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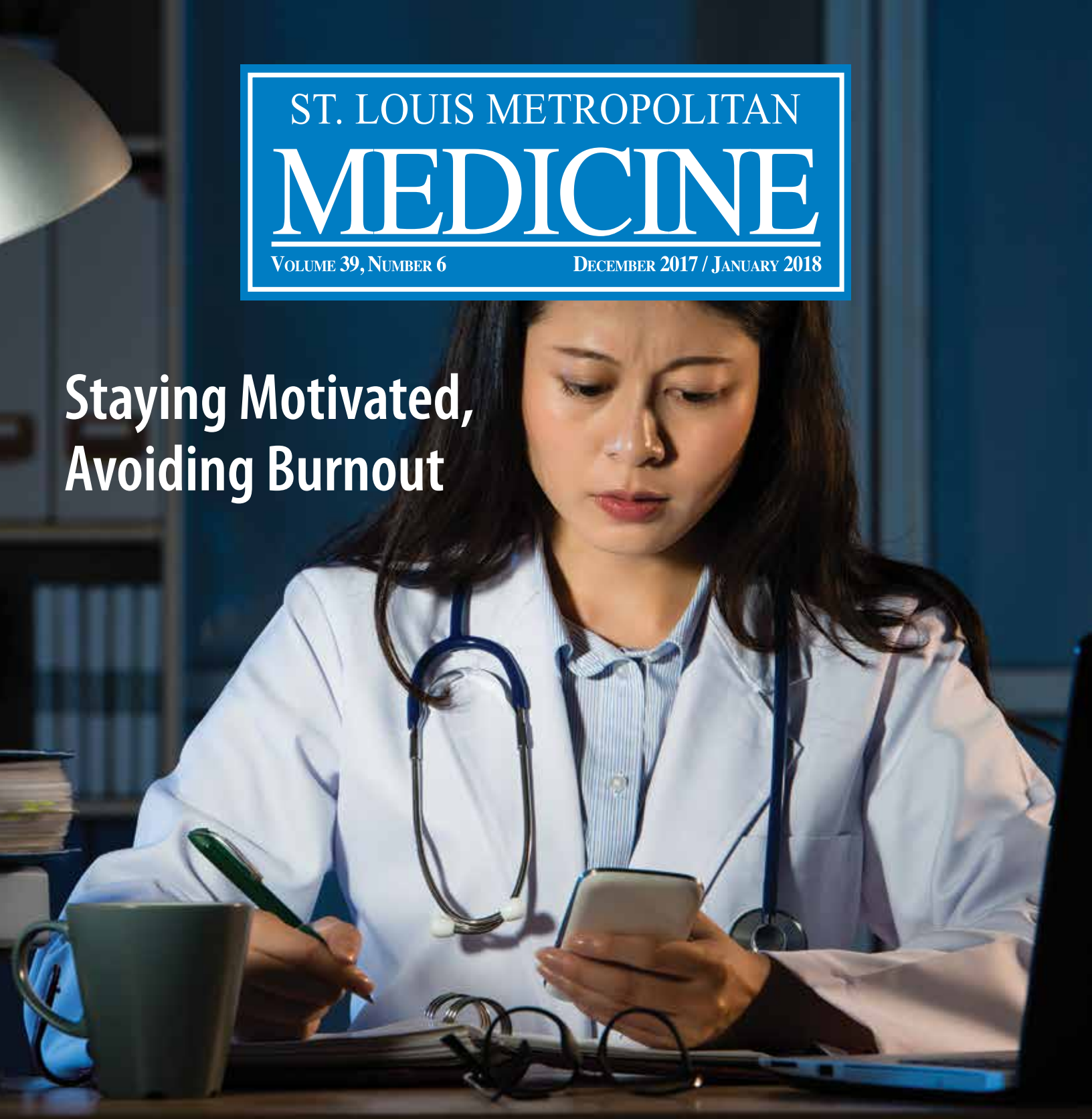
Staying Motivated, Avoiding Burnout



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We Need to Reflame the Fire Before It Burns Out

Lost control over work, EHR burdens, hours at work all contribute to spike in physician burnout

By J. Collins Corder, MD, FACP, Medical Society President

Medical Society President
J. Collins Corder, MD, FACP

Burnout is a long-term stress reaction characterized by depersonalization, including cynical or negative attitudes toward patients, emotional exhaustion, a feeling of decreased personal achievement and a lack of empathy for patients.

As physicians we are faced with challenges in patient care that involve making many decisions in a concentrated time frame and interacting with our peers to give appropriate care to our patients. We expect this as we have been trained to diagnose difficult problems and work long hours that lead to stress between our work and personal lives. The physician selection process is rigorous and eliminates those unable or unwilling to accept this lifestyle. Most physicians are altruistic and committed to their profession. They are taught to address complex problems and to embrace challenges, including grueling training, ongoing night calls and long work hours.

A Public Health Care Crisis

An escalating problem which is beginning to receive much-needed attention from health care leaders is physician burnout. Burnout is a long-term stress reaction characterized by depersonalization, including cynical or negative attitudes toward patients, emotional exhaustion, a feeling of decreased personal achievement and a lack of empathy for patients. The rate of physician burnout ranges from 30-65% across medical specialties, with the highest rates among physicians in the front line of care including emergency medicine and general internal medicine. We must address burnout among physicians as a national imperative as health care reform necessitates greater reliance on primary care.

The Quadruple Aim recognizes that a healthy, energized, engaged and resilient physician workforce is essential to achieve the national health goals of higher quality, more affordable care and better health for populations we serve. Studies continue to show more than half of physicians report at least one symptom of burnout, a substantial increase over previous years. This indicates that burnout among physicians has become a national health crisis that CEOs of institutions are recognizing. They are stating their commitment to address the root causes of burnout and reposition the health care work force for the future.[1]

We will address this scope of burnout and ways in which this is being dealt with in the medical community.

The Scope of the Crisis

Physicians from 27 specialties graded the severity of their burnout on a scale of one to seven in a recent Medscape survey—one being that it does not interfere, and seven indicating thoughts of leaving medicine. All but one specialty selected a four or higher. The most affected specialty? Emergency medicine, with nearly 60 percent of ED physicians saying they feel burned out, up from half in 2013. How can the rising prevalence and severity of burnout be addressed? Regulatory, systemic and practice environment issues appear to be key.

More than 14,000 physicians surveyed designated four concerns of too many bureaucratic tasks, spending too many hours at work, feeling like you're just a "cog in a wheel," and increased computerization of practice.[2] "Today's medical practice environment is destroying the altruism and commitment of our physicians," said Tait Shanafelt, MD, a hematologist and physician-burnout researcher at the Mayo Clinic, in a presentation at a NEJM Catalyst event last June. He also stated that "We need to stop blaming individuals and treat physician burnout as a system issue … If it affects half our physicians, it is indirectly affecting

half our patients."[3] In any other business this would call for immediate assignment of a team of system engineers, physicians and administrators to correct this catastrophic problem that affects quality of care, limits access to care, and is eroding patient satisfaction.

Issues of burnout get in the way of physicians' ability to provide care to a patient. This primarily relates to the physician's professional spirit of life, involving individuals who work in intense interaction with people. A physician's present daily activity is a double-edged sword: what makes doctors great also drives burnout![4]

The quality and safety of patient care, and indeed the very vitality of our health care systems, depend heavily on high-functioning physicians. In light of this compelling evidence that burnout negatively affects patient care, health care leaders are rightly alarmed and are searching for answers.

Burnout is a term that many professions both medical and non-medical experience on a daily basis. Does the physician burnout rate differ from that of the general working population? The AMA and the Mayo Clinic study published in the *Mayo Clinic Proceedings* found that physicians work a median of 10 hours more per week, display higher rates of emotional exhaustion and report lower satisfaction with work-life balance. This clearly is driving increases in physician burnout at a higher rate compared to the general U.S. population.[5]

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Sources of Burnout … The Flame Will Flicker

Studies clearly show that the more satisfied physicians are, the less likely they are to leave their practices. Physicians who have tried a go-at-it-alone approach have found they were impacted negatively. We must find ways to relieve this burden through team-based care.

As physicians we entered medicine to help patients. Obstacles that get in the way of patient care which are systemic or environmental should be the focus of change. The EHR system requires half of the physician work day to be devoted to entering data and performing other administrative desk work. The AMA and Dartmouth-Hitchcock Health Care System Time Motion Study found that only 27 percent of physicians' time is spent on direct clinical care. They also found that for every hour of face-to-face time with patients, physicians spend two additional hours on their EHR and clerical desk work.[2]

This spike in burnout is directly related to lost control over work, increased performance measurement, escalating complexity of medical care and EHR burdens and waste, all leading to altered workflows and changed patient interaction. The end result is that many previously well-adjusted physicians are prompted to retire early, give up teaching and mentoring young physicians, go into "nonclinical" business, or leave the profession altogether.

As a physician, I find a very trying problem is the "challenging patient." I do not mean patients who challenge my clinical expertise or that of my colleagues. I am referring to the patients whose circumstances make it impossible to arrive at a satisfactory therapeutic plan.

