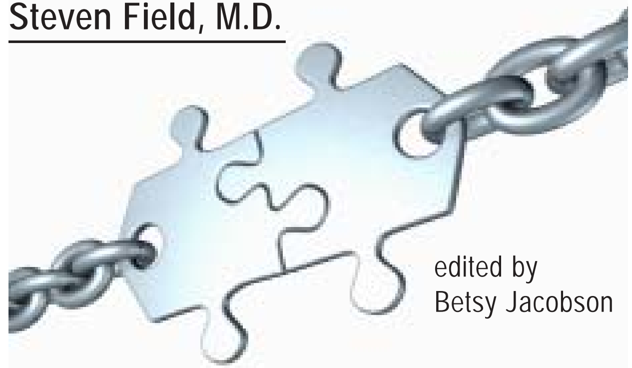
Steven Field, M.D.



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The Doctor-Patient Relationship

Key To Healing In Chronic Illness

Sir William Osler (1849-1919), one of the legendary giants of medicine, once remarked, "Listen to the patient. He will tell you the diagnosis." While Sir William was referring to diagnosing, his dictum holds true for most aspects of medical care. "Listen to the patient" may be among the most important words I can impart to any medical student because the patient is telling a story, and if you would know the diagnosis and the treatment and the way to help heal, you should know the story and know the patient.

As physicians, we often get caught up in the technology, and while technology and basic science research are key-—even crucial—in understanding disease and developing therapies, we can never lose sight of the fact that we are treating people, not cytokines or chemical equations. Ideally, we treat people with diseases, not disease in people; and it's important not to lose sight of that difference.

Twenty-first century medicine has become a very complex animal. It is a science grounded in scientific evidence and best practices, all emanating from randomized, controlled, clinical trials and computerized databases. It is a business, a business in which the ideal time for the patient encounter has been quantified by actuaries (it's an unbelievable seven minutes, for your information); where electronic records speed up rendering of care; where health care providers refer to sub-specialists at the drop of a hat; and where there's no time in those seven minutes to really think about what's going on. It is, in fact, a commodity, a very fragmented commodity whose availability has been analyzed, priced, and rationed by a system which has done little to fix it and, in fact, has little vested interest in trying to. End of diatribe.

The point of this harangue is to introduce the idea of what medicine traditionally was and hopefully still is, and what must be preserved. Medicine is also an art—a scientific art to be sure—but an art nonetheless. Nowhere is the art of medicine so crucial, so vital, and at the same time so rewarding as it is in the longitudinal care of patients. This is especially true for patients with chronic illnesses and certainly for those patients with illnesses which medicine has a hard time pigeonholing like fibromyalgia, irritable bowel syndrome, chronic fatigue [syndrome], and others which for years were thought to be psychogenic in origin. In recent years, as the roles of doctors have shifted, people have started to look at the workings of the doctor-patient relationship—to analyze, criticize, and reformulate it. It is within the dynamic of this relationship that the art of the practice of medicine is to be found. Interestingly, an extensive literature exists in psychiatry addressing the nature of the patient/therapist relationship. Much less has been written about this in the context of "medical" illnesses. Given how much we now understand about the fine, almost nonexistent, line between the physiologic and the psychologic, this is unfortunate.

History of the Relationship

Physicians and patients have been around for a long time. In most early cultures, the healers—shaman or physician—traditionally occupied a position of some respect in society for several reasons. First, they performed a service that was perceived as valuable, if not necessary, for the survival of the society. Second, they were possessed of certain skills, gifts, or training which other members of the society did not have. Whether this was due to the vertical transmission of a presumed ability, as in the patrilineal inheritance patterns of primitive tribal shamans, or to the accumulation of skill and knowledge in academies of learning, as was the case in Greek and Roman civilization, mattered little. The doctor was different, and this difference set him apart. (It was almost always a "him." There were healers who were women as well. In most European

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cultures they were called witches. Interesting sociological point.)

