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HEADLINE: Confronting the Trauma of Breast Cancer;
Pastor's Revelation Sets Silver Spring Congregation on a Shared Journey

SERIES: IN THE SHADOW OF BREAST CANCER: REVERBERATIONS OF A DISEASE, Part 1 of 2

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:
First of two articles

On a Sunday like so many Sundays, the Rev. Joey Noble listened quietly until the familiar cadence of the service at her Silver Spring church reached the proper place for the sermon.

But on that morning last autumn, Noble stepped to the pulpit, searched the faces in the sanctuary and felt sorrow. For years, she had comforted her congregation. Now she would share her pain with them.

"Several weeks ago, my life was on such a good journey," she began. ". . . Then I hit a wall.

"Breast cancer."

For a moment, the filled sanctuary of Christ Congregational Church was utterly still. Somewhere, a woman started to sob.

Noble's revelation, four days before a surgeon carved a deep chunk from her right breast, "was like a thunderbolt," one parishioner recalled. The congregation was all too familiar with the disease. Now their minister had it too.

At 49, Noble is associate pastor of a 770-member church in which 20 other women have had breast cancer. Two have died, and a third has abandoned medical treatment.

This is the story of their journey and how it has transformed a particular congregation, but it could be told in many places. Breast cancer has become so common that it will strike one American woman in nine sometime in her life. More than one-third of American adults already have had a close relative or friend die of the disease, according to a Washington Post poll.

"I never heard of it hardly until the last 10 years. Now, every time I turn around, someone else has it," said Pennie Harvison, a member of the Colesville Road church who knows 15 women diagnosed in the last year.

The Washington Post, October 18, 1992

Through its sheer prevalence, breast cancer has evolved from a disease that women often harbored in secret even 15 years ago. The disease is less lonely today. Hazel Ewing, a parishioner who had a mastectomy in 1990 and chemotherapy last year, has been her minister's role model. "As I was losing my hair, hers was growing back," Noble said. "There has been a kind of sisterhood in that."

Yet Noble's own struggle with cancer -- her openness, her fears and her strength -- is the one that has reverberated most strongly through the congregation. Old silences have shattered. The church secretary, Ruth Avery, confided to Noble that she had a mastectomy 19 years ago.

In a broader way, Noble's cancer has attuned members to their own vulnerability. "Whenever you have a minister go through some kind of illness, it is a special kind of crisis for the church," senior minister James Todhunter said. "Especially someone like Joey. For a very, very strong, nurturing person to get breast cancer, that is a very powerful symbol of loss.

"Now, if you are going to love Joey, you have to experience some of her pain," he said. "It is encouraging people to move right toward what they fear the most."

Noble agrees. "This isn't the same church it was [last] October," she said.

Part of the United Church of Christ, a Protestant denomination, Christ Congregational grew up with Silver Spring. Its founding minister went door-to-door in the 1940s to recruit the young families moving into the new suburb.

The congregation today is a blend of original members, now reaching old age, and newer generations of families and single adults. Mostly professionals and government workers, the members share a belief in activism on such issues as housing, homelessness and abortion rights.

"The faith that is expressed here is not a magical, mystical sense that God is here to rescue us," Todhunter said.

Noble arrived five years ago to take her first full-time ordained position. Married the weekend after she graduated from college in Kansas in the mid-1960s, she had taught high school English in Massachusetts for four years until her older daughter was born. She then did a stint as full-time homemaker and volunteer: League of Women Voters, the local school board and -- always -- her church. By 1979, she was a part-time seminary student in Montclair, N.J.

Noble is sensitive, affectionate and smart -- an extrovert who loves long walks, long letters and afternoon tea.

At Christ Congregational, she quickly became the ballast. Todhunter handles most of the preaching and political causes. Noble comforts the sick and weaves newcomers into the church.

Even before her cancer, she had shared private milestones with her congregation: divorce, diabetes and a second marriage, performed during a Sunday worship service in 1990.

For years, Noble had gotten regular mammograms, or breast X-rays, to check for cancer. They showed nothing amiss. But on Oct. 9, 1991, as she was applying moisturizer after her shower, she discovered a distinct, hard lump about the width of a dime.

Her gynecologist immediately recommended that it be removed but said the problem seemed minor. Confident that she was fine, Noble persuaded her husband, David Smock, to leave that weekend on a business trip to Turkey, Ethiopia and Egypt.

She was not a likely candidate for breast cancer, she told herself. No family history of it. A careful diet. Two children, both born while she was young.

After her biopsy, Noble was still on the operating table when the surgeon told her she had a tumor. It was relatively large -- 1.3 centimeters -- and malignant.

It was as if she had smacked full-force into a closed door. She could not see beyond it but felt sure that nothing in her life would be the same.

A parishioner had waited outside during Noble's biopsy. For a long time, they held one another and sobbed. "I felt totally helpless, devastated for her, seeing this person who always takes care of everybody else," the woman later recalled.

That night, Noble called her younger daughter, Faith, a student at Northwestern University. Listening to her strong mother cry, the 19-year-old decided to come home for several days. In Istanbul, Noble's husband was trying desperately to reach her, stymied by time differences and bad telephone connections. When he finally talked with his wife, he rejected her advice to continue with the trip.

Once he was back, they began a dizzying whirl of doctor appointments to assess her choices: a mastectomy to remove the entire breast or a less drastic form of surgery, called a lumpectomy, that would preserve much of the breast but require radiation afterward.

"You were choosing what your body was going to look like for the rest of your life," recalled Noble's husband, a grant officer with the U.S. Institute for Peace. "And you were choosing without knowing all the facts. You didn't know if it had spread."

Noble confided in a few lay leaders, who debated whether to summon Todhunter from a five-month sabbatical. They did not want to undermine Noble's authority, yet did not want the congregation set adrift.

The senior minister was not called back, but rumors were starting to filter out.

The congregation, Noble decided, needed to hear about her cancer directly from her.

"Writing the sermon, having to put it down on paper, to be specific, objectified it a little bit for me," she said. "Kind of realizing, for whom is life fair? It also helped give me a sense of my own strength."

The morning of Oct. 27, the Sunday before her lumpectomy, Noble dressed as usual in her unbleached clerical robe. Waiting to give the sermon, she wondered how her news would affect the women diagnosed in the months and years before.

Then, slowly and evenly, she read her carefully rehearsed words: " . . . In the middle of the night, when I awake in terror at the destruction . . . inside my body, as doctors deliberate and I vacillate, I am tempted to despair. 'It is too much, God,' I cry out.

"But . . . as I talk with the many courageous women who have walked this path before me, I realize . . . I am not alone. One day I said to one of you, 'I don't know if I can be strong.' The reply came back, 'You don't have to be. Lean on us for a while.' "

The congregation grieved that morning. A parishioner, Kay White, who had a mastectomy in 1970, remembers "bawling" in her pew. Few in the sanctuary had her firsthand experience with the disease, but most knew women with breast cancer. They loved their minister. They knew what she would go through.

Even in a church with a tradition of openness, Noble's sermon broke barriers.

A few members of the congregation questioned whether the pulpit was the proper forum for Noble's news. "There is a fine line between revealing yourself to the congregation and unloading yourself on the congregation," said Christine Wood, 38, a parishioner studying for a master's degree in divinity.

Yet nearly everyone thought her disclosure appropriate, a Post telephone survey of the church found.

Parishioners believe Noble enabled them to respond as a real community. And they saw strength in her ability to reveal her fears -- her uncertainties and her rage -- when they still were raw.

For Noble, the revelation has had profound trade-offs. It produced a torrent of emotional support but deprived her of emotional privacy.

She was deluged with telephone calls and cards, hundreds of each. For this outpouring of care, she was grateful. At the same time, she felt too many people were anxious about every test result, every doctor's appointment.

"It was kind of unhealthy for the congregation and for me. I couldn't deal with 400 people caring for me," she said. "There was definitely a part of me that would have liked to flee to the hills. On the other hand, I felt this was my family. This is the stuff of life."

By December, Noble was receiving chemotherapy along with radiation treatments. Her surgery had revealed that the cancer had indeed spread to nearby lymph nodes.

Todhunter ended his sabbatical early.

And for the congregation, Noble's cancer had a new, more tangible effect: Her doctor insisted that she stop her ritual of hugging each church member after every Sunday service.

The problem was in her blood chemistry. Her white cells and platelets had been ravaged by the chemotherapy, leaving her so vulnerable to infections and bleeding that close physical contact was dangerous.

She broke this news from the pulpit too, striving for a tone that would not further frighten her congregation. "I said I had just found out I had platelets. I hadn't even known I had platelets, but now I wished I had more. It meant I couldn't hug them until Easter."

A few days later, a man in the congregation who is fond of puns gave her a small china plate. Around the border, he had printed "A platelet for pal Joey."

"It was moments like that that sustained me," she said. "And there were many."

For the members of Christ Congregational, such gestures were familiar. In the Post survey of the church, most of the women and nearly half the men said they had done a favor for someone with breast cancer. They have given free legal and medical advice, brought food and read aloud. One woman helped plan a family reunion as her cousin was dying.

Many reached out to their minister.

A different member of the church drove Noble to each of her 12 chemotherapy treatments. A woman she knew only casually chauffeured her one day when her blood count proved so low that the treatment had to be postponed. Noble began to cry, and the woman suggested stopping for a cup of tea. By the end of the afternoon, Noble had become absorbed in the pleasure of a budding friendship.

The afternoon "was a gift to me," she recalled. It lifted a little of the emotional burden from her husband as well.

Some gifts have been spiritual. Cathy Balmer, a member of the church since birth, prays for Noble every night.

Others gave tokens meant to lighten her burden. A woman left feathers in Noble's mailbox and under her office door as a symbol of her concern and God's.

Barclay Shepard, whose wife, Marta, had breast cancer in 1988, told Noble that several families wanted to chip in to buy her a wig to help her cope with one of chemotherapy's side effects.

Members of a women's group gave Noble 50 little, carefully wrapped gifts. One was a Christmas angel. "It said to me, I am going to see another Christmas," she said. "They were a sensitive group of women anyway, but Hazel is part of this group, and they had just been through this with her."

And men whose wives had survived breast cancer sought out her husband, a quiet man who also is ordained. "Husbands said, 'I know what you are going to go through. My wife had it years ago, and look at us,' " Smock said. He found their message hopeful and optimistic.

Noble finished chemotherapy during the third week of April, Holy Week in Christianity. "Symbolically, this is very powerful in terms of the possibility of renewal," she said.

Her hopefulness was tempered by remembrance. It had been exactly one year since Sylvia Rydell, a longtime leader in the congregation, had died of breast cancer. She was 66.

On Easter, parishioners stood in line at the front of the sanctuary to be hugged by Noble for the first time in months.

On May 1, her doctor found a new lump.

She was crushed. "The sense of relief [that] it is over is very much a false sense," Noble said. "It just goes on and on."

More than a week passed before she found out whether the lump was malignant. During those days, Noble made a decision.

She would not tell the congregation. She would spare them this time.

"People are feeling hopeful now," she said. "I am beginning to feel there are going to be a lot of ups and downs, and people don't need to go through that."

The new lump proved benign.

What the people of Christ Congregational have gone through -- their immersion in a disease that women once hid -- has changed them.

Some have awakened politically. One parishioner, Mark Clark, is angry that breast cancer hasn't gotten as much research funding as AIDS or heart disease. Two years ago, his wife, Stacy, had a mastectomy. "It is a terrible disease," he said, "and the message isn't getting out."

Yet, despite their enthusiasm for other forms of social action, most members have responded to breast cancer apolitically. The effects on them have been strong but personal.

Wood, the parishioner working toward a divinity degree, discovered a lump late last year. It turned out to be a cyst. But as she waited to find out, she said, her closeness to Noble "ratcheted up the fear."

The eight women in a bridge club, all church members, talked one another into getting their first mammograms. Before friends in the congregation got cancer, "I never even gave it a second thought," said one of the women, Ruth Haigh, who is 68.

Others have changed in broader ways. Caroline Dorworth, 30, a microbiologist who has belonged to the church since third grade, said her closeness to Noble and to a friend with breast cancer outside church has made her more appreciative of her own life -- more tolerant of its small disappointments.

As Dorworth has watched those two strong women cope with difficult medical treatment, with the disfigurement of their bodies, she has felt herself becoming more sensitive to issues of oppression and discrimination.

For many in the congregation, such sensitivity is a central legacy of Noble's public journey through breast cancer.

"If it is possible to become a more compassionate people," said Hazel Ewing, who has been her minister's cancer role model, "we just seem to be more compassionate because of Joey."

