

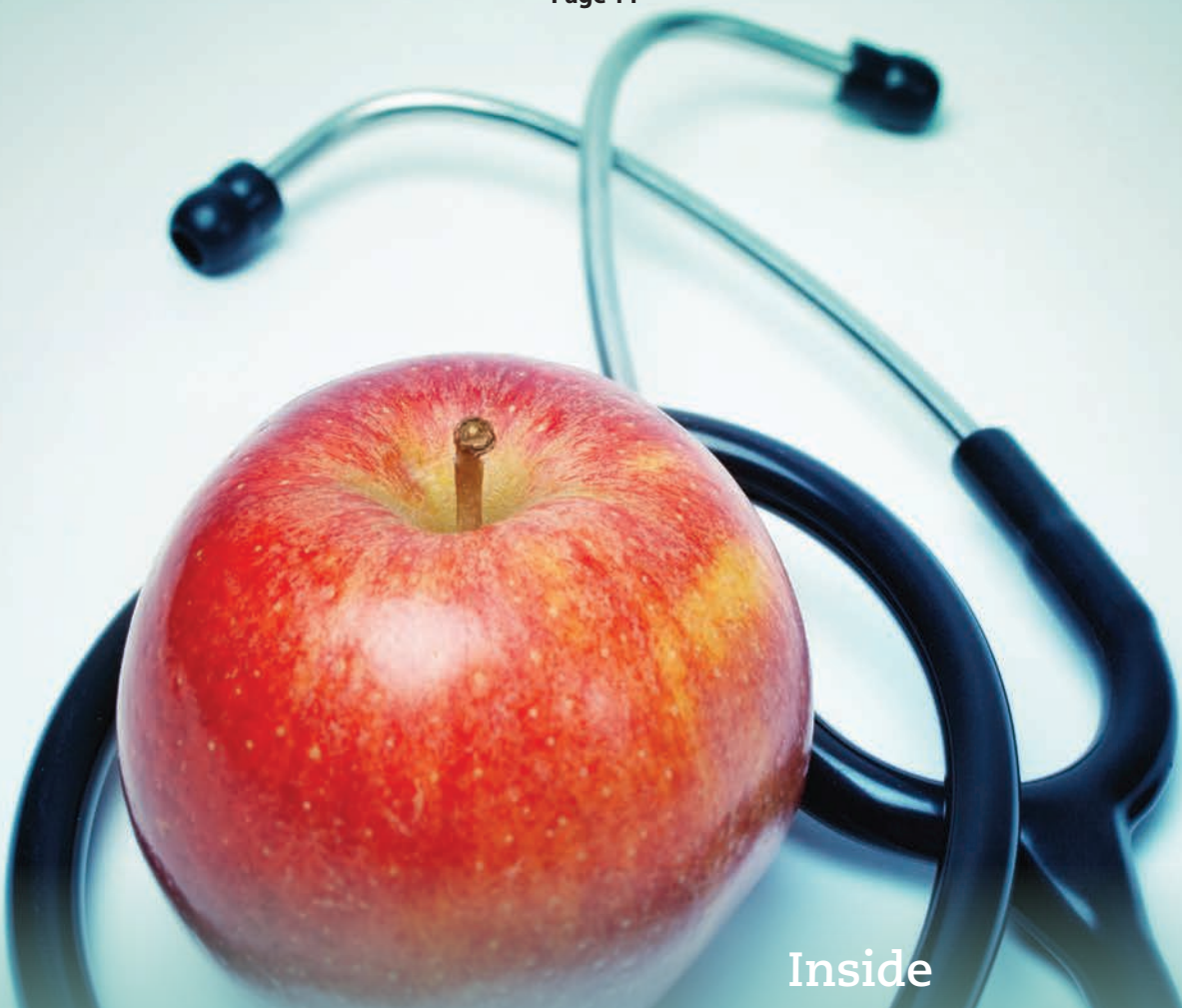
ST. LOUIS METROPOLITAN MEDICINE

VOLUME 44, NUMBER 4

AUGUST / SEPTEMBER 2022

Physician Wellness

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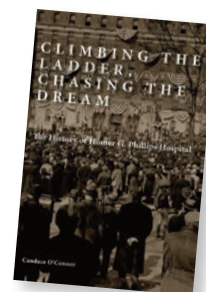
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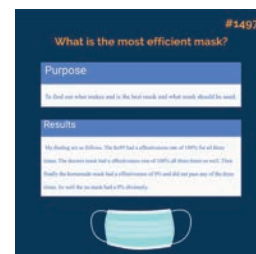


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Physician Payment Reform Is Another Facet of the Enduring Health Care Delivery Challenge

By Erin S. Gardner, MD, President, St. Louis Metropolitan Medical Society 2022



Erin S. Gardner, MD

The federal government by fiat has forced physician compensation into a fixed system, in which increased payments in one portion of that system by definition result in decreases in payments in another portion.

Physician compensation can be a sensitive topic in the public realm. There is a persistent stereotype perceived by so many of our friends, neighbors and patients that physicians make outsized incomes, and are thus among the rich in society; there aren't many who envision a destitute physician providing them with clinical care. And the reality is that most physicians do in fact make an income greater than the median income in America today. Yet physician compensation has become yet another front in the conundrum of effective health care delivery that the country faces, made more acute by the coronavirus pandemic.

In truth, that enduring stereotype sprouted in part from a reality pervasive in western society. A study of physician wealth from the *British Medical Journal*, comparing physicians in the 19th century to those at the end of the 20th century, showed that physicians were the fourth most wealthy occupational group (of 10 total) in the 19th century.¹ By the end of the 20th century, however, physicians had descended down the ladder to become ninth in that grouping. Though one explanation for these observations was that those who became physicians in the 19th century were often wealthy to begin with, that phenomenon became steadily scarcer in the succeeding century.

The unfortunate trend has only continued in our current century. The American Medical Association compiled some sobering data last year evaluating physician compensation over the last 20 years (Table 1). As health care has morphed during that time, physician compensation has suffered a vexing decline when the depreciating effects of inflation are considered. Though on its face physician compensation has increased by 11% over the past two decades, inflation-adjusted earnings

have actually declined by 20%.² This has occurred in the inevitable setting of expected inflation in other services and goods, specifically the expenses to host and run a medical practice. For those physicians still in independent practice, increased expenses directly impact physician compensation, as there is only a single tranche of funds to pay both expenditures.

