Editor's Note

What Makes a Good Doctor?

Key words: good doctor, characteristics, doctor and patient

Introduction

One year ago, I was asked to address medical students in Shanghai, PRC. I was assigned the topic, “What Makes a Good Doctor?” What follows are some thoughts I have on the subject.

In the United States and, I suspect, in all parts of the world, good doctors are individuals who, in addition to training in areas of interest, for example, family practice, internal medicine, or a subspecialty area, have participated actively in educational programs that make them eligible to take examinations in their areas of training (if they are available) and pass them. All physicians generally like to have some procedural skills, but the most important of their skills relate to cognitive knowledge that, in the long term, insures optimal patient care.

How Is Competency Measured?

In the United States we have examinations that certify physicians as competent to practice in their areas of interest. The certifying examination in internal medicine is known as the American Board of Internal Medicine, and there are several subspecialty boards, such as cardiovascular, endocrine, infectious disease boards, and so forth. Of course, passing one of these board examinations does not guarantee that the physician is a good doctor, but it is a metric by which many physicians are judged.

What Else Constitutes a Good Doctor?

In addition to good training and passing an examination, a good doctor should have the following characteristics. I will simply list them as bullet points:

- A good doctor understands the pathogenesis and pathophysiology of disease and uses that understanding to solve clinical problems. Thus, if one understands the basis for the disease, the treatment becomes much easier.

- A good doctor maintains a solid foundation of medical knowledge by reading the literature on a regular basis, capturing the rapid changes in medicine that have occurred over the last 30–40 years. It is essential to keep up with these rapid changes in order to maintain status as a good doctor.
- A good doctor obtains all possible information from all sources, not just from the patient. However, although the best source of information is usually the patient, important information is oftentimes gleaned from the patient’s family as well as previous hospital records, and so forth.
- A good doctor questions casual historical points. For example, many patients or their families mention a heart attack in the past. Sometimes there is confusion about this, since “heart attack” does not necessarily mean myocardial infarction to the patient or the relatives. Thus, it is quite important to have documentation of a previous electrocardiogram or information from a physician who has cared for the patient in the past.
- A good doctor maintains good clinical skills, that is, the ability to talk with patients, perform physical examinations, and understand the significance of simple laboratory tests.
- A good doctor performs specific tests to achieve specific goals. The typical example in my specialty, that is, cardiovascular medicine, is a patient with chest pain. Obviously, one of the first tests to perform after the history and physical exam is the electrocardiogram, which will allow the doctor to see whether there are any changes such as ST-segment shifts, arrhythmias, conduction abnormalities, heart block, and so forth.
- A good doctor searches at all times for new clues. If the diagnosis has not been made or if the differential diagnosis has not been narrowed down to one or two problems, one needs to continue to look for other pieces of information, not only information that corroborates the initial diagnosis. For example, patients with angina pectoris can have other problems such as hypertension, diabetes, or vascular disease elsewhere—carotid artery stenosis, for example.
- A good doctor searches for secondary medical problems even if there is an obvious cause of the patient’s illness. This statement expands on the previous statement. Anyone who has taken care of patients with coronary artery disease, for example, knows that many have renal disease as well, and this needs to be evaluated since it is a risk factor for a poor outcome in patients with coronary artery disease.