GRAPHIC: PHOTO, DRAWING CLOSE AS A COMMUNITY: ABOVE, THE REV. JOEY NOBLE LEADS A COMMUNION SERVICE. SENIOR MINISTER JAMES TODHUNTER SAID NOBLE'S ILLNESS HAS BEEN A "SPECIAL KIND OF CRISIS" FOR THE CHURCH. "NOW, IF YOU ARE GOING TO LOVE JOEY, YOU HAVE TO EXPERIENCE SOME OF HER PAIN. IT IS ENCOURAGING PEOPLE TO MOVE RIGHT TOWARD WHAT THEY FEAR THE MOST.", NANCY ANDREWS; ILLUSTRATION, COMPILED BY SHARON WARDEN

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HEADLINE: Coping With Breast Cancer Together; Shared Disease Bonds Women at Silver Spring Church

SERIES: IN THE SHADOW OF BREAST CANCER: AN EMERGING SISTERHOOD, Part 2 of 2

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

Inside a pink fitting room in a Bethesda lingerie shop, Barbara Muller stood before a mirror and tried on yet another silicone-filled pouch where her right breast used to be.

For 4 1/2 months, she had been impatient for this day, when her scar would have healed enough to let her wear a prosthesis. Yet as a saleswoman handed her various shapes and sizes, she felt awkward. She slipped each one carefully into a special bra. Some looked too pointy, others too flat.

Watching from a corner of the tiny room, a woman from Muller's church tried to put her at ease. It had been nearly two years since Hazel Ewing lost a breast to cancer. She knew that for Muller, the shopping trip was a rite of passage.

With a prosthesis, her body would resume its usual appearance to the outside world. Yet the fabric-covered insert meant acceptance that her breast was really gone. From now on, it would be part of the beginning and the end of her day. "It is sort of this little ritual," Ewing told her. "You take it off, wash it off and go to sleep."

Muller and Ewing are two of 21 women, including associate minister Joey Noble, at Christ Congregational Church who have had breast cancer. All but two are still alive. The shopping trip last July is testament to the emerging sisterhood that bonds the women of the Silver Spring church who have shared the disease.

In many ways, Muller and Ewing are unlikely companions.

A social worker for the mentally ill, Muller, 44, is a single workaholic who attends church irregularly and describes her social life as "pretty nonexistent." Newly retired and long divorced, Ewing, 62, is gutsy and effervescent, an energetic fixture at the church.

Breast cancer is not the same for every woman. Yet there are common threads. The disease often leaves a feeling of fragility -- of finite time -- even among women with no further trace of cancer. In response, some who survive have changed the way they live.

After 27 years in Silver Spring, Ewing moved to California this month. During difficult months of chemotherapy, when sleep was elusive, she packed. Between 2 and 4 a.m., she filled 90 boxes.

"The cancer said to me, you definitely don't know what the future holds, so why not do something different?" Ewing said before she left. "I think I have wanted to move for a long, long time."

Patricia O'Connor, 62, a retired teacher who sings in the church choir, has begun a psychological quest. Eight months after her 1989 mastectomy, she found a counselor. Together, they explore her mild and yielding personality, her perfectionism and the effect of her parents' nearly simultaneous deaths.

"My cancer was a wake-up experience," O'Connor said. "I woke up and asked, 'Who am I? What am I like that I could take on an illness like this?' "

Stacy Clark, 44, a medical office manager who moved here recently from Tucson, has reconfigured her time. A year after her mastectomy in 1990, she chose a less rigorous job with plenty of vacation. Now, she commutes to work with her husband, who has traded his longtime political causes for shared hobbies.

Clark said: "I was a perpetual-motion machine. Cancer stops your life so cold in the tracks. You realize the show isn't going to go on forever. It is a matter of slowing down and balancing out your life.

"When I heard 'cancer,' I really thought I would be dead the next Tuesday. But as I got farther out from the diagnosis, I realized it had changed me in positive ways."

Such changes did not occur right away. The experience of breast cancer unfolds in phases: discovery of the disease, medical decisions and treatments, often an altered body shape, altered relationships and -- ultimately -- living with the possibility of recurrence.

The stages once were private, and some remain intrinsically personal, psychological. Yet for many of the 21 women of Christ Congregational, breast cancer has been almost a community event, shared with the rest of the 770-member congregation and most of all, with one another.

"I feel very closely related to those women," O'Connor said. "You have faced a reality of life, each of you separately. And that is what you have in common."

Such connections did not always exist.

Kay White was a busy 31-year-old with two young children when she had a mastectomy in 1970. "I had a feeling of uniqueness," she recalled. "It was like I was the first person ever to have breast cancer."

O'Connor's feeling 19 years later was quite different. She spent the 10 days between her biopsy and mastectomy on the telephone, searching for advice from friends, friends of friends. "I called a woman's cousin-in-law in Tennessee," she said. "I kept saying, 'Other people have this too.' "

Two years after her mastectomy and a year after she arrived from Tucson, Stacy Clark remains acutely aware that breast cancer surrounds her. She has a mental habit, a reflex almost, that triggers when she walks into a crowd: She calculates how many women have had the cancer based on the number of people in the room.

For some women, this awareness cushions the impact of their own diagnosis. Last November, seven months before her shopping trip with Ewing, Muller discovered a "tiny, little hard something" in her breast. She was not surprised.

Breast cancer is "the family curse," she said. Her grandmothers had it. So did a first cousin. An aunt had it twice. "I'd been expecting it almost," Muller said.

But for Joey Noble, the associate minister, the lump in her breast seemed random and inexplicable. One day soon after her diagnosis last October, Noble got angry as she found a magazine article listing nine secrets to a longer life. "I was doing all nine," she said.

Like Noble, Stacy Clark had no breast cancer in her family. She didn't even have a lump. She was 42 when she got her first mammogram. The next day, her doctor called to say, "Something is funny."

"You have no pain. You are not sick. You have a full life, an exciting life, and it just blindsides you," Clark said. "Then I said to myself, 'Why not me?' It isn't like you get so many Brownie points and bad things don't happen in your life."

As breast cancer has become more common, the relationship between women and their doctors has changed.

In 1970, no one offered Kay White medical options when she checked into a hospital for a biopsy of a lump that had persisted for months.

The night before surgery, she was writing Christmas cards from her hospital bed when a nurse dropped off a form. "It said, 'We are going to do a biopsy. And if it is malignant, we are doing a radical mastectomy,' " White recalled.

It was the first time anyone had mentioned the possibility of a mastectomy.

White did not know whether she would emerge from surgery with two breasts or one. She was groggy as she was wheeled out of the recovery room. As she looked up, she noticed her minister walking down the hall. "I said, 'Uh-oh, something must have happened to me.' "

By the time O'Connor, the retired teacher in the church choir, discovered she had cancer, surgeons were less autocratic. She had choices, and she found them excruciating.

A mastectomy would remove her entire breast. A lumpectomy would leave much of the breast intact but require radiation afterward.

The decision came to her during an aria at the Kennedy Center. The singer was a soprano, like O'Connor. "When she came to one note, it was so beautifully done, this emotion came out of me completely unexpectedly."

To spare her body the radiation, she would sacrifice her breast.

Before her mastectomy, Hazel Ewing stood naked before her bathroom mirror. "I told my breast I had enjoyed it . . . . I wanted to keep it forever, but I couldn't because it was diseased."

"I'm sorry," she told her breast, "but I'm saying goodbye."

Surgery was easier than what followed. "Chemotherapy is the pits," Ewing said.

It usually begins easily enough. A perky cancer nurse at Georgetown University's Lombardi Cancer Research Center ushered Barbara Muller into treatment room G, where three other nurses hovered over three women in reclining chairs, with fine plastic lines dangling from their arms.

One at a time, four drugs flowed into Muller's veins. Three were to fight nausea. One, a ruby liquid called Adriamycin, fought the cancer.

The session ended 24 minutes after the drips began.

Muller's first round of chemotherapy knocked her kidneys out of kilter. Then came pancreatitis and gallbladder problems. It took her body nearly two months to regain the strength to resume the cancer treatment.

Noble, the minister, found that her body reacted differently. The evening after her first chemotherapy session, she ate dinner and felt fine. "I thought, 'This is a piece of cake.' "

But after midnight, she became violently sick. She dragged herself to the bathroom to vomit again and again. Once, she fainted, struck the vanity and knocked her teeth out of alignment.

After Ewing's second session, her hair started falling out. "There is hair on the bedclothes, hair in the shower," she said. "You feel as if you are a cat."

The hot, heavy wig was only one result. Food tasted like metal. Her energy ebbed, and her personality changed. "I would get nasty," she said, "and I couldn't stop it."

Ewing's 12 chemotherapy cycles were unvarying. Every fourth week, just as she felt nearly normal again, a new cycle began.

As she struggled with chemotherapy, she also was struggling with her body's new shape. Not until the treatments ended, eight months after surgery, did Ewing buy a prosthesis. Waiting was a form of denial, she said.

"Snakes shed their skin and get new skin," she said. "A worm you can cut in half, and it grows back. I wanted to grow another breast."

O'Connor did not need chemotherapy. Her husband said it mattered only that the cancer had been caught early, that she was alive. But like Ewing, she needed months to find peace with the loss of her breast. One night she finally grieved, awaking in tears, in rage. "I was so angry. What if they threw it in the garbage?" she said.

Her rage was a release. After that night, she felt a new calm.

Unlike other women at her church, Stacy Clark had a surgical implant in Tucson immediately after her mastectomy. Her body looked much as it had. So she had not expected her sense of loss to be so sharp -- to so shake her image of her sexuality and herself. "It is very good reconstruction," she said, "but it is . . . not like a normal breast. It is numb."

As a feminist, Clark feels awkward too about her very choice to have an implant. "You know, all those years I spent saying, 'It doesn't matter if you're pretty. It's who you are and what you know.'

"Well, obviously it means a lot to me to have a breast," she said.

Social worker Muller has never dwelled on makeup or hairstyles, either. She had not thought ahead about what to wear to her mental health agency's annual dinner, the Festival of Hope.

The dinner was on a Saturday last spring, before her scar tissue had healed enough to allow her to wear a prothesis. She got home from work at 5 p.m., took a shower and tried on dress after dress. Nothing looked right.

Suddenly, it was 6:30. The dinner had started at 6. She stayed home.

Clark hated parties for a different reason. People looked at her, she believed, "like I was laid out on a coffin."

"It isn't just dealing with your own feelings when you get breast cancer. You have to deal with everyone else's feelings."

Ewing remembers the well-meaning lies. During her chemotherapy, friends gently took her arm to tell her she looked "just wonderful. And I would think, 'I want to punch your lights out!' My body was puffed up. I had on a wig. I knew how lousy I was feeling."

Yet from her friends and her church, Ewing also drew strength. "There were times when I really felt I was being cradled and lifted up," she said. "Knowing people were praying for me was important because I didn't always do my own praying. Sometimes I was too tired, and sometimes I was too angry."

For Muller, the relationships that changed most were those in her family. After 15 years in Washington, she was startled when her mother urged her to quit her job and move back to Pennsylvania. When she refused, her parents made the two-hour drive to most of her chemotherapy sessions.

She was flattered by the attention, yet it sometimes felt intrusive.

In Noble's family, roles reversed. The minister's younger daughter, Faith, an economics major at Northwestern University in Evanston, Ill., took her final exams two weeks early so she could get home.

She and her mother took walks, drank tea, played piano duets. "It was important to be normal," said Faith, who is 19. Yet their relationship was not.

"Your mom, who is like a rock, was crying and worried and sick and confused. And I had to be strong for her," she said. She was the one relaying news of her mother to her 22-year-old sister, Vicki, who was in China for a year. In her journal, Faith wrote about being scared that her own children would never know their grandmother.

Kay White's husband, Perry, remembers similar fears two decades ago. "There is this attitude, 'The guy isn't the one under the knife.' It ignores the fact there is another scared person out there."

In the years since his wife's cancer, he said, he has not loved her less for having a single breast. Yet he still has twinges of resentment at the way the disease intruded into their lives.

"You had a young girl who, even at 30, would go out and wear dresses with no straps. No longer. She used to wear bikinis. No longer.

"There are just times that the fact of the surgery stands out," he said. "It steps in between you and your relationship with her."

Another residual effect is fear -- sometimes subtle, never absent -- that the cancer will come back. Kay White thinks of herself as healthy. Her cancer has stayed away for 22 years. Yet she will be surprised if it does not eventually return.

The same pessimism made it difficult for Noble to sit through a meeting on ministers' retirement benefits. "I thought, 'Oh, I should only be so lucky to live to retirement,' " she said.

