

THE 15-MINUTE VISIT IS KILLING THE HEALER— AND FAILING THE CHILD

By Jeffrey Hanson, PhD



When Pediatricians Become Factory Workers and Medicine Loses Its Heart

First, a Love Letter to Pediatricians

For more than four decades, I have had the extraordinary privilege of working alongside pediatricians. I am a fellowship-trained pediatric psychologist, with developmental pediatrics at the heart of my fellowship training. My professional journey unfolded across three distinct chapters: 10 years as an active-duty Army pediatric psychologist, 20 years in pediatric private practice, during which I founded Pediatric Associates, LLC, and another 10 years as a pediatric staff psychologist and faculty member at Madigan Army Medical Center.

Forty years. Three different professional settings. Countless children, adolescents, families, and pediatric colleagues. I know these physicians. I know their hearts. And I know what brings them into this extraordinary profession.

Nobody chooses pediatrics because it is easy. It is a calling, and a noble one at that. Pediatricians witness suffering, heartbreak, frightened parents, developmental struggles, and sometimes unimaginable tragedy. But they also witness extraordinary triumphs, resilience, recovery, and the magnificent unfolding of young human lives. The premature infant who survives against the odds. The adolescent who emerges from depression. The mother who leaves with hope where there had been despair.

These are among the finest physicians I have ever known. And that is precisely why what has happened to their profession troubles me so deeply. Over the course of my career, I have watched far too many gifted healers become exhausted, frustrated, and disillusioned. They entered medicine to care for children. Yet they now find themselves practicing under conditions that increasingly resemble an assembly line.

The clock is running. The electronic record is waiting. The insurance company has its requirements. The next patient is already in the examination room. Somewhere in this machinery, something precious is being lost. We are not simply stealing time from pediatricians. We are stealing the conditions under which healing relationships are formed. And our children are paying the price.

When the Joy of Healing Becomes the Burden of Surviving

Over the years, I have heard the complaints. Sometimes over lunch, sometimes between patients, and sometimes in those quiet conversations when a physician finally felt comfortable enough to admit just how miserable things had become. Too many patients. Too little time. Endless documentation. Insurance companies second-guessing clinical decisions. Administrators demanding productivity. Electronic records that seem to require more attention than the human beings sitting across the examination table. And always, that damned clock.

I have watched wonderful pediatricians grow weary. Physicians who once seemed genuinely delighted to walk into an examination room began to look exhausted before the day had even started. Some became cynical; others discouraged. Some reduced their hours, and some retired earlier than they had planned—not because they had lost their love for children, but because they had lost their tolerance for the conditions under which they were expected to care for them.

These were not weak people. They were conscientious, compassionate, capable physicians. They were simply burned up. Burned out. There is something particularly tragic about watching someone who entered a profession out of love become emotionally depleted by the very institution in which that love was supposed to find expression.

Not every pediatrician shares this experience. Many continue to find enormous fulfillment, and some practices remain supportive. But the suffering is real, and it deserves more than another wellness seminar, mindfulness app, or lecture about work-life balance. I believe in self-regulation. I teach it, practice it, and make it foundational to NeuroFaith®. But there is something almost comical about telling an exhausted pediatrician to practice deep breathing while simultaneously demanding another six patients before lunch.

Perhaps the problem is not that the physician has forgotten how to breathe. Perhaps the problem is that the system has its foot on her throat. And that brings me to an uncomfortable philosophical question.

When Evil Leaves Government and Enters Medicine

Andrzej Łobaczewski knew something about evil that most of us have been mercifully spared. He lived through Nazi occupation and Soviet-backed communist rule in Poland, where power could destroy careers, imprison dissenters, and make truth itself dangerous. He was a psychologist trying to understand how human beings—and eventually entire institutions—could become organized around cruelty, manipulation, and the ruthless pursuit of power. This was not evil contemplated from the safety of an armchair. It was evil experienced in the streets, in universities, in professional lives, and in the terrifying silence of people who knew what might happen if they spoke.

His book, *Political Ponerology* (Łobaczewski, 2022), explored how pathological personalities and destructive processes can acquire institutional authority. He used the term pathocracy to describe a system in which such forces become dominant. The truly chilling insight is not merely that evil people sometimes gain power. We already know that. It is that they can recruit the machinery of an institution—its rules, rewards, punishments, and respectable vocabulary—until the institution itself begins doing their work.

