Rheumatologists are disappearing. The physicians who care for patients with diseases due to our immune system are dwindling just as more and more patients need their attention. Programs to train them have not measurably increased, and the current rheumatologists are getting older and retiring - less in, more out.

I wish I could say that rheumatologists were the early warning canaries in the physician workforce coal mine, but they are not, they are the miners, the canaries died long ago. For 100 years, not coincidentally related to the end of World War I, there have been increasing concerns about the supply and distribution of physicians. It is a global issue, no longer confined to the 1st world developed countries.

If economic theory, matching the supply of doctors to the demand of patients held true, new graduates would join the 7% of rheumatologists serving the 20% of our rural population.[1] Why instead do they join the 90% of rheumatologists already located in cities? The difference in income for a rheumatologist shows little variation between rural and urban areas so how physicians choose where to work must involve factors beyond income. Two studies, now over 40 years old, spotlight two salient considerations medical leadership has chosen to ignore – home and autonomy.

How physicians choose where to practice.

Where we grow up is the single greatest determinate of where we live and work as adults, accounting for half of our weighting. Growing up in a rural or disadvantaged area is the most potent motivator for those physicians to return. Home is familiar, surrounded by care and trust,
home connect us and creates a safe base to grow into our potential. Physicians, like the rest of us, choose to work where they are most comfortable.

Our desire for professional autonomy is reflected in the organization of medical practice we choose, solo, small or large group settings. Solo practice affords the greatest independence; you are only answerable to your patients, you act as you see best. The cost is a consuming professional life, with only gaps and pauses for your family. Group practice, [2] trades some autonomy for more peer collaboration and oversight, for greater control of your family time. Larger groups are attractive to physicians who rank work-life balance, measured in on-call hours and practice unfettered by business concerns as most important - willing to participate as team members or corporate employees. 2017 was the first year when more physicians worked as employees than in solo or small group practice.

Geography, it appears, is a shorthand for many social and cultural factors that foster one form of practice over another. Rural areas, perhaps reflecting a “pioneering spirit,” encourage autonomous practice while requiring more resilience, especially concerning that work-life balance. Rural areas have higher percentages of solo practices than urban areas. Urban areas provide more expression of the family part of work-family balance - cultural, educational, economic opportunities in greater abundance and diversity. Urban areas have a higher percentage of group practices.

In step with society, physicians are increasingly concerned about balancing professional and personal lives, work hours that provide proper patient care and leave sufficient room for our families. Physicians are not choosing urban over rural; it is that urban geographies support the practice climate they want.

There have been two other significant change since those studies. First, the cost of opening a practice has skyrocketed. You need to have money for malpractice, employees, a physical office, electronic medical record software and enough savings to live for the minimum three months you will wait to see the first insurance payment. That is a great deal of money, especially given the increasing debt load physicians acquire in obtaining their education. In short, solo practice even if it is desired if often beyond new physicians financial reach.

Today, 41% of rheumatologists are women, and that percentage continues to rise. Women represent half of all medical students and trainees, although percentages within specialties vary. Women balance work and family differently (not better or worse) than their male colleagues, e.g., 23% of female rheumatologists work part-time, compared to 8% of men. Part-time employment functions best in large groups, where physicians are measured in full-time work equivalents; part-time work is impossible in solo practice.

**Like rheumatologists, hospitals are disappearing too**

For small-town America, the arrival of Walmart elicits mixed emotions. Walmart brings more choice and lower prices, but it shutters the no longer competitive mom and pop stores. A day comes when Walmart realizes their investment is not yielding the expected return and they either significantly downsize or close altogether, leaving the small town with no stores and little chance for their return.
Health systems are our Walmart. They come into town purchasing the small struggling hospital. It initially is a great win for patients, a greater depth of consultants, ability to transfer complex problems into a hub hospital, perhaps even better care. But after a while, the health system realizes that maintaining the small hospital is more drag than an enhancement to their bottom line. They either downsize the hospital to an urgent care center or close it entirely. Where the town once had a hospital, it now has a triage center. Almost half of the hospitals lost in the last few years represent the “service-reductions” by health systems. Health systems with names like Mayo, Cleveland Clinic and Partners Healthcare, Boston’s health system - nonprofits. [3]

For patients, losing a hospital requires them to travel further for care, reducing access because of the logistics of travel or lodging. For the rural physician, the loss of a hospital means, extending that earlier pioneer analogy, that the fort has closed and the cavalry moved away. Hospitals are a safety mechanism for physicians; you can bring your patient to a hospital and get the community of physicians to help you with a failing patient. Hospitals mean you are not alone. Once settled physicians rarely move, rural and urban retention rates are nearly identical. But when asked why they might leave rural practice, one of physician’s three reasons was the loss of the hospital; loss of home or family were the two others.

Solutions

A number of “solutions” to our supply and distribution problem have been proposed but are often compromised by self-interest. Medical school, ignoring all that we have learned about where physicians locate, recommend more medical schools. While raising the number of physicians trained, will it address their selection of specialty or geographic choices? The short answer is no. Medical schools situated in rural areas produce more rural physicians; but of the 19 new medical schools opened since 2008, only one is in a rural area. If you consider towns like Camden, New Jersey rural you can add four more. The faculty of medical schools is no more inclined than they students to locate in rural areas.

Greater incomes, the “solution” of primary care providers will certainly increase their ranks, but it will not get them to move to the country when their sense of home is urban and corporate employment offers the best work-life balance. Government incentives may have some small impact. Debt forgiveness may encourage some to return home; it will not make it home.

For nearly 100 years we have lamented the maldistribution of physicians and their dwindling numbers in relationship to the population they must serve. Building more schools has increased physician numbers but not altered their choice of specialty or place of practice; it may have accelerated those problems. The changing locale of what we consider home and how we balance our families with our work are societal shifts, not amenable to government’s inducements or regulations.

When insanity is defined as repeatedly doing the same thing and expecting a different outcome, then efforts to correct the problem are just that, insane. Perhaps it is time for rethinking our roles, both as patient and physician, rather than mindlessly graduating more physicians, who will, in turn, prescribe more care at more cost.
[1] Rural areas are defined as having towns of 50,000 or less.

[2] The definition of small groups varies, but they are small enough that everyone knows one another and is on equal footing.

[3] As a reminder, a non-profit is a tax status, it means you pay fewer taxes in exchange for community/charitable services. All health systems must generate a profit to survive.

Sources: Why doctors choose small towns: A developmental model of rural physician recruitment and retention Social Science and Medicine DOI: 10.1016/j.socscimed.2009.08.002

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