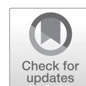

Chapter 3
Manners, Morals, and Medicine

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> *Manners are of more importance than laws. Upon them, in a great measure, the laws depend. The law touches us but here and there and now and then. Manners are what vex or soothe, corrupt or purify, exalt or debase, barbarize or refine us, by a constant, steady, uniform, insensible operation, like that of the air we breathe in. They give their whole form and color to our lives. According to their quality, they aid morals, they supply them, or they totally destroy them.*
>
> —Edmund Burke, 1729–1797

Manners Versus Etiquette

Patients bare their body voluntarily, prepared to suffer the poking and prodding into crevices and crannies where others have not ventured, or bravely suffer the insertion of sharp and painful instruments where none belong—and they pay for the experience. This is not a bizarre initiation rite, and the patient has not stumbled into a sadistic terrorist den. They are in their doctor's office.

One might suppose the medical staff, with whom they have entrusted the integrity of still-attached body parts, to exhibit sympathy and just a little deference for their bravery. Furthermore, it is not unreasonable to expect courtesy at least comparable to a bank teller, responsible only for money, or a barista at a coffee house, accountable for the foam on the latte. But often the medical staff in the office or in the hospital exhibits rude and churlish behavior, justifying a bad attitude with excuses: They are rushed, overbooked, dealing with emergencies, or underpaid by third parties. They are not responsible for their attitude—it is all a result of circumstances beyond control. Besides, the office manager might say if the patient has the temerity to complain, the doctor is the best in town and it does not really matter if he is rushed, or if she is frequently interrupted by phone calls, or if the computer screen gets more face time than the patient. What really matters is if the patient will get well.

Not so. Brusque and often rude behavior is not merely a question of incivility—good manners can make a difference in the quality of care a patient receives. We are all supposed to act in a civil and courteous manner, having been taught

lessons in manners and proper behavior since early childhood. However, if the number of books and articles complaining about and offering advice on interpersonal behavior is any indication, additional instruction is needed. The problem is modern society looks on lists of complex rules of behavior, etiquette, as a gate designed and erected by the privileged to exclude the unwanted and unschooled.[1]

The terms "manners" and "etiquette" are often used interchangeably, but they are different. Manners are a description of behavior in social situations. We learn our manners from our parents and teachers by example, instruction, and training, or we mimic the behavior of our friends and role models. Bad manners might reflect on childhood training, deliberate contrariness, or social mimicking.

Every society has rules defining the norms of social behavior. Rules of etiquette deal with table manners, dress codes for work and social events, and behavior in school, on the athletic fields, in the office, and for every personal decision about behavior, whether it affects others or not.

Rules of etiquette always seem to be under attack. Each new generation views the behavior of their elders as archaic and stuffy, and rules of behavior and those who advance them as unnecessary tools. In the Victorian era, complex rules of etiquette were used to separate social groups, advance snobbery, describe the way the best people were to behave, and distinguish the so-called well-bred from the common man. In a society where new wealth made possible by commerce and industrialization caused ancestral barriers to crumble, social rules of etiquette limited the elite class to the "well-bred." If you did not know the rules, you were not admitted into the game, but if you followed the rules, you could hide your background.

Up until the 1950s, rules of etiquette were often complex, restrictive, and unreasonable lists for everything from how to enter and leave an elevator, when a man should lift his hat, and who should be first through a doorway. The rules were designed to preserve the social status of those born to wealth

[1] The French word etiquette means ticket.

and position, protect the power of a male-dominated, and exclude those without the time, training, or desire to master their complexities. For many, the rules of etiquette were considered an elitist attempt to preserve a culture that no longer had a place in a modern egalitarian society and were counterproductive to social integration of the workplace.

