MAYO CLINIC

COMMENTARY

# Dumped: How a Quest for Administrative Efficiency Lost a Doctor His Doctor

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I have been dumped.

The physician who treated me for 15 years probably would not describe it that way. Up to a point, the physician part of me does not either. But the part of me that is a patient? No doubt about it. I feel dumped.

A few months before I received my Aesculapian pink slip, I bumped into my not-yet-former doctor in the hallway. He gave me a friendly slap on the back and told me that my termination notice would be forthcoming. He said it had become harder and harder to fit me and several other physicians he took care of into an unforgiving clinical schedule that was increasingly beyond his control.

When the official announcement on his letterhead arrived via snail mail a few days later, his casual warning made the formal notice no less shocking. There, on paper and in 12-point type, the message was spelled out. It was frank. Over time, new administrative policies had become increasingly proscriptive about both how he parsed his clinical hours and whom he could treat. First, an administrative quest aimed at improving clinical efficiency and throughput for the specialized clinics to which he was primarily assigned had dictated that he no longer commandeer appointment slots designated for external referrals to accommodate the internal patients for whom he provided care. He was further instructed to limit his practice to the mission of his clinic: customized assessment, facilitation of subspecialty referrals throughout the institution, and integration of the results of these consultations. At first, he had responded by continuing to see his long-established physician-patients off the calendar and off the clock, although critically with ongoing support from physician extenders, front desk staff, appointment schedulers, and his secretary. But then a second administrative dictum came that decreed he must not appropriate support staff resources for the care of off-the-grid patients like me. In the aggregate, these policy changes compromised his ability to provide what he considered acceptable care. Even on his own time, he was not willing to treat his few remaining physician-patients in the absence of the same level of staff support afforded to his "official" patients, and who could blame him?

My former doctor tells me he has always considered it an honor and a privilege—never a burden—to care for fellow physicians. "Doctors are a special breed," he says. "They're not the best patients. They blow stuff off or overreact. They self-medicate." In his opinion, doctors need doctors who respect how much they know but ultimately have the self-confidence to tell them what to do. He expressed sincere regret that he felt left with no choice but to terminate caring for his small cadre of physicians.

In an era when physician wellness has become a professional buzz phrase, I can grudgingly laud my former doctor for deciding to reduce his exposure to uncompensated work, particularly when he was discouraged from using his clinic's most basic infrastructure for a small subset of his practice. Several of the national thought leaders on physician burnout are my professional colleagues, and they have developed their ideas and done their research to great acclaim.[1,2] Although I have not mentioned my particular situation to them, surely they would question the wisdom of administrative decisions that have made it nearly impossible for doctors like mine to maintain continuity of care with long-standing physician patients like me. I do not believe anyone meant—even inadvertently—to harm my well-being, even as I wonder whether rules have to be so absolute that patients like me lose their care, even as I further wonder whether, in this contemporary medical world, it is selfish of me to expect my doctor—or his clinic—to push these boundaries.

Experts in the care of physicians have long encouraged us to have doctors of our own we

can rely on when we are ill, rather than turning to curbside consultations from friends or, even worse, treating ourselves.[3] All these years I thought I had that covered by having a formal relationship with a highly talented general internist who saw me in his office for our appointments, looked after my general health screening as well as my idiosyncratic concerns, and documented the nature and outcomes of our interactions in the medical record, as he would for any patient.

On reflection after being dumped, I conclude that, despite the mainstream features of our interactions, it had always been an illicit arrangement we shared, our little secret. I had approached him on the psychiatric inpatient unit on which we both worked because I admired how he cared for our mutual patients. He was thoughtful, detail-oriented, not quick to order tests, but also not averse to doing so if his formulations of patients' problems demanded them. He took the necessary time to get to know his patients. He clearly liked them, and I liked that. When I asked him to be my doctor, he told me he had the flexibility to work me in before the workday officially began, over the noon hour, in between his "official" patients, or in his scant administrative time. No one needed to know about the irregular scheduling in a clinic not designed for ongoing care. Our "marriage"—if one can use that metaphor to describe the doctor-patient relationship—would be common-law, unsanctified by administrative "clergy," a same-time-next-year sort of affair. We made it work for more than a decade.