The example I will give is the 88-year-old who lives with her frail husband. Their children live in another state, their friends are no longer living or able to help, and they have difficulties finding transportation to office visits. She was stabilized in her recent hospitalization and sent out doing well, only to return as a readmission within the next 30 days. She refuses to be placed in a nursing home or assisted living facility. Since the social work team rates her as mentally competent, she is sent home from the hospital. She refuses home health services, saying she "does not need them." The medical team knows at the time of discharge and her follow-up visit in the office, that it will be only a matter of time before she will land in the ER as a readmission.

As the population ages, we will see more of these types of patients. We must find ways to deal with these situations in case management and public assistance to enable them to live independently. I am thankful for the many patients who do not fall into this category of the aging-challenging patient, but their number is increasing and that is very concerning.

Another problem I see in the "new" health care delivery reimbursement system is the primary care providers (both the physician and hospital) are the ones that have to bear the costs of these types of patients who are readmitted due to reasons beyond the provider's control. This creates a large amount of stress on the providers because the new value-based payment systems require the providers to pay back the system for something they cannot control. Yes, we as physicians are responsible to an extent, but we should not bear the burden for those who are incapable of caring for themselves or those patients who are irresponsible and non-compliant as they continue to smoke, not follow directions to change lifestyle, and/or do not take their medications.

Continued on page 4

Reflame the Fire… *continued from page 3*

Another primary care physician stress I have experienced is inheriting a patient in an advantage risk plan who has not been adequately worked up for a previous problem by their prior risk-participating physician who "gained" by not ordering certain tests. As the unhappy and undiagnosed patient then changes his care to another physician in the risk plan, the new physician and hospital system then become responsible for the high costs to treat that patient. Examples can include aortic valve replacement, defibrillator placement, or long-needed back surgery/intervention. This new physician and provider network may have to pay back the system if the limited funds for treatment are exceeded. Since the risk is now on the physician assuming care, he or she becomes a "victim" of this system. Unfortunately, the patient is caught as the victim as well. These are the added new stressors that make a physician look at early retirement and shorten a career which one thought would continue until we eventually "push up the daisies."

The experience from Atrius Health suggests that replacing a physician who retires early or leaves to pursue other career opportunities can cost between $500,000 and $1 million due to recruitment, training and lost revenue. All of this is in addition to the significant toll, sometimes with tragic consequences, that burnout exacts on physicians and their loved ones.[1]

Changing the Flicker to a Flame … Solutions and Help

I am sure that those reading this are not surprised by these results which are undercutting the patient-physician relationship. These problems take up the majority of our work day. Kevin Hopkins, MD, a family physician at the Cleveland Clinic, was staring at his computer screen rather than looking at his patient, when he concluded that if he did not have to do this documentation he would really like his work. His team developed templates for health maintenance reminders and he has made workplace modifications such as curtains to allow medical assistants to remain in the exam room to document while maintaining "privacy" for his patients. Multi-tasking skills have been developed for his MAs to be more engaged in patient care than they have ever been and they enjoy their work. Utilizing the MAs can give a big return on investment and achieve a real sense of team work resulting in better satisfaction for both the physician and the patient.[6]

Another suggestion is reducing the work time outside office hours, since physicians spend another one to two hours of personal time each night doing clerical work related to EHRs. (I have frequently referred to this as more "bean-counting work as we click!") By getting documentation support either through dictation or documentation assistant services, we may be able to increase direct clinical face time with patients and reduce "home office clerical hours."

Ways to Reflame the Fire

A very good collection of practice improvement start strategies can be found in the **AMA Steps Forward Module** as it relates to bringing team documentation to your practice. The collection offers several models to help physicians relieve the burden of current EHR in deficiencies as well as aiding EHR software selection, purchase and implementation.

An excellent local source is the **Missouri Physicians Health Program** which is sponsored by MSMA and local medical societies along with other health care systems. Sharing office space with SLMMS in St. Louis, MPHP is available to help physicians in many areas of mental health. They "know more than just substance abuse" as they address physician problems with mental health including stress, burnout, depression and suicidal thoughts. Their other areas of professional assistance are numerous.

Another source of assistance can be found in the article, "10 Bold Steps to Prevent Burnout in General Internal Medicine,"[4] which was initially presented at the annual meeting of the Society of General Internal Medicine in 2013.

Institutional Metrics

1. Make clinician satisfaction and well-being quality indicators.
2. Incorporate mindfulness and teamwork into practice.
3. Decrease stress from electronic health records.

Work Conditions

4. Allocate needed resources to primary care clinics to reduce health care disparities.
5. Hire physician floats to cover predictable life events.
6. Promote physician control of the work environment.
7. Maintain manageable primary care practice sizes and enhanced staffing ratios.

Career Development

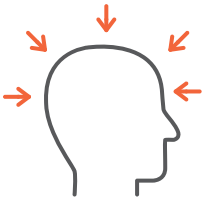
8. Preserve physician "career fit" with protected time for meaningful activities.
9. Promote part-time careers and job sharing.

Self-Care

10. Make self-care a part of medical professionalism.

These 10 steps are presented to identify stress at its earlier stages and choose programs to prevent it. Institutional success must include physician satisfaction and well-being. It also incorporates mindfulness and teamwork for training practicing clinicians. Mindfulness, a known stress reducer, is a means for internally accommodating external stress orders. Teamwork is critically important for burnout prevention through sharing and support of clinician workload. The patient-centered medical home is an example of this.

CEOs of health care institutions have a vital role; their attention is paramount to help in easing this problem of physician burnout. To further this objective, the CEOs of 10 leading health care delivery organizations held a summit meeting at the American Medical Association (AMA) headquarters in Chicago in September 2016. They concluded leaders must recognize burnout in the physician/health care worker and work in areas of burnout prevention and restoring the joy in medicine. Boards should hold CEOs accountable to implement these approaches to address physician burnout.[1]



Mindfulness, a known stress reducer, is a means for internally accommodating external stress orders. Teamwork is critically important for burnout prevention through sharing and support of clinician workload.

The strength of the physician's immediate supervisor's leadership has been shown to matter. Each one-point increase (on a five-point scale) in leadership decreases the odds of the physician burnout by 3.3 percent and increases satisfaction by 9 percent. Successful leaders hold career development conversations with their physicians, inspire and empower their physicians to do their job well, and recognize the physician for a job well done.[1]

This meeting came to the consensus that addressing burnout is a matter of urgency. A local hospital is addressing low patient satisfaction scores and is having mandatory physician meetings to improve scores in the future. They must address "physician burnout" as a source and contributor to these low patient satisfaction scores and how to constructively deal with this problem.

Volunteering

Last but not least, giving back to the community "recharges a doctor's battery" and provides new motivation as a full reset for physicians. It reminds us of why we chose medicine as our calling. Physicians deal with problems that have no easy fixes, including increased scrutiny, more administrative hassle, and rising costs and responsibility for controlling these costs—all while we are trying to give the best of care to our patients. Volunteering has its own rewards and the research bears that out. After adjusting for socio-demographic factors, multiple studies have shown that adults who volunteer enjoy better mental and physical health and have lower mortality rates. There are additional benefits for physicians as volunteering can serve as inoculation against physician burnout even to causes unrelated to medicine, according to Gail Gazelle, MD, hospice and palliative care physician in Boston, who provides executive coaching for physicians and physician leaders.[7]

Volunteering can be done in the form of serving the medical community or the nonmedical community. Since the early 1990s, I have found this to be very beneficial as I have served in a homeless center and coordinate one night a month in serving a group of 15-20 homeless people in our community. When I watch the impact on their lives and see their faces, sometimes the tears and hugs, it humbles me and makes me recognize that what I do has a lot of value. We can truly make a world of difference for people. It is true that I am tired on that Friday evening after working in the office as "I may drag into the door of the homeless shelter but on the next morning I am skipping out." My office staff volunteers to help; they have prepared food and worked with these homeless that we serve. It is a great team builder and I feel has helped bond our office. This has been an opportunity to help someone else and get our busy minds off of ourselves and the "hassle" of running an office.

Thoughts Overall on Turning Up the Flame

We need comprehensive, systematic and sustained efforts to improve physician well-being. The drivers of physician well-being must be addressed from the three reciprocally related areas: practice efficiency, a culture of wellness and personal resilience. A balanced approach is necessary to build this platform to drive sustained improvements in physician well-being and our health care performance. All of us in the health care system owe it to ourselves, to our patients and to generations to come, to work together for improvement in all areas of health care delivery.

Our patients deserve care from a compassionate, competent, caring, engaged and resilient physician. We must be committed to work with our patients, EHR vendors, medical leaders of our institutions, insurance companies, pharmaceutical companies, hospital CEOs, physician health programs, and last but not least our physician/health care colleagues and assist them in their daily dance with the crisis of burnout. ◄

Continued on page 6

Reflame the Fire… *continued from page 5*

Burnout Prevention Resources

AMA Steps Forward

- Seven key steps to help you prevent provider burnout
- Ten-item survey designed to assist you in assessing burnout
- Examples of successful burnout prevention programs in a variety of practice/organization settings

https://www.stepsforward.org/modules/physician-burnout

The HAPPY MD Website

- Physician burnout resources, trainings and tools

https://www.thehappymd.com/

Missouri Physicians Health Program

http://www.themphp.org/

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Early Deadline for 2018 Resolutions

The 160th Annual Convention of the Missouri State Medical Association takes place March 23-25, 2018, at the St. Louis Renaissance Airport Hotel. The deadline for submitting resolutions for inclusion in convention materials is Tuesday, Feb. 6, 2018, at 5:00 p.m.

