The Bulletin

FOR MEMBERS OF THE MEDICAL SOCIETY, COUNTIES OF ERIE AND CHAUTAUQUA SPRING 2018

ANNUAL MEETING

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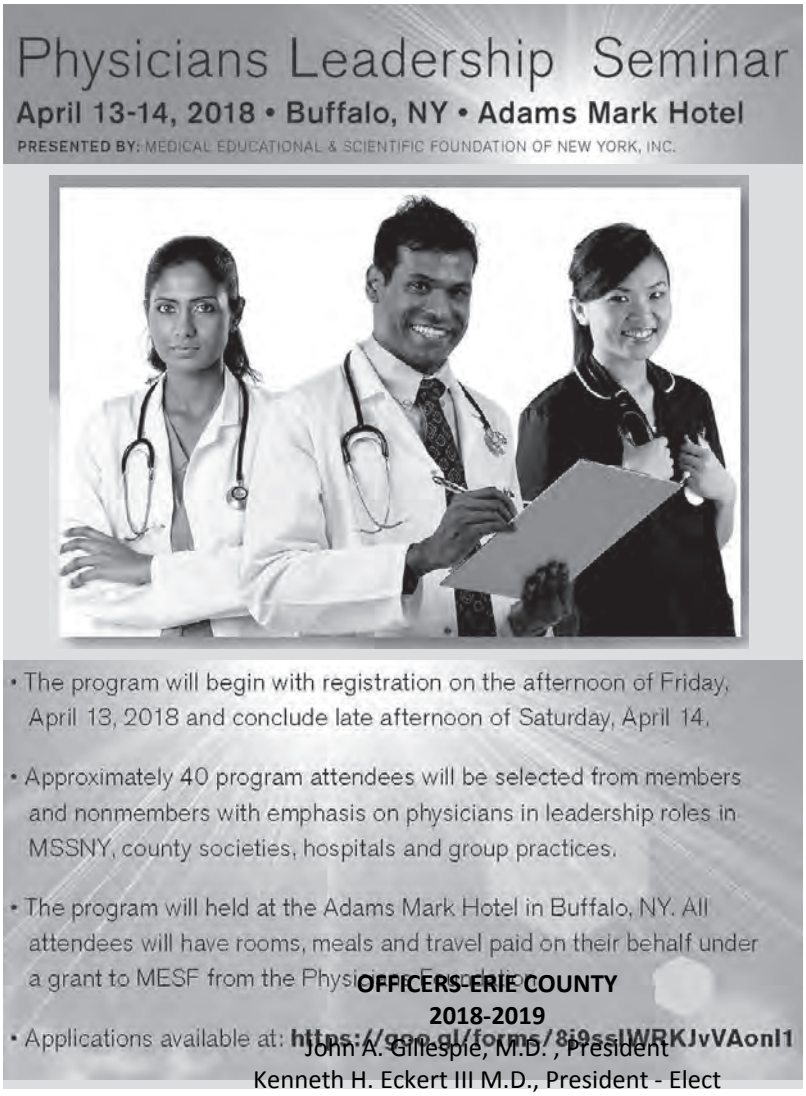

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Medical Society, County of Erie
"Better Health Through Advocacy"™
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Medical Society of the County of Erie
Medical Society of the County of Chautauqua

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A Message from the President:

Unwarranted Variation: Now Is the Time to Own It, Resolve It and Not Be Financially Punished for Fixing It

Willie Underwood III, M.D.

I would like to first state that we the physician didn't create the problem of unwarranted variation alone. I agree that there is plenty of blame to go around. However, we are being blamed for it. If we don't work together to reduce unwarranted variation, reduce cost by improving quality and outcomes, we will continue to see physician payment reform in the form of payment reduction and greater support for the independent practice of physician assistants and nurse practitioners as a lower cost alternative to physicians. These are nothing more than cost reduction measures with little to no regard for improving the quality of care being delivered to patients. Our goal must be to focus on the quality of and appropriateness of care. We must figure out how to improve the value of the care that we deliver and by doing so increase our value to the healthcare system as well.

$$\text{Value} = \text{Appropriateness of Care} \times \frac{\text{Quality of Outcomes}}{\text{Cost to Patient}}$$ [1]

Reducing inappropriate use of care. The Institute for Healthcare Improvement[1,2,3] published a white paper reducing cost by improving appropriate use of specialty services. They offered a six-step framework to reduce unnecessary care.

1. Engage physicians, patients and key stakeholders to search for opportunities for cost reductions.
2. Where opportunities exist, use consensus criteria to define a standard of care.
3. Coach physicians in "discernment" the process of determining whether the standard is appropriate for treating a given patient.
4. Evaluate the aggregated outcomes of multiple applications of discernment so that everyone involved can understand whether the standard is being applied properly.
5. Intervene as needed to adjust the standard or its application.
6. Implement the standard.