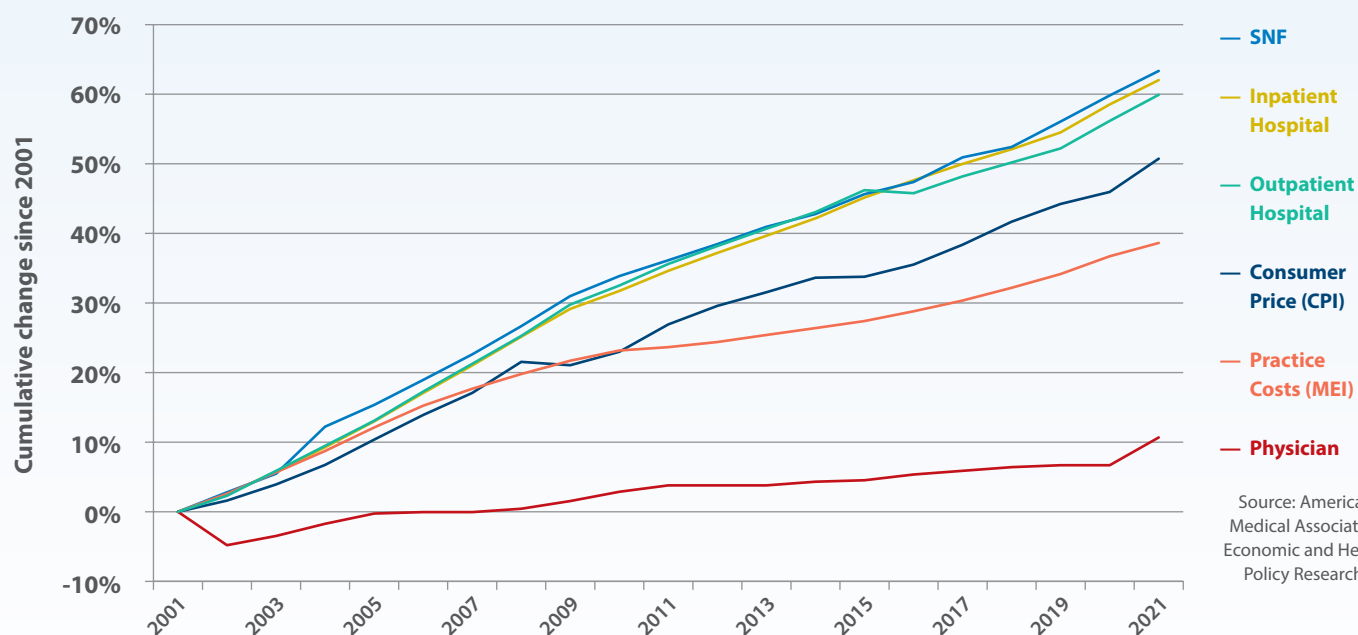
Medicare Increases Offset by Cuts

The AMA has now identified that trend as a threat to the successful provision of care in the decades ahead. As most all of us know, Medicare reimbursement for physician services resides in the lower tier of market compensation for most specialties. Irksomely, reimbursement from commercial insurers (I won't even start with Medicaid payments) is often pegged to Medicare reimbursement rates. This becomes a problem when the Center for Medicare and Medicaid Services, Medicare's steward, implements regulatory payment cutbacks for some or all of the physician specialties, since reimbursement falls thus not only with Medicare, but also with most all of the commercial insurers as well.

So we find ourselves with a puzzling challenge here, and that is not the only facet of the compensation problem. All too often unadjudged in strategic approaches to address declining physician compensation is that the federal government by fiat has forced physician compensation into a fixed system, in which increased payments in one portion of that system by definition result in decreases in payments in another portion.

Thus, though we may reasonably cheer when Medicare declares that they will provide coverage for an expensive medication or service previously not covered, we little

TABLE 1: MEDICARE UPDATES COMPARED TO INFLATION (2001-2021)



acknowledge the price pressure that will bring to other parts of this fixed financial system. As in our personal lives daily, life is lived in a world of limited resources, and we must in turn choose how we are going to employ those limited resources. It seems to me that physicians as a group don't often acknowledge this phenomenon in the main.

Other Providers See Large Increases

The AMA data further elucidate an approximation of this zero-sum universe. For example, in the setting of real physician compensation declines over the past 20 years, Medicare hospital-payment updates totaled roughly a 60% increase between 2001 and 2021 (Table 1). Medicare skilled nursing facility-payment updates totaled more than 60% over that time span. For comparison, economy-wide inflation (Consumer Price Index data) increased 51% during the period. For the fortunate hospital and skilled nursing facility groups, both were able to keep their incomes above inflation during the 20 years; physicians obviously were not so lucky.

Another element of the payment reform difficulty is the federal fisc. Beyond the particular Medicare physician payment zero-sum mechanism, the federal government, and in particular Congress, have been loath to provide additional funding for physician compensation. This may be in some measure due to the lingering perception that physicians are highly compensated already and do not deserve another boost, especially when the legislators have so many other perhaps equal or higher priorities.

There are some solutions, perhaps many of them incremental, but that is a topic sizeable enough for another writing. But in short, physicians must be clear-eyed about the fiscal realities that exist within the federal government in regard to increasing

spending on physician payment reform. There are many competing interests in Washington, all aiming for the same outcome. An obvious general solution would be to break free from that zero-sum universe, a development seen in the advent of direct pay primary care and the proliferation of specialty offices offering lifestyle medicine or aesthetic services. These services have been opened back up to the market economy, where individuals are willing to pay market rates for the value that they are receiving. In line with the market forces considerations, modulating the power of insurance companies to dictate payment and other policies, by increasing competition between third-party insurers, seems also a move that would benefit physician payment reform efforts.

The path to a more rational physician payment model will not be straight, but our course over the last 20 years is one that is unsustainable. Patient access to physicians will continue to decline, as physicians increasingly leave the flawed system, and medicine is perceived less favorably among potential aspirants. Ultimately, physician compensation should characteristically reflect the value that society places on the services rendered, and for physician services, that value remains high indeed.³

Editor's Note: The AMA is speaking out against CMS' proposed 2023 physician payment rates that would reduce physician payments. See the advocacy section of ama-assn.org for details.

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3. OECD. "Happy, Healthy, and Wise" are Top Priorities for American, Canadian Users of OECD Better Life Index. May 5, 2014. <https://www.oecd.org/unitedstates/bliusacanadarelease.htm> Accessed July 17, 2022.

SLMMS General Society Meeting on September 20 Will Include Presentation on Population Health



Dr. Rishi Sud

Rishi Sud, MD, MBA, chief medical officer with Esse Health, will be the featured presenter during the annual SLMMS General Society Meeting scheduled for Tuesday, September 20 at 6 p.m. via Zoom. All SLMMS members are invited to participate.

Dr. Sud, a SLMMS member, is a board-certified family physician with Esse Health, a St. Louis-based independent physician group. He holds an undergraduate degree in mechanical engineering from the Illinois Institute of Technology, and earned his medical degree from Finch University of Health Sciences/The Chicago Medical School. He holds an MBA from Washington University, and attended the health care executive program at UCLA Anderson School of Management. His topic will be "Succeeding in Population Health – A Primary Care Perspective."

The General Society Meeting is an annual event where the slate of nominees for SLMMS officers and councilors, proposed by the Nominating Committee, is presented to the membership.

Pre-registration is required to receive the meeting link and information. Please register using the link at slmms.org, or email Dave Nowak, executive vice president, at dnowak@slmms.org and the registration link will be sent to you.

Agenda

- Call to Order –
2022 President Erin S. Gardner, MD
- Nominating Committee Report –
Ravi S. Johar, MD, committee chair
- The committee will be recommending members for nomination to the following offices:
 - President-Elect
 - Vice President
 - Secretary-Treasurer
 - Councilors (4)
- Educational Presentation by Rishi Sud, MD, MBA, Chief Medical Officer, Esse Health, "Succeeding in Population Health – A Primary Care Perspective," followed by Q&A.

2022 GENERAL SOCIETY MEETING

Tuesday, September 20, 2022

6:00 p.m. via Zoom

Registration: slmms.org

Harnessing Artificial Intelligence to Support Medicine

Artificial intelligence is an emerging tool that medicine is still learning to use effectively, said speakers at a June 22 seminar sponsored by SLMMS in conjunction with the Missouri Chapter of the American College of Healthcare Executives and VirtuSense Technologies. About 70 physicians and health care executives attended the session, which was presented both in person and virtually.

Damon Broyles, MD, FAAFP, vice president for clinical innovation services with Mercy Technology Services, provided an overview of how artificial intelligence, also known as augmented intelligence, processes large volumes of data to detect patterns. This can benefit physicians, he noted, by organizing the large and ever-growing amount of clinical data available, but still leaving the cognitive processing to humans.

"AI is not going to replace doctors," Dr. Broyles said. "But doctors who don't embrace it will be replaced because this is going to be a basic component of the practice of medicine."

Thomas Hale, MD, PhD, chief medical officer for VirtuSense Technologies, also expressed his belief in the future of



Panelists at the artificial intelligence seminar, from left: moderator Kirsten Dunn, MD, SLMMS vice president; Thomas Hale, MD, PhD; and Damon Broyles, MD, FAAFP.

machine learning and artificial intelligence. He emphasized the importance of the physician correctly designing the question and criteria around which the AI will gather information. Dr. Hale formerly was executive medical director for Mercy Virtual.

"An AI does not substitute for judgement or creativity," Dr. Hale said. "Be sure the purpose you put into the machine is the purpose you really desire."