Resolutions to positively influence the practice of medicine are an important part of organized medicine. We encourage all members of SLMMS, whether you are a delegate to the convention or not, to bring forward topics for resolutions. In consideration of the early convention dates and resolution deadlines, the SLMMS Political Advocacy Committee has established the following schedule:

- For a resolution to be introduced and sponsored by SLMMS, it must be presented and reviewed twice by our body of delegates. The first opportunity will be at the SLMMS Delegates' Briefing Session on Thursday, Dec. 14, 2017, at 7:00 p.m. in the First Floor Conference Room at the SLMMS office at 680 Craig Road in Creve Coeur. All District 3 delegates will receive a mailing announcing this meeting, but all SLMMS members are invited to attend.
- Resolutions accepted at that meeting will go forward for a second review to be held in conjunction with the monthly SLMMS Council meeting on Tuesday, Jan. 9, 2018, at 7:00 p.m. at the SLMMS office. Resolutions receiving final approval at this meeting will be submitted as sponsored by SLMMS.

If you are researching or planning a resolution, even if it's still in the conceptual stage, please notify the SLMMS office for it to be included in the meeting agenda. It is preferred, but not required, that the author attend both meetings to present the resolution. Visit the SLMMS website to view the 2018 SLMMS legislative priorities as well as the link to MSMA's Guidelines on Resolution Writing. If you have questions, contact the SLMMS office at 314-989-1014 or email dnowak@slmms.org.

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Into the Light

More physicians are coming to terms with the threat of burnout and how to address it

By David M. Nowak

Executive Vice President David M. Nowak

For years, physicians didn't talk about fatigue and burnout for fear of how it might be perceived. But we're seeing the conversation change.

Just a few short years ago, we would not have dedicated an issue of *St. Louis Metropolitan Medicine* to addressing the topic of "Staying Motivated, Avoiding Burnout." But so much has been written and researched on the topic of physician burnout, that what has been a well-documented problem for decades—beginning with the stress of medical school, continuing through the long work hours of a residency, followed by the various demands of practicing medicine—is now receiving more attention than ever as an epidemic among health professionals. As a contemporary problem in the field of medicine, it has stepped out of the shadows and into the light.

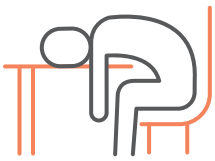
Ask any physician and they can tell you why they experience fatigue and burnout. It's an industry with continuously changing payment and reimbursement methods. The rapid growth of technology brings advancements in treatment and care delivery; but it has also created electronic medical records, patient portals and applications that require additional training and make more demands on a physician's time. The shift to quality metrics greatly impacts how care is provided, documented and reimbursed. The physician, whose work is critical to the success of all of the above, is constantly navigating a changing landscape. It's no wonder they're feeling stressed.

A recent report from the National Academy of Medicine found that more than half of the physicians in the United States are experiencing substantial symptoms of burnout. Physicians working in specialties such as emergency medicine, family medicine, general internal medicine and neurology are at the highest risk. Burnout is nearly twice as prevalent among physicians as workers in other fields after controlling for work hours and other factors. Between 2011 and 2014, the prevalence of burnout increased by 9 percent among physicians while remaining stable among other workers in the United States.

With all the studies about burnout, mindfulness and finding meaning in one's work, physicians are being offered positive solutions designed to help manage the problem. The National Academy of Medicine study concluded that despite decades of publications documenting the problem and some of its causes and potential consequences, many questions remain, and suggested the need for more research to identify organizational and health system factors that contribute to distress and threaten well-being.

Hopefully, we're beginning to see the signs of a cultural shift. For years, physicians didn't talk about fatigue and burnout for fear of how it might be perceived. But we're seeing the conversation change from "we don't talk about burnout" to "of course you work in a very intense environment that has an impact on you, so what are we going to do about it?"

So perhaps from the negative comes something positive. Shining the proverbial light on the topic of physician burnout forces us to examine its implications and the consequences of it continuing unaddressed. Doctors are coming to terms more with its causes and learning how to address it. In turn, they can find more meaning and fulfillment in their work and rediscover the joy of practicing medicine.



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More on the Anthem Outpatient Imaging Coverage Issue – Now It's Personal

In the last issue of this magazine, we shared with our readers how SLMMS was responding to the decision by Anthem Blue Cross and Blue Shield in Missouri to deny covering for outpatient imaging procedures performed at hospitals (*St. Louis Metropolitan Medicine*, October/November 2017, p. 21). Since then, you can add me to the Anthem patients victimized by this intolerant policy.

My physician recently ordered an MRI following the preliminary diagnosis of spinal stenosis from spine and shoulder X-rays. Fully aware of Anthem's policy, I scheduled my procedure at an outpatient facility, only for it to be denied because the center was hospital-owned. Bad karma for me, I guess, for calling out Anthem's non-patient friendly policies in print. But I experienced first-hand how the insurance company undercuts the physician-patient relationship. It didn't seem very fair. When the issue strikes so close to home, it only adds to the determination to see such policies overturned. ◄

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2018 Physician Leadership Institute Begins February 10

With a slightly modified schedule, the Physician Leadership Institute returns in 2018. The program will be presented over five Saturdays from February 10 through April 28, including four half-day morning sessions and one full-day session.

The highly-interactive, high-intensity course is designed for physicians only, and focuses on the development of leadership skills and a better understanding of the business side of practicing medicine. The PLI is planned and presented by Anders Health Care Services, Maryville University and SLMMS.

Tailored for physicians who want to improve both their practice management and leadership skills, the PLI covers current relevant topics such as population health management, technology in health care, recent developments in employment law, and a better understanding of revenue cycles, documentation and coding, and reimbursement. Experts also provide updates on legal issues in medicine, medical ethics, and a practical risk management discussion. The program also includes a session aimed at reducing the risk of burnout and promoting balance in the medical practice.

Responding to input from past participants, the program has expanded its focus on building leadership skills. These are the primary topics of the first and final sessions, the latter now designed to be a "capstone" session aimed at application of the knowledge gained for future success.

The sessions on Feb. 10 and 24, as well as April 7 and 28, will be half days running from 8:30 a.m. to 12:15 p.m. The middle session on March 10 is planned as a full day from 8:30 a.m. to 3:30 p.m. Classes will be held at Anders' educational facilities in their offices at 800 Market Street, Suite 500, in downtown St. Louis. Up to 20 CME hours will be awarded for completion of the entire curriculum. Tuition is $900, discounted to $600 for SLMMS members or Anders clients. Group discounts are also available.

Nearly 40 physicians from St. Louis and throughout the state have graduated from the earlier Physician Leadership Institutes. These alumni will be invited to join this year's participants for the final session to share how they are incorporating what they learned in the program in their medical careers.

Interested physicians may register as well as view the full curriculum and speaker line-up at www.anderscpa.com/physician-leadership-institute or use the link found on slmms.org. For more information, contact Dave Nowak, SLMMS executive vice president, at 314-989-1014 or dnowak@slmms.org. The deadline for registration is Wednesday, Jan. 31, 2018.

THE 2018 PHYSICIAN LEADERSHIP INSTITUTE

February 10 and 24
March 10
April 7 and 28

- The February and April sessions meet from 8:30 a.m. – 12:15 p.m.; the March 10 session meets from 8:30 a.m. – 3:30 p.m. (lunch included)
- Anders Headquarters, 800 Market St., Suite 500, St. Louis
- Up to 20 CME hours will be awarded
- Tuition: $900 for six sessions ($600 for SLMMS members)
- Information/Registration: www.anderscpa.com/physician-leadership-institute

Members of the 2015 PLI class, from left: Drs. Jack Galbraith, Michael Beat (SLMMS), Sri Kolli (SLMMS), Christopher Bowe (SLMMS), James DiRenna, Sandra Ahlum, Mary Grimm (SLMMS), Lent Johnson, Sunny Desai, Radna Patnana, David Pohl (SLMMS), Sarah Snell, Yazan Abdalla, Helen Nguyen, Alan Sandidge, Adam Fitzgerald, Fangxiang Chen, Raghav Govindarajan, Steven Shields (SLMMS), and Ari Levy. Not pictured are Drs. Eric Baggstom, Maria Baggstom, John Galanis (SLMMS), Bassam Hadi and Babul Kulkarni.

Members of the 2016 PLI class, from left: Drs. Lisa Thomas, Bridget Early, Munier El-Beck (SLMMS), Susan Meidl, Ernest Graypel, Pearl Serota (SLMMS), Roderick Bartlett, Toniya Singh (SLMMS), I.J. Singh (SLMMS), Ravi Johar (SLMMS), Brian Bergfeld, and Jeffry Evans. Not pictured is Dr. Michele Woodley (SLMMS).

