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Special Health Report

Who Will Take Care of You?

A growing gap separates doctors and patients. The new healers are now stepping in to fill the void

By Josh Fischman



It is no longer a happy marriage, this relationship between doctors and patients. A bond once tight with intimacy is under incredible strain. Doctors have changed. Patients have changed. The caring is gone. Well, not gone but buried under the crush of everyday life. Buried under insurance headaches as patients now come burdened with reams of paperwork for doctors to fill out for reimbursement, paperwork that eats away at the time they might spend on other patients. So do fees, doctors say, because what insurance pays them is well below their costs. So in a vicious circle that steals more time, they have to see--and bill--a lot of patients each day and shuffle them out of the office no matter how much attention they might really need. "Family physicians are getting stressed to the max," says Mary Frank, who is president of the American Academy of Family Physicians and has a private practice in Rohnert Park, Calif., north of San Francisco.

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Patients, for their part, frequently switch insurance plans to save money, but changing plans means changing care, because the new plan may not cover the old doctor. Nobody gets to know anybody anymore. "Look, docs are nice people, but they're really time pressed," says Todd Ringler, 37, a public relations executive who lives in Swampscott, Mass., outside of Boston. "I found I wasn't able to have conversations that went beyond 'Tell me where it hurts. What's the level of your pain, from 1 to 10?' If you can't go further than that, you can't develop honest communication about your health or health problems."

And going further turns out to be much more than a touchy-feely relationship issue. It is, in fact, vitally important to the patient. Research

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Who Will Take Care of You?

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So where did the time to build that relationship go? The average physician visit hasn't shrunk; from the late 1980s through the end of the 1990s, it has hovered between 16 and 22 minutes, depending on which survey you look at. But what's happening is that both doctors and patients are walking into that visit with new, expanded agendas, says Dana Safran, director of the Health Institute at Tufts-New England Medical Center and another researcher who monitors the doctor-patient pas de deux. "Patients have taken to heart the message to be informed and smart, and they are coming in with a lot more questions and a lot more of their own info that they've taken off the Internet and from other places," she says. "Doctors, for their part, have their own concerns." If they don't ask a lot of straight biomedical questions, insurance companies and healthcare oversight agencies will penalize them, making it harder to get paid. So while the office visit didn't get shorter, docs and patients need to say more than ever in that same tiny time frame.

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Psychosocial ties. So something gets cut out. And what docs cut, says Levinson, are the psychosocial aspects of the visit. "They're not asking about patients' lives, about their communities, about anything that leads to continuity of care," Levinson says. "And these are exactly the questions that patients want to be asked and need to be asked. The biomedical and the psychosocial are so intertwined in primary care."

And that's why Todd Ringler sees Anne Krekis, his nurse practitioner. "I've been seeing her

since 1992," he says. "She really knows me, and I have complete confidence in her and her clinical ability. For instance, I used to be a social smoker, you know, out in a bar. Anne and I had a discussion about it, about the risks to my health and to my family--I have kids--and I never had that kind of talk with a doctor. I've had to switch health plans, or switch care centers in the same plan, and they tell me to get a new primary physician. And I say, 'Fine. Give me anyone. As long as they work with Anne.' She does

my annual physical. She's who I call when I get sick. She really is my doctor."

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has shown that a good conversation that thoroughly explores problems and possible treatments means better health. Physician Sheldon Greenfield and social scientist Sherrie Kaplan of the University of California-Irvine and their colleagues, in an oft-cited series of studies, audiotaped doctors' discussions with a variety of patients, including people with ulcers, diabetes, high blood pressure, and HIV. Some of these patients asked more questions about their illnesses and how to manage them and participated more in developing a program of care. These patients and their physicians said they had the best communication. And after they completed these visits, these patients also had the best control over their blood sugar and blood pressure levels, reported fewer limitations on their lives, and took their HIV medications on schedule. It's not really surprising that they did better with their treatments. After all, they had an active role in devising them, a role

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allowed by these detailed conversations with their physicians. The doctor-patient relationship, the researchers concluded, "must be taken into account."

"This relationship has clearly been shown to affect diagnostic accuracy, adherence to treatment plans, and patient satisfaction," says internist Wendy Levinson, chair of medicine at the University of Toronto. "And the most important part of patient satisfaction is communication with the doctor. Repeatedly, we've found that people will put up with hassles like longer waiting times if they have this good relationship."

