

Pursuing Humanistic Medicine in a Technological Age

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Stephen Bertman¹

Abstract

The humanistic practice of medicine requires that the practitioner have sufficient time and appropriate focus. Both elements, however, are under assault by the high-speed, distraction-filled environment within which primary care is delivered today. Despite or perhaps because of modern medicine's technological advances, the potentially healing bond between doctor and patient is being frayed and the quality of care consequently degraded.

Keywords

primary care, empathy, time, distraction, listening, multitasking, technology

A Tale of Two Physicians

It was the best of times, it was the worst of times
—Charles Dickens, *A Tale of Two Cities*

The other day I accompanied my sinus-blocked wife to her internist's office. As he breezed into the examining room, he snapped, "Just give me the highlights." So many patients, I thought. So little time.

"So you just want the *highlights*?" I quizzically asked. "You have *no idea*" was his curt rejoinder.

Of course, it wasn't always that way. When Dr B was part of a small 3-man practice, he was able to spend more time with his patients. But when illness forced his senior colleague into early retirement, the remaining 2 partners in the practice, Dr B and his younger colleague, Dr C, went their separate ways.

Dr B knew my wife's history, was astute enough to ask the right questions, and humble enough to realize when he didn't have all the answers, and so remained her internist. But the new practice he joined had over a dozen other doctors, a bottom-line corporate philosophy, and a waiting room the size of a small airplane hangar. Though he would not admit it, Dr B now seemed pressured to see more patients per day and process them faster. Welcome to assembly-line medicine.

His former partner, Dr C, went on to set up his own practice and continued to be my own internist. Though young, he possessed a judgment beyond his years. He always spent time talking with me about the reason for my visit and

took time to listen to how I answered, not just to what answers I gave.

Four years later, I received a form letter from him informing me that he was changing his practice and would now become a "concierge" physician (1). I was welcome to continue as his patient, the letter said, but for an annual surcharge of about US\$1500 a year. I was also invited to meet with a representative from the umbrella organization, MDVIP (2), that for a percentage of his earnings would be handling his practice's transition and would assist in its marketing. After her smooth sales pitch, the representative whom I eventually met handed me a business card identifying her as my "patient advocate." This personal touch struck me as especially ironic after I discovered that MDVIP was in fact a subsidiary of Procter & Gamble.

Before I received his letter, I had sensed from my conversations with Dr C that something was bothering him. He had spoken about how new federal regulations and the corporate demands of the big, multicampus hospital he was affiliated with were robbing him of his autonomy as a physician. His growing frustration eventually led him to change the structure of his practice and limit the number of his patients to no more than 600 so he could give each one more

¹ Department of Languages, Literatures, and Cultures, University of Windsor, Windsor, Ontario, Canada

Corresponding Author:

Stephen Bertman, Department of Languages, Literatures, and Cultures, University of Windsor, Windsor, Ontario, Canada.
Email: profbertman2@aol.com



of his time and help them in more proactive ways. Their “membership fee” would presumably make up for the drop in his income from the reduction in the size of his practice. His future patients, I assumed, would be well heeled enough to pay the price.

At my last appointment with Dr C, I told him that his radical decision to change the nature of his practice might be an impulsive one. In a strange case of role reversal, I the elderly patient became the younger man’s physician trying to heal his wounds, telling him that I cared about him and his future, and didn’t want him to make a decision out of a frustration with “the system,” a mistake he might later regret.

When he bristled at my urgings, I could tell my office-visit “counseling session” had come to an end.

Dr B, the first physician I described, was distracted from rendering empathetic care to his patients by the sheer number of patients he was obligated by his group practice to see. As a result he gave less time to each. Dr C, for his part, was distracted from rendering empathetic care by what he perceived as onerous regulations that limited his autonomy. In consequence, he downsized his practice so he could give each of his patients more attention. But the method he chose (probably to insure his income) was to join an organization that effectively made him a physician to the wealthy few. In the case of each physician, some form of distraction had reduced the amount of empathy he ultimately rendered (3).

The Preciousness of Time

For any interpersonal experience like medicine or, for that matter education, to be transformative, it is ultimately the “human in-between” between patient and doctor, or between student and teacher, that matters—the “shared presence” that Drs William Ventres and Richard M. Frankel recently and so passionately described (4,5). But like any other delicate organism, that “human in-between” needs time to grow and flourish. Nowadays, however, in the practice of medicine—as everywhere else—time has become a rare commodity.

Increasingly ours has become a “hyperculture,” (6) a society driven by electronic technologies whose texts and images travel at nearly the speed of light. Their speed, and the demands they place upon us, have set the tempo of our lives and filled our everyday existence with stress, a stress that comes from the simple fact that, unlike the inanimate devices we use, we ourselves as human beings were never organically designed to operate that fast. However much these technologies once promised to make our lives easier, we now spend our hyperstimulated hours playing a game of “catch-up” we can never win. As Henry David Thoreau once wrote “We have become the tools of our tools” (7).

An Age of Distraction

The multiple electronic signals we constantly receive have created what some have called “an age of distraction”(8,9). In the days of the 19th and 20th centuries, advanced

technology was confined to factories, vehicles, and then homes. But today, we carry it around in our pockets. The smartphones we own (or rather the phones that own *us*) beckon us seductively with their addictive apps, proffering nonstop information and 24/7 diversion. But as a perverse side effect, these devices have also spawned an array of novel 21st-century neuroses: “nomophobia” (10,11), the fear of having *no mobile phone handy*; “phantom vibration and ringing syndrome” (12), the sensation that a phone has vibrated or rung when it really hasn’t; and, most basic of all, “fomo” (13), the underlying *fear of missing out*.

