Chapter 5
How to Act as an Effective Physician

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The physician's job is to treat and care for people; not to just diagnose and cure an illness.
Cary Grant as Dr. Praetorius in the movie "People Will Talk," 1951

The Essence of Bedside Manners

How should a doctor act? What constitutes good bedside manners? Professor Sarah Buss writing in the academic journal *Ethics* about the moral significance of manners in society, notes "one of the primary objectives of…manners are to encourage us to make ourselves *agreeable*" [1] [emphasis in original]. Professor Buss describes the most important lessons in manners as "the lessons in how to avoid being discourteous, impolite, rude, inconsiderate, offensive, insulting." To flout these lessons, she writes, is not only impolite, it is immoral. Judith Martin, writing about manners and etiquette, and Professor Buss, addressing manners and morality, agree that people have a basic moral obligation to make themselves agreeable to others.

Medical professionalism includes as one of the core values a moral commitment to medical service based on "the potential for health and illness and on a resultant respect for the inestimable value of human life and health" [2]. What Professor Buss calls the "subtle language of good manners" is how you or the members of your staff say, "I respect you." If a show of respect requires good manners, then good manners is not just a core value of good medical care, it is what your patient should expect from you and the people with whom you work.

You must make it clear that you respect your patient, not only to satisfy the ethical principle, but because when patients are treated with respect, they will believe you care about their welfare. Just as importantly, as Professor Buss points out in the same article, "[I]t is precisely because treating people with courtesy is a direct way of acknowledging their dignity that treating them rudely can undermine their belief in their own intrinsic worth." The practice of good manners is espe-

cially important in medical care where the requirements of a thorough evaluation, if not conducted in an agreeable manner, can be stressful and embarrassing. There are few situations where a person is more vulnerable to assaults on their self-esteem than sitting in the doctor's waiting room ill, or in pain, or fearful of survival. Manners are a way of one person communicating to another the message: I believe you have dignity, and I respect that. As Dr. Buss states, "When we treat one another politely, we are expressing respect for one another…We are, in effect, saying: I respect you, I acknowledge your dignity."

Improving Communication

Good manners are not only a form of communication; good manners foster good communication. Implicit in an office appointment or a hospital consultation is an unstated request to work with the patient to improve a condition or maintain good health. A display of good bedside manners signals you are willing to cooperate in that venture and will devote time to fulfill it. Anything less than this response would limit the effectiveness of your consultation. Without it, your patients might not be entirely forthcoming about the history of their illness, or might view the recommended treatments with suspicion and very likely will not follow the treatment plan. Most of the time you spend in conversation allows your patients to tell the story of their illness. Many patients are anxious and uncomfortable. The bedside or office manner is critical in establishing the relationship necessary for them to open up freely and discuss their problem. If your patient is intimidated, or feels in any way disrespected, or you are rushed, frequently interrupted, fiddle with the computer or phone, communication necessary for a diagnosis will be lacking.

This means bedside manners include a smile, eye contact, complete attention to the patient, body language that conveys you want to be there, and are very interested in your patients and their concerns—really their fears and anxieties.

Their story, the medical history, will be incomplete if you do not convey a real interest. It is why you are there. Forget everything else when you step to the bedside; just focus on your patient.

All medical students have heard the aphorism dating from horse and buggy days, "When you hear hoof beats, don't look for zebras." It is also true you have to guard against missing the uncommon disease. Your patient's ability to tell their story completely without many interruptions, voice their concerns, and state what they believe is their problem is critical to the delivery of good medical care. An attentive doctor engaged with the patient is more likely to provide the information needed to make the correct diagnosis and provide good follow-up care. This is illustrated by the following true story. (All names and places are fictional and the dialogue is recreated.)

Mary Carruth first came to see Dr. Cooper after an 8-month history of heart failure. Her first cardiologist had diagnosed her as having hypertrophic cardiomyopathy, an unusual disease, but not a rare one, occurring in as many as 1/500 people in the general population. Some people with this condition, a thickening of the heart muscle, have no symptoms, and for some it can cause fatigue and shortness of breath. This disease is the most common cause of sudden death in young athletes in the USA.