Clark knows her tumor was caught at an early, generally curable stage. Even with an implant, she thinks about the cancer almost every day. "I have a new sense of how much time I have . . . . I can't stop cancer, and the next time, it may be fatal.

"I'm not a famous person," she said. "After I die, they aren't going to build a memorial to me, so the time I have to interact with people, I have now."

From now on, she has promised herself, her life will be in order: no delinquent bills, lots of life insurance, no unresolved relationships. Just in case it comes back.

That uncertainty -- that altered sense of time -- is propelling Hazel Ewing to California. It is driving Pat O'Connor to dig into her personality and her past.

Barbara Muller is striving to improve her rapport with her father. Kay White refuses to worry about hypothetical problems and counsels women with breast cancer -- even though it churns up her own memories every time.

Joey Noble and her husband, David Smock, married only two years, splurged last summer on a new patio and a restful vacation in Maine. "David and I are just treasuring each day," she said. "We've said to each other, 'If this is all we have, this is good, really good.' "

Cancer has pressed the women of Christ Congregational more deeply into their families, more quickly into their futures. It has drawn the women toward one another too.

After O'Connor's mastectomy, Louise Petzold, a church member who had breast cancer in 1988, gave her a sweet-smelling soap, Bare Elegance.

O'Connor gave the same liquid soap to Ewing the next year and to Noble the year after that. Ewing recalled: "She said, 'It just feels so soft on your body. And it'll make you feel so good.' And when I used it, I thought, 'Isn't this nice? Here is somebody who knows just exactly how I feel.' "

When Ewing helped Muller shop for a prosthesis, she remembered how comforted she'd been when Petzold had helped choose hers.

One day last December, Ewing stopped by the church to give Noble a bag. Inside were medical books, pamphlets, a wig stand and scarves. "I was starting my treatment," Noble said. "She was just finishing hers."

At Eastertime, Noble's chemotherapy treatments ended and Muller's began. Noble gathered the contents of the bag and passed it on.

"I thought, will this never end?" Noble said. "Who is Barbara going to pass it to?" On Woman's Odyssey...And the Journeys Of Many

The women, in addition to Muller, at Christ Congregational Church who have had breast cancer (in chronological order, beginning with the first diagnosis):

IRENE HARTIG, 81 1965

A Silver Spring resident, she has been married for 57 years, with two children and several grandchildren and great-grandchildren. Because her mother had died of breast cancer, Hartig was nervous when, at 54, she found a lump. It was benign, but cancer was discovered in her other breast. Radical mastectomy to remove breast and lymph nodes. No recurrence.

KAY WHITE, 53 1970

An administrative assistant for a money-management company, the Burtonsville resident is married with two grown children. She counsels women in whom cancer is newly diagnosed. Modified radical mastectomy at age 31. Two benign lumps in late 1970s.

RUTH AVERY, 60 1973

A Bethesda resident, the office administrator at Christ Congregational Church is divorced and has three daughters. She had a modified radical mastectomy at 41 after a breast discharge led doctors to discover her cancer. No recurrence.

MARGARET YOUNG 1974

Married with one son, she was a Prince George's County teacher and supervisor before opening a yarn shop in College Park. She loved art, music, theater and sewing. She found a lump through a self-examination and had a modified radical mastectomy. The cancer spread to her bones 2 1/2 years later. She responded

temporarily to chemotherapy and spent a summer traveling to Nova Scotia and Minnesota, but died in December 1977 in her mid-fifties.

ANONYMOUS, 75 1978

She noticed a lump at age 61 but didn't seek medical care until 1989. Her cancer was found to be inoperable.

KAY PERRY, 74 1979

Married with three sons and a daughter, the Silver Spring resident has been blind since she was 36. After feeling discomfort in her breast while reading Braille in bed, she found a broad, flat lump that doctors confirmed as cancer. Modified radical mastectomy at age 61. No recurrence.

RUTH LUGAR, 75 1984

A widow with two daughters, the Silver Spring resident went to a cancer-screening booth at the Montgomery County Fair because of a sore spot on her breast. Cancer diagnosed at 67. Modified radical mastectomy. No recurrence.

ELAINE WUNDERLICH, 54 1987

A Laurel resident, she is living in England on a three-year assignment for the U.S. government. Married with two children, she began frequent breast checkups after her mother got breast cancer. Wunderlich's cancer was diagnosed at age 49, less than a year after her mother's. Modified radical mastectomy. Six months later, a preventive mastectomy to remove her remaining breast, and surgical reconstruction. There has been no recurrence.

LOUISE PETZOLD, 68 1988

Married with five children and seven grandchildren, the Aspen Hill resident discovered her cancer at 54 through a mammogram. Modified radical mastectomy. No recurrence.

MARTA SHEPARD, 64 1988

Married with three sons, she divides her time between Rockville and Maine and enjoys creating sculpture. At 60, she had lymph nodes removed and six weeks of daily radiation treatments after a mammogram found specks of what her doctors diagnosed as breast cancer under her arm. No recurrence.

AFAF McGOWAN, 57 1988

A Silver Spring resident and an acquisition specialist for the Library of Congress, she is married with two children. A mammogram showed four tiny specks of calcified cells that she had removed. No recurrence.

PAT O'CONNOR, 62 1989

A Silver Spring resident who retired from teaching at Acorn Hill Children's Center, she is married. She had a modified radical mastectomy after doctors discovered her cancer from spots of calcified cells that showed up on a mammogram. Since then, she has taken homeopathic medicine and changed her diet

to try to prevent recurrence.

ANONYMOUS, 89 1989

A widow who lives in a retirement community, she had a lump that was discovered by a doctor four years ago. Modified radical mastectomy. No recurrence.

HAZEL EWING, 62 1990

She moved this month from Silver Spring to California. A retired administrative assistant for the United Church of Christ regional conference, she is divorced and has a son. She had a mammogram after finding a lump but was told it was benign. By November, the lump had grown, and doctors discovered it was malignant. Modified radical mastectomy, followed by six months of chemotherapy. No recurrence.

HELEN FOLEY, 76 1990

The Silver Spring resident, married with two children, discovered her cancer through a mammogram. Lumpectomy, plus 35 radiation treatments. No recurrence.

STACY CLARK, 44 1990

An administrator for a group of doctors, the Silver Spring resident is married and has two children from a previous marriage. She was living in Tucson when the first mammogram she ever had revealed cancer. Modified radical mastectomy and surgical reconstruction. Because of infection and other problems, the implant required six operations during the next several months. No recurrence.

SYLVIA RYDELL 1991

She was a Washington tour guide and a member of the church board of deacons, married and living in Silver Spring. After discovering a lump that turned out to be malignant, she had a lumpectomy, but the cancer had spread through her body. Despite laser treatment and chemotherapy, she died on April 2, 1991. She was 66.

JOEY NOBLE, 49 1991

A Silver Spring resident and associate pastor of Christ Congregational Church, she discovered a cancerous lump after showering. Lumpectomy, radiation treatment and chemotherapy. She has found three more lumps, all benign.

NANCY HUGHES, 61 1991

An office manager for the Council for a Livable World, she lives on Capitol Hill, is married and has four children. She had a lumpectomy after a mammogram revealed malignant calcium deposits. No recurrence.

BARBARA WHITTLESEY, 64 1992

Married with two daughters and a family automobile repair business, the Ashton resident had a modified radical mastectomy after discovering two tiny tumors through a mammogram in July. -- Amy Goldstein

The Washington Post, October 19, 1992

GRAPHIC: PHOTO, SOME CHURCH MEMBERS WHO HAVE HAD BREAST CANCER, POSING, ARE IRENE HARTIG, FRONT; BARBARA WHITTLESEY, RIGHT; LOUISE PETZOLD (BEHIND HARTIG); BARBARA MULLER, FAR LEFT; RUTH LUGAR, FAR RIGHT. NANCY ANDREWS

LANGUAGE: ENGLISH

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The Washington Post

July 31, 1994, Sunday, Final Edition

SECTION: FIRST SECTION; PAGE A21

LENGTH: 930 words

HEADLINE: In Suburbs, Paying Patients And Well-Staffed Offices

SERIES: WORLDS APART: HEALTH CARE IN WASHINGTON, Part 1 of 3

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

Internist Robert H. Blee closed his eyes, pressed his fingers into his patient's gut and sensed that the pulse in the main artery didn't feel quite right.

Probably nothing, the doctor thought. But Blee knew that the patient, Leon Miskin, had ignored his warnings to stop smoking two to three packs of cigarettes a day. Besides, his cholesterol count was high.

Deciding that prudence was worth the price, Blee told his patient to get an ultrasound test from a radiologist who works downstairs in his Chevy Chase medical office building. And when the radiologist found the aneurysm -- a dangerous, three-inch sac in the weakened lining of the aorta that probably would have killed him within a year -- Blee sent his patient to a vascular surgeon who works on the 11th floor.

That the aneurysm was discovered was more than good luck. It was a measure of the way Blee works. In a practice with four partners and a dozen employees, he has time to give plenty of preventive care. In a neighborhood saturated with doctors, he can readily refer patients to specialists nearby.

His patients, most of them professionals who are well educated about their health, can be demanding. But they are a rewarding group too. They are fun for Blee to talk with, follow his advice most of the time and pay their bills.

"That is one of the reasons I want to stay here," said Blee, who has worked since 1986 on the 14th floor of the Wisconsin Avenue building, just outside the District. "At least you get paid for what I do."

Chevy Chase is a popular location among Washington area doctors. Blee's office, a few blocks from the Mazza Gallerie shopping mall, is along a commercial strip with good bus service, a Metro stop and plenty of parking in the Saks Fifth Avenue store lot across the street. Most of the residents of the surrounding houses and high-rise condominiums are well-off and white.

There are 254 doctors with office practices in the neighborhood, including 43 who are internists like him. The supply of internists is four times as great there as in the metropolitan area overall, but it is typical of communities stretching from upper Northwest Washington to Bethesda.

In many ways, Blee is typical of his colleagues there. He works in a well-staffed medical group. And after 15 years of practice, he is steeped in what has been the culture of care for the well-insured. But at 43, he also has a big stake in the rapid health care changes being made by insurers and the prospect of federal legislation.

Married and the father of two young children, Blee has built his practice from scratch. After he finished training at Georgetown University Medical Center, he juggled part-time jobs for government agencies for seven years while he accumulated his own patients. He shared office space with two sets of doctors before joining his current partners eight years ago.

All internists, those doctors have settled into the niches that medicine has formed. Two specialize in endocrinology and one in hematology. Blee is one of the two generalists.

He works conscientiously. Throughout the day, he returns patients' telephone calls between appointments. He walks, annoyed, to the receptionist's desk, to find out if anyone knew why his 11 a.m. patient was a few minutes late.

One late patient can throw off a whole day. "It pushes you back, and everybody gets irate, and it is a big mess. ... I've had people stomp out of here after 10 minutes."

If his patients are exacting in their expectations, they also are well informed and often seek his advice early. When Pat Kassebaum, of Silver Spring, visited Blee to check on her stiff shoulder, she brought a list of medical questions about her upcoming vacation in China.

The amenities of Blee's office extend beyond his care. One full-time nurse answers patients' call-in questions. She also arranges consultations with specialists, at-home care by visiting nurses, physical therapy sessions and appointments with the dietitian who works in the office on Thursday afternoons.

"If the patients want it, they get it," said the nurse, Anne Lafferty.

The office also contains a well-equipped laboratory where five employees analyze blood and urine samples, take X-rays and screen for breathing, hearing and vision problems.

For tests that are too complicated, the lab sends specimens to an outside laboratory. The two labs are linked by computer, so the outside one already has records of the tests that Blee wants -- and tests the patient has received in the past -- by the time the specimens arrive.

The two bookkeepers in the office's accounting department also have computers. About 30 percent of the patients qualify for Medicare, the federal insurance program for patients 65 and older. Nearly all the rest have private insurance.

The office doesn't accept Medicaid, the government insurance program for the poor. Rarely do patients ask about it.

In this well-ordered environment, Blee worries about the future. He thinks the federal government may intensify the pressures on him from insurance

companies to see more patients in less time, making medicine "just a grind" and making it less likely that he will notice possible trouble in his patients' aortas.

But he also knows that by working in the group, he always will have certain advantages: an office manager to handle the hiring and the payroll, bookkeepers to handle the bills.

"If I was by myself, I'd end up being the chief cook and bottle washer," he said. "We try to keep it simple: Do the doctoring, and have people help with the other things."

