PATIENT-CENTERED MEDICINE
THE THOUGHT EXPERIMENT
WHAT DO DOCTORS REMEMBER BEST FROM SCHOOL OR POSTGRADUATE YEARS?

TEXTS?

LECTURES?

PROCEDURES?

LAB RESULTS?

TEACHERS?
PATIENTS AND THEIR STORIES?
BUT IS THIS A PATIENT?

THE EMPTY BED
EVEN WHEN THE PATIENT IS IN BED, WE MAY NOT SEE THEM!

1982: BEDSIDE: 2.5 MINUTES
CHART, HALL, SMALL ROOM:
69 MINUTES...
“WHERE IS THE WISDOM WE HAVE LOST IN KNOWLEDGE? WHERE IS THE KNOWLEDGE WE HAVE LOST IN INFORMATION?”

T.S. ELIOT
INFORMATION

DATA

INTERNET, TEXTS, JOURNALS, PRACTICE GUIDELINES, QUESTIONNAIRES, DIAGNOSTIC TEST RESULTS, IMAGING, EVEN EVIDENCE-BASED MEDICINE.
KNOWLEDGE

THE PROPER APPLICATION OF INFORMATION TO THE UNIQUE INDIVIDUAL WHO IS OUR PATIENT.
WISDOM

KNOWING WHAT TO DO WITH THAT KNOWLEDGE
“MEDICINE IS A HUMAN ENDEAVOR THAT USES SCIENCE AS A TOOL”*

TO APPLY SCIENCE TO A PERSON WITHOUT KNOWING ABOUT THAT INDIVIDUAL IS AKIN TO PLATING BACTERIA ON AN UNKNOWN CULTURE MEDIUM: IT IS NOT ONLY A DEFICIT IN HUMANITY... IT’S BAD SCIENCE AS WELL.

*JOCK MURRAY MD
THE ENDURING **CORE JOY OF MEDICINE FOR THE CLINICIAN**

INTERACTION WITH PATIENTS

BUT TIME FOR THAT IS GETTING LESS AS WE STRUGGLE TO...

GET THE WORK DONE!
WHAT IS THE WORK?
A DOCTOR’S WORK

ACQUIRE THE TOOLS

LEARN THE ART

SCIENCE, TECHNOLOGY, INFORMATION

HUMAN EXPERIENCE
OUR PRINCIPAL TEACHERS

OF THE SCIENCE AND
OF THE ART OF MEDICINE
Yet doctors spend less time with patients now than in the past.

In fact, patients are themselves seen as a major impediment to ‘getting the work done’: Hits! Black Cloud! Surviving the wards!
BARRIERS IN AN ACADEMIC HOSPITAL...

BETWEEN DOCTORS AND PATIENTS

EFFICIENCY
ECONOMICS
ENVIRONMENT
EVALUATION
1. EFFICIENCY

A SYSTEM IS MOST EFFICIENT WHEN INDIVIDUALS WITHIN IT BEHAVE THE WAY THEY ARE SUPPOSED TO. IF THEY ARE ‘TOO MUCH TROUBLE’ THEY UPSET THE SYSTEM....
BARRIERS BETWEEN DOCTORS AND PATIENTS

EFFICIENCY

“PATIENT-FLOW”
“THRU-PUT”

ADMISSION

DISCHARGE
EFFICIENCY IN HOSPITALS

1. **THINKING** IS TIME-CONSUMING. (ALGORITHMS ARE FASTER, SOMETIMES BETTER, BUT IMPERSONAL.)

2. **PRE-ADMISSION WORKUP** IN EMERGENCY ROOM OR CLINIC MUST ‘JUSTIFY’ ADMISSION.

3. **WHEN TEST RESULTS RETURN**, OFTEN, THE PATIENT IS DISCHARGED.

4. **PROBLEM → SOLUTION → OUT**

   (e.g. ROMI → MIRO)
(THIS HAPPENS IN CLINICS AND MANAGED CARE PRACTICES ALSO)
EFFICIENCY IN EDUCATION

REAL PATIENTS ARE ‘TOO MUCH TROUBLE’

1. THEY HAVE DIFFICULT OR VARIABLE HISTORIES AND PHYSICAL EXAMS;
2. THEY’RE PERIODICALLY UNAVAILABLE, GONE FOR STUDIES;
3. THEY GET EMOTIONALLY INVOLVED IN THEIR OWN EVALUATION;
4. THEY MAY HAVE A FAMILY WATCHING AND CONCERNED WITH WHAT IS HAPPENING;
5. THEY MAY BE “TOO ILL TO PARTICIPATE IN TEACHING”.

BARRIERS IN AN ACADEMIC HOSPITAL BETWEEN DOCTORS AND PATIENTS

EFFICIENCY
ECONOMICS
ENVIRONMENT
EVALUATION
BARRIERS BETWEEN DOCTORS AND PATIENTS

2. ECONOMICS

PHYSICIANS IN PRACTICE CANNOT EARN INCOME BY TEACHING.