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Special Health Report

Nurses Step to the Front

In hamlets and high-tech hospitals, nurses are taking on bigger roles

By Samantha Levine and Angie C. Marek



When white-haired Harry Curry shuffles into the Minnie Hamilton Health Care Center in rural Grantsville, W.Va., he says he'll see only "his doctor." That's his name for Teresa Ritchie, the nurse practitioner who looks after the 71-year-old at this tiny complex tucked in the Appalachian hills. And it's not really a misnomer. The veteran nurse takes on everything from minor surgery to emergency room crises. Ritchie has admitting privileges at area hospitals, still unusual for a nurse, and can prescribe medication with just a doctor's checkoff. Her autonomy surprises her as much as anyone. "When I started out, nurses were not told we could think for ourselves," says the West Virginia native, who delivers care with a dollop of down-home gossip and finds ways to give her predominantly low-income patients free medicine. "We just did what a doctor planned out for us."

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But those times are long gone. Many of the country's more than 2 million nurses are taking on jobs that were once the purview of physicians, like administering chemotherapy and running their own primary-care practices. They are carving new niches in fields such as genetics and computerized patient records, where nurses were once hard to find, and bringing philosophies oriented toward health promotion and problem prevention to geriatric care and case management. "When we are allowed to think outside the box, there is a lot we can do," says Jane Barlow, a University of North Carolina nurse who is developing a

disability screening and intervention system for children in her home state. "In every situation, there is more that nurses can do if they feel empowered."

The seeds of nurses' liberation from doctors' white coattails were sown in the 1960s. That's when a nationwide shortage of primary-care physicians, especially in rural and inner-city areas, pushed many nurses into advanced roles. "Nurses were doing things that most people thought just

physicians were doing, like seeing patients and recommending medication," says Lynne Vigasaa, who in 1972 became the first nurse practitioner in the state of Washington and later helped write the state's regulations defining and governing that role. Through the 1980s, the idea of nurses' doing more than just assisting doctors gained acceptance as patients began seeking out nurses--who seemed to have more time for them--and resistance from physicians' organizations eased. States began formalizing nurses' expanded roles. "It's pretty amazing, when you think about it," says Vigasaa, who now manages a dermatology clinic outside Seattle.

Filling a void. The advent of managed care also opened doors. The law defining health maintenance organizations was passed in 1973. But the idea--prepaid plans that enroll members and arrange their care from a designated network of doctors--brought on serious complications. The plans often tightly control how, when, and why doctors offer medical services. The reimbursements doctors get from the plans are prearranged but haven't all risen in step with the ballooning cost of healthcare. That problem now extends beyond HMOs to all insurance plans, doctors complain, which means they must see ever increasing numbers of patients to remain profitable. Those busy schedules have created voids in patient care--and nurses are filling them. "When patients call doctors for advice these days, many times nurses are the ones at the other end of the line," says Patricia Rowell, a senior policy fellow for the American Nurses Association.

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Special Health Report
Nurses Step to the Front
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Over time, as the hours and roles of medical residents and interns changed, many nurses with master's degrees who specialized in fields such as pediatrics were called upon to perform tasks once reserved only for the med-school set. Rowell, a pediatric nurse practitioner, remembers hearing of her colleagues in infant intensive-care units being allowed to insert breathing tubes down the throats of delicate babies. "It was an incredible thing," she says. These trends are continuing today as residents' exhausting schedules are further cut back--for reasons of patient safety.

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As nurses are asked to do more, they are also trained to do more. In 1980, 60 percent of nurses received their basic education through on-the-job training courses in hospitals. That number was cut in half by 2000. During that same time, the share of nurses earning associate's degrees more than doubled, to 40 percent. The number of nurses pursuing master's degrees and doctorates has tripled over the past two decades--by 2000, one in 10 registered nurses had made the leap. And the number of doctoral programs nationwide has grown from 52 in 1990 to 93 today. By 2015, the American Association of Colleges of Nursing wants all nurses doing advanced practice work that now requires at least a master's degree--this includes nurse practitioners, clinical nurse specialists, nurse

midwives, and nurse anesthetists--to hold a doctorate of nursing practice.