GRAPHIC: PHOTO, ABOUT THE SERIES, MARGARET THOMAS; ILLUSTRATION, LAURA STANTON

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HEADLINE: Many Doctors In Few Places

SERIES: WORLDS APART: HEALTH CARE IN WASHINGTON, Part 1 of 3

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

The nearly 14,000 doctors in metropolitan Washington inhabit a lopsided world of medical care.

It is a world with excesses of specialists but shortages of family doctors, clusters of patients hospitalized for avoidable medical problems, and scarcities of doctors in many communities that need them most, according to a year-long study by The Washington Post.

In the affluent, largely white neighborhoods along the border of Northwest Washington and Bethesda, there is one pediatrician for every 400 children. But in the poor, mostly black neighborhoods 10 miles to the southeast -- neighborhoods where many toddlers are not immunized and infants often die needlessly -- there is one pediatrician for every 3,700 children.

Doctors are more plentiful in the Washington region than in any metropolitan area except Boston, but the study found that in parts of Prince George's County, they are scarce. A surgeon who scrimped to build the first medical offices in the crime-ridden neighborhood in Prince George's where he grew up cannot find enough physicians to fill them.

And at the region's southern edge in Prince William County, new subdivisions are springing up more quickly than doctors' offices. Patients routinely drive north into Fairfax County to get checkups or have babies.

The study's ground-level view of medical supply and demand shows why the federal government is trying to make care more accessible and less expensive. But this view also shows a more intricate, more intractable reality than the one that the Clinton administration and Congress are trying to address.

Even though the political obstacles to changing the health care system are formidable, those obstacles could prove less daunting than overcoming the ingrained customs and culture that determine where doctors want to work, what kind of medicine they want to practice and whether potential patients have the means and motivation to get care.

Even if Congress finds a way to guarantee all Americans health insurance, the study suggests, that won't guarantee a doctor within reach. And even if Congress finds a way to offer basic, inexpensive care, that won't eliminate the excess of specialists or create more family doctors.

Just giving people health insurance is equivalent to saying, "You've got an American Express card. The [real] issue is the availability of services," said Dalton Tong, chief executive officer of Greater Southeast Community Health Care System in Congress Heights, a neighborhood at the edge of the District where many residents are unhealthy and doctors are scarce.

The Post found this gap between theory and reality through its study, which included a computer analysis and interviews with more than 200 doctors, patients, health policy specialists, social workers, public health officials, politicians and administrators of hospitals, health maintenance organizations and medical schools.

The computer analysis was based in part on American Medical Association records covering virtually all local physicians who work outside the federal government. The study focused particularly on the locations of doctors in office settings, which many health researchers consider the truest measure of the medical care available to a community's residents.

The analysis found the area has almost twice as many doctors in its most prosperous neighborhoods as in its poorest ones. And even when residents' incomes are comparable, predominantly white communities have more physicians than predominantly black ones.

Location, Location, Location

Physicians avoid the low-income neighborhoods east of the Anacostia River in the District and in western Prince George's because of high crime, long commutes and patients who can be difficult and uncommonly sick, according to the study. Those deterrents would remain even if more residents in those neighborhoods get medical insurance after congressional action.

"With real estate [and] with doctors, everything is location, location, location," said Edward L. Mosley, 46, the surgeon who scraped together financial and other help from relatives to build the Uplift Medical Center in Fairmont Heights, a Prince George's neighborhood hugging the District line.

The redwood building he opened in 1981 has space for 14 doctors. But in a neighborhood where crime and poverty are common, where professionals and hospitals are remote, many of Mosley's offices remain empty.

Mosley works in one of two distinct environments of the Washington area where physicians are scarcest. The other exists in fast-growing communities at certain edges of the region, including Prince William.

There are no clear-cut guidelines as to how close doctors should be in major metropolitan areas to allow patients reasonable access. Some large health maintenance organizations have found that patients visit their main doctor less readily if they are more than a 15- or 20-minute trip away.

Many people try to choose doctors near their homes, although some workers prefer doctors near their jobs. But whether considered from the perspective of

where people live or where they work, the study found, the geographic imbalances in the concentration of doctors are great.

Having doctors and other health care workers farther away is just one of the reasons residents of low-income communities get less care. Some people see doctors infrequently because they cannot afford them, others because they have a habit of waiting until emergencies strike. In immigrant neighborhoods, even the patients who receive care sometimes leave without its full benefit because their doctors speak a language they don't understand.

But the doctors' frame of reference is different.

Although many physicians consider the market for patients in choosing where to open an office, their decisions often are only marginally related to where the need for medical care is greatest as judged by the supply of doctors in a neighborhood or the quality of its residents' health.

Physicians tend to be influenced more strongly by the salaries, safety and kinds of patients a community offers, and by whether there are hospitals, convenient office locations and colleagues in the area.

A Doctor Drought

Not all doctors are deterred from practicing in the poor neighborhoods along the eastern edge of Washington and the adjacent communities of Prince George's. Some want to work with the needy patients who live there. Others settle in such places if they cannot find work elsewhere. Still others have stayed there since the days when the neighborhoods were better kept.

Some find working in those areas too hard. Massimo Righini used to have his office in the medical building next to Greater Southeast Community Hospital in Congress Heights, where he is chairman of the surgery deparment. Each year, it seemed, fewer of his patients were insured.

By 1988, he was giving $ 80,000 worth of free care to patients without insurance. His accountant told him he needed to draw $ 30,000 less in salary to cover the office's expense.

With two children in college, Righini found a different solution. He moved his office to Fort Washington, one of the most affluent parts of Prince George's.

"I felt sort of bad," the surgeon said, "but I became solvent again."

One of the most powerful deterrents to practicing in a neighborhood is crime.

Benning Road NE was a promising location for young black doctors in 1946, when internist J. Harold Nickens opened his office inside a new apartment building. With postwar houses going up, the neighborhood soon had a dozen physicians, many of them Howard University graduates.

By the late 1960s, crime was rising, and the doctors were moving out. Nickens was robbed at gunpoint in his waiting room one day as six patients watched. Burglars struck twice.

When Nickens retired in 1979, he found a young Prince George's doctor who promised to visit the Benning Road office every other day to care for his patients. The arrangement ended within a year. "I don't blame him," said Nickens, now 80. "After I left, the building I was in became a crack house."

Few doctors live in such urban neighborhoods, so accepting a job there often means accepting a long commute to an unfamiliar place.

An Anacostia clinic offered child psychiatrist Steven Rebarber a position in 1991, when he finished training at Children's National Medical Center in Washington. He almost took it.

"The families are under such incredible stresses out there, and they really need more doctors," Rebarber said.

But he and his fiancee had decided to live in Bethesda, and he hated the idea of daily drives across town. He worried about Anacostia's reputation for crime. And outside the clinic on Martin Luther King Jr. Avenue, he felt conspicuously white.

So he turned down the job offer and started a solo practice in Bethesda, 12 minutes from home.

In low-income, urban neighborhoods, the patients themselves can be more difficult: sicker, unable to afford their medicine and sometimes lacking in the middle class manners many doctors expect.

Pediatrician Lloyd Charles bought children's tables and chairs to brighten the waiting room in his office in Greater Southeast's medical building. The little furniture was the color of crayons, and the salesman had promised it would be childproof. Within a week, the children had unscrewed the legs and were using them as swords while their mothers watched them fight.

Charles, 43, oversees that office but no longer works there himself. When he opened it in 1980, he had hoped to attract a blend of children, some with private insurance and some covered by Medicaid. He found that privately insured patients were difficult to keep.

Some of the middle-income parents told him they were offended by sharing the waiting room with Medicaid patients who, the complaint was, tended to be noisier and less polite. So he devised techniques to market himself to the privately insured families. He sent birthday cards to their children and held special Saturday hours just for them.

His stable of insured patients kept dropping, though. Two years ago, he gave up. He sublet the office. Medicaid patients soon accounted for three-fourths of the children treated there.

Now Charles works six miles east in suburban Forestville. Most of his patients belong to middle-income families. He doesn't accept Medicaid.

In the Prince George's communities near the District line, a little more than one-third of the 93 primary care doctors accept Maryland Medicaid cards, according to state data analyzed by The Post.

Many of these poorer communities, and those in Northeast and Southeast Washington that doctors avoid, are the places where people describe themselves as least mobile.

In the District neighborhoods east of the Anacostia River, more than 40 percent of the households lack cars, compared with 12 percent area-wide, according to U.S. Census information examined as part of The Post's study. Some residents east of the river do not always have a spare $ 2 for the round trip downtown by Metrorail or bus.

Commuting to Care

They face greater stumbling blocks in getting to medical care than do residents of certain outer suburbs, such as in Prince William, where doctors also are scarce.

Although Prince William has the region's smallest supply of doctors, most of its residents are middle class. Most have medical insurance. Only 3 percent of the households lack a car.

Accustomed to commuting to work, some of the county's residents also commute for medical care, choosing doctors in Fairfax County or other closer-in suburbs where physicians are plentiful.

In exurban communities, medical finances and working conditions do not pose the problems for doctors that they do in poor, urban settings. The number of Prince William doctors is growing. But it is not keeping pace with the rapid growth of the population.

If outer suburbs such as Woodbridge and Manassas have disadvantages for doctors, those disadvantages are less tangible than uninsured patients or unsafe neighborhoods. Some doctors are simply uncomfortable with the quality of life on the region's fringe.

"We have a good school system, enough places to spend your money. We are close enough to get into the city for the Kennedy Center, museums," said William M. Moss, president of Potomac Hospital in Woodbridge, one of the two hospitals in the county working to recruit primary care doctors to the area. "But some people want to be in the city. Others want to be in the country. We are neither."

Although Prince William's middle-class patients are mobile enough to find doctors outside the county, there are enough low-income residents searching for treatment that patients start lining up hours early outside the Manassas branch of the Prince William Area Free Clinic.

The year-old clinic, open only on Thursday nights, is a godsend to its patients, including many recent Latino immigrants. It also is useful to doctors, who can treat Medicaid patients there without accepting them into their practices. But the clinic has its limits.

Dieter Von Oettingen, a retired surgeon who is one of the volunteer doctors, talked for a half-hour with Corrine Mulholland, 37, about her multiple sclerosis and undiagnosed bleeding. Then he told her he should have spent less time with her, that with so many people in the waiting room, he should have been seeing a patient every five to 10 minutes.

"See, we are here for primary care," the doctor told Mulholland, offering to send her for free tests to a university hospital in Richmond or Charlottesville. "You are chronically ill. ... I couldn't possibly tell you what you have."

Crowding in the Suburbs

Although doctors are scarce in some exurban and urban communities, they pour into places such as McLean, Chevy Chase and Bethesda that already are crowded with physicians.

Those suburban neighborhoods are populated with residents who are well-insured, well-educated and middle class or affluent -- residents who in many ways resemble the doctors who treat them.

"There is an adequate wealth base," said Kent Johnson, a rheumatologist who works in a part of Bethesda where nearly 300 other doctors have office practices. The location he chose 12 years ago has other advantages for him too: hospitals, academic activities and plenty of colleagues.

Internist Marilyn Coruzzi was aware of those advantages in 1990, when she opened a solo practice in the heart of Bethesda. When she left a large medical group downtown, she wanted to work on her own in a slower-paced practice in which she and her patients could know one another well. But she also wanted other doctors nearby.

When Coruzzi's patients visit her office, they can get an X-ray without leaving the Wisconsin Avenue building. If Coruzzi discovers a worrisome lump while examining a patient, she finds it reassuring to have a surgeon she can call on downstairs.

Such suburban locations offer physicians collegiality. Shirley Papilsky, 45, a Rockville psychiatrist, belongs to a monthly study group with five other Montgomery psychiatrists. They invite speakers, discuss journal articles and cases and fill in for one another when they take vacations.

Across metropolitan Washington, many doctors are finding that competition is starting to increase as more employers enroll their workers in managed care plans, which limit the number and variety of doctors patients may visit. But in neighborhoods crowded with doctors, some physicians do not perceive an excess.

"My practice has grown exponentially," said Irving Mizus, a general internist and lung specialist who moved to Bethesda from Los Angeles in 1987. He and his wife, Deborah Litman, a rheumatologist, considered several cities before settling in the Maryland suburbs because of their cultural offerings, school quality and reputation as places where doctors stay busy.

Unequal Tiers of Care

Individual choices such as Mizus and Lit man's have produced the scarcities of doctors in some parts of the area, the excesses in others. The cumulative effect of those choices has produced a health care system that contains two unequal tiers of care.

Pediatrician Joseph Sherman sees one tier as he works from a van, outfitted as a tiny doctor's office, that stops in the neighborhoods of Northeast and Southeast Washington that have the city's fewest doctors and most unhealthy children.

