

NY Times

August 20, 2005

Sick and Scared, and Waiting, Waiting, Waiting

By [GINA KOLATA](#)

Freddie Odlum spent two terrible days waiting by the phone for her doctor to call. She had had a CT scan to investigate a suspicious mass in her lungs and Ms. Odlum, a Los Angeles breast [cancer](#) patient, was all too aware that if the cancer had spread, her prognosis would not be good.

Her doctor, she said, informed her that he was going on vacation in two days and "that we needed to 'wrap this up' before he left for a few weeks."

"All those clichés when someone is facing a terminal diagnosis are used because they are true," she said. "Racing pulse, dry mouth, total self-preoccupation with what-ifs to the point that real life doesn't exist, willing the phone to ring."

But her doctor did not call.

The next day, the day he was leaving, she left phone messages at his office and sent an e-mail message saying, "Don't leave without calling me with the results."

"That night I waited," she said, "jumping at every noise, not letting anyone use the phone, imagining every scenario."

Her doctor left for his vacation. He never called, not even when he returned.

The scan did not show cancer, but she could not forgive her doctor.

"This internist had been my family doctor for years," Ms. Odlum said. "This physician's wife had breast cancer and was treated by the same oncologist as me."

How could someone whose wife had breast cancer not realize the impact of being left hanging, she asked, adding, "I never spoke to him again."

Waiting has long been part of medicine. Patients like Ms. Odlum wait for test results; others spend weeks or months waiting for appointments or stranded for hours in doctors' waiting rooms.

But health care researchers say the waiting problem has only gotten worse. Advances in technology have created more tests and procedures to wait for, and new drugs and

treatments mean more people need more doctor visits. Doctors' appointments for people over 45 increased by more than 20 percent in the last decade, according to the National Center for Health Statistics. Emergency room visits increased by 23 percent, although the number of hospitals declined by 15 percent.

Some doctors say they doublebook appointments to make up for patient cancellations. And doctors say they are pulled in so many directions that, in many cases, long waits are unavoidable.

"There is nothing magic about waiting," said Dr. Charles K. Francis, president of the American College of Physicians.

"Most of us have patients in the hospital and patients in the office," Dr. Francis said. "Then the patient has to go to the lab, and medicine is unpredictable."

He added that insurance companies reimbursed doctors at lower rates than in the past, resulting in intense pressure to see large numbers of patients. "You have to work long hours and see more patients just to keep your office open," he said.

Recently, however, patients, some doctors and researchers have begun to ask why medicine cannot be as accountable to its customers as any other business. And some doctors' offices and hospitals are starting to solve their waiting problems by applying techniques that businesses use.

Change cannot come too soon for irate patients like Howard Levine of Boca Raton, Fla., who endured a two-hour wait before storming out of a vascular surgeon's office.

"I was in the restaurant business for 20 years, and if I made you wait in a restaurant for two hours, you would be pretty upset," Mr. Levine said. "We're not coming there for social visits. We're coming because something is wrong."

While all waits can be frustrating or even infuriating, the worst, many patients say, are when they fear getting bad news.

"The hardest waiting," said Pam Breakey, a cancer patient in Michigan, was the five weeks from when she initially suspected she had breast cancer until the day she started treatment. Cancer was always on her mind. And everything required waiting: appointments with the oncologist, the surgeon and "test after test, I stopped counting at 20."

There was waiting "to learn if the cancer had spread," she continued. "It had. Then waiting to learn about the cancer cells themselves. Waiting, waiting, waiting."

Her friends would call, she said, "and I have nothing to tell them."

Her husband looked at her with anxiety, her daughter's voice was tight with fear. It is, she said, "like waiting to find out if a jury has convicted you of something awful."

Yet while little can be done about the fact that test results can be scary, health care researchers and doctors say a lot can be done to improve the delivery of results so patients are not left waiting for days or even weeks. And a lot can be done to improve waits for appointments and in doctors' offices and emergency rooms.