Evil does not always announce itself with a uniform and a raised fist. Sometimes it arrives in a tailored suit, smiling pleasantly, armed with a productivity dashboard and a PowerPoint about organizational excellence. The mission statement remains on the wall. The people beneath it are being ground into dust.

And this is where Michael Rectenwald becomes essential to the story—not as a casual footnote, but as the intellectual bridge. Rectenwald was directly and substantially engaged with Łobaczewski's work. He wrote about *Political Ponerology* and contributed the foreword to its revised 2022 edition. He recognized that the corrupting dynamics Łobaczewski examined in political systems could illuminate what happens in other powerful institutions as well. His subsequent work, including *The Great Reset* and *The Struggle for Liberty*, examined concentrated power across government, corporations, universities, and the interlocking structures of modern institutional life.

There is an almost painful irony in Rectenwald's own story. During his years at New York University, he challenged prevailing orthodoxies and later described professional ostracism, marginalization, and treatment that made his academic life increasingly intolerable. He ultimately left. I want to be careful about attributing the particulars: these are elements of his

own account, not findings of an independent inquiry. But the larger question is impossible to ignore. What happens when an institution does not need to refute the dissenter because it can simply make dissent unbearably expensive?

There is the progression that has seized my attention: Łobaczewski studied the psychology of evil as it captured political institutions. Rectenwald carried that warning into the wider architecture of institutional power. And I am bringing that question straight into the pediatric examination room. Because I fear that medicine, one of humanity's noblest callings, is being bent toward purposes that have precious little to do with healing.

I have spent four decades among pediatricians. I know these men and women. I know what it costs them to sit with a dying child, to comfort a terrified parent, to notice the small change in an adolescent's face that says something terrible has happened. They did not enter this profession to become obedient servants of an insurance algorithm. They did not endure years of training so a distant executive could dictate how many minutes of human attention a frightened child deserves.

Yet here we are. The pediatrician wants to spend another twenty minutes with a young person whose headaches and stomachaches may be the first clues to trauma, abuse, bullying, depression, or chaos at home. The schedule says no. The physician wants to explore the family system and make a thoughtful mental-health referral. The appointment clock says no. The doctor wants to practice the medicine that conscience and training demand. The machinery wants another billable encounter. And the machinery is winning far too often.

Who the hell gave the machinery that moral authority? Who decided that the child must fit the business model instead of the business model serving the child? And who gets rich while the physician goes home hollowed out, carrying the faces of patients who needed more than the clock would allow?

The pharmaceutical dimension deserves scrutiny, too. Medication can be appropriate and sometimes lifesaving; I have seen it help children tremendously. But a prescription can be produced in minutes, while understanding a child's trauma, attachment, family distress, and developmental history takes time and relationship. When the system makes the quick intervention easier to deliver and reimburse than deeper assessment and coordinated care, it creates an incentive toward compromised medicine. That is not proof that every prescription is inappropriate or that every pharmaceutical company is corrupt. It is a reason to interrogate the incentives—and the influence of industry—without blinking.

Let us not hide behind the comforting fiction that every person in an institution must be wicked for the institution to become destructive. Plenty of administrators, insurers, executives, and industry professionals are honorable. Hospitals must pay their staff and keep their doors open.

But it takes only enough concentrated power, enough greed, enough cowardice, and enough rewards for the wrong behavior to turn a healing institution into something that feeds on the very people it claims to serve.

That is the ponerological question. Not whether every executive is a monster. Whether an institution has begun to reward behavior that betrays its purpose. Whether it prizes obedience over conscience, revenue over relationship, throughput over thoughtful medicine. Whether the healer is being consumed to keep the machine running.

And let us be clear about who pays. The child pays when the question that would have unlocked the story is never asked. The parent pays when concern is reduced to a hurried checklist. The physician pays in sleep, health, moral distress, and the slow erosion of a calling once experienced as sacred. We are not simply inconveniencing doctors. We are grinding down the very human beings on whom healing depends.

Somewhere ahead in this essay we must confront the harder question: how long can physicians remain passive while their profession is dismantled around them? Resistance may cost something. It may cost advancement, favor, comfort, even employment. But so does silence. Before asking physicians to fight back, however, we owe them something more than rhetoric. We owe them a serious look at the research documenting what this system is doing to them—and to their patients.

They Still Love the Children. They Are Losing the Joy.

A longitudinal study by Frintner et al. (2022), published in *Pediatrics*, followed 1,794 pediatricians from 2012 to 2020. The proportion describing their work situation as a major source of frustration rose from approximately 25.5% to 37%. Yet nearly 86% continued to describe their work as personally rewarding.

