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The Rise and Fall of the Doctor-Patient Relationship

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ThomasRCole_HOM_Lecture
The Rise and Fall of the Doctor-Patient Relationship
January 4, 2012

DR: Welcome to our first lecture for 2012. As you all know, our History of Medicine Society is sponsored by three organizations: Baylor College of Medicine, University of Texas, and the library. Our speaker today is our coordinator for the University of Texas program and has spoken for us almost every year for the last three or four years. Dr. Tom Cole is Director of the McGovern Center for Humanities and Ethics at the University of Texas. Tom wrote a book that was nominated for the Pulitzer Prize back in '92 called *The Journey of Life: A Cultural History of Aging in America*. He also has co-authored a number of other books that have turned into movies. He has a degree in History, a degree in Philosophy, and a Ph.D. in History from the University of Rochester, so we're delighted to welcome him back. Today's topic: The History of the Doctor-Patient Relationship. Tom?

[Applause]

TC: **(01:35)** Thank you. Happy New Year. I'd like to spend some time today talking about the history of the doctor-patient relationship. This really will be taken from a chapter of a book I'm working on with Dr. Carlin, *An Introduction to Medical Humanities*. I'm responsible for the history sections, and this chapter I'm abstracting from my chapter on the doctor-patient relationship. It'll be more or less informal and I'd like to do an exercise at the end of it so that we have some interactive dimension to this. It'll be a little halting because I have to figure out how much material to leave in and how much to take out as we go, so forgive me for that.

So first, let's just think a little bit together about why we study history. Why does history matter? And I would just say a couple of things. The doctor-patient relationship or any other phenomenon does not exist in a vacuum. Our lives, human existence is framed by the contexts in which we live. If we want to know about something and fully understand it, we need to know where it came from, where it seems to be heading, what kind of interpretations there are of it, what kind of social structure it's involved in, what kind of conflicts of interpretation or political interest or economic interests shape it. All these things impinge on the history of the doctor-patient relationship.

Just for example, a few things to be thinking about when we're thinking about the history of the doctor-patient relationship: What's the social structure in which medicine exists? Is it a medieval society? Is it a contemporary, modern society? Is it an ancient society where you have slavery, you have warfare, you have patricians. Sometimes in the period of the Greek Republic, you have actually a class of free men participating in the poll lists. This is the situation in which the school of Hippocrates arose in the 5th century, so social structure matters. Medical knowledge matters. We don't live in the world anymore where people think that all medicine and the study of health and disease comes from the four humors. The four humors are the way Greeks and many physicians in times scientists thought about the fundamental nature of physiology and pathology well into the Middle Ages.

(04:38) What about the level of education? What about the level of technology? What about the dynamic between religion and medicine or the ethnic or racial or gender composition of both doctors and patients? These are just some of the reasons why studying history helps us understand fully aspects of the history of medicine or aspects of the doctor-patient relationship.

What I want to do today is debunk one of the myths in the history of medicine, and this is the myth of progress. We know more than we ever knew. Our technology is better than it ever was; all aspects of the doctor-patient relationship are improving. This is sometimes called a "wiggish" interpretation of history and there are some aspects of it that are true, but many aspects of it are misleading.

The history of the doctor-patient relationship is not a linear path to progress. It's a much more complex path, and what I want to do today is spend a little time talking about the rise and the fall of the modern doctor-patient relationship.

The modern doctor-patient relationship emerged at the end of the 19th century around the 1880s and it began to deteriorate rapidly in the 1970s. I'll explain what I mean by that in a while, but basically what I'm saying is that our ideal of the doctor-patient relationship where relationships are long-term, where it's primary care medicine, where it's personal, where there's trust, where there's continuity, that this ideal is a historical ideal of the doctor-patient relationship. It's not a universally true or desirable relationship and it had a beginning and a middle and it seems to be seriously in decline today, so I want to talk a little bit about that and then do an exercise with you to get at some of these issues.