Nearly three-quarters of the new patients who approach the van, operated by the Georgetown University Medical Center, lack the proper immunizations. Children come with eye problems, bodies that grow too slowly or young teeth that already are decaying.

Mizus sees the other tier of care from his office across the street from the National Institutes of Health. One day, he gave a checkup to Dorothy Rowley, 71, who first visited him after an asthma attack and now considers him her main doctor.

Rowley trusts Mizus. He talks with her long enough that she doesn't feel part of an assembly line. But she does not rely on his care alone. She also has a cardiologist, an otolaryngologist, an ophthalmologist, a surgeon, an orthopedist, a gynecologist and a dermatologist.

A work force of doctors that reinforces two tiers of care also has implications for health care reform.

The metropolitan area's sheer concentration of doctors would make it difficult to curb medical costs. The reason is that "medicine is very different than other goods we purchase... . The seller has much more influence," said Steven A. Schroeder, president of the Robert Wood Johnson Foundation, a health care philanthropy.

The more doctors a community has, the more likely each of them is to order special medical tests for their patients, perform diagnostic procedures and give treatment. In fee-for-service medicine -- the familiar system in which doctors bill patients or insurers for every service they provide -- each doctor adds $ 500,000 to $ 1 million a year to the nation's health care costs, according to various recent estimates.

Bringing About Change

For such reasons, consensus is forming among health care specialists inside and outside the federal government that the central goals of reform -- more widely available and cost-effective care -- will be thwarted unless the doctor work force is reshaped.

But how much would the health care revisions contemplated by the Clinton administration and in Congress balance the worlds of medical scarcity and excess?

Each approach would, to varying degrees and with varying speed, enable more people to get medical insurance.

Giving more people the means to pay their medical bills would be important, because it would reduce the financial disincentives that dissuade doctors from working in low-income neighborhoods, said David Kindig, chairman of the Council on Graduate Medical Education and chief of the transition team of Donna E. Shalala, secretary of the U.S. Department of Health and Human Services.

But even if the financial barriers were lowered, persuading doctors to move would be difficult because they choose their workplaces for reasons that go far beyond economics.

"If you gave everybody the same [insurance] card ... I don't think it would help much," said Charles Inlander, president of the People's Medical Society, a small consumer advocacy group based in Pennsylvania. "Doctors have gone through prestigious institutions and think of themselves as the most highly trained professionals in the world, and the last thing they want to do is sit in the middle of a ghetto."

Of the health care revisions that congressional committees have proposed, almost all would tinker directly with the medical work force in some way.

The main strategy, proposed by the Clinton administration and three of the Congressional committees that have produced health care bills, lies in trying to change the mixture of doctors by preparing more students for careers in general medicine. Most bills also would expand medical school subsidies for students who promise to work for a few years in urban or rural communities where physicians are scarce. And some would pay bonuses to certain doctors in such places.

None would reshuffle Washington's 14,000 physicians.

"There is an unwritten assumption that making more primary care physicians will correct the geographic maldistribution," said Jordan Cohen, president of the Association of American Medical Colleges.

Few doctors will move, though, without changes in their basic incentives, said Thomas W. Chapman, chief executive officer of George Washington University Medical Center and a member of last year's White House Task Force on Health Care Reform.

To lure doctors into neighborhoods that are unsafe or far from where they want to live would require potent inducements. Said Chapman, who has worked to extend care to under-served patients, "It is like paying farmers not to grow corn."

But as Congress grapples with the demands for wider medical coverage and lower medical costs, it has yet to resolve the lopsided geography of medical care.

Computer analysis by William Casey, director of computer-assisted reporting. Richard Morin, director of polling, and Sharon Warden, senior polling analyst, also contributed to the computer analysis.

GRAPHIC: PHOTO, CHEVY CHASE PACE: INTERNIST ROBERT H. BLEE CHECKS A PATIENT. IN A PRACTICE WITH FOUR PARTNERS AND 12 EMPLOYEES, HE CAN GIVE PLENTY OF PREVENTIVE CARE. MARGARET THOMAS; ILLUSTRATION, RICHARD FURNO

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HEADLINE: For the Poor and Elderly, Internist Keeps a Promise

SERIES: WORLDS APART: HEALTH CARE IN WASHINGTON, Part 1 of 3

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

On the roof of a shopping center -- a shabby strip along Benning Road NE where drunks gather and a murder occurred last year -- are two small signs for the doctors' offices that fill the second floor.

One sign reads, "Family Dentistry -- children and adults." The other announces the presence of a general surgeon and a foot doctor.

But the podiatrist retired in 1992. Both the surgeon and the dentist are dead.

These days, Robert W. Yancey is the only doctor using the cavernous space. He arrives late in the afternoon, after his full-time job at a nursing home has ended for the day.

Four evenings a week, the internist unbolts the heavy locks, carries his medical supplies up the steep flight of stairs and treats patients into the night.

Many of them elderly and most of them poor, the patients require elementary kinds of care. They weigh too much, have high blood pressure or arthritis or have been taking expired medicine.

The work is not glamorous. It is not lucrative. Yancey skirts rats in the basement when the boiler balks.

But he is keeping a promise to the surgeon, his late friend and mentor Robert E. Lee, that he would treat his patients as long as he could. And the truth is, even if he is tired when he arrives, he enjoys talking with them and knowing that he helps many people feel better.

Yancey, 41, is one of few private internists in Kingman Park, a neighborhood of small row houses and subsidized apartments in Northeast Washington. Almost all the residents are black, and about one-fourth live in poverty. Almost nowhere else in metropolitan Washington are doctors as scarce.

Yancey never planned to spend so much time there. Trained at Howard University College of Medicine, he worked at local hospital emergency rooms, for a large health maintenance organization and at the D.C. Jail before he became the chief doctor at the city-run nursing home, D.C. Village.

It was at the jail that he met Lee, who was medical director at the time. "He was like a father," Yancey said. "He was the old pro."

So when the elderly surgeon asked him to help occasionally in his Benning Road office, the young internist didn't think to refuse. Nor did Yancey refuse later when his mentor asked him to take over for a spell while he recovered from cancer.

"After about the second month," Yancey said, "everybody but Dr. Lee knew he was never coming back."

Until lately, Yancey took patients' examining gowns home to wash, pouring in lots of ammonia and cranking up the hot water heater after his wife had finished the day's laundry for their two young sons.

He has little office help. Once a week, a college student who hopes to become a doctor volunteers to file patient charts, type letters, stock shelves and take blood pressure readings. Yancey pays another woman to help with his billing eight hours a week.

His office doesn't mail bills directly to patients. So many are so poor that the amount he might collect wouldn't warrant the billing and bookkeeping costs.

Instead, his office sends bills to Medicare and Medicaid -- government insurance programs that subsidize the elderly and the poor -- and to private insurance companies. He knows the insurers will notify the patients of their share of the bill. Sometimes the patients will pay.

Often, Yancey himself discusses payment with his patients. "You don't have to do it today. When you get a chance," the doctor told Grover Patterson, 71, who has Medicare but owed a $ 100 deductible and $ 7 per visit for his high blood pressure and a sinus infection.

If Yancey's billing method acknowledges his patients' meager finances, his scheduling system acknowledges their poor memories.

He doesn't give patients appointments more than a few days in advance. Often, he gives them enough medicine -- free samples from drug companies -- to last until he wants to see them next. Come back, he tells them, when they need more.

The method works well, but it isn't foolproof. One day, Yancey chided a patient named Edgar who had used up his blood pressure medicine two weeks earlier.

"I told you to come before you run out," the doctor said.

"I don't have a car," replied the patient, who lives in Southeast Washington. "You don't know how hard it is to get a ride."

Yancey offers no laboratory services beyond simple urine tests. First, he gets the key to the bathroom that he has kept locked since discovering a neighborhood drunk passed out there a few months ago. Then he checks the specimen with a dipstick.

Yancey answers his own telephone and takes out his own trash. When it got hot in May, he climbed onto the roof to find that the air-conditioning system had a worn-out fuse and no Freon.

Even though he is his own handyman, Yancey is losing money.

Last year, the office took in $ 39,000. With $ 52,000 in expenses, it cost him nearly $ 1,000 a month to stay open. Yancey makes a comfortable living from D.C. Village and some consulting work. But for the long term, he said, the office arrangement doesn't make sense.

The ideal solution, he thinks, would be to share the rent with another doctor. He has talked with nearly two dozen but hasn't found anyone willing to join him.

So he wonders whether to move to the suburbs. Or whether he has kept his promise to his mentor long enough.

"From a purely business sense, I should sell the equipment, close the office and walk away," he said. "After a while, you get to know the patients. It is difficult to leave, and I'll hang on as long as you can.

"But after a while, it is that or financial suicide."

LANGUAGE: ENGLISH

LOAD-DATE-MDC: July 31, 1994

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The Washington Post

August 1, 1994, Monday, Final Edition

SECTION: FIRST SECTION; PAGE A1

LENGTH: 3288 words

HEADLINE: As Patients Differ, So Do Treatments;
Income, Location and Habits Affect Routine Medical Care

SERIES: WORLDS APART: HEALTH CARE IN WASHINGTON, Part 2 of 3

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

To keep asthma under control, some people spray medicine into their mouths, then hold their breath for a few moments while it seeps toward their lungs. It is a simple process that they repeat three or four times a day, checking with their doctor every few months to make sure they are inhaling the proper amount. The typical cost of treatment: less than $ 800 a year.

But when asthma gets so out of control that it forces people into a hospital, they arrive feeling as if they must force air into and out of their lungs through a pinhole. They often lie in bed too tired to move, even if it weren't for the plastic lines dripping medicine into their veins or tubes pushing oxygen into their nostrils. The typical cost of treatment: $ 700 a day.

People are more likely to be hospitalized with asthma if they lack routine medical treatment and the ability to take care of themselves.

In Congress Heights, a Southeast Washington neighborhood where many people are poor and most are black, residents are hospitalized for asthma 12 times more often than those a half-hour drive away in McLean, a Northern Virginia suburb where many people are well-off and white.

That is part of the unequal toll that disease takes on patients and on the health care system in metropolitan Washington, according to a year-long study by The Washington Post.

Residents of low-income communities in the Washington area are hospitalized three times as often as people in high-income communities for asthma, diabetes, high blood pressure and dozens of other medical conditions that usually can be controlled by getting routine medical care.

And such avoidable hospital stays are 3 1/2 times more common in the area's most heavily black neighborhoods than in those where most residents are white, according to the computer-assisted study of doctors and patients across metropolitan Washington.

The reasons that diseases afflicting people in all neighborhoods have particularly harsh consequences in only some are deep-rooted and interwoven.

Health care is less available in poor neighborhoods than in affluent ones. Some diseases are more common among certain racial or ethnic groups; for example, diabetes is more common among African Americans than whites. And the living conditions that accompany poverty are unconducive to sound health.

The neighborhoods whose residents are hospitalized most often tend to be areas where doctors are scarce. Such neighborhoods have five times fewer doctors than those in which residents' health is best, the study found.

Health insurance, medicine and other ingredients of the health care system also are in shorter supply in the neighborhoods where people suffer the most from conditions that could be controlled.

The many patients in McLean who have private doctors can telephone their physicians' answering service 24 hours a day. Patients at the Congress Heights clinic run by the District government must wait two months for an appointment and cannot call anyone there when it is closed.

At the same time, residents of low-income communities tend to have less adequate housing, transportation and nutrition. Some are in the habit of visiting doctors only for medical emergencies.

The tendency for residents in poor and black neighborhoods to be hospitalized most often has been found elsewhere in the United States.

Yet as the Clinton administration and Congress debate ways to improve health care, they are not trying to eliminate these uneven patterns of sickness and health. Instead, they are focusing on holding down medical costs and spreading insurance to people who lack it, goals that are difficult but narrower.

Even universal health insurance -- a goal that President Clinton and most Americans consider important -- would not translate automatically into universal health.

Hurdles to Good Health

Making medical insurance more widely available would help make some people healthier. But the Post study suggests that insurance alone would not guarantee everyone a doctor within reach. Nor would it erase the many differences in people's behavior and living conditions that sometimes cause diabetes, asthma or high blood pressure to veer out of control.

It would not help Felix Jones with his diet. Jones, 50, has diabetes and already gets free care from a nonprofit clinic. He keeps a food guide taped to the refrigerator in the little kitchen of his subsidized apartment on East Capitol Street near Prince George's County. The yellow chart says he should eat three to five vegetables and two to four fruits each day.

At the start of each month, Jones uses part of his $ 560 monthly disability payment to bring home heads of lettuce and cabbage and small cans of green beans, stewed tomatoes and peas. "I buy apples by the bargain bag," he said, "but halfway through the month, they get rotten or soft."