I find that contrast extraordinarily revealing. These physicians had not abandoned their calling. They still valued the children and families they served. But an increasing share were finding the conditions of their work deeply frustrating. There is a world of difference between becoming disillusioned with a profession and becoming disillusioned with the circumstances under which one is forced to practice it.

The study also linked improved professional satisfaction with more favorable work conditions, including flexibility, colleague support, and time with patients. Imagine that. Give doctors more freedom to practice medicine, colleagues who support them, and time to see their patients, and they are more satisfied. Perhaps we did not need another multimillion-dollar administrative initiative to discover that.

The larger physician literature is sobering as well. A systematic review and meta-analysis by Hodkinson et al. (2022) in The BMJ pooled 170 observational studies involving more than 239,000 physicians. Burnout was associated with lower job satisfaction, greater intentions to leave, increased reported patient-safety incidents, and more patient dissatisfaction. These are associations, not proof that burnout causes each outcome; and this evidence covers multiple specialties, not pediatrics alone. But the pattern is difficult to ignore.

When people become emotionally exhausted, patience, sustained attention, flexible thinking, and interpersonal availability can suffer. Burnout researchers sometimes call the withdrawal that follows depersonalization. What a tragic word to associate with medicine: a profession devoted to persons operating under conditions that can make its practitioners less personally engaged.

And then, when a physician reaches the breaking point, we prescribe resilience. I am not opposed to resilience training; much of my life's work concerns precisely that. But resilience must never become an excuse for preserving destructive working conditions. Teaching a pediatrician to breathe while adding patients to the schedule is like teaching someone to swim while steadily adding bricks to their pockets. Eventually, we might want to discuss the bricks.

What Parents Are Telling Us: Give Us Time

Parents do not simply bring their children for diagnoses, prescriptions, and referrals. They come with questions, fears, intuition, and sometimes a desperate desire for reassurance. Beneath their immediate medical concerns is often something more fundamental: they want to know that their pediatrician truly sees their child.

In a Pediatrics study, Halfon et al. (2011) examined reported well-child visit duration, family-centered care, and satisfaction. About one-third of parents reported ten minutes or less with the clinician, nearly half reported eleven to twenty minutes, and only about one-fifth reported more than twenty minutes. Longer encounters were associated with substantially greater odds of parents reporting enough time to ask questions, developmental assessment, and willingness to recommend the clinician. These data came from an older parent survey and do not precisely describe every contemporary office; nevertheless, the relationship between time, communication, and perceived care is hard to dismiss.

A pediatrician must assess growth, development, nutrition, physical symptoms, emotional well-being, family circumstances, safety, and often a worried parent's unspoken concerns. Sometimes the most important information does not emerge until the physician has slowed down enough for a child or parent to trust the conversation. A mother may begin with her son's headaches and only later mention that he has withdrawn since his parents separated. An adolescent may present

with abdominal pain while carrying bullying, depression, or trauma. A father who appears demanding may actually be terrified.

These are not distractions from medicine. They may be essential to understanding the child. And they require something our system seems determined to ration: time.

The Child Who Finally Speaks at Minute Fourteen

Imagine a fourteen-year-old girl who arrives with recurring stomachaches, difficulty sleeping, and reluctance to attend school. The pediatrician conducts an appropriate medical assessment. Nothing immediately suggests an emergency, though further medical evaluation may be needed. The mother wants answers. The girl sits quietly, giving brief responses, her shoulders tense and her gaze averted.

Something about the encounter troubles the physician. So she slows down. She asks about school, friends, sleep, and home. She allows a silence instead of filling it with another question. Her voice softens; the conversation begins to feel less like an interrogation and more like an invitation. And slowly the girl begins to speak. Perhaps she is being bullied. Perhaps she is terrified by something happening at home. Perhaps she is carrying a burden she has never dared disclose.

For the first time, the important story is emerging. And then the physician glances at the clock. Fourteen minutes. Another patient is waiting, documentation remains unfinished, and the schedule is already behind.

Many pediatricians would stay, absorb the consequences, and care for the girl. I have admired that devotion throughout my career. But why should good care require the physician to rescue patients from the limitations of the system? Why must clinical conscience repeatedly collide with the appointment book?