ACADEMIC FACULTY CANNOT EARN INCOME OR ADVANCEMENT BY TEACHING OR PATIENT-CENTERED CARE.

MOST OTHER DUTIES OF ACADEMIC FACULTY DON'T GO AWAY WHEN THEY ARE ON SERVICE.
ECONOMICS

PROCEDURES PAY BETTER THAN LISTENING OR TOUCHING.

FOR ALL ITS WONDERS, TECHNOLOGIC DIAGNOSIS CAN SEPARATE PATIENTS AND DOCTORS.....AND HAS DONE SO.
THIS IS NOT JUST AN ECONOMIC ISSUE, BUT PART OF OUR BELIEF SYSTEM THAT IMAGES AND NUMBERS ARE MORE ‘REAL’ THAN PERSONALLY OBSERVED DATA.
PART OF IT MAY BE THE ANCIENT MYSTICAL POWER OF THE WRITTEN WORD

A THING ASSUMES AUTHORITY BY BEING WRITTEN
THE SCIENTIFIC METHOD

- OBSERVABLE PHENOMENA
- ISOLATED WITH CONTROLLED VARIABLES
- MEASURABLE AND NUMERABLE
- REPRODUCIBLE

PAIN
ANXIETY

FATIGUE
DESPAIR
AND PART OF IT IS INSECURITY ON THE PART OF DOCTORS...

AS WELL AS A DISTURBING DISTRUST OF PATIENTS:

“THE PATIENT ALLEGES SHE HAD SUBJECTIVE PAIN…”

“THE PATIENT DENIES UNSAFE SEX…”

“HE STATES THAT HE EXPERIENCED EMESIS AT THAT TIME….”
WHAT’S REALLY INTERESTING TO ME IS...

OUR MOST HIGHLY VALUED AND TRUSTED STUDIES – IMAGING – ARE READ BY EXPERIENCED AND SKILLED RADIOLOGISTS: WHAT THEY ARE ACTUALLY DOING IS PHYSICAL DIAGNOSIS... ‘INTERIOR’.
BARRIERS IN AN ACADEMIC HOSPITAL...

BETWEEN DOCTORS AND PATIENTS

EFFICIENCY
ECONOMICS
ENVIRONMENT
EVALUATION
CAN ANYBODY REMEMBER THESE SIGNS?
BARRIERS BETWEEN DOCTORS AND PATIENTS

ENVIRONMENT:
NOISE IN AND NEAR THE ROOMS
ENVIRONMENT

DISTRACTIONS AND INTERRUPTIONS
BARRIERS IN AN ACADEMIC HOSPITAL...

BETWEEN DOCTORS AND PATIENTS

EFFICIENCY
ECONOMICS
ENVIRONMENT
EVALUATION
MEDICAL EDUCATION IS AT HAZARD FROM ENVIRONMENT, ECONOMICS AND EFFICIENCY.*

RESIDENTS AND STUDENTS ARE BEING TAUGHT THAT INTENSIVE CONTACT WITH REAL PATIENTS OVER THE COURSE OF THEIR DISEASE IS NOT ESSENTIAL TO THEIR MEDICAL EDUCATION...

*THESE ARE SYSTEMS PROBLEMS.
BARRIERS BETWEEN DOCTORS AND PATIENTS…

EVALUATION

INCREASING REQUIREMENTS FOR A FORMAL CLASSROOM CURRICULUM FOR DOCTORS AND STUDENTS, WITH MASTERY BY THEM AS EVIDENCED BY WRITTEN EXAMINATIONS, OF GREATER AND GREATER AMOUNTS OF EXPLICIT INFORMATION IN AN EVER EXPANDING NUMBER OF FIELDS.

THIS IS BOTH POLITICAL AND SPECIALTY BOARD IMPOSED: WE DO MOST OF IT TO OURSELVES.
EVALUATION

SINCE MULTIPLE-CHOICE EXAMS DO NOT TELL EVALUATORS ABOUT CLINICAL SKILLS, EDUCATORS HAVE ASKED FOR OBSERVED CLINICAL EXAMINATIONS........
EXAMINATIONS MUST BE RELIABLE*

RELIABLE = REPRODUCIBLE, NOT NECESSARILY PERTINENT OR ‘TRUE’
ENTER THE VIRTUAL PATIENT

THESE MAY BE EITHER SIMULACRA

WHICH HAVE A VERY REAL PLACE IN THE TEACHING AND EVALUATION OF PROCEDURES

OR...
STANDARDIZED PATIENTS

ACTORS TRAINED TO GIVE A HISTORY AND MIMIC SOME PHYSICAL FINDINGS.
WHY IS THIS A BAD THING?

WHEN **STANDARDIZED PATIENTS** ARE USED TO TEACH AND ASSESS, NOT JUST PROCEDURAL MASTERY, BUT HISTORY AND PHYSICAL:

THE QUESTION IS DIFFERENT!