Aware he was seeing me on the side as a favor, I tried not to be a difficult or demanding patient—not to ask more than a tiny aliquot of his time for my annual examinations. I looked forward to our assignations. Relaxed and unhurried, he would lean back in his office chair, elbows outstretched, hands interlocked behind his head, and launch into a therapeutic conversation that traversed the previous year's voyage. He would inquire about my recent health history while weaving in anecdotal strands about his children and the love of gardening we shared. He would ask about everything from the stresses of my job to the quality of my sex life.

Now and again issues arose that demanded urgent—even immediate—attention and coordination outside of these annual visits. Pericarditis, recurrent sinus infections, atypical asthma, abscessed teeth, peculiar skin lesions—he always found time to shoehorn me in, order the necessary tests and specialty consultations, and follow up on the results. I hated having to be a burden at these times, but sometimes I could not help it. Health crises typically respect the schedules of no man, not even a physician. He was my doctor.

In the aftermath of our breakup, I continue to ponder why he had been willing to assume my care in the first place. Maybe he had been operating from the increasingly quaint notion of "professional courtesy," a venerable tradition that probably always came out of the professional's hide. I have always had—and continue to have—a small panel of such patients for whom no official beans are counted: physicians, trainees, challenging referrals from colleagues who believe that I have special (even unique) expertise to offer a patient. I have almost always said yes, even though my clinical department neither expects me to do this work nor allocates the time in my schedule template for me to do it. I consider myself to be honoring the memory of my maternal grandfather—dead before I was born—idealized by my mother as a doctor intensely and perpetually available to those lucky enough to fall under his care. Like my former doctor, I squeeze and sneak and juggle to work these referrals in. Maybe I am being duped—or duping myself—into considering it an honor to be "the doctor's doctor." Instead of continuing to perform clinical and educational duties that total far more than the 1.0 full-time equivalent I am allotted for the work that I do, I could more profitably use the time that I spend treating my colleagues and other special request patients for puttering in my garden, practicing my clarinet, going on bicycle rides, or attending yoga class. Maybe I should start saying "no" more often, but so far, I just cannot bring myself to do it.

In fairness, when my doctor dumped me, he did not abandon me without potential options. He gave me the names of several respected colleagues whose calendars grant them time to see local people, including physicians, and whose clinics provide the ancillary staff necessary to assist in efficient, team-based delivery of coordinated care. He suggested I


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ask whether one of them might be willing to take me on. He also reminded me that our institution has taken steps to make sure its staff gets necessary care by hiring a cadre of internists fresh out of training specifically to look after physician staff members. (To its credit, our Office of Staff Services has recently advertised this option in an effort to reach staff doctors who currently lack primary care physicians for themselves or their families.) He saw me one last time, and with another back slap and a handshake, my now-former doctor wished me well.

Yet I have balked for more than a year at contacting any of the physicians he recommended or anyone else I know, even as I increasingly fret about what I will do when the next medical crisis flares, as it inevitably will. I struggle with feeling simultaneously irritated with and sympathetic to the needs of a colleague who was providing something as basic as my health care. I do not enjoy second-guessing my motives. Why would I deliberately choose to add to a peer's burden by asking him or her to see me? Why would I expect him or her to be any less overbooked than my former doctor was, or I am? What if he or she assumes my care at some personal sacrifice and I am once again interfering with a frazzled physician's effort to achieve wellness? Why am I feeling snotty and entitled about not wanting to give myself over to a freshly minted doctor? Am I hopelessly old-fashioned in believing that physicians and patients are not interchangeable cogs in a well-oiled health care machine? Should efficiency always win the day? There is always the emergency department, I suppose.

On further reflection, I have come to recognize that contemporary health care models with their emphasis on screening and prevention may offer better care than the comforting but gauzily anachronistic way I experienced my relationship with my former doctor, his avuncular style seemingly more suited to a Norman Rockwell portrait of a venerable country physician than the modern health care scene. What I know, alas, is not what I feel, but I imagine I will get used to it.

If I am truthful with myself, my reluctance to engage a replacement doctor has not actually been about my fears of becoming a burden at all. Fifteen years was a long time together. Illicit or not, we had a significant, meaningful, and not easily replaced collaboration that mattered to me and—I am certain—to him. With the divorce so recent, I have hesitated to jump into a new relationship so quickly. I find it especially unnerving to embark on a remarriage to someone ignorant of my physical and mental foibles, whose intimacy with me and my body will rival only that that I share with my spouse.

To be brutally honest, however, once dumped, I am terrified I will be dumped again.

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