

SPECIAL REPORT

Dissatisfaction with Medical Practice

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The profession of medicine has taken its members on a wild ride during the past century: a slow, glorious climb in well-being followed by a steep, stomach-churning fall. In the decades after World War II, sociologists portrayed American doctors as the lucky heirs to a golden age of medicine. They were surrounded by admiring assistants, loyal patients, and respectful colleagues and had full autonomy in their work, job security, and a luxurious income. This era was short-lived. By the 1980s, newspaper headlines proclaimed that many of the nation's "dispirited doctors" were considering bailing out of medicine, and subsequent observers have continued to describe a profession in retreat, plagued by bureaucracy, loss of autonomy, diminished prestige, and deep personal dissatisfaction.

The commentary from within the medical profession has been equally bleak. Anecdotes and an expanding body of empirical data suggest a widespread professional malaise. One disturbing metaphor has likened the prevailing emotional climate in medicine to the atmosphere surrounding a deathbed, arguing that doctors are mourning the passing of a beloved professional identity with the full cascade of denial, anger, bargaining, depression, and acceptance.¹

Physicians' dissatisfaction with the practice of medicine may have public health implications over and above the obvious problems of recruiting new members into a troubled profession. Data suggest that dissatisfaction on the part of physicians breeds poor clinical management, as well as dissatisfaction and noncompliance among patients, and that the rapid turnover of unhappy doctors in offices and hospitals may lead to discontinuous, substandard medical care.²⁻⁴ This article reviews subjective and objective indicators of present-day dissatisfaction among physicians, attempt to place the phenomenon of dissatisfaction in a cultural and historical context, and summarize some of the solutions that have been proposed for relieving dissatisfaction.

SUBJECTIVE INDICATORS

SURVEYS

Survey results suggest that levels of professional satisfaction have dwindled substantially during the past few decades. In 1973, less than 15 percent of several thousand practicing physicians reported any doubts that they had made the correct career choice.⁵ In contrast, surveys administered within the past 10 years have shown that 30 to 40 percent of practicing physicians would not choose to enter the medical profession if they were deciding on a career again, and an even higher percentage would not encourage their children to pursue a medical career.^{6,7} In a telephone survey of 2000 physicians that was conducted in 1995, 40 percent of the doctors said they would not recommend the profession of medicine to a qualified college student.⁸

In a national survey in 1981, 48 percent of 1426 office-based doctors said they would not recommend the practice of medicine as highly as they would have 10 years earlier. In a follow-up survey in 2001, 58 percent of 2608 physicians said that their enthusiasm for medicine had declined in the previous five years, and 87 percent said that the overall morale of physicians had declined during that time.⁹ Massachusetts physicians who were asked in 2001 to recall their thoughts about medical practice five years earlier reported more current dissatisfaction with virtually all aspects of practice, including income, workload, and time consumed by administrative tasks.⁶ Among California physicians questioned in 1991 and again in 1996, the percentage who said they were less than fully satisfied with the practice of medicine rose from 53 percent to 63 percent.¹⁰

DEMOGRAPHIC CHARACTERISTICS

Doctors' demographic characteristics do not clearly affect patterns of satisfaction. In one study, female doctors were more likely than male doctors to say

they were satisfied with their relationships with patients and colleagues and were equally likely to say they were satisfied with their overall careers, but they were 60 percent more likely than the men to report burnout.¹¹ A survey of 4500 female physicians found that overall levels of career satisfaction were similar to those found in mixed groups.¹²

Age appears to influence satisfaction inconsistently. In a study in 1991, older internists were far more likely than younger ones to report a steep decline in the level of professional satisfaction since they had entered practice.¹³ In another study, a U-shaped curve represented the likelihood of career satisfaction plotted against age, with the most-satisfied doctors those less than 35 years old and those 75 or older.¹⁴ In contrast, in a study of female physicians, younger doctors reported the lowest levels of job satisfaction, whereas older doctors reported the highest levels.¹²

Income does not always generate happiness, although in one study, physicians earning from \$250,000 to \$299,999 a year were 98 percent more likely to report being very content with their medical career than those earning half as much.¹⁴ However, a large study of primary care physicians showed that income level was irrelevant to levels of either satisfaction or stress.¹⁵