The disorder usually stabilizes for decades on the medication her first cardiologist recommended. Mary (she preferred her given name) had been followed closely and taken her medication, but despite this, her weakness and heart failure progressed. She was hospitalized six times at a large, state-of-the-art facility.

Her cardiologist, a well-trained, technologically competent physician, attributed her worsening condition to failure to follow his recommendations.

When Mary visited the cardiologist's office, she usually saw the physician's assistant. Despite asking for the doctor when she called his office, she spoke only with the physician's assistant who advised her to continue her medication

until her next visit. Her longest conversations with the doctor followed her procedures, when he told her the results of her tests.

Mary had a very supportive family of six siblings and multiple uncles and aunts, all of whom lived on farms they had worked for more than four generations. Her husband seemed resentful when she could not do her housework. He never discussed her illness with her physicians, and they never suggested he accompany her to the cardiologist's office so he could learn about her disease, its management, and her deteriorating course. As her health declined, her family insisted their general practitioner, who had known Mary for 20 years, find another cardiologist to offer a second opinion. Her family doctor recommended Dr. Cooper.

Dr. Cooper sat down with Mary and asked her about the course of her illness. She said there had been so many problems, hospital admissions, and tests she could not remember them all. With a little prompting, she told a story of progressive fatigue, no energy, and feeling tired all the time. When she tried to do housework, she had to rest between rooms. Just walking to the second level of her home was exhausting, and she had to sit on the top of the stairs to recover. She remembered at least three hospitalizations where she had repeat cardiac catheterizations performed. And all these events occurred despite scrupulously following her complicated medication schedule and diet.

Mary had the pale complexion of an individual with poor heart function. While she was overweight, she was not obese. Careful observation of the veins in her neck demonstrated she had not taken on too much extra fluid, and she was on the correct diuretic dose, always a concern in patients with heart failure. The apical impulse, usually easily felt in patients with hypertrophic cardiomyopathy, could not be felt at all. In addition, her very soft heart tones were another unusual finding. The unusual course of her illness despite standard treatment and her unexpected physical findings led Dr. Cooper to believe Mary had something other than the given diagnosis. Rather than repeat her tests, he reviewed what had been

done—her electrocardiogram, echocardiograms, and cardiac caths. He could see the progressive changes typical of a rare heart condition called primary amyloid heart disease.

Once Dr. Cooper was absolutely sure of the diagnosis, he felt he could provide Mary and her family with an honest and thorough assessment of her illness. Although the prognosis was dismal, he could still offer therapy to make her life easier. For one thing, she no longer had to feel her illness was a result of her failure to follow the doctor's directions. For another, after educating the family about her illness, they had a better appreciation of Mary's daily struggle to carry out her activities and were eager to provide the support she needed.

Dr. Cooper discontinued several of her medications, some of which were harmful, the others not necessary, and together with her family physician, developed lifestyle changes appropriate for her condition. On a simplified but more effective treatment plan, and with a more realistic outlook for her future, her family members and friends rallied around to provide support and comfort. Her daughter, who lived away from home, moved in to help care for her. Dr. Cooper promised to provide all the care and support she and her family needed and to be available to answer any questions they had. He also promised to continue to research the literature to be sure she had the opportunity to receive any new therapies as they became available. Fortunately, today new therapies are available for this once incurable disorder. For Mary there was no cure at the time, but she could be helped. Knowledge of the true disease process allowed her physicians to help her and her family understand her condition and what she required.

What Mary needed was a caring and empathetic physician willing to sit down with her and believe the story she had to tell. Her family physician, who knew Mary professionally and socially for many years, could now provide her medical care since no complicated medical regimen was necessary. Mary's trust and respect had to be earned and her story listened to otherwise, she would be no more satisfied with Dr. Cooper's opinion than with her first cardiologist.

While we cannot cure every patient, good bedside manners can relieve anxiety and show true caring for the patient. This supports both patient and family. If respect and trust are not established, the opportunity for healing is lost.

Mary's experience is far from unique. The single most striking change in medicine in the last 40 years is not the new, incredible, and astounding technologies, but the loss of confidence patients have in their physicians. *The New York Times* reported that when doctors are arrogant, patronizing, dismissive, callous, impatient, or judgmental, patients do not trust the diagnosis that results from their consultation or follow the recommendations they are given [3].