(06:52) So let me just begin with the present, which is the situation in which I think the modern doctor-patient relationship is seriously compromised and under stress. In the last quarter of the 20th century, a chronic dissatisfaction emerged over relationships between doctors and patients. People were doing better but feeling worse. Medicine had dramatically reduced deaths from infectious disease and extended life for the masses. Surgeons and specialists in hospitals were saving people who would have died only a generation earlier, but clinical practice was increasingly impersonal, hurried, commercialized, and technological, especially in the third quarter of the 20th century. Patients felt skeptical about doctors' genuine concern for them as people and doctors were troubled by patients' lack of realism, lack of compliance, and patients who were increasingly challenging the authority of physicians. And so given what seemed to be these increasingly miraculous cures in the rapid pace of technological and scientific progress, patient expectations exceeded, really, what was often possible, and this contributed also to tension in the doctor-patient relationship.

So again, my point is that the modern doctor-patient relationship is in disarray, maybe in some ways passing out of existence. Most physician encounters today take place with specialists who work in hospitals or HMOs or corporations or group practices. These physicians are often hurried. The relationships are mediated by technology. They're paid for by third parties. They take place in impersonal hospitals, emergency rooms, clinics, and ironically, some of the advances such as evidence-based medicine or electronic medical records pose further challenges to what you might call the relational quality of medical care.

On the other hand, the countervailing side of that is the rise of bioethics, the rise of medical humanities, of narrative medicine, spirituality in medicine, patient-centered care, professionalism, and other humanistic movements that testify to the renewed awareness of the importance of ethics communication and the healing power of the doctor-patient relationship, so there are important countervailing forces to what I think is the growing decline of the modern doctor-patient relationship.

Am I making sense so far? This relationship that we imagine, that we're kind of nostalgic for, that we wish we had and in some cases still exists; I'm sure Dr. Rakek's patients have that kind of relationship with him, but I think he's a growing minority. I'm not sure if I'm right about that, but this relationship that we kind of long for, that we wish we had, it's a historical relationship. It's a norm and it arose at a period in time and it came to its height somewhere in the 1940s or '50s and it's in some ways seriously being challenged today.

So let me get a little bit more specific. What about the rise of the doctor-patient relationship? Before the time of the 1880s or 1890s—which is what I’m talking about as the beginning—the United States was overwhelmingly a rural country. In 1800, only 6 percent out of a population of 5,000,000 lived in communities of over 2,500. A sick person was ordinarily treated by a relative or a neighbor. In a case of serious illness, the person might consult a physician whose education was limited to that of an apprenticeship with the local practitioner. The local practitioner usually knew his patients and treated them in their homes.

Only a few hospitals existed in urban areas in 1800. The Pennsylvania Hospital in Philadelphia was founded in 1752; the New York Hospital in the 1790s; Boston’s Mass General in 1821, but for most of the 1800s, hospitals provided a statistically insignificant amount of medical care. The patients who were cared for there were drawn from what are called “the worthy poor.” These were widows, people who were victims of an accident or insanity or the working poor. These were people treated in the very few hospitals that we had.

(12:05) “The unworthy poor,” that is, people who were thought to be unworthy because of alcohol or some form of their own failings—whether it’s masturbation or dirtiness or the wrong ethnicity—these people were cared for in almshouses or poor houses; were more like really warehouses than treatment centers and it’s a little bit different than Europe, which, of course, having a longer history had hospitals earlier; Christian hospitals founded after the fall of the Roman Empire, say in the 5th century. Also, Islamic hospitals were founded then, and then the modern hospitals arose in France and in Britain to care for the poor, and they were really the first teaching hospitals, which is where we get the history of like our LBJ. Hospitals for the poor; also teaching hospitals, also places for research. So that’s a very, very brief sketch of doctor-patient relationships before what I’m talking about is the 1880s or the rise of the modern doctor-patient relationship.

By the 1880s, this relationship did begin to take shape. Patients were seen by physicians in their homes or doctors’ offices, and still, very few people before 1880 ever saw a physician compared to other healers—their folk medicine, quacks, herbal medicine, self-help—all kinds of medical care or self-help really prevailed over and against what we think of as physicians because there was so little university-based education for what we think of as genuine physicians today.

