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DOES A GOOD BEDSIDE MANNER MATTER?

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Introduction

Over that last 50 years, the changes in medicine have been obvious to anyone who reads a newspaper, watches television or interacts with health care systems. It has become more dependent on technology, increasingly specialised, and increasingly complex. It has also been successful, with more diseases becoming diagnosable and treatable, and thus more people live longer. The demand has risen, and with it the complexity. Doctors work in different ways and often have less time to spend with the patient. The role of other health care professionals has expanded and, as a patient, your interactions with the system can be with any number of people. Many of the specialist developments are very technical, including in my field of surgery. Many new roles have developed, in which interaction with patients is either not necessary or only intermittent.

Yet medicine remains inherently about **people**. Its purpose is to improve the health of the population, manage and sometime cure illness and improve the quality of life for those who cannot be cured. You go to the doctor with a problem, the doctor arrives at a diagnosis and advises (I trust) evidence-based treatment. Everyone hopes it works. But how important is the way in which the doctor relates and speaks to you? How important is their bedside manner?

Bedside manner refers to the way in which a health care professional treats people who are ill and in their care. Good bedside manner equates to kind, friendly and understanding behaviour. It is empathetic behaviour. Empathy, at its simplest, is awareness of the feelings and emotions of other people. It is a key element in emotional intelligence. It is how we as individuals understand what others are feeling **as if** we were feeling it ourselves. It is much more than 'sympathy' which implies feeling **for** someone, whereas empathy implies feeling **with** someone. Empathy is thus much more than pity.

A good bedside manner reflects **compassionate care**. Haslam has defined[1] compassion as *"The humane quality of understanding suffering in others and wanting to do something about it"*. But there's more to it I think. It involves concepts of kindness, personal warmth, concentration, attention, listening, engagement, seeking understanding, being empathetic, whilst offering respect and dignity. Simply considering how you yourself would like to be spoken to, examined and engaged with takes you quite a long way towards defining compassionate care.

These thoughts from Anatole Broyard[2], written after his treatment for cancer, encapsulate the expectations of many patients;

> *"I see no reason for my doctor to love me - nor would I expect him to suffer with me. I wouldn't demand a lot of my doctor's time: I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind and just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way"*

You would think that anyone entering a caring profession like medicine would have the awareness to behave like that, and that they would need to be inherently empathetic, but experience shows us that is not the case, despite the fact that most do have some sort of fundamental altruism, particularly if they work in the NHS. Sadly, we

have all met physicians and nurses who clearly lack that skill. I have certainly heard colleagues described as having 'the bedside manner of a border guard'.

Let me describe what I want for me or my family if they or I meet a doctor or nurse for the first time, or if we haven't seen them for a while.

- I want them to stand up, to greet me (shaking hands will be fine) and to introduce themselves **"#hello, my name is".** Staying seated at the desk is not good enough.
- I want eye contact. I want them to look at me and not the computer, and preferably not over a desk with me on a lower chair. I hate power-plays.
- I want them to be clean.
- If there are other people there, I want to be introduced to them too, and told what their role is. And to be asked my permission for them to be there.
- I want the doctor to treat those *other* people with respect and dignity too. Good behaviour is catching.
- I want them to have read my notes, know my history and have access to any results I need.
- I want them to demonstrate confidence and competence, but not arrogance or superiority. I want them to know their stuff.
- I want them to give me time to 'present my case', and I want to feel that they have time for me (just like Anatole Broyard).
- I want them to listen and be attentive; not to draw conclusions too soon.
- I want them to be warm, compassionate, understanding and thorough.
- A good sense of humour helps!
- I want them to be honest; I want to be able to trust them.
- I want them to be friendly. Not to **be** my friend, but to act **as if** I were a friend.
- I want them to be gentle.
- I want them to understand I might be scared.
- I want them to speak in plain language, in my case preferably in English.
- I want them to use as little jargon as possible, and never, ever say "This is what we call"!

