

## From the President

# Fulfillment vs. Burnout

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### Statist Control of Medicine

There are so many examples of outside interference in physician autonomy today that you might think there is an actual war on doctors in operation in the Land of the Free.

Current examples include ACA (the Affordable Care Act), MACRA (Medicare Access and CHIP Reauthorization Act of 2015), MIPS/APM (Merit-based Incentive Payment System/Alternative Payment Model), EHR (electronic health record), ABMS MOC®/MOL (American Board of Medical Specialties Maintenance of Certification/ Maintenance of Licensure), prior authorization, delay-and-denial tactics, and many others. At AAPS, we fight daily for the preservation of the patient-physician relationship. We help physicians and surgeons preserve liberty in medicine and autonomy and, we hope, resurrect the joy in practicing medicine. We are now fighting against ACA, MOC, price controls in California, abuse by the Texas Medical Board, single-payer socialized medicine, and sham peer review.

If the *Communist Manifesto* (Karl Marx and Friedrich Engels, 1848) had an unpublished plank, it might well have been state central control of medicine. Present examples include expanding Medicaid; guaranteed issue, which destroys catastrophic insurance and promises pre-paid medical care; massive data capture with E&M/ICD-10/CPT® coding (evaluation and management, International Classification of Diseases, AMA's copyrighted Current Procedural Terminology) and corresponding price controls; hospital acquisitions and mergers; purposeful destruction of the insurance market, thus leading to one "Medicare/Medicaid for all"; hospital-employed physicians without due-process rights; and the general erosion of the practice of private medicine in America.

It is uncertain how much longer private medicine will exist in America. The footsteps of a long death march down the road of socialized medicine are still heard because busy physicians and the faith community are not effectively convincing Congress to frame the debate properly, message the people effectively, and gain a coalition of support before attempting to pass sub-optimal bills that neither repeal nor replace ACA (C. L. Gray, M.D., Physicians for Reform, personal communication, October 2017). What Congress should do is carefully read and act upon our wisdom and logic in the AAPS white paper on repeal/replace so that they can pass legislation that is right and good for America in the short and long term.<sup>1</sup> Meanwhile, 6.5 million people are paying penalties for not purchasing plans that they cannot afford or do not want, and many millions more are paying outrageously higher premiums since government interfered with the free market for true insurance. Cash, catastrophic insurance, and true charity are

foreign concepts to hospitals and employed physicians, but they exist in wonderful form among AAPS physicians enjoying the practice of private medicine.<sup>2</sup>

### Burnout: an Occupational Hazard in Medicine

Symptoms of burnout include feeling worn out, loss of energy, depletion, debilitation, fatigue, loss of enthusiasm for work, de-personalization, negative and inappropriate attitudes toward patients, irritability, loss of idealism, withdrawal, low sense of personal accomplishment, reduced productivity or capability, low morale, inability to cope, work-life imbalance, and dissatisfaction. About 46–54 percent of American physicians experience these symptoms! Symptoms are most prevalent among emergency department physicians, general internists, neurologists, and family physicians.<sup>3,4</sup> The current dimensions of physician burnout are a triad of 1) overwhelming exhaustion, 2) cynicism and detachment from the job, and 3) a sense of ineffectiveness and lack of accomplishment, as quantified by the Maslach Burnout Inventory (MBI) from 1981, which is comprised of 22 statements divided into three sub-scales assessing each dimension using a six-point scale. Each sub-score is counted separately. The inventory is not diagnostic, but rather identifies those at risk for burnout and their predominant dimensions.

Some MBI example statements from each of the three dimensions include:

- **Exhaustion:** "I feel emotionally drained by my work. I feel frustrated by my work. I feel I work too hard at my job."
- **Cynicism:** "I feel I look after certain patients impersonally, as if they are objects. I really don't care about what happens to some of my patients. I have become more insensitive to people since I've been working."
- **Ineffectiveness and lack of accomplishment:** "I accomplish many worthwhile things in this job. I am easily able to understand what my patients feel. I look after my patients' problems very effectively. I am easily able to create a relaxed atmosphere with my patients."

The answer choices range from zero to six and correspond to "never, a few times per year, once a month, a few times per month, once a week, a few times per week, and every day." Based on how the statement is phrased, a higher score on the first two sub-scales and a low score on the third sub-scale may indicate burnout. The final conclusions are "low-level, moderate, and high-level burnout."