So before the 1880s, you'd only see a physician if a family member was dying or they had a grave symptom, such as coughing up blood or a bowel obstruction, a broken bone, or the disabling effects of trauma, but with rising income and the increasing availability of scientific medicine at the end of the 19th century, urban men and women who were white, middle-class, of course, began to have an increasingly sensitized to what's going on in their own bodies and they began to increasingly willingly consider themselves as patients and submit more aspects of their lives to the care and authority of physicians. Sometimes we talk about this as medicalization. Something that you never would have thought in the middle of the 19th century at a rural area to go to a physician for—a rash, a sore throat, a cough—suddenly becomes something that can be attended to by a physician and treated.

(15:38) If you're going to have a modern doctor-patient relationship, you have to have a modern patient and a modern doctor, right? Before, pre-modern patients and doctors were completely different, in many ways, than modern doctors and patients. In education, for example, in the 1880s, doctors were still trained mostly by apprenticeship. Among those who were educated, there were a handful of universities in the 1880s that gave out what we would think of as legitimate academic degrees and most people who wanted scientific training in the 19th century went to Europe. In the first half of the 19th century, they went to Paris where the French pioneered pathological anatomy, the tracing of lesions with postmortem examination.

In the second half of the 19th century, to get a good medical education, people went to Germany, which pioneered microscopy and the birth of bacteriology. In America, most people got their degrees from proprietary schools, which unfortunately are making a comeback in many areas. Proprietary schools where you paid your money, you took a course of maybe two years a little bit of apprenticeship, and your diploma was kind of cranked out as if it was a diploma mill. Most people had little more than a high school education, but by 1920, things had shifted around in a dramatic way, which is what I'm talking about in terms of the education of the modern physician. By 1920, the physician had earned a bachelor's degree from an accredited institution and then an M.D. after three additional years at an accredited medical school, so this is the fundamental change that took place during the period exemplified by the Flexner Report in 1910.

What we also see in this period after 1880 and increasingly after 1920 is that more and more people, as I said, were subjecting their different bodily symptoms to the care of physicians and the growing medical knowledge in the end of the 19th century with

bacteriology, x-rays, all kinds of new equipment, was making medicine much more scientific, but in an interesting way, it didn't really translate much into improved medical care because that led the way, really, to an invention of antibiotics in the 1940s and so.

(18:34) But still, the modern doctor-patient relationship did begin to emerge during this time period. Growing house calls were more and more common. In the middle of the night, if a family member was sick, a servant or a phone call would bring the doctor to the patient's home on horseback or a horse-drawn carriage or later in an automobile and relationships between doctors were gradually built up over many years. They were based in local communities. People knew each other and there was an increasing emphasis on a detailed physical examination.

So patients didn't really expect to be cured in this period, but they did expect to be cared for and comforted, and stories don't really have a lot of information about what happened except for anecdotes. This is a famous example of a doctor looking at a sick child, perhaps a dying child, exemplifying this connection; the sense of caring, the sense of observation, the sense of locality of relationship that typifies this modern doctor-patient relationship. Let me give you a couple of examples; sort of anecdotes from physicians about how this relationship might have worked.

The American physician Arthur Hertzler studied at Northwestern University and studied in Berlin, then came back to teach surgery at the University of Kansas, and towards the end of his career, he wrote a book called *Horse and Buggy Doctor*, and he relates one interesting instance of surgical heroism. He's driven three hours to attend to a boy suffering from empyema—pus in the lungs—and was close to death. He writes, "Grabbing a scalpel, I made an incision in his chest with one stab. He was too near death to require an anesthetic. As the knife penetrated his chest, a stream of pus the size of a finger spurted out, striking me under the chin and drenching me. After placing a drain in the opening, I wrapped a blanket around my pus-soaked body and spent another three hours reaching home."

So in a very striking admission a little later in the book that revealed the medical realities of the turn of the century, he writes, "I can scarcely think of a single disease that doctors actually cured during those years. All that could be done was to relieve suffering, set bones, sew up cuts, and open boils on small boys." But nevertheless, under these conditions, the quality of the doctor-patient relationship itself was understood to have the healing power. Still, in the midst of the healing power of this relationship, there's always

a tension between the self-interest of physicians and the interest of patients because doctors' livelihoods depended on the fees and doctors' income and standard of living did not dramatically grow until after the Second World War. So there's always this kind of tension and this led to a pressure that physicians felt to satisfy the needs of their patients, even if they seemed unrealistic.