Third, but crucially important, there was an element of trust. The members of the society truly believed that the healer had the ability to heal. Here was perhaps the central focus of the issue, for the belief that one is going to get well is critically important to the process of getting well. The converse is also true and is, in fact, the basis for the phenomenon of "voodoo death." Lastly, people believed not only that the doctor could help, but that he wanted to help. He was genuinely concerned. Being a doctor has, over the years, never solely been about what you know and can do but about what the patient believes you know and can do—and about the manner in which you do it.

Physicians have not been free from criticism over the years, however. They have been portrayed as foppish narcissists in literature innumerable times, and at times when they seemed particularly impotent, such as during the Black Death, they were occasionally run out of town or left hurriedly, leaving their patients behind. The message is clear: patients may need us, but their respect must be earned.

The Relationship Today

Time and progress have altered our relationship with patients. Perhaps the two leading factors in this alteration have been technology and commerce. Technology has brought discoveries about the very nature of disease and about better treatments for those diseases to the bedside, resulting in longer life and better quality of life—all good things. The "bedside" in question, however, is much more crowded than before. The physician and patient are now joined by monitoring devices, laboratory data, quality assurance and risk management personnel, and not least of all by insurers trying to provide cost-effective care. It's a crowded bedside and a crowded interaction.

However, the relationship between physician and patient is not just another interaction. It is a highly complex process involving both participants. It is not just the *place* where healing occurs—although it is that, a "sacred place" where the outcome is ideally greater than the sum of its parts—but it is also a very important part of the *process* by which healing occurs. To borrow a term from the nursing literature, the relationship is a mutual process involving physician and patient in an interdependent fashion whose purpose is to promote healing—not necessarily to cure, although that would be nice. Unfortunately, many diseases are not currently curable, although the patients can be "healed." The process can have a negative side as well. When it goes wrong, the patient's psychological and even physical (they may be the same) well-being can suffer.

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What are the components of this relationship? First of all, it is non-linear. I don't do something to the patient, nor does the patient do something to me. We act in concert, and one's actions continually modify and influence the other's. Interestingly enough, this kind of interaction is characteristic of the way quantum mechanics describes the world: a situation in which at any given moment every actor is simultaneously acted upon in an infinite series of transactions. How do we act in concert? While the patient is talking about a symptom, I may be observing how he is sitting or fidgeting, how comfortable or frightened he looks, and what he says and how relevant (or seemingly irrelevant) it is to the symptom at hand. Much of the information a patient transmits is non-verbal and may seem irrelevant. To miss this information is to lose part of the data.

Example: A woman comes in complaining of an ongoing difficult symptom for which she had been evaluated in the past and which was found to be a harmless condition. This time, however, she is very anxious about it, sure that she has "something terrible."

It would be a mistake not to recognize that there is a piece missing in this narrative. Something else is going on here. She may have had a friend recently diagnosed with colon cancer, or she may be at the

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age at which her father died of that disease, or she may be having personal problems which are generating guilt. Regardless, dismissal of her complaint as something simple misses the point. Exploration of a missing piece and reassurance based on the facts and on an understanding of the emotional issue will be far more effective. Appraisal of the patient is incomplete if only the history and physical exam are taken at face value.

Second, there is the concept of caring. The physician has to genuinely care about what's happening to the patient, and there needs to be intentionality—which means an intention on the part of the physician to heal. There also needs to be empathy—a "feeling with" the patient which can only come from knowing the patient and caring about him. Knowing the patient doesn't always require years of interaction; it simply requires being interested and listening. The physician must also respect and appreciate the uniqueness of each patient.

Third is trust. This clearly cuts both ways. The patient needs to trust the doctor, and the doctor also needs to trust the patient in terms of his/her reporting of symptoms and the patient's willingness to follow a diagnostic/therapeutic plan. After we present a set of options to a patient for his/her care, she will often ask, "What should I do?" or "What would you do if it were you, doctor?" Some patients will even say something like, "You tell me what to do, doctor." That interchange is the moment where trust becomes the linchpin of the discussion. Patients desperately want to put their trust in someone whom they feel knows more than they do and who can help them. They want that trust to be honored on a human level, and, as physicians, we owe them that. Patients don't have to think we are infallible, which is a good thing since none of us is, but they do have to trust us. And we need to trust them, to honor and validate symptoms such as pain, which is hard to quantify objectively in the course of routine daily practice.

