Lost in a System Where Doctors Don't Want to Listen

Advertisement

By Benjamin H. Natelson
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I'd like to tell you about one of my patients. She's the kind of patient that I enjoy seeing but that many doctors go out of their way to avoid. This means that she's also the kind of patient I worry about most -- a patient who in the near future may be stranded without proper care as fewer and fewer doctors, constrained by time and the economics of our health care system, are willing to perform the fundamental task of diagnosing difficult or unclear medical problems.

My patient is a 37-year-old woman, a mother of two teenagers, with a busy career. She was in perfect health until July 2007, when, overnight, she came down with what her doctor said was a case of flu. This "flu," however, wouldn't go away. Her doctor assured her that she'd get better, but three months after her first visit to him, she was back in his office, still feeling ill. The doctor did a thorough medical evaluation, told her that he couldn't find anything wrong and again assured her that she'd eventually recover. A few months later, she was back again. This time, as she described it to me, the doctor sort of shrugged his shoulders and told her that maybe her problem was all in her head.

As you might imagine, the patient was put off by her doctor's dismissal, which set her off on a gyre of doctor-shopping. Over the next six months, she saw eight physicians, as well as a chiropractor and a homeopath, without getting a diagnosis or any real help. Finally, she did an Internet search and found me, a specialist in medically unexplained illness. All her tests were normal, but I listened to her and was ultimately able to make a diagnosis of chronic fatigue syndrome. We then launched into the treatment of her symptom-based illness, a slow process that unfortunately doesn't end in a cure but often leads to improvement.

The fact that this woman couldn't find a doctor to help her until she found me says a lot about where the U. S. health care system is heading. The economics of modern medicine have converted the doctor from Ben Casey to a factory worker on a conveyor belt, and those economic forces are driving more and more physicians toward specialties where they can spend less time with patients and earn more money.

Learning how to make a diagnosis is a critical part of medical education. It requires the doctor to listen to the patient describe the illness and then put it in a personal health framework by asking about other symptoms, previous medical problems (extending to the patient's family) and elements of the patient's life story. Doctors usually schedule an hour for these initial consultations, then 30 minutes for follow-up appointments.

Half an hour of a doctor's time is normally plenty for a straightforward health problem and more than enough for a cold with a runny nose or a cough with no fever. But what happens when your symptoms don't add up to a clear-cut diagnosis? Studies have shown that in more than 50 percent of cases, patient complaints don't have any diagnosable medical cause that can be determined by careful laboratory testing. Pain, fatigue, dizziness and trouble sleeping are among the most common symptoms, and doctors have problems with these because they don't point to any particular diagnosis.

When that happens, the diagnostic algorithm learned in medical school breaks down. The doctor's not sure what's wrong with the patient, and if he has a busy office, he won't have time to think through the patient's complaints to arrive at a coherent diagnosis. Very often, when all the tests are normal and time has run out, the doctor will conclude a visit, as my patient's initial physician did, by saying: "There's nothing really wrong with you. I'm sure you'll feel better in a few days -- or weeks."

Even doctors with time often prefer dealing with straightforward medical problems. I have a friend who's

an allergist in private practice. When I asked him whether he'd be willing to work with some of my patients, he quickly said no. Why, he said, would he want to tackle difficult cases like that when he can take someone suffering from severe allergies and make them better in a day?

Doctors are being lured away from primary care by economic factors as well. Eighty percent of medical students have to borrow money for medical school. The expected median debt of this year's graduating class is about $120,000 for state medical schools and $150,000 for private, according to the American Association of Medical Colleges. At the same time, medical students face a candy store of career choices, all with widely varying earning (and debt-reduction) potential.

I, for instance, am a medical school professor with a practice devoted to patients with medically unexplained symptoms such as fatigue and pain. My patients often have complex medical histories and feel they're at the end of their rope. If a patient has Medicare coverage for disability caused by an illness, Medicare will reimburse me $196 for each hour of interaction with that patient. After expenses and other charges, I'll keep $86, a very good hourly salary.

But consider the neuroradiologist, who specializes in interpreting brain MRIs. Just a few years ago, it would take a radiologist a long time to organize and view many sheets of a patient's X-ray films, but today, thanks to computerization, the well-trained neuroradiologist can assess dozens of images of the brain in just a few minutes. He or she can probably read a patient's images and dictate a report in about 15 minutes. At my previous institution, the hourly reimbursement from Medicare was $492, and the doctor's take-home totaled $216, a substantially better salary than mine.

Physicians in a procedure-driven specialty such as neuroradiology -- and there are many others, such as cardiology and anesthesiology -- always earn more than patient-centric doctors. American medical students are aware of this as they make their career choices. And fewer and fewer are choosing patient-oriented medicine: In 1996, American graduates filled 76 percent of residency training slots in family medicine, while in 2002, they filled only 48 percent. We see similar shifts in general internal medicine. The remaining positions are filled by foreign-born and foreign-trained medical school graduates. They pass the same qualifying tests for licensure as American graduates, but cultural diversity and varying communication skills may affect their approach to patients and their ability to hear subtleties in their patients' stories.

Society has come up with a partial solution to the growing gap in primary care providers: "physician extenders." These master's level health-care professionals are trained to deal with commonly occurring, easy-to-diagnose problems: a flu, hay fever, a splinter, even severe chest pain. Usually, however, they haven't had enough training to give them the know-how to sort through a complex medical history to arrive at a diagnosis that isn't immediately evident. When they're stuck, they have to call the physician, and by then, the 30-minute visit is very often over. The patient is left hanging and disappointed -- on his or her own to figure out what to do next. The inevitable result: patients falling between the cracks of classical medicine.

There's one silver lining in this situation: the increasing number of women choosing medicine as a profession. Approximately 50 percent of most medical schools' entering classes today are women. This trend may work to offset a major patient complaint -- that doctors don't spend enough time listening to them. Research studies show that women in general and women physicians in particular are better listeners than men. Since the turn toward more women in medicine is relatively recent, I'm not sure which path the young female doctor will choose, but I can say anecdotally that quite a few of my own female students seem to be choosing primary care -- either family or internal medicine. I hope that in the next few years, their presence may help offset the dearth of U.S.-trained doctors in primary care.

Meanwhile, what are patients with an elusive diagnosis to do? If they're fortunate enough to live near a medical school, they can search the doctor list for generalists. Physicians in academic centers are encouraged to see patients as part of their duties, and they often have more time than their colleagues in the community. More important, patients can help themselves by knowing more about their bodies, how they work and what can go wrong with them.

But finally, patients will have to understand that finding a doctor who has the time to listen, diagnose correctly and then know how to treat them is going to get harder and harder. Reversing the trend away from patient-oriented and toward procedure-oriented medicine will require attention by legislators as well as medical educators. Reducing the debt of newly minted doctors who choose primary care might be one way of doing this. Cutting back on both the number of postgraduate training positions in procedural medicine and the salary paid such trainees, while raising the salaries of those in primary care, could be another.

None of this will happen, though, unless patients make their voices heard. Otherwise, they may just find themselves on their own the next time puzzling symptoms arise.

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