What must physicians do to earn back the trust of their patients? Dr. Philip Tumulty, in a 1978 speech to the Johns Hopkins medical students called "The Art of Healing," gave them some advice.

> A clinician must be patient and forbearing, strong yet gentle, unselfish of his time and unstinting in his efforts. He must be willing to bite his tongue and to turn his cheek. He must have an attentive ear as well as the ability to question probingly. His attitude must create trust and confidence, and his manner thoughtfulness and security. He must hear what the patient doesn't say and be sensitive to the anguish which cannot be expressed. Patients are anxious; they are frightened; they inwardly anticipate the very worst, although they may cover up with apparent lack of concern. Some are very brave, while others cling in terror. All grasp tightly to life, and in all, some glimmer of hope, no matter how flickering, is essential to the vitality of their spirit [4].

Changing Times Changing Behavior

For the first half of the last century, the social framework in organized medicine promoted cooperation, self-regulation, noncompetitive behavior, and collegiality. Court and legal academic challenges during the era of social and economic disruption from 1960 to 1980 claimed that such an organized network was nothing more than a means of monopolizing trade. Together with the increasingly large economic role of the federal government through Medicare and

Medicaid grants—plus anti-trust litigation against doctor groups and the influence of profit-driven managed care organizations—the ethic of collegiality and civility, while not eliminated, seemed to take a back seat to competition. Many healthcare organizations, responding to government and business communities, especially healthcare insurers, adopted business models that gave increasing importance to seeing more and more patients in less and less time. A profitable bottom line is the main concern of a corporation setting up possible conflicts with the principles of medical professionalism.

That said, we doubt if poor manners are a result of a deficiency in medical professionalism. Most of the colleagues and staff we have met in our three-quarters century of combined practices are well motivated and truly concerned about their patients. However, the change in behavior among and between doctors and between doctors and administrators of medical institutions, whether by coincidence or as a result of pressures to behave in a more business-oriented way, affects the way patients are seen and treated.

In the worst organizations, patients are dehumanized and become a commodity. On more than one occasion, we have heard patients referred to as "job security." When a doctor or nurse acts in a disrespectful manner, their behavior indicates a lack of knowledge, not only of what patients expect, but also of what is expected of them as healthcare professionals. Or perhaps rude physicians and staff are not aware of the messages sent by their actions. It is therefore important for healthcare professionals to "act the language," to behave in a manner to demonstrate they recognize their behaviors affect the healthcare of their patients. Recognizing the changes in the way patients are sometimes treated, organized medical education has instituted required curriculum in medical schools to teach medical professionalism to medical student and residents in training. Training in good manners and respect for their patients is part of that curriculum.

Trust in Patient Care

On what do your patients base their trust? They cannot reasonably be expected to perform an evaluation of your abilities, knowledge, or training. Other than the recommendations given by friends, who may have had one or two experiences with doctors, or other physicians' recommendations, the average patient has little information to evaluate the quality of care they receive.

They may inspect the diplomas hung on the wall and check out "health grades" and other online evaluations. Maybe they are impressed by pictures of their physician with civic leaders and celebrities who are presumably their patients. They may read the framed certificates from organizations with important sounding names. However, the most important impression is the one they form based on the way the doctor acts, the "bedside manner."

Patients cannot evaluate their doctors' surgical techniques, but they understand if the doctors are agreeable, neat, responsive to their questions, have a clean office, and treat their staff and are treated by their staff with respect. Clues and insights with which they leave the office will lead to expectations of care they will receive. Chances are patients are willing to grant a degree of slack for the state of the office surroundings, although the physical environment can say a lot about a practice. Patients may accept a waiting time if it is not interminable. But they expect the staff to treat them politely and in a civil way, and when it comes to the doctor and the nurse, the people to whom they literally and figuratively bare themselves, they expect a standard of behavior higher than what they might expect from others.

Consider the following from a leading American physician. In 2006, George Beller, a past president of the American College of Cardiology, wrote the following in an editorial in the *Journal of the American College of Cardiology*. His wife was suffering from a serious illness, and he made the following recommendations related to the behavior of the doctors responsible for her care:

> The patient should expect the physician to be caring and empathetic, take the time to explain what was found in the medical evaluation, describe the disease process in lay terms, not hurry when answering questions, show sensitivity and compassion when having to relate bad news, display a realistic but positive attitude about treatment plans, and fully explain why certain tests are being ordered and specific drugs or procedures are being recommended [5].