Several hospitals attempted to implement this strategy, but some dropped it as soon as they noted a reduction in hospital reimbursement. Other hospitals tried a top-down approach that placed them at conflict with physicians. Some hospitals and communities have made progress because the process was led by physician leaders and I don't mean hospital physician administrators.[1]

You may ask, why bother to reduce cost when all the savings will go to insurance companies who will not share it with physicians through cost sharing or the patients by reducing their premiums. I agree that this a major concern that needs to be worked out with the payors by creating pilot projects and cost sharing programs.

In creating physician lead variation reduction programs, we must not:[1,4]

1) Lower physician's incomes
2) Skew physician/patient satisfaction stats
3) Negatively impact physician productivity
4) Interfere with physician autonomy
5) Create "cookbook medicine"

These are all valid concerns that need to be addressed. By setting agreed upon physician led standards will increase office efficiency by reducing unnecessary office visits to specialty care and allow specialist to focus on providing top care to patient who in fact needs their services (increase productivity and patient satisfaction). Of note in today's world of healthcare delivery, physician autonomy is pretty much an illusion. By creating local guidelines that make sense this will allow all the "cooks" to use the same recipe. This doesn't mean that from time to time the cook will not deviate from the recipe to make a better dish. I am not implying that the practice of medicine can or should be equated to making eggplant parmesan, but I hope you get the point.

In conclusion, we the physicians of Western New York need to lead the process of improving outcomes and reducing cost to improve value. Instead of being place in a position of competing with one another, I suggest that we work together and make our outcomes the best in the region and country. Therefore, we make the region more attractive to employers because we will have a healthier community and their healthcare cost will be lower compared to other areas. We make our region more attractive to physicians because we will create a better working environment and more desirable reimbursement because of the higher quality of care provided.

Benjamin Bensadon, Ed.M., Ph.D. is an Associate Director, Internal Medicine Residency—Geriatrics & Palliative Care Rotation, Assistant Professor of Integrated Medical Science Department of Integrated Medical Science Charles E. Schmidt College of Medicine, Florida Atlantic University. I first met Dr. Bensadon in 2012 as a

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A Message from the Executive Director: What Now?

Christine Ignaszak Nadolny

Life as a physician is complicated. Life as a physician is rewarding.

Life as a practicing physician in New York State (currently ranked as the 51st worst place to practice) may have just dropped lower. And that just might be due to the change to the Statute of Limitations (aka Lavern's Law) for missed cancer diagnosis cases which was recently enacted – without any inclusion of tort reform.

While many physicians may consider this new legislation a loss, that MSSNY did not achieve a veto – that is certainly a rush to judgment not based on facts. MSSNY helped coordinate advocacy efforts among various allied interests, including other specialty societies, MLMIC and hospital associations, to substantially improve the final version. They "snatched victory from the jaws of defeat" because of the chapter amendments which were achieved for each of you:

- A fix to the ambiguous language that would have applied the "Date of Discovery" rule to all cases, not just alleged failure to diagnose cancer.
- A fix to provisions that would have allowed plaintiffs to revive already-expired claims based on negligence that occurred up to 7 years prior to the suit being filed. The legislation deletes the original "effective immediately" language and replaces it with language that makes the discovery rule applicable to negligence occurring after the effective date, plus any accrued claims that have not yet expired as of the date of signing. In effect, the past exposure would be tied to the applicable statute of limitations for the defendant – 2.5 years prior to the effective date for health care providers, as opposed to the original bill's seven years. It would also provide a limited re-opener for claims that expired in the last 10 months (under the old non-DOD rule) which must be filed within 6 months after the bill is signed.

Year after year, MSSNY and its component county societies continually advocate for relief. Year after year when our county society meets with local legislators, there is always a plea for relief. Why then does it seem that effective medical liability reform is not a reality? Perhaps our voice had not been loud enough. Perhaps we are not consistently meeting with our elected representatives. Perhaps the monies that the MSSNYPAC has to work with are not sufficient. To be effective the MSSNYPAC needs contributions so that the medical profession is not "out of sight and out of mind" when so many other interest groups are making their voices heard loudly in Albany.

Not only do we need additional dollars, we need additional "man/woman power". Now is the time that you develop a personal relationship with each legislator that represents you, at both the Federal and State level. Be mindful that there are multiple sets of legislators that you may need to work with --- those legislators that you vote for (based on your Board of Elections address) and those, in whose district(s) your office is located. This personal relationship requires that you keep them apprised of the issues that may impact the provision of health care to their constituents (possibly you, your family, your employees, your patients). Besides a quick phone call, email or scheduled appointment – you should consider attending their fundraisers. This is a great way to develop or enhance a personal relationship with policymakers – if you don't take the time, someone representing another constituency or profession may use that same time to voice a contrary perspective to the issues that matter to our profession and our patients.