Changing Social Conventions

No wonder the rules of etiquette were challenged, especially in the reactionary 60s and the two generations that followed. The baby boomers and to a lesser extent that transitional generation of depression and war babies before them (the Silent Generation) dispensed with the old rules and developed new codes of behavior wherever possible. They rebelled against authority in general and social conventions specifically, disdaining any authoritative edict on how to dress, act, or carry on relationships. If a particular behavior seemed appropriate and was not against the law, and sometimes even if it was, individuals or groups would do it.

In the past 50 years, we have seen an increase and an increasing tolerance of public incivility, rude, and inconsiderate behavior. There is a general perception that our society has lost its manners, and that short of inviting a court appearance, we take delight in flaunting behavioral norms or watching those who do. In a nationwide study entitled *Aggravating Circumstances: A Status Report on Rudeness in America* prepared for the Pew Charitable Trust by the nonprofit organization Public Agenda published in 2002, the majority of Americans surveyed believed rudeness is on the rise in our society and surprisingly, almost half admitted to being part of the problem. Seventy-nine percent believed lack of respect and courtesy is a serious national problem, and 73 percent believed Americans in the past treated one another with more respect [1].

Aggressive drivers, parents at youth sporting events, flagrant littering, cell phone users in public spaces, rude face-to-face attendants in retail stores, even ruder telephone customer service operators were all mentioned by respondents in the survey and are daily anonymous irri-

tants. It seems everyone has a story to tell about the shopper with the full basket in the quick checkout line, a healthy individual using a disabled parking spot, or the young, athletic office worker sitting in front of the granny standing in the bus aisle.

Examples of bad behavior are easy to find. Just consider celebrities like Jerry Springer, Howard Stern, Don Imus, and Maury Povich. All have made careers by celebrating rudeness. Uncivil behavior is in danger of becoming the norm. Our most prominent politicians deliberately exhibit rude, unseemly, and demeaning behaviors. They clearly feel this behavior is acceptable, but to many are offending and disrespectful.

Dependent on shock for entertainment, when the shocking is commonplace, these individuals create new frontiers of public incivility. Some "reality shows" reward rudeness. Rude behavior became such a problem in New York City that Mayor Giuliani, noted for his own brusque behavior and at times prickly demeanor, made public displays of civility an initiative of his second term, only to later change his behavior to mimic the President he admires.

We should not be surprised. Our elected representatives on both sides of the aisle have displayed incivility. Former Georgia Democratic Representative Cynthia McKinney struck a Capitol police officer when he failed to recognize her and stopped her at a checkpoint. Former Republican House Majority Leader Tom DeLay and Rep. David Obey (D-Wisconsin) got into a shoving match on the floor of the House of Representatives in 1997, and in 2006 Rep. Obey was seen on YouTube calling some of his fellow Democrats "idiot liberals." The 2016 Republican nomination process and to a lesser extent the 2020 Democratic nomination process, both "Reality shows" not unlike "Survivor," displayed examples of such behavior too numerous to list.

Is Civility Pertinent in Medicine?

If a list of rules of etiquette is outdated, civility is still pertinent. A voiced thank-you for a favor is not just a thank-you; it is an acknowledgment of a good deed or favor performed, and perhaps selfishly, an invitation to a repeat performance.

Listening and responding in a dialogue is not just a way of showing the person with whom we are engaged that we care about them and what they are saying; it is a critical tool for the effective exchange of ideas.

Unfortunately, the medical profession is not immune to the nihilism of manners in general society. In her book, *Miss Manners Rescues Civilization*, Judith Martin devotes four pages to the healthcare profession. She lists specific examples of rude behavior which include the following: systematically making patients wait for appointments, failure to treat patients with respect, skipping introductions, not asking for permission before touching a patient, not explaining procedures adequately, and discussing patients in hearing distance of non-medical personnel. She devotes an entire paragraph on the manner of dress and lack of neatness of the medical profession [2].