So his kitchen also contains a 10-pound bag of potatoes and a big jar of peanut butter -- staples of his diet for the second half of the month. "I know it isn't good, but I don't have the vegetables to carry me through," he said. "I kind of start to cheat myself, and I'm cheating my own life."

The patterns of sickness and health, and their causes and consequences, were part of the Post study, which was based on a computer analysis and more than 200 interviews with patients, doctors and other people who work in or are trying to change the nation's health care system. The uneven patterns of hospital stays were found with help from John Billings, a health policy researcher who conducted much of that part of the computer analysis.

The study found that health care resources are distributed unevenly. The nearly 14,000 doctors in the Washington area form a large, lopsided work force, with scarcities of doctors in some communities and excesses in others that vastly complicate the task of those who would extend health benefits and control medical costs.

The patterns of sickness and health show that the benefits of the medical system are uneven too.

Both kinds of imbalances are evident daily to Stacey Thornburg, 27, of Upper Marlboro, a social worker who has diabetes. In her job at a dialysis center, she helps many patients whose kidneys have been damaged because their diabetes -- unlike hers -- is out of control.

Thornburg visits her endocrinologist every three months. Her eyes are examined yearly by an ophthalmologist specializing in vision problems associated with diabetes. And she is checked by a kidney specialist in the rare instances that the results of her periodic urine tests are abnormal.

When she was a college freshman, she began to use an insulin pump, an innovative gadget the size of a beeper that delivers the vital medication in a steady drip. When her first pump broke, her stepfather gave her $ 1,500 to help replace it.

Because of good doctors, good medical insurance and a middle-class life, Thornburg has kept her diabetes from harming other aspects of her health. She wishes her diabetic clients at the Landover dialysis center had the same advantages.

She meets them just after they have been hospitalized for kidney failure. Many of them are poor and have had only sporadic medical care. She helps them apply for government disability benefits and adjust to dependency on a machine to remove waste from their bodies.

The Price of Poor Health

If uncontrolled diabetes and other diseases have painful human costs, their costs for the health care system also are substantial.

Nearly half the estimated $ 3.6 billion spent on treating asthma in the United States in 1990 was the result of a half-million hospital admissions,

most of which could have been avoided through early treatment in doctors' offices and at home at a fraction of the cost, according to a recent academic study.

No one knows how much health care expenditures in the Washington area are heightened by hospital stays that could have been prevented, but recent experience in at least one state offers a clue. In Massachusetts, there were 110,000 hospitalizations for avoidable problems in 1989 and 1990, according to a state study. The price of those patients' care was $ 473 million.

Within metropolitan Washington, avoidable medical problems are most common among residents of two different environments. One stretches across northern Anne Arundel County through a band of older, blue-collar communities. Most of the residents are white, and, although few live in outright poverty, they tend to have working-class jobs in small businesses that offer no insurance. Some are unemployed.

The other environment includes neighborhoods in the District east of the Anacostia River and in Prince George's County close to the District. Poverty is common in those communities, and nearly all the residents are black.

In such urban neighborhoods, it is not surprising that people are hospitalized more often for diabetes, because the condition is 40 percent more common among black Americans than among whites.

But that tendency only partly explains the discrepancies in the rates of hospitalization in different communities. It does not explain why, for example, residents in parts of Northeast Washington are hospitalized for diabetes 18 times more often than those who live in Georgetown.

Is a Doctor Near the House?

Few doctors practice at the eastern corner of the District, near the subsidized apartment in East Capitol Dwellings rented by Douglas Brown, 47, an unemployed house painter who has high blood pressure and no medical insurance.

"Knowing a doctor ... in the neighborhood, you probably would stay more conscious of your health," Brown said one afternoon while waiting in the emergency room at D.C. General, Washington's only public hospital, to refill his blood pressure medicine. "Just knowing the system you go through waiting in the emergency room is enough to encourage you to put [medical care] off."

Brown thinks the scarcity of doctors in his poor, black neighborhood is unfair. "Health has no color, no income," he said. "Blood runs through both our bodies the same."

Although there is no shortage of doctors in Herndon, Alberto Cruz has been searching for a private physician for his 6-year-old twin daughters since the family moved to the Virginia suburb a year ago. Both girls have severe asthma.

Cruz, 28, got no medical insurance through the job he had until last month as maintenance supervisor for the apartment complex where his family lived. The girls have Medicaid, though, and he has gotten several lists, compiled by the

Fairfax County Health Department, of physicians who accept the government health insurance for the poor.

"In my spare time, I basically start calling doctors," Cruz said. "But by the time you get a list, it is outdated. They say either 'We aren't taking new patients' or 'We aren't taking Medicaid.' "

Last winter, one of his daughters, Frances, nearly died during an unusually severe asthma attack. She stayed at George Washington University Medical Center for 2 1/2 weeks.

Frances has recovered, and she gets checkups at a Fairfax health department clinic. But her father would worry less if his daughters had their own doctor close to home.

Even when patients are pleased with their source of medical care, they sometimes do not use it if they find it too expensive or inconvenient to get there.

It used to take Maria Wallace 1 hour and 20 minutes each way to make the three-bus trip from her Congress Heights apartment to the pediatricians at Children's Hospital in Northwest Washington. "Every time the children got sick, it was just too much traveling and crying," she said.

Sometimes, she missed appointments even for her son Desmond, 16, who has diabetes and high blood pressure. She didn't have the bus fare, $ 2 a person for a round trip.

"You might have [the fare] when you made the appointment, but then I had to spend it on something else," said Wallace, 36, who has never learned to drive and lives on $ 759 in monthly government subsidies for two sons and twin toddler grandsons who live with her.

Last year, she started taking Desmond and the younger children to a pediatric van run by Georgetown University. It stops one day a week along Alabama Avenue SE, a five-minute walk from their home.

The van was not always there the days the children got sick. But the arrangement was far more convenient than the latest change in Desmond's care. Under new Medicaid rules in the District, he has been assigned to doctors at a D.C. General Hospital clinic, a two-bus trip away.

Even after seeing a doctor, patients sometimes do not get enough of the medicine needed to keep certain chronic problems under control.

Douglas Brown, the unemployed painter, ran out of his blood pressure medicine in September. He'd been trying to save money to fill a prescription for Procardia, a medication that costs $ 63 for a 30-day supply. But he hadn't saved enough.

So he let one day go by without his medicine, then another. At first, he didn't suffer headaches or lightheadedness, familiar warning signs that his blood pressure is too high. "I thought, well, maybe I can go without it."

He knew that not taking medicine was a bad idea. Both his parents had died of heart attacks, and his heavy cigarette smoking makes him especially vulnerable to cardiovascular disease. Still, he waited six months until the headaches and sweats got so bad that he stopped at a drug rehabilitation clinic in his neighborhood and asked whether someone could give him a blood pressure test.

The reading frightened him enough that he went to D.C. General the next day to wait for free medicine.

Breathing Lessons

The availability of medicine and other aspects of the health care system, such as the patterns of disease among various groups of people, are just part of the reason people in some communities are less healthy than those elsewhere.

Asthma patients tend to have more trouble breathing if they live in apartments where they cannot regulate the humidity, air conditioning and heat. The disorder also is worsened by the living conditions that can accompany poverty, such as cockroaches, poor sanitation and mold.

Marc Himmelstein, 46, the president of an environmental consulting firm, found a decidedly middle-class solution after a flare-up of the asthma that he thought he'd outgrown in college. It turned out that the problem was his house. Mold had built up over the sides.

So he and his family moved.

Himmelstein, who lives in Woodley Park in Northwest Washington, also returned to his previous allergist, a 10-minute walk from his office, for monthly allergy shots and frequent tests that help his doctor tinker with his medication. He pays just a few dollars. His insurance pays the rest.

Other patients cannot always control the most basic aspects of their well-being, such as what they eat.

Harvey Petway, 48, of the Cardozo neighborhood in central Washington, knows what kind of food is best for controlling his diabetes. But at the grocery store, he has trouble checking ingredients. He cannot read.

"You get a can off the shelf, [and] you have to wait around for someone and say, 'Hey, my eyes are bad. What does that label say?' " Petway said. Some strangers tell him. Some refuse.

Petway was hospitalized for diabetes at D.C. General two years ago. Since then, he has tried to be careful. But it is too late to stave off some complications of the disease.

"Man, I'll tell you, it feels like someone is taking a knife and slamming your feet," he said. "If the sun is shining [and] you walk out there, water foams up in your eyes, and you can't see anything."

The health of other patients is affected by their personal habits or their beliefs about when doctors' visits are necessary.

Georgetown University Medical Center sent a taxi three times last year to pick up Sharon McClure and her baby daughter, Channell, in the Woodland Terrace neighborhood of Southeast Washington. They missed the free cab ride each time.

Channell was being treated for asthma at the Georgetown van that stops weekly across from their apartment complex. But the baby needed hospital tests to help her doctor decide how to treat her best.

McClure said that twice the cabs didn't arrive and that once she overslept. Finally, Channell had an unusually severe attack, wheezing, running a high fever and vomiting. Her mother rushed the baby to Georgetown. She had to stay for five days.

Good health can be more elusive in poor communities because their residents are prone to several chronic medical or social problems at once.

It is hard for Donna Anderson, of Congress Heights, to control her diabetes, because she also suffers from manic depression. Anderson, 32, knows she is fortunate that her grandmother, Olivia Coleman, helped her get a subsidized apartment, takes her shopping for the right foods and calls to check on her many times a day.

Yet when Anderson is feeling down, she gets careless, skipping insulin shots and failing to eat when she should. Other times, she gobbles her favorite foods -- cheese omelets, fried potatoes and bacon.

"It is part of that swing thing," Anderson said. She has been admitted to Greater Southeast Community Hospital every few months lately, her blood sugars fluctuating as wildly as her moods.

Health Reform Vs. Health

Given that the causes of avoidable hospital stays so often are interwoven, how much healthier could people become under the various proposals for health reform?

For now, the Clinton administration and Congress are debating the mechanisms of change: employer vs. employee insurance mandates, voluntary vs. mandatory medical cost controls.

Donna Shalala, secretary of the U.S. Department of Health and Human Services, said, "Thirty years from now, [you] shouldn't judge us by whether we got the mechanics right, but whether health is better."

Shalala and others contend that the greater the government's ability to extend medical insurance, the greater the improvements in Americans' health. Without insurance, people are more likely to defer medical care until emergencies, ignoring the preventive care that helps safeguard health.

Mark Chastang, who resigned recently as administrator of D.C. General, had a different vantage point at the city's only public hospital. The idea that universal insurance would create universal health is "absolutely false," he said.

"All you will do is allow [patients] access to providers they haven't had before. You will not eliminate their nutritional problems, their housing problems, their employment problems -- which are more important determinants of health than insurance."

Others are not certain even that insurance would promise all patients access to care.

Without more clinics, more doctors -- even more social workers -- available in the communities where residents' health is worst, the financial safety net of medical insurance "is doomed to be only marginally successful," said Kevin Weiss, a George Washington internist who has researched asthma in poor, urban neighborhoods.

"The poor, the sick aren't in a position to demand anything. They don't have a lobbyist," said Mohammad Akhter, until recently the District's public health commissioner. "If you are waiting for the people to rise up, it'll never happen. So it is a matter of political will."

The question, then, is whether the political fervor of the moment for health reform will translate eventually into an effective web of medical help for the people who need it most.

Computer analysis by William Casey, director of computer-assisted reporting. Richard Morin, director of polling, and Sharon Warden, senior polling analyst, also contributed to the computer analysis.

GRAPHIC: ILLUSTRATION, WHERE PEOPLE ARE HEALTHY AND SICK (GRAPHIC NOT AVAILABLE.), COMPILED BY WILLIAM CASEY/ AMY GOLDSTEIN/ DON SENA; MAP, RICHARD FURNO

LANGUAGE: ENGLISH

LOAD-DATE-MDC: August 1, 1994

2ND STORY of Level 1 printed in FULL format.

The Washington Post

August 1, 1994, Monday, Final Edition

SECTION: FIRST SECTION; PAGE A9

LENGTH: 894 words

HEADLINE: Life of Poverty Complicates Struggle to Control Illness

SERIES: WORLDS APART: HEALTH CARE IN WASHINGTON, Part 2 of 3

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

Deborah Drummond was in church on the Sunday last winter when she noticed her vision was starting to blur. The familiar words of the Bible refused to come into focus.

"I just closed my eyes and listened to the minister," she said.

By springtime, she had to turn down the annual requests from her Northeast Washington neighbors who wanted her to make their prom dresses and wedding gowns. Most days, she could no longer see well enough to sew in a straight line.