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A Three-Part Prescription for Combating Physician Burnout and Restoring Balance

Burnout and professional satisfaction are a shared responsibility between individual physicians and the organizations that employ them

By Kathy Gibala

Physician burnout is a complex issue and a growing concern across the country. The statistics are alarming. For example, according to a Mayo Clinic study conducted in partnership with the American Medical Association, between 2011 and 2014 there was an almost 10-point increase in physicians who reported feeling burned out (45% in 2011 vs. 54.4% in 2014), with more than half of physicians reporting that they were feeling at least one symptom of burnout.[1] An October 2016 *New England Journal of Medicine* survey indicated that 96% of executives, clinical leaders and clinicians overwhelmingly agreed that physician "burnout" is a serious or moderate problem in the health care industry.[2] Similarly, in the Advisory Board's 2016 topic poll, 90% of medical group executives identified burnout across the organization as a high-level priority with more than half indicating that reducing burnout is at the top of the priority list.[3]

Burnout affects physicians across all specialties and is particularly acute in primary care. This has potentially significant consequences for physicians, practice teams, medical groups, health care organizations and patients across the continuum of care. It is encouraging to see that organizations are grappling with and seeking meaningful solutions to this multi-faceted issue.

What are the potential implications? According to the Mayo Clinic, some potential professional and personal implications of physician burnout include decreased quality of care, increased medical errors, decreased patient satisfaction, reduced productivity, physician turnover, broken professional and personal relationships, alcohol and substance use and mental health issues.[1]


Kathy Gibala

Kathy Gibala is a leadership coach, trusted advisor and change catalyst for health care executive and physician leaders across the U.S. who are seeking to raise the bar on their leadership, build high performance teams, facilitate transformative change and accelerate results. Based in St. Louis, she is a senior vice president with MEDI, a firm dedicated exclusively to the development of health care leaders and teams. She can be reached at kgibala@medi-leadership.org, 636-536-9443 or 904-543-0235.

What is burnout?

Burnout is different from day-to-day stress or job dissatisfaction. While stress is characterized by over-engagement, burnout is characterized by disengagement. It is often defined as a loss of enthusiasm for work (emotional exhaustion), feeling more callous or cynical (depersonalization), and a low sense of personal accomplishment. Often it's a feeling of being disconnected from one's core purpose.[4]

What causes physician burnout?

Many factors can contribute to physician burnout. Some examples include increased workload and productivity expectations, expanding regulatory and documentation requirements and inefficient workflows. Others are feeling undervalued and uninvolved, frustration with referral networks and reimbursement, staffing issues, difficult patients, medicolegal issues and challenges in finding work-life balance. This is not an exhaustive list as the causes of burnout are often unique and variable from individual to individual and between groups.

How can organizations and physicians address burnout?

Despite the increased recognition of the problem and the visibility of the issue in the national media, organizations and physicians struggle with identifying and implementing clear action steps for addressing physician burnout. Organizations are beginning to recognize that burnout and professional satisfaction are not solely the responsibility of individual physicians but rather an area of shared responsibility. Below is a three-part prescription or framework, focused on actions that individual physicians, the practice/workplace and the

An end of day self-check-in provides individual physicians a moment to intentionally reflect on where he/she made a difference. Physicians who find their work meaningful are less likely to be burned out.

organization can take to help better recognize, reduce and address burnout and promote balance.

1. **Individual Physicians:** As a leadership coach to physicians and health care executives, I tend to focus first on the individual. How can individual physicians combat burnout and restore balance in their lives? Physicians often have a strong sense of commitment and personal responsibility so it can be difficult to admit feelings of burnout. Individual physicians must take an honest look at themselves. They can help themselves by identifying what being "in balance" means for them, creating a clear mental picture and writing down examples of what it looks/feels likes to be in balance. Through this they should take into consideration the domains of ***Body*** (nutrition, exercise, sleep); ***Heart*** (personal values, what is important); ***Mind*** (self-awareness, presence, emotional regulation, how they interpret things); and ***Spirit*** (sense of peace, purpose, gratitude, meditation, positive energy).

   The physician can then honestly assess the gap between where he/she is and would like to be and create a simple personal action plan with specific, meaningful actions that he/she will take to help improve personal balance and reduce the potential for burnout. Other helpful tips are to actively seek out resources to promote resilience and self-care, take a one-minute mini-meditation break at various times during the workday, engage in hobbies or activities that are meaningful and incorporate an end-of-day self-check-in. The self-check-in provides a moment to intentionally reflect on the bright spots in the day—what went well and where he/she made a difference. Physicians who find their work meaningful are less likely to be burned out.

   With regard to feeling a lack of control, it is true that physicians have lost some autonomy overall as more physicians have entered into employment or affiliation arrangements and the practice of medicine has become more regulated and standardized. However, there are many meaningful things that physicians can directly control or actively influence. Physicians may have opportunities to lead or actively influence the design of care delivery systems and processes, for example. A simple tool like Stephen Covey's Circle of Control can help physicians reconnect with things they can control (the inner circle) and meaningfully influence (the outer circle) and serves as a reminder to focus valuable energy and time on the things inside these circles and not on things which they can neither control nor meaningfully influence.[5]

2. **Practice or Work Setting:** As leaders in the practice/work setting, physicians can help to proactively manage the risk of burnout for themselves, their colleagues and their teams. Examples of meaningful activities in this arena include:

- Acknowledge and assess the risk for burnout
- Recognize signs of burnout and offer support
- Facilitate role clarity and reinforce how roles meaningfully contribute to patient care
- Train team members to optimal performance
- Conduct daily huddles
- Seek input, listen, offer choices, act and close the loop
- Develop adequate administrative support systems
- Build positive relationships, trust and a collaborative team culture "We, Our, Together…"
- Enhance connection to purpose; Ask "What matters to you?" and collaborate to identify and address the unique impediments to joy in the workplace[6]
- Show appreciation for the team and its members; celebrate successes
- Collaborate to improve quality, efficiency and service
- Make meetings meaningful and accountable
- Implement practices and policies that provide choices, flexibility
- Establish appropriate expectations for patients
- Promote and be a positive role model for work-life integration and well-being

3. **Organizations:** Organizations play an important part in understanding and addressing physician burnout. Assessing the risk for burnout, through a survey or other method, and partnering with physicians to better understand and address opportunities for improvement is key. Developing strong physician leaders is also important as their leadership qualities directly impact the well-being and satisfaction of individual physicians, according to results of a Mayo Clinic study.[7]

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A Three-Part Prescription…

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In addition to the actions listed under the practice/workplace section above for consideration, organization leaders can help build trust by maintaining an open and ongoing two-way dialogue, listening, actively engaging physicians and giving them choices in organizational and operational initiatives. Organizations are using a variety of methods to facilitate meaningful dialog, including one-on-one and small group discussions, forums and rounding. Creating meaningful opportunities for physicians to lead or participate in areas such as care model design, system, process and quality improvement, EMR templates and interfaces, etc. can help align everyone around creating a care experience that is safe, compassionate, coordinated, high-quality and cost-effective. Organization and physician leaders can also collaborate with payers, EMR providers, regulators and others to help encourage continuous improvement, improved usability and reduced clinical burden.

We know physician burnout is a serious and complex issue that won't be solved overnight. However, there is hope. I believe changes are on the horizon since meaningful conversations are occurring and because there is a great deal of joy in the practice of medicine. It is important to remember that not all providers are burned out and many who experience burnout can and do recover. Incorporating some of the strategies outlined above can help physicians, their practices and organizations move to deliberate, meaningful and sustained action to positively address this important issue.

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HARRY'S HOMILIES©

Harry L.S. Knopf, MD

ON BURNOUT

You know you are near the end of your career when you exhibit signs of "compassion fatigue."

I'm sure you have seen the WWII movies about soldiers with "battle fatigue." This was the term used before we knew about PTSD. Now we understand that constant stress and trauma may overburden one's psyche and lead to depression, illness, and even suicide. I would like to introduce you to a term applicable to us physicians: compassion fatigue. It usually occurs at the end of a long career in which "caring" is a major part of the service. (My senior partner once told me that each time you perform surgery on one of your patients, you leave a little of yourself—until there is no more.) These are the essentials of compassion fatigue: You have given so much of yourself to help others, that you run out of compassion. You may recognize it by the fact that you no longer get pleasure from explaining a problem to your patients. Perhaps you cut people off on phone calls. Maybe you are angry, or frustrated or sad. Whatever is your set of symptoms, try to recognize them for what they are. Take time off, retire if you can or do something else that requires less of your personal responsibility. You will thank me—and so will your patients!

Dr. Knopf is editor of Harry's Homilies.© He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

The Missouri Physicians Health Program: A First Response for Victims of Burnout

By Robert Bondurant, RN, LCSW

In the early 1970s a remarkable event occurred. Concern shared by the American Medical Association and the Federation of State Medical Boards resulted in an effort to help "the sick physician." Substance abuse among physicians and physician suicide were the primary issues.

They sponsored educational programs about the "sick physician." Because of the increased awareness that was generated, a plan was formulated. It was decided to sponsor a physician health program in each state under the leadership of each state medical association.

This new development came to the attention of a Missouri anesthesiologist, Don McIntosh, MD, who practiced in Kansas City. He had a strong interest in helping troubled colleagues, and thus in the mid 1970s, introduced the concept of showing compassion to his colleagues by initially offering his services as a one-man program. Later, in concert with the Missouri State Medical Association, a statewide program was initiated in the mid-l980s. Dr. McIntosh was part of the leadership that provided oversight for the fledgling program.

The first clients were primarily those with substance abuse issues. The most significant concept that the MPHP introduced to help these physicians was monitoring following a period of treatment. The gold standard that was implemented was five years of monitoring.