And that is just for a consultation. For something which requires detailed explanation, for example consent for surgery, or if they are sharing bad news with me, then I want all the above but with knobs on.

I am not alone in such demands. Anderson and colleagues[3] studied on-line reviews of doctors in the USA and grouped the responses of 2917 of 5030 patients according to what they considered to be positive aspects of the doctor and what were negative. Seven domains were considered to define **outstanding quality**. These were; *access (how easy it was to get to see the doctor), communication, personality and demeanour, quality of medical care processes, care continuity, quality of the healthcare facilities, and office staff.* Four domains were defined which drove **negative** ratings, these were; *communication, care coordination, interpersonal skills, and barriers to access*. Patient satisfaction ratings were thus highly influenced by the core issues of **communication** and **follow-up** care and its **coordination**.

Patients valued physicians who took time to listen, time to work **with** them, time to care **about** them, time to support them in managing their healthcare and who made an effort to personalise their care. Physicians who worked hard on their patient's behalf were highly though of and better trusted than those who did not. Anderson et al[3] point out that patients were adept at pointing out good qualities, but at the same time dismissing them in the absence of necessary skills and qualities. "*Patients may like you as a person but will judge you on your bedside manner*". A good bedside manner improves patient satisfaction.

Why can't some clinicians do this? As I indicated earlier, medicine has changed hugely since the NHS was formed immediately after the 2nd World War with a commitment to care for everyone, regardless of wealth, culture or creed. Overall, it has been a huge success, with more treatments available, major public health

initiatives (smoking, vaccination etc.), innovative surgery etc., all resulting in longer and largely better lives. But that very success, combined with a rising population, increased complexity of disease in the elderly and budgetary constraints has imposed huge pressures on the staff. Health-care workers have to manage burgeoning technology, increasing bureaucracy, market forces, routinized practices and frequent scrutiny.

Doctors have less 'face-time' with patients; GP visits are now supposed to be about 10 minutes. Many general practices are so busy that they have to let the patients manage their own long term follow up and interaction, encouraging them 'to take responsibility for their health or disease'. Emergency rooms run at full capacity. Clinics are over-booked and pressured. It is harder than ever to form relationships with 'a' doctor, since you are encouraged to see the first one available. All at a time when patients are better informed, and have access to more information via the internet, leading to longer discussions. Against this background, is it possible to remain compassionate?

We have seen many press reports of lack of compassion or even cruelty in care. At its worst, this was seen in the awful events in mid-Staffordshire (http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report) and in several care homes. It is clear from patient surveys that many health workers seem to struggle to deliver care with the compassion that patients both expect and deserve.

Here is one example from the Francis report about mid-Staffordshire

> *"As I walked in my Mum was on the bed, on a bed pan, and she was falling off and she was in agony. She had been left like that for over an hour. The nurses' button which, if you read in the notes, my Mum had said before, please don't put it out of reach, was left on top of a drip. I struggled to reach the nurses' button. My Mum was in absolute agony, I can hear her screams now, as I walked into the ward. I slammed the nurses' button, the emergency button. Nobody came and I ran out and said: please, somebody come and help my Mum. As we went back in with the nurse, they went: "ooh, we'd forgotten about her. I said: "can't you hear?" And at that point she grabbed my hand and said: please don't let me die in here… the nurse that came in said: I am so sorry, we had forgotten about her; yes, she has been there for some considerable time" (Francis Report)*

Just four weeks ago in The Guardian[*], an anonymous senior NHS doctor recounts his distress at seeing the way in which his father, himself a GP for 40 years, was treated. Badly and without compassion. He reflected on some of his own patients and realised that his father's experience was not unusual. It happens, he said, all over the country. He asks; have we just accepted the mediocre, accepted the way things are? He questions whether it is a failure of leadership, government investment or other factors, and postulates that perhaps '*our altruism has slowly decayed and we're too exhausted to change a broken system'*.