This is how George Bernard Shaw put it in *The Doctor's Dilemma*: "The doctor who has to live by pleasing his patients in competition with everybody who has walked through the hospitals scraped through the examinations and bought a brass plate soon finds himself prescribing water to teetotalers and brandy or champagne jelly to drunkards, beefsteaks and stout in one house and uric acid-free vegetarian diet over the way." So sort of trying hard to meet the needs of different constituencies mostly in order to receive the income that they needed when they really didn't have anything standard to offer.

(22:50) In America, this is the advice that Daniel Cathell offered in 1882. He writes, "You will probably find the poor much easier to attend than the higher classes. Their ailments are more definite and uncomplicated, but the wealthy and the pampered, on the other hand, there's often such a concatenation of unrelated or chronic symptoms that it is difficult to judge which symptom is more important." And you all understand this. The higher up a person is on the socio-economic scale, the more needs they have, the more complicated and more used to being in control they are as opposed to people who are poor. You see this, for example, at LBJ. I constantly hear from medical students how grateful the patients from LBJ are—of course, they're poor—for the small things, the simple things that are done to help them.

So another pressure on the doctor-patient relationship that grew up at the end of the 19th century was this tension between the new biomedical science that allowed scientists to see microorganisms that had x-rays, new ways to measure blood pressure, EEG. All these increasingly new, sophisticated technologies made physicians really giddy with a sense of power, but ironically, they had the effect, often, of distancing physicians from their patients, and one of the first people to notice this was the great physician humanist Sir William Osler, who is often mentioned in the series and whose society Dr. Rakel has been very active in over the years and who Dr. Boutwell knows a lot about.

Osler was a professor of medicine at Johns Hopkins and he was one of the first people in the earlier 20th century to realize that the new scientific medicine of diagnostic precision was endangering the old medicine of care and compassion. He advised physicians to stay

away from the many useless drugs that they encountered and to stay focused on the patient as a person. He writes, “The good physician treats the disease, but the great physician treats the patient. It is much more important to know what sort of patient has the disease than to know what sort of disease the patient has.” So of course, this is a way of thinking that has become more and more common as a counterweight to technology and impersonal tendencies of contemporary medicine.

What began to happen to the doctor-patient relationship that increasingly began to pull it apart? One thing is specialization. More and more specialists grew up and then the practice of family doctors who knew patients on a consistent basis declined significantly, and by the third quarter of the 20th century, there was a new kind of edginess among patients towards physicians and this corresponded to the Civil Rights Movement, to feminism, to other—there was a lot of—this is sort of my generation of 20 and 30-year-olds suspicious of authority. This was during the Vietnam War. This was during the attacks on racism in the Civil Rights Era. Young people thought that authority was something to be suspicious of and this also transferred over into medicine. The most famous example of this is Ivan Illich’s book called *Medical Nemesis*. One of Illich’s emphases was on iatrogenic disease and the over-leaning power that physicians have.

(27:00) So patients began to suspect that many doctors were motivated by greed and that they did unnecessary tests, procedures, surgeries, and drug prescriptions, and we see this sort of more and more—this kind of suspicion—and we see some of the reality of it. The public’s faith in physicians was further shaken by many scandals that many of us are familiar with in the second half of the 20th century. In 1966, for example, Henry Beecher, the Harvard professor, wrote an article in *The New England Journal* documenting 22 instances in which harmful medical experimentation was carried out on individuals without their consent. Live cancer cells were injected into unknowing patients. Mentally defective children and soldiers were used as guinea pigs.

Beecher characterized these experiments as the result of thoughtlessness or carelessness rather than willful disregard of a patient’s rights, but they were often performed by senior academic physicians who assumed that their experiment’s potential benefits to the larger society justified trampling the rights of individuals and protection of the poor and vulnerable.

Americans at the time should have known about—but many did not know about—the experiments of the Nazi doctors and the Nuremberg Code that emerged at the time of the

Nuremberg trial in 1945 whose basic essential moral truth is that informed consent of the patient or subject is absolutely essential to a successful, morally adequate form of experimentation.