It has been my experience that only one-third of those referred to treatment are still in recovery after one year. However, when physicians were required to be monitored, the success rate was in the 90th percentile after five years. This experience was confirmed by a study conducted by the MPHP and published in the *Journal of Addictive Diseases*. The years covered by the study were 1990–2002. The rate of recovery was 90%.[1]

The concept of a physician health program blazed a new trail for professionals. Physicians were the first to mobilize resources to help their colleagues. Several other professions have followed in the physician footsteps.

Robert Bondurant

Robert Bondurant, RN, LCSW, is executive director of the Missouri Physicians Health Program. He can be reached at 800-958-7124 or rbondurant@themphp.org.

When physician health programs were first developed, the country did not have the problematic medical landscape that we have today. Our services have been expanded to include mental health, behavior and boundary issues. In Missouri, virtually any problem that interferes with a physician's ability to practice can be addressed. The target population now includes physicians-in-training, both medical students and residents.

Burnout: A Fundamental Issue

Today we have a new concern that was not identified in the 1970s—burnout.

The subject of physician burnout has become a major concern since Tait Shanafelt, MD, published the results of his survey on burnout in the *Annals of Medicine* in 2002. After joining the Mayo Clinic staff, he was tapped to head Mayo's Physician Well-Being Program. He and his team published the first national study on physician burnout in 2010. The study attracted national attention with its findings that 45% of physicians were expressing professional burnout.

Colin West, MD, a member of Shanafelt's team, who also brought the same topic into the national prominence, said: "Ten years ago, burnout was something you just didn't talk about. The traditional attitude was that physicians were supposed to be super-humans, immune from burnout and capable of handling anything."[2]

Burnout is often manifested in all the areas now responded to by the MPHP. Burnout is a fundamental issue that can lead to a dysfunctional response.

Mosby's Medical Dictionary addresses the definition of burnout as follows:

> *A popular term for mental or physical energy depletion after a period of chronic, unrelieved job-related stress characterized sometimes by physical illness. The person suffering from burnout may lose concern and respect for other people and often has cynical, dehumanized perception of people, labeling them in a derogatory manner.*[3]

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The Physicians Health Program… *continued from page 15*

Burnout can be manifested as the disease of addiction, mental illness, sexual activity, eating disorder, grumbling, disruptive behavior and, therefore, all the problems that the MPHP encounters.

Prevention: A Balancing Act

Hospitals, groups, and colleagues call us with many concerns. These usually include substance abuse, troubling behavior or performance issues. The MPHP can intervene or will provide a one-on-one assessment before referring to the appropriate caregiver.

The MPHP is usually the first caregiver that is called to conduct an evaluation and then initiate an appropriate response. We are first responders for troubled physicians.

Physicians are great caregivers but have not been taught how to take care of themselves. They have been trained that the patient comes first and to never show weakness.

I would like to refer you to a series of articles presented in the *Missouri Medicine* magazine on burnout. These three articles were written by coach and trainer Dike Drummond, MD, and provide a good clinical overview of burnout. They are to be found in the July/August, September/October and November/December 2016 issues. In addition, there are many good articles available on the Internet about the current work on burnout at the Mayo Clinic.

Dr. Drummond, in the introduction to his second article, offers these insights about burnout:

> *Before we begin you must understand that burnout is not actually a problem. Let me explain.*
>
> *Problems have solutions. When you apply a solution to a problem, what happens to the problem? It goes away … yes? So often physicians come to me asking, "What is the one thing I can do to lower my stress levels and make burnout go away?" Notice how this request presumes burnout is a problem that has a solution. When you can't find that "one thing," many doctors simply slide back into their old work habits and give up on the possibility that things could be different.*
>
> *In reality, burnout is a dilemma. It does not have a solution, because it is not a problem in the first place.*
>
> *Dilemmas are perpetual balancing acts. You are "between the horns of a dilemma," taking specific actions every day, week and month to maintain the balance you seek. You address a dilemma with a strategy, not a solution. By its nature, a strategy has multiple parts and in order to maintain balance you have to be measuring how you are doing in some fashion.*

The MPHP is usually the first caregiver that is called to conduct an evaluation and then initiate an appropriate response. We are first responders for troubled physicians.

> *The fundamental question at the heart of preventing burnout is this: What is your burnout prevention strategy and how are you measuring your effectiveness?" The horns of the burnout dilemma are the amount of time and energy you put into your practice on one side and your ability to maintain a positive energy balance and your desired quality of life on the other.*
>
> *Dilemmas are very common in health care. Here are just a few examples: burnout, your compensation formula, the best care at the lowest cost, your call schedule, your accounts receivable, work-life balance, and EMR.*
>
> *From this point forward, we will be discussing tools to lower stress by increasing your efficiency at work and decreasing the time it takes to complete the tasks of your practice. One way to measure your effectiveness in this effort is to track the amount of time between your last patient leaving the office and you getting home—with your charts done.*
>
> *Each tool is a potential component of your personal burnout prevention strategy. You may be utilizing some of these already. If so, make sure you read the Power Tips for that technique. As you read, take note of the tools that seem simplest to implement or feel most attractive to you. I will be giving you implementation pointers at the end of the article.*
>
> *Remember nothing changes unless you change your actions. This is an active learning process.*[4]

Dr. Drummond supports the MPHP method of involvement with physicians suffering from burnout. We address the problems that stem from burnout, rather than prevention. Our resources are dedicated to the responses to the problem of burnout: substance abuse, disruptive behavior, mental health issues, legal and social ramifications.

MPHP: Your First Responder

The MPHP provides educational presentations throughout the state every year to medical students, residents and medical staffs. Through these lectures, we hope to provide information about the availability and type of help that can be provided through the MPHP.

Each physician and physician-in-training that is referred to the MPHP will learn about the necessity of lifestyle change that can minimize the effect of burnout.

Burnout is a dilemma that requires awareness and personal commitment to change. The MPHP will support and encourage this effort. But the resources of MPHP are dedicated to extricating our clients from being trapped by the problem caused by burnout. Our resources include legal, psychiatry/psychological, multi-disciplinary evaluation, residential/in-patient treatment, counseling and medical services provided by third-party professionals. We do not diagnose or treat. The MPHP responds, assesses and refers to the appropriate third-party resource. The MPHP will then monitor the implementation of the recommendations from those resources.

The role of the physician health program has greatly expanded from what was visualized in the 1970s. In view of the evolving stresses and complications encountered by physicians, this is the right program for today's physician.

The MPHP is **your first responder**. Start with us. We can guide you to the appropriate resource, document your progress and then advocate for you with the pertinent regulatory or legal authorities.

Contact MPHP

800-958-7124

info@themphp.org

www.themphp.org

Facebook: MissouriPhysiciansHealthProgram

24 Hour Telephone Hotline: 800-274-0933

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SLMMS Members Discuss Their Strategies for Promoting Personal Wellness and Preventing Burnout

From exercise to family time to mindfulness, physicians strive to stay ahead

1 What do you do to promote your personal wellness and prevent burnout?

2 What should the health care system do to reduce and prevent physician burnout?

Anjum Shariff, MD
Radiology, Midwest Radiological Associates

1. Contributing factors to burnout come from within an individual and externally. We can control internal factors better than external ones most of the time. Having a positive attitude, keeping challenges in perspective, understanding that things could always be worse, and believing that all things happen for the best are how I deal with my immediate stressors. External factors are more varied and require concrete approaches.
2. Health care systems can go a long way to reducing burnout by seriously considering physician input in software purchases and various organizational processes. Health care systems should seriously consider the impact on their physicians' workplace satisfaction as it relates to the tools they must work with.

Holly Kodner, MD
Ob-Gyn, Balanced Care for Women

1. I try to maintain balance in my life by creating clear definitions in my priorities and finding partners and employees who respect and support my needs. I could not maintain any sort of balance without the support of those around me. There is a fairly equal give-and-take between my family and my practice.
2. No single change can fix the problems. However a lot of issues come down to decreasing reimbursements and frustrations regarding how physicians have such little input in justifying how much their time and effort is worth in caring for another person.

Kirsten Dunn, MD
Internal Medicine, Washington University

1. I am fortunate to have balance built into my work. I see patients in primary care clinic half the time and do academic work with the remainder. My job also allows for some flexibility and schedule control, both of which contribute to increased work satisfaction. Outside of work, I prioritize exercise and family. I do a kickboxing workout three times a week. I always leave the gym with more energy, less stress, and in a better mood. On the weekends, I try to stay present with my family and don't regularly check work email. I also prioritize healthy sleep patterns and food choices, because those can really make a difference in energy level and mood.
2. While system issues like electronic medical records and administrative tasks can be burdensome, I think much progress can be made by ensuring that physicians have the resources and time to truly be the doctors/healers/caregivers we intended to be. We also should have the opportunity to be involved in any decisions or changes that affect our daily work.

Paul Ganninger, MD
Family Physician, Esse Health

1. I exercise often and found a practice where volume was not emphasized or rewarded.
2. The health care community needs to promote quality care over quantity and compensate accordingly.

