*From time to time, an article or editorial in this journal has prompted a response from a reader. Much is the case with Dr. Arvey I. Rogers, professor emeritus at the University of Miami Miller School of Medicine and a retired gastroenterologist in Florida. Dr. Rogers sent me his thoughts on the physician-patient relationship as an adjunct to editorials that previously appeared in this journal addressing guidelines for consultants and the an and science of medicine. His editorial, "The Corner Stone of Medicine: The Physician Patient Relationship," is reproduced here with permission from Dr. Rogers, the Unii,ersity of Miami Miller School of Medicine and the Dade County Medical Association, publishers* of Miami Medicine.

*- William L. Winters, Jr., MD, Editor-in-Chief, journal of the Methodist DeBak$_{ey}$ Heart Center*

# THE CORNER STONE OF MEDICINE: THE PHYSICIAN-PATIENT RELATIONSHIP

Arvey I. Rogers
*From University of Miami Miller School of Medicine, Miami, Florida*
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Medical care and the practice of medicine as we have known it, and in many ways still wish it to be, is no longer what it once was and unlikely ever co be again. The major consequence of the changes we have experienced is the loss of a degree of control we physicians once possessed. There is less of the passion once felt by many of us who were drawn to the medical profession for mostly the right reasons. External pressures, well known and coo numerous to recount ac chis rime, are damaging the cornerstone of medicine, the physician-patient relationship. Physicians are angry, frustrated, and working harder than ever co adapt to changes and pressures and co continue to deliver high-quality medical care despite the obstacles. Patients are angry, frustrated, and working harder than ever co learn how to cope with changing rules and doctors. The cornerstone has been chipped, eroded somewhat, but not destroyed and is still recognizable easily whenever some circumscance, scheduled or otherwise, brings together che physician and patient no matter the setting. This brief editorial is directed to physicians who still care and will continue to care about the physician-patient relationship.

During the 37 years that I was a member of the full-time faculty at what has since become known as the University of Miami Miller School of Medicine (UMMSM), I saw many patients, indigent and private, and taughc many students, house officers in internal medicine, and residents specializing in the field of gastroenterolo$_{gy}$. In all these interactions, I focused on the ph$_{ys}$ician-patient relationship whenever possible. Ie was during those early years chat I began to assemble a list of ways for physicians co enhance chat relationship. An evolving list was first presented publicly at a memorial lecture I was invited to give in 1997 at the 32nd annual meeting of the Florida Gastroenterologic Sociery; che tide of my presentation was "ON BEING A PHYSICIAN: The Physician-Patient Relationship." It was an average presentation, in my view, which was surprisingly well received by an actencive audience of predominantly practicing gastroenterologists. My interpretation of their response was that some, possibly much, of the content of that presentacion resonated with and perhaps aroused the almost-furgotcen feelings for becoming a physician. Perhaps it stimulated an anamnesis of a once-felt passion. Every year since I retired in lace 2001, I have participated in a series of professionalism lectures coordinated by the Division of Gastroenterology at UMMSM. In my discussion, On Being a Physician, I present copies of Enhancing the Doctor-Patient Relationship, which lists 20 suggestions. I believe char genuine efforts to incorporate these suggestions into daily physician-patient interaction and encounters will provide some of the mortar needed to repair the cornerstone of medicine and prevent its further erosion.

## ENHANCING THE DOCTOR-PATIENT RELATIONSHIP

1. Demonstrate genuine caring and compassion.
2. Acquire skills to bond quickly. Be human in your interactions.
3. Give the patient your full attention; liscen with a third ear {what our patient is really saying or attempting to convey).
4. Be quick co apologize co your patients for: being late, appearing discracced, interrupting their visit by accepting or making a phone call or chatting with a colleague, forgetting something the patient just cold you or cold you previously.
5. Avoid acting as arrogant as patients ofcen assume physicians can be.
6. Remember something of a personal nacure about your patient and mention it during a visit, whether in the office or hospital room sening.
7. Be respectful when you respond to a patient who has questioned you regarding a test or treatment you have recommended.
8. Be prepared to react to results of tests you have ordered, i.e. normal,

abnormal, or equivocal.