Haslam argues[1] that compassion is not an optional extra, but all too frequently it is seen as being much less important than other aspects of care. There are many reasons for this, but the changing workload and system failures clearly contribute.
As Professor Michael West of the King's Fund has pointed out this year[4], in the process of trying to respond to these pressures, we are damaging the health and wellbeing of the very people we ask to deliver health and wellbeing to others. Of the 1.4 million people who work in the NHS in England, more than 50% say they're unable to meet all of the conflicting demands on their time at work. Nearly 40% say that they've been unwell as a result of stress at work in the previous year. Around 50% more staff report debilitating levels of work stress, compared with the general working population as a whole. We know that this has an impact on the quality of care, we know that it affects error rates, it affects people's ability to be compassionate and, in the acute sector, affects patient mortality.

To argue that it is different now implies that we were more compassionate in the old days, and I am not sure that is true. In the old days, doctors were more authoritative and patronising. When I started medicine, it was

[*] https://www.theguardian.com/healthcare-network/2018/jan/18/dad-gp-nhs-let-him-down-when-needed-most

routine not to tell patients they had cancer; the relatives might be informed, but often in a brief and harsh way, with little if any on-going support. Doctors thought that the patient needed to be protected from 'harmful' knowledge, and perhaps some did. Ward rounds were led by senior consultants, remote in their white coats and revelling in their authority. Patients were 'interesting cases' and discussed as such in front of the entourage. Informed consent was less informed or even absent. Doctor knew best. The old days were not necessarily the good old days.

Yet the idea that the way in which a doctor relates to his or her patient might influence outcome is not new. In 400BC, Hippocrates wrote that;

> "*The patient, though conscious that his condition is perilous, may recover his health simply through his contentment with the goodness of the physician".*

Silverman[5] quotes Hippocrates' clear instructions as to how doctors should behave;

> *"The physician ought also to be confidential, very chaste, sober, not a winebibber, and he ought to be fastidious in everything, for this is what the profession demands. He ought to have an appearance and approach that is distinguished. Everything ought to be in moderation, for these things are advantageous, so it is said. Be solicitous in your approach to the patient, not with head thrown back (arrogantly) or hesitantly with lowered glance, but with head inclined slightly as the art demands.*
>
> *He ought to hold his head humbly and evenly; his hair should not be too much smoothed down, nor his beard curled like that of a degenerate youth. Gravity signifies breadth of experience. He should approach the patient with moderate steps, not noisily, gazing calmly at the sick bed. He should endure peacefully the insults of the patients since those suffering from melancholic or frenetic ailments are likely to hurl evil words at physicians".*

We may now be more relaxed about what doctors wear or how they present themselves, but how they are **perceived** by their patients still matters. Imagine how you would feel if the doctor was visibly dirty, with filthy fingernails, severely unkempt or smelly. Not a good start. Or the old lady who hears "Sit up Doris", when in her own daily life, she is used to being called Mrs Jones, or maybe Professor Jones. This failure to ask the lady how she prefers to be addressed shows a lack of respect; one step away from a lack of compassion.

It horrifies me that some doctors and nurses never engage the patient with eye contact, don't shake hands or use another culturally appropriate greeting and don't introduce themselves. It is so rude, so degrading to the patients and such a gross way of demonstrating contempt or disrespect. Dr Kate Granger experienced this during her own treatment for a rare form of cancer. She was appalled in 2013 that so few of the people caring for her introduced themselves. She began a very successful national campaign called **# hello my name is…..** and you will see many doctors and nurses now wearing that badge and who have been trained in appropriate introduction. That doesn't mean saying my name is DOCTOR something. Doctor is a qualification, not a name. Using the title like this is a kind of power play, using your degree to imply status, and I hate it.

Kate received an MBE for her work, but sadly died in 2016. Her husband Chris is keeping the campaign alive with speeches, teaching and via social media. Her idea is so simple, so obvious and so important.