Here are a few ways you can get involved:

MSSNY has recently introduced the "Physician Advocacy Liaison" or "PAL", where volunteer physicians will be "assigned" legislators with whom they will be asked to regularly contact. Consider this in the realm of "key contact". The assignment will not be random, but based upon relationships that each participant may already have with the elected representative. That relationship might exist because he/she may be your neighbor, possibly be one of your patients. With your participation, our grassroots activity will be substantially empowered. If you are interested, please call me at 716-316-0565 so that we can discuss your involvement in this very important advocacy effort.

In addition to developing that one-to-one relationship with legislators, consider a contribution to the MSSNYPAC of at least $1.00 per day, that's $365 per year. Not a lot, possibly less than the cost of a daily cup of coffee – but if every member of the Medical Society would contribute that amount – your voice would be amplified and your issues "would not be out of mind". And, if you want to "up the ante" to $2.00/3.00 or more per day - not only would the physician voice grow louder, but we would become more pro-active than re-active.

If every physician were to take these steps, rather than the relative few who do, just think what we could accomplish.

Chris

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CHRISTOPHER L. JACOBS
SENATOR, 60TH DISTRICT

February 5, 2018

Ms. Christine Ignaszak-Nadolny
91 Briarhill Road
Orchard Park, NY 14217

Dear Christine:

Congratulations on your selection for the Medical Executive Lifetime Achievement Award by the American Medical Association. Your dedication, leadership and hard work are a shining example to others. I am proud to have you as a constituent of New York State's 60th Senate District, and this resolution is now part of the New York State Senate permanent record. May your future be filled with success and good fortune.

Sincerely,

Chris Jacobs
New York State Senator
60th District

E-mail: jacobs@nysenate.gov **Website**

State of New York
Legislative Resolution

Senate No. 3195

BY: Senator Jacobs

HONORING Christine Ignaszak-Nadolny upon the occasion of her designation as recipient of the Medical Executive Lifetime Achievement Award by the American Medical Association

WHEREAS, It is the sense of this Legislative Body to recognize and pay tribute to outstanding individuals who distinguish themselves through professional excellence and who have made significant contributions to the quality of life of citizens in the State of New York; and

WHEREAS, Attendant to such concern, and in full accord with its long-standing traditions, this Legislative Body is justly proud to honor Christine Ignaszak-Nadolny upon the occasion of her designation as recipient of the Medical Executive Lifetime Achievement Award by the American Medical Association; and

WHEREAS, This auspicious award recognizes a medical association executive who has contributed substantially to the goals and ideals of the medical profession; and

WHEREAS, Christine Ignaszak-Nadolny serves as the Executive Director of the Medical Society of the County of Erie (MSCE); and

WHEREAS, In this capacity, Christine Ignaszak-Nadolny has worked tirelessly to support physicians and identify, recruit and engage members; and

WHEREAS, A sustaining force for the organization, Christine Ignaszak-Nadolny is respected and admired by members of MSCE for her widespread service to the county, district, and other medical and community organizations; and

WHEREAS, In addition, Christine Ignaszak-Nadolny is being honored for her steadfast leadership and rare talent for bringing people together in her 22 years of committed service at MSCE; and

WHEREAS, A resident of Orchard Park, Christine Ignaszak-Nadolny has developed strong relationships with both local and state officials, helping advance legislative initiatives and respond to evolving regulatory challenges; and

WHEREAS, It has always been the objective of this Legislative Body to honor and support those individuals who have displayed their commitment to the betterment of their communities, and it is the intent of this Legislative Body to inscribe upon its records, this tribute to Christine Ignaszak-Nadolny, that future generations may know and appreciate her admirable character, her many benevolent deeds, and the respect and esteem in which she is held by her peers; now, therefore, be it

RESOLVED, That this Legislative Body pause in its deliberations to honor Christine Ignaszak-Nadolny upon the occasion of her designation as recipient of the Medical Executive Lifetime Achievement Award by the American Medical Association; and be it further

RESOLVED, That a copy of this Resolution, suitably engrossed, be transmitted to Christine Ignaszak-Nadolny.

ADOPTED IN SENATE ON
January 9, 2018

By Order of the Senate,
Francis W. Patience, *Secretary*

Appropriate Use of Mid-Levels and Clinical Support Staff in Your Practice

Leah S. Ranke Esq., Law Office of Leah S. Ranke, Esq.