1. Maintaining personal wellness is paramount to my ability to work as a solo practitioner who takes calls 24/7. I eat a mostly clean diet and work out daily. In addition, I play in a handball and bowling league and keep my social and family life rich. Every weekend includes at least one fun activity with my son. My wife and I have a date every Saturday night. On a larger scale, we make it a priority to leave town for a weekend or a longer trip. This allows me to totally unplug. Because I work around the clock, I balance this by limiting my office hours to about 25 hours a week.
2. The health care system could make hours reasonable and regulate quotas. Family and personal time should be encouraged or made mandatory. Perhaps work/family activities could be facilitated by the workplace. Unassigned patient call should be limited. Mental health services ought to be made readily available to physicians and promoted to reduce stigma. Insurance issues and time spent dealing with the often unreasonable insurance system needs to be remedied.

Shanon Forseter, MD
Ob-Gyn, Private Practice

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1. One key to preventing burnout in medicine is focusing on purpose. Whether it is making your patients' lives better, refining/improving health care delivery, providing for your family, or supporting charities, these concepts provide additional "worth" to what we do every day. Another method for me is that I started working out about five years ago and have gotten into a routine so now it feels abnormal if I don't exercise. Finally, most physicians would benefit from the insight of this prayer: "God, grant me the serenity to accept the things I cannot change, the courage to change the things that I can, and the wisdom to know the difference." Personally, I am still working on this one!
2. The health care system should improve EMRs so they are actually more physician friendly, deregulate the over-regulated health care industry, make common sense malpractice liability reforms, outlaw non-compete clauses in physician contracts, and allow collective bargaining for physicians.

Gregory Galakatos, MD
Orthopedic Surgery, Mercy Clinic

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1. I try to exercise regularly, eat healthy food and disconnect from technology as much as possible when I'm not at work.
2. We need to swing the pendulum back to having doctors see fewer patients and get reimbursed more for each patient visit. We also need to improve our electronic health records so that they make the work of documentation easier rather than harder.

Lisa Alderson, MD
Cardiology, Saint Louis University

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1. I started running about three years ago when a medical student challenged me to do a 5K. Best challenge ever! I did make it with a slow but steady pace and I now run almost daily and about 50 miles per month. I left my previous triple-hat job to work for UnitedHealthcare. The company supports time off, including time for my running.
2. Most physicians want to meet the demands of current medicine but often don't have the support and staff needed. I also feel that shift work is a huge problem and when working full time never wanted to take a vacation because you had to make up the time. Most physicians just need a little "me" time built into their lives. Encourage free gym memberships, on-site massage therapy or other pro-active wellness approaches. Physicians need to learn to be more humanistic in their lives.

Kimberly Perry, DO
Emergency Medicine, UnitedHealthcare

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1. I try to maximize the quality of my free time by spending it with my wife and attending my children's events. I also like to travel and duck hunt. My personal fitness plan includes running, use of an elliptical trainer and light weightlifting.
2. It is the responsibility of each physician to manage his or her mental well-being while practicing medicine. However, system-wide changes that could help decrease physician dissatisfaction, stress and burnout would include strategies to decrease "on-call" duty, continued tort reform efforts, elimination of prolonged-duration non-compete employment clauses and improved physician-insurance company interaction (prior authorizations, etc.).

James Forsen, MD
Pediatric Otolaryngology, Sound Health Services

Surviving the Stress: Malpractice Risk Reduction

Ways to reduce the risk of a lawsuit and tips on working through the process in the event of litigation

By Diane S. Robben, MGMA St. Louis

Think back to when you first decided you wanted to be a doctor—that feeling deep in your soul of pride, accomplishment and amazement that you would be helping people improve their lives, and even save lives. You made it through medical school, your residency, fellowship and training, and finally landed at that first real job. However, as the years go by, if you are like most physicians, your altruistic vision of practicing medicine becomes tarnished by the ever-increasing stress of the complexities of reimbursement, regulations, litigation and compliance that seem to eat up more and more of your time. The stress of all this "business" of health care can take its toll on even the best of practitioners. Having some perspective and resources which can help you stay the course is essential to maintaining your professional career.

If you have not yet had to defend a medical malpractice lawsuit, just wait—your turn will come. According to statistics, the average physician spends nearly 11 percent of a 40-year career with an open unresolved lawsuit(s).[1] The average case may take two, three or four years to resolve, whether through settlement, as most often happens, or trial. Regardless, the stress and emotional toll a lawsuit can have on the accused can often be insurmountable. Having a realistic perspective of the process, and open communication with your trusted advisors, can help you survive the stress.

Diane S. Robben

Diane S. Robben is a shareholder with Sandberg Phoenix & von Gontard, focusing on health law. She frequently defends physicians, hospitals, nurses and others in defense of medical malpractice claims. In additional to litigation, Ms. Robben leads the firm's transactional and regulatory practice where she advises health care providers on various risk and compliance issues. She is the vice president–business partners for MGMA-St. Louis. She can be reached at 314-446-4274, drobben@sandbergphoenix.com.

As an attorney, I am challenged daily with the complexities of litigating a malpractice case, researching a nuance in the ever-changing health care system, or navigating the administrative red tape of governmental regulations. However, there are days when I get the satisfaction of knowing that I can truly help health care providers get through one of the scariest times in their lives—days when I get to be the "counselor" of Attorney and Counselor at Law.

The stress that comes along with defending a medical malpractice lawsuit can consume you and adversely impact your daily functioning. There are several tips that can help you through the process, and others to help reduce the risk of a lawsuit being filed. When you first receive the suit papers, there is a myriad of emotions that rush through your mind—anger, fear, frustration, sadness, embarrassment. What follows are some tips to help you work through the process and stress of defending a malpractice suit, and how to prevent them.

Documentation, Documentation, Documentation

Good documentation can provide a written testimony of your actions and reasoning at the time the events occurred. Lawsuits are usually filed years after you last treated a patient and your documentation can provide the best evidence of what occurred. It often serves as its own witness at trial, in living color and bigger than life enlarged for the jury to see. Poor documentation tends to be a driving force behind the filing of lawsuits. The lack of essential details, a thought-out plan, or rationale for the treatment often form the basis of claims against a health care provider. Therefore, it is best to regularly chart everything as if the document was going to serve as your recollection in court. Get into the habit of completing medical records in a timely and complete fashion. If you utilize templates, fill in all the blanks.

Relationships Matter

Patients typically do not sue doctors they like, and may be more forgiving if they believe you care. Establishing a solid relationship with your patients and having thorough communication can go a long way when and if a complication occurs. When defending lawsuits, I often ask the patient plaintiff why they've brought the lawsuit or what they believe the defendant doctor did wrong. Many times it's the lack of communication when something has gone wrong, and the failure to explain the events or take the time to show concern. By the time I am asking that question of the plaintiff, which is often the first time, it is more than two years after the event and the patient has a lot of built-up anger that finally comes out. Imagine how effective diffusing that anger during the hospitalization would be, before they've hired a lawyer. Bottom line, when you encounter a complication with your patient, do not disappear, do not avoid talking to them—tackle it head on.

Follow Up and Monitoring

A leading basis for malpractice suits that we see is for failing to follow up on test results or missed appointments. It is imperative you develop a process within your practice for reviewing and following up on abnormal test results, such as labs, imaging and cardiac testing. While patients certainly have an obligation to advocate for their own health care, when abnormal test results are in your chart and you've not addressed them, hindsight is 20/20 through the lens of a plaintiffs' lawyer. Utilize your support staff to record follow-up and missed appointments.

Create Reasonable Expectations

When speaking with a patient to obtain informed consent for a procedure or a planned course of action, involve the patient and family in the discussion and decision-making, encourage them to ask questions and listen. It is also imperative you create reasonable expectations for patients, who are more likely to be forgiving if a complication occurs which they were aware of ahead of time. Furthermore, document those conversations in the medical record.

If you find yourself served with a lawsuit, there are additional steps you can take to aid your defense lawyer and also ease the stress it creates for you.

Gather the Entire Chart

Your attorney will need the complete medical record on the patient, including all correspondence, secondary records and other sources that are part of your contact and care of that patient. It is imperative that you provide the entire set of records, including those you gathered from outside sources that form part of the thought process of how you cared for a particular patient. Spend time personally reviewing the chart for completeness before it is sent off to your attorney. Be sure to send the entire record and all communication, and your attorney can then determine what will be produced in litigation as the official legal health record.

Be Patient

Most lawsuits move at a snail's pace. There is quite a bit of fact-gathering, referred to as discovery. This is the phase when both sides are gathering information from their opponents and also from outside sources to piece together the puzzle. In addition to your office records, it is important for your counsel to gather medical records from prior and subsequent treaters to better understand the full picture of the plaintiff's health care. You can assist your counsel by making suggestions of other providers you are aware of or family dynamics that may be relevant to defense of the case. Don't be afraid to ask, or to make suggestions. This open dialogue with your attorney will be beneficial to the defense of your claim.

Ask Questions

Hopefully your attorney will keep you updated as the case proceeds and provide details of depositions and other investigation into defense of your case. Review the reports and offer suggestions and additional follow-up to your counsel. Don't be afraid to ask questions.

Don't Go It Alone

You are not alone in defending a malpractice case. Rely upon your attorney, your colleagues, support networks or others to keep your perspective. There are a wealth of services out there to assist practitioners in dealing with stress and depression.