Why are you here?

There is more to the opening salvoes of a consultation than the formal greeting. A doctor can easily make assumptions about why a patient is attending, and just as easily narrow the conversation to a particular topic or interest. Start by saying "How's your knee?" and unsurprisingly you will spend the time discussing knees. If you only have 10 minutes, that might seem tempting. But it may well miss the real reason the patient has come to see you.

More open-ended questions which give the patient a chance to talk are much more effective in getting at what really worries the patient. It is better to ask, for example, "What can I help you with today?" Most doctors are

inherently worried that allowing the patient such an opening may lead to a long, rambling speech littered with false trails and unsolvable complaints. The whole 10 minutes eaten up, and nothing achieved. Or worse, the next **twenty** minutes gets consumed and the waiting room fills with upset patients threatening the quality of the rest of your day, as well as theirs.

As a result, in the USA it seems patients are usually allowed to speak for (on average) only 22 seconds before the doctor interrupts. However, it was demonstrated[6] in a study of 331 patients that if the consultation started with an open-ended question, and if the doctor did not speak until the patient has finished, the median duration of the patient's speech was only 59 seconds (mean 92 seconds). Three-quarters of the patients had finished in less than two minutes and only 7 of the 335 patients spoke for more than 5 minutes. Even in a busy practice, faced with time constraints and financial pressures, two minutes of listening should be possible and will be sufficient for nearly 80% of patients. It is only by listening and paying attention that the truth will out.

Listening

Danielle Ofri, in a recent excellent book[7], points out that listening is one of the most intricate skills we possess, yet also one that seems so obvious we hardly ever think about it. Like walking. The doctor is listening in the hope, theoretically, of extracting information to help define the problem. Ofri quotes Graham Brodie, a listening researcher form Louisiana State University;

> "*Extracting information is too simplistic a definition of listening. It presumes that talking is a linear process, that words are a mere conduit with meaning packed inside; that the listener just needs to unpack at the other end, like opening a letter.*"

Put like that, it is clear that the primary burden to get their story right falls on the speaker, in this case the patient. A good listener **helps** the speaker, drawing out the story with verbal encouragement and nudges. Interestingly, it is not uncommon to read in medical records that a patient was a 'poor historian', which means that the clinician/listener hadn't been able to work out what the patient meant; hearing but not listening. It is not meant as an insult yet reads like one. Whilst the patient might present the story in a disorganised way, a good listener can help reorganise it and add clarity without distorting meaning.

Most of us need some kind of signal to re-assure us that someone is listening. This can be a nod or a sound like 'mm-hmmm', or perhaps repeating back a sentence. These 'grounding' interventions encourage the patient to continue and can help show that the listener is paying attention. They work in normal conversation, so why wouldn't they work in a consultation?

So far so good. But can we be sure that what we have heard is right, or if the patient hears or understands what we say? Miscommunication is surprisingly common in medical consultations[8], and can have adverse consequences for the patient's quality of care, health outcomes and adherence to treatment regimes. Miscommunication is a common cause of complaints and the root cause of much litigation[9]. Relying on a patient to remember the detail of a consultation is thus asking for trouble. Much better to give them a summary in writing, or perhaps record the interview so it can be heard again. This is easy to do on a modern mobile phone, indeed in some centres in India, WhatsApp is used for exactly this purpose as so many patients are illiterate. Certainly, for chronic conditions drawing up and sharing an agreed plan of what is to happen can be incredibly helpful and minimised the risk of misunderstanding.

When I was Chairman of my unit a few years ago, our leadership team was full of smart people with strong opinions who were dedicated to delivering the best care to patients and to making the unit a success in other ways. Yet our meetings were quite hard going, and arguments often broke out, even though our goals were the same. It was upsetting and emotionally draining. In the end, we hired a coach, an organisational psychologist, to help us. She was tough on us, but she got to the bottom of why we were arguing.