Evolution or Revolution

The behavior of the medical community has changed. Following World War II, large numbers of veterans from all social strata were determined to enter every profession. Many sought careers in medicine, and medical schools opened their doors to qualified applicants who might have previously been denied entrance due to class, ethnicity, or income. Initially barriers broke down slowly. Then, in the general upheaval of the 1960s and 1970s, with the confluence of the civil rights and anti-war movements and the push for female equality, the young, brash, bright, and self-confident men and women of the Boomer generation found many rules of behavior in medical culture either incomprehensible or irrational. This included a shirt and tie dress code, how long to wait for the often tardy professor before starting rounds, withholding opinions unless specifically asked, the formality of address, and standing at military attention at the bedside.

They simply refused to go along. Interns discarded uniforms of all white shirts, ties, white pants and shoes, and adopted informal dress. Scrub clothes became the new uniform of the day, not just for the OR but in hospital wards and

in the office. It was not just physicians but the nursing uniform of starched white dresses and nursing caps that disappeared, replaced by scrubs adorned with cartoons of animals, medical instruments, or abstract designs.

These symbolic changes reflected greater shifts in the profession itself. As the need for doctors increased, and in response to federal and state funding of care for the elderly and indigent (Medicare and Medicaid), medical school class size expanded, per capita grants to training programs were increased, and access to medical care improved.

Medicine had always attracted the intellectual and the empathetic, the problem solver who wanted to help a neighbor. Now the qualified student had the opportunity to enroll in medical school without regard to social class or background. With passage of the Hart-Celler Act in 1965, legislation of The Great Society that ameliorated the restrictive immigration laws of the 1920s, foreign medical graduates raised in alien cultures and unfamiliar with the formalities of American life entered practice, as did first-generation Americans raised in ethnic communities. This resulted in a melding of cultures and behavioral norms. This social fluidity further encouraged a relaxation of arbitrary rules of conduct that served no utilitarian purpose.

As medical school classes increased, so did the enrollment of women, who now make up over 50 percent of medical school students [3]. Like it or not, this has introduced gender politics into medicine. Deference in social mannerisms within the workplace, once considered courtly, is now looked upon as antiquated at best and demeaning by some. The traditional male/female, doctor/nurse hierarchical relationship has shifted as women and men assume roles in both categories. Nurses, once considered subservient to doctors, now provide first-responder care in emergencies and are included in decision-making at the bedside.

Transformation on the Medical Wards

Some practices considered symbolic of respectful behavior disappeared along with the superfluous. Attending physicians arrive on the floor in jeans and men with unruly facial hair.

The same scrub clothes worn in the operating room and the procedure room are worn in the office, often not covered by a white coat. It is interesting to note that in the nineteenth century, doctors wore suits on the wards (still a tradition at the Mayo Clinic) and in the office. White coats as a tradition began in Germany where laboratory medicine originated, and the physician came from the laboratory to the ward wearing his lab coat. Of course, the laboratory coat was to protect his clothes from chemistry lab stains. It is our impression that today's lab coats are just as likely to be stained with blood or other organic material and are frequently offensive to patients.

Doctors and nurses in the hospital, barely acquaintances, address each other on a first-name basis. Trainees and professors address each other informally. Patients are referred to as the gall bladder in room 350, the complainer in 234, or the gomer (a dehumanizing term for a debilitated, confused, often dying patient) in bed six. In the new culture, subtle mannerisms on rounds that demonstrate disrespect for the patient are all too common. Patients are frequently addressed by their first name, when their names are used at all. Teaching rounds are conducted without doctor introductions and trainees eat or drink coffee in front of the patients—we have seen a hungry resident take the toast off a confused patient's breakfast tray during teaching rounds.