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Disturbing Rise in Local Congenital Syphilis Cases

A potentially life-threatening and debilitating illness for mother and child

By Yusra Arooj, MD; Nebu Kolenchery and James Hinrichs, MD, MPH, FIDSA

Recently, the Centers for Disease Control and Prevention pointed out a nationwide increase in sexually transmitted infections (STIs) in its 2020 surveillance report.¹ Unfortunately, the St. Louis region exhibited higher rates of chlamydia, gonorrhea and syphilis than state and national rates.

In addition, rates of syphilis in women of child-bearing age and most alarmingly, the rates of **congenital syphilis**—transmitted during pregnancy or delivery—have also continued to rise. There were 11 cases of congenital syphilis in St. Louis County and 11 cases in St. Louis City in 2021. By comparison, in 2017, St. Louis County—with three times the population of St. Louis City—had three cases and St. Louis City had one case. These represent congenital syphilis increases of 233% and 1,000% respectively.

So far in 2022, eight probable congenital syphilis live births have been reported, making a total of 19 cases in St. Louis County in the last 18 months. In addition, there have been two syphilitic stillbirths in St. Louis County since January 2021. Sadly, there is an ongoing increase in the number of congenital syphilis cases.

The rates of congenital syphilis cases correlate with rising rates of syphilis in young women. In the county, 69 cases of early syphilis were diagnosed in St. Louis County women under 40 years of age in 2021, an increase of 23% from 2020 and a 165% increase from 2017. The 69 cases are the highest number since 1994.

About Congenital Syphilis

Syphilis is an infection caused by the bacterium, *Treponema pallidum*. Congenital syphilis is a grave consequence resulting from vertical transmission of syphilis infection during pregnancy or delivery. The transmission is more common with maternal

primary, secondary or early latent syphilis but can also occur with late latent or partially treated syphilis infection. Ideally, pregnant patients are screened for syphilis during the first trimester (at the first prenatal visit), at 28 weeks gestation, and at delivery.

Congenital syphilis is a life-threatening and a debilitating illness that can lead to miscarriage, stillbirth or early infant death as well as late physical and neurological disorders if the baby survives, as the baby can be asymptomatic at birth. Congenital syphilis is completely preventable—given the seriousness of this infection in babies, it is now crucial to screen for syphilis and provide timely treatment to the pregnant population and those desiring pregnancy.

We are alerting both health professionals and the public about the rising trend in congenital syphilis cases and their potential role in its prevention.

So far in 2022, eight probable congenital syphilis live births have been reported, making a total of 19 cases in St. Louis County in the last 18 months.



Review of Cases

A thorough review of maternal syphilis and congenital syphilis cases in St. Louis County over the past 18 months shows that the more common social determinants present were 1) lack of or inadequate prenatal care, in part due to poor socioeconomic status and access, and less provider contact due to the COVID pandemic, 2) inadequate treatment based on syphilis stage (less than 30 days prior to delivery), 3) active drug use, and 4) homelessness. (Table 1)

The rate of occurrence of congenital syphilis in St. Louis County is twice as high among African Americans, at 10.8 per 100,000 per year, versus 5.9 for whites. (Table 2)

Among the two syphilitic stillborn cases, the mothers of neither had treatment prior to 30 days before delivery, and one mother was never presented for screening prenatally and had a history of illicit drug use.

In addition, the Missouri Department of Health and Senior Services (DHSS) over the past 18 months originally classified an additional 22 St. Louis County cases as congenital syphilis but later reclassified these as “not a case” on further analysis.



Dr. Yusra Arooj



Nebu Kolenchery



Dr. James Hinrichs

Yusra Arooj, MD, is a post-doctoral research fellow for the St. Louis County Department of Public Health.

Nebu Kolenchery is director of the department's Division of Communicable Disease Response. James Hinrichs, MD, MPH, FIDSA, is infectious disease advisor to the department. Dr. Hinrichs can be reached at JHinrichs@stlouiscountymo.gov, or 314-503-0883.

While these 22 cases are not part of our St. Louis County analysis of congenital syphilis cases, they serve to emphasize the growing number of possible cases that are identified in women of childbearing age. Among those 22 cases reclassified as not congenital syphilis:

- Seventeen had appropriate screening during prenatal visits, with positive results, and subsequent appropriate treatment more than 30 days prior to delivery, effectively preventing congenital syphilis in the baby, although follow-up testing on the child was ongoing.
- In four cases, the mother had documented prior treatment of syphilis and titers were appropriately reevaluated during pregnancy, with no evident risk to the infant.

In these cases, the guidelines for screening and treatment were followed, thereby preventing the passing of the infection to the newborn and averting a potentially catastrophic outcome.

The rate of occurrence of congenital syphilis in St. Louis County is twice as high among African Americans, at 10.8 per 100,000 per year, versus 5.9 for whites.



Recommendations

In light of this clear public health crisis, it is strongly recommended that we follow a dual-pronged approach that involves educating both the public and health professionals about syphilis and congenital syphilis preventive measures including screening, treatment and follow-up. Also, health professionals need to take thorough sexual histories from patients who are pregnant/women of childbearing age as well as male patients who are in a relationship with a pregnant woman, to increase screening and timely treatment of syphilis regardless of stated risk factors.

In addition, the local public health departments are taking evidence-based actions including engaging with local health partners to establish a congenital syphilis morbidity and mortality review board in the latter half of 2022 in response to this issue. The morbidity and mortality review board will perform an in-depth analysis of every congenital syphilis case to determine missed opportunities for prevention and treatment. Actions that could be taken to prevent congenital syphilis and treat a future case of syphilis infection in pregnancy will inform additional recommendations to the public and providers to address this public health crisis. Of note, per the CDC² and Missouri DHSS guidelines:

- Adequate treatment of syphilis in pregnant women as soon as possible during pregnancy dramatically decreases the rate of congenital syphilis. Syphilis known to be acquired within

continued

TABLE 1: Characteristics of Congenital Syphilis Cases

St. Louis County, January 2021 to June 2022 (provisional)

SYPHILIS SCREENING AND TREATMENT	FREQUENCY
Maternal Stage of Syphilis	
Primary	2 (11%)
Secondary	1 (5%)
Early non-primary non-secondary	4 (21%)
Late or unknown duration	12 (63%)
Total	19
Prenatal Care	
Yes	6 (32%)
No	8 (42%)
Unknown	5 (26%)
Total	19
Maternal Syphilis Treatment (Trimester of Pregnancy)	
First trimester	1 (5%)
Second trimester	0 (0%)
Third trimester	8 (42%)
At delivery	3 (16%)
Unknown	7 (37%)
Total	19
Other Characteristics	
Homelessness	1 (5%)
Maternal drug use during pregnancy	3 (16%)

TABLE 2: Congenital Syphilis Rates by Race

St. Louis County, January 2021 to June 2022 (provisional)

	CASES	POPULATION (females aged 15–44 years)*	CASES PER 100,000 (annualized)
Black or African American	9	55,507	10.8
White	10	113,074	5.9

*2020 American Community Survey 5-Year Estimates

the prior 12 months (primary, secondary, early non-primary non-secondary) should be treated with 2.4 million units of IM Benzathine penicillin G. Syphilis acquired more than 12 months prior (late syphilis) or of unknown duration should be treated with Benzathine penicillin G 7.2 million units total, administered as three doses of 2.4 million units IM each at one-week intervals. If doses are further apart than nine days or missed, the treatment schedule must restart from the beginning.

- Patients with penicillin allergies should be desensitized and treated with penicillin, as it is the only known effective antimicrobial for preventing maternal transmission to the fetus and treating fetal infection.
- Partners should (at a minimum) be presumptively treated (2.4 million units of IM Benzathine penicillin G) to prevent

reinfection during pregnancy no matter their test results. Ideally, they should be evaluated for syphilis by a provider and staged and treated appropriately.