Probably the most famous or infamous research scandal of this period was carried out by the public health service, beginning in the 1930s when no treatment for syphilis was available. Investigators were studying the natural history of syphilis in a population of African-American men in Macon County, Alabama. After 1945 when penicillin was found to be an effective treatment for syphilis, the new drug was never given to these men who might have been or would have been cured by the disease, and in the early 1970s, journalists uncovered similar scandals involving poor, uneducated African-Americans in Cincinnati or Mexican-American women in San Antonio.

As these stories were breaking, the public and the federal government became increasingly suspicious that widespread abuses were taking place, and this really stimulated some physicians like Ed Pellegrino, who recently served as the head of Bush's Bioethics Commission and Andre Hellegers, to take a leading role in advocating humanistic reform in medical education.

(30:00) A new society—the Society for Health and Human Values—came into being, and really, the movement towards bioethics, professionalism, and humanism grew up in response to these kinds of abuses and in many ways. The McGovern Center for Humanities and Ethics, the History of Medicine Series are part of a general attempt to respond to the depersonalization and impersonal nature and potential for moral abuse in contemporary modern medicine.

I won't go into some of the details of the new emphasis on bioethics which many of you know in terms of clinical ethics, the new emphasis on narrative medicine in literature and so on. But these are important counterweights to the unraveling, really, of the doctor-patient relationship.

(31:00) I guess the one important thing to say is that the new emphasis on informed consent in clinical care and truth-telling in clinical care and in research really marked an attempt to shift the grounds of power; to put the power not in the hands of the physician but in the hands of a patient or a research subject. For 2,000 years, from Hippocrates, medicine was governed by what you might call a beneficent or benevolent paternalism, the idea being that doctor acting on behalf of the patient made decisions based on the

patient's best interest and that there was not a dialog, that there was not a role for the patient in this sort of arrangement. The patient's voice was not heard.

Jay Katz's famous book, *The Silent World of Doctor and Patient*, makes this case very clearly. So again, it's more complicated than this, but for 2,000 years, doctors had decision-making authority that was unchallenged, and in the '60s and '70s, this authority was challenged. The emphasis was on informed consent, on truth-telling, on autonomy, and so the pendulum switched; shifted really quite dramatically, but not without conflict. This was a very conflictual period. I remember when I got into the field in the early 1980s, there was a real adversarial sense between people who were emphasizing autonomy and many physicians who felt threatened, who still felt that paternalistic decision-making was the appropriate, morally-justified form of decision-making.

Myself, I think we've moved too far to the autonomy end of the spectrum and that what we're moving towards now is a more dialogical way of making decisions, a joint construction of what needs to happen based on the values and life story of the patients on the one hand and the expertise and the medical knowledge of the physician on the other.

So what do I want to say in conclusion before we try an exercise? I think one more thing about what it is that has led to such a fracturing or fraying of the doctor-patient relationship and I would say that this is basically the corporate transformation of medicine that's taken place and began in the 1980s. The doctor as an independent professional and solo practitioner has slowly given way to the doctor as employee of hospitals, insurance companies, HMOs, and for-profit healthcare corporations. Medicine has always been a business as well as a profession, but doctors have never before been employees of larger organizations dominated by bureaucratic authority and motivated by commercial gain. As doctors saw and needed to see an increasing number of patients per day, it became more and more difficult to advocate for their patients, and doctors had conflicting loyalties for the first time. They had an obligation to their employer on the one hand and to their patient on the other instead of having an obligation to their altruism directed only to the patient, which itself is complicated because there's always a tension between the self-interest of the physician and the needs of the patient. But in general, in the history of professionalism, the idea is that the patient's best interest is what trumps. That's the nature of professionalism. That's the nature of altruism, that you subordinate your self-interest even though they're always in tension. When you had the new commercialization of medicine—the bureaucratization of medicine—you added another piece to the puzzle because you had these impersonal organizations that you had

obligations to that had a bottom-line emphasis, so I think that's the other piece that I wanted to emphasize that has undermined the modern doctor-patient relationship.