Everyone can change, says Dr. Mark Murray of Sacramento, whose company, Mark Murray & Associates, helps doctors eliminate waits. "It goes back to motivation. The principles, the strategies are pretty basic."

A Doctor Sees the Other Side

As a physician himself, Dr. Philip Greenland, chairman of the department of preventive medicine at the University of Michigan, had always gotten deferential treatment from other doctors. If he wanted an appointment, he would page a colleague and ask to be seen that day. He never waited for test results or for doctors to call.

His epiphany came when his 89-year-old mother broke her hip.

Dr. Greenland and his brother flew to Maryland where their mother was hospitalized, arriving late on a Saturday night.

"On Sunday at 6 a.m., I said to my brother: 'We ought to get to the hospital. This doctor is an orthopedic surgeon, and he will make rounds early. If we're not there, we won't see him.'

"By noon," Dr. Greenland said, "it was apparent to me that we won't see this guy." A nurse told him that the doctor had been there and gone.

"I was in total shock," he said. "I said to the nurse: 'Get him on the phone. Page him, wherever he is.' "

The nurse paged the orthopedist, but he told her that he was going into surgery and that she should ask Dr. Greenland what his question was. When he had time, the orthopedist said, he would give the nurse his answer and she could relay it to Dr. Greenland. That only made Dr. Greenland madder. "I said: 'That's not acceptable. My questions depend on his answers and I will not play telephone tag all day.' "

Dr. Greenland never got the prompt attention he wanted from the orthopedist. And he was shaken.

"What was shocking about this experience to me is that it's almost the only time in my life since I've become a doctor 35 years ago that I ever experienced medicine directly, from the patient's point of view," he said. "What this tells me is that the profession has

lost sight of what medicine is all about. It's not about them. It's not about their schedule. It's about the patient."

He added: "Doctors are not victims here. If they are unable to handle the workload, they need more help. If it means inconvenience, they have to live with it."

No Waiting Here

After five years of practicing medicine, Dr. L. Gordon Moore was miserable. His schedule was out of control, patients were piling up in his Rochester waiting room, and they were seething.

"I was starting every patient visit late and rushing to see the next patient," he said. "I was staying two hours late at the end of the day. And I was thinking, This is my career?"

But when Dr. Moore asked around to see if there was another way, he was told, he said, to "suck it up."

When he heard about an idea to apply industrial engineering principles to doctors' offices, he investigated the flow of work in his own office.

For example, he asked, what happens when a patient calls needing a prescription refilled? A secretary writes a note. When a pile of notes accumulates, the secretary pulls the patients' charts and delivers them to a nurse. The nurse divides them into two piles, urgent and nonurgent. It could take a day and a half before a nonurgent refill is called in. Meanwhile, the chart could be in any of 39 places in the office.

Dr. Moore opted for radical change. He quit his three-doctor practice and started a new one.

"I started with one room, an exam table and no employees, just me," he said.

Instead of having about 2,000 patients, he cut back to 500. Not only did he get rid of waiting times, but, by getting rid of most of his office and all of his staff, he eliminated his overhead, making his practice affordable.

But few doctors are ready for such a solution. Most, Dr. Murray says, tell him, "Waiting times are not bad, waiting times are acceptable."

That attitude, he noted, is part of the culture of medicine.

"It grows out of that insularity that we get to decide who waits and who doesn't," Dr. Murray said.

He said that delays often started with the way an office was run. Doctors assume, he explained, that the most efficient office is filled with waiting patients, like a company

making sure its warehouses are always full. But companies have learned that there is a cost to keeping warehouses full. The same principle applies to doctors' offices.

People get mad, Dr. Murray said. And at some point, patients start to leave.

Long delays are why Roberta Weintraub left her doctor. Ms. Weintraub, of Beverly Hills, Calif., said that her internist was first-rate, but that the waits had become intolerable - up to an hour and a half in the waiting room, then 20 to 30 minutes in the examining room. And, she said, there was the wait for testing and the wait to get test results. "I got to a point in my life where I could afford not to put up with that," Ms. Weintraub said.

