A Half-Century Reflection on the Practice of Medicine

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Deane Hutchins was born in Kingfield, Maine, and graduated from the University of Maine in 1950 after serving in the Navy during WWII. Following his graduation from the University of Rochester, he did his internship and residency at the Worcester City Hospital in Worcester, MA. After five years in general practice and five years at the student health center of the University of Maine, he worked as an epidemiologist in Nigeria and Sierra Leone with the WHO/USAID/CDC Smallpox Eradication Program. He served in several underdeveloped countries as an American Embassy Regional Medical Officer and in Washington, D.C., as the Deputy Assistant Secretary in the Department of State for the Health Care Program. After his retirement in 1986, he served as the Chairman of the Board of the Trustees at the Regional Medical Center in Lubec, Maine, and still serves as a Board member.

Change is inevitable with the passage of time. It may be a change in the practice of medicine such as the doctor/patient relationship, the quality of living, or in our life values as reflected by morals and attitudes to which we are exposed. Change is here only to be changed again.

I came from a family closely associated with the practice of medicine and was brought up believing the ideals of the old concept of the doctor/patient relationship. This relationship was something the doctor valued and the patient wanted. Money was not the reason for seeing a patient. The patient appreciated your services and advice. Ministers, nurses and colleagues were given professional courtesy. Health insurance, collection agencies, and malpractice were not significant factors in the doctor/patient relationship.

I spent my first five years as a general practitioner and enjoyed practicing medicine with the ideals I had accumulated during my early life and my years at the University of Rochester Medical School. It was at the University of Rochester where I learned not only basic medical teachings but was exposed to the humanity of outstanding medical practice. I regarded the entire family as my medical responsibility and my patients relied on my medical expertise. I first noticed the deterioration in the doctor/patient relationship with advent of health insurance and when a third party was paying the bill. It became an impersonal relationship - a business. Doctors no longer accepted lobsters, potatoes, and a thank you for their payment of services but started using collection agencies.

My next five years were at the University of Maine Student Health Center, which was a form of socialized medicine. Physician services and prescriptions were free and the relationship between the students (patients)/doctor was skeptical and often merely tolerated. Part of the coolness of the doctor/patient relationship was due to the historical belief that all college health services were of poor quality, but a significant part was due to the concept that the patient demanded the service because it had been paid for in their miscellaneous fees.

The next four years I spent in Africa with the Smallpox Eradication Program and was exposed to some of the indigenous patients who brought back the old concept of a close doctor/patient relationship. No insurance, no malpractice, no collection agencies, but a big thank you from the patient in his local dialect and a smile on his face.

During the next fifteen years I was back into "socialized medicine" taking care of the American Embassy personnel at various overseas posts. The doctor/patient relationship was the best where the local medical facilities were the poorest. The U.S. government was paying for their health care and their demands for treatment and/or medical evacuation to the continental U.S. was not always due to health problems. Again this reflected the third party influence on the doctor/patient relationship.

After I retired from the Foreign Service, I worked a few days a week in a walk-in clinic. I was given the opportunity to increase my salary based on the number of patients I saw and the number of tests I ordered above the average. This was a business - not a good practice of medicine. The doctor/patient relationship meant nothing to the doctor except to please the patients so they would come back. Patients would demand unnecessary tests because the third party was paying for them. My colleagues encouraged this because it was money in their pockets and the patients thought they were getting better treatment.

I am currently giving my time as the Chairman of the Board of Trustees in a large rural health center in Maine. Managed Care, third party payment, government-subsidized payment, and the attitude of the health professionals for an 8-5 hour workday, five days a week has changed the original concept of a close meaningful doctor/patient relationship to one of distrust and arrogance.

The contemporary ways of treating patients represent a significant change from what we were doing forty years ago. Some of these changes were necessary and have added to the quality of treatment. Many of the changes are due to third party payments, managed care, malpractice insurance, and attitudes of the current health professionals, all of which have decreased the positive aspects of the doctor/patient relationship. Changes will continue and I would project that in another forty years the pendulum will move back to a kinder and more compassionate doctor/patient relationship. I do not believe the politicians, insurance companies or government agencies will cause the pendulum to swing back but it will be something from within the original doctor/patient relationship concept.