March 2021

Reflections on the Doctor-Patient Relationship

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With COVID on the rampage and being "locked-down" at home, I've had countless hours to think and reflect on all kinds of strange and wondrous things. One of the things my mental meanderings got me to reflect upon, was the nature of the doctor-patient relationship (notice I didn't write "healthcare provider-client relationship"). As I age and develop more medical conditions myself, this relationship acquires a new dimension, one that takes me from practitioner to patient -- therefore, becoming ever more important to my sense of well-being. As a result of my imaginative (and imaginary) wandering, I've come up with some not-very-earthshaking ideas.

First and foremost, I feel that the actual doctor-patient interaction is the core and crux of any medical visit. It is this relationship that forms the core of a therapeutic relationship that extends beyond "pushing pills," and giving injections. While the love and support of a person's family is phenomenally important, the one-on-one relationship between doctor and patient ofttimes is the crucial relationship in healing.

I'm still naive and knight-errant enough to believe that there is a personal mystical bond between doctor and patient that carries its own therapeutic touch. This is a bond that extends back into the mists of time when physicians were shaman-healers waving rattles and bones while communing with spirit guides as their treatment regimen.

Over the millennia that relationship between healer and patient evolved toward our modern world, in terms of both technological advances and the changing physician-patient relationship. In a case of PhotoShopped history, the “Golden Age” when physicians possessed both phenomenal technology at their fingertips and almost complete autonomy on how they ran their practices was probably the 1980's. Since then, while there’s certainly been an explosion in technology in the past 40 years -- new imaging technologies, whole new classes of therapeutic drugs and treatments among other changes -- the physician-patient relationship has also been irrevocably altered to the point where healers have now become healthcare providers and patients have become clients. This is so wrong on so many levels.

An interaction with a patient is a ritual, and it is this ritual that is part of the healing process. Multiple studies have shown that patients derive more satisfaction from their visit and have better outcomes when the doctor actually lays hands on them.[1,2] Obtaining a history and talking *with* the patient is part of this same ritual. Patients feel that physicians are really listening to their concerns when the physicians shove the computer monitor aside and look them in the face. The way it’s set up now is that the computer robs us of this interaction, and the ritual gets short-circuited. Not only are we missing part of their story, we’re also missing an opportunity to indulge in a bit of healing and treating. Most of what we do doesn’t require extensive searches of data bases or googling the latest treatments, or even “thumbing” through a million old lab, radiology or consultants’ reports. But we must engage in human to human rituals with every patient visit and ZOOM encounter, and this provides the basis for healing to occur.

A good part of the ritual also includes narrative. “Humans are story telling animals, and they rely on narrative to make sense of the world.” I originally used that phrase when mentoring

medical students or nurse practitioner students on their History & Physicals. Only more recently, as I thought about it, did I realize that this is how we actually teach and educate our patients. We tell them stories. The stories may be improvisational in nature, but stereotypical in structure. Whether we're trying to teach them about their diabetes or deal with that nasty case of flu we tell them a story: a narrative that has a beginning, a middle and an end–where your disease came from, what it's doing now, and where it's going. That's how I've always attempted to communicate to patients. If anything, the COVID epidemic has made that kind of story-telling all the more important, as we have to convince many patients to socially distance, wear masks and get vaccinated, despite their reticence, the volume of mis-information in cyberspace and their fear of government conspiracies.

When we're spinning our yarns to our patients, like all good story tellers, we need time. Time to engage our audience, especially since many, if not most, of the questions and patient conditions have no right answers. We're trying to put together the best evidence for their treatment, framing it in narrative form, so the patient can process the information. We need Time for "audience" participation as the patients help guide the narrative, so it has meaning for them and their lives. This is, after all, the only reason we're sitting there.

Practicing medicine is an educative process. Physicians constantly engage their patients in the give and take that characterize the best classroom settings. The word "doctor" is derived from the Classical Latin *docere: "to show, to teach or to cause to know."* We are teachers as much as we are healers, and one of the primary functions of the medical visit, even if it is via ZOOM, is teaching patients about their health.

However, people can only learn at their own maximal rate, and, for most of us, that rate doesn't fit into the framework of the scheduled fifteen minute visit. What makes this worse is that although most office visits are scheduled for fifteen minutes, numerous studies show that the average office visit actually lasts only seven minutes.[3,4] This is a situation that was forced on physicians by publicly traded HMOs, when they began restricting the doctors in their employ to an average seven-minute "encounter" with each customer. This apparently kept shareholders happy. Since then the time restriction has spread to almost all employed physicians.[5]

In medicine, each patient is an individual that requires individual, "customized" care. This holds true whether we're treating a strep throat, or trying to convince someone why it's important that they take their blood pressure pills regularly.

If we want good medicine, we must value the human element of patient care, and that especially extends to medical education.

I worry because today's medical students and residents are very much into bite-sized information, the Twitter feed level of discourse. When I mentor younger physicians, and I ask for case presentations they just give me a bare bones synopsis of the issue. I spend countless minutes prying out the full story from the young physician. They are under such time constraints that they have to "cut to the chase" in their patient encounters. Young primary care doctors are relegated to assembly line clinics; their patients pass through as widgets, not as individuals with complex inner lives, wrought family structures, varied spiritual and cultural beliefs — not to mention their individual capacities to understand and deal with their medical symptoms, diagnoses, multiple medications, and their own hopes and fears.