At the St. Louis County Department of Public Health, we are devoting additional personnel to become trained to investigate cases identified as positive during pregnancy and intervene to assure effective treatment and contact tracing so that reinfection is minimized. Please contact Dr. Hinrichs to learn more about St. Louis County's efforts and how you can help, JHinrichs@stlouiscountymo.gov. ➤

References

1. <https://www.cdc.gov/std/statistics/prevalence-incidence-cost-2020.htm>
2. <https://www.cdc.gov/std/treatment-guidelines/default.htm>

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CME Webinar August 16 Will Focus on Cybersecurity

Program open to all physicians and their staff members

The St. Louis Metropolitan Medical Society will sponsor a CME webinar, **Cybersecurity Update 2022 – Cyber Liability Insurance for Health Care and Associated Risks**, on Tuesday, August 16, at 6:00 p.m. over Zoom. The free program is open to all physicians and medical professionals, including office managers and practice administrators. Participating physicians may claim 1.0 Category 1 CME credit hours.



Derrick Weisbrod



Josh Barker

The program will be presented by Health Care Technology Advisors, a division of Inerva Technology Advisors, and techrug (The Technology Risk Underwriting Group). The presenters, **Derrick Weisbrod**, CEO of Inerva Technology Advisors, and **Josh Barker**, senior account executive and advisor at techrug, will provide an update on the current state of cybersecurity issues and how you can protect yourself and your practice.

Cyberattacks on all types of businesses are on the increase, especially health care, where it is most pertinent that protected health information is secure. Cyber liability insurance is crucial to that protection. Medical practices must be assured that any cyber liability insurance follows the National Institute of Standards and Technology (NIST) when determining the risk associated with underwriting a policy for a given business.

The NIST standards are best practice as the basis for regulatory compliance that is known as HIPAA in health care.

Learning Objectives

At the conclusion of this activity, participants will be better able to:

- Articulate cybersecurity risks and the methods used to compromise patient privacy and cybersecurity of the medical practice.
- Explain cyber liability insurance protection and its importance.
- Understand the correlation between government regulations and NIST standards.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Missouri State Medical Association through the joint providership of Institute for International Medicine (INMED) and St. Louis Metropolitan Medical Society. The Institute for International Medicine is accredited by the Missouri State Medical Association to provide continuing medical education for physicians.

Institute for International Medicine designates this Live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program is free of charge but advance registration is required to receive the link to participate. Please visit www.slmms.org for more information or to access the registration link. ➤

CYBERSECURITY UPDATE 2022 – CYBER LIABILITY INSURANCE FOR HEALTH CARE AND ASSOCIATED RISKS

Tuesday, August 16 ➤ 6:00 p.m. via Zoom ➤ Free ➤ Registration and more information available at slmms.org

Hospital News



St. Luke's Hospital has named **Andrew Bagnall** president and chief executive officer. He most recently served as president and chief executive officer of Hospital Sisters Health System (HSBS) Wisconsin.

Barnes-Jewish West County Hospital and Washington University Physicians are opening an **outpatient center for ophthalmology and otolaryngology services**, including clinics and operating rooms, at 450 N. New Ballas Rd.

Mercy Hospital St. Louis opened a **proton therapy center** at the David C. Pratt Cancer Center, one of only 40 proton centers in the U.S. Pictured at the July 5 opening: **David Meiners, MD**, Mercy Hospital St. Louis president; **Steve Mackin**, Mercy system president and CEO; **Tina Yu**, Mevion CEO; **Robert Frazier, MD**, division chief of radiation oncology at Mercy St. Louis; **Joe Pecoraro**, Mercy St. Louis executive director of oncology services; **John Timmerman**, vice president of operations.



Physician Wellness Remains a Priority

Quick poll shows one-third of members rate their burnout level as medium high

Even as the COVID-19 pandemic wanes, physician wellness remains a priority concern. With office closures and infection controls in place, the pandemic laid additional stress on top of the negative elements already affecting physicians. These ongoing stressors include excessive administrative tasks, declining reimbursements, and outside sources exerting control over the practice of medicine.

In a June poll, one-third (33%) of SLMMS members rated their level of burnout as medium high. Another 27% categorized their burnout level as medium low.

For many members, the past year has marked a return to normal as pandemic-related closures and restrictions have lifted. Among respondents, 38% said their level of stress and burnout has decreased as the pandemic has abated. Another 38% indicated their burnout level is the same as pre-pandemic. That is the good news. But a significant minority—22%—say their burnout level is increasing. The poll is unscientific and is based on 35 responses; it is reported here to provide a general insight into trends.

How do SLMMS members work to maintain wellness and ward off burnout? Among respondents, exercise is by far the most-often mentioned strategy, noted by over half. Also mentioned frequently is the importance of work-life balance. “Fitness, family time, making boundaries between work and home,” commented one. Said another, “Time and vacations with family. Decreasing remote work at home before/after hours.” Responded one, “Have strong family support and enjoy spending time with my family outside work.”

Several pointed to creating a supportive environment in the office for both physicians and support staff. Said one: “Developing a richer, more supportive work environment for employees and physician colleagues.”

Health Systems, Medical Schools Promote Wellness

Area health systems and medical schools have been taking steps during COVID-19 and before the pandemic to address burnout issues and promote wellness.

St. Luke’s has a Physician Health Promotion and Resiliency Task Force that since 2017 has developed and implemented a broad range of wellness programs. The goal is “to meet the

ongoing needs and challenges of the practice of medicine in this environment,” said Thomas Pohlman, MD, program director.

Besides developing wellness videos and educational conferences, the task force has addressed a variety of specific needs. Because electronic health records systems are a major source of physician stress, the task force assembled a team of information technology professionals to work with physicians and staff on optimizing their use of the hospital’s Cerner EHR system.

To recognize physicians and remind them of the importance of wellness, each receives a birthday letter signed by Dr. Pohlman and the hospital CEO. Quarterly interdepartmental small group gatherings of physicians are organized to break down silos and build work support networks. “Buddy badges” are given to providers and feature a seven-point well-being index that offers providers a quick check on how they are doing. An online communications hub is being developed that will enable physicians to easily locate information from hospital administrative departments.

In a June poll, one-third of SLMMS members rated their level of burnout as medium high.



Saint Louis University School of Medicine since 2017 has run a “Wellness Champion” program for residents, fellows and graduate students. The Wellness Champion team consists of 12 to 15 faculty members and 15 to 20 residents who serve as liaisons on wellness initiatives. They also promote efforts to improve wellness across the School of Medicine. The program was designed by a steering committee composed of faculty members, residents, mental health professionals and others.

Other wellness initiatives at the school include a professional oversight committee monitoring resident duty hours and fatigue concerns, as well as a quiet room for residents and students to use as a place for meditation and prayer. Various wellness events are held throughout the year.

At the Mercy system, a Peer Care Team was established during COVID-19. Composed of physicians and advanced practice professionals, the team makes wellness outreach calls to peers to physicians and APPs in the critical care and emergency departments. Any personal information shared is strictly confidential. —

How and Why Physicians Must Address Burnout

Utilizing available resources to relieve the physician workload and improve wellness

By Karen S. Schechter, RHIA, MBA, CMPE

Just when we think it's winding down, the Omicron variants continue to plague our communities. Cases have increased this summer, as have hospitalizations.¹ The CDC continues to monitor the Omicron variants and provides tools to help communities and health care professionals navigate the changes. However, physicians are still left dealing with the effects of this situation with respect to access, staffing and personal health.

The "Great Resignation" is affecting the health care sector with particular ferocity, with nearly one in five health care workers having left their jobs during the pandemic.² Many in this sector had already been experiencing varying degrees of burnout due to numerous other factors, and there was already a shortage of physicians.³ And the pandemic made an already challenging situation worse. Since one of the primary factors contributing to physician burnout is long-term stress,⁴ it becomes all the more vital now for physicians to proactively address these issues.

Before I begin, I want to provide some context in that most of my work is with private practice physicians. Having said that, I do think there are many parallels between the experiences of physicians in private practice and those in other practice settings, including hospitals and urgent cares.

It's Not Just About COVID

One thing that may be helpful to remember as a way of contextualizing physician burnout is that much of it is not due to COVID itself, at least not directly. Social distancing guidelines earlier in the pandemic, combined with people's anxieties about going into medical care facilities in person, have led to a backlog of work due to patients delaying their needed care. Regardless, the end result for physicians is

the same: more work and more stress. Added to this is the aforementioned shortage of staff that may be creating more work for physicians as well.

