

Etiquette-Based Medicine

Michael W. Kahn, M.D.

Patients ideally deserve to have a compassionate doctor, but might they be satisfied with one who is simply well-behaved? When I hear patients complain about doctors, their criticism often has nothing to do with not feeling understood or empathized with. Instead, they object that “he just stared at his computer screen,” “she never smiles,” or “I had no idea who I was talking to.” During my own recent hospitalization, 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 empathic than whether they are respectful and attentive.

I believe that medical education and postgraduate training should place more emphasis on this aspect of the doctor–patient relationship — what I would call “etiquette-based medicine.” There have been many attempts to foster empathy, curiosity, and compassion in clinicians, but none that I know of to systematically teach good manners. The very notion of good manners may seem

quaint or anachronistic, but it is at the heart of the mission of other service-related professions. The goals of a doctor differ in obviously important ways from those of a Nordstrom’s employee, but why shouldn’t the clinical encounter similarly emphasize the provision of customer satisfaction through explicit actions? A doctor who has trouble feeling compassion for or even recognizing a patient’s suffering can nevertheless behave in certain specified ways that will result in the patient’s feeling well treated. How could we implement an etiquette-based approach to patient care?

The success achieved by Peter Pronovost and colleagues in solving a different kind of complex problem — reducing the likelihood of central-line infections in critical care patients¹ — provides a thought-provoking suggestion. Instead of taking an elaborate, “sophisticated” approach — say, tackling infections by developing more advanced antibiotics or clarifying the genetic basis for drug resistance — Pronovost et al. introduced a checklist to enforce the use of hand washing, thorough draping of the patient, and other tasks that could be easily performed. The results of this simple intervention were swift and dramatically effective. I would propose a similar approach to tackling the problem of patient satisfaction: that we develop checklists of physician etiquette for the clinical encounter. Here, for instance, is a possible checklist for the first

meeting with a hospitalized patient:

1. Ask permission to enter the room; wait for an answer.
2. Introduce yourself, showing ID badge.
3. Shake hands (wear glove if needed).
4. Sit down. Smile if appropriate.
5. Briefly explain your role on the team.
6. Ask the patient how he or she is feeling about being in the hospital.

Such a checklist has the advantages of being clear, efficient to teach and evaluate, and easy for trainees to practice. It does not address the way the doctor feels, only how he or she behaves; it provides guidance for trainees whose bedside skills need the most improvement. The list can be modified to address a variety of clinical situations: explaining an ongoing workup, delivering bad news, preparing for discharge, and so forth.

Training for an etiquette-based approach to patient care would complement, rather than replace, efforts to train physicians to be more humane. Pedagogically, an argument could be made for etiquette-based medicine to take priority over compassion-based medicine. The finer points of patient care should be built on a base of good manners. Beginning pianists don’t take courses in musicianship and artistic sensibility; they learn

how to have proper posture at the piano and how to play scales and are expected to develop those higher-level skills through a lifetime of study and practice. I may or may not be able to teach students or residents to be curious about the world, to see things through the patient's eyes, or to tolerate suffering. I think I can, however, train them to shake a patient's hand, sit down during a conversation, and pay attention. Such behavior provides the necessary — if not always sufficient — foundation for the patient to have a satisfying experience.

Furthermore, it's simpler to change behavior than attitudes. Although reading medically relevant literary classics and writing reflection pieces (as is now done in many medical schools) may make some students more mature

and humane, I wonder whether these exercises are most helpful for those students who arrive at medical school already in possession of those qualities to some degree. For many students, I suspect that these exercises may have a more limited effect, if only because they are too brief to allow the student to comprehend, practice, and master the intended values. It isn't easy to modify a person's character or outlook in a classroom; besides, clinical training is more effective when it resembles apprenticeship rather than graduate school. Trainees are likely to learn more from watching colleagues act with compassion than from hearing them discuss it.

Etiquette-based medicine would prioritize behavior over feeling. It would stress practice and mastery over character development.

It would put professionalism and patient satisfaction at the center of the clinical encounter and bring back some of the elements of ritual that have always been an important part of the healing professions. We should continue our efforts to develop compassionate physicians, but let's not overlook the possibly more immediate benefits of emphasizing good behavior.

No potential conflict of interest relevant to this article was reported.

Dr. Kahn is a psychiatrist at Beth Israel Deaconess Medical Center and an assistant professor of psychiatry at Harvard Medical School — both in Boston.

1. Pronovost P, Needham D, Berenholtz S, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. *N Engl J Med* 2006;355:2725-32. [Erratum, *N Engl J Med* 2007;356:2660.]

Copyright © 2008 Massachusetts Medical Society.