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Special Health Report

Doctors Vanish From View

Harried by the bureaucracy of medicine, physicians are pulling back from patient care

By Katherine Hobson



It was slow water torture," says Paul Ryack. That's how the 63-year-old board-certified internist describes his working life just a few years ago. With a few thousand patients, many of them elderly, he could barely find time to listen to halting explanations of their immediate complaints--let alone talk about the importance of lowering blood pressure or losing weight--in the 15 or so minutes he could allot to each. "I was unable to make the time to sit with patients, to get to know them, to help with preventive activities that we need and want," says Ryack, who practices in Santa Barbara, Calif. His costs were so high, and payment per patient so low, that taking even another dozen minutes wasn't possible. "You'd go broke," he says. The end result: a creeping sense of burnout.

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Many doctors around the country are similarly frustrated. A 2001 California survey of physicians found that 75 percent of respondents grew less satisfied with practicing medicine over the previous five years. A nationwide survey by the Henry J. Kaiser Family Foundation found that 87 percent of doctors say the overall morale of the profession has gone down in the past few years, and nearly 60 percent said their own morale had declined.

Chat with your own doctor--on the off chance she has time for a conversation--and she is

likely to echo those sentiments. "The practice of medicine does not offer the kinds of rewards for what you have to put into it," says Carl Getto, associate dean for hospital affairs at the University of Wisconsin Medical School, who oversees a staff of more than 1,000

physicians.

The hassle factors. Those rewards--including satisfying relationships with patients, autonomy, high status, and comparatively high pay--are increasingly outweighed by the reality of a 21st-century U.S. medical practice. In their place: reams of time-consuming paperwork that is out of proportion to time spent caring for patients, declining reimbursements from insurers, a loss of autonomy from managed care, and fear of malpractice lawsuits.

For patients, the implications of these changes are huge. Some doctors are retiring or cutting back their hours. That means fewer doctors are available. Others are opting for specialties, such as radiology, with less demanding schedules. Many are cutting out certain insurers, and thus cutting out patients who use those insurers. A handful are deliberately

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restructuring their practices to see fewer--and richer--patients. "It's like a casino," says Doug Farrago, a family medicine physician in Auburn, Maine, and publisher of *Placebo Journal*, a publication filled with the dark ironies of current medicine. "Older docs can cash in their chips, and younger ones are looking for a different game," he says. In a country that will demand more and more from its healthcare system as the population ages, this is only going to get worse--and your doctor's problems may become yours.

It's not surprising that the doctors who are most upset about how things are now are the 50- and 60-year-olds who remember how it used to be: You made medicine your top priority and reaped emotional and financial rewards. "It was the golden age of medicine when they came in--it was fee for service, and you did what you thought was the best thing for the patient," says Phil Miller with Merritt, Hawkins & Associates, an Irving, Texas-based physician search firm. But the rise of managed care and large insurers, for better or for worse, has changed things. Insurance companies may not cover the drug a doctor prefers to prescribe for a given condition. Mountains of paperwork are required to gain approval for consults or outside services. Then there is the threat of malpractice suits. Doctors in so-called crisis states have stopped delivering babies or staged walkouts in the face of climbing insurance rates; even where insurance is more affordable, doctors fear being sued. That takes a toll.

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So does the ever ticking clock. Insurers, doctors say, keep reimbursements so low that it's not economically possible for a primary-care doctor to practice with fewer than a few thousand patients on the rolls. That's where the squeeze comes in--the average 17-minute office visit may not be sufficient to get enough information to diagnose the problem and talk about the ever growing list of health issues they're supposed to bring up, from screening for skin cancer to advocating exercise and a healthful diet to being alert to signs of domestic abuse or addiction. That doesn't even count time to answer patients' questions about drug ads they've seen or information they've researched on the Internet. "The average doctor sees 25 people a day," says Rachel Naomi Remen, cofounder of the Commonweal Cancer Help Program and a family and community medicine professor at the University of California-San Francisco (story, page 51). "I don't know how to say hello to 25 people a day."

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A matter of time. Worse, those meager 17 minutes may be with a different doctor every few years, because when employers switch insurers, or people change jobs, their old doc often isn't part of the new plan. That's a real loss. When you aren't familiar with a patient's past care, it becomes difficult to track, monitor, and anticipate the medical needs.

Patients in turn feel less connected to doctors whose names they may not even remember; that contributes to eroded respect. "My father had a lot of health problems and was taken care of by a gentleman who was fairly old at

the time," recalls Jeffrey Sartin, a 43-year-old infectious disease specialist in La Crosse, Wis. "My dad regarded Dr. Murphy as only slightly below God, and that awe and respect . . . is something I learned at a very early age. That has definitely changed. Not only are doctors

not accorded respect, people are waiting to throw brickbats at them."