Medical Students Learn Their Behaviors at the Bedside

Where does the young doctor-in-training learn manners and other social skills? Rarely in medical school courses, already challenged to incorporate into the curriculum an ever-enlarging body of medical science in a limited amount of time. Since all medical school students must have a college education and the vast majority have a degree, those accepted for admissions are expected to be caring and empathetic individuals who have already received extensive training and instruction in common courtesy and good manners. Twelve

years of elementary and high school followed by college classes in history, philosophy, and the humanities should render even the most contrary of individuals socially competent, and based on our experience with medical students, most are exceptionally well mannered, very caring, and empathetic when they enter medical school. However, some are changed by their experiences as they train and mature.

How does this happen? For the entering students—mostly young, inexperienced, and sheltered by family and the university—life's existential problems, if considered at all, have been studied at a distance rather than experienced. When they confront death or suffering in infants and children, or a young mother or father, or watch a family grieve as they themselves feel frustrated in their attempts to alter an inevitable course, the caregiver suffers personal emotional pain, depression, and feelings of inadequacy. The defensive response of some students may be to devalue the experience, or trivialize the dilemma with humor. The students risk a loss of perspective and empathy for the individuals involved. Young students, responsible for their patients' survival, exposed perhaps for the first time in their lives to the reality and absurdity of life, death, and disease, use dark, degrading humor as a temporary crutch. This can show up as inappropriate behavior and sometimes shape lifelong attitudes.

Learning from Mentors

A great deal of medical education and almost all postgraduate medical instruction is mentored training. The student or newly minted doctor learns not only diagnosis, treatment, procedures, and policies from his mentors, but also social skills. Young doctors learn professional manners at the bedside from senior residents in an unstructured manner and with little or no feedback from the senior physicians or patients. The senior attending physicians or professors serve as role models. But today's professors are often laboratory scientists and not experienced clinicians. They may also lack

the interpersonal skills required to handle difficult situations. Patient interactions are mostly limited to highly structured and formalized rounds that rarely mimic the true environment in the hospital or the office. Student contact with most patients is brief and episodic with no opportunity to observe the impact of bedside behavior on the patient or family.

When it comes to manners, medical students and residents seem to suffer from arrested development, and if students are supposed to learn professional behavior by example, then the system is doomed. In 1994, the *Journal of the American Medical Association* published a report "Disputes between Medical Supervisors and Trainees," citing several studies documenting misconduct and mistreatment of trainees by their supervisors and suggesting abuse and mistreatment of all kinds from a variety of sources—residents, nurses, medical students, and patients [4]. The perception is, when abuse arises, the victims suffer as a result of having less authority than the victimizers. In one study, abuse ranged from threats of academic punishment, trivial duties assigned to punish the student, verbal abuse, belittlement, humiliation, and even threats of physical harm. Sixty-three percent of trainees reported being belittled or humiliated by more senior colleagues and over half of female trainees reported having been sexually harassed at least once, with about half the incidents arising in medical school and half during residency. The manners students learn are the manners they observe.

It Is All About Respect

Boorish behavior by medical professionals is not just about generational attitudes. Consider Dr. Jesse James, a superbly trained urologist, a graduate of an Ivy League college and medical school, and the recipient of training at outstanding residency programs. Dr. James is known on the surgical wards for his abrupt demeanor and often disruptive behavior. He is condescending at best and very often rude to the nurses caring for his hospitalized patients. He seems to especially enjoy berating the nurses at his patients' bedsides. Dr. James mis-

takenly believes his behavior ensures the best and most meticulous care for his patients.

However, because nurses do not enjoy caring for his patients, when nursing assignments are made, his patients are assigned to the nurse with the least seniority or whoever draws the short straw. Nurses avoid him. When he rounds on his patients, the nurses make themselves scarce. Dr. James jeopardizes patient care with his outwardly rude behavior and the nurses compound the problem with passive-aggressive avoidance.

Dr. James is not likely to endear himself to those around him. If communication is poor among the healthcare team, even the most skillful physician will have difficulty achieving the desired results. His behavior and the effect on his colleagues negatively affect the health of his patients.