Why This Is So Important

Being mindful of burnout and addressing it when it occurs—or, better yet, to prevent it before it occurs—is important for the same reason that the "triple aim" of the medical profession has been updated as "the quadruple aim."⁵ The fourth aim—the health and well-being of physicians and their staffs—is necessary for achieving the other three aims: enhancing the patient experience, improving population health, and reducing the cost of care. This has always been true, but it becomes all the more critical due to the pandemic and its secondary impacts.

Emphasizing Communication

There are ways to mitigate stress by managing its symptoms. But there are also ways to lessen stress by preventing some of it in the first place. Most important is strengthening communication, both internally and externally. By internal communication, I mean sitting down with staff and laying it all out, identifying priorities and brainstorming ideas for how to streamline workflow. One of the biggest problems during earlier periods of the pandemic had been miscommunication or a lack of communication. While more communication may seem like additional work, the amount of work and stress it saves in the long run makes it more than worthwhile. Physicians, nurses, and staff can waste less time and energy on fixing mistakes or confusion caused by poor communication and focus instead on providing quality care.

In addition to internal communication, good external communication needs to also be prioritized. For instance, the backlog of patients wishing to come in for overdue checkups or treatment may necessitate longer wait times for appointments. Without sufficient communication, patients may become frustrated or dissatisfied. But generally speaking, people get more frustrated about a lack of information than they do with the content of the information. Determine what communication approaches are most suitable for your practice and make sure that your staff is adequately trained regarding what needs to be communicated to patients and how.



Karen S. Schechter

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Identifying and Using More Resources

Times like now may also warrant looking into and utilizing resources that lighten your burden somewhat. Many doctors spend unnecessary amounts of time and energy on tasks that could be done by other types of professionals—medical case managers, for instance, or members of their staff. Reallocating certain kinds of tasks not only lifts some of the burden from the shoulders of physicians but can also provide the additional benefit of empowering the staff.

In addition to resources that can make life easier for physicians and their staffs, there are also resources to which physicians can refer their patients as well. One of these is telehealth. Many patients may still, even now, not realize that their insurance plans offer telehealth services. Referring patients to these services can help reduce workload while ensuring that patients can still get the care they need for medical concerns that can be adequately addressed through telehealth.

Of course, in addition to referring patients to third-party telehealth services offered through their insurance, physicians can offer their own telehealth services as well. Many who utilized telehealth during earlier parts of the pandemic have, for whatever reasons, stopped using it, but telehealth shouldn't just be a temporary measure. Ideally, it should become a permanent tool that not only increases access to care but can also help streamline the act of providing care. In fact, not only is telehealth an important resource for patients, it can also be a wonderful resource for physicians by helping them to optimize scheduling⁶ and support work-life balance.⁷ At this time, Missouri and Illinois continue to require insurance providers to reimburse for telehealth visit. You can use the National Conference of State Legislatures (NCSL) State Telehealth site⁸ or the Center for Connected Health Policy's (CCHP) policy finder tool⁹ for the most current state regulations.

Doctors Need Self-Care, Too

Although it may sound overly obvious, in my experience physicians need to be frequently reminded that they too are human. It is all-too-common for physicians to neglect their mental health.¹⁰ Self-care is not just a good idea; it should be considered a professional imperative. Left unaddressed, chronic stress increases the risk of not just burnout but also depression and anxiety.¹¹ This is another area where telehealth can help, and there is no reason that physicians can't also take advantage of the benefits and convenience of using telehealth for mental health services.

Physician support groups such as the Physician Moms Group¹² and Physician Dad Support Group¹³ on Facebook, or physician-focused support channels such as the peer-to-peer Physician Support Line¹⁴ or the text-based Frontline can help. The Reddit groups r/medicine and r/physicians,¹⁵ while not expressly support groups, also feature many discussion threads where physicians and other health care professionals offer various kinds of emotional support to each other. And digital tools

such as Headspace, a leading mindfulness and stress management app, can serve as a useful adjunct to behavioral health services targeted towards physicians and health care providers. Normally a paid service, Headspace is offering a free two-year subscription for AMA members throughout the pandemic.¹⁶

Finally, physicians should also try to heed the same recommendations that are often given to their patients, basic principles such as getting enough sleep, staying physically active, and eating as healthy as possible. Again, as obvious as these principles seem, physicians can be quite quick to forget them during busy and stressful times. Many useful reminders such as these can be found on the AMA's resource page for managing mental health during COVID-19.¹⁷ While many of these things are certainly easier said than done, the important thing to remember is that they can indeed be done and often make all the difference.

The pandemic really has opened our eyes to different ways of delivering care. With many valuable and effective resources available, it shouldn't just be about the doctor doing everything. We have learned many useful lessons over the last two years and, hopefully, applying those lessons will help reduce burnout and increase physician resilience. —

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Q&A on Physician Burnout with Jessi Gold, MD, MS

What to look for and what to do

Jessi Gold, MD, MS, is a widely read and referenced expert on mental health among physicians and other health care workers. An assistant professor and the director of wellness, engagement and outreach in the Department of Psychiatry at Washington University School of Medicine, her research has been published in *JAMA*, the *American Journal of Psychiatry* and others. She is also known for her articles and interviews in general audience publications including *The Washington Post*, *The New York Times*, *Forbes*, *SELF* and *InStyle*, as well as her social media accounts. She works clinically as an outpatient psychiatrist and primarily sees faculty, college and graduate students, as well as staff and hospital employees. During the pandemic, she has been a major wellness resource within the hospital system and the entire university. She has spoken at major national and international meetings and at grand rounds around the United States. You can follow her, @drjessigold on social media or on her website, drjessigold.com.



Dr. Jessi Gold

Here she offers her latest thoughts on the topic of physician burnout with *St. Louis Metropolitan Medicine*.

Can you give us a definition of physician burnout?

The definition most often used is that burnout is a combination of three things: 1) emotional exhaustion, 2) depersonalization, and 3) reduced sense of personal accomplishment. I also think it is helpful to conceptualize burnout as a mismatch between what you think work is going to be like and what work actually is. So, we often think work as physicians will be patient care or mentoring, things we like, but it is often a lot of paperwork. That difference—because we don't get meaning and purpose from paperwork—often causes burnout.

What portion of the physician workforce is suffering from significant burnout? How has this increased during COVID-19?

Depending on what measuring tool is used and what specific population is studied, approximately 50% of the physician workforce was burned out before COVID-19. Burnout is only compounded by the different new stressors of the pandemic. What stressors we have had may vary by where we lived, our specialty, the setting we work in, or even the phase the pandemic, but the fact that there are stressors has not changed. Those have been constant and compounding.

How does physician burnout vary among specialties?

What workplace factors influence greater or less burnout?

Burnout varies by specialty and across time. *Medscape* tracking during the pandemic shows that the specialties most affected by COVID-19—critical care, emergency medicine, infectious disease—worsened in their rankings compared to other physician specialties.¹ There are many workplace factors that contribute to burnout, from the aforementioned lack of meaning in work (more time spent on paperwork, for example), to the lack of control or autonomy in the workplace, to the lack of social support. One of the consistent ways to lessen burnout—and we have seen this in our own numbers at Washington University over COVID-19—is supervisor support.² Having a supportive supervisor, one who at least seems to respect and value work/life balance, is key.

Now that we've had months of lower COVID hospitalizations, what is the state of the hospital workforce, including physicians and nurses?

The situation is that while we may have different stressors, the stressors still remain. Trauma, in particular, does not have a timeline, and health care workers have been “all systems go” for years. They have not had time to process, grieve, or even breathe. When they do, it will not surprise me if people have trauma symptoms appear months, or even years later. Additionally, the workforce has had people leave in large numbers. Not only is that caused in part by burnout, but it subsequently contributes to further burnout in the remaining staff members. We will be reckoning with workforce shortages for years to come.

Are women physicians more vulnerable to burnout?

What factors make women more vulnerable?