- A good doctor pays attention to details. If a patient or a patient's family tells you something that may not necessarily be related to the patient's presenting complaint, save that information for later consideration, even if it does not immediately seem pertinent. It may be pertinent to the illness, particularly if the patient does not respond quickly and classically to treatment for what you consider the primary diagnosis. An example of this would be a patient who has an acute illness such as heart failure or acute coronary syndrome who is anemic. The anemia may, of course, precipitate the acute coronary syndrome, but it may be due to something entirely unrelated to vascular disease. Make sure that the patient does not have a treatable cause of that anemia, for example, iron deficiency, bleeding, leukemia, pernicious anemia, and so forth.
- A good doctor pays attention to the entire clinical presentation rather than just focusing on the single details taken out of context. Physical findings and clinical presentation need to be assessed in the same way that we assess an abnormal laboratory test. As in the previous example, anemia is an indication that something is wrong, but it does not have a single diagnosis. Depending on the patient, it could be hemoglobinopathy, gastrointestinal bleeding, pernicious anemia, a blood dyscrasia, and so forth.
- A good doctor reevaluates the initial clinical impression of the patient's problem and if not satisfied with the initial diagnostic tests, should repeat them before initiating treatment. As anyone knows who has taken care of seriously ill patients in hospital or in the outpatient clinic, for that matter, any laboratory test can be a false positive. If the clinical situation does not seem to be consistent with any single abnormal laboratory test or physical finding, then that laboratory test and physical finding should be reassessed. A typical example would be the patient who has white cells in the urine yet has absolutely no symptom relating to urinary tract infection.
- A good doctor consults with other doctors if there is doubt about diagnosis or treatment. This is simply good practice and common sense and, in my view, establishes an excellent relationship with the patient and the patient's relatives since it indicates that you, as the patient's doctor, are making every effort to come up with the correct diagnosis and therapy.
- A good doctor monitors treatment to make sure it remains appropriate and does not trigger new problems in the short term. A typical example of this would be the treatment of an infection such as a pneumonia in a patient who is responding slowly to therapy, who then develops a rash. In this circumstance, a good doctor will consider drug allergy and inappropriate selection of antibiotics.
- A good doctor integrates medical facts and data obtained from the history, physical exam and laboratory tests. In my specialty of cardiology, Dr. Proctor Harvey of Georgetown University has always advocated the five finger approach to diagnosis, which includes: (A) history, (B) physical exam, (C) chest x-ray, (D) electrocardiogram, and (E) other tests. In the area of cardiology, these other tests would include echocardiography, nuclear studies, coronary angiography, or other imaging tests, as well.
- A good doctor records in the clinical record in a clear and accurate manner. It has been my experience, working with medical students, housestaff, and trainees in subspecialty areas, that the good doctor does not write page after page of information when a simple paragraph of several sentences will get to the point and clearly illustrate what is going on with the patient. In other words, length is not the gauge of a clear and accurate record.
- A good doctor is an educator, both to the patient and the patient's family. If patients understand what is going on, and families understand what is wrong with the patient, it will be much easier to deal with complicated therapy and management strategies.
- A good doctor understands potential benefits of therapy as well as the potential risks, complications, and unwanted effects of therapy. This means that the good doctor must be able to explain to the patient and the patient's relatives, the benefits of the proposed therapy that outweigh the risks, complications, or unwanted effects of that particular therapy, and convince the patient that the doctor's recommendation is in the patient's best interest.
- A good doctor, before discussing tests or treatment with a patient, is aware of exactly what these entail and can answer questions fully. If the patient asks the physician a question that the physician cannot answer, it should never be brushed aside. Tell the patient you do not know, but you will find out. Then, make sure you get back to the patient with the answer as soon as possible.
- A good doctor, when discussing prognosis with patients and family should be gentle and optimistic while also being realistic. Remember that data from clinical trials are rough guidelines for treatment and prognosis, and they should never be used to predict the course of disease or recuperation in the individual patient.
- A good doctor, in taking a history, lets the patient relate what is going on. The good doctor obviously must direct the conversation, but it is important to be subtle and as polite as possible. Never interrupt a patient who is talking about something he or she feels is important. However, when repetition occurs, I have always thought it appropriate to say, "Let's go back to that other point, because I was unclear about that." You can then shift the discussion in a direction that is more helpful for diagnosis.
- A good doctor knows whether the treatment plan is curative or palliative. For example, in my specialty the closure of an atrial septal defect is curative, but replacement of an aortic valve is not. It is a palliative procedure. Patients need to understand this, and they need to know that they will probably have to take anticoagulants for the rest of their lives, and antibiotics on occasions to prevent infective endocarditis.
- A good doctor does not frighten the patient by relating everything there is to know about the particular problem, unless specifically asked. A good physician remembers

that there is a bell-shaped curve with practically every disease process; there are mild cases and severe cases, with the majority, of course, in the middle. Prognoses may not be similar—prognosis will be good in some instances, and very poor in others.

- A good doctor talks with, and not at, the patient. I have made it a practice, particularly with patients whom I have met for the first time or who are having a complicated course, to sit down at the bedside. This tells patients, as you are looking into their eyes, that you are concerned about them and you are responding to those concerns. If you do this, you would be amazed how often patients think that you have spent a lot of time with them, even though it may have only been a few moments on rounds in the morning.
- A good doctor, when telling the patient about several options of therapy, does not ask which one the patient wants. The good doctor recommends to the patient what therapy the doctor thinks is appropriate. The good doctor then respects the patient's decision to accept or reject the recommendation.

- Finally, a good doctor is not afraid to change a diagnosis if facts learned later in the evaluation are not consistent with the initial impression. The worst kinds of physicians are those who make a diagnosis based on an isolated piece of data and then spend a great deal of time and money trying to prove themselves right. To be the greatest help to your patients, you must first be honest with yourself. The best physician in the world is the one who is willing to say, "This case is beyond me, and I need help. I'm going to consult with or refer this patient to another physician."

No matter what field of medicine you ultimately choose, you are in training for a discipline that has become so complex that no one can know it all. Good doctors work in concert with one another. Watch your teachers closely, not only for the "answers" to questions, but the way they relate to their patients and the way their patients respond. Get into the habit of searching openly for what you need to know. We learn by study, certainly, but also by asking.

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