Dr. James's behavior reflects ignorance in social skills. He suffers from a lack of training in bedside manners. Unfortunately, his patients and colleagues must suffer as well. As we have pointed out, most medical schools have paid little to no attention to training students in courtesy and manners or building skills in social behavior in the core curriculum. The assumption is that the desire to do good necessarily leads to proper behavior. This assumption is as common in medicine as it is in everyday affairs. As Judith Martin writes, the error is "that from personal virtue, acceptable social behavior will follow effortlessly. All you need is a good heart, and the rest will take care of itself" [5].

Not so. We have noted a remarkable change and a lack of consensus in what is considered acceptable behavior. While we do not object to the trend toward an easing of formality, the corresponding decrease in civility, from the trivial omission of a title of address to the critical display of disrespect inherent in any public confrontation, has affected the quality of patient care.

Informality does not have to be tied to rude behavior. Along with relaxed standards of personal dress and the move away from plush office design with which we have no complaint and even welcome, we have seen a laxness in neat appearance and personal hygiene. We have observed some

offices, hospital rooms, and corridors in serious need of a cleanup crew. An open shirt collar looks so much nicer when connected to a cleaned and pressed shirt. Perhaps with the exception of a long weekend of in-hospital call, facial hair can be neatly groomed, and long tresses washed and combed.

Despite the loosening of formality in greetings between peers and colleagues, it is still not proper for doctors and nurses to address patients more than three times their age by first names upon initial meetings, or ever without permission. These may seem like inconsequential concerns, but they illustrate the bigger issue: the dignity of the patient and the need to address patients with empathy and politeness. Ignore those qualities and there can be no hope for open communication, and it is open communication that is critical to the doctor's improved understanding of the patient's complaint.

The profession of medicine no longer commands the respect it did 50 years ago; today doctors must *demonstrate* respect for each other and their patients to promote communication and mutual trust. That respect is no longer a given based on professional status. Without this, patients will not open up and recount the critical facts necessary for a diagnosis, be willing to submit to required testing, or even undergo the necessary treatment to recover. Civility builds trust and provides a basis for professional behavior that encourages positive, beneficial human interaction.

Modern medical care is all about teamwork. Individual members of the team must support and respect each other. Saving a life is like flying to the moon; it takes a lot of individuals each working in concert with the other. When physicians, office, or hospital employees are rude or disrespectful, they will be avoided and their patients will suffer.

Do Good Manners Need Guidelines?

Isn't it enough for the doctor to be pure of heart and want to do the right thing? Even in everyday personal exchanges, without guidelines for best behavior, we would not know what to expect when approaching another, and have no way to

measure rude behavior. Taking offense if poorly treated would be considered inappropriate because there would be no rules as to what constitutes poor treatment or fair treatment. Anarchy of manners would follow, and any behavior would be acceptable up to the point where the law is broken.

Imagine how this might work in a medical clinic. The internist decides his patients should sit naked in the exam room, reasoning that it will save time and the patient can dress when the visit is over. The surgeon calls his patients at home after 10 p.m. to tell them the biopsy was a malignant tumor. The psychiatrist schedules all his patients at 9 a.m. and the afternoon patients at 2 p.m. If he has a no-show, he can call a patient from his waiting room to fill in the empty slot, and he can be sure he is never waiting for a late arriving patient. Sure, the patient with the noon and 5 p.m. slot will wait 3 hours, but the psychiatrist will maintain a full schedule.

Of course, these examples are ridiculous (but are, in fact, actual examples), but so is a lunch-stained lab coat or not explaining to a patient why they need certain tests or medications. We expect a certain amount of privacy, neatness, and order in the doctors' offices. Although there are no laws addressing office management [6], there cannot be any argument about "clothing the naked" being both moral behavior and good manners, and alleviating anxiety a mark of the compassionate person.