Nurses already have rigorous training. Most undergraduate nursing schools require students to take a variety of courses, from

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statistics to biology, before they can even enter the nursing program. Once in a program, students' classes include anatomy and ethics, and they must complete several

practicums. After earning an undergrad degree, every student must pass a nationally standardized test before officially becoming a nurse.

Rules governing what nurses are allowed to do with this training vary by state. "You sometimes push for 15 years, so hard, just to take one baby step," says Marie-Annette Brown, a nursing professor at the University of Washington who helped lobby to give nurses in her state more power to prescribe medication. Before such efforts, nurses could not prescribe controlled substances like morphine without doctors' supervision. That's still the case, though, in 37 states that demand a doctor's sign-off. But 27 states allow nurses to open their own private practices without a doctor in the house. Many nurses still have trouble, however, persuading insurance companies to reimburse them for their work.

Whole-patient care. But more than the ability to prescribe drugs, nurses are pushing to practice a breed of care that bears their unique imprint. "More so than doctors, we focus on health promotion, the strategy of teaching our patients how to live healthier lives," Brown explains. This means helping patients manage their symptoms and chronic conditions and avoid health pitfalls like poor diets. "If I have a child with diabetes, I try to teach him to self-regulate his condition," says Rowell. "But I also tell him to . . . engage in after-school activities; don't be afraid to live a normal life."

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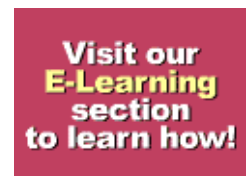
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Special Health Report

Nurses Step to the Front

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Looking at the whole patient is critical for oncology nurse Ann Welsh. As a senior nurse in the chemotherapy division at the University of Pittsburgh Medical Center's Hillman Cancer Center, she is doing more than she could have imagined when she graduated with an associate's degree in nursing from Northern Virginia's Marymount University in 1973. At that point, she was given a little white nurse's cap and went to work on the National Cancer Institute's pediatric ward. "Early on, I was the liaison between the doctor and the patient," she explains. But through the 1980s, as more cancer treatment moved to an outpatient basis, her responsibilities grew to coordinating most aspects of her patients' therapy regimen. With her understated manner, Welsh, 51, gently administers chemo to hundreds of patients. Though she closely collaborates with Hillman's oncologists, there's nary a doctor in sight while she sets up complicated webs of intravenous drips for folks like Mario Urlini, a hearty 83-year-old who's getting his last treatment for non-Hodgkin's lymphoma. While Welsh connects the clear tubes, Urlini's wife, Grace, looks on and says: "I went through two major operations, and I never found a nurse like Ann."



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Welsh also trouble-shoots problems with patients, such as sorting out whether an older man with worrisomely low blood counts can undergo needed cataract surgery. Patients call Welsh, not their physicians, with day-to-day concerns. "I know them inside and out, so I can assess if there is a big change," she says. "We can take better care of our patients if we use our own judgment, provided we know them and fully understand the course of their disease." As for that nurse's cap? "I wore it for a few months," says Welsh. Then she threw it out.

Balancing act. The ability of nurses to balance complex elements of long-term care while acting as counselors has made them a good fit as case managers. They work as the

primary contact for patients, like the elderly, who have complex treatment plans. They can help eliminate frustrating redundancies among various doctors' offices and keep a constant record of detailed medical regimens. In San Francisco, gerontology expert and nurse Monika Pettross started her own case-manager business four years ago. One year into the venture, she began working with an elderly woman whose family found a suicide note in her home. Pettross, 32, discovered that some of the patient's medications could badly interact and lead to depression. After suggesting changes to the woman's prescriptions, she helped place her in a therapy program and counseled the family on how best to offer support. After two months, the woman was looking for a part-time job. Pettross still works with her today. "This work is so important I can't take off a badge in my free time and walk away from it," says Pettross.

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Pettross is on to something. As people live longer and the nation's 78 million baby boomers approach retirement, more nurses are taking on elder care. The federal National Institute of Nursing Research is devoting millions of research dollars to the topic. One project explored the effect of delivering education and follow-up care at home to older patients hospitalized for heart trouble, says institute director Patricia Grady. Home delivery decreased the number of visits to the hospital, saving \$4,845 in Medicare expenses per patient.