9. Don't dismiss the fact that *you* are responsible for the development of a new set of complaints in a pacient you have been following, i.e. side effects of treatment; symptoms or signs of a misdiagnosed underlying condition; a new illness, etc. Premature referrals by "passing the buck" may trigger patient anxiety.
10. Whenever possible, set aside time to review test resulcs personally or by phone (when appropriate) and document that you have done so (sometimes sending the results with a note to the patiem).
11. Recurn phone calls within a reasonable period of time.
12. Document your phone conversations and the results of laboratory or other test results by dictating or handwriting a note and plans for follow-up when appropriate. The same suggestion applies to times when you are covering a colleague or one of your patients contacts you after office hours or on a weekend.
13. Avoid criticizing a colleague or the institution in which you work (or any colleague in "elsewhere" inscicutions, for that maner). Remember that your own candle burns no brighter just because you blew out a colleague's; it only seems to. Be diplomatic when suggesting that the patient seek another opinion when you are concerned about the one given.
14. Remember that while you may not be concerned about a particular problem, your patient usually is (ac some level), may not express it, or may be more fearful char you feel is justified. Remember to be aware of your patient's feelings; be careful not to project (or protect) your own {which may make you more comfortable).
15. Demonstrate a sense of humor to lighten che situation (when appropriate), display your human side, but always act in a professional manner.
16. Never be reluctant to say "I don't know" when you don't; or refer co a colleague "down the street" who may know something more than you or perform a procedure you can't.
17. Transmit appropriate information co your patient and involve chem in a shared decision-making process. Be certain to summarize for your hospitalized patient ready to be discharged a) why s/he was hospitalized; b) what transpired during the hospitalization; c) what medications you are prescribing and why; and d) when you intend to see him or her again in your office.
18. Never assume that your patients understand the information you have given them unless you have confirmed thac they in fact do.
19. As well, never assume that your patient has taken a medication the way it has been prescribed, or, for that matter, has taken it at all. Attempt to confirm as delicately as possible, recalling that non-compliance is a common problem for many reasons.
20. Be prepared to respond to your patient's questions about the recent OTC advertisements with which s/he is bombarded daily. Give them your unbiased opinion. The same applies to information obtained from the Internet.

Before concluding my comments, I hasten to add that the physician-patient relationship is a two-way street. We are all familiar with the difficulc patient who comributed to the erosion of that relationship. In my presentations on professionalism, I have always emphasized the characteristics char define rhe "difficult" patients, the ones who cry our patience. They include:

I. Always late
2. A frequent "no show" for a scheduled appointment
3. Assumes s/he is your only patient
4. Calls frequently
5. Asks numerous questions, most of which have been asked and answered in the recent pasr
6. Never content with any explanat10ns
7. Never gets better or worse but always complains; usually, no organic illness has been detected
8. Is non-compliant with medications, changes in diet, or ocher minor lifestyle changes recommended
9. Presents long lists of drug "allergies"
10. Your Rx recommendations have already been cried/failed under the care of other physicians
11. Makes negative remarks regarding your colleagues
12. You suspect drug seeking behavior
13. Repeatedly delinquent on paying bills and neither offers explanations nor suggests alcernative payment plans
14. Never really thanks you for your efforts

These patients present difficult challenges. Optimizing the doccor-patient relationship under challenging circumstances is difficult bur not impossible. Frank discussions may help. When the relationship is compromised irreconcilably, rhe wisest decision may be to inform the patient that you can no longer assume their care. You have coo much co offer those patients who understand the importance of che doctor-patient relationship and are willing to work with you to keep it strong. The responsibili$_{ty}$ co maintain che scurdiness of che cornerscone of medicine should be shared equally by patient and physician. Each has something co give to a relationship which benefits both.