In contrast, levels of satisfaction vary with geographic location. In a 1997 nationwide survey, the proportion of physicians in Miami who said they were dissatisfied was twice that in Lansing, Michigan, or Little Rock, Arkansas. The same study also showed dramatic local fluctuations in the level of satisfaction over short periods of time. In Newark, New Jersey, for instance, a significant improvement in reported levels of satisfaction between 1997 and 2001 could be directly traced to increasingly stringent state supervision of health maintenance organizations (HMOs) and a requirement for prompt payment enacted during that time.¹⁶

MEDICAL SPECIALTY

Surveys have not identified medical specialists who are clearly happier or less happy than others. In one small study, researchers compared the professional satisfaction that general internists, cardiologists, and ophthalmologists said they derived from outpatient work. Overall, internists found the work significantly less rewarding than did the others, and they ascribed what pleasure they did derive to social interactions with patients rather than to intellectual stimulation (the major source of satisfaction for car-

diologists) or good therapeutic outcomes (the major source of satisfaction for ophthalmologists). The authors concluded that boredom and infrequent therapeutic success might underlie many physicians' dissatisfaction with primary care medicine.¹⁷

A much larger study, however, showed that levels of dissatisfaction were actually lowest in such primary care subspecialties as geriatrics and infectious diseases and were highest in such surgical subspecialties as gynecology, otolaryngology, and plastic surgery. The researchers guessed that their results reflected the steep reductions in income and job availability that many surgical subspecialists have experienced lately, owing to managed care. Escalating malpractice rates, which disproportionately affect surgeons, may also have been responsible.¹⁴

OBJECTIVE INDICATORS

NUMBERS OF APPLICANTS TO MEDICAL SCHOOLS
Subjective survey data may be influenced by poor response rates, and unhappy members of the profession are likely to be overrepresented among respondents. More objective indicators of levels of satisfaction do not yield clear evidence that medicine is a less appealing profession than it once was. Changes in the numbers of applicants to U.S. medical schools during the past several decades have been cyclical, with little apparent relation to increased publicity about the profession's woes (Fig. 1).¹⁸ Despite anecdotal reports, there is scant evidence that large numbers of physicians are retiring from practice earlier than in the past (Table 1).^{19,20} The proportion of physicians of working age who report that they have left patient care for other kinds of work has not changed significantly in the past 25 years.²¹

UNIONIZATION AND WORK STOPPAGES

Recent efforts by physicians to bring the tools of organized labor to the field of medicine constitute more substantial evidence of widespread professional unhappiness. Although house-staff unions have been active since the 1970s, the late 1990s saw a surge in the recruitment of physicians into established labor unions, and in 1999, the American Medical Association reversed its cast-iron antiunion stance and launched an effort to unionize private practitioners.²² Doctors in several states initiated work stoppages in 2002 and 2003—unprecedented actions that were specifically designed to protest escalating malpractice premiums.²³ Not surprising-

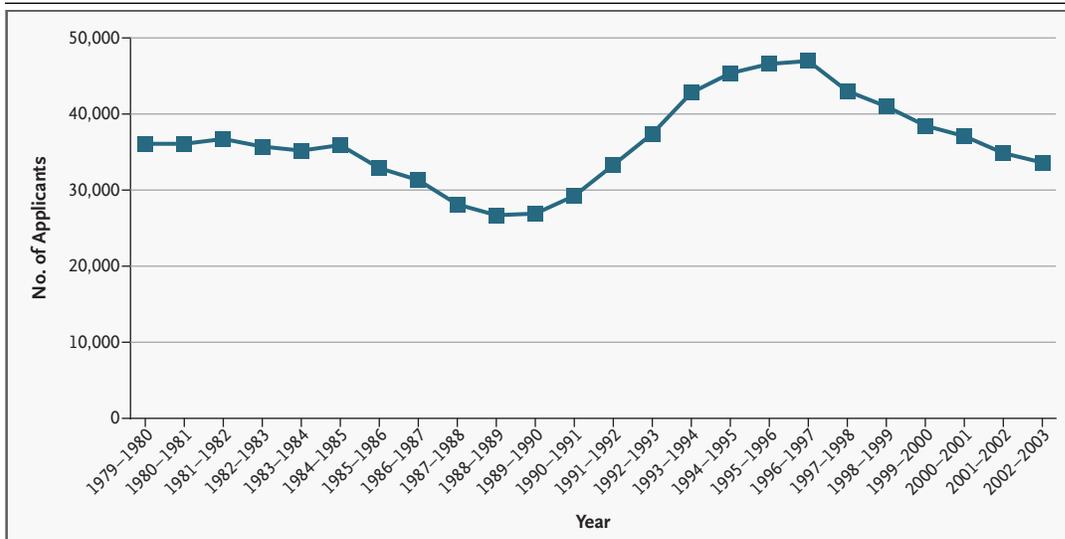


Figure 1. Applicants to U.S. Medical Schools, 1979 through 2003.

