategic virtue

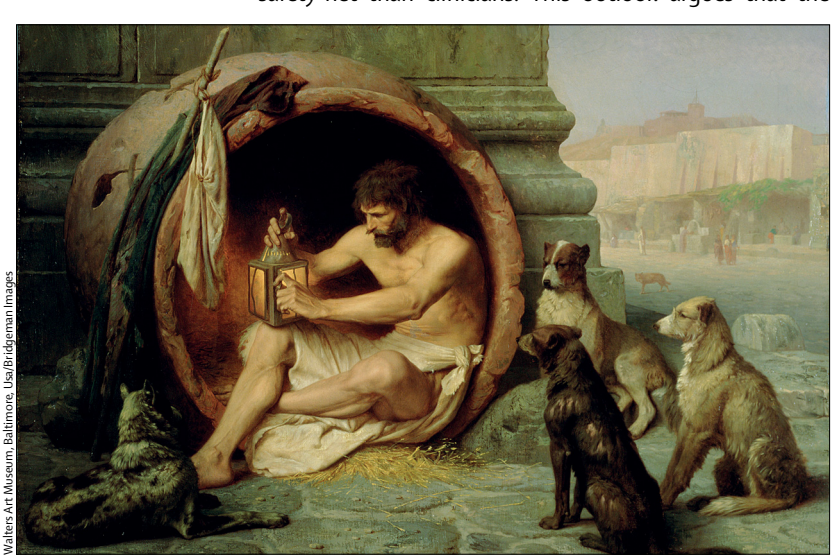
Doctors are often forced to negotiate between imperatives of policy and the demands of good practice. Cynicism arises in the welter of difficult feelings elicited by such contexts, and is widely assumed to be bad for patients, national health systems, and for the clinicians themselves. Cynicism is typically regarded as a cause of distrust, professional misconduct, and a pathway to burnout. It is true that untempered cynicism can have these consequences. However, much of the cynicism seen in contemporary health care is not untempered, nor is it simply negative or unprofessional behaviour. Rather than simply the shrivelled hope of good practice, we argue that more balanced forms of cynicism can support rather than undermine quality of care.

Readers will be familiar with accusations of cynicism as a pervasive problem for the medical community. One example may be found in the Francis Report, a public inquiry into the Mid Staffordshire NHS Foundation Trust in the UK, where failures of care led to deaths of patients and mistreatment amounting to cruelty. Robert Francis's conclusions highlighted an "institutional culture that ascribed more weight to positive information about the service than to information capable of implying cause for concern", citing "assumptions that monitoring, performance management or intervention was the responsibility of someone else". At first glance it might appear that cynicism is partly to blame. Part of the response to the Francis Report has followed this logic: distrust in clinicians' moral sense and their concerns about the context of their practice combined with trust in abstracted audit systems that are valued as providing a more robust safety-net than clinicians. This outlook argues that the moral insufficiency of clinicians can only be guarded against by metrics of oversight.

According to this outlook, cynicism is taken to be no more than indifference and fatalism. Negative feelings are assumed to be capable only of negative outcomes, and index of moral decline at the level of individuals. But this is not how things work. A common complaint against managerialism in health services is that interests of economics and measurement are seen to supersede those of care. The clinical workforce, brought up to believe they were working for the care and treatment of patients, find themselves caught by the need to balance the books. In this context, they have to discover a different kind of practice for themselves and manage their expectations of themselves, their colleagues, and their organisations. This discovery is the ongoing, lived negotiation of the distance between policy and practice. In such contexts, cynicism can form part of a protective response to the discrepancy between policy and practice. It can allow clinicians and other health-care workers room to manoeuvre, so that they can register the moral dimension of their work as it is formed and deformed within the uneven, unpredictable reality of health-care organisations. To criticise cynicism as the problem would be to mistake the immune response for the disease. It treats as a disorder what is in fact a common part of the emotional toolbox used by clinicians and allied practitioners to stave off despair.

Health-care organisations, in the UK at least, have become increasingly objectifying and unpredictable institutions, developing metrics instead of critical engagement. Cynicism serves as both a protection from, and an expression of, this logic. One reason is that, in general terms, cynicism represents an affective bargain made with life about caring. Far from synonymous with indifference or fatalism, we suggest that cynicism is a kind of optimism: not an optimism of wild and open possibilities, but an optimism of critical distance, keeping one from being hurt by something cared about. This is opposed to cynicism as a fixed state that responds to every circumstance in the same way, and which we characterise as unalloyed cynicism. When cynicism is disparaged, criticisms often refer to unalloyed cynicism, while tarring all forms of cynicism with the same brush. Such criticisms miss the strategic use of cynicism, as part of a wider emotional toolkit, which we wish to highlight here.

Such strategic uses of cynicism can be readily recognised when they are tempered in relation to something else. So, for instance, wry cynicism can allow clinicians to regulate their expectations of their organisation, making the double binds of practice more bearable, within an overall commitment to the organisation, its goals, and the needs of patients. Thoughtful cynicism can inform responses



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Diogenes (1860) by Jean Leon Gerome

that use a cool, distrustful eye to consider what really matters in a situation, consider their frame of reference, or acknowledge the true scope of challenges and what needs to be done. Most modifying adjectives that can feasibly be attached to cynicism represent valuable alloys, organising ways of finding enough clarity and meaning to operate in contexts humming with incompatible messages and demands. When resourced rather than drowned by their sense of disappointment, cynics are not silent. They may express their views wryly and gently, or forcefully and critically, but they are likely to express them.

