Richard M. Glass
(JAMA, Janeiro de 1996)

The patient physician relationship is under siege. I believe there are two sources that underlie the distress experienced by many patients and physicians in their interactions with each other. First, there is an intensification of the tension between the science and the art of medicine. Second, there are severe strains related to the rapid changes in the economics of medical practice. (...)

A physician can hardly be "too scientific" in the sense of having an understanding of a disease and the knowledge necessary to diagnose and treat it successfully. (...)

But there is no need to turn back the scientific clock in order to have good patient-physician relationships. (...)

The compassionate and effective application of the best medical science to a particular patient is the essence of the art of medicine.(...)

We also need more scientific studies of the patient-physician relationship, particularly regarding the effects of various types of communications and physician behaviours on outcomes of care (...)

Recent changes in the organization and economics of medical practice constitute the other major source of stress in the patient-physician relationship. These changes have increased the tension between medicine as a business and medicine as a profession. The language of business has become pervasive in medicine, with patients becoming customers, clients, or consumers and physicians becoming just one type of provider . (...)

In the new era of cost controls and managed care, the incentive to do more that was present in fee-for-service practice has shifted dramatically to the incentive to do less. The "less" usually includes less time spent with each patient, a fundamental threat to establishing a good patient-physician relationship. (...)

The patient-physician relationship is the center of medicine .(...)

The integrity of the profession of medicine demands that physicians individually and collectively recognize the centrality of the patient-physician relationship and resist any compromises of the trust this relationship requires.

Allan S. Detsky
(New England J Med, Janeiro de 1996)

For more than 20 years, investigators have documented substantial variation in the use of medical and surgical procedures, hospital resources, and medications at both the regional and international levels. From this research we have learned that the type of medical care that patients receive may depend on where they live. More recently, investigators began to study another type of variation — variation in clinical outcomes such as mortality after cardiac surgery. Once again we have learned that there is substantial variation among regions, hospitals, and even individual physicians. (...)

There are three main reasons why there might be variation in the use of diagnostic and therapeutic procedures: differences in health care systems, physicians practice styles, and patients characteristics. (...) More recently, investigators have focused on variations in the clinical results of particular medical interventions among both regions and the patients of individual physicians. The first reports of variations in outcome were greeted by physicians with the response that "my patients are older and sicker, and that's why they have worse outcomes". (...)

Who cares about variation? Patients care. They will be unhappy to discover that the care they receive is sometimes merely a function of chance, affected primarily by where they live and by differences in knowledge among doctors .(...)

Those who manage health care systems also care about variation in medical practice. They are held accountable by those who pay the insurance bills to give them good value for their money. (...)

Finally, physicians care about variations in care because they are fundamentally interested in delivering the best possible care.

Robert Steinbrook
(New Eng J Med, Março de 1996)

Emergency department care for patients whose problems are not true emergencies has become a fashionable scapegoat for the ills of the health care system in the United States. Such care is considered wasteful and expensive and is therefore a prime target for cost-cutting efforts by health maintenance organizations (HMOs) and other insurers. In 1992, there were 89.8 million visits to the emergency departments of nonfederal short-stay hospitals in the United States, or 35.7 visits per 100 persons. The majority (55.4 per cent) were classified as nonurgent. Patients with nonurgent conditions often face long waits at emergency departments; they contribute to overcrowding, particularly at public and urban hospitals, and may divert attention from severely ill patients.