Finding a balance between your passion for medicine and the headache of the "business" of health care can be challenging. Surround yourself with great support staff, such as an educated medical practice manager, competent legal counsel, and qualified employees and you will be well on your way to surviving the stress.

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1. Seabury S, Chandra A, Lakdawalla D, Jena A. On Average, Physicians Spend Nearly 11 Percent Of Their 40-Year Careers With An Open, Unresolved Malpractice Claim. *Health Affairs*. 2013 Jan;32(1):111-9. http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.0967

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SLMMS 2018 Annual Meeting and Installation Banquet

SATURDAY, JANUARY 27, 2018

The Chase-Park Plaza, Starlight Ballroom

212 NORTH KINGSHIGHWAY BLVD., ST. LOUIS

6 P.M. COCKTAIL RECEPTION
7 P.M. DINNER AND INSTALLATION

Installation of Christopher A. Swingle, DO, as SLMMS 2018 President
And the 2018 SLMMS Council
Presentation of SLMMS Awards

Watch for your invitation in the mail.
Information: Liz Webb, 314-989-1014 ext. 100, lizw@slmms.org

CALENDAR

DECEMBER

12 SLMMS Council, 7 p.m.

14 SLMMS Delegates' Briefing on Resolutions, 7 p.m.

25-26 Christmas Holiday, SLMMS office closed

JANUARY

1-2 New Year's Holiday, SLMMS office closed

27 SLMMS Annual Meeting & Installation Banquet, Chase Park Plaza

FEBRUARY

10 Physician Leadership Institute, First Session

AMA President: "Getting the Physician Voice Where It Needs to Be Heard"

The American Medical Association is active in a wide range of major issues affecting medicine today, described AMA President David O. Barbe, MD, MHA, at the SLMMS annual Hippocrates Lecture on Oct. 4.

David O. Barbe, MD

"The AMA is playing an absolutely critical role in getting the physician voice where it needs to be heard—Congress, the administration, insurance companies, hospitals, medical schools and more," said Dr. Barbe, of Mountain Grove, Mo. He is a family physician and vice president of regional operations for Mercy Springfield Communities.

Among the AMA recent successes and activities he noted:

- Successfully worked to ease Medicare Access and CHIP Reauthorization Act (MACRA) requirements on small practices.
- Formed a 17-member Coalition to Reform Prior Authorization that set forth 21 principles for prior authorization. As a result, large insurers already have eliminated prior authorization for many services in several states.
- Successfully opposed insurance mega-mergers including Aetna-Humana and Anthem-Cigna. He also credited the Missouri State Medical Association for its leadership role in opposing these mergers.
- Advocating with Congress to increase funding for residency positions, and conducting public awareness campaigns including the website www.saveGME.org.
- Granted $11 million to 11 medical schools to help develop innovative approaches to medical education.
- Opposing the Trump administration's travel ban, and supporting the Deferred Action for Child Arrivals (DACA) program and another that allows foreign-born physicians to stay in the U.S. after residency.

John Sappington, MD: The Missouri Country Doctor Who Introduced Quinine for the Treatment of Malaria in North America

Ahead of his time, he produced and sold "anti-fever" pills based on medicinal bark later identified as containing quinine

By Arthur Gale, MD

Symptoms of malaria were first described in China in 2700, B.C. Hippocrates described the symptoms of malaria in Greece in the fourth century, BC. In the 17th century, indigenous Indian tribes in the New World used a medicinal bark for the treatment of fevers.

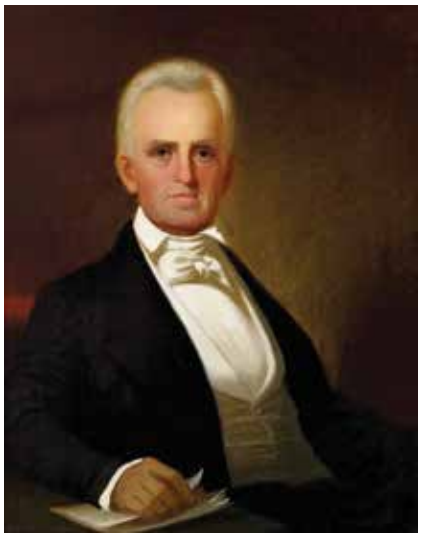
In 1880, Charles Louis Alphonse Laveran, a French army surgeon stationed in Algeria, noted parasites in the blood of a patient suffering from malaria. In 1907, Laveran was awarded the Nobel Prize for his discovery. In 1897, Ronald Ross, a British officer in the Indian Medical Service, was the first to demonstrate that malaria parasites could be transmitted by mosquitoes. Ross was awarded the Nobel Prize in 1902.[1]

In the 1820s and 1830s—long before the cause, mechanism of transmission or even the name malaria was known—a Missouri country doctor, John Sappington, was defying standard medical practice by prescribing and selling pills containing quinine to treat fevers.[2]

Malaria was carried to the New World by European colonists and African slaves. In North America, the malaria parasite thrived among mosquitoes in swampy waters like those in coastal Carolina, the Mississippi bottom lands, and along the Missouri River where Sappington set up his practice. In fact when Thomas Jefferson made the Louisiana Purchase in 1803, opponents of the purchase and his political enemies criticized him saying that he had bought "a swamp unfit for human habitation."[3]


Arthur Gale, MD

Arthur Gale, MD, is a past president of SLMMS and frequent contributor to St. Louis Metropolitan Medicine *and* Missouri Medicine. *His writings over the past five-plus years have been compiled into a recent book,* A Doctor's Perspective on Medical Practice in the Twenty-First Century, *available on Amazon.com. Dr. Gale can be reached at agalemd@yahoo.com.*


John Sappington

Long before the cause, mechanism of transmission or even the name malaria was known, Sappington was defying standard medical practice by prescribing and selling pills containing quinine to treat fevers.

In Europe, physicians had treated the symptoms of malaria with a remedy from the Andes where Jesuit missionaries had seen the Incas use the bark of the cinchona tree to treat "shivering." By 1832, Sappington began commercial production of the cinchona bark and mass-produced the pill adding myrrh, licorice and sassafras to mask quinine's bitter taste.

Sappington sent numerous salesmen across Missouri and mainly the southern states to sell his anti-fever pills. At the time, most doctors were still bloodletting and purging for all sorts of illnesses. Ahead of his time, Sappington strongly condemned these practices. As a result the physicians of the "prestigious St. Louis Medical Society" denied him membership in the society and called him a quack.

Despite the criticism from his fellow physicians, Sappington remained undeterred. In 1844, Sappington published a book *The Theory and Treatment of Fevers*. It was the first medical book to be published west of the Mississippi. He gave away all copies. Much to the chagrin of his relatives the book revealed his heretofore secret formula for his anti-fever pills.[5]

Advertisement for Sappington's pills.

John Sappington was born in 1776, the same year the Declaration of Independence was signed. He grew up in Tennessee and apprenticed to his physician father. He was a friend of future Missouri senator Thomas Hart Benton, who encouraged him to come to Missouri. He settled in Arrow Rock, Mo., which was on the fur trade route between St. Louis and Santa Fe, N.M. Benton lent Sappington $950 with which he bought several thousand acres of land in the Boonslick area of Missouri.

Sappington was born into a family of doctors. He apprenticed to his father, who was a doctor as was the custom in those days. He married Jane Breathitt, the daughter of the governor of Tennessee. Sappington was the patriarch of a family political dynasty that included three Missouri governors—sons-in-law Meredith Miles Marmaduke and Claiborne Fox Jackson, along with grandson John Sappington Marmaduke. A more contemporary descendant, the singer, dancer and actress Ginger Rogers, was his great-great granddaughter.

One author described Sappington as follows:

"For over 30 years Sappington traveled horseback on the roads and cow paths of the frontier—a tall, ruddy handsome clean-shaven figure … bearing a remarkable resemblance to his friend Andrew Jackson. In his saddlebags he carried a supply of drugs and a brace of pistols, and in his hip pocket was a long, sheathed knife on whose point he measured out his doses of Peruvian bark and later its extract quinine. He had a quick wit and polished manner, but he often spoke with savage denunciation of the murderous puke, purge and bleeding that other doctors used in treating malaria."[6]

Sappington became wealthy from his anti-fever pills and from other investments and businesses. He was philanthropic. He was a strong believer in education and established the Sappington School Fund which helped underprivileged children attend schools. It is still in existence today. In recent years, the fund has helped students obtain a college education.

By 1951, malaria was considered eliminated in the U. S. mainly through the use of better sanitation and the insecticide DDT. However throughout the world malaria is still a killer. In 2015, it caused 214 million infections and 438,000 deaths, with 70% occurring in children under 5 years of age. Cases treated in the U.S. are mainly in persons who have traveled to or are from Africa. Quinine still remains an effective treatment of malaria and is one of the two main drugs used for the treatment of central nervous system malaria.

Without knowing what disease he was treating or how it was transmitted and relying solely on testimonials from patients, what today we would call anecdotal evidence, John Sappington's anti-fever pills have come a long way.

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2. Richardson, Sarah. Missouri Medicine Man. *American History*. December 2016.
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SAPPINGTON MUSEUM IN ARROW ROCK, MO

To learn more about Dr. John Sappington, visit the Sappington Museum in Arrow Rock, Mo., about two and one-half hours west of St. Louis. The museum contains exhibits on his anti-fever pills and on his family. His descendants included three governors of Missouri as well as the singer Ginger Rogers. The museum is one of a number of historic sites in Arrow Rock.