It seemed that we were not really hearing what the other person was saying to us. Not listening. Whoever was speaking thought that they were being clear, but each of us interpreted it differently. Simply by asking us to

pause and repeat back to the speaker what we thought had been said to them, and then giving the first speaker another chance to explain what they *really* meant (they always thought they were clear) until we agreed what the message actually was solved the problem. I still use that technique in meetings now, and it can be just as useful in a consultation to be clear that the patient has heard correctly what you thought you had said, and that the true meaning of the words was clearly expressed. Surprisingly, it doesn't take long…certainly nowhere near as long as sorting out the consequences of miscommunication.

It is easy to be misunderstood. Danielle Ofri points out in her book[7] that the language we use as medics is often unintentionally judgmental. For example, if cancer treatment does not work, we say the patient '*failed*' chemotherapy, as if it was the patient's fault in some way. Similarly, patients who choose not to have a recommended treatment are said to have '*refused*' treatment and if they don't take the drugs they are '*non-compliant'*. We have to be careful to find neutral and accurate language. As Wu et al states[10], it's not what you say that counts, it's what they hear. Jane Ogden, a British psychologist, pointed out to Ofri[7] in an interview that;

> "*No two people speak the same language. They have different childhoods, different cultures, different family backgrounds, different contexts. Doctors have additional specialist knowledge and a litany of terms with which the patient is unfamiliar. The patient has symptoms that the doctor does not, and each patient responds differently."*

It pays to listen. The Catholic philosopher Catherine de Hueck Doherty (1896 – 1985) once said "*With the gift of listening comes the gift of healing".* You might not share her faith, but there is no doubt that listening is at least a good start.

Power in the doctor-patient relationship

Power is present in all social relationships and is inherently neither good nor evil but all power can be misused[11]. It can originate from three key sources; force, material resources and knowledge. Against this background, there are different models relating to the power balance between doctor and patient. At one end of the spectrum, is **paternalism** in which the doctor makes decisions without patient input and **doctor-as-agent** when decisions are made based on the *perceived* preferences of the patient. At the other extreme, is **the informed-decision-making** model, in which the doctor simply offers information and the patient makes all the decisions. There are various grades of sharing power between these two extremes. Yet simply by having greater knowledge or experience, the balance of power clearly tends to favour the doctor. Some have argued that this power might be necessary in order to be an effective advocate.

The knowledge gradient between doctor and patient, can easily be exploited by an unscrupulous, insensitive, pompous or arrogant doctor using jargon, acronyms and obfuscation. Such a power relationship may be encouraged by seating arrangements, heights of chairs, and other environmental tricks. For example, excessive use of letters after one's name, an ego wall of certificates and photographs, a large wide desk or excessively smart clothing. It is not uncommon to hear people labouring the word "Doctor" to emphasise this knowledge gradient. Goodyear-Smith & Buetow have considered[11] how power might be misused by both Doctor and Patient. This table, taken from their paper, makes clear how power can be abused.

Table 2. Examples of the misuse of power in the doctor / patient relationship

Type of power	Misuse by doctor	Misuse by patient
Social authority	'Playing God', e.g. using selective euthanasia or abortion to create an improved human population.	Using high social standing to obtain unfair access to medical resources, e.g. jump waiting-list queue.
Material resources	Making decisions about investigative or management resources influenced by own monetary gain.	• Failing to pay for services received (excluding cases of genuine poverty); • Engaging in unscrupulous lawsuits against doctors for the primary motive of making money.
Information & knowledge	• Withholding medical information from patient to maintain position of superiority; • Continuing treatment when doctor's knowledge & skills are inadequate; • Controlling or punishing patient because patient is not following advice or is disliked; • Making decisions not in patient's best interest because based on doctor's own beliefs & values.	• Withholding information e.g. denying or minimising alcohol or tobacco use; • Providing the doctor with misinformation, e.g. falsely claiming compliance with doctor's treatment; • Consciousley or unconsciously manipulation doctor to initiate examinations, investigations or treatments which the doctor may on reflection regret; • Sabotaging doctor's attempts at diagnosis & treatment.