Today's young physicians are not used to narratives and stories. But, they are conscious that they don't have the skills of our generation, and they want them.[6] When students come to me, their first request when I ask them what they expect to get from their experience with me is that they wish to learn more about engaging in dialog with patients. We have an obligation to impart those skills to them. When I mentor students or residents, that's exactly what I do, I focus on narrative and its importance.

A vital accompaniment of narrative is the actual "laying on of hands;" actually, touching a patient with hands and stethoscope. This is truly where therapeutic touch comes into play. Danielle Ofri, MD. writes:

"Countless times, I have found that it is only during the physical exam that patients reveal what is truly on their mind. Whether it is the cough that they are reminded of now that I am listening to their lungs, or whether it is the domestic violence, the eating disorder or the genital symptoms that they feel comfortable revealing once we are in a more intimate setting — there is something about touch that changes the dynamic.

"So while the utility of the physical exam for diagnosing illness may not be quite as refined as it once was (though certainly still quite useful), it has become a tool of a different sort, a refuge from the intrusion of technology, a moment of only touching and talking. In the medical world — as in the world at large — there are precious few moments left of just touching and talking. As a diagnostic and therapeutic tool, it is irreplaceable."[7]

Narrative and physical exam are the concrete manifestations of the mystical bond between doctor and patient. They constitute the absolute core of what medicine is all about. It is via narrative and physical exam that patients begin to heal, irrespective of their diagnoses.

This relationship is independent of technology. While the technology explosion has vastly increased our reach, it comes at a human cost. Unfortunately, for each new piece of technology

we use, our actual contact with patients becomes more distant, rushed and impersonal. Our ability to cure people has mushroomed, yet they become ever more disaffected and "dis-eased;" we seemingly cannot actually *heal* many people.

By healing, I mean that physicians provide a platform and venue that promotes the ability to achieve an integration of patients' health with their environment, thus allowing them to achieve their full potential. This is more than putting yet one more stent into someone's artery or berating them because they refuse to quit smoking. Healing means creating an environment that allows us to act with compassion and understanding irrespective of someone's basic disease or economic status. A healing environment is one where people can function to their maximal capacity within the constraints of their overall health status. Healing requires relationships—relationships which lead to trust, hope, and a sense of being known.

Our current healthcare environment doesn't deliver relationships. And this is where it fails. Our healthcare system doesn't deliver healing. It delivers services, which can never take the place of relationships. Our job and our goal is to marry the personal touch and relationships of healing with the rapidly escalating amount of technology at our disposal.

When all the new technology is used appropriately, and physicians have a suitable amount of time to open a dialog and create a relationship, then the partnership between patient and physician is strengthened, and everybody wins.

Unfortunately, both narrative and physical exam take time – the one thing that the new healthcare provider-client relationship makes no allowances for. In the context of the "new" paradigm, these time-consuming interactions just aren't cost-effective. The financial interests that control the system have decided that implementing technology is more cost effective than the

human interactions involved in medical care, and everybody loses. They conflict with one patient every ten minutes and the income generated. The artisan physician-healer is slowly ground into a lowly, faceless cog in a gigantic money collecting scheme.

I see Medicine's evolution away from that ancient shamanistic paradigm toward a two-dimensional commercial interaction between healthcare provider and client as a bad thing. It removes an important weapon in a physician's armamentarium; one with no adverse side effects nor potential drug interactions. Talk about the perfect risk:benefit ratio. The benefit may be small or large or none-at-all, but since the risk is exactly zero, therapeutic touch should be one more arrow in the healer's quiver.

I fear that healthcare policy experts are making a huge mistake. In an effort "to ease the burden" on physicians, they're pushing "team care," electronic resources and standardization. Not only do these actions predispose toward "moral injury" and burn-out to physicians, they also demean and dehumanize both physician and patient in the "one size fits all" mentality of today's medical care climate.

While standardization and increased reliance on electronic resources may make for improved "productivity," they don't make for good healing.

References

1. Jerald Winakur, "In America, the art of doctoring is dying" *The Washington Post* February 12, 2016

2. Talal Asif, Amena Mohiuddin, Badar Hasan and Rebecca Pauly "Importance Of Thorough Physical Examination: A Lost Art" *Cureus* May 2017, 9(5): e1212. (National Library of Medicine)

3. Peter Salgo "The Doctor Will See You for Exactly Seven Minutes" *The New York Times* March 22, 2006

4. Charles W. Smith "Never Enough Time for Patient Care — What Can We Do?" *Journal of Participatory Medicine* March 7, 2012

http://www.jopm.org/opinion/editorials/2012/03/07/never-enough-time-for-patient-care-what-can-we-do/

5. Salgo op cit

6. John M. Mandrola, MD; Abraham Verghese, MD "Abraham Verghese: Hope for Hands on Medicine in the EMR Era" *Medscape* April 6, 2015 www.medscape.com/viewarticle/842296_print

7. Danielle Ofri, M.D. "The Physical Exam as Refuge" *The New York Times* July 10, 2014