Sartin hastens to add that he doesn't want to return to the paternalistic days when patients were so in awe of doctors that they accepted their decisions, no questions asked. But some doctors are frustrated that while they have less sway with patients to comply with treatment, they have more expectations heaped on them to produce perfect outcomes and are left holding the bag when something--even something out of their control--goes wrong. Says Stephen Sokolyk, a cardiologist in New Braunfels, Texas: "We have the responsibility but not the authority."

None of these problems are going away, because the dismay of the elders has now trickled down to newly minted healers. "Even young physicians who come out eager and excited at the end of their training program

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encounter frustrations early on," says Jack Lewin, CEO of the California Medical Association. When Merritt, Hawkins surveyed residents to see if they would still go into medicine if they had it to do over again, those frustrations surfaced. In 2001,95 percent said they'd pick medicine over an alternative career. But in 2003--just two years later--that had dropped to 74 percent. "In my residency, if you had polled, at least half would have said that if they could go back to college they wouldn't choose medicine," says one new physician doing an endocrinology fellowship.

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The doctor is out. While it's still very competitive to get into med school, some worry the best and the brightest may soon avoid the profession altogether. Med school applications are more than 10,000 below 1996's peak of 47,000. In a 2001 survey by the California Medical Association, two thirds of doctors were not advising their kids to enter the profession. "When I did my rotations, I had older physicians every other day telling me to get out now," says one recent med school graduate who subsequently dropped out of her residency program.

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You may be thinking, "I don't like Monday mornings either, and I'm sure not getting paid as much as a doctor." Indeed, doctors still earn a very good living--an average of about \$150,000 for family practitioners and two or more times that for lucrative specialties like cardiology. But doctors also spend many years in training earning little or nothing and face big bills from med school. In 2003, the median debt for graduates of public med schools was \$100,000 and, for those graduating from private schools, a whopping \$135,000, according to the Association of American Medical Colleges. (In 20 years, the median

debt level has increased more than 4.5 times.) Meantime, malpractice insurance rates are still climbing. An obstetrician-gynecologist in Illinois could pay as much as \$230,000 per year in Illinois or \$90,000 in Los Angeles, according to *Medical Liability Monitor*.

All of this adds up to a growing concern that people may soon have trouble finding a doctor.

Estimates of the shortfall vary. Miller is predicting a shortage of between 90,000 and 200,000 physicians by 2020. Richard Cooper, director of the Health Policy Institute at the Medical College of Wisconsin, has long predicted shortages and also says the gap could hit 200,000 by the same year. Both urge an increase in the number of doctors being trained, which has been stagnant for years. The Council on Graduate Medical Education, the American Medical Association, and the Association of American Medical Colleges, all of whom had projected surpluses in the past, have

recently changed positions and acknowledged the problem.

Shortages will (and do) vary by geographical area, depending on reimbursement levels, malpractice insurance rates, and the cost of living. The problems are always grim in rural regions--the National Rural Health Association says that 25 percent of the population lives in rural areas, though only 10 percent of doctors practice there. Most experts say shortages of primary-care physicians will occur mainly in these parts of the country--primary care isn't appealing for its relentless office schedule and relatively low compensation. (Last year, the Task Force on Wisconsin's Future Physician Workforce said that the state is already short 506 primary-care physicians, with no relief in sight.) Already underserved inner-city areas may also be at particular risk. African-American doctors, who are far more likely to treat minorities in these urban areas, are no less bummed out than the rest of the profession; a survey of African-American doctors sponsored by the National Medical Association last year found that most were dissatisfied with practicing medicine.

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In California, where the cost of living is high, there are shortages of primary-care docs, neurologists, and surgical specialists. "The wait is three weeks to a month to see a pediatric neurologist, and pediatric nephrologists are as rare as hens' teeth," says Harvey Cohen, head of pediatrics at Stanford University School of Medicine. Already, Merritt, Hawkins reports that the average wait for a new patient wanting to see a cardiologist is 37 days in Boston and 22 days in New York. For an obstetrician-gynecologist, the wait is 45 days in Boston and 31 days in San Diego.



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Specialty problems. In certain specialties like geriatrics, cardiology, neurosurgery, and oncology, the shortages are projected to be nationwide, even in areas with a high concentration of doctors. Demand for their services will rise as the baby boomers age and develop chronic conditions, but there isn't a corresponding surge of interested students.