One review of 42 studies found that, while both male and female doctors have high rates of burnout, the likelihood of being burned out is higher in female doctors, particularly when it comes to emotional exhaustion.³ There are many reasons for this—from work/life integration to harassment in the workplace, to gender bias and discrimination.⁴ Additionally, female physicians typically spend more time documenting (in and out of work) than their male counterparts, which can further contribute to burnout.⁵ Their burnout has only worsened during the pandemic with extra burdens facing women. For example, even in dual physician households, there was more of an expectation for the female physicians

to handle childcare or schooling or household tasks than the male physician parent. As a result, more women reduced their work hours and experienced work/family conflict.⁶

How do stress and burnout impact medical students and residents?

This is another population on which we need to focus, and in particular look at how the pandemic has affected their training (or lack of training) and how that might impact their future careers. Studies have shown that compared to the general population, medical students, residents/fellows and early career physicians were more likely to be burned out. However, being a resident or fellow was associated with increased odds of burnout, and trainees have higher burnout levels than even medical norms, particularly in the subscale of depersonalization. There has been a difference by specialty, as well. One reason for this, of course, is the lack of control and autonomy experienced as a trainee.^{7,8}

What are some signs of physician burnout to watch for?

Signs of burnout are often person-specific. We tend to blow past the emotional exhaustion signs because it is America and we are in medicine, and as a result, we are supposed to be tired from work. It is practically a badge of honor. It really isn't until we get to symptoms of reduced sense of personal accomplishment that we notice something is wrong. We notice either because we aren't being as productive as we would want to be or someone else tells us we aren't. Both things give us pause.

Unfortunately, that experience is pretty late in a burnout cycle, and it can be important to pay more attention to the early signs so prevention might happen earlier. For example, I get really angry at my email and my EPIC inbox. That anger is a burnout sign and is important to notice and then intervene on. We should get used to asking ourselves how we are doing, and actually give ourselves the time to answer.

What should a physician do if he or she thinks she may be getting overwhelmed? How can burnout be treated?

The first step is to acknowledge that they are overwhelmed and realize it is normal. Our career is hard, and we will have emotional reactions to it—it is impossible not to, especially

during this time. Once we acknowledge it, and name it, we can then do things to improve upon it. I think early on in burnout things like coping skills, which I view more like hobbies instead of prescriptions of "these are the only things that work" can help. You can journal, run, deep breathe, do mindfulness ... whatever works for you.

In later stages, you might need to take time off, place limits on your work hours into evening and weekends, and/or find ways to put more meaning and control into your schedule. Of course, social support remains key, and some people might seek out someone like me or a therapist to help them, and that can definitely be beneficial. My own therapist helps me manage my burnout regularly.

Does stigma remain among physicians about seeking treatment/assistance? What portion of physicians continue to not seek help for burnout?

Absolutely. Stigma comes out in many ways in our culture—from viewing mental illness or vulnerability as a weakness, to being afraid of judgement from supervisors, colleagues, or even our licensing/credentialing boards for needing help. We can see this in pandemic data, when only 13% of health care workers received mental health services, and 18% said they needed services but didn't receive them. Of course, there are clear systemic barriers (time, money, access), but the culture of medicine adds another barrier that we need to improve for each other. Asking for help is a strength, not a weakness.⁹

How do you manage your own mental health and stress level?

I am still a work in progress, which might surprise you as I am an "expert on burnout." I have noticed that different things work at different times for me, and for different needs. I have found benefit in reducing notifications on my phone and email, journaling when I feel like I have something I need to get out, and taking the time to acknowledge and appreciate my own feelings. I also have a dog who does a great job cheering me up, a fantastic support system (which as things have opened up finally can play more of a role again), and a therapist whom I see weekly and appreciate more than I could put into this paragraph. ➔

References on page 19

PHYSICIAN BURNOUT BY SPECIALTY 2021					
Emergency Medicine	60%	Pediatrics	49%	Surgery, General	44%
Critical Care	56%	Pulmonary Medicine	48%	Cardiology	42%
Ob/Gyn	53%	Gastroenterology	48%	Allergy & Immunology	42%
Infectious Disease	51%	Internal Medicine	48%	Nephrology	40%
Family Medicine	51%	Urology	48%	Plastic Surgery	40%
Physical Medicine & Rehabilitation	50%	Anesthesiology	47%	Ophthalmology	40%
Diabetes & Endocrinology	50%	Rheumatology	46%	Psychiatry	38%
Radiology	49%	Neurology	46%	Dermatology	33%

Source: Medscape survey of 13,069 physicians conducted June-September 2021, reported January 2022.¹

Guardianships in the Missouri Court System: A Necessary Part of Medical and Legal Practice

How physicians could be involved in the court process of determining guardianship

By Tina N. Babel, JD

The American Medical Association notes in its Code of Medical Ethics Opinion 2.1.1 that informed consent to medical treatment is “fundamental in both ethics and law.” Medical treatment and the legal process often intersect when adult patients¹ in need of medical care are no longer able to make competent, rational decisions on their own. Most medical articles examining capacity and guardianships state that physicians should seek court intervention only as the “last resort;” however, guardianships may be necessary for appropriate patient care. Doctors and hospitals, like most people, prefer to avoid the legal system when at all possible.

The World Health Organization reported in 2017 that mental health conditions and substance use disorders rose 13% in the last decade.² Guardianship cases are on the rise in the St. Louis area and nationwide, due in large part to demographics, the rise in substance abuse, as well as the increase in an aging population and the inevitable capacity issues that develop as a result. COVID-19, in turn, triggered a 25% increase in the global prevalence of anxiety and depression worldwide.³ The Britney Spears saga and recent Netflix movie *I Care a Lot* have done nothing to make doctors, hospitals or the general population more comfortable with the legalities of guardianships. The guardianship process, however, is often necessary and should be utilized when needed for consent and appropriate and proper patient care.

The Difference Between Guardianships and Conservatorships

A guardianship is the legal process of determining individuals’ capacity to make decisions for themselves regarding personal affairs. If a full guardianship is awarded, the guardians thereafter have the power to make all decisions for the ward/patient,

including who can see them, where they reside, and what medical care they receive. The guardian essentially steps into the shoes of the ward/patient for all “personal” decisions.

Of course, the court could choose to implement a limited guardianship,⁴ which would mean the ward/patient maintains full autonomy and capacity, except for whatever delineated rights the guardian has in the ward/patient’s stead. For those reasons, when providing care based upon a guardian’s decision, it is important to review the letters of guardianship (the legal document that gives the guardian authority), to make sure the guardian has the power to make medical decisions and there is not a limitation on the guardian’s ability to act.

Guardianship cases are on the rise in the St. Louis area and nationwide, due in large part to demographics, the rise in substance abuse, as well as the increase in an aging population and the inevitable capacity issues that develop as a result.



In Missouri, a court can implement a conservatorship, which is like a guardianship but deals only with the financial affairs of the ward/patient. Due to bonding and complicated reporting requirements, most attorneys try to avoid conservatorships whenever possible. In some states, including Illinois, the courts do not have a procedure called “conservatorship,” but rather, refer to the differences as guardianship of the person and guardianship of the estate.

The Guardianship and Its Requirements

Often, a Durable Power of Attorney for Health Care (a “POA”) will work just as well for the need to consent to patient health care. If the POA provides sufficient delineation of the attorney-in-fact’s power to consent to and make health care decisions—as most do—a POA is the less expensive and quicker route. Guardianships are used in lieu of POAs where the POA does not provide sufficient power or direction, the patient/ward has not yet signed one and no longer has the capacity to do so, there is no one to serve, or where there is concern of undue influence



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by the attorney-in-fact or concern that the attorney-in-fact is not working in the ward/patient's best interests. In many courts, upon filing a petition for guardianship, the court will deem the POA no longer valid until the guardianship can be determined.

