MEDICINE AND SOCIETY

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A Tale of Two Doctors — Structural Inequalities and the Culture of Medicine

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I recently had two doctor's appointments in the same week, one in general medicine and the other in orthopedics, both at the same highly ranked medical institution. Occurring so close together, these visits quickly morphed in my mind from personal experiences with individual doctors into metaphors for the current state of U.S. medicine — where, to borrow the words of Charles Dickens, it is the best of times and the worst of times. During a period of profound national political upheaval that will have far-reaching effects on health care,[1,2] the visits also provided insight into changes we can make from within medicine to improve health outcomes for our fellow Americans.

I saw my internist first. Her practice is in an older part of town, where I can sometimes find street parking and avoid the astronomical fees at the patient parking garage — fees not covered by health insurance, though of course I can afford them better than many other patients can. The offices are clean but drab, and the clinic runs relatively efficiently. It has separate lines at the front desk for checking in and out, and shortly after my arrival, a friendly medical assistant called me in to take my vital signs and review my medication list.

Ten minutes later, I was in a narrow exam room, and 13 minutes after that, my internist appeared, looking tired yet radiating her usual warmth and concern. She apologized for running late, and I told her it was no problem. I didn't tell her that I always block out 90 minutes for my 20-minute appointment and bring work to do while I wait. As I answered her questions, we studied each other. I noted the subtle tension in her torso while we discussed my multiple concerns, each of which required decisions, tests, and referrals and each of which she had to attend to, given her broad skill set and primary care purview. Because of me, we both knew, she would end up running further behind.

At first, I had her full attention, but soon her fingers began moving along her keyboard while we talked, and her eyes strayed from me to her screen.[3] I knew she was working to fit my problems into the electronic record's template, with its dozens of menus, billing-required but often clinically irrelevant checkboxes, and subsections not sequenced in the way our conversation was proceeding.[4] Meanwhile, as I knew all too well from my own geriatrics practice, her clinical inbox was filling with an ever-growing list of tasks, all amounting to hours of work for which no time was allotted in her clinic day.[5,6]

Of course, many of the challenges my internist faced that day aren't unique to primary care. That's why some practices have adopted two approaches that increase efficiency: relying more on midlevel providers[7,8] and using scribes[9,10] — strategies that I saw in action later that week at my orthopedist's office.

Although she's part of the same institution as my internist, my orthopedist works in a new, glass-walled building in a part of town that is rapidly being revitalized. There's no street parking, but a cafe on the ground floor serves farm-fresh salads and organic drip coffee. I went to see her not because I needed an appointment but because I'd been unable to get answers to a simple follow-up question through the patient portal. The problem wasn't that I couldn't get a response, just that I couldn't get one from her. I sent versions of the same query a few times, and each time it was handled without resolution by a different nurse practitioner who didn't know me and either couldn't (for reasons that might range from not having read my chart to not having the

necessary knowledge) or wouldn't (since I wasn't his or her patient) answer my question.

So there I was in person at the orthopedics clinic. And then I almost didn't get to see my doctor. After I checked in, the person at the front desk told me someone would call me shortly for an x-ray, so I should sit by the x-ray room door. (In orthopedics, there's an x-ray room on the same floor as the doctors. In primary care, you have to walk a block and a half to another building.)

I said I didn't need an x-ray.

He said everyone got an x-ray.

"Before they even see the doctor and whether they need one or not?" I asked in a tone that was as even, polite, and cheerful as I could muster, though loudly enough that other patients might be inspired to join me in "Choosing Wisely,"[11] if appropriate.

He didn't reply. I told him I'd already had an x-ray at this same clinic for this same doctor about this same problem, and nothing had changed since that time. He called his supervisor and asked her whether a patient could be seen if she refused the x-ray.

Fortunately, the supervisor said yes. I sat down, and a short while later a medical assistant called my name and took me back into a large, sunny exam room, entered my chief symptom in the computer, and told me where to sit and what clothing to remove.

I had only just begun to do some work when my doctor came in, followed by a young woman carrying a laptop. The doctor and I exchanged pleasantries, and I was introduced to the scribe, who sat discreetly to one side, saying nothing during the visit while her fingers moved quietly on the keyboard.

For the entire appointment, I had my doctor's full attention: eye contact, smiles, a targeted physical exam, and answers to my questions — the original one and some others I came up with to make the visit seem more worthwhile, though all related to the single body part that is her focus. She didn't seem to miss the x-ray I hadn't had and showed no interest in my other medical issues, or the parts of me that, though not in the orthopedics domain, might influence my treatment preferences and recovery. With some prodding — I used words like "physical therapy" and "exercise" — I was able to get her recommendations for approaches other than medications or the sort of high-tech surgery that the medical center touted daily on local radio, television, and billboards but that was unlikely to address my primary concerns.