Some imbalance of power seems inevitable, but both doctors and patients have rights and responsibilities. But behaving respectfully as a doctor is the least one can do to approach a sensible balance.

Ending a consultation

We all know how difficult it can be to end a conversation with someone, especially if there are time constraints. In a busy clinic, it is a common problem. How to keep the clinic moving without making the patient feel that they have been rushed, ignored or neglected. In a study in primary care, White et al[12] observed that the doctor initiated the closing of an interview in 86% of visits, clarified the care plan in 75% of visits, but only asked if the patients had any more questions in a quarter of cases. Even so, 21% of patients raised **new** problems during this process of closure, emphasising the need to pay attention throughout the period of contact with the patient. Not only does anyone hate to be rushed but rushing appears to bring with it a 1:5 chance of missing something potentially important, at least to the patient. It pays to ensure that each party is confident that everything has been both covered and understood.

There is a huge and important skill in making people feel they have been given enough time. I have been privileged both to work with, and to see as a patient, some doctors who seem to be able to make the 10 minutes allotted to me seem like 30 minutes of full concentration. They focus, smile, question and engage and by their body language pull you into a conversation. It feels like a conversation and not a consultation. They somehow give the impression of never being rushed, and always being there for you. It is a form of charisma I think, and a precious talent to possess. I would love to tell you their names!

Treatment and Outcomes

Doctors *treat* patients. Balint in 1955 wrote[13] that what mattered was not just the medicine or the pills, but;

"*the way the doctor gave them to the patient – in fact the whole atmosphere in which the drug was given".*

In the 1990's, this concept became more formalised in the concept of the *placebo effect*[14].

I once did a spell as locum GP for a single-handed GP in Wallsend. It was like Dr Finlay's casebook for those old enough to remember, complete with a housekeeper like Janet and a daily hearty lunch. The doctor kept no or minimal records. Patients came in and asked for a repeat prescription of the blue, green or red medicine. I finally phoned the local pharmacy and asked what they were. They were coloured sugar solution. Placebos. But his patients were happy and not complaining. As far as they were concerned, the placebo was their medicine and it was doing its job.

A good bedside manner clearly improves patient satisfaction and the quality of the relationship between doctor and patient, but does it also help clinical outcomes? It might be rather surprising if it did. In fact, it has been demonstrated that **some** clinical outcomes can be improved by an empathetic approach, for example in the quality of blood sugar control in diabetes[15] and in terms of the rate of recovery from the common cold[16]. In 2014, Kelley and colleagues[17] reviewed 13 randomised studies which had looked at the effect of modifying the doctor-patient relationship (by training the doctor in empathy, communication skills etc.) on various clinical outcomes. They concluded that the relationship had a small but statistically significant on healthcare outcomes (such as pain, weight loss, blood pressure, depression scores and quality of life), but that because the available number of trials to review was small, more research was needed. A good doctor-patient relationship was not the primary treatment for the patients' condition in any of the studies but could clearly modify the effect of that treatment. No attempts were made to modify the patients side of the relationship.

Di Blasi et al [18] reviewed a group of trials designed to see if the doctor-patient relationship itself influenced outcome. None of the trials was particularly well designed and there was much inconsistency in reported effects, but a consistent finding was that physicians who adopted a warm, friendly and reassuring manner are more effective than those who keep consultations formal and do not offer reassurance. Di Blasi and her team summarize[18] the influences on the doctor-patient relationship in this diagram;