The numbers of applicants to U.S. medical schools have not shown a steady increase or decrease during the past 20 years. Data are from the American Association of Medical Colleges.¹⁸

ly, studies in countries where physicians' labor actions are more common than they are in the United States confirm that levels of professional dissatisfaction correlate directly with the likelihood of a strike.²⁴

CAUSES

MANAGED CARE

Managed care is routinely cited as a major reason for the dissatisfaction of physicians in the United States, and unhappiness with its constraints has been lavishly documented. Most survey data have focused on physicians who participate in group-model or staff-model HMOs, with little distinction between the two. A 1991 survey of about 4000 physicians from across the United States found a direct correlation between the level of HMO market penetration in a physician's community and reported dissatisfaction with the practice of medicine.²⁵ A 1995 survey found that the ambient level of professional dissatisfaction among physicians in states with a high level of HMO market penetration was exactly double that found in states with a low level of penetration.⁸ A study probing for causes of discontent showed that physicians who worked for HMOs were happier with their degree of autonomy and administrative responsibilities than were other physicians but were significantly less satisfied with

their work overall and less committed to their current practice than other physicians were.²⁶

Although only a small fraction of the physicians in the United States are employees of HMOs, more than 90 percent have at least one contract with a managed-care plan and thus know this system's regulations firsthand.²⁷ Commonly cited reasons for unhappiness with managed care include the traffic of patients in and out of care for insurance reasons, administrative paperwork, limitations on referring patients to specialists of the physician's choice, financial incentives to curb medical workups, pressure to see high numbers of patients, and limitations on the prescribing of drugs.^{8,28} Of doctors who were polled in a 2001 survey, 75 percent said managed care had deleteriously affected not only the way they practiced medicine but also the medical services available to patients and the quality of health care provided.⁹

THE MALPRACTICE CRISIS

The past 30 years have witnessed both a rising tide of medical-malpractice litigation and recurrent difficulties between physicians and their insurers; these events, for many practicing physicians, have merged into a single, continually escalating malpractice crisis. The problems that some physicians are having in finding malpractice insurance, in paying steeply rising premiums, or both, are at or near

Table 1. Studies of the Retirement Patterns of Physicians.

Study	Study Period	Group Studied	Findings
Donelan et al. ⁸	1995	2000 Physicians across the United States	25% Were considering retiring or leaving clinical practice within the next three years
Sibbald et al. ¹⁹	1998–2001	1949 General practitioners in England	The proportion intending to leave direct patient care within the next five years rose from 14% in 1998 to 22% in 2001
Kletke et al. ²⁰	1980–1996	All active U.S. physicians who were 55 years old between 1980 and 1996	No changes in mean retirement age were found, but there was a significant association between managed-care market penetration in a community and the likelihood of retirement

crisis proportions in 44 of the 50 states, according to the American Medical Association.²⁹ Affected physicians have repeatedly described to the media their intentions to leave medical practice prematurely, to stop providing care for high-risk patients, or to move away from areas where premiums are particularly high. Young physicians already saddled with heavy educational debts are increasingly concerned about the additional financial burden of malpractice premiums. A 2003 survey showed that 62 percent of final-year residents who responded reported considerable concern with malpractice issues, and 24 percent said that, were they to start their education again, they would not choose a medical career.³⁰

Physicians who are not financially burdened by the malpractice crisis also say they feel its repercussions. “Defensive medicine,” a strategy of using tests and procedures primarily to thwart potential litigation rather than to advance the well-being of patients, is widely deplored as a growing blight on medical practice that raises health care costs, compromises the physician’s professional integrity, and drives a wedge through the doctor–patient relationship. Although lawsuits have become common, doctors are not yet inured to their emotional punch. No matter what the background or outcome of the suit, physician-defendants routinely describe feelings of shame, self-doubt, and disillusion with medical practice that may persist for years.³¹

DISPARATE EXPECTATIONS

Some authorities maintain that most causes of professional dissatisfaction are rooted in local practice conditions, and most physicians in the United States might agree that the major source of their professional woes is their country’s troubled health care system. However, physicians practicing medicine

in other countries are also disillusioned with medical practice, which suggests that certain universal aspects of modern medicine may underlie much professional unhappiness.