Rules of behavior do change and are reflective of society, but moral principles such as consideration, respect, and tolerance do not. Rapid changes in medical science affects our system of delivering medical care; technology revolutionizes how we communicate both in the medical community and in general society. Acceptable behavior, once thought as established as arithmetic, now seems to need redefinition with every election cycle, but quality medical care based on good manners reflects unchanging moral principles. The heavy responsibility of caring for our fellows when they are at their most vulnerable is also a privilege and an honor. If this is kept uppermost in your mind when you are about to enter a hospital room or an exam room, you will be well on your way to achieving the goal of becoming a medical professional.

Photo Courtesy the Estate of Yousaf Karsh

Helen Taussig M.D.
Groundbreaking Pioneer

The story of Helen Taussig is about overcoming childhood hardships, systemic societal and institutional prejudices, bias, bigotry, and unoriginal thinking. She was a remarkably determined individual who used brilliance, tenacity, patience, and determination to achieve her goals. She was dogged but not intransigent and worked almost tirelessly to solve problems and care for patients. As with every great advancement, it was a team effort that for Helen came together in a very serendipitous way.

Helen Brooke Taussig (HT) was born on May 24, 1898, in Cambridge, Massachusetts, and was the youngest of four children. She has described herself as from a "direct line of teachers." Her father, Frank William Taussig, was a well-known Harvard economist and the first chairman of the United States Tariff Commission. Her mother, Edith Guild Taussig, studied natural sciences and zoology and was one of the first graduates of Radcliffe College. In childhood, she suffered recurrent ear infections which left her with permanent hearing impairment and was infected with debilitating tuberculous, a disease which killed her mother when HT was only 11 years old. She was dyslexic with considerable difficulty with reading, but her compassionate and caring father worked tirelessly to increase her competence and self-assurance in reading. Writing about HT's life, Gerri Lynn Goodman credits her father's compassion, determination, and investment of time as the qualities she acquired and modeled in her own work habits[2].

HT entered Radcliffe College but was not happy there possibly feeling the pressure of being referred to as Frank's daughter, and after several years transferred to University of California in Berkeley to complete her degree. She was interested in medicine but Harvard was not admitting women, and on the advice of her father she applied to the School of Public

[2] Goodman, Gerri Lynn. A Gentle Heart: the life of Helen Taussig. Yale University Press 1983

Health. There the Dean told her, "Well, we have decided that everyone should have 2 years of medicine and then we will permit women to study but we will not admit them as candidates for degrees." Her response was "who is going to be such a fool as to spend 4 years and not receive a degree." The Dean's response was; that is the point. The result of this hostility was that HT enrolled in Boston University medical school in 1922. After 2 years, Alexander Begg, the Dean of the Medical School and a mentor, advised her to transfer to Johns Hopkins in Baltimore where he felt there was an exceptional faulty and, most importantly, women were being admitted on an equal basis with men. In Baltimore, she excelled as a student, was elected to Alpha Omega Alpha, and graduated in 1927.

She continued at Johns Hopkins as an intern and cardiac fellow until Edward Parks tapped her to run the pediatric cardiac clinic in 1930. Dr. Parks, who assumed the directorship of Pediatrics in 1927, was a critical champion of Dr. Taussig throughout out her career. He was once asked to recommend someone who was not a woman or a Jew for an academic position and his response was, he would never recommend anyone for an institution that would not take women or Jews as they had made so many important contributions to his department.

The primary heart disease of American children at this time was rheumatic fever and these patients filled her clinic. She had no interest in congenital heart disease, but Dr. Park let her know this was part of her responsibility in running the children's heart clinic. Children with congenital heart disease were often sick, difficult to manage, and physicians who did not readily refer patients to a woman were happy to send her these ill, complicated patients. In HT's meticulous, thorough, organized assessment of her patients, she began to understand the anatomical anomalies and their physiologic consequences. In one disorder, referred to as the blue baby syndrome, a combination of defects including pulmonary valvular stenosis, ventricular septal defect, overriding aorta and right ventricular hypertrophy resulted in inadequate pul-

monary blood flow. Taussig noted that children whose ductus arteriosus remained open after birth had a better survival and less symptoms. The ductus arteriosus is a vascular connection between the pulmonary artery and the aorta. It is necessary before birth for the blood from the mother's placenta, healthy, oxygenated blood which enters the baby's right heart and crosses to the baby's circulation through the ductus. After birth as the baby's lungs expand, the ductus closes in most children spontaneously. If it does not close in healthy children, it is an internal shunt that overworks and exhausts the heart[3].