Instead, today's med students are gravitating toward nonsurgical specialties with regular hours. In last year's "match" of new grads to postgrad medical residency programs, grads of U.S. med schools filled 97 percent of the dermatology slots but only 41 percent of the

family med slots. There were about 2.5 applicants for every family medicine position open and about 14 for every radiology position. The American Association of Neurological Surgeons said last year that demand was vastly outstripping supply and noted that the field isn't perceived by

med students as offering a regular schedule or enough personal time. Some specialties may change training to attract more doctors. The American College of Cardiology, for example, is considering whether to trim the current six-year training by a year, cutting out the interventional procedures that aren't done by general cardiologists anyway. That would increase the supply as well as possibly attract candidates turned off by the longer training period.

It's not to say that young doctors are slackers or that no one is interested in the most academic specialties. But as a group, they are thinking very differently about their careers than did their predecessors, refusing to put medicine above family and personal time. One saying: The R.O.A.D. to happiness lies in radiology, ophthalmology, anesthesiology, and dermatology. "There is a generational difference in what we see as important in our careers and personal life," says Jennifer Shu, immediate past chair of the American Medical Association's Young Physicians Section. "Whereas career might have defined you in the past, it doesn't anymore." She and her husband are a good example: She took two years off to have children and now works part time as an instructor of pediatrics and medical director of the nursery at Dartmouth (and writes books in her off time), and her husband is back at school for public health and outcomes research, with an eye toward a career in epidemiology. "I have to take care of my house, my own life, and my son--I make limits," she says.

Statistics show that women--who now make up the majority of med school applicants--work fewer hours than male physicians do. But this desire to have a life is more generational and linked to expectations about what a medical career will and will not provide these days. "It's very clear that all physicians are looking towards having a life outside their medical practice," says Getto of the University of Wisconsin.

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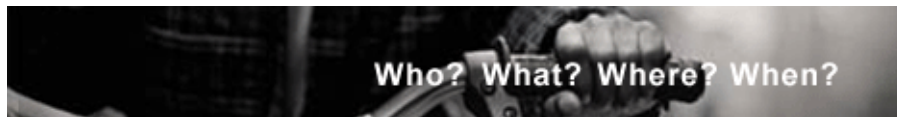
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Meantime, doctors already on the job may consider changing their practice to adapt to the new realities--often in ways that affect patient access, especially for the poor (the rich can always pay cash or buy more comprehensive insurance). Only 11 percent of those elusive Boston cardiologists surveyed by Merritt, Hawkins accept Medicaid. About 17 percent of family practitioners nationwide don't take new Medicare patients, and those figures are worse in metropolitan areas. A 2002 study in California found only 58 percent of the state's doctors were accepting new HMO patients, while a third of specialists had no HMO patients at all. Some are turning to cash-only systems. All these restrictions squeeze out the poorer segment of the patient population.

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A handful of physicians are finding relief by turning to so-called boutique, or concierge, practices, typically charging an annual fee to cover preventive services not covered by Medicare. A perhaps not-so-coincidental benefit is that the extra fees mean a smaller practice, which in turn means less waiting time and more access to your doctor. Though the \$1,500-\$1,800 annual fee has been called elitist, Darin Engelhardt, chief financial officer and general counsel of MDVIP, which provides business support services to boutique practices, says only a tiny fraction of doctors have a practice appropriate for this kind of

care. For the doctors who do sign up with his and other services, "there is a uniform theme--the desire to be able to take back control of a primary-care practice," he says.

Scant rewards. In a special report in the *New England Journal of Medicine* last year, physician

and journalist Abigail Zuger compared the discontent in medicine to similar feelings in other professional fields, including law, nursing, and teaching. Maybe, she says, doctors are just no longer isolated from the pressures that plagued their colleagues in other professions. "It is an exception whose time has finally expired," she concluded.

There are still plenty of doctors who see their work as a higher calling or at least love their jobs.

And some studies duck the image of disgruntled docs: The *Journal of the American Medical Association* reported last year that most doctors are still satisfied with their jobs, though they voiced unhappiness with the administrative aspects. When done right, medicine "is one of the most deeply rewarding lifestyles in the world," says Remen. But many docs are feeling those rewards are only available by practicing medicine on their own, radically revised terms.

Paul Ryack feels invigorated again--but only after making big changes. He joined MDVIP, and his practice is down to 600 patients. Now he spends as much as 90 minutes with some of them. "I'm enjoying what I'm doing again," says Ryack. "I don't worry that I'm missing something because there's a line at the door. My quality of life has improved, and my patients love it." His is only one solution to the problems of practicing medicine these days, but the others that are appearing will also leave gaps that the country has not yet figured out how to fill.

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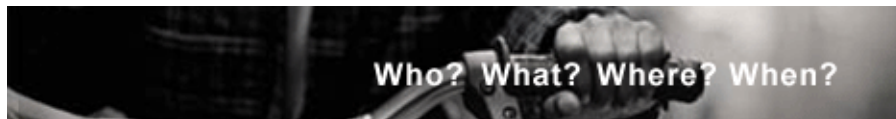
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