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Nurses are also walking the cutting edge of health technology. They are at the vanguard in shifting hospitals away from mountains of problematic paper patient charts to automated, computer-based systems that cut down on de-lays and errors, says Scott Young, director of health information technology at the federal Agency for Health Research and Quality. About an hour south of Pittsburgh at Uniontown Hospital, Chief Nursing Officer Rebecca Ambrosini is one of those pioneers. Tired of 40-plus-page medical charts that "were never where we needed them when we needed them," she helped make a monumental change. After two years of work, nearly 85 percent of Uniontown's patient information is now available in a user-friendly desktop program called PowerChart. Only about 13 percent of U.S. hospitals have done anything like this.



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The Uniontown system not only records patients' vital stats, like allergies and blood pressure, but also automatically sends doctors' orders to nurses, organizes reminders on necessary lab work, and sets up schedules free of hassles like double booking. The program also fires off automatic requests for help from social workers and even interpreters if one is needed. "Before, you had to pick up a phone and call for this assistance--if you remembered," says Darlene Ferguson, a critical-care nurse who is now Uniontown's director of clinical informatics and runs the system on a day-to-day basis. "We would grab

a paper towel, write down what we needed, and stuff it in a pocket."

New ventures. At first, this high-tech onslaught made some Uniontown nurses a little nervous. "Some people talked about quitting" because they were worried about using computers, says registered nurse Donna Martin. But Ambrosini and Ferguson ran hours of workshops to get everyone up to speed. Now, wireless PowerChart workstations on wheels line the beige hallways at the 230-bed facility. Nurses roll the computers into patients' rooms to take information and update charts with a keyboard and mouse rather than paper and pencil. There also are computer

stations that are built into the walls and fold up like Murphy beds.

Nurses are also gaining ground in one of the fastest-growing areas of medical practice: genetics. According to Grady, of the nursing research institute, it makes sense for nurses to be involved in this fast-moving field because while genes may put patients at risk for health problems, changes in lifestyle and habits--a topic close to nurses' hearts--can help mitigate them. One recipient of the institute's funding is Lorraine Frazier, who holds a doctorate in nursing, a postdoc in genetics, and a teaching position at the University of Texas at Houston College of Nursing. Several years ago, when she first told a molecular medicine researcher that she wanted to work with him, "he was surprised," she says. "No nurse had ever asked to do that. Then, he asked me what nurses do." Now he knows. Frazier runs studies looking at how genetics shape the risks faced by patients with unstable heart disease; the results will eventually help tailor treatments for these patients.

For all its advances, nursing is still bedeviled by one old problem: lack of respect. When it comes to funding for nursing research, for instance, the money is a trickle. The nursing institute's budget makes up just 0.5 percent of the overall research pot at the National Institutes of Health. And according to a recent survey from VHA, a Texas-based healthcare cooperative, disrespect often takes a more direct, virulent form: abuse by doctors. Hospital nurses report vicious arguments. This toxic environment causes a breakdown in communication that can adversely affect care.

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Special Health Report

Nurses Step to the Front

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Down in Grantsville, nurse practitioner Ritchie hopes that the research that is going on will not just win more respect one day but will also help her patients with chronic illnesses. In her green cargo pants, black turtleneck (from which hangs her ever present stethoscope), and lug-soled boots, Ritchie ducks from crowded office to examining room to the "extra medicine" supply closet as country music plays on a boombox. She tells Harry Curry she'll go to Wal-Mart and buy him more of the salve he likes to rub on his dry, scaly shins. Then she tells another patient, Delberta Hickman, that it's OK to trust in Jesus to heal her diabetes but that medicine can help, too. She gives a 15-year-old girl free antibiotics and an enormous stack of condoms. "I plan to stay here," says Ritchie. "I couldn't leave my patients."

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It's a simple thing really, says Uniontown's Ferguson: "A nurse always wants to make things better."

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Special Health Report
More Nurses Needed

Call it the shortage that won't quit. Job incentives for nurses that began in the 1990s lured more into the workforce. But not enough. The U.S. Department of Health and Human Services estimates that by 2020, hospitals will be shy almost 810,000 nurses. That represents a 29 percent vacancy rate, up from 7 percent today. "The shortages threaten to grow so big they'll cripple our healthcare system," says Peter Buerhaus, an associate dean at Vanderbilt University's School of Nursing. "We're headed for a crisis."