Dimming eyesight is one of many complications that can affect people with diabetes. Since Drummond was diagnosed with the disease three years ago, she has had no private doctor, no steady income and until recent weeks, no medical insurance.

Day to day, she can only guess how badly her diabetes is out of control. She doesn't own a meter to measure her blood-sugar levels. She knows the procedure is crucial to preserving her health but doesn't have the $ 70 to buy one. Nor has she ever been treated by an endocrinologist, the kind of doctor who specializes in her disease.

"I am 30-some years old, sick as I don't know what, and I can't get help," said Drummond, who is 33. "I don't want to go to some hospital in a diabetic coma to get some assistance. It shouldn't have to be like that."

Drummond lives off Benning Road NE in the Central Northeast neighborhood, where she shares a worn duplex with her parents, a sister and two nephews. In their neighborhood, one of every 380 people was hospitalized for diabetes in 1991. In virtually no place in the metropolitan area was diabetes responsible for a higher rate of hospital admissions.

Drummond is a perfect candidate for a disease that takes its greatest toll on people who are poor or black. Like nearly one-fourth of her neighbors, she lives in poverty. Like many of them, she has no means to pay for medical care. Like all of them, she lives in a neighborhood where doctors are scarce.

Three summers ago, when she found out why she had been so thirsty and had been urinating so often, she wasn't surprised. Diabetes "is in my family big time," she said. And she knew her weight -- more than 400 pounds at the time

-- made her prone to the disease.

But the timing was bad. When her illness was diagnosed at D.C. General, the city's public hospital, she had just quit her tailoring job at a men's clothing store. Her HealthPlus insurance ended with her job.

She didn't take her condition seriously at first. She got medicine at D.C. General from a parade of doctors -- young interns and residents who would treat her for a few months, then leave. She also got advice on what to eat: lots of vegetables and fruit; little sugar and small amounts of other carbohydrates and meat.

Drummond would take her medicine, then sneak forbidden ice cream and cake.

Last year, she started dieting. She has lost 72 pounds. Still, the medicine wasn't effective enough, her doctors decided. Now she picks up free insulin and syringes at the D.C. General pharmacy.

Because she shares meals with her family, it is hard to eat what she should.

She barters for food from her sister by fixing her hair or baby-sitting for her young nephews. For a week afterward, "I do real good. After that, whatever is here, I go for it."

In a typical month, she eats oranges, grapefruit and fresh vegetables 10 or 11 days. "The other days, I'm seriously winging it," she said.

Without a blood-sugar meter at home, she relies on D.C. General to find out how much her diet is harming her health. She should visit every three months. Sometimes the hospital postpones her appointments. Sometimes she doesn't have the $ 1 bus fare when she needs it. No one in her family has a car.

Ten of the 14 times she has been tested at the hospital, Drummond's blood-sugar concentrations were above 350 milligrams per deciliter of blood. That level is high enough to damage eyesight and cause other complications.

The month after she was diagnosed, Drummond asked the District to pay for her medical care. She was enrolled briefly in Medical Charities, a local fund covering treatment for the poor at D.C. General or city clinics.

She repeatedly has been ruled ineligible for Medicaid, although she has tried to be classified as disabled to qualify. Sometimes, her Medicaid applications have been judged incomplete.

Her requests for food stamps were turned down too. Because she is an adult without children, her eligibility was based on the monthly income of her whole household: her father's $ 700 disability check, the $ 370 her sister and nephews receive in public assistance and the $ 900 her mother was paid as a homemaker's assistant until she quit a few months ago after she learned she had breast cancer.

After The Post obtained her medical records and her applications for assistance, Drummond was ruled eligible again for Medical Charities, and she has been tentatively approved for food stamps.

Her new medical assistance card means that the city will pay for the blood-sugar meter she has been unable to buy, as long as she gets one from D.C. General or a public clinic. The hospital's pharmacy doesn't stock the meters. Nor do the six clinics she called. So she consulted her city social worker, who gave her a name and phone number in a city office where, he promised, someone would find her a meter.

Drummond left a message. No one called back.

GRAPHIC: PHOTO, 'I CAN'T GET HELP': DEBORAH DRUMMOND, A DIABETIC, SAYS THAT FROM DAY TO DAY, SHE CAN ONLY GUESS HOW FAR OUT OF CONTROL HER CONDITION IS. MARGARET THOMAS

LANGUAGE: ENGLISH

LOAD-DATE-MDC: August 1, 1994

5TH STORY of Level 1 printed in FULL format.

The Washington Post

August 1, 1994, Monday, Final Edition

SECTION: FIRST SECTION; PAGE A9

LENGTH: 850 words

HEADLINE: Insurance, Care, Vigilance Help a Diabetic Stay Healthy

SERIES: WORLDS APART: HEALTH CARE IN WASHINGTON, Part 2 of 3

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

Georgetown University computer scientist Timothy Snyder opened the middle drawer of his office desk and pulled out a lancet, a strip of paper and a thin device the size of a calculator.

He jabbed the lancet into a fingertip, dribbled blood onto the strip and knew without looking what kind of blood sugar level the meter would show. By the time the letters "LO" appeared, he already was reaching for the jumbo bag of candy he keeps in his bottom desk drawer.

As Snyder returned from teaching his midday class, he felt woozy, a clue that his blood sugars had fallen. At 35, he has had more than two decades of practice attuning himself to the sometimes subtle and occasionally frightening effects of his diabetes.

His fingertips are covered with tiny bumps from endless lancet pricks. Checking his blood sugars is part of the rhythm of his days. So are the quick-energy foods he always keeps handy and the insulin shots he gives himself every morning, at dinner time and before bed.

"Everything you do, you have to think about it," Snyder said.

When was his last injection? Into what part of his body did he slide the insulin? How much has he exercised since then? What has he eaten? Is he feeling stress?

His vigilance has its rewards. He has none of the trouble with his eyes, kidneys or circulatory system that can be side effects of diabetes.

"I've been lucky and careful," he said.

Careful, for example, in where he chose to live. Knowing that exercise is important to his health, he bought a condominium on Cathedral Avenue NW in Wesley Heights, a two-mile walk from work.

It is a neighborhood in which residents are hospitalized less often than almost anywhere else in the region for diabetes or other controllable diseases. Like Snyder, most of his neighbors are middle class and white. And many of their lives, like his, contain the basic ingredients of sound health: private medical insurance, doctors nearby and attentiveness to their own well-being.

As a high school student and undergraduate who sang in a Toledo rock band, as a Princeton University graduate student, and as a Georgetown faculty member for seven years, Snyder always has had good insurance and good care.

Now, as the new chairman of the computer science department, his office is two buildings away from his endocrinologist, who directs the Georgetown University Medical Center's diabetes treatment center.

"Because I'm sitting right on top of this hospital ... if I have any question, I know exactly who to call. They know me," Snyder said.

He also teaches himself. He subscribes to journals on diabetes. From one of them, he learned about a new device, called a Mediject, that uses pressure to force insulin through the skin without a needle. His insurance paid for 80 percent of the $ 700 gadget. Now he gets calls from other diabetics debating whether to try it.

Despite his knowledge, despite his vigilance, diabetes can be inconvenient. Like the time he was best man in a wedding and kept the guests waiting for his toast while he was in the men's room struggling to unfasten his tuxedo for an insulin shot.

He has had terrifying moments too. Like the rare times when his blood sugars plunge, leaving his mind working fine but his body feeling as if it were "under the heaviest blanket ever created."

One of the most frightening times was the morning in Princeton he awoke at 6 a.m. and realized he could not move. He'd stashed a chocolate bar in a cabinet next to his bed, in case he needed a quick jolt of sugar. But he could not reach it.

"It took me an hour to get on the floor and get the drawer open. ... You're thinking, 'Oh, my gosh, I'm becoming this helpless being.' "

He had images of how he died. Images of his mother discovering his lifeless body.

He managed to open the cabinet with his feet. He smashed the dishes and glasses inside, hoping a neighbor would hear the clatter. The telephone rang. He knocked it off the hook but could not get his mouth to the receiver.

He reached the candy bar at last. He tore the wrapper with his teeth and rubbed his mouth across the chocolate.

Such moments have taught him lessons. Snyder thinks that diabetes patients and their doctors can become obsessive in a mistaken belief the disease can be controlled entirely.

But being careful helps. There is always candy in his pockets. When he stays away from home, he checks where to find sugar. He has three blood sugar meters -- one in his briefcase, one at home and the one in his office desk.

And his knowledge, his attention to the rhythms of insulin and blood sugars inside his body, have a liberating aspect. He knows how to tinker with his insulin dose, for example, if he wants dessert one of the many evenings he

goes out to dinner with friends.

He resents people's efforts, well-intentioned but misguided, to play nurse, to presume to know what he can and cannot do. "There is this booze thing. People will tell you, 'I won't have a drink because Tim is here,' " Snyder said.

"That is when you look at the waiter and say, 'I'll have a dry martini up with a twist.' "

GRAPHIC: PHOTO, MONITORING HIMSELF: FEELING HIS BLOOD-SUGAR LEVELS DROPPING, TIMOTHY SNYDER, A DIABETIC, EATS SOME CANDY FROM THE RESERVES IN HIS POCKETS. MARGARET THOMAS; ILLUSTRATION, LAURA STANTON AND DON SENA

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SECTION: FIRST SECTION; PAGE A1

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HEADLINE: Specialists Feel Losses As Generalists Win Favor

SERIES: WORLDS APART: HEALTH CARE IN WASHINGTON, Part 3 of 3

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

Patients poured into Sidney Lesowitz's dermatology practice for 26 years. No matter the season, the economy, the other doctors moving in near his Seven Corners office, he always had a backlog of patients wanting his help for their acne and their rashes.

In the last two years, he noticed something changing. Instead of waiting two weeks for an appointment, patients sometimes could call in the morning and see him that very day. And still his schedule wasn't full.

Now, his practice has shrunk by about one-fourth, and he takes off every Thursday afternoon. With his patients being siphoned into insurance plans he has chosen not to join, he worries whether he'll be able to stay in business until he is ready to retire.

Lesowitz, 56, is on the leading edge of a health care revolution for doctors and patients across the Washington area.

A medical world dominated by specialists like Lesowitz is colliding with an emerging world order being created by insurance companies and advocates for health care reform who favor care by family doctors and other medical generalists.

In few places is the collision between the medical past and the medical future likely to be as jarring as here.

Seven out of 10 doctors in metropolitan Washington are specialists, and they are in greater supply than almost anywhere in the United States. The only type of doctor rarer here than in the nation overall is the family practitioner, a mainstay of primary-care medicine.

And the supply of specialists continues to grow. Two-thirds of the physicians training in residency and fellowship programs here are preparing for specialty careers.

But the specialists are out of sync.

The new breed of private health insurance is designed so that generalists provide at least half of all care, seeing more patients and offering more preventive care at lower cost. Most of the changes in health care being

considered by the Clinton administration and in Congress anticipate the same kind of arrangement.

Should the transformation envisioned by those seeking to change the health care system be trusted to the marketplace? Or should the change be forced, as the Clinton administration and some members of Congress believe, through new government reins on medical training?

And in the meantime, what will happen to the physicians -- including 8,000 in metropolitan Washington -- who are in the midst of specialty careers?

"I just feel glad I was able to practice at the time frame I did," Lesowitz said. "In a way, it was the golden years of specialty practice."

The Washington Post examined the types of doctors in the area as part of a study of how the health care system works and what that implies for health care reform.

The study, based on a computer analysis and more than 200 interviews, found that the region's supply of nearly 14,000 doctors is large and lopsided, creating scarcities of physicians in some parts of metropolitan Washington and excesses in others.

The study also found that people in certain neighborhoods are hospitalized most often for many medical conditions that could have been avoided or controlled. In those neighborhoods, residents tend to be poor and black and to have few doctors nearby.

To focus on the specialists who have dominated U.S. medical practice and culture for the second half of the 20th century, The Post used computerized records showing the type of medicine practiced by local physicians and those in other large metropolitan areas and the United States as a whole.

Within this area, specialists are clumped even more closely together than their primary-care counterparts. They are concentrated in downtown and upper Northwest Washington, and in the well-to-do suburbs of Bethesda and McLean, just west of the city.

Those neighborhoods are especially attractive to physicians because patients there tend to be well insured, well educated and thus relatively easy to treat. They are able to afford medicine if they need it.

Such locations also offer doctors hospitals nearby and enough other physicians to promote a sense of collegiality. That collegiality is especially important for specialists, who get most of their patients through referrals from other doctors.