(35:17) So let me stop there, take a few questions, and then try an exercise. Yes, sir?

Q1: You mentioned that the fall of the relationships start in the early '70s.

TC: Yes.

Q1: It just so happens that Medicare was signed in 1965.

TC: Yes.

Q1: Is it Medicare on the good side that allowed the residencies that we see here especially to flourish because they paid for it?

TC: Yes.

Q1: They also paid for the doctors a lot more than they used to.

TC: Right.

Q1: Which led to the next thing, which is the rise of the legal profession intervention in the relationship.

TC: Do you mean because of abuse or-?

Q1: I mean suing the companies. If you look at it as a number among practices, this was before 1980, and you look at the number of small practices after 1980, you see a tremendous rise.

TC: Yeah. That's interesting because what that suggests is an unintended consequence of Medicare is the conflict engendered by new lawsuits and growing lawsuits against physicians, which is another unraveling of the relationship. That's your point, I take it? Yes? Am I right about that?

Q1: Uh-hunh (affirmative). That's my point, and my point is that in the rise of the consequence, fairly large potatoes have led to the fracture in all of the relationships.

TC: Yes.

Q1: **(36:58)** And unfortunately, it's going to go on for the future now because there's not a relationship between the patient and the doctor. We're hearing about the stewardship of the healthcare by the physicians so we have changed the relationship to a stewardship and that is the consequence of the third-party payoff.

TC: Yep. I don't disagree with that. It makes things more complicated, it makes things more difficult, and it's not going away, so we need to redouble our efforts at a high quality of relational care under the constraints of third-party payers, pressures to reduce healthcare costs, emphasis on stewardship. Yes?

Q2: What you were alluding to about the corporatization of medical care?

TC: Yeah.

Q2: That's still unfolding. I'm just going to use an example of the metal-on-metal hip replacement.

TC: Yes.

Q2: If the failure rate's there, if figures are coming out that it—the corporatization of medical care, it's still unfolding. The metal-on-metal hip replacements—you're probably all familiar with that and the cost of replacement. A lot of people are Medicare recipients and their estimates could nearly bankrupt the system and that particular—I'm not an expert in that field, but because it's a (s/l core-provided) push for new technology that necessarily hasn't had the proper vetting process or funds to study, they were very fashionable to go to the community type of hip replacement, that also underlines people's idea of that because—I was going to mention that the name, Medtronic, they have a cement to help prevent osteoporosis so they're using that in the best ones that have spinal injuries and backs breaking down. For the layperson reading the newspaper, that undermines the whole idea about any type of medical treatment.

TC: **(39:25)** Yeah. It's a similar point that corporate interests—bottom-line interests on the one hand, the limitations of technology as itself a problem, combined really then to further erode this quality of trusting relationships.

Okay, let's shift to the exercise I'd like to do, and it's an exercise really designed to help you experience this question that we've been talking about of where we are in the relationship between the doctor and the patient because I made this case that the modern doctor-patient relationships grew up in the 1880s and had peaked maybe in the '40s or '50s and has gradually been declining for the reasons that we've been talking about, and I'm not sure that's true. It's what I believe. I think the evidence is there for it. There are other perspectives, and one way to test the question or one way to get into it is for you to ask yourself about your own relationships with doctors, so here's what I'd like you to do. Take out a pen or a pencil and a piece of paper and take five—can we go to 1:00, or when do we have to stop, Bob? Can we go to 1:00 or stop earlier? Okay, we've got ten minutes. Take five minutes and answer this question: Think back to your last visit to the doctor's office and write for five minutes. Write about your interactions with the physician. Where did the meeting take place? Had you seen him or her before? What did you talk about during the examination? What are the notable memories and aspects of that interaction between yourself and your physician the last time you were in the doctor's office?

We'll just take five minutes. I've never tried this before. It's sort of an experiment in your own experience and see how that stacks up against the kind of things we're talking about, so five minutes. This is called "free writing," right? Your teacher's never going to see it. I'm never going to see it. The spelling doesn't matter. Punctuation doesn't matter. Just write what comes to mind and don't try to craft it. Or if you've got your computers open, write it on your laptop.