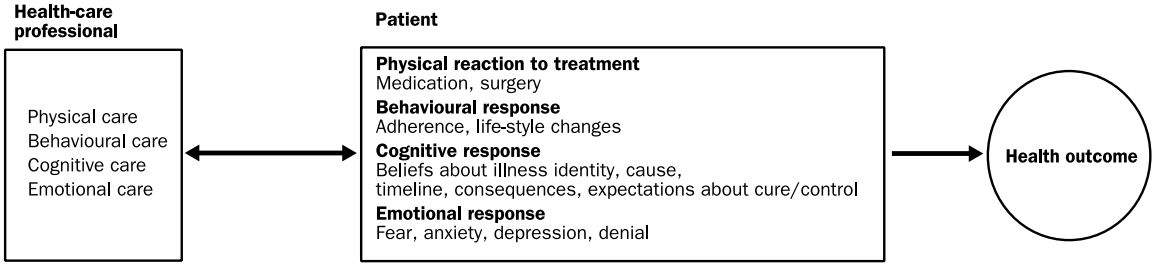

Figure 2: **Healing and the biopsychosocial consultation**

Can you teach a good bedside manner?

I think I have demonstrated that a good bedside manner has clear advantages, even in our pressurised world. Perhaps even more so. If that is the case, and if, as it seems, there are many doctors and nurse out there who either lack or have lost the skill, we should ask how we can teach the medical and nursing students of today and the recidivists of the past how to acquire a good bedside manner.

Indeed, might it not be better to simply to select people with empathetic skills for entry into medical training? It is so hard to get into medical school these days. The bar is set high, and it is not uncommon to see students with 4 A* at A-level. But do 4 A* make you an empathetic person? Do they give you good people skills?

Sadly, there appears to be no effective screening test for empathy which can be applied to clinicians. A systematic review of 1147 relevant citations was performed in 2007 by the department of public health and epidemiology in Birmingham[19]. Only 3 involved only medical school applicants. No empathy measures were found with sufficient predictive validity to use as selection measures.

Fortunately, most students do start off with good intentions and with a natural dose of empathy, but sadly this vicarious empathy gradually decreases during medical education and it decreases most in men and those entering non-core specialities (just like me).

Women who entered core disciplines (medicine, general practice, paediatrics, obstetrics and gynaecology, psychiatry) maintained their empathy but if they went into non-core specialties (surgery, pathology, radiology) they did not[20]. It has been suggested that students are attracted to role models who are authoritative, skilled and effective (Dr House is a good example. Investigative skill but grumpy bedside manner). Or that they get 'compassion fatigue', anxious that the more the feel the patients pain, the less they will be able to bear it and the less the will be able to do their job. Clearly there is a need for training.

Medical schools throughout the world have developed courses which attempt to teach listening and communication skills. These can be taught using real patients or more commonly now with actors playing roles of patients in various emotional states. Video allows the students to observe their own behaviour and the teachers can help improve it. In London, there is an outstanding group called "Performing Medicine" (http://performingmedicine.com) whose members have been helping train medical students at St Bartholomew's and the London Hospitals, Guy's and St. Thomas' Hospitals and at King's College. I spoke to Carly Annable-Coop from the group. She said that both students and medics were faced with huge pressures in their 'hardcore' jobs. The workload, competitiveness, and the distressing things they have to see and do can leave them scarred, and they can get 'compassion fatigue'. By using methods developed from the performing arts, the group has found ways of 'putting the humane back into them'. Even students who see such aspects of their work as unnecessary 'soft skills', compared with the hard skills of science or surgery, come round with practice to realise the benefits of good listening and communication skills. Life gets better for their patients and for them.

Carly also pointed out (as did West[4]) that the continued pressure of medical work can impact negatively on the well-being of the health care worker themselves. The Performing Medicine team have developed (with colleagues at Guy's and St Thomas' NHS Foundation Trust) a model which shows that it is important to look after your own well-being as a healthcare worker. They called this model 'The Circle of Care' and you can see a short animation of its principles here http://performingmedicine.com/project/circle-of-care/ .