Thanks Holiday Sharing Card Contributors

The following SLMMS and Alliance members and friends contributed to the 2017 Holiday Sharing Card with donations to the American Medical Association Foundation and the Missouri State Medical Foundation.

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Annual Holiday Gift-Sharing Luncheon

All SLMMS members and guests are invited to attend the annual Alliance Holiday Gift-Sharing Luncheon on Friday, Dec. 8, from 11: 30 a.m. to 1:30 p.m. at the home of Dr. and Mrs. Timothy O'Leary, 1005 Scarlet Bend Court in Kirkwood. RSVP: Kelly, 314-966-8662. Please bring a gift to benefit St. Martha's Hall, Loyola Academy or the St. Louis Area Food Bank. Suggested donations: $20 to one or more charity, women's toiletries, children's books, toys, boy's belts or canned foods.

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Provider News

- **SLPA ACO**, the accountable care organization of the St. Louis Physician Alliance (SLPA), achieved more than $13 million in total savings in the Medicare Shared Savings Program (MSSP) in 2016, its second year in the program. This savings was accomplished with an overall quality score of 91.27%, which means that the Centers for Medicare and Medicaid Services will provide $5.8 million in shared savings to SLPA ACO and its member providers. SLPA ACO serves 19,000 Medicare beneficiaries and comprises more than 600 providers including physicians, mid-levels and non-hospital facility participants.
- Patients at **SSM Health** now can benefit from streamlined information sharing with **MU Health Care** and other members of the Tiger Institute Health Alliance HIE. Both organizations are now members of the national Sequoia Project eHealth Exchange which promotes interoperability. SSM Health announced a similar relationship last November with the U.S. Department of Defense and its health care facilities. And earlier last year, SSM Health became the first health system in the country to implement a national record locator service.

Elbert H. Cason, MD

Elbert H. Cason, MD, a board-certified surgeon who specialized in occupational medicine, died October 2, 2017, at the age of 103.

Born in St. Louis, Dr. Cason received his undergraduate degree from University of Missouri-Columbia and his medical degree from Washington University. He completed his internship and residency at St. Louis City Hospital.

Dr. Cason served in the U.S. Army from 1943-1946, receiving the Bronze Star and Purple Heart for his service.

He was on staff at the former Lutheran Hospital where he was chief of staff, along with the former Incarnate Word Hospital and the former St. Joseph Hospital-Kirkwood.

Dr. Cason joined the St. Louis Metropolitan Medical Society in 1943, and became a Life Member in 1984. At the time of his passing, he was the oldest living member of the Medical Society and was a member for more than 70 years.

SLMMS extends its condolences to his wife, Elizabeth Arbeiter Cason, and his children, Carol Heidel, Cathy Cason, Michael Cason and Tammy Cason.

William D. Landau, MD

William D. Landau, MD, a board-certified neurologist, died Nov. 2, 2017, at the age of 93.

Born in St. Louis, Dr. Landau received his undergraduate degree from the University of Chicago and his medical degree from Washington University. He completed his internship at the University of Chicago Clinics, his residency at St. Louis City Hospital and a fellowship at Washington University.

For his military service, from 1952-1954 Dr. Landau served as senior assistant surgeon with the U.S. Public Health Services at the National Institute of Neurological Diseases in Bethesda, Md.

Dr. Landau was a professor of neurology at Washington University School of Medicine. From 1970-1991, he was head of the Department of Neurology, and from 1974-1991, he was also the co-head of the combined Department of Neurology and Neurological Surgery. He was neurologist-in-chief at Barnes-Jewish Hospital and St. Louis Children's Hospital.

Active in many professional organizations, Dr. Landau was president of the American Neurological Association in 1977 and president of the American Board of Psychiatry and Neurology in 1975. He served on the editorial boards of several leading neurological journals. He was medical staff president of the former St. Louis Regional Hospital.

Dr. Landau joined the St. Louis Metropolitan Medical Society in 1956, and was made an Honor Member in 1993.

Dr. Landau was predeceased by his wife, Roberta Landau. SLMMS extends its condolences to his children, Julie Landau-Taylor, David Landau, John Landau and George Landau; 11 grandchildren and seven great-grandchildren.

PARTING SHOTS

Care for Your Teeth, Eyes and Ears

By Richard J. Gimpelson, MD

This column is dedicated to the correction of a significant flaw in Medicare. Most of the material comes from the article in *JAMA* on August 15, 2017, written by Amber Willink, PhD, and Karen Davis, PhD, (both from Roger C. Lipitz Center for Integrated Health Care at Johns Hopkins University) and Cathy Schoen, MS, from the New York Academy of Medicine. I have used much of their article since I cannot express this topic any better. Only one out of five physicians belongs to the AMA; therefore, many physicians that do not get *JAMA* have not read this article.

Medicare excludes dental, vision and hearing services (DVH) as a core benefit, so beneficiaries must pay for these services on their own or go without. Without DVH there is a higher risk for avoidable hospitalization and ER visits. Some Medicare Advantage plans provide this coverage; however, the Advantage Plans lock people into one carrier and they have limits on which provider they can go to for care.


Dr. Richard J. Gimpelson

Dr. Gimpelson, a past SLMMS president, is co-director of Mercy Clinic Minimally Invasive Gynecology. He shares his opinions here to stimulate thought and discussion, but his comments do not necessarily represent the opinions of the Medical Society or of Mercy Hospital. Any member wishing to offer an alternative view is welcome to respond. SLMM is open to all opinions and positions. Emails may be sent to editor@slmms.org.

Lack of DVH often means patients must forgo care. This lack of care can lead to many medical problems. The average annual spending on DVH can run into multiple thousands of dollars which can be a significant burden for those on a fixed income.

Two bills have been introduced in Congress, but neither bill has gone very far.

One suggestion for providing DVH could be modeled as a voluntary supplemental benefit similar to Medicare Part D with cost related to income. Even with the above plan, there are still some who could not afford the plan, and those who just refuse to participate.

A basic benefit could be one preventive dental exam and cleaning per year, an annual eye exam and more affordable hearing aids.

Obviously the plans suggested are not cheap and would cost the federal government several billions of dollars that must come from somewhere. That somewhere is the big mystery; however, continuing to exclude DVH fails to acknowledge that these health services and the system that provides other health services are inter-connected.

I admit there is not much humor in the above presentation, but it is not very enjoyable to see millions of older or disabled people go without DVH and the problems that are created for them.

Don't forget to floss!

Lifting Cancer Patients' Spirits With Music

By Shannon Tai, Medical Student, Saint Louis University School of Medicine

Outside of medicine, one of my greatest passions is piano. Thanks to my parents, this passion began at the age of 4 when they had me take weekly piano lessons. I was so drawn to this instrument that I spent my evenings practicing rather than watching TV. Even to this day, whenever I play, everything else fades to background noise.

I've been very fortunate in that I have been able to continue playing piano throughout the intervening years. Playing the piano has always been an outlet for me to relieve stress and to calm my nerves before stressful events such as taking an exam. This passion for music has led me to spending my free time volunteering as a musical therapist at the Saint Louis University Cancer Center. Before a long night of studying, playing the piano during the day for cancer patients has been particularly satisfying.

Throughout my life, I've spent a lot of time playing in front of large audiences at piano competitions. And while I have derived great joy and satisfaction from such performances, the privilege of playing to people that are undergoing treatment to purge this insidious disease inside of their bodies is truly a humbling experience.

As one might imagine, cancer patients must constantly deal with the discomfort and pain of receiving chemotherapy infusions or radiation treatments. Through my piano, I provide these individuals with some solace and comfort while they are receiving these grueling treatments. I really believe that music is a tool like all the other tools that we utilize in health care. We use music to help patients feel more relaxed, take some of the anxiety away and provide them with a place of safety and solace.

I believe that piano is great music therapy. It has many short-term and long-term health benefits for listeners. Research in music therapy supports its effectiveness in increasing people's motivation to become engaged in their treatment, providing emotional support for patients and their families, and providing an outlet for expression of feelings. Further, there is evidence that patients who employ musical therapy after surgery need less pain medication.

Shannon Tai is a second-year medical student at the Saint Louis University School of Medicine. She is the AMA Missouri alternate delegate and a SLMMS medical student member. She can be reached at shannon.tai@health.slu.edu.

Throughout my life, I've spent a lot of time playing in front of large audiences at piano competitions. And while I have derived great joy and satisfaction from such performances, the privilege of playing to people that are undergoing treatment to purge this insidious disease inside of their bodies is truly a humbling experience. It's my job to provide them with something they can latch onto that doesn't have to be pain, anxiety or agony. They can disappear into whatever I'm playing if they decide to listen. It's an empowering, sobering, and uplifting experience for them and for me.

To my joy, I have seen many patients in low spirits when they come into the Bone Marrow Transplant Clinic, and then become transformed when they hear my playing. Yes, I see their ears perk up or they start to smile. When I played Christmas music in December, they started singing along and clapping while I was playing the piano. I will cherish the memories I've made at the SLU Cancer Center, but the meaning and fulfillment that I get out of what I am able to do there are far greater.

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