Dr. David Pendleton and co-authors, in the book *The New Consultation: Developing Doctor-Patient Communication*, identified the following five key issues a doctor should address for a consultation to be effective [6]. By "effective," the authors mean the consultation results in an improvement in the patient's health.

The doctor must: (a) understand the problem, (b) understand the patient, (c) the doctor and the patient must agree on the problem, (d) share decisions and responsibility, and (e) maintain a relationship.

Over the course of an effective consultation, patients should develop a firm understanding of what to do to improve their health and why. By following these recommendations, patients will increase their resolve and commitment to follow medical instructions. Keeping in mind that practical considerations do limit the amount of time a physician can spend with each patient, at the end of the consultation patients should leave the office satisfied that they have been encouraged to tell their whole story, that they were attentively listened to, and that they understood what was said and what further tests and treatments are to be done and why.

Together doctors and healthcare professionals make a social contract with their patients and all must be in agreement concerning follow-up plans. Although the physician is the medical expert in charge of the consultation, patients understand themselves better than anyone, and they are in charge of following the advice. If physicians do not have their trust and respect, it just will not happen. Patients must believe and understand the diagnosis and the plan to be able to effectively execute it.

Ninety percent of diagnoses can be made by listening carefully to a skillfully elicited history, yet Howard Beckman, MD,

and colleagues have shown that on the average, the patient gets interrupted by the doctor's questioning within the first 23 seconds [7]. In allowing patients to tell their story, they gain confidence that the doctor's care and will help them. Otherwise, they will not believe the doctors came to the correct conclusions about their illness.

Listening is important, but it is not only listening that improves trust in the doctor. A number of studies on physician-patient communication demonstrate that health outcomes are improved by verbal and nonverbal behaviors. How a physician dresses, facial expressions, how the patient is approached, and whether the doctor's attention is focused all play important roles in building trust and how likely patients are to follow their doctor's advice [8].

In his popular book *How Doctors Think*, Harvard physician Dr. Jerome Groopman notes that freedom of patient speech is necessary to reach a correct diagnosis and therapeutic plan [9]. Referencing other researchers, he notes how the interview process not only exchanges information between patient and doctor, but also establishes trust and "a sense of mutual liking." It is the "liking" part, based on mutual respect that results in improved patient follow-up or adherence to the therapeutic plan.

Looking back to Mary's story, at first she did not receive the correct diagnosis and an appropriate treatment plan. The diagnosis did not become clear until she had the opportunity to sit down with her new doctor and tell her complete story. The heartache and suffering Mary experienced were a personal loss, but the wasted doctor visits, unneeded and extremely expensive procedures, and excess medication are added costs, not just to Mary but to all healthcare consumers.

Doctor-Patient Relationship

Some of the negative views patients have of their doctors are due to failure to establish a relationship, and some are due to an estrangement of doctor and patient due to the deperson-

alization of medical care. Your patient may navigate the medical forms online, including a medical history, before even arriving at your office. Once there, they are asked some of the same questions they answered in the online questionnaire. When they finally get to tell their story directly to the doctor, usually in response to a variation of the question "What brought you here today," the doctor is frequently sitting at a desk facing a computer and typing responses into the medical record.

Once in the exam room, many doctors no longer make eye contact, act more like they are in a hurry, often do not ask their patients to disrobe, instead listening to the chest and feeling the abdomen over clothes. Patients are very aware when they feel the doctor is rushing and become suspicious when the evaluation is not thorough or meticulous. Lewis Thomas, now deceased, a respected researcher, teacher, and thoughtful observer from Rockefeller University, wrote in the *New England Journal of Medicine* noting that "medicine is no longer the laying on of hands; it is more like the reading of signals from machines" [10]. CT scans, PET scans, MRIs, and ultrasounds have replaced probing fingers and stethoscopes.