Fourth is empowerment. The doctor/patient relationship is, by its very nature, an unequal one. One party has knowledge, and one party seeks advice. One party is ill, and one is healthy. For patients with chronic illnesses, a critical dimension is added—loss of control. Something has happened, and now something is wrong with their bodies, and their lives have often been dramatically changed. The sense of not being in control of one's health is a devastating one, and part of the doctor's job is to try to restore some sense of control for the patient. Giving patients information, listening to them, validating them, and fostering their participation are all sources of empowerment —helping patients to actualize their ability to knowingly participate in change for their own benefit.

Example: An elderly patient of mine had very mild hypertension and occasional ankle swelling. She had been placed by other doctors on a salt restricted diet and told to watch her cholesterol. All she talked about was how much she missed eating a pastrami sandwich. She was an intelligent woman who took good care of herself, but her cardiologist had laid down the dictum about salt and fat which allowed for no compromise, and she followed his directions. So I wrote her a prescription for a pastrami sandwich, one time, with refills. She kept that prescription in her purse for years. I don't know if she actually ever had the sandwich, but I assume she did. I do know that her blood pressure was always fine, and she never developed any fluid overload. She knew that I trusted her judgment and that she had control over this one aspect of her life.

Fifth is teaching. The word "doctor" comes from the Latin docere, "to teach." Giving a patient the facts about her condition, as opposed to simply saying, "do this," is a form of empowerment. Some patients with chronic illnesses may even know more about their illnesses than their doctor does. The internet has made available a flood of information about every medical condition, some of it correct, a lot of it not. Being able to help patients sort through this data is an important skill. Being willing and able to learn from them is a skill in itself.

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Lastly there is advocacy. The patient needs to know that you're on his side and that you are his point person. Patients with illnesses are often adrift

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in a sea of sub-specialists, tests, procedures, diagnoses, and the like. They need one person to act as a touchstone, through whom all this information can be filtered and to whom they can turn for advice and help.

The patient I sent to the oncologist checks back with me to be sure I know what's going on. She knows that I don't know the correct dosing of the chemotherapy she's getting, but she needs to know that the oncologist has communicated with me and that I'm okay with this. Another patient comes in to be sure that I agree with another doctor's plan of treatment, and a third calls to say that he was told he needs a procedure, but he won't have it unless I agree. Aside from feeding the narcissism that helped drive many of us into medicine in the first place, actions like these are among the highest compliments one can receive. When it works (and it takes effort to make it work), the relationship between doctor and patient is a truly special one —the creation of a magical space in which an ongoing process of healing occurs and can occur independent of whether or not there is, or can be, a cure for the underlying condition.

There can be no interposition of third parties in the relationship. It is by its very nature a dyad. I continually learn from my patients—sometimes about their diseases—more often about their lives, about what makes them tick. There is no question that understanding the latter helps me to better take care of the former. The interplay of the physical and the psychological has taught me that there is a very fine line between the two, an idea that research is finally catching up with. In what we do and how we do it, we physicians may unconsciously be far more shamanistic than we think or would dare to admit. For patients with chronic illnesses which impact daily on their lives and for which we have as yet no cure, the relationship with the physician is key, for it is a critical part of the treatment and one of the most important items in the therapeutic armamentarium if it's done right. It's critical that patients and physicians be aware of this. Until we have a cure for these diseases, we do the best we can with what we have, and we "are there" with the patient. Being there—engagement —is both process and treatment. It is the keystone of the structure of patient care, and its absence diminishes our attempts to mitigate human suffering. There is no generic for this one, and no insurance company can insist on one.

Steven Field, M.D., is an internist and gastroenterologist at New York University Medical Center in New York. A graduate of Yale College and New York University School of Medicine, Dr. Field completed his house staff training at Bellevue Hospital and his fellowship at Mount Sinai Hospital, both in New York City. He is currently Clinical Assistant Professor of Medicine at NYU where he teaches and maintains a private practice. He holds a certificate in Bioethics and Medical Humanities and is a candidate at the NYU Psychoanalytic Institute.

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