

The Doctor-Patient Relationship of Listening, Caring, Compassion and Advocacy Developed as the Result of Spending Time With the Patient and His Family Without Expectation of Remuneration

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Howard Meyer was born in Norwich, NY, and served in World War II in the U.S. Army as a combat infantryman in the European theater. He received his baccalaureate and medical degrees from the University of Rochester. Following graduation he received his training in General Surgery at the University of North Carolina, Strong Memorial Hospital and the State University of New York Medical Center in Syracuse. After a year as Instructor in Surgery on the Syracuse faculty, in 1960 he entered private practice in general surgery in Duluth, MN, and practiced until retirement in 1991. During his surgical career he served as Chief Surgeon for the Duluth, Mesabi and Interlake Railroad and as Chief of Surgery at St. Luke's Hospital and St. Mary's Medical Center.

Upon completion of my surgical training, I was appointed an instructor in general and thoracic surgery at Syracuse, NY. After a short time, I left and started a private practice in Duluth, MN in 1960. The area was experiencing an economic depression and the patients were struggling to keep their "heads above the water." The payments of many patients to a physician were delayed or absent. A few local industries asked me to care for their injured workers and I became involved with industrial medicine as a third interest.

I was on call twenty-four hours a day, seven days a week. The patients were referred to the office and had a minimum workup. Each patient would require a history, physical examination, laboratory studies, and X-rays. The patient would be admitted to the hospital the day before surgery. At that time, the patient would be visited in the evening and briefly examined. I would discuss with the patient and family the surgical problem and the contemplated operation. On the day of surgery, the entire family would be present and the findings at surgery discussed. The patient would remain in the hospital for four to five days after surgery. The daily visits allowed me to listen to the many concerns of my patients. I became involved with the well being of the whole patient. This often led me to take an advocacy role.

A bond developed between the patient and the physician. On one occasion when I had gone on a fishing trip to a distant isolated lake, one of my patients was admitted to the hospital with an apparent acute surgical abdomen. The patient refused to allow anyone but me to operate on her. Her husband located me on the lake and drove me back to the hospital. Surgery revealed a "gall stone ileus" with a small area of necrotic ileum.

The interns managed the Emergency Room (ER). This required frequent daily visits to the ER to train and teach the interns while evaluating and treating my patients. This provided an opportunity to listen to my patients under stress and learn of needs not revealed previously.

The winds of change were felt in the mid- and late- nineteen sixties. Medicare legislation was passed in 1965; the free-standing internship was abolished; a neonatology unit was started in 1966; a three-year family practice residency program was developed; the government promoted the expansion of the number of individuals graduating from medical schools by increasing the size of the classes and the number of medical schools, which allowed us to establish a two-year medical school at Duluth in 1972; fully trained ER physicians at the hospital twenty-four hours a day evolved; and cardiac surgery started in 1983.

The introduction of flexible endoscopes, staple guns, laparoscopic surgery, computerized tomography scans, magnetic resonance imaging, mammograms, and invasive radiology stimulated a steep learning curve resulting in a multitude of new procedures and advances in surgical knowledge.

This was supported by the growth of oncology, respiratory support services, parenteral intravenous nutrition and the availability of many new antibiotics to control infection and for prophylaxis.

The passage of Medicare and the rapid expansion of third party payers eliminated the patient's concerns for cost, resulting in an exponential growth of demand for medical services. We were able to satisfy this demand by selecting new physicians from the expanding number of doctors graduating from the medical schools. Duluth was soon serviced by a wide spectrum of specialists. The public and many in the medical profession expected miracles every day. It became difficult for a terminally ill patient to die. Surgery ceased being a spiritual experience but became a minor inconvenience. The families stopped coming to the hospital at the time of surgery and requested that they be phoned after surgery, as they desired not to lose time from work. Surgery changed from "an art" to a "technical skill."

This explosion of demand created an inflationary spiral of medical cost. This made medical care and health insurance too costly for many. The third party payers reacted with a vigorous attempt to control costs by limiting hospitalizations, encouraging outpatient surgery, reducing consultations and requesting prior approval for certain surgical procedures. The physician was given the role of gatekeeper as well as provider. The medical provider was placed under heavy pressure to modify his/her treatment to reduce costs. The time previously spent with the patient was eroded by paper work, utilization and outcome reviews, and telephone calls to providers.

The doctor-patient relationship of listening, caring, compassion and advocacy developed as the result of spending time with the patient and family without expectation of remuneration. It is under siege by a society that wants more and more. Production is the "Holy Grail." The emphasis is on maximizing profit and income. The future course of this relationship will be decided by our diverse society. The course will reflect multiple compromises between the competing groups. At this time, I do not expect any significant improvements in health care resulting from legislative action. I worry that our judicial system will continue to disrupt our medical care systems as we have witnessed with the silicone breast implant trials.

My years of surgical practice were joyous and spiritually rewarding. I would gladly do it again.