In our perspective, tempered cynicism has three elements. First, it forms around recognition of the disparity between promises and reality. Second, it is organised by attentiveness to disappointment and the potential for disappointment given this disparity. Third, such forms of cynicism are animated by continued caring, albeit with chastened expectations. Recognition, attentiveness, and continued caring are all critical elements in adapting cynicism to contemporary health care. Pragmatic realism can be part of this approach, and is a useful perspective that every clinician needs. However, the moral dimension of practice necessarily requires more than this: it requires, at least at times, consideration of how aspirations and reality match or mismatch within clinical practice.

Or again, consider a lack of attentiveness to disappointment. This perspective leads to cruel optimism, in which disparities between promises and reality fuel more and more desperate efforts to maintain a positive outlook under crushing conditions. Protective measures and looming threats are ignored, in an effort to put disappointments out of mind. Adequate supervision, camaraderie with colleagues, and a supportive working atmosphere discourage cruel optimism, since they specifically allow disappointments and potential problems to be acknowledged and managed. It is therefore unsurprising that empirical studies have shown that these supportive factors are each associated with reduced rates of professional burnout.

Finally, consider cynicism without caring, a view that follows the conventional image that associates cynicism with indifference. It is a mistaken simplification. Cynicism lays a limit around who and what physicians allow themselves to care about, and who can make a claim on them. Such defences become needed when clinicians might otherwise feel unbearably responsible for making things right. Such a limit is generally destructive in unalloyed forms of cynicism in health care, particularly if such feelings are left unnoticed or ignored. However, as a flexible perspective, adopted strategically, cynicism can offer protection of caring itself. Cynicism defends the inner core of caring about good practice, keeping it flickering. Yet cynicism suffocates itself if left alone. It needs some relation, some alloyed form, if continued caring is to be possible. Part of the complexity of cynicism—its paradox and secret—is that in environments leached of trust and coherence, tempered cynicism can protect the inner core of care and good practice.

Cynicism's value can be recognised when one acknowledges that clinical practice is unevenly studded with reasons for hope and apathy, with painful contradictions between the promises and realities of health-care organisations. Although the insistence on putting the patient at the centre of the clinical narrative is admirable, it implies that issues can be solved only at the level of face-to-face relationships with individual patients and by systems of audit and monitoring of clinical behaviours. Such an image involves no recognition of disparities between promises and reality and contradictory demands within the workplace. It strings clinicians to targets that pull impossibly in different directions. Yet the particular demands of relationships with patients are still felt as individual failures when not achieved. Cynicism offers the prospect of some critical distance. It need not imply disinvestment from the desire to achieve quality care. Critical distance can be an asset for coping with the situation, retaining composure, and avoiding being crushed. This perspective might help a clinician to change things for the better or preserve something good from being undone.

In a discussion of physician burnout in this journal last year, Epstein and Privitera argued that "Health-care organisations should move beyond a culture of endurance, which overvalues stoicism and dismisses complaints as signs of weakness, and help clinicians be better at self-care than they are at present." We perceive cynicism as a self-care strategy already in widespread use: it is best tempered and resourced rather than treated scornfully. Although it flourishes in the cracks, it does not necessarily widen them. Unalloyed forms of cynicism may readily degrade into despair and anger. But other forms of cynicism are more robust, responsive, and flexible. Such healthy cynicism can be expressed with others, thinking and laughing together about difficult situations and offering acknowledgment and support. Negative information can be attended to; possibilities can be weighed without illusions or half-willed compromises with how things stand. Disappointment can be turned into question, and question into openness: an openness cushioned by compassion and realistic expectations. We observe the presence of such cynicism among clinicians as the enactment of a strategic virtue, an adaptive and partial response to contemporary health-care environments.

Arthur Rose, Robbie Duschinsky, Jane Macnaughton
Department of English Studies (AR, JM), Centre for Medical Humanities (AR, JM), and School of Medicine, Pharmacy and Health (JM), Durham University, Durham DH1 3AY, UK; and Primary Care Unit, School of Clinical Medicine and Sidney Sussex College, Cambridge University, Cambridge, UK (RD)
arthur.rose@durham.ac.uk

Further reading

Aveling EL, Parker M, Dixon-Woods M. What is the role of individual accountability in patient safety? A multi-site ethnographic study. *Sociol Health Ill* 2016; **38:** 216–32

Ballat J, Campling P. Intelligent kindness: reforming the culture of healthcare. London: Royal College of Psychiatrists, 2011

Berlant L. Cruel optimism. Durham, NC: Duke University Press, 2011

Duschinsky R, Lampitt S, Bell S. Sustaining social work: between power and powerlessness. London: Palgrave, 2016

Epstein RM, Privitera MR. Doing something about physician burnout. *Lancet* 2016; **388:** 2216–17

Yankeelov PA, Barbee AP, Sullivan D, Antle BF. Individual and organizational factors in job retention in Kentucky's child welfare agency. *Children Youth Serv Rev* 2009; **31:** 547–54