Who Will Care for Me When I Get Sick?

Since I am apparently now considered a senior member of our specialty, a fact with which I have not yet become comfortable, I am permitted, and in some circles expected, to begin to share my perspectives and points of view with my younger colleagues. Those of you who know me recognize that I have not waited until my “senior status” to exercise this “rite of passage.”

The concern I wish to present to you in this brief time is the apparent change in the focus of our profession as a whole and our specialty toward the delivery of health care. This may be less complex and medically challenging than discussing diagnosis and treatment, and probably less stimulating, but I refer to the alteration in perspective of physicians regarding the time one should commit to the practice of medicine.

The imposition of the 80-hour work week for residents, while positive in many ways, has sent a message to our younger members and residents that the commitment of time and effort, irrespective of patient needs, has a fixed maximum. Exceeding this maximum, so the thinking goes, is unnecessary, and, in the case of resident education, is a violation. One can only assume that this, among a number of other factors, has had a significant impact upon the recent practicing physician’s decision about his or her work efforts, even when confronted with dire circumstances.

It is no secret that some of our subspecialties are flourishing with full fellowships, while head and neck surgery fellowships and faculty positions languish relative to need. It is not difficult to recognize that performing a rhinoplasty or face-lift on a healthy, young adult as compared with performing a major head and neck resection on a senior citizen with cardiovascular disease, diabetes mellitus, or COPD is not only less stressful but provides greater remuneration. This perhaps accounts for the shift to a preference for dealing with less complex clinical problems, which is not restricted to our field. Community hospital CEOs are having greater difficulty enlisting neurosurgeons, orthopedic surgeons, and otolaryngologist–head and neck surgeons to take emergency department trauma call [ER call]. In a survey of 1328 emergency department directors performed by the American College of Emergency Physicians in 2005, otolaryngology ranked fifth on the list of the “top 11” specialties that required stipends to be on call for consultations.

I often receive inquiries from community hospital administrators asking whether ER call is part of our specialty training, and why new doctors requesting privileges at their institution do not want to take ER call. There is also a shift in the type of practice, with many physicians choosing to use the increasing number of physician-owned hospitals and outpatient surgicenters. This results in less doctor dependence upon the general hospital and less pressure to provide emergency services.

I am well acquainted with the rising number of uninsured patients, and I often hear specialists complaining about the lack of payment for their care rendered in the emergency department. This and the threat of malpractice suits rising from treating trauma cases plus increased malpractice premiums when one treats trauma, not to mention the disruption of one’s personal and professional life by taking ER call, all contribute to reluctance to take ER call by the physician.

In the Friday, December 21, 2007, issue of The Washington Post, an article discussing this general problem shared a very distressing episode of a 74-year-old woman who had sustained a severe, soft tissue injury to her lower extremity that the ER physician felt required the skills of a plastic surgeon. The plastic surgeon on call refused to evaluate the patient at that time, but made an appointment for her the following week, only to call the patient during the weekend to cancel the appointment, stating she only performed cosmetic procedures and was not trained to handle severe wounds such as the patient apparently had sustained. This patient then spent the next 6 days seeking the services of a plastic surgeon who would evaluate and care for her.

Those of you who know me can probably anticipate the focus of my final words to you this morning. Having been a program director and department chairman for many years as well as having 2 sons in their late 20s and early 30s who have pursued professions, I am very aware of the attitudinal changes of professionals as a whole and the focus toward leisure time and family, not all of which is bad. I am also cognizant of the increasing financial burden of graduating medical students that averages $115 000 for a public institution and $150 000 for a private one. I ask that each of you stop and consider the reasons that attracted you to practice medicine when you began your career. The future of medicine and our specialty as a profession is predicated upon each of us providing some health care to the uninsured; continuing to gain satisfaction from providing exceptional medical care, even if the payment for that care does not parallel its quality; and understanding that sometimes one needs to sacrifice one’s self a little for our fellow man. It is important for us as professionals to continue to reap personal satisfaction and pride from our profession, and selfishly, it is becoming more important for me as I grow older, because I do not want to worry about who will care for me if I become sick.

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This is a brief address I delivered to the Southern Section of the Triological Society as its vice president on Friday, January 11, 2008, in Naples, Florida. Following the presentation, a number of those present suggested I publish it. I do hope that it strikes a meaningful note in those who read it.