

Medical Care among Strangers

Increasingly, I believe, physicians and patients encounter each other as strangers, especially in urban settings, in spite of the popularity of advertising slogans that promise "care" and "caring" from hospitals, insurance companies, and other medical organizations and institutions. We often meet each other under the chanciest of circumstances that depend upon work and on-call schedules, payment plans, and contractual arrangements. We whirl in each other's orbits for more or less brief times of mutual interest and obligation and then are flung apart to be captured by new centers of attraction when next the need arises for medical care. Clearly, it seems, centrifugal forces dominate the contemporary medical marketplace. Particularly odious examples of our caving in to anonymity are the walk-in clinics that exhibit no physicians' names on their exterior signs. If I were a patient, I would be chary of such places.

It is tempting to blame recent changes in medical knowledge, medical economics, and health policies for the relative anonymity of physicians and patients, but truth be told, the process began in the nineteenth century when Americans began their steady migration from farms to cities, transportation became motorized, and large city hospitals came into being.¹ No longer were most patients destined to be sick among family and friends, under the care of local physicians, but alone and often poor, they had no choice but to trust their lives to unknown experts who clustered around the new hospitals. What happened to doctors and patients was no different than what happened throughout society to loosen traditional ties to family, church, and community and to dilute the probability of being known by the person from whom one seeks expert help.

The last two decades, however, have made special contributions to the institutionalization of "strangeness" among physicians and patients. Not only do the growing number of poor, minimum wage earners, and uninsured have to take their medical care wherever they can find it; but the well employed, through their medical insurance plans, are forced also to play musical chairs with their doctors in response to lowest bids. Even

the wealthy, with their ability to travel and seek the most prestigious hospitals and physicians, cannot buy what the medical care system does not offer; namely, stable, continuing relationships with physicians who know them apart from their technological encounters.

At the macro-system level, the increasing size and complexity of medical care organizations have become intimidating, not only to patients but also to the professionals who work in them. Medicine has not escaped the "merger-mania" that characterizes American industry. Ellwood² foresaw the radical shift from individual to corporate entrepreneurship and predicted that, in the 1990s, medical care will be provided for more than half our population (mainly the employed half) by 15–20 nationally competing firms. The local doctor's office is going the way of the neighborhood grocer and the corner drugstore.

A less publicized feature of such firms is the relative youthfulness of the professionals who work for them. It is inevitable that most professional experts in the U.S. now are "baby boomers," and in medicine, this phenomenon is especially clear. Our "graying" population is destined to receive the bulk of its medical care from physicians who are in their 30s and 40s. In itself, this phenomenon is not necessarily estranging, but it suggests that ageism is a factor that must be dealt with as the baby boomers preside over the deaths of their parents' and grandparents' generations.

Moreover, classism, sexism, and even racism are deducible from physician demographics. They are not necessarily new, but they are continuing contributors to estrangement. It is hard to imagine that the predominate whiteness, maleness, and affluence of physicians could avoid constituting a mismatch with the population of patients. While it is true that the proportion of women physicians has increased, no such correction in the numbers of ethnic minorities is in the offing. As a matter of fact, it has become more difficult for less affluent students to finance a medical education. I do not mean to imply here that patients can only be served well by physicians of their own kind, or even that patients want that, but there is abundant evidence that social and cultural differences

are barriers to doctor-patient understanding, particularly when it entails sexual and reproductive issues, health maintenance, mental health problems, chronic pain and disability, and medical care of the terminally ill.

On the up side, what has made this evolution work as well as it does is the standardization of medical training and care. Board certification of physicians has become the norm, new and presumably better protocols of care are rapidly disseminated, and medical accountability has been better defined. Patients are less vulnerable to the idiosyncrasies and limitations of local physicians, and on the whole, medical paternalism has diminished. These trends can only be seen, on balance, in a positive light.

Moreover, it cannot be said that modern medical care lacks intimacy. Physicians and nurses, along with journalists, TV reporters, salespersons, and talk-show hosts, have become experts at interviewing, and the public have learned to talk about their personal lives on cue. Self-disclosure has become a modern art form, especially about formerly taboo topics such as sexual behavior, addiction, and eating disorders. No one can deny the genuine affection that patients exhibit for those who have served them in intensive care units and transplant hospitals. Even physicians who have made a career of treating strangers in emergency departments claim to be able to practice personal medicine in that setting. Intimacy, however, especially when it is transient and unidirectional, should not be mistaken for deeper forms of personal knowing. One may cuddle a puppy or infant, but warmth and friendliness do not make one a master or a parent, who ultimately must come to know also the darker side of those objects of affection. While user-friendliness is not to be condemned in any way, the fragile, dependent, and desperate need of sick persons for tenderness is only a small sample of their full repertoire of needs and behaviors under different circumstances.