One of the first surgeries ever done on the cardiovascular system was the closure of a persistent ductus arteriosus by Robert Gross in 1938. Dr. Taussig approached Gross and asked if, since he could ligate a ductus could he create one. Too dangerous, too difficult not interested was the response. In 1941, Alford Blalock came to Johns Hopkins from Vanderbilt to be chief of surgery. He had ligated a ductus arteriosus and studied hemorrhagic and traumatic shock with surgical approaches including transplanting the subclavian artery into the pulmonary artery. Taussig approached him with her idea about creating an aortic to pulmonary artery connection. Dr. Blalock had brought with him to Hopkins, a very special man, Vivien Thomas. Thomas, an African American was trained by Blalock to be a lab assistant. A man of great ability, skill, and intelligence, Blalock officially titled him a janitor, not a lab assistant, and although he had great respect for his judgment and skills, he treated him like a servant. This emotional, complex story of American medicine is portrayed in the movie *Something the Lord Made*[4].

Thomas felt the subclavian shunt he had developed in Nashville to treat shock might be the best approach for this

[3] Engle MA. Dr. Helen Brooke Taussig: Living Legend in Cardiology. Profiles in Cardiology edited J Willis Hurst, C Richard Conti, W Bruce Fye Foundation for the Advances in Medicine and Science, Inc Mahwah, NJ 2003

[4] Something the Lord Made. https://www.imdb.com/title/tt0386792/

surgery. They created a dog model of the congenital defect and studied hundreds of dogs before their first operation on a child. On November 29, 1944, Blalock operated on the first child with Helen Taussig in the OR observing and Vivien Thomas leaning over Blalock's shoulder advising and conferring with the surgeon during the procedure. This was a truly remarkable advance by an incredible team led by a woman working with a brilliant bigoted, chauvinist, southern surgeon, and an African American who could not afford to go to college.

I studied under Dr. Taussig when I was training at Johns Hopkins in 1971. She was a tall, lanky woman with a large, radiant smile, so gracious, and her bedside manner was flawless. I would ask the patients, who were from all over the world, how they came to be Dr. Taussig's patient. They told me they were very sick and their parents had read about Dr. Taussig and wrote her letters asking if they could come to Hopkins to be treated. She answered their letters and told them when to come to Baltimore. They had been returning once a year ever since. They were truly devoted to her. She was a great clinician and even though she was nearly deaf at this time, she described every clinical detail and physical sign each patient exhibited. She was awesome, and I admit I was in awe.

Helen Taussig went on to many other achievements which included an authoritative textbook on congenital heart disease, the standard for decades, training several generations of America's pediatric cardiologists, advocating for prevention of death from lightening strikes, and helping save many Americans from the thalidomide disaster in pregnant women. She received numerous awards and was recognized by many societies, universities, and countries. The Time Magazine featured her face on its cover.

Issues Addressed in This Chapter

- Moral principles do not change.
- Courteous behavior communicates the principles of medical ethics.

- Good manners encourage good communication.
- Good manners are about respect.
- Every society has rules of social behavior.
- Behavior in the medical office has changed.
- Change in the doctor-patient relationship.

Study Guide

1. Have you seen or experienced abusive behavior from an attending or supervising physician? If so, describe the experience.
2. List three ways the case study with Dr. James jeopardized patient care.
3. What is your definition of empathy?

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