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## MEDICAL NARRATIVE

### The Changing Patient-Physician Relationship

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There is a general perception that the practice of medicine has evolved in a linear way. In my view the progression is quite nonlinear and involves quantum leaps. Periodically, there are major shifts in the standards of practice, and when entering a new paradigm we are met with new rules. In this article, I will briefly outline the continual dynamic evolution of medical practice over the last forty to fifty years, drawing anecdotally from my personal experience as a physician.

#### Yesterday

In 1960, *Life Magazine* published a photograph of a rural doctor, taken after he had performed a two-hour emergency surgery, that depicted the strain and sleep deprivation that was common in most medical specialties at the time [1]. So why did so many pursue this pathway? I believe there was a shared perception that this total commitment to practice-as-life was what being a doctor meant.

My own career began in 1977 as the director of the emergency department in a small ER in a 100-bed hospital. Because we were a rural hospital and most of the contracting physicians did not live locally, it was the policy to have 48-hour shifts in order to make the commute economical. It was assumed that you would get a few hours of sleep during a shift, but there were many nights that were pretty much nonstop work. No one considered this particularly unusual. My routine was to eat very little and to drink coffee for 48 hours straight. After 36 hours on duty, I realized, my cognitive function was not optimal, and I would have the nurses double-check my prescriptions for dosage errors.

In 1980, I opened a private solo practice in a retirement community 15 miles from the local hospital. I was extremely busy right from the start, with a typical patient load of 35 to 50 patients a day and a hospital census of about 3 to 5 patients. Office hours were from 8:30 a.m. to 6 p.m., and our policy was that, if you were sick today, you were seen today, which meant that I usually did not get out of the office until 7 or 7:30 p.m. Hospital rounds were at 7 a.m. and 8 p.m. At first the office was open Monday through Friday, but soon office hours were extended to Saturday mornings and, finally, a full day on Saturday. Every other Sunday I would go and see six to eight nursing home patients. I was always on call at the ER for admission of my patients.

During these early days in my career, I had wonderful relationships with my patients. There was a high level of appreciation and true friendship between us. However, as group practices enlarged and the use of referrals for specialists increased, physician-patient exposure decreased—visits became shorter, and the patient was exposed to different physicians and nurse practitioners.

### **Today**

As a recent inpatient, I was unable to recognize the inpatient care process I knew as a physician attending to hospitalized patients. I was referred to the ER for my acute condition and to hospitalists for admissions and hospital care. The physician has become even more remote from his or her patients with the proliferation of answering services, making the insulating wall between them almost complete. I don't think that many patients today have any ability to contact their physicians directly.

Patients may be more distant from their doctors, but they have more access than ever to medical information. They are far more sophisticated about their pathology and the available treatments, and they have a desire to participate in treatment decisions.

On the "business" side, the physician no longer appears to have any significant control over his or her practice. The physician has become more like a contract worker with no influence on office management or policies. And since the patients belong to the practice and not to the individual physician, the physician is in a weak position in negotiations with management. Sometimes the only recourse is to leave and look for a new contract position.

### **Tomorrow**

It is my belief that the practice of medicine will take another leap in the next decade. We are not only experiencing exponential growth in our understanding of medicine and the tools at hand, but also witnessing a complex system in motion. In a complex system whatever is reacted upon also produces changes that, in turn, alter the original system. As a trained chemist I dealt with "competitive consecutive reactions," which exhibit these same characteristics.

An interesting book on the type of changes we are likely to see is Ray Kurzweil's *The Singularity Is Near: When Humans Transcend Biology* [2]. He postulates that the progress of artificial intelligence is going to speed up to the point at which artificial intelligence surpasses human intelligence and humans transcend our biological limitations. An example of this progress is IBM's Watson (a giant artificial intelligence computer) examining the medical records of MD Anderson and the Cleveland Clinic to find optimal treatments for cancer and heart disease, respectively [3, 4]. This is a massive big data project.

The process of examining vast collections of big data and scientifically analyzing procedures and outcomes promises more evidence-supported treatments in the future. Big data will likely replace the subjectivity of “the art of medicine” with scientifically derived analysis, a trend that will likely lead to a more formulaic practice of medicine. And, as more structured protocols narrow the scope of treatment, we are likely to see a much increased use of ancillary people and technicians.

### Conclusion

Some might think that I am biased toward the old ways, but I am not. I am not nostalgic about man-killing hours, chronic sleep deprivation, and the limited tools (medicines and procedures) we had. It should have been obvious that a sleep-deprived physician is not going to function at full capacity. I do have good feelings about the past patient-physician relationship of the past, but I am not aware of any studies indicating it was better for patients. The economic realities of studying such complex interrelationships of factors make it prohibitively expensive and therefore unlikely to be undertaken.

I am sure that there are those who will disagree with me on some of the points of the future course of medical practice, and my rebuttal is that I don't believe their crystal ball is any better than mine. The only thing that I am positive about is that we are on the steep part of the exponential curve in a changing complex system. I believe we are going to see amazing progress and that the practice of medicine will be very rewarding and interesting, but very different from today. If you were able to walk with me on a typical practice day 35 years ago, most of it would appear very foreign. You may experience the same feeling about 10 years from now thinking back to today.

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