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The trouble is that most nurses are now headed toward retirement. In the 1980s and 1990s, enrollment in nursing schools sank as young women took advantage of increased career opportunities in other fields. By 2000, the average age of RN s was about 43. In the past few years, high wages have drawn former nurses back to hospitals--but two thirds of the new hires are older than 50, making things more lopsided than ever.

Nursing schools would have to increase enrollment by 40 percent annually just to compensate for retiring RN s. That's going to be hard, because schools recently had to turn

away 26,000 qualified undergraduate candidates for lack of space: They don't have enough faculty. To deal with the problem, states and healthcare companies are luring nursing faculty by funding more positions. Buerhaus predicts more already-trained nurses will be brought in from abroad. Yet it may not be enough: Seventy-eight million graying baby boomers will contribute to a 40 percent increase in demand for hospital nurses over the next two decades. -Angie C. Marek

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Special Health Report
By Bernadine Healy, M.D.

Teaming Up



A young girl with a ruptured appendix; a middle-aged man with a massive heart attack; a mother of three with a scary lump in her breast. Or perhaps it's your mother who fell on the pavement and broke her hip. Or your son who just attempted suicide at college. Or your husband, whose spleen began leaking after an automobile accident. These are everyday events in the world of medicine, but they are all personal crises that quickly make most other everyday things seem trivial.



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At those moments of treacherous illness, what matters most is that the patient is in the trusted hands of expert, caring doctors. Ones who explain what's going on, who are there with round-the-clock ministrations if need be, and who secure the best possible outcome. This is the expected way, honoring no clock or self-interest. And this is the stuff of medicine that makes nice people want to be doctors.

There is no greater thrill than seeing a sick patient heal. No greater joy than knowing hard-earned human efforts made a difference. But to achieve that in today's world, doctors can't fly solo anymore. For one thing, by today's rules no docs should be working around the clock; they need to be spelled by rested colleagues. Beyond that, however, medical advances have led to an ever finer carving of medical disciplines into specialties and sub-specialties, driven by scientific discovery, which has brought good results in the curing or quelling of human disease.

Uberdocs. But this is recent history. Surgery was medicine's first one-on-one therapeutic specialty, flowering over the past 100 years. It was enabled not only by understanding infection

and its prevention through clean hands, masks, rubber gloves, and sterilized instruments but also by the discovery of anesthesia. Without anesthesia, doctors dared not penetrate the belly or chest or drill into the skull. But with it, and accompanied by postoperative teams specialized in intensive care, surgeons began to cure many diseases that, left to their natural course, were killers. The surgeon became the uberdoctor, the center of hospital life, and the ultimate healing hands.

Further medical advances ushered in other disciplines to rival surgery, using less blunt instruments. The internist, for example, started as the learned diagnostician who grasped the disease, pontificated on its outcome, and called in surgeons as needed. In those good old days of the solo doctor making house visits late into the night, his signature black bag was actually pretty empty--and what was there often did more bad than good. It was Oliver Wendell Holmes Sr., the renowned Boston physician and father of the famous Supreme Court justice, who summed it up in a speech before the Massachusetts Medical Society in 1860. After deriding the use of emetics, cathartics, blistering agents, and opium, he told his colleagues that if the whole existing formulary of drugs and potions available to them were sunk to the bottom of the sea, it would be all the better for mankind--and all the worse for the fish.

Drug therapy was mostly quackery back then. Since, research breakthroughs have turned medicinals into rational, safe, and dose-specific therapies. Bearing veritable nanoscalpels in the form of drugs that zero in on a disease pathway invisible to the eye or even the microscope, internists rose alongside surgeons as healers. Much of the diagnostic work was turned over to newer specialties. For example, CT scans and MRI s give physicians the X-ray vision to peer inside a troubled body; and sonograms turn the noises of the stethoscope into images of a beating heart or a growing fetus. Diagnosis got better and much easier on the patient--but high-tech and expensive. This pattern has been replicated in virtually every domain of medicine. At the same time, the general field of nursing spawned nurse practitioners, allied health therapists, and physician assistants to complement medical expertise in the vastly more complex care of both the healthy and the sick.