Now she pays \$1,800 a year to be a patient in a concierge practice, in which patients pay an extra fee and, in return, get prompt attention. Ms. Weinstein's new internist, Dr. Judith P. Delafield, says she was unable to prevent waits when she was part of a conventional practice and seeing 2,000 patients.

"The handwriting was on the wall for me," Dr. Delafield said. "It was that everyday packing of your waiting room because you have to see a certain number of patients." Now she restricts her practice to 600 patients.

"All in all, you can control your life so you can be on time," she added. "It's a matter of respect."

Long Waits in the E.R.

Last fall, on a day when her husband was restless and violent, Peggi Durand knew she had to take him to the hospital for a possible admission to the geriatric psychiatry ward. At age 59, John Durand has suffered from dementia for seven years and Ms. Durand has cared for him.

She and her husband arrived at an emergency room near their home in Malden, Mass., at 9:30 a.m. They began their wait.

"John was agitated when we got there, and the longer we were there, the worse it got," Ms. Durand said.

"We were still in the emergency room at 3:30 in the afternoon," she recalled. "There were just waits - waiting for a social worker to interview him, waiting for a psychiatrist. Then they had to get his room ready."

Their wait, while long, was not unusual, researchers say.

In one study, Dr. Steven M. Asch, a health care researcher at the RAND Corporation and the Veterans Affairs Greater Los Angeles Healthcare System and his colleagues observed that 40 percent of emergency room patients waited longer than an hour to see a doctor.

That, of course, is often only the beginning. Patients can wait for a bed, wait to be admitted, wait for a scan. Typically, Dr. Asch and others say, patients end up waiting for hours, even a day.

Hospitals often ask for forbearance. Long waits arise, they say, because there are no beds or a flood of patients coming in.

But increasingly, economic factors are causing hospitals to worry more about long delays. And some hospitals are paying for consultants to help them reduce waits.

The emergency room can be a lucrative source of patients, said Dr. Saum Sutaria of McKinsey & Company, the consulting firm, with some hospitals making \$2,000 to \$3,000 for every patient admitted through the emergency room and \$250 to \$750 for each patient who is treated and goes home. But when hospitals get so backed up that they have no more intensive care beds, they go on diversion, sending patients to other hospitals.

"That is very painful for the hospital," said Paul Mango, a McKinsey executive, but he added that some hospitals were on diversion 25 percent of the time.

The result is a booming business for companies like McKinsey. The company finds problems everywhere.

For example, Mr. Mango says, over half the time, when surgery patients showed up for their operations, simple requirements, like taking a medical history, were not met. Mr. Mango has even seen patients arrive, as scheduled, at 5:30 a.m., only to have the admitting staff discover that they still need laboratory tests. But the laboratory does not open until 7 a.m.. So everyone waits.

"It costs \$60 a minute for an idle operating room," Mr. Mango says. "There will be three or four operating room technicians, an anesthesiologist and a surgeon waiting for a patient who couldn't get through the admissions process."

Another common problem is that doctors wait until the end of the day to discharge patients, locking up a bed all day. But discharging patients does not help an emergency room unless someone tells the emergency room that a bed is free. "Rarely are there good communications," said Dr. Russ Richmond, also with McKinsey.

For patients, these explanations are hardly enough.

Pam Stephan of Austin, Tex., went to her local hospital near collapse. She had had chemotherapy, had developed a fever, and now she was gasping for breath. Her oncology center had put her off for days before she could get an appointment. Once there, she waited for hours, and then learned that she was dangerously anemic. "Go to the hospital for a blood transfusion," she was told.

She arrived at the hospital at 5 p.m., but all the rooms were full and the wait was expected to be several hours. Ms. Stephan and her husband went home, an hour's drive, returning hours later.

"Then began a long stream of paperwork, and questions, and more blood tests, and by 2 a.m., I actually started the three-pint blood transfusion," Ms. Stephan said.

"I was glad to be through with waiting," she added. But by then, she said, she was so sick and so exhausted that "dying would have been too much trouble."