A guardian will be appointed by the probate court when it is proven to the court that the guardianship is the "least restrictive alternative" and the ward/patient is determined to be "incapacitated." Incapacitation is defined when the patient/ward "by reason of any physical, mental, or cognitive condition" is unable to "receive and evaluate information or to communicate decisions to such an extent that the person, even with appropriate services and assistive technology, lacks capacity to manage the person's essential requirements for food, clothing, shelter, safety or other care such that serious physical injury, illness or disease is likely to occur."⁵

"Any person"⁶—including a physician, nurse and social worker—may file a petition to be appointed as a guardian or petition some other qualified person to be appointed. St. Louis County and St. Louis City have done their best to make the petition for appointment of a guardian as simple as possible, and the forms for both courts are the same. The entirety of the forms that need to be filed can be located online at the court's website under "Forms."⁷

The Need for Physician Interrogatories

As a treating physician, you may be asked to fill out what used to be called "physician interrogatories." In St. Louis County and City courts, this form is now called an "Affidavit in Support of Petition for Appointment of Guardian-Conservator."

Filling out the physician interrogatories is an exception to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because the information used in the interrogatories is to be used "solely in the course of a judicial proceeding."⁸ In the Physician Interrogatories, you will be asked to answer questions (and to notarize your answer) regarding the last time you examined the ward/patient, your diagnoses of the ward/patient, what the diagnoses are based upon, what medications have been prescribed, and whether—based upon a reasonable degree of medical certainty—you believe a guardianship is necessary.

It is highly suggested that you provide enough information from a medical perspective for the court to evaluate the necessity of the guardianship for your patient/ward.

The Guardianship Hearing

In a large majority of cases, filling out the physician interrogatories should be the end of your involvement as a treating physician. Though you will be identified as a potential witness, the *guardian ad litem* appointed by the court to represent the ward, will stipulate to the introduction of your physician interrogatories without needing to call you as a witness; it is assumed the answers you filled out are accurate and complete, and you will not change your opinion if you

are called as a witness. However, if you are subpoenaed to testify, you will often need to appear. That said, with the recent improvements in technology in our courts, a health care provider's request to appear virtually for a guardianship hearing would likely be granted.

If you appear in person, the questions will likely involve the necessity of the guardianship, whether the ward/patient is incapacitated, chance of improvement, whether there should be limits on the guardianship, and the depth of care you have provided.

What Happens Next

When important decisions of patient care are before you, and the patient lacks the capacity to consent to the care needed, it is incumbent upon you to make sure the person consenting for your patient has the authority to do so. In many situations, the patient will have already executed a POA that would allow an attorney-in-fact to speak for your patient. But when there is not a POA, the patient revokes it, or you have concerns regarding the attorney-in-fact's decision-making, a guardianship proceeding may become necessary.

Emergency guardianships—to be used only in emergency situations as the court is required to immediately act upon their filing—are always an option and can happen very quickly. A regular guardianship may take up to one to three months to be determined (more, if it is adversarial), depending upon the circumstances of the case.

Despite the time, potential cost, and adversarial nature of the guardianship proceedings, they remain a necessity in our legal system and provision of health care to ensure our disabled and incapacitated adults are being properly cared for, despite what TV shows and pop star dramas may show otherwise. —

This article is for informational purposes only. Nothing herein should be treated as legal advice or as creating an attorney-client relationship. The choice of a lawyer is an important decision and should not be based solely on advertisements.

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Book Review

Homer G. Phillips Hospital and Its Legacy of Medical Excellence

By Nathaniel Murdock, MD

I Was In Awe of Homer G. Phillips Hospital.

The first time I saw Homer G. Phillips Hospital, I was so impressed. It was so very large and filled with Black doctors and nurses giving the Black community excellent health care.

When I was a sophomore at Meharry Medical College, I came to St. Louis to spend the summer of 1961 living at Homer G. Phillips Hospital. I worked as a research assistant under J. Owen Blache, MD, in the pathology department, studying the heart.

The next summer, 1962, my junior year of medical school, I came back to Homer G. Phillips to do an externship. This summer was mostly spent working on the ob-gyn floor and learning a tremendous amount of medicine.

As a result of such a wonderful place to work and learn, I returned to Homer G. Phillips as an intern and resident. Working with excellent physicians daily gave me expert training in ob-gyn.

Climbing the Ladder, Chasing the Dream: The History of Homer G. Phillips Hospital is a true account of the life and death of Homer G. Phillips Hospital. The testimonies and pictures of the doctors and nurses make this book a great read for anyone. This book describes how Homer G. Phillips' dedicated physicians and nurses were exceptional health care providers. I saw this daily.

Homer G. Phillips Hospital was the only public hospital for African Americans in St. Louis. It opened in 1937 through the efforts of attorney and civil rights activist Homer G. Phillips, a graduate of Howard University, where I obtained my undergraduate degree. The hospital trained Black physicians and nurses from all over the United States, and at one time had the nation's largest residency program for Black physicians.

While I was on staff at Homer G. Phillips from 1963 until the hospital closed in 1979, we delivered more than 300 babies per



Dr. Nathaniel Murdock

Nathaniel Murdock, MD, is a retired obstetrician-gynecologist and a past president of SLMMS. He trained at Homer G. Phillips Hospital and practiced there for 16 years.

CLIMBING THE LADDER, CHASING THE DREAM: A HISTORY OF HOMER G. PHILLIPS HOSPITAL

By Candace O'Connor

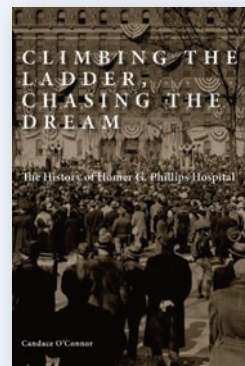
With help from
Will Ross, MD, MPH

Foreword by Eva Frazer, MD

University of Missouri Press

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month. We also handled over 100 gynecology cases per month. The standard joke was, "If you did not read about a case, you would see one."

Some patients we served believed in very old cultural myths, such as bad blood as a source of illness. The Homer G. Phillips staff did a great job of educating patients and raising their awareness around the real causes of common illnesses. The staff advocated for preventive health care.

My training in ob-gyn at Homer G. Phillips was under William Smiley, MD, chief supervisor of the department of obstetrics and gynecology, who was a brilliant surgeon. Most patients

continued



Aerial view of Homer G. Phillips Hospital (Missouri Historical Society).

Robert F. Owen, MD



Robert F. Owen, MD, an internist/rheumatologist, died June 20, 2022, at the age of 94.

Born in Poplar Bluff, Mo., Dr. Owen received his undergraduate degree in biology at Princeton University, and his medical degree from Yale

University School of Medicine. He interned and completed his residency at Barnes Hospital and Washington University School of Medicine as well as at St. Louis City Hospital.

His medical training was interrupted from 1954-1956 for military service with the U.S. Army Medical Corps, serving active duty in Korea. In 1958, with a group of fellow associates, he established a medical practice in Florissant, and was in private practice for nearly 40 years.

Dr. Owen joined the St. Louis Metropolitan Medical Society in 1958, and at 64 years of membership was one of the association's longest-term members at the time of his passing.

SLMMS extends its condolences to his wife and fellow SLMMS member Dr. Edith Trugly; his daughter Suzanne Owen; and his two grandchildren. —

Homer G. Phillips Hospital ... — continued

had health care needs that were preventable. Their poor health was mostly poverty related.

My daughter Lisa was born at Homer G. Phillips Hospital and was delivered by Dr. Smiley. I was on call the night she was born. My wife Sandra worked at Homer G. Phillips in the chemistry lab. She grew up in St. Louis and knew many of the hospital's health care workers.

Here is Sandra's recollection of Homer G: "I was a part of the auxiliary that decorated special private rooms at Homer G. Phillips. I had my baby in one of those rooms. The loss of this hospital left a big hole in the community where I grew up. Before Homer G. Phillips, my mom and family had to go to very, very small hospitals such as St. Mary's on Papin Street. They had poor equipment. Those were the only places where Black doctors could practice. We loved Homer G. Phillips Hospital. People I knew called it "The G."

In 1960, with efforts of racial integration under way, community leaders started to believe that a uniquely Black hospital did not serve the Black public well. I stayed as a doctor in service at Homer G. Phillips Hospital until its closing in 1979.