The positive antithesis of burnout is called engagement and is the positive spectrum of the three dimensions, yielding a pattern opposite of burnout scores. Engagement embodies a state of high energy, strong involvement, and a sense of

efficacy or a persistent positive state of fulfillment with vigor, dedication, and absorption.<sup>5</sup>

There is no ICD-10 code for burnout. Some concern has been raised regarding the potential for numerous disability claims. Physicians are unable to bill for diagnosing burnout. The MBI rating scale predates the onslaught of EHR systems and compliance mandates that oppress and burden good physicians; diminish eye contact, healing touch, and bedside manner; set the stage for cold and hurried “encounters”; and impede efficiency for many physicians.

So far, we are achieving the opposite of the government's intended Triple Aim purpose (improving population health, enhancing patient experience, and reducing costs). Government programs in medicine usually end up achieving the opposite of their stated purpose, and in this era, the patients pay more for less choice and less time with their burned-out physician. The slow march toward socialized single-payer medicine has resulted in a significant increase in commentary, publications, and presentations on physician burnout.

If a diagnostician were to address a chief complaint of burnout in a patient, what would the examination show and where would the lesion or the source of the pathological condition be located?

In neurology, we are taught to localize the lesion after conducting a good history and examination. If we cannot formulate a differential diagnosis, then our history is likely inadequate and/or the bedside examination insufficient. The serologies, electrophysiology, and neuro-imaging are there to support or reject the most probable clinical diagnosis. In this example of the physician's complaint of exhaustion, depersonalization, and/or lack of accomplishment (burnout and dissatisfaction)—all symptoms that interfere with the patient-physician relationship—the differential diagnosis could be mental illness, emotional and physical exhaustion, or other, but the pathology would more likely be found within the medical system rather than in the physician's mind, blood, or body. The most probable diagnosis is Toxic Workplace Syndrome or what R. S. Emmons, M.D., referred to as “EHR Brain” at the AAPS 74th Annual Meeting, Tucson, Ariz., Oct 7, 2017.

Note that a physician does not need to adhere to any published code for a diagnosis to be accurate or legitimate. No E&M, ICD-10 or CPT code is necessary to help a physician diagnose and help a patient improve or fully recover clinically and regain quality of life. Moreover, in the AAPS circle of inspired, innovative, rejuvenated, and ultimately satisfied physicians and surgeons, no code is necessary for the doctor to get paid market value for his services in a third-party-free, patient-doctor-direct clinic. [Nota bene: “Burnout,” “impaired physician,” and “disruptive physician” are all descriptions of physician interactions with diseased systems that masquerade as individual physician pathologies (R. S. Emmons, M.D., personal communication, Oct. 7, 2017).]

Interventions for managing physician stress and burnout include cognitive-behavioral therapy (CBT); mindfulness-based stress reduction programs; relaxation/stretching exercises; supportive discussion strategies such as Balint

sessions (group therapy for doctors which focuses on patient-physician relationships); changing work settings and reduction of adverse job psychosocial factors; self-care lectures; didactic/interactive sessions; and counseling and psychosocial training. However, the research quality is suboptimal, with CBT showing the strongest evidence of effectiveness.<sup>6,7</sup>

It is imperative that anyone involved in serving the patient realize that even though a rare physician may be suffering from a pathologic condition, so may the system he works in! The system disrupts the physician as he tries to complete core tasks, thus making him less efficient, more disengaged, and ultimately less satisfied. Job satisfaction and the joy in medicine are related to remediable work conditions where there is less chaos, more cohesion, improved communication, and values alignment at work.<sup>8</sup> Probably, the most effective intervention, not mentioned in the literature as often, is removal from the toxic workplace environment.

### **A Common Contributor to Toxic Workplace Syndrome**

Clinician burnout has been rising over the past decade as doctors sacrifice, endure, and comply with the gorilla in the consulting room—the “meaningful” EHR.<sup>9</sup> Labor-intensive documentation, order entry, prior authorizations, billing/coding, performance measurement, numerous patient portal messages, lab result inquiries, prescription renewal requests, system security, and other administrative and regulatory work places immense strain on the responsible physician's complex tasks. Sadly, many physicians are spending 40–55 percent of their time on EHR documentation daily, and unfortunately, up to 90 minutes of digital charting time extends into the doctor's private home life!