A series of papers from different sites have revealed that students who have undergone such training demonstrate significantly more effective communication skills. Their questions become less leading and more open-ended. They refrain from interrupting and are better at summarising information for patients. They are more astute in following patient's leads in conversation. And it has been shown that these skills are maintained, at least for a full year after training. Web-based tools are also effective.

These learnt skills are tools. Learning continues throughout life, and there is an element of trial and error in gradually getting right one's interactions with patients. The core skills can be re-learnt and reinforced throughout ones working life, and institutions which provide such teaching and those who subject themselves to it will continue demonstrate respect and compassion for the patients they treat.

Good manners

When I was preparing this lecture, my wife pointed out that much of what is described as a good bedside manner is actually little more than simple **good manners.** She was clearly on to something! Michael Kahn writing in the New England Journal of Medicine in 2008[21] recalled how many of his patients had been heard complaining about doctors 'just staring at the computer screen' or who 'never smiled' or 'I had no idea who I was talking to'. He then describes his own hospitalisation and his reaction to an individual doctor.

"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. What- ever 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."

How like Hippocrates! Kahn formed the view that medical education should pay more attention to this aspect of the doctor-patient relationship and coined the term **etiquette-based medicine** to describe it. Etiquette-based medicine would prioritise behaviour over feeling; practice and mastery over character development. It would put professionalism and patient satisfaction at the centre of the clinical encounter. He even proposed a clear, efficient and easy to teach checklist to support its implementation in a hospital;

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

Compassion is essential to be a caring doctor or nurse, but Kahn and my wife are completely right. Good behaviour, professionalism and mastery of skills can have immediate benefits.

Concluding Remarks

Medicine, for all of those working in it, is a profession devoted to the care of people. There is, in my view, no excuse for treating those people without compassion or respect. However technologically advanced we become, there is a need for a relationship between care provider and care receiver at multiple levels. Every time a patient meets a receptionist, a nurse, a radiographer, a physiotherapist, a psychologist or a doctor the success of that relationship is at the heart of one's satisfaction as a patient. A good bedside manner is needed not just from doctors, but from all the people involved in care. It is uniformly beneficial. When a bedside manner is missing, compassion is the next thing to be lost and as we have seen in Mid-Staffordshire and in countless care homes, cruelty is not far behind, and trust is lost. Trust is crucial to the relationship-between clinician and patient.

Maintaining a good bedside manner in the current pressurised NHS may be challenging, but not to do so is inexcusable. You could reasonably argue that is precisely the time we need it most. Health care professionals are the servants of the public who are our customers and clients as well as patients. They have to be satisfied with the service they receive.

Those who have a responsibility to fund the service and to fund medical education must recognise the importance to patients of a good bedside manner and provide enough resources to ensure that both initial training is adequate and that in-service training by simulation, role-play and video monitoring are supported. It is obvious to all that financial pressures, rising demand, staff shortages, time constraints and increased bureaucracy will challenge any relationship between patient and professional. But all in the system must recognise the core importance of a good bedside manner, leading to better relationships. It encompasses the primary values of healthcare, it reflects the altruism which led most of us to enter the profession, and it leads to both patient and job satisfaction.

Compassionate care **can** be taught and **must** be sustained. The consequences of its loss are unacceptable in both human and economic terms. It makes no sense to undervalue it. Leaders at every level in health care must recognise this and act as role models for those they supervise. Healthcare workers who show no compassion should be identified and retrained. As Carly Annable-Coop so pithily said, 'We need to put the humane back into them".

If healthcare workers prove not to be re-trainable, they are almost certainly in the wrong job. Leaders must listen to patient complaints and act on them. Patients are incredibly tolerant of bad behaviour because they are vulnerable and at the mercy of the system. They complain late. And if we do not respond, it may itself be too late to modify the behaviour of those whose compassion has failed or is missing.

A good bedside manner DOES matter.

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