In response to an editorial on physicians’ unhappiness that appeared in a 2001 issue of the *British Medical Journal*, a doctor from India wrote, “My father’s patients regarded him as a God. Now the patients treat you as one and demand miracles. You know it all (or ought to), and you cannot let a patient die no matter what.”³² The editorial elicited many similar comments from doctors all over the world. The comments shared a theme of unhappiness caused by profound disparities in expectations. These include the discrepancy between what patients demand from a doctor and what the doctor can actually accomplish, the discrepancy between standards set in a doctor’s training and the compromises forced by practice, the discrepancy between how physicians practiced medicine 50 years ago and how physicians must practice today, and the frequent discrepancy between the wide-open promise of medical science and the limited results that individual doctors — whether hamstrung by the poverty of a developing country or by the bureaucratic tangles of a wealthy one — are able to achieve. For every failure to live up to goals and expectations large and small, the doctors who responded to the editorial described feeling guilty, defensive, and estranged from colleagues and patients, often railing at the inadequacies of their local health care systems when the problems transcend those systems.

LACK OF TIME

Among the aspects of practicing medicine that particularly frustrate conscientious physicians around the world is the lack of time to accomplish neces-

sary tasks. “Indicated” tests and treatments must be scheduled, checked, and paid for; administrative and regulatory requirements mount; and financial considerations demand an emphasis on volume and turnover. E-mail and the Internet have conditioned many patients to expect instant responses to all concerns. “The single greatest problem in medicine today is the disrespect of time,” said Kenneth Ludmerer, a physician and medical historian at Washington University in St. Louis, in an interview. “One cannot do anything in medicine well on the fly.”

Although many clinicians assume that their time with patients has been increasingly curtailed over the years, one study has shown that the average duration of office visits in the United States actually lengthened slightly during the 1990s.³³ What has been shortened is the time available to address each of dozens of new tasks deemed essential to patient care. Providing the full array of currently recommended disease-prevention services alone may consume most of a physician’s workday.³⁴ Owing to the number of acute and chronic illnesses that also need to be managed, many necessary tasks must be omitted or given short shrift.

“Doctors’ anguish seems to come from violating every day what they know they ought to be doing,” said Renee Fox, a noted medical sociologist at the University of Pennsylvania, in an interview. “The pain is from the degree to which they still espouse values but can’t live up to them.” In addition, Dr. Fox said that the recent intense interest in identifying and preventing medical errors has magnified feelings of insecurity even beyond the high levels generated by fear of litigation.

DOCTORS’ ROLE AS DOUBLE AGENTS

Considerable unhappiness is also caused by the many nonmedical roles doctors now have for which they were never trained. Saddled with regulatory duties, doctors serve as de facto “double agents” for insurers, government agencies, and courts. The once-inviolable doctor–patient relationship now includes third parties that second-guess the doctor. Psychiatrist Martin Lipp, in a pioneering exploration of physicians’ dissatisfaction, writes that doctors “are assaulted from within by the impossibility of knowing everything they feel they have to know, and from without by a system that removes authority and forces adherence to conflicting allegiances.”³⁵ The public reacts with hostility. Says Lipp: “Complaints about medicine . . . bombard the physician at every turn. . . . Our fuzzy science

isn’t scientific enough, and our awkward art is not artful enough. . . . The real world in which they function fails to support the inner sense of dedication which many doctors feel.”³⁵ Doctors who disappoint themselves, Lipp concludes, will inevitably disappoint their patients, too.

THE HISTORICAL CONTEXT

Is the profound unease within the medical profession today a historical aberration? Most evidence suggests that it is not. Rather, it was the golden age of medicine in the mid-20th century that was the oddity. Although standard histories of medicine tend to focus on a few famous and wealthy physicians through the ages, most ordinary physicians of the past appear to have lived somewhat troubled lives, scrabbling for patients and fees, bitterly defending their turf against healers of other persuasions, and often feeling mortified by the inadequacy of their clinical tools.