In an observational study of 302 rural pediatric visits, Cooper et al. (2006) found behavioral, emotional, or developmental concerns in nearly one-quarter of encounters. When unexpected behavioral concerns emerged, visits were longer on average; physicians generally attempted to respond through assessment, support, treatment, or referral. I love that finding. It reminds us that pediatricians are not indifferent. When concerns arise, they try to help. But helping takes time.

The child does not disclose trauma according to the appointment schedule. Trust does not obey a billing code. And the human nervous system does not become ready to reveal its deepest fears because the physician has ninety seconds left.

Two Nervous Systems Walk Into an Examination Room

We have discussed economics, institutional incentives, physician frustration, and parent satisfaction. Now I want to take the discussion somewhere more fundamental: into the human nervous system. Every pediatric encounter involves at least two, and often three, interacting nervous systems: the child's, the parent's, and the physician's. Each arrives carrying a physiological and emotional history.

A frightened child may be withdrawn, restless, irritable, or unusually compliant. An anxious parent may be hypervigilant or overwhelmed. And the pediatrician may have spent the morning managing difficult diagnoses, late appointments, insurance denials, and the accumulating emotional weight of human suffering. All three may enter the room under stress. And then we expect healing to happen—in ten or fifteen minutes.

Stephen Porges' polyvagal theory has influenced how I think about perceived safety, autonomic state, and social engagement. I have studied Porges' work and attended his lectures. Polyvagal-informed clinical practice genuinely useful. Specific anatomical and evolutionary claims within the theory remain debated, but the clinical importance of safety, interpersonal responsiveness, and physiological regulation is supported by broader bodies of research. A physician's voice, expression, pace, and attention can help a child feel safe enough to communicate—or convey tension when the physician is rushed and distracted.

These ideas connect naturally with the NeuroFaith® model I have developed, which integrates polyvagal-informed therapy, neurocardiology and HeartMath® approaches to physiological self-regulation, Internal Family Systems, and faith and identity. Heart-rate variability biofeedback and paced-breathing approaches have evidence for helping some people manage stress, though not every broader claim about heart–brain mechanisms is established. The point here is not to advertise a technique. It is to recognize that the clinician's own physiological state matters to the quality of the encounter.

We Are Burning Out the Healer and Then Asking the Healer to Heal

There is something almost breathtakingly contradictory about the expectations we place upon pediatricians. We ask them to enter an examination room with warmth, patience, compassion, and exquisite sensitivity to the emotional needs of a frightened child and anxious parent. We expect careful listening, clear thinking, sound judgment, recognition of subtle distress, and the creation of safety and trust. And we give them ten or fifteen minutes to accomplish it.

Meanwhile, the physician may already be carrying the physiological burden of an extraordinarily stressful morning. The schedule is behind. Documentation is piling up. Insurance authorizations

are waiting. An administrator wants productivity. Another family is impatient. And the physician knows there simply are not enough hours in the day to meet every demand.

Repeated stress can activate sympathetic and hypothalamic-pituitary-adrenal responses, influencing cardiovascular activity, cortisol regulation, attention, sleep, and emotion. Chronic stress can contribute to allostatic load—the cumulative wear associated with repeated adaptation. This does not mean every exhausted doctor walks around with continuously elevated cortisol; chronic stress physiology is far more complicated. But the burden on the body and mind is real.

Now here comes the absurdity. We expect that same physician, whose nervous system may have been repeatedly mobilized by the demands of the day, to walk into the next room and instantly become a model of regulation. Calm. Attentive. Patient. Emotionally available. Really? How the hell is that supposed to happen?

We know that attunement requires attention and responsiveness. We know that a frightened child may need reassurance before disclosure becomes possible. We know that chronic stress can erode the resources needed for patience, empathy, and flexible thought. Yet we construct clinical environments that place those capacities under relentless pressure. And when doctors become exhausted, irritable, emotionally depleted, or ill, we tell them to develop greater resilience.

There is a certain cruelty in that reasoning. I believe deeply in resilience and in the value of self-regulation. But no breathing exercise manufactures more appointment time. No amount of heart-rate variability training substitutes for adequate staffing, sensible schedules, supportive leadership, and professional autonomy. We cannot continually dysregulate the healer and then demand that the healer regulate everyone else.

The consequences can compound. A stressed physician has fewer resources for emotional connection. The child may become more anxious or withdrawn. Communication becomes harder, and the clinician must work even harder to accomplish what might have unfolded more naturally under humane conditions. Both leave dissatisfied. The physician moves immediately to the next room, carrying the accumulated burden of the day.