The most important thing we did at Homer G. Phillips Hospital was serve the community by healing the sick. —

John E. Hironimus, MD



John E. Hironimus, MD, a dermatologist, passed away June 29, 2022, at the age of 88.

Born in New York City, Dr. Hironimus earned both his undergraduate and medical degrees from Indiana University. He completed his

internship at Los Angeles County General Hospital, then came to St. Louis to complete his residency at Barnes Hospital and Washington University School of Medicine.

He completed military service in the U.S. Navy in 1956-57 prior to entering medical school.

He maintained a private practice in dermatology for more than 30 years, and practiced at the former Deaconess Hospital and St. Anthony's Hospital. An accomplished tennis player as well as a passionate fan, Dr. Hironimus was team captain at Indiana University and won three Big 10 conference championships in the 1950s.

Dr. Hironimus joined the St. Louis Metropolitan Medical Society in 1971.

SLMMS extends its condolences to his wife Joan (Callahan) Hironimus; his children Gail Bauer and John Hironimus; and his five grandchildren. —

Q&A References ... — continued from page 15

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Are We Training Our Mid-Level Provider Replacements?

By Samer W. Cabbabe, MD, FACS

I've been in private practice for 12 years, and during that time, health care has changed faster than I could have ever imagined. Private practice numbers have decreased annually, hospitals have been purchased and merged, and corporate medicine now rules the land. Doctors have lost their independence and now mid-level providers (MLPs) are slowly replacing physicians, driven by the desire to maximize profit margin in corporate medicine. Accordingly, the quality of health care has deteriorated and the patient-physician relationship has changed for the worse.

I foresee a future of health care where MLPs provide the vast majority of inpatient and outpatient services with minimal physician supervision, much like the anesthesia model.

MLPs have been around for years. Physician Assistants (PAs) began to practice in the mid-20th century and have worked alongside surgeons for years. Nurse Practitioners (NPs) started in the 1960s and their role expanded in 2010 with an Institute of Medicine recommendation. Realizing they could not staff operating rooms with only attendings and recognizing that their profits may increase, anesthesiology practices began to staff surgeries with Certified Registered Nurse Anesthetists (CRNAs). Now, many patients who have surgery in hospitals or surgery centers never even see an attending physician anesthesiologist. Due to physician shortages, hospitals have hired increasing numbers of NPs and PAs to help physicians see patients in both the inpatient and outpatient settings. Hospitals even encourage physicians to allow the NPs to see the inpatients for them so that they can focus on outpatients/new patients.

In my opinion, a major turning point—for the worse—in the patient-physician relationship occurred when family doctors



Dr. Samer W. Cabbabe

Samer W. Cabbabe, MD, FACS, is a plastic surgeon in private practice. He is chief of plastic surgery at Mercy Hospital South and has served as president of SLMMS and the Missouri Association of Plastic and Reconstructive Surgeons. He can be reached at scabbabe@stl-psc.com. The comments in this column represent the opinions of the author and not necessarily the opinions of SLMMS.

JOIN THE DISCUSSION

This page in each issue *St. Louis Metropolitan Medicine* will feature insightful commentary by SLMMS members on timely issues in medicine. Do you have a reaction to this article by Dr. Cabbabe? Do you have an idea for a commentary you would like to publish? Send your letter or commentary idea to editor@slmms.org, and it will be considered for publication.

stopped seeing patients in the hospital, and hospitalists and MLPs took over the inpatient care of their sick patients. Physicians were essentially telling patients, “I only take care of you when you are healthy.” In the outpatient family care setting, MLPs see a significant number of outpatients without physician supervision. The physician message to patients is, “This MLP can do just as good a job as I can.”

Given our reliance on MLPs and the message we have been sending to our patients that “MLPs can take just as good of care of you,” it should come as no surprise that patients have accepted the loss of physicians in their medical care and turned to MLPs for care.

I foresee a future of health care where MLPs provide the vast majority of inpatient and outpatient services with minimal physician supervision, much like the anesthesia model. This could easily be accomplished in emergency departments, hospital floors, ICUs and clinics, where MLPs could see all the patients, order diagnostics, call consults, and discuss complex care with one or two attending physicians, much like a residency.

The reality is that physicians are training their eventual (MLP) replacements! The first three years of work for a NP is essentially their own “residency.” However, compared to physician residencies, they are being compensated handsomely (>\$100,000), working less than 80 hours/week and starting without the same medical school debt! Some employed physicians have stepped forward and refused to work with MLPs, and the result has been termination by these corporate hospitals. We are being forced to train our replacements!

Eventually, MLPs will take over surgical practice; they are already performing procedures in emergency departments,

continued

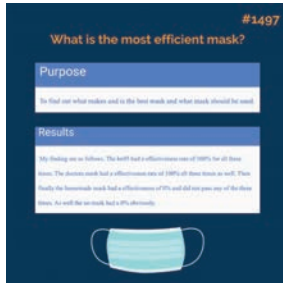
Congratulations Science Fair Winners 2022

Congratulations to the following high school and middle school students who earned top honors in the Health and Medicine category of the 2022 Greater St. Louis Science Fair, which was held virtually for the third consecutive year. Each received a scholarship award from the Medical Society's charitable arm, the St. Louis Society for Medical and Scientific Education.

Grade 6 – Seamus Nichols

Gateway Science Academy of St. Louis – Middle School

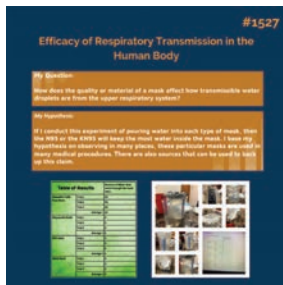
What is the Most Efficient Mask?



Grade 7 – Tori Atsepoyi

STEAM Academy Middle School

Efficacy of Respiratory Transmission in the Human Body



Grade 10 – Lauren Shocker

St. Joseph's Academy

The Rates at Which Different Pill Capsules Release Medication in Hydrochloric Acid

Grade 11 – Sonali Sharma

Metro Academic and Classical High School

Insight into Recent Changes in Nucleocapsid Phosphoprotein of SARS-CoV-2

Grade 12 – Kaitlyn Finnegan

Cor Jesu Academy

The Modern Sling: A Product to Enhance Patient Recovery

"Thank you so much! The idea for my project came when I realized that the global pandemic was still continuing. So I decided to conduct an experiment on how to keep yourself safe from COVID-19. ... This award inspires me to learn more about the science in the medical field."

– Tori Atsepoyi, Grade 7

"Thank you so much for selecting me for your award! It means so much to me, I have always loved science and am considering a career path in that field. Receiving this award has inspired me to continue pursuing a scientific career path. Thank you!"

– Lauren Shocker, Grade 10

Alliance Earns AMA Alliance Award



The SLMMS Alliance was presented with a 2022 AMA Alliance Health Awareness Promotion Award during the AMA Alliance Annual Meeting in Chicago in June. The award recognizes the "Hungry Heroes" project through which the Alliance prepared and distributed hundreds of gift bags to frontline workers at area hospitals from late 2020 through 2021. Pictured with the award are SLMMS Alliance members Gill Waltman; Sue Ann Greco; project lead Angela Zylka; AMA Alliance 2021-2022 President Heather Rifkin, PharmD; and Sandra Murdock.

Provider Replacements ... ➤ continued from page 20

outpatient settings and even in interventional radiology to name a few. They can be trained to do surgery just like any resident.

As long as corporate medicine drives health care, profit margin will be the priority. With the Medicare lump-sum payment model pending, hospitals know they can pay an MLP less than a physician to do the same work and pocket the profit. And, they won't have to deal with "difficult physicians."

What can be done now? Sadly, I can't see any situation where this ends well for physicians. Most states are passing legislation that increases NPs' independent practice. The Accreditation Council for Graduate Medical Education has increased residency positions, but that is too little and too late. Even if we adopted universal Medicare, undoubtedly the government will see value to utilizing MLPs over more expensive physicians.

Unfortunately, the MLP train has already left the station! ➤



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