Notwithstanding our standardization of competence, increased technological power, and facile familiarity with patients, there are signs of increasing estrangement, even antagonism, among patients, physicians, and the institutions in which they meet and have to do with each other.

"Strangeness" poses special problems for family physicians who claim that personal medicine and continuity of care are essential elements of our stock in trade and who identify our best ideals

with general practice ancestors who lived and worked in the communities they served. Few of us practice in such circumstances nowadays, and the uncomplaining way we have given it up suggests that either it lacks the importance we once attached to it or that forces opposing it are irresistible. While I issue no naive call for a return to a practice style that for most of us is irretrievable, I want to reaffirm the importance of knowing our patients and to suggest why we ought to struggle against the alienating features of our times.

What I find most disconcerting about the modern climate of practice is what it appears to be doing to me in my physician's role. It is risky to generalize from one's personal experience, also to confess publicly, but a certain hardness of heart has crept into my attitudes and style that I cannot simply attribute to my age and character flaws. No longer do I see patients as mainly innocent victims of their illnesses and fears, nor am I willing to accept the lion's share of responsibility for success of our relationships. I know that their loyalty has a relatively small price, and I am preoccupied more with accountability than responsibility, more with a contract than a covenant.

The modern application of tort law to medical practice has changed its face more than any other factor in my professional lifetime. While the reasons for this are not wholly unjustified, there can be no doubt that it diminishes the affective quality of the doctor-patient relationship. On the one hand, there is a consensus that a "good" relationship is the best protection against litigation; on the other, the potential threat of litigation puts forming a good relationship at risk.

Being right, i.e., correct, in one's diagnostic judgments has become less important than not being wrong, i.e., not missing anything. Knowing that one's patient has benign headaches does not mean that one also knows that the patient does not have an arteriovenous malformation in the brain that might rupture next week. The same can be said about chest wall pain and silent myocardial ischemia, constipation and cancer of the pancreas, and paresthesiae and multiple sclerosis. The same inverted medico-legal rationale applies to treatment decisions; it is safer (for the doctor) to do no harm than to take the risks of seeking maximum therapeutic benefit from the use of drugs having a narrow therapeutic-toxic ratio, or even to putting oneself out to form a relationship with a difficult patient. The more one knows about and the closer one gets to a difficult patient, the more one has to

deal with negative emotions. These are fragile relationships at best, and the risks of dissolution are high. Why take such risks in the modern medico-legal climate? Keep the patient at arm's length, reduce the frequency of contacts, and refer early and often. These are not my ideals of proper medical practice, but they intrude themselves even on the most conscientious physicians.

I have now had 3 years' experience in "gate-keeping," and I am convinced that it is an alien role for family physicians. We have yet to plumb its depths of liability and meaning. How can physicians enforce a contract between patients and insurers without distancing themselves both from their patients and from other physicians? Saying "no" to patients is unnatural. How can one refuse a referral to a dermatologist, otolaryngologist, podiatrist, or for that matter, a chiropractor, even though strictly speaking it is not medically necessary, and then undertake to treat the condition for which the patient wants referral? The conditions for therapeutic success have already been compromised by the refusal. Who needs a reluctant and sullen patient who is now challenging you to cure their acne, dizziness, bunions, or backache? Such therapeutic efforts are bound to fail, no matter how appropriate, and the harvest of ill will is yet to be reaped.

If these problems are difficult for physicians, how much more they must be for patients. In my better moments, I know that the patient's welfare comes first, and I am still committed to that. Some patients, perhaps many, continue to feel uneasy, alone, misunderstood, and strange in the medical care system. They have a great deal of information about their diseases and procedures, but they lack a perspective that allows them to interpret their medical experiences, to incorporate them into their lives, and to give meaning to them. They do not lack familiarity, but they are alienated within the familiar. They are not "at home" within a system that seems to offer them so much by way of cure and care. They have no point of contact with the system that gives them any control over their

destiny within it or that allows them to function as discriminating participants in it. They cannot read its signs.

Perhaps our problem after all is less one of "strangeness" than alienation. Schmitt defines the latter as:

The unnecessary blocking of human fulfillment by a social order which allows wide play to individual liberty while depriving its members of the power to make full use of these liberties.³

The power of medical science is surely among the greatest liberating achievements in human history. It can free us from superstition and pain, prolong our lives, and increase our happiness, but it cannot prevent all suffering, postpone death indefinitely, or give meaning to our lives. We have to do that through other powers, humane relationships, community, and moral values. We have to distinguish the power of medicine from the social, political and economic packages in which it comes wrapped. If we and our patients feel alienated in using it appropriately for everybody's good, we should not see this as either "an unavoidable human problem" or an individual psychological problem. It is also structural, a human creation, yet this is our basis for hope. If we made it the way it is, then we can also change it and thereby also change ourselves, if not from strangers into friends, then at least into fellow human beings with an equal stake in both health and society.

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References

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