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Special Health Report
Teaming Up
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Through necessity and opportunity, medicine has become a huge group effort. The titans of yesterday fought hard for their autonomy and happily polished their individual pedestals of near godliness. Yet, the wisest of them set the stage for their own toppling by embracing the endless frontier of medical science, which ultimately transformed the way we give care. But, solo or group, yesterday or today, on the frontier or in the midst of today's fast-paced clinic, the practice of medicine by all its participants has never been easy. It comes with long and continued study, hard physical and mental work, and heavy responsibility. Plus, it demands a piece of one's soul. Future doctors, nurses, and other health specialists always have been chosen not just for their smarts but also for their humanitarian values. They must be kind, merciful, and sympathetic to those they care for, whether the patient is old or young, rich or poor, appreciative or ornery.

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beggars and medicine a trivial part of the nation's economy. Today, the medical professions surely help the good Lord out, but the financial cost is mighty. Healthcare consumes 1 out of every 7 dollars of our national economy, and, as policy wags note, most of it is driven by the physician's pen.

There is an old saying that a physician is one upon whom we set our hopes when ill--and our dogs when well. That's easy to do, since at any one time most people are well and there's a certain suspicion about hefty resources being consumed by the ill. The steady, four-decade rise in health insurance costs, both government and private, has made modern healthcare possible. But at the same time it has introduced a new and less solicitous interest in between doctor and patient--that anonymous, often heavy-handed "third-party payer" holding most of the dollars.



Doctors have gripes galore about the third parties looming large at the bedside and in the examining rooms who effectively drive care by setting fees, dictating benefits, even making medical decisions such as whether a patient can have an extra hospital day or be allowed an MRI. It's legitimate for payers to question expenses, but it's also hard for the solo practitioner to stand up and be heard in this environment.

That brings us squarely to the question: What is replacing our romantic notion of the solitary, autonomous doctor? Ideally, one would hope for an integrated team working together on behalf of common medical goals, with the patient at the center. This, as opposed to what so often happens today: a loosely allied group of independent, unrelated practitioners drawn together in a defensive huddle to meet the needs of insurance contracting and managed care.

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Special Health Report

Teaming Up (Page 3 of 3)



The integrated team model has been around a long time, but it is still the exception in today's private medical practice. It was pioneered by the Mayo Clinic more than 80 years ago. The architect was the surgeon W. W. Mayo, who was fond of saying, "No man is big enough to be independent of others." Mayo and his two surgeon sons, Will and Charlie, developed a model of "cooperative individualism," in which top-notch physicians from all disciplines were carefully selected to work together in salaried positions. Salary was key, because it meant the docs were not answerable to accountants for their medical decisions, and it was understood upfront that some of their fees would be plowed back into the institution. Many in the medical field saw such a cooperative venture as downgrading the medical profession, by making doctors cogs in a wheel. Ironically, the problem today is that all too many individual practitioners see themselves as little more than cogs--but in a broken wheel.



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Sidelines. The clinic model, or some variation of an integrated team, is just what medicine needs today. It will work, however, only if it comes with the purpose and the faith that this will bring better care of the patient and enable the squeezed practitioners to remember what brought them to medicine in the first place. Indeed, the 21st century finds physicians and their patients struggling to meet the medical and economic demands that necessitate team-

oriented healthcare. Here we might learn a thing or two from America's most favorite spectator sport, football, and one of football's best, Coach Bill Belichick of the New England Patriots.

Belichick astounds the sports world by his ability to build a Super Bowl-winning team of solid but

not splendid players. His strategy seems simple: Accentuate any given player's strength, and manage around the weaknesses, something you can do if you have a versatile team. He is proud of his team for being made up of unselfish guys, who work hard, respect him and one another, and on the field are committed only to winning. A group of comparable or even higher-quality athletes, unable to consistently work in unison, would be self-defeating.

That is a lesson for the kind of teamwork that is essential in the medical field now and as we look ahead. It comes with benefits, including pride in doing better for patients, intellectual stimulation, fewer administrative hassles from the third parties, and more reasonable work hours. And, as in football, a successful medical team's glue is that intangible called faith--in one another and those they serve. That timeless ethos is captured in words penned by the Cleveland Clinic's late surgeon George Crile Jr. in 1955: "No physician, sleepless and worried about a patient, can return to the hospital in the midnight hours without feeling the importance of his faith. The dim corridor is silent; the doors are closed. At the end of the corridor in the glow of the desk lamp, the nurse watches over those who sleep or lie lonely and wait behind closed doors. No physician entering the hospital in these quiet hours can help feeling that the medical institution of which he is part is in essence religious, that it is built on trust. No physician can fail to be proud that he is part of his patient's faith."

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