Once we'd made a plan, she left the room, telling me to wait there for her physician assistant, who would review my discharge instructions. Miraculously, she walked out the door with her note largely written, though she had done nothing but attend to me during our encounter. We were both pleased and relaxed as a result.

My internist and my orthopedist are both highly trained, highly skilled, and hard-working doctors. Although I don't know their specific salaries, a 2013 survey by the Medical Group Management Association cited median compensation figures of $193,776 for internists and nearly three times that, $525,000, for orthopedists — a gap that grossly exceeds the differential between their training periods and belies my internist's greater experience.[12] And of course that's only part of a larger and more complex financial picture that also includes wide variation in institutional revenue for different clinical activities, a system that provides incentives for procedural and hospital-based care and specialties over relational and outpatient ones. Those revenue differentials, in turn, affect the size and quality of a specialty's institutional real estate, the numbers and types of support staff at their disposal, the appeal of their specialty to trainees, and the discretionary income available to them for piloting innovations to improve the clinical environment for patients and providers alike.

It would be hard, even morally suspect, to argue that the salary disparities among medical specialties in U.S. medicine are the most pressing inequities of our health care system. Yet in many ways, they are representative of the biases underpinning health care's often inefficient, always expensive, and sometimes nonsensical care — biases that harm patients and undermine medicine's ability to achieve its primary mission.[13,14]

The National Library of Medicine defines health disparities as "differences in access to or availability of facilities and services . . . between socioeconomic and/or geographically defined population groups."[15] The Healthy People 2020 initiative has further noted that "health disparities adversely affect groups of people who have systematically experienced greater obstacles."[16]

By these definitions, there are health disparities, professionally, between my internist and

orthopedist, and they reflect systematic, nationwide biases in how we value and reward different medical conditions and types of care — biases that developed as side effects of medicine's greatest successes. In the 20th century, as scientific progress brought unprecedented gains in health and longevity, we began assuming that newer, more invasive, higher-tech, and more specialized care was always better, and we set up a system that prioritizes and generously rewards that sort of care. That philosophy affects not just physician salaries, but also institutional, educational, and research priorities, and indeed the very culture of medicine.

At a recent meeting of the Harvard Medical School Alumni Council, a first-year student was asked about his debt. "Huge," he answered, shaking his head and adding that he also had college debt. "What will you do?" asked the council president. The student grinned. "Oh, I'm not worried. I'm going into ortho."

Now, maybe this brilliant man would have chosen orthopedics even if doing so wouldn't quickly dispatch his debt.[17] Or perhaps absent the current, highly skewed hierarchy of specialty salaries and prestige, he might have moved through medical school with an open mind about his future career.[18,19] And maybe, if choosing a primary care specialty wouldn't have penalized him, his soon-to-be wife, and their future children, he would even have factored patient and societal needs into his decision making.[20,21]

In study after study, greater reliance on primary care has been shown to prevent illness, reduce mortality, and lower costs, while increasing patient satisfaction.[22] A growing literature also reveals high rates of overuse and waste systemwide in health care, as well as serious harms from higher-tech, more aggressive, specialty-driven care.[23] Globally, the countries and regions with the most robust primary care systems have the best health outcomes. Yet primary care remains U.S. medicine's second-class citizen.

The terms "structural violence" and "structural inequality" pertain here. As the physician-anthropologist Paul Farmer has explained, these concepts offer "one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world"[24] — in this case, of U.S. health care.[25]

Those structural inequalities might lead a Martian who landed in the United States today and saw our health care system to conclude that we prefer treatment to prevention, that our bones and skin matter more to us than our children or sanity, that patient benefit is not a prerequisite for approved use of treatments or procedures, that drugs always work better than exercise, that doctors treat computers not people, that death is avoidable with the right care, that hospitals are the best place to be sick, and that we value avoiding wrinkles or warts more than we do hearing, chewing, or walking.

Ours are the best of times in U.S. health care because we can do so much for people, from quickly curing infections to replacing damaged joints and organs. But ours also are the worst of times because we continually fail to prioritize the sort of care that helps patients most[26,27] and make it far harder than necessary for clinicians providing that care to succeed.[28,29] Yet like the aristocratic audience for whom Dickens wrote *A Tale of Two Cities*, physicians and health system leaders are in a position to transform the culture of medicine to better serve patients and health. We should use the abundant available evidence about what works best in medicine to inform a reprioritization of care, reduce structural inequalities, and provide better outcomes at lower costs. Doing so will move us closer, as individuals and as a profession, to fulfilling our Hippocratic Oath.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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