In early-19th-century America, lay practitioners and “botanical” specialists routinely undercut doctors. Do-it-yourself medical manuals also undermined physicians’ expertise, in a way quite similar to the militant consumerism that infuriates many physicians today. Several mid-19th-century American doctors wrote in their memoirs of their fathers’ “contempt” and “disgust” on learning that their offspring had decided to enter medicine. One doctor, writing in a medical journal in 1869, called medicine “the most despised of all the professions” for educated men.³⁶ In the first years of the 20th century, medical education was haphazard — the nation’s ragtag array of substandard medical schools accepted all comers — and in 1913, the American Medical Association estimated that no more than 10 percent of physicians were able to earn a comfortable living.³⁷

Earlier generations of physicians had experience with much of the anxiety that we sometimes assume is unique to modern medical practice. “A doctor’s life is made up of moments of terrible nervous tension,” wrote one physician in the early 20th century. “A sudden turn for the worse in a convalescent patient, an incurable who cries for relief, the impending death of a patient, the ever present possibility of an untoward accident or mistake. . . . There are times when the powers to continue such a life are entirely exhausted and you are seized with such depression that only one thought remains — to turn your back on all and flee.”³⁸

 DISSATISFACTION WITH
OTHER PROFESSIONS

Unhappy doctors today may find that many of their complaints are echoed by professionals in other fields. Once regulated largely by the conscience of the individual practitioner, many fields are becoming constrained and corporatized by governmental and professional structures, resulting in the professional's loss of autonomy, status, and the respect of the public. A 1999 exploration of lawyers' dissatisfaction with their careers, for instance, found rising rates of unhappiness during the previous two decades, with many lawyers stating that they intended to leave the profession.³⁹ Teachers are increasingly plagued by restrictions on autonomy similar to those experienced by doctors.⁴⁰ Nurses voice the same anger as doctors about the structures imposed on the profession by managers and administrators, which often make good patient care impossible.⁴¹ According to the sociologist Paul Starr, for most of the 20th century, medicine was "the heroic exception that sustained the waning tradition of independent professionalism."³⁶ It is an exception whose time has finally expired.

 POSSIBLE SOLUTIONS

On the whole, then, subjective indicators of discontent in the field of medicine have increased substantially during the past few decades, and objective signs of discontent are present as well. However, the majority of doctors still take satisfaction in their work, and the all-out flight from the profession that was predicted 20 years ago has not come to pass. Members of other professions echo some doctors' complaints, and a historical perspective suggests that earlier generations of physicians experienced similar distress. It is also possible that a certain amount of dissatisfaction may be inherent, even necessary, to the practice of medicine. "One of the virtues of medicine, in my view, is its self-critical nature," said Dr. Ludmerer, at Washington University. "Intrinsic dissatisfaction can lead to significant social good."

Nonetheless, the present climate of unhappiness has drawn outpourings of concern from most professional societies in medicine, and various solutions have been proposed for easing discontent. Some authorities advocate a conscious reemphasis of professionalism in medicine, with its mandate for altruistic, "patient first" behavior.⁴² Others sug-

gest that physicians muster nonprofessional sources of happiness instead, such as time with family and friends, exercise, good nutrition, and spiritual activity.⁴³ Encounters between doctors and patients may provide enough joy to serve as antidotes to other woes; a survey found that physician-executives who saw patients were happier with their careers than those who did not see patients.⁴⁴ In contrast, another study found that decreasing contact with patients is often a successful way to restore a physician's sense of well-being.⁴⁵

The steady stream of applicants to medical schools has inspired both hope and fear — hope that good students will continue to discern the enduring bedrock of satisfaction that underlies medical work, and fear that levels of dissatisfaction that are perceived by prospective medical students may influence the quality of applicants. In private, some doctors darkly envision a future of disengaged, intellectually lazy doctor-technicians who have made their peace with protocol-driven "cookbook" medicine in return for leisurely, salaried jobs. Others believe that despite these fears, the excellence and commitment of medical students and residents remain unchanged.

Meanwhile, medical training itself has slowly evolved. "Medical schools have made fundamental changes in the way they educate students," said W. Brownell Anderson, senior associate vice-president for medical education at the American Association of Medical Colleges, in Washington, D.C., in an interview. Some schools are providing didactic sessions on such topics as risk management, cost containment, and utilization review, whereas during the clinical years, all students are now exposed to the breakneck pace, payment dilemmas, and paperwork of outpatient medicine. A recent study suggests that medical students' expectations of peak income are more modest and realistic now than they were in the 1970s.⁴⁶ The key to restoring a sense of contentment to the medical profession may lie in the hands of educators who encourage students to have more accurate expectations of a medical career than did the generations trained during the tumultuous past 50 years.

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