In primary care, the EHR tax on time is 5.9 hours of an 11.4 hour work day in which EHR use is 4.5 hours in the clinic and 1.4 hours at home. Physicians are frustrated with numerous EHRs they did not have any input in designing, and that are still not interoperable. The EHR is good on documenting compliance, excessive and compulsive coding and billing, repopulating static data, information overload, and perpetuation of mistakes, but it is poor on the decision-making process/treatment plan and care coordination. The computerized record does not integrate sufficiently well with other physicians to optimize care coordination. There are at least 25 pros and 25 cons with 22 clinician work-arounds, and 19 areas of potential improvement in a typical outpatient practice EHR.<sup>10</sup> The art of terse medical prose is lost, and the resulting medical record is longer and bloated with data overload.

Computers are a time drain, and enslave the doctors and staff as data-entry clerks in return for paltry sums and bonuses. They are programmed to prioritize static documentation and billing/coding instead of improving patient care and coordination. Did computer programmers and marketers actually think any computer could efficiently document the amazing human intellect? Computers are supposed to facilitate calculations, not impede the art of medicine. They increase costs per patient consult due to the team-based

approach and the overhead of the human scribe. The growth of EHR use is directly proportional to the increase in physician burnout, as shown by interviews with physicians and published research.<sup>3,10,11</sup> Do you ever recall slaving four-and-a-half hours per day on routine charting or dictating in the analog world? Forget the obvious neck, back, eye, and carpal tunnel problems; how about the physician being separated from his family every night for an additional one to two hours just to satisfy some billing/coding mandate, population health research, and the meager incentive payment/bonus for the clinic at the end of the year?

The current response in primary-care practices is team-based care, in which the physician focuses on medical tasks and delegates all other tasks to medical assistants (MAs) who function at the top level of their respective qualifications. This allows the clinic to have a fighting chance at surviving. For example, if the team has two MAs, one acts as a scribe in the office and the other handles intake vital signs or prior authorizations/referrals/etc. Or, a surgeon may hire a physician assistant-certified (PA-C) or nurse practitioner (NP) to assist with follow-up visits, coordination of care, and minor procedures.

We know that the private practitioner finds great difficulty in affording all the computerized EHR and staffing demands, along with increasing compliance demands and declining third-party payment. Hence, the physician sees no other recourse than to join a large group or a hospital health system where he can be saved by hospital-financed team-based care, which attempts to provide lean work flow. This approach makes the patient-physician consultation more of an “encounter” than a “visit,” is certainly more expensive than in the analog domain, and runs the risk of even more error perpetuation and digital disruptions. However, some primary physicians have noted that patients do not object to the MAs in the room and consider the assistant as another trusted advocate. Moreover, some clinics are seeing a slight increase in income and favorable outcome measures such as control of hypertension and blood sugar, etc.<sup>12</sup> However, I suspect that doctors were perfectly capable of such good outcomes before MACRA/EHR and team-based care. A team-based care approach might work even better in a third-party-free model where more brain power could be used to render personalized and innovative medical care as opposed to wrestling with multi-level over-regulation.

## **Fulfillment**

At AAPS, we know that many primary care physicians and specialists prefer to set up a direct primary care office with no third-party contracts, and thus avoid the expense and logistics of a team-based care approach. These simple models are working well and are examples of practical solutions to the current medical crisis, which results from the expansion of comprehensive third-party payment and the destruction of cash, catastrophic insurance, and true charity. AAPS physicians who have partially or totally disentangled themselves from the chain-and-ownership models do not manifest the burnout

symptoms of toxic workplace syndrome.

Empathy toward the burned-out physician is appreciated, but emphasizing that he is the sick one in the “health care system” is short-sighted when the pathology resides in the system, not the doctor. The system needs medical, psychiatric, and psychological treatment, not just more staff support including MAs, nurses, front-office staff, billers, coders, prior authorization staff, and delay/denial appeal staff. The real pathology should be identified and eradicated—the toxic workplace. The most harmful components include ACA, MACRA, and EHRs. The administrative overload has spread from the Veterans Administration and corporate merged hospitals/satellite clinics promoting “health” to solo/group medical practices. The metastasis must be stopped before physicians and surgeons lose all autonomy, surrender their private cognitive property, and relinquish the joy and satisfaction of practicing medicine.

I predict that patients at some point will seek a private physician because they are exasperated with the care system that rushes them in and out, doesn’t answer all their questions, costs too much for too little value, only sometimes helps, and leaves them afterward crying in the parking lot. Even in England, Harley Street still exists despite a long 69-year track record of single payer with the National Health Service.