The physician, once the valued confidant and adviser for the family, not only assisted with the medical problems but also with the social and emotional ones. That physician is no longer in practice. Today's doctors are working just as hard and putting in the long hours but in a vastly different medical environment. Present-day practice is complicated by the demands of managed care, profit-oriented medical management companies, health maintenance organizations, and the need for increasingly focused specialty practices. Practices are divided by organs or disease types, such as neurology or endocrinology or cardiac surgery, and also by the location where the patients are seen: emergency department doctors, hospitalists, health maintenance clinic doctors, and multispecialty group practices. All this compartmentalization makes

an ongoing relationship with one physician more difficult and seem less and less important.

What has been lost in the rush to technology is the trust that is established by face-to-face time with the doctor and a sharing of secrets. Lost is the gentle yet expert physical exam where probing fingers identify and even reproduce an area of discomfort or pain, followed by a sympathetic response from the doctor. If a lump in the belly is carefully identified and circumscribed by the doctor's palpation, the patient's confidence in the examiner is established. If the doctor takes the time to listen carefully to the patient's chest, elicit the wheeze experienced the evening before, or have the stethoscope over the heart when it breaks out of normal rhythm, patients will be confident in their doctors' ability. If additional questions elicit symptoms not mentioned, both patient and doctor know they are on the right track. When a sympathetic nod acknowledges fears and presumptions, patients begin to feel a connection and confidence of growing trust.

Teaching the Lost Art of Healing

Bernard Lown, the famous Boston cardiologist, clinician, and Nobel Prize winner, expressed this opinion in his 1996 memoir *The Lost Art of Healing*: "The American public is suspicious, distrustful of, even antagonistic to, the profession" [11]. He comments that a doctor establishes credentials as a caring practitioner by listening attentively, and he sees the trust between patient and doctor, established over several millennia, slipping away. This lack of trust is not only a problem for the individual practitioner and the patient, the problem extends to the role organized medicine will play in the ongoing reinvention of the medical care system in America. Medicine as a profession needs to re-establish its position as a trusted adviser and steward of the patient's health, an invaluable partner in care, and an indispensable resource for the health of the community and the nation.

One opinion that has surfaced in our country's debate concerning the best way to finance our medical care is that a trusting personal relationship with the doctor is missing. We Americans take pride in believing we have the best medical care in the world even as the statistics for infant mortality, heart disease, patient satisfaction, life expectancy, and medical errors demonstrate otherwise. Newspaper articles air complaints about arrogant and difficult physicians; patients complain about missed diagnoses, inability to get appointments due to insurance policies, and doctors opting out of government programs that insure older patients or patients living near or below the poverty line.

Life-saving advances in medicine improve our health, and in the end, better health is what we all want. Today's doctors know more about the basic science of diseases, have more and better diagnostic tests and treatment options than ever before, and can help many more patients regain well-being than any previous generation of physicians.

Indeed, a first priority for most patients when choosing a physician or surgeon is their *perception* of the doctor's knowledge and skill. Yet many patients leave the physician's office dissatisfied and unconvinced. They believe their health is not the doctor's first concern. It is useless to diagnose an illness and recommend a course of testing and treatment if your patient does not trust your opinion.

A lack of confidence in scientific medicine is one reason Americans spend billions on alternative care, herbal medications, and even quackery. Often an uncomplicated illness can be rapidly diagnosed with a little patient history and an abbreviated physical exam. However, the respect and trust that should develop between doctor and patient during the office visit can make the difference in how determined the patient will be to follow up with diagnostic studies and treatment plans. When the longest conversation one has is with the billing office, or if your patients feel they never really got to know who is in charge of their

medical care, the likelihood they will closely follow your advice is diminished, and the outcome of the consultation will be less than satisfactory.

Threats to the Doctor-Patient Relationship

There are many reasons patient-doctor communication can break down. In fairness, the busy, overworked physician who has just administered to a terminally ill patient might not remember there are no trivial complaints and appear brusque to a patient with a URI. Each patient's complaints are important.

If you feel you are distracted, try to refocus all your attention to the person in front of you. If your patient is emotional, distracted, wondering, take a minute to address their immediate concerns. Consider a statement like "Mr. Smith, you seem distracted, is there something else you would like to talk about." If she is worried who will walk her dog, asking her to mention it will help refocus on the medical visit. If there is a serious problem, you have an opportunity to discuss it and in the end that will be important to your relationship. A patient may be in a heightened emotional state and not listening to or understanding what you are saying. The anxiety about their illness can cause so much discomfort they just want out of your office and away from the source of their unease about the illness and their mortality. For such patients consider asking them to bring a family member or a friend to accompany them to the office and the hospital.

