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In America, the art of doctoring is dying

For almost 40 years, I practiced general internal medicine and geriatrics in my own office. I had tens of thousands of face-to-face interactions with a group of folks who, with time, grew to trust me. I respected them as well; many I came to love – a term that I hesitate to use in this hypersensitive age. Given how geographically dispersed families are today, for many of my older patients I functioned as a surrogate son.

There is no doubt that the kind of medicine I was fortunate to practice is disappearing. Most doctors are employed by large group practices, hospitals or insurance companies. Many want to have personal connections with their patients but have too little time. Young primary-care doctors are relegated to assembly-line clinics; their patients pass through as widgets, not as individuals with complex inner lives, wrought family structures, varied spiritual and cultural beliefs – not to mention their individual capacities to understand and deal with their medical symptoms, diagnoses and multiple medications, as well as their own hopes and fears.

Physicians are now insulated from knowing too much about their patients. It is all about the technology, the testing, the imaging, the electronic health record, the data – once collected by the doctor, but now so regulated and overwhelming that paramedical professionals have been enlisted to record the so-called minutiae, the often rote information in which may lie important clues. Some of these may remain forever buried, the patient not wanting to share sensitive details with just anyone, especially someone who no longer makes eye contact, whose face remains buried behind a computer screen, who seems

uninterested or just unskilled in reading body language – that downward glance, that shift in the chair, that half-swallowed response.

I teach medical students now. All they have to do is look at me to know that I am – in the vernacular of the day – a "dinosaur." Many are already jaded by their fourth and final medical school year. They know little to nothing about how medicine was once practiced. They have experienced the system only as it currently exists. Students nowadays – and, of course, there are exceptions – are looking to choose a field that will allow them the lifestyle and personal time they want, along with the compensation they feel they deserve for the hard work they will endure, for the debt they have accumulated. Most won't consider a career in family medicine, general internal medicine or geriatrics.

Many new career opportunities have opened up as the role of the old primary-care attending physician has been crushed and splintered in this postmodern medical age. The shards sparkle with possibility: hospitalists care for sick inpatients and are charged with rapid throughput by their administrative overlords; nocturnists do this job as well – but at night; intensivists take over when work in a critical care unit is required; transitionalists step in when the patient is ready to be moved on to rehabilitation (physiatrists) or into a skilled nursing facility (SNFists). Almost at the end of the line are the post-acutists in their long-term care facilities and the palliativists – tasked with keeping the patient home and comfortable – while ending the costly cycle of transfers back and forth to the hospital. Finally, as the physician-aid-in-dying movement continues to gain support, there will be suicidalists adept at handling the paperwork, negotiating the legal shoals and mixing the necessary ingredients when the time comes.

And to think that not so very long ago I did all these tasks myself – except for the last one – and practiced across all these varied settings. I was there whenever and wherever my patients needed me.

My students want to know – in all the tumult of medical care today – how they can appear to patients as if they are "connecting" with them. "I think sitting down in the hospital room by the bed – even if it's just a moment – is important," says one. Another remarks, "Try to notice something special about them, maybe a book they might be reading or a piece of jewelry they are wearing."

I suggest examining their patients: listening to hearts and lungs, palpating abdomens, assessing extremities, pulses. This intimacy between a caring doctor and a trusting patient seems a time-honored, engaging and even useful way to cement the doctor-patient relationship. But, for many, this is a bridge too far. Students learn now on plastic dummies; their physical examination skills are poor to nonexistent. They are taught an almost slavish reliance on technology.

If I could, I would reinvent myself today as a "confidentialist." Someone who has the time to really get to know a patient. Someone available to be confided in. An advocate, not just for the moment, but across time. An explainer about what's wrong; an educator about what will help and what will not. Someone who has the knowledge and confident wisdom to stand down the legions of specialists with their scalpels, catheters and scopes; the backbone to stand up to bottom-line-toeing administrators and self-serving insurance executives and policy wonks.

Once I was a primary-care attending physician. It was the closest I came.

By Jerald Winakur

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