We are not merely asking physicians to do too much. We are asking them to give their patients something the healthcare system increasingly refuses to give them: safety, patience, compassion, and the time to be human. If that is not a profound contradiction at the heart of modern medicine, I do not know what is.

Restoring the Heart of Pediatrics

I began this essay by expressing my admiration for pediatricians, and I want to return to it. I do not believe pediatrics has lost its heart. I believe too many pediatricians are being prevented from practicing with the fullness of heart that originally brought them into medicine. The profession still attracts extraordinary people. I have seen their compassion, courage, dedication, and willingness to walk with families through the hardest moments of their lives.

What troubles me is that we have built a system that too often treats those qualities as secondary to productivity. We measure visits completed, records signed, reimbursement collected, and schedules maintained. But how do we measure the frightened child who finally feels safe? The mother who leaves feeling genuinely heard? The physician who comes home tired but fulfilled rather than mechanically exhausted? The adolescent whose suffering is discovered because someone had time to ask one more question?

I am not proposing that every pediatric visit last an hour. Some concerns can be addressed competently and compassionately in brief encounters. Nor does a longer appointment automatically guarantee better medicine. I am arguing that clinical time should be responsive, as much as reasonably possible, to the needs of the child and family rather than dictated by an inflexible production model.

We need systems that let pediatricians exercise judgment, make room for complex developmental and emotional concerns, and respond without being punished for disrupting the schedule. We need to protect the physician's health and emotional well-being as seriously as we expect the physician to protect the child's. And we must stop pretending that the relationship is merely a pleasant addition to the real business of medicine.

The relationship is part of the medicine.

After four decades alongside pediatricians, I remain convinced that these remarkable physicians possess the knowledge, compassion, and dedication necessary to provide extraordinary care. What they increasingly lack is the freedom to practice that care under humane conditions. Perhaps it is time to stop asking how many children a pediatrician can see in an hour and start asking how much healing can actually happen in the time we give them.

Because a child is not a billing code. A pediatrician is not a factory worker. And healing was never meant to operate on an assembly line. I have spent more than four decades loving, admiring, and working alongside pediatricians. I know their hearts. I only wish the institutions entrusted with supporting them loved them half as much. Too often, the ponerological poison of greed, power, and institutional self-interest has infected the very organizations that should protect these

extraordinary healers. It is time we stopped calling that progress—and started calling it what it is: a betrayal of medicine’s sacred trust.

References

- Cooper, S., Valleley, R. J., Polaha, J., Begeny, J., & Evans, J. H. (2006). Running out of time: Physician management of behavioral health concerns in rural pediatric primary care. *Pediatrics*, 118(1), e132–e138. <https://doi.org/10.1542/peds.2005-2612>
- Frintner, M. P., Leslie, L. K., Gottschlich, E. A., Starmer, A. J., & Cull, W. L. (2022). Changes in work characteristics and pediatrician satisfaction: 2012–2020. *Pediatrics*, 150(1), e2021055146. <https://doi.org/10.1542/peds.2021-055146>
- Halfon, N., Stevens, G. D., Larson, K., & Olson, L. M. (2011). Duration of a well-child visit: Association with content, family-centeredness, and satisfaction. *Pediatrics*, 128(4), 657–664. <https://doi.org/10.1542/peds.2011-0586>
- Hodkinson, A., Zhou, A., Johnson, J., Geraghty, K., Riley, R., Zhou, A., Panagopoulou, E., Chew-Graham, C. A., Peters, D., Esmail, A., & Panagioti, M. (2022). Associations of physician burnout with career engagement and quality of patient care: Systematic review and meta-analysis. *BMJ*, 378, e070442. <https://doi.org/10.1136/bmj-2022-070442>
- Łobaczewski, A. M. (2022). *Political ponerology: The science of evil, psychopathy, and the origins of totalitarianism* (H. Koehli, Ed.; A. Chciuk-Celt, Trans.; rev. ed.). Red Pill Press. <https://search.worldcat.org/title/1319074898>
- Rectenwald, M. (2022, March 26). The science of evil: A personal review of political ponerology. <https://www.michaelrectenwald.com/essays/the-science-of-evil-personal-review-of-political-ponerology-lthfa>
- Rectenwald, M. (2023). *The great reset and the struggle for liberty: Unraveling the global agenda*. New English Review Press. <https://store.mises.org/Great-Reset-and-the-Struggle-for-Liberty-Unraveling-the-Global-Agenda-P11271.aspx>