You may have trouble communicating with your patient, or you may be asked the same question over and over. If your patient is not demented, then repeatedly asking the same question indicates their true concerns have not been addressed and possibly not even articulated. Try to encourage them to talk about how they feel or what else about their symptoms bother them. This may reveal the true concern. One of the goals of the consultation is to discover and resolve your patient's fears.

Set an Example

> Setting an example is not the main means of influencing another, it is the only means.
>
> —Albert Einstein

Professor Cheshire Calhoun writes in the essay "Expecting Common Decency" that the helping professions: medicine, nursing, and teaching, among others, "take on a special responsibility for promoting something of moral value that those outside the profession do not have a similar responsibility to promote" [12]. For doctors, this means behavior that exhibits caring, empathy, expertise, compassion, and a commitment to medical service. You can demonstrate all of those key qualities of medical professionalism during an office visit.

As an incoming medical student, you were selected based on academic performance in college. While the intellectual level of your classmates is universally high, humanistic values and social skills are difficult to assess from a college transcript or a written exam and may vary widely. Some entering students and physicians in training may need instruction in the language of manners as it applies to their patients.

Dr. William T. Branch, Jr., a professor of medicine at Emory University School of Medicine, demonstrated that faculty members coached on issues such as how to listen carefully, how to be a caring person, and how to use personal and social information in patient care were better at teaching these skills to medical students than faculty who had not been coached [13]. Interviewed by *The New York Times*, Dr. Branch pointed out that the skills taught to the faculty "can help physicians grow, not just in terms of knowing more but in becoming a whole person" [14].

Reflecting on his own hospital care, Dr. Michael Kahn, a psychiatrist writing in the May 2008 issue of *The New England Journal of Medicine*, noted that while compassion is preferred, most patients would be well served with a doctor who is well behaved. He wrote about his attending surgeon:

> I found the Old World manners of my European born surgeon—and my reaction to them—revealing in this regard. Whatever he might actually have been feeling, his behavior—dress, manners, body language, eye contact—was impeccable. I wasn't left thinking 'What compassion.' Instead I found myself thinking, 'What a professional,' and even (unexpectedly) 'What a gentleman.' The impression he made was remarkably calming, and it helped to confirm my suspicion that patients may care less about whether their doctors are reflective and empathetic than whether they are respectful and attentive [15].

Dr. Kahn goes on to describe a checklist, similar to the ones used by doctors and nurses when performing bedside procedures. He suggests using it when first approaching a patient. As he points out, it is easier to modify behavior than to change attitudes. Commenting on the best way to teach behavior to the student doctor, he writes, "Trainees are likely to learn more from watching colleagues act with compassion than from hearing them discuss it." Dr. Kahn includes in his prescription for better care the requirement that physicians be trained to pay attention to the patient. Listening, demonstrating attention to the patient's story, and engaging in a back-and-forth conversation are all dimensions of good medical manners.

