

## Demise of a physician

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*“Avarus animus nullo satiatur lucro (A greedy mind is satisfied with no [amount of] gain)”*

– Publilius Syrus, Sententiae

We have already discussed the precipitous decline of academic medicine in the United States,<sup>1</sup> a decline accompanied by the rise of nonphysician professions in academic medicine. We have gradually become inured to the fact that most research (at least in psychiatry) is done by nonphysicians. We are also starting to see more PhDs involved in medical education while also populating graduate medical education and other administrative offices within medical schools.

It seems we are starting to face a similar trend in clinical medicine. With increasing frequency, we hear about how complicated patients are being managed by advanced practice nurses and physician assistants (PAs), that these providers are being allowed to perform procedures that have in the past required a medical degree and residency training,<sup>2</sup> and that legislation is being put forth granting independent practice authority to nonphysician practitioners.<sup>3</sup> There are reports of anesthesiologists (even entire groups) being replaced by certified registered nurse anesthetists (CRNAs) in some hospitals,<sup>4</sup> and we are aware of psychiatrists being let go from a local prison system and replaced with nurse practitioners (NPs). After learning this information, we read with great interest the book by Drs. Al-Agba and Bernard,<sup>5</sup> which succinctly describes the rise of NPs and PAs in present-day medicine.

As these 2 physicians point out,<sup>5</sup> the role of NPs and PAs was originally “designed for the two to work side-by-side to provide complementary care, with physicians providing careful supervision and mentoring, and treating the most complex patients.” This model of practice began to change in the 1970s with the organization of NPs and subsequent expansion of their responsibilities and numbers. Regarding the latter, at the end of the last decade, there were more than 1 million physicians, 290,000 NPs, and 131,000 PAs in the United States. In the last 10 years, the number of NPs has doubled,

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the number of PAs has grown 53.8%, while the number of physicians has only increased 12%.<sup>5</sup> If this trend continues, NPs and PAs will outnumber physicians within the next 20 to 30 years. We should note that in addition to NPs and PAs, others such as pharmacists, psychologists, chiropractors, and optometrists are attempting to expand their role in health care and take over for some, if not all, of the roles of physicians.

Interestingly, another phenomenon occurred concurrently with the expansion of NPs: the transformation of the term “provider” within the medical lexicon. As Erlich and Gravel Jr<sup>6</sup> point out, the word originally referred to “entities such as hospitals, home health agencies, nursing homes and laboratories, but soon shifted to describe physicians, dentists, pharmacists, and transportation providers contracting with Medicare/Medicaid, as in ‘Medicare providers.’ Understanding the power of words, private insurers co-opted ‘providing’ within Medicare by relabeling all physicians as ‘providers.’” Erlich and Gravel Jr<sup>6</sup> also note that private insurers, “concurrently rechristened themselves ‘health plans,’ despite offering insurance, not health care.” This is, as the authors write, a very harmful rebranding, implying that physicians and other health care workers are interchangeable, “rendering a commoditized, untailed service.”<sup>6</sup>

The overuse of the term has blurred training levels, encouraged lower costs to insurance companies, and led to a loss of physician autonomy and increased automaticity. As Ehrlich and Gravel Jr<sup>6</sup> write, use of the term has also led to the deprofessionalization of physicians and has the potential to erode public trust by “surrendering individual physicians’ clinical judgment to utilitarian cost-cutting algorithms,” an act that may ultimately dissuade “altruistic, humanistic people from entering medicine.” Nearly a quarter century ago, the roots and impact of deprofessionalization in medicine were discussed by Reed and Evans,<sup>7</sup> who recognized the corporate takeover of health care and warned, “The precipitous drop in the professional autonomy of physicians is alarming if one believes that professionalism still provides the best model of health care delivery in terms of benefits to patients and society.”

While the overarching message is that the expanded role of nonphysicians will improve medical care and access to it, this profound change has little to do with better patient care and everything to do with “money, politics, and control.”<sup>5</sup> The financial benefit of utilizing nonphysician providers has been called into question, for example, as a recent study concluded resident teams are economically more efficient.<sup>8</sup> In addition, patients are more satisfied