However well intended, the electronic medical records (EMRs) in doctors’ hands and the computers in their examining rooms have done their share of contributing to distraction in health-care settings (14-17). Whether handheld or table mounted, their screens mesmerize physicians in the same way smartphones affect family members seated around a dinner table who barely make eye contact with each other, so fixated are they on the glowing toys in their hands.

One of the biggest challenges with any new device is its potential to distract the clinician and alienate the patient, ultimately emphasizing technology over people. When the clinician becomes too focused on the data collection process, he or she begins to lose the personal connection that lies at the heart of the patient-clinician relationship (18).

Rather than looking at the real patients in front of them, doctors may look at the data on a screen, thereby losing the precious opportunity to connect with the flesh-and-blood person in front of them and thus discover what disembodied data can never convey (19).

The Art of Listening

Sir William Osler (1837-1901), one of the founders of Johns Hopkins Hospital and regarded by many as the father of modern medicine, counseled his students with these words: “Listen to the patient. He is telling you the diagnosis” (20). But if the physician does not listen, truly listen, he will never hear. Osler also told his students: “Care more particularly for the individual patient than for the special features of the disease” (21). But if the doctor does not take time to truly get to know that patient, but instead depends only on laboratory test results, he or she may never discover the best and most trustworthy avenue for cure. In this respect, clinical detachment, a hallmark of scientific objectivity, may in fact prove a detriment to the healer’s art.

The good doctor develops a rapport with his patient; he builds trust and establishes a relationship. I write “doctor” in order to underscore an important aspect of the physician’s art. The word comes from the Latin *docere*, meaning “to teach,” a duty that the good doctor does not ignore . . . The physician may restore health, but until he reforms the patient’s life-style, his art’s object can never be served . . . [He must] consider the whole man, not simply his parts (22). (pp. 593–594, 596)

For physician-patient empathy to exist, 2 factors are needed: time and focus. But if either is lacking, the 2 necessary halves of the therapeutic equation will not coexist. Indeed, if a reliance on dehumanized data overshadows the human bond, and as a result the patient in front of the physician becomes reified in his or her eyes, the full potential for healing may never be realized. Paradoxically, the more automatically a doctor interacts with keyboards and computer screens, the less skill he or she may develop in interacting with people face to face, especially if those people are vulnerable and have a narrative they desperately need to tell someone who is patient enough to listen (23).

Multitasking and the Quality of Care

Doctors who live time-pressured lives may ultimately rely on multitasking (24) in the firm conviction that they can just as effectively do 2 or more things at once. Research, however, has demonstrated just the opposite. As one Stanford University researcher colloquially summed up his findings: “Multitaskers were just lousy at everything . . . They’re suckers for irrelevancy . . . Everything distracts them” (25-27).

Inevitably, the quantity of things multitaskers simultaneously do dilutes the quality of the very things done, not unlike one of my wife’s specialists who always, perhaps for legal self-protection, sends her a detailed letter summarizing her most recent office visit and drawing upon the electronic notes he took as she sat before him. Reading over his terse reports, I invariably find—with mixed amusement and consternation—glaring errors in his transcription of what my wife actually said.

The Lady With the Lamp

Perhaps, the most perceptive comments on the physician-patient relationship and its requirements come not from the writings of a doctor but from those of a nurse. In her otherwise dispassionately prescriptive *Notes on Nursing*, Florence Nightingale (1820-1910) appended an uncharacteristically emotional coda she entitled “What Is a Nurse?” (28).

A nurse *ought* to understand . . . every change in her patient’s face, every change in his attitude, every change in his voice. And she ought to study them till she feels sure that no one else understands them so well. She may make mistakes, but she is *on the way* to being a good nurse. Whereas the nurse who never observes her patient’s countenance at all, and never expects to see any variation, any more than if she had the charge of delicate china, is on the way to nothing at all. She will never be a nurse. (pp. 196–197)

The Best of Times, the Worst of Times

To be sure, the Victorian world of William Osler and Florence Nightingale was less technologically advanced than our own. But it was also less pressured. The limited face-time

today’s doctors normally have with their patients during an office visit—an average of 15 self-reported and exaggerated minutes with “one eye on the patient and one eye on the clock” (29,30)—does not grant them the kind of familiarity with their patients that Nightingale expected of her hospital nurses or Osler expected of his residents. But by the same token, the very compression of those few minutes makes it all the more incumbent upon today’s harried physicians to fully know the human beings they treat.

To the extent that profit driven, assembly-line medicine arbitrarily quickens the pace of office visits or, worse, drives caring and talented physicians out of a system originally meant to serve the many rather than the few, to that extent medicine itself as a humane profession will inevitably be diminished.

It’s enough to make old Hippocrates roll over in his grave!

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Author Biography

Stephen Bertman is professor emeritus of Languages, Literatures, and Cultures at Canada's University of Windsor. His books include *Hyperculture: The Human Cost of Speed*, *The Healing Power of Ancient Literature* (coedited with Dr Lois Parker), *The Genesis of Science: The Story of Greek Imagination*, and the forthcoming *Distracted Doctoring: Returning to Patient-Centered Care in the Digital Age* (coedited with Dr Peter Papadakos).