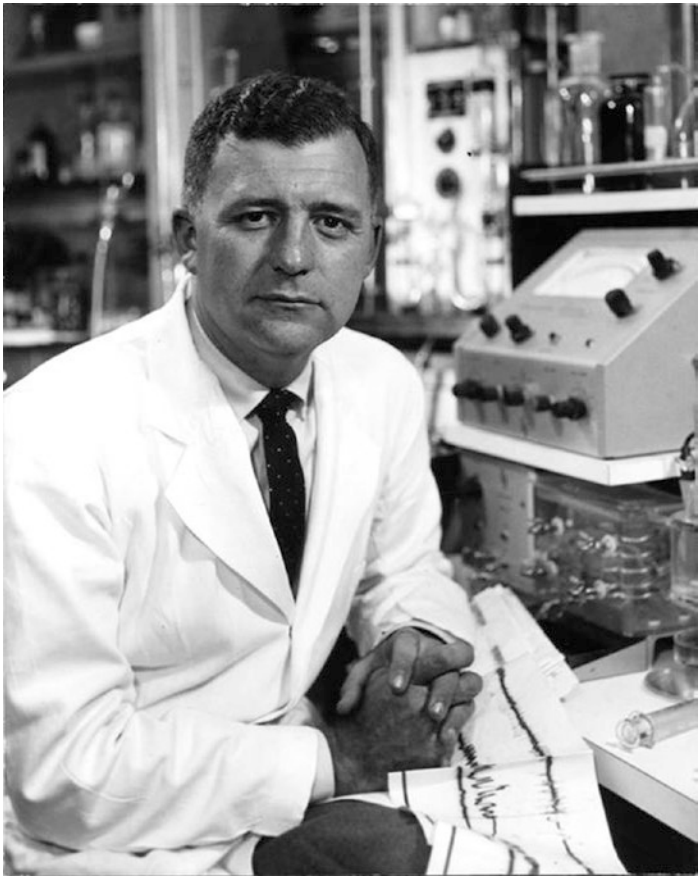
Your training is long and difficult and very little time is devoted to teaching bedside behavior. The typical primary care physician spends 7 to 8 years in medical school and residency training before starting in practice, and the training periods for subspecialists can last as long as 11 years. Training is so demanding that medical schools and residency training programs are required by law to set limits to your working hours so you do not become exhausted or overextended.

In almost every other field, real-life experiences interrupt or end formal training. Adults barely out of their teens learn how to conduct relationships and how to behave in business situations from mentors much older and experienced than they, and from their peers by observing errors. Given the peer group and age of the non-medical school-bound college graduate, errors are forgiven and for the successful, not

repeated. A traditional medical student, because of a cloistered education, minimal socialization with peer groups outside of medicine, and mentoring in the clinical years by authority figures usually little older than they, can remain socially challenged when training is completed.

Medical schools have begun to recognize these deficiencies. Professors do lecture on the essentials of professional bedside behavior, and some medical schools have initiated courses on humanistic values including required readings in fiction and essays. Doctors in training are encouraged to present their patients in a humanistic manner rather than as a compilation of symptoms and diseases. They are instructed in medical ethics and receive lectures about right and wrong in terms of medical conduct. What is not taught is how the practitioner should behave in a manner that indicates to the patient what Dr. Calhoun calls the "moral attitudes of respect, tolerance, and considerateness." They may not be taught the nonverbal behaviors that demonstrate respect for the dignity of the patient, nurse, or colleague.

No other professional has the responsibility to ask for permission to poke and prod, elicit pain, or explore the most intimate areas of the body to help another individual. Out of the medical environment, such behavior would be criminal. This unique privilege makes the clear display of manners necessary to place the behavior in context and reassure your patient of your essential moral character. Medical manners communicate, in everyday professional behavior, the principles of medical ethics. Good manners signifying respect for your patient can be taught to both students and teachers. Dr. Kahn has it right when he emphasizes polite behavior over feelings. This is because conduct can be taught, behavior can be mimicked, and manners are teachable. Furthermore, repetitive actions yielding positive results can lead to fundamental changes in attitudes and beliefs.



Eugene Braunwald. Image Courtesy of the Lillian and Clarence De La Chapelle Medical Archives at NYU

Eugene Braunwald
Teacher, Scientist, World Leader in Cardiology

I was a student at the National Heart Institute at the NIH when Dr. Braunwald was the director and attended the regular meetings and conferences at the Heart Institute. He had a charisma and leadership that stood out even in the presence of the outstanding faculty and researchers in the institute. His insightful, original thinking, careful and thoughtful approach to experimentation, and organization and teamwork were on display with every project I observed during my rotation.

Eugene Braunwald was born in Vienna, Austria, in 1929. His nearly idyllic early childhood was suddenly interrupted in 1938 by Nazi Germany's annexation of Austria. After some harrowing experiences, he and his nuclear family fled Austria and came to London with literally only "their shirts on their backs." When World War II began, Eugene and his younger brother were evacuated from London to live on a farm in northern England. They emigrated to New York in 1939, where he entered the New York public school system and graduated as class valedictorian; attended New York University and graduated magna cum laude; and progressed to the New York University School of Medicine where he graduated in 1952 with the highest academic record in his class and received the student research award.