(44:07) Okay, one more minute. I'm sure this was a really memorable encounter you've had, so get the most out of it. Okay, last sentence. What did you come up with? Yes?

M1: **(45:11)** I think the most amazing thing to me was that I didn't see the doctor at all. I had some tests and some of them very complex tests. The whole billing was for \$2500 and he just called me in the evening for that and this was what the results were and that was it.

TC: Yeah. Okay. So you didn't see him at all. You just got the tests and then you got the results?

M1: Yeah. There were some PAs, there were techs, there was a nurse—a couple of practitioners. There was a whole faculty, but I didn't see anything like when (inaudible).

TC: Yeah. Interesting.

M1: And you have been through surgeries and stuff like that.

TC: Yeah. Interesting. Thank you. Who else had a-?

M2: I did. I had a really positive experience with my primary care physician because I've known him a long time.

TC: Yeah.

M2: I just recently had an examination and he walks in and he knows me pretty well, so I leave reassured and it's a very nice relationship, so I really like that. It makes a lot of difference.

TC: So this an example of a long-term primary care relationship.

M2: Yeah. And it's very good and I would say he's responsible for saving my life by his care. Johnny Carson went to him many years ago and I think it's just because he's comfortable with what he saw and it's just different.

TC: Yeah? Great. So there's good news here, too. There's good news in here, too. It's not all black and white. Who else?

F1: One of the physicals we did when my husband was dying of cancer and we went to see the oncologist and he talked about his levels, his liver enzymes, his kidney levels. He told us that he wasn't eligible for a liver transplant because his nutrition was bad, but we didn't really know what to do for help or answers. That's all right, and he started crying.

TC: Oh, no. No, no.

F1: There was no indication—and he was very nice and he had known us for more than a year. We saw him all the time. He was working on his EMR, so he did all his interaction on the computer and then anytime we asked a question, he would pull stuff up on the

laptop and then would answer us, but there was no indication of whether there was any hope or what we could do.

TC: Yeah. First of all, I'm really sorry to hear about your husband's death. And I guess second of all, the question is did the typing into the EMR take away from the quality of his interaction with you?

F1: I don't know. The easy answer is yes, but I don't think that's necessarily true. It did add some distance, but on the other hand, I was reassured that he was looking up the answers to my questions, so-

TC: **(48:43)** Yeah, that there was real data there.

F1: Yeah. It was much more technical than it used to be, but there were no clear answers. There was no guidance. We didn't know what to do.

TC: Yeah. Okay. Thank you for that. I'm sorry for that. Who else? Sir? Yes?

M3: This was actually an oral surgeon and I went in and they fixed my tooth and they showed concern for me and I was relieved of my pain. It's the way it should be. Now, I, of course, went without prior authorization from my insurance company to pay. Then I got the bill, which then the insurance place says, "We're not covering this now. You didn't-." (Inaudible, speaking at same time) Which I guess brings to my story the question of "What should I do with this position of responsibility?" Now I have evidence-based medicine that's removed my clinical judgment. I have an actuarial table quoting the physician of the insurance companies making this (inaudible) decisions on money so when something goes wrong, they're not responsible, but I'm responsible. So for me, it's a responsibility issue and the people who are pulling the strings are still hiding under a rock (inaudible, speaking at same time) or out there in the sunlight.

TC: **(50:16)** Yep. That's a very good example of the way modern corporate medicine and even aspects of an evidence-based medicine detract from your clinical judgment and your capacity to maintain this bond. One more. We had one more up there.

F2: Oh, I was just going to say the electronic medical records—the last doctor I saw, it was for a well-woman exam, and she had an iPad, which I actually found less—because I've

had other doctors who have used it and I found it actually a lot easier because it was just like she could write it down but it's still (inaudible). So I liked that.

TC: Yeah. So it did not detract from the interaction?

F2: Yeah.

TC: Yeah? Good. Good. There's a wide range of experiences here. Some of the pressures that we've been talking about are clear. I suspect this is a select audience. We have much better access to both general practitioners and specialists, but still you can see this all illustrates the range of issues that are impinging on the quality of the doctor-patient relationship.