Patients do not need surgeons or doctors specializing in the skin or nervous system as nearby as their main doctor because they tend not to see specialists as often. But the tight concentration of specialists means that low-income patients, some of whom lack good transportation, often have to travel the farthest.

An American Specialty

Reliance on specialty care is a defining quality of American medicine. It has created a wealth of medical knowledge, expertise and -- before the advent of managed care -- choices for well-insured patients.

"It is just wonderful having all these doctors in town," said neurologist John Lossing, who has worked in Washington since 1977 on 24th Street NW. He is one of 250 specialty physicians with office practices in the neighborhood surrounding George Washington University Medical Center.

"My patients ... have access to second, third, 19th opinions," Lossing said.

Although it has fostered a depth of expertise, this specialty-dominated system is incompatible with central goals of national health care reform: wider public access to basic health care services at a lower cost.

Each of the proposals Congress is considering would encourage patients to form lasting relationships with a main doctor who would keep close tabs on their health and their use of specialty care.

Without the constraints of managed care, cardiologists and endocrinologists order more diagnostic tests, perform more medical procedures and hospitalize patients more often than do family doctors and general internists -- even when treating similar patients with the same illnesses of the same severity, a recent study found.

"It isn't necessarily greed; it is their orientation," said Sheldon Greenfield, a Tufts University professor of medicine who conducted the study. Specialists are trained to detect rare ailments -- to risk missing no problem, no matter how unlikely.

Since the late 1980s, health maintenance organizations and similar treatment systems have expanded by 50 percent to cover nearly 600,000 of the Washington area's residents. That is not as fast as in other parts of the country, notably the West Coast. Traditional, fee-for-service medicine has endured longer here because the large federal work force has enjoyed good, varied medical benefits, and many other residents are well off and well insured.

Losing Business

As the new world of managed care arrives, some local specialists continue to thrive. They have plenty of patients who pay their own bills or who have fee-for-service insurance that allows them to visit any doctor whenever they want.

Like Lesowitz, other doctors are finding their patients slipping away.

Fairfax County obstetrician-gynecologist Robert Bettini gets calls every week from former patients who want his opinion whether their new primary-care doctor has put them on the right dose of medicine or is dealing with abnormal

bleeding correctly. They call, but they no longer come to see Bettini, 54, for exams or Pap smears. If they did, their insurance would not pay -- or pay much -- for the visit.

As some doctors lose patients, others are having trouble building practices.

Dermatologist Dale Isaacson worries about the associate he added to his downtown practice on 19th Street NW. When he hired Susan Elliott three years ago to work 24 hours a week, he expected that her schedule would be booked by now.

It is only half-filled. His 45-year-old colleague "sits there and reads journals," said Isaacson, whose own waiting list has dwindled from three weeks to one.

Meanwhile, some young specialists fresh out of training are having difficulty finding work.

"I expected several people jumping all over a new grad with my qualifications," said a 30-year-old anesthesiologist who finished a residency program in the District in June.

The doctor, who is married and wants to stay in the area, applied to 40 academic medical centers and community hospitals. He had 10 interviews. No one has offered him a job.

Hooking Up With HMOs

Worried that they cannot keep or attract patients on their own, both younger doctors and seasoned ones are rushing to sign up with HMOs or preferred-doctor networks, which offer patients better benefits when they use physicians chosen by their insurance companies.

Such arrangements offer an imperfect way to stay busy, in most doctors' view. They usually pay physicians less than traditional kinds of insurance, and they represent a loss of independence.

They have a crucial advantage, though. Employers are turning to managed care in hopes of controlling their benefit costs. So the plans enroll ever-larger blocs of patients.

But as more doctors try to hitch their futures to managed care, they are discovering a catch. Many plans, particularly the ones that pay doctors the most, already have all the specialists they want.

Daniel Framm, 65, an eye specialist in Vienna, has been applying to HMOs and preferred-doctor networks.

"Some don't respond at all. Or when they do call back, you find there aren't any openings for ophthalmologists," he said.

Framm and his daughter, Lisa Sklar, also an ophthalmologist, started applying last year, after colleagues advised them they'd better sign up with plans or risk being shut out. "I think it has already happened to some of us," Framm

said.

Physicians are infuriated by managed care's growing influence over doctor-patient relationships. "I didn't go to four years of college, four years of medical school, four years of residency to become a board-certified eye surgeon to get rejected by an insurance company," said Mary Ann Duke, 32, a Potomac ophthalmologist. Last winter, she helped lead an unsuccessful effort in the Maryland General Assembly that would have required managed-care plans to admit any doctor who wanted to join.

Kaiser Permanente Health Care Program, one of the area's largest HMOs, gets 40 to 50 calls and letters a day from local doctors who want to join. It has no openings for any kind of specialist.

"There is such a large overproduction of sub-specialties we don't need," said William J. McAveney, associate medical director for Kaiser's mid-Atlantic region, which employs 450 doctors in the Washington area and Baltimore.

The irony is that the specialists who are getting locked out of Kaiser and similar plans tend to be those who have been the busiest and best established until now. With bustling practices, they had the least incentive to invite the nuisances that accompany managed care.

Some physicians discover that even when they are admitted to preferred-doctor lists, they aren't much better off, because of the plans' limits on patients' access to specialists.

Kenneth Gaarder, a Chevy Chase psychiatrist, is a member of managed-care programs run by Aetna Health Plan, Metropolitan Life Insurance Co., and Prudential Health Care Plan, among others. None has funneled him more than 10 patients a year. Most of those patients stay with him only briefly because their insurance pays for only so many visits.

Gaarder, an authority on biofeedback who teaches medical students and supervises residents part time, has noticed that insurers refer patients to psychiatrists less often than to lower-priced social workers.

In this climate, Gaarder, 64, has become more business-minded.

When new patients approach him to switch from their current psychiatrists, he reacts differently than in the past. Years ago, he would have consulted with the other therapist, and they would have decided together whether the patient would be helped or hindered by the switch. Now he often tells prospective patients, "Okay, come on."

Gaarder needs the work. His practice has dwindled in recent years by one-third.

Other doctors are trying to compete by diversifying. Ophthalmologist William L. Rich III and his four partners have opened optical shops in their offices at Seven Corners and Fair Oaks. They carry an extensive line of contact lenses.

Despite his own entrepreneurial efforts, Rich was startled this year when a longtime patient showed him a coupon that had arrived when he bought a new house. It was an offer from another ophthalmologist for a half-price eye exam.

The erosion of the comfort and collegiality of specialists' careers would accelerate under most of the health care plans that Congress is considering.

Efforts to limit the number and change the mixture of doctors working in the United States are part of President Clinton's health care legislation. They also are found in bills produced by the Senate Labor and Human Resources Committee and the House Education and Labor and Ways and Means committees.

Although their details vary, the proposals seek to reshape the work force in two basic ways. They would try to rechannel the pipeline of future doctors. Some bills also would encourage at least some existing specialists to go back to school to become generalists.

The success of both approaches hinges, in other words, almost entirely on changing values and priorities within the nation's 126 medical schools.

'How Do We Change?'

For several decades, medical professors and administrators have been steering their most promising students into ever-narrower specialty niches -- pediatric neurosurgery, for example.

Jobs in those fields, often based in the teaching hospitals that inherit especially complex cases, have been regarded as intellectually challenging and ripe with new medical technology. Compared with primary-care jobs, they also have tended to offer better work hours, more prestige and greater incomes. The typical family doctor makes $ 100,000, one-third less than the average for U.S. physicians.

"The question is not, 'Can medical schools do business as usual?' but 'How do we change?' " said Marc Rivo, executive secretary of the Council on Graduate Medical Education, which advises Congress and the U.S. Department of Health and Human Services on doctor work force policy.

In some ways, medical schools acknowledge that change is inevitable. It would be a waste of talent and billions of dollars in federal subsidies if training programs churned out specialists who ended up jobless or underemployed, said Jordan Cohen, president of the Association of American Medical Colleges.

Until now, the federal government has attached few strings to the Medicare subsidies -- amounting to nearly $ 6 billion this year -- that pay for new doctors to get advanced training through internships, residencies and fellowships. The government has not restricted how many or what kind of doctors such graduate training programs may produce.

Jordan and most medical school deans want those reins to stay loose, arguing that teaching hospitals should not become cookie-cutters, each stamping out the same mixture of doctors.

Besides, they contend, the changing job market means that schools can be trusted to train more generalist doctors and narrow the spigot of specialists. Medical schools already are working to expose students earlier and more often to the world of primary-care medicine.

George Washington University Medical School, Georgetown University School of Medicine and Howard University College of Medicine are teaching students more about family practice and moving some of their training out of hospitals and into doctors' offices and community clinics.

But not all schools or teaching hospitals are eager to start restricting the number of specialists they train. Such residents are a prime labor source for hospitals, and each one now translates into $ 70,000 a year in federal subsidies.

Howard University would resist any government cuts in the number of specialists it could train, said Charles H. Epps Jr., the dean of medicine. As one of the nation's four predominantly black medical schools, he said, Howard has a special mission to correct the underrepresentation of minorities in medical specialties.

At Georgetown, John F. Griffith, executive vice president for health sciences, opposes limits on specialists for a different reason.

"I am bothered by the idea we can take young people and condition them to become what society wants done," Griffith said.

He said students often "get mesmerized by the miracles of modern medicine," by the specialized, technological treatment for which places such as Georgetown are known.

Janet Donohue was among the mesmerized. After graduating from Georgetown in May, she started an orthopedic surgery residency in Philadelphia in June.

She started it even though she expects that most of the jobs for doctors in five years, when she is to finish, will be in primary care.

"It seems like I'm going into a field that might be phased out, but you have to do what you want to do," she said.

Donohue, 25, thinks she could never find family medicine as much fun as surgery because the gratification is less immediate.

"You're going to control someone's high blood pressure, but you'll never cure them of it," she said. "[With] surgery, the bone is broken, you fix it, and right there you made a difference."

Retooling Doctors

Because of choices such as Donohue's, combined with medical schools' financial incentives to keep producing specialists, Clinton and some members of Congress want strict controls on the kinds of doctors who are trained.

They also want to encourage some specialists to become generalists.

The possibility of retooling physicians is fraught with controversy. One delicate question is whether established doctors need as much training as first-time students. Another is whether someone with the predisposition to

have chosen surgery initially would make a good family doctor.

Even when confronted with shrinking practices, many local doctors don't want to switch. "I love the specialty I chose," said Lesowitz, the Seven Corners dermatologist. "I will practice dermatology, or I will not practice medicine."

Nevertheless, administrators at George Washington and at Inova Health System, Virginia's largest nonprofit hospital chain, are exploring whether to start retraining programs.

And at least a few local physicians think the possibility of becoming a family doctor is not far-fetched.

"I think about it every night before I go to bed, when I think about the expenses I face in my practice the next day," said Howard Smith, a District obstetrician-gynecologist who left the large Yater Medical Group two years ago.

Smith's new solo practice is growing more slowly than he'd expected. He is getting rejected by HMOs. His 1993 salary was less than $ 100,000 -- less than half of what he had made at Yater the previous year.

Neither retraining doctors nor rechanneling the pipeline of new ones is likely to prevent dislocation in some doctors' careers.

By the most optimistic estimates, transforming the physician work force would take 30 years.

"This isn't going to be a slam-dunk in terms of everything being right right away," said David Kindig, chairman of the Council on Graduate Medical Education and senior adviser to the transition team of Donna E. Shalala, secretary of the U.S. Department of Health and Human Services.

"But things aren't right right now," he said.

And what will happen in the meantime?

The concentration of specialists in Washington and other big cities will hinder the nation's ability to control medical costs.

The dearth of family doctors will hinder the nation's ability to guarantee basic medical care, even if Congress finds a way to guarantee Americans health insurance.

A turbulent shakeout lies ahead.

Computer analysis by William Casey, director of computer-assisted reporting. Richard Morin, director of polling, and Sharon Warden, senior polling analyst, also contributed to the computer analysis.

GRAPHIC: PHOTO, SMALLER WORKLOAD: SIDNEY LESOWITZ, LEFT, SAYS HIS ARLINGTON DERMATOLOGY PRACTICE HAS SHRUNK BY ABOUT ONE-FOURTH IN THE LAST TWO YEARS AS

SOME OF HIS PATIENTS HAVE JOINED INSURANCE PLANS IN WHICH HE DOES NOT PARTICIPATE. MARGARET THOMAS; ILLUSTRATION, LAURA STANTON; ILLUSTRATION, RICHARD FURNO; ILLUSTRATION, COMPILED BY WILLIAM CASEY AND AMY GOLDSTEIN

LANGUAGE: ENGLISH

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