IT IS NO LONGER “WHAT’S WRONG WITH THIS PATIENT AND HOW CAN I FIX IT?”

THE QUESTION NOW IS: “WHAT AM I **SUPPOSED** TO FIND?”
WHY IS THIS A BAD THING?

WHEN **STANDARDIZED PATIENTS** ARE USED TO TEACH AND ASSESS, NOT JUST PROCEDURAL MASTERY, BUT HISTORY AND PHYSICAL:

THE TRUE INTERRELATIONSHIP BETWEEN HISTORY AND PHYSICAL EXAMINATION IS LOST...WITH THE IMPLICATION THAT IT IS NOT IMPORTANT

CC: HEADACHE AND VISUAL CHANGE
WHY IS THIS A BAD THING?

THERE CAN BE NO TRUE PATTERN RECOGNITION:

THE ‘CASE’ OF THE VIRTUAL PATIENT IS NOT A GENUINE DUCK!
WHY IS THIS A BAD THING?

INTERACTION WITH VIRTUAL PATIENTS IS, BY DEFINITION, A LIAR EXAMINING A LIAR

THE DOCTOR MUST PRETEND TO BE EMPATHETIC, AND TO BELIEVE WHAT THE ‘PATIENT’ IS TELLING THEM.
WHY IS THIS A BAD THING?

VIRTUAL PATIENTS MAY BECOME VIRTUAL FACULTY.....THEMSELVES DOING THE EVALUATIONS.

AND THEY DON'T KNOW ENOUGH TO DO THIS IN A FLEXIBLE WAY.
WHY IS THIS A BAD THING?

WHATEVER ELSE THE INTENT MAY BE, THE MESSAGE INCREASINGLY SENT TO MEDICAL STUDENTS IS THAT REAL PATIENTS ARE LESS VALUABLE THAN ACTORS IN THE TEACHING AND EVALUATION OF COMMUNICATION WITH AND PHYSICAL EXAMINATION OF PATIENTS.
FINALLY
WHY IS THIS A BAD THING?

A PRINCIPAL COMPLAINT OF PATIENTS IS THAT THEY ARE EITHER RUSHED BY OR EVEN NEVER SEE THEIR DOCTORS....

AND WE LEGITIMATIZE THE DOCTOR’S ABSENCE FROM THE PATIENT IN THE NAME OF IMPROVING PATIENT CARE. DOES THIS MAKE SENSE?
HOW ABOUT ELECTRONIC MEDICAL RECORDS?

- MORE ACCESSIBLE
- CAN BE TERRIFIC WHEN INTEGRATED WITH PERSONAL PATIENT INTERACTION

BUT.....

MAY ELIMINATE VALUABLE INFORMATION, AND- AS ALWAYS-

G.I.G.O.
AND NOW PROPOSED: THE **VIRTUAL OFFICE**

- **Patients fill out computer questionnaires to determine whether they need to come in to see the doctor.**

**What does this teach young doctors?**
THE IMPLIED LESSON OF THE VIRTUAL OFFICE

IS IT NOT THAT READING THE SCORE AND LIBRETTO OF AN OPERA IS EQUIVALENT TO SEEING AND HEARING IT PERFORMED ON STAGE?

AFTER ALL, THE WORDS AND NOTES ARE THE SAME.... AREN'T THEY?
WE ARE AN APPRENTICESHIP SYSTEM OF EDUCATION

BOTH HUMANITIES AND THE SCIENCE OF MEDICINE ARE BEST LEARNED IN THE CONTEXT OF CLINICAL CARE.
WE MUST RETURN TO PATIENTS

- Interpersonal skills, keen observation, perceptivity to nuance of voice and body language, physical diagnostic integration with history, iterative hypothetical differential diagnosis, critical analysis of fluid change, and the power of the physician as a therapeutic instrument can be learned and taught only by personal contact with real patients and the example set by skilled clinicians.
SO WHAT CAN WE DO?

- Pressures of **Efficiency** of care, **Evaluation** requirements, difficulty in obtaining suitable real patients in a suitable **Environment**, and **Economics** are all increasingly interposed between students, teachers, doctors, and patients.

- And an increasing number of teachers and practicing doctors cannot know what they’re missing... because they never had it themselves as students.
SO...RESIST AND SABOTAGE ANY SYSTEM THAT SEPARATES DOCTORS FROM PATIENTS
OTHERWISE WE RISK CREATING THE ‘VIRTUAL PHYSICIAN’

WHOSE EXPERTISE IS DOING THINGS TO ‘THINGS’ BECAUSE THEY HAVE BEEN TRAINED ON THINGS.
IT HAS ALREADY HAPPENED

REALLY?
SCIENCE AND TECHNOLOGY ARE NOT INHUMANE, BUT WE CAN BE....

THE GREATEST ACT OF INHUMANITY IS TREATING REAL HUMAN BEINGS AS UNIMPORTANT OR EXPENDABLE.

AND IT IS TRULY BAD MEDICINE