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Invisibility and modern medicine

"Invisibility" is a state in which something is "incapable by nature of being seen."[1] While it is a word that typically applies to inert objects, psychologists use the term to describe an individual's self-perception of being unseen. Could it be that the dominant feeling of the modern American physician is one of invisibility?

At a recent gathering of physicians, several individuals lamented the state of their institution and their professions. "Too many administrators, too much interference," one physician remarked. These men and women once beamed with pride about their work. What was different in better times?

> "When we wanted to do something, we could just get it done. When we needed equipment to do a procedure, we called the single administrator—and it would appear the next day. Today, I can't get paperclips without filling out a form—and no one cares if I get them."

> "Policies are made by bureaucrats who don't understand patient care. Our voices don't matter."

Said another way, these physicians were expressing feelings of invisibility.

1. Sources of invisibility

A clue to the changing visibility of the American physician may lie in the massive consolidation of American medicine and growth of the size and scale of healthcare organizations. It is well-known that economic imperatives have led small, intimate, family-owned practices to merge into large multispecialty groups, often owned by hospitals and other entities.[2] Community hospitals have been morphed into constituent parts of large multi-division health systems.[3] Local health plans have been acquired by national players. Every institution is bigger and, as a result, everyone feels smaller. Formal processes have displaced the comfortable informality that dominated the practice of medicine in an earlier time. The leadership of many organizations and health policy-making bodies lacks true physician presence or engagement.

Another clue might be the emergence of the word "provider" which is at once is used to refer to 1) systems and groups that provide care to patients (short for "provider organization"), but is also used to describe 2) the group of people whose primary work is caring for patients. In the latter use, a highly differentiated group of professionals—physicians, physicians' assistants, nurse practitioners, physical therapists, and pharmacists, among others—are collapsed under a single, all-encompassing umbrella term. Nuances in training and expertise can be made to feel insignificant to individuals who spent significant effort to achieve specific skillsets and professional distinctions. Calling all patient-facing staff "providers" may drive perceptions of interchangeability and invisibility.

Another clue to the changing visibility of physicians is, in some ways, more literal. For many, the dominant source of joy for many physicians entering the medical profession was time spent interacting with one's patients. The strange, unexpected reality of modern medical practice is that many physicians spend more time documenting patient care than they do interacting with patients, families, and colleagues. For every hour physicians provide direct clinical face time to patients, nearly 2 additional hours is spent on the electronic health record and desk work within the clinic.[4] The work of being a physician—once highly social and interactive—has become increasingly isolated and lonely. Physicians are literally less visible to their patients.

Some might argue that physician invisibility has been at least partially self-inflicted. For many, the departure from solo and small-group medical practice was as much an active decision for some as an economic imperative. The short nature of many visits is grounded in an income expectation that is at least partially of their own choosing. For much of the past 50 years, physicians largely remained absent from discussions of national policy and local efforts to drive systemic improvement in health care. Some argue that physicians have failed to use the implicit moral authority associated with the profession for good except to occasionally advance their own parochial interests. The seat at the decision-making table was not taken away, rather it was never affirmatively asserted out of a lack of concern for the broader social context in which they practice.

2. Consequences of invisibility

Invisibility manifests in marked disaffection with clinical practice and burnout. A growing number of physicians are disenchanted with their work. A recent survey of 15,000 physicians revealed that 44% reported being "burned out."[5] Some are departing clinical practice to work in non-clinical organizations where they find a more rewarding work environment. At the heart of what makes these environments more rewarding may be the opportunity to exercise creativity, to work collaboratively with others, to drive clinical thinking into new domains—in short, to be visible, to be seen.

One physician recently expressed thoughts about leaving the practice of orthopedic surgery in favor of a healthcare startup. "I don't feel like *anyone*." Patient care was rewarding, but he felt like his impact was limited. He felt like a "cog in a machine." Perhaps things would be better in the startup.

An implicit cost of the subjective feeling of invisibility is that we are losing the benefit of the care, compassion, and services delivered by physicians whose clinical expertise was hard-won and, often-times, significantly needed. Whatever financial rewards physicians are conferred are obviated by a decline in the psychological reward. With

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looming physician shortages, physicians are being increasingly replaced in leveraged staff models involving physician assistants, nurse practitioners, and other "providers" that worsens their invisibility.

3. Becoming visible again

How do we escape this cycle? How do we make physicians feel visible again? For the answer to this question—we turn to Ralph Ellison, whose unnamed narrator in the book "Invisible Man," avoided retreat in the face of the racism and structural forces that made him invisible. Rather, he rejected cynicism and embraced optimism that he could be seen.

To make physicians visible again, physicians themselves will need to embrace this optimistic outlook recommended by Ellison. They must decide that their voice matters—and ignore any signals (subtle or explicit) that it doesn't. They must decide that they would like to participate in local and national public discourse about issues that affect them. Instead of leaving medical practice altogether, they may decide to escape the clutches of large institutions and return to clinical practice environments in which they are more fully in-charge.

They will also need help. Leaders of hospitals and health systems must endeavor to make big, impersonal institutions feel small again—to recommit to physicians as critical stakeholders in institutional success. Journalists, academics, and others who write and speak about healthcare must definitively strike down the use of the broad term "provider" and revert to more nuanced descriptions of the professionals who work within healthcare. Technologists and regulators must work hand in hand to make the work of physicians more decisively about interacting with patients and families, not rote data-entry. And physicians must once again be offered a seat at decision-making tables where their expertise can only enrich and enhance the quality of decision-making—even if they themselves are not asking for it.

Visibility is a core human need. Bringing America's physicians out from the shadows will not be an easy task or a simple one, yet it is clearly more necessary than ever. At stake is nothing less than the vibrancy and viability of the US healthcare workforce.

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