After 2 years of clinical training in medicine and cardiology at the Mount Sinai Hospital in New York, he served a postdoctoral research fellowship in the laboratory of Dr. André Cournand, a professor at Columbia University considered by many to be the "father of cardiac catheterization" and winner of the Nobel Prize in Physiology or Medicine. In 1955, he continued his training in the intramural research program of the National Heart Institute at the NIH, becoming chief of cardiology in 1961 and clinical director in 1966. His first wife, Nina Starr Braunwald (now deceased), became the first female cardiac surgeon and the first female member of The American Association for Thoracic Surgery.

In 1968, the Braunwald family (by then including three daughters) moved to La Jolla, California, where he served as the founding chair of the Department of Medicine of the new University of California, San Diego School of Medicine.

During his 4 years there, he established a strong department and demonstrated that he was an innovative medical educator, administrator, and academic leader. In 1972, the family moved back to the East Coast when he filled the post of Hersey Professor of the Theory and Practice of Medicine at Harvard Medical School, the oldest endowed medical chair at Harvard. He also became chair of the Department of Medicine and physician-in-chief of the Peter Bent Brigham (now the Brigham and Women's) Hospital. Under Dr. Braunwald's leadership, the Department of Medicine flourished; he recruited outstanding physician-scientists and trained two generations of academicians who in turn have exerted a major influence in academic medicine.

His first major article was published in Circulation Research in July 1954, and he has been a major force in cardiology ever since. Science Watch has listed Eugene Braunwald as the most frequently cited author in cardiology. On the basis of his contributions, he has received numerous honors and awards.

Cohn LH. Eugene Braunwald MD. The Journal of Thoracic and Cardiovascular Surgery. 2013; 146:743–744

Issues Addressed in This Chapter

- Respect and communication are key in a consultation.
- After a consultation, you and your patient should agree about the plan.
- Ordering tests is not a substitute for listening.
- Trust is established by face-to-face time with your patient.
- Listen to your patient, try not to interrupt, understand their concerns.

Study Guide

1. Why is respect for the patient important in caring for the patient?
2. How do good manners improve patient communication?
3. How did the doctor providing a second opinion for Mary C improve her care?

4. Consider Mary's first physician. What was his explanation to Mary about why she was not improving? Who did he blame for that? Why is that a problem?
5. What is your take away from Philip Tumulty's advice to medical students?
6. How do you gain the trust of your patient?
7. What is the social contract you make with your patient?
8. What are some of the ways a doctor-patient relationship falls apart?

References

1. Buss S. Appearing respectful: the moral significance of manners. Ethics. 1999;109(4):795–826.
2. Wynia M, Latham S, Kao A, et al. Medical professionalism in society. N Engl J Med. 1999;341(21):1612–6.
3. Kolata G. When the doctor is in but you wish he weren't. The New York Times. 11/30/2020. www.nytimes.com/205/11/30/health. Accessed 3 30 2020.
4. Tumulty PA. The art of healing. Johns Hopkins Med J. 1978;143:140–3.
5. Beller G. President's page: patient satisfaction: a personal perspective. JACC. 2001;37:687–8.
6. Pendleton D, Schofield T, Tate P, Havelock P. The new consultation: developing doctor-patient communication. Oxford: Oxford Univ Press; 2003.
7. Beckman H, Frankel R. The effect of physician behavior on the collection of data. Ann Int Med. 1984;101:692–6.
8. Stewart MA. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995;152:1423–33.
9. Groopman J. How doctors think. Boston: Houghton Mifflin Co.; 2007.
10. Thomas L. The youngest science-notes of a medicine watcher. New York: Viking Press; 1983.
11. Lown B. The lost art of healing. New York: Ballantine Books; 1996.
12. Calhoun C. Expecting common decency: Philosophy of Education Society Annual; 2002. p. 28–35.

13. Branch WT, Kern D, Haidet P. Teaching the human dimensions of care in clinical settings. JAMA. 2001;286(9):1067–74. https://doi.org/10.1001/jama.286.9.1067.
14. Pauline W. Chen the hidden curriculum of medical school New York times January 29, 2009.
15. Kahn MW. Etiquette based medicine. NEJM. 2008;358:1988–9.