At AAPS, we educate and inspire doctors to maximize physician autonomy, preserve the sanctity of the patient-physician relationship, optimize clinic practice models, and sustain the practice of private medicine. Private medicine is under assault, but it will survive because today’s patients demand a certain level of customer service and quality, and have more opportunities than ever to participate in the medical decision-making process, to voice complaints, and even to take their money elsewhere. When the patients are routinely paying the bills, the doctor has to listen, stay engaged, and heal effectively on a consistent basis. Accordingly, he will enjoy a reduced risk of burnout and stress-related illness. The joy of medicine will be palpable and fulfillment will be sustained.

AAPS educates physicians via newsletters, e-mail alerts, our website, podium presentations, videos, conferences, journal articles, regional “Thrive, Not Just Survive” meetings, state chapter and annual national meetings, and personal communication, including limited legal counsel. Our physicians can learn how to gain more autonomy, establish healthy patient-physician relationships, and navigate the logistics of thorough and affordable medical care without having to resort to hospital employment or an expensive team-based care approach. Are there ways to help employed physicians, who now may be in the majority, realize the freedom and joy in medicine that so many of our members experience in their outpatient clinics? Warning of dangerous contract provisions is one of our services.

Conceptually, the current medical practice environment resembles the coliseum of Plato-inspired governance, under which people serve the state, rather than the temple of the Hippocratic physician-patient relationship.<sup>13</sup>

As AAPS director Kristin Held, M.D., observed in her

presentation “Securing Our Blessings of Liberty to Practice Hippocratic Medicine,” at our Oct 7 meeting in Tucson, Ariz., Thomas Jefferson and our Founders said: “Virtue is an essential element of liberty. If the people lack virtue, no government can rescue them from tyranny.”

## Conclusion

In the end, we shall not be judged by God based on our titles, publications, presentations, honors and awards, possessions, accomplishments, power and influence, but rather by our humble service to others. Thus it is crucial that every physician reflect on the question: Is there any devil impeding my ability to love God, love myself, love my neighbor as myself, and serve others? If so, be wise, be courageous, take action and free yourself from any oppressive entity that has no jurisdiction over your practice, your intellect, your body, and your peace of mind. Cut the Gordian Knot and preserve the Hippocratic practice of private medicine.

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### Practical Tips to Increase Fulfillment and Reduce Burnout Risk by Returning to the Practice of Private Medicine

- Place your own health of body, mind, and spirit first.
- Nurture your spiritual life.
- Take charge of your own schedule.
- Receive payment for medical care directly from the patient, and educate patients to understand that payment is due at the time of service.
- Stop extending credit to patients; do not wait months to get paid based on codes and price controls from insurance companies.
- Officially opt out of Medicare, and contract privately with Medicare beneficiaries.
- If not opted-out, change your Medicare status to non-participating. (This means you can collect from patients at the time of service, and can opt out immediately if you choose to do so.)
- Sever all oppressive third-party insurance contracts; insurers should negotiate with their subscribers, not with physicians.
- If patients are filing a claim with a private insurer, help by providing needed data in the form of a paper receipt.
- Recognize that Medicaid patients in Arizona may elect to pay a non-contracted physician privately for consultation; check the law in your state.
- If you need hospital privileges, find a hospital that does not require contracts with Medicare, Medicaid, or insurance panels, and allows opting out of Medicare.
- If such a hospital cannot be found, encourage or help establish an independent third-party-free surgical center or even hospital.
- If a third-party-free surgical center or hospital is not readily accessible, seek special accommodations to allow private contracts with patients and operating on a cash basis as desired.
- Decline to acquiesce to ABMS MOC®, and fight for laws that forbid tying privileges, certification, or state medical license to participation in ABMS MOC®.
- Continue to learn in academic areas that are pertinent to your practice, and to grow professionally.
- Use paper charts or customized computer software programs that enhance the patient-physician relationship, efficiency, accuracy, and research quality for the medical/surgical practice.
- Reflect on the most common complaints by patients about doctors, office staff, communications, follow-up care, and the whole consultation experience, and strive to improve deficiencies without coercion or penalty.
- Refuse to sign any contracts that place you under the jurisdiction of unelected bureaucrats who lack medical training.
- Refuse to sign any contracts that waive due-process rights.
- Allow for some weekly time off for personal needs, family, hobbies, creative pursuits, rest and relaxation, recreation, etc.
- Resolve not to quit in disgust or become eternally cynical, but rather continue practicing medicine if desired, using a third-party-free independent model.