with the care provided by resident teams, which is not surprising given the differences in education between NPs and PAs and Doctors of Medicine (MDs) or Doctors of Osteopathic Medicine (DOs). PAs are required to complete 4 years of undergraduate education, 27 months of graduate school, and 2,000 clinical hours of training. NPs complete a 4-year undergraduate degree or a 2-year Bachelor of Science in Nursing program, a 1- to 2-year master’s or doctorate degree—with some programs offering their curriculum entirely online—and 1,000 nonstandardized hours of clinical training. Physicians, on the other hand, complete 4 years of undergraduate and 4 years of medical education, 3 to 7 years of residency training (and potentially more with a subspecialty fellowship), and at least 15,000 hours of clinical training prior to independent practice.<sup>9</sup> Depending on the jurisdiction, varying levels of physician supervision is required for NPs and PAs. Twenty-one states allow NPs to practice without physician collaboration or supervision.<sup>10</sup> Although most jurisdictions in the United States require some level of supervision of PAs—which is either undefined, depending on the state, or ranges from physician “ready availability” for communication to intermittent physical presence—2 states allow PAs to practice without supervision, and 2 require collaboration (either communication available for consultation or monthly meetings via email, phone, or direct physical contact).<sup>11</sup> As noted by Al-Agba and Bernard,<sup>5</sup> “in patients with minor medical complaints or low-risk chronic conditions, non-physicians using protocols and being supervised by physicians can unequivocally provide safe, high quality, and cost-effective care. However, the data has not demonstrated that nurse practitioners or physician assistants can deliver safe care to patients independent of physician involvement.”

One of the arguments for the increased use of non-physicians is the shortage of physicians in the United States, especially in rural areas. First and foremost, “workforce data shows that nonphysician practitioners do not work in rural areas in greater numbers than physicians.”<sup>5</sup> Even if this were not the case, is the solution to this shortage to replace physicians with nonphysicians?

Doing so reminds us of the now-abolished bare-foot doctor movement initiated during China’s Cultural Revolution, when the government tried to solve a shortage of rural doctors by sending out people with only several months of medical training. Although this type of system may have a positive impact in the practice of preventative medicine, it is concerning to imagine minimally trained clinicians providing more complicated care in areas that

are often poorly resourced in terms of specialists and tertiary centers. The shortage of physicians in any environment should be solved in the most logical way: by training more physicians. As it stands, we are already behind other industrialized nations in this matter, with “far fewer physicians per capita in our country compared to our industrialized nations. Here are the facts: In 2013, the U.S. ranked 24th of 28 countries in the number of practicing physicians, with only 2.56 physicians for every 1000 people.”<sup>5</sup> The only countries behind the United States were Canada, Poland, Mexico, and Korea. In contrast, countries with high physician ratios include Austria with 4.99, Norway with 4.31, and Germany with 4.04 physicians per 1,000 people.

How did we get to this position? It seems that we are facing a perfect storm of the rise of nonphysicians working beyond their training and abilities, deprofessionalization of physicians by insurance companies and the health care industry, and capitalist forces in the form of corporate greed commoditizing medical care and cutting costs via the “midlevelization” of medicine in the United States. Do our patients deserve to receive this substandard care that industry leaders and politicians themselves would likely not accept? As Al-Agba and Bernard note,<sup>5</sup> we can be certain that neither President Clinton nor Arnold Schwarzenegger chose to have their anesthesia administered by a CRNA rather than a MD anesthesiologist during open heart surgery.

We need to ask ourselves if this is the beginning of the demise of physicians and the field of medicine that we have known for centuries, because it seems to be the case. We may be (hopefully) wrong, but it looks to us as if we are standing at the beginning of a precipitous slippery slope. We need to reverse this tide, starting with even the smallest measures. As both Al-Nagba and Bernard<sup>5</sup> and Erlich and Gravel Jr<sup>6</sup> recommend, we should insist on using the titles of MD and DO in all communications, require

precise, respectful terminology regarding our training, and resist corporate language that uses the term “provider.” In addition, we need to educate patients about who is who in medicine, and communicate that it is appropriate to ask for or demand physician-led services. We must lobby with legislators to ask for more residency slots, create public safeguards for independent nonphysician practitioners, and utilize the media to galvanize public support. (On the latter, what are our organizations such as the American Medical Association or American Psychiatric Association doing?) Al-Nagba and Bernard<sup>5</sup> stress the importance of eliminating disreputable midlevel training programs and the “direct-to-nurse practitioner” route and insist that physicians and not midlevel practitioners train physicians. Finally, the authors emphasize that medical students should be trained to lead health care teams, properly supervise nonphysicians, and understand the importance of getting out of the corporate practice of medicine.

If we do not all get involved in some ways, we will soon see the demise of the physician. As Reed and Evans<sup>7</sup> wrote, “Perhaps it is historically determined that professionalism inevitably will disappear as our society follows its course of economic and organizational evolution. But a fatalistic capitulation to predetermined historical trajectories seems to fly in the face of the ethos that has made medicine one of the most action-oriented occupations known to humanity ... Becoming an entrepreneur or a politico may be the farthest thing from most physicians’ minds when they dedicate themselves to becoming healers. But occupations must change as their historical circumstances evolve. However, physicians can be much less the prisoners of history than of their own remarkable freedom either to act creatively, quickly, and decisively in the interests of their profession and their society, or to acquiesce to changes planned by others.”

Physicians, is it already too late? ■

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