Appropriate Use of Mid-Levels and Clinical Support Staff in Your Practice

Medical Assistants, LPNs, RNs, NPs and PAs. It is difficult to imagine the practice of medicine without them. Hiring the right individual for the jobs you need them to perform is essential. Establishing collaboration relationships with referral sources and participating in patient care can benefit patients. But you may not know the rules about the use of these professionals in direct patient care, or what happens if you misuse them or your relationships with them. There are many rules and laws, but here are the basics:

PAs. New York State has been registering Physician Assistants since 1972. PAs must earn a bachelor's degree in a qualified PA education program, and pass an exam. Today, there are about 15,000 PAs registered by New York State. PAs may not practice medicine, and may not engage in an independent practice. It is inaccurate to say a PA. "has his or her own patients." PAs are considered dependent practitioners who must work under the supervision of a licensed physician responsible for the actions of the PA. PAs cannot practice without a physician, co-own a practice with a physician, supervise a physician, or hire a physician as an independent contractor. New York Education Law states, "The supervising physician may delegate to the physician assistant any medical procedures or tasks for which the physician assistant is appropriately trained and qualified to perform and that are routinely performed within the normal scope of the physician's practice." Your PAs cannot practice certain areas of medicine, including radiologic technology and optometry, or any area of medicine that is outside your scope of practice.

Extensive physician-supervised duties CAN be delegated to a PA, including: taking patient history, performing patient evaluation, physical exam, monitoring, identification of deviations from the norm in routine diagnostic tests, recording progress notes, performing routine procedures such as injections, immunizations, suturing and wound care, managing simple conditions produced by infections or by trauma, counseling patients and families on therapeutic regimens, and making referrals.

Rules governing PAs working in the hospital setting are NOT the same as PAs in the outpatient office setting, and this can be confusing. In the inpatient setting, a PA is functioning as the physician's agent, and might have the physician's and hospital's permission to write medical orders for inpatients. Physician countersignatures are not required in that case, before nurses and others must execute them. There are additional rules regarding PAs in long term care facilities, ambulatory care centers, community clinics, and in rural and urban settings.

In the outpatient private practice office setting, both New York State law and the coverage policies of all major patient health insurance state that there must be one clearly designated supervising physician who is physically present in the office any time a PA sees a patient. A physician must timely read and co-sign the PA treatment notes, stating they agree with the PAs handling of the patient visit. A physician may not employ or supervise more than four PAs in the physician's practice. The supervising physician may delegate to the PA any clinical functions within that physician's scope of practice providing the PA is appropriately trained and competent to perform those functions, including writing medical orders and prescribing medications. PAs may apply to the DEA for their own registration numbers as mid-level practitioners. Once duly registered and subject to any limitations set by the supervising physician, PAs may prescribe Schedules II, III, IV and V drugs, in compliance with Article 33 of the Public Health Law and Part 80 and Part 94.2 of Title 10 regulations, as well as federal laws.

Patient health insurance coverage rules require a physician to see a patient for every initial consultation, where a treatment plan is made by the physician. Your PA can thereafter see your patient for routine follow-up and maintenance. However, you as the physician must see the patient personally for any subsequent visit where the patient presents with new, undiagnosed problems, complications, or concerns, AND at least once a year. PA progress notes should routinely be reviewed the same day as your PA saw the patient, and when you co-sign the notes, you must state that you read and medically agree with the PA's handling of the visit. PAs are paid at approximately 85% of the full physician rate, unless you also saw the patient at the same visit and meaningfully contributed to the office visit. It is not enough that you may have popped in to say hello to the patient, or answered a question the PA had. In order to bill the full 100% physician rate for an office visit at which a PA

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Appropriate Use of Mid-Levels…

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was involved too, you must meaningfully examine the patient face-to-face yourself, diagnose the patient, make the medical decisions, develop the treatment plan, and (of course) properly document that you did all of the above.

Medical Assistants. The State of New York does not license medical assistants. New York Education Law Section 6530 (11) states that physicians may not allow (permit, aid or abet) any unlicensed person to perform activities requiring a license. Knowingly delegating a medical task to an unlicensed person is professional misconduct, even if you know that person to be experienced and competent to perform the medical tasks you delegated to them. A "medical task" is any activity that requires "medical judgement and assessment," and is off limits for any medical assistant to perform. New York State Office of Professions has stated that it IS okay for you to have your medical assistant perform office secretarial work with charts and billing, take vitals, perform ECGs, take lab specimens like bloodwork, and be a second set of hands alongside you for a specific non-medical task such as handing supplies to you. Examples of the sorts of tasks IT IS NOT permitted for you to allow a medical assistant in your practice to conduct include: triage, administer any medications (through any route,) administer contrast dyes, perform any injections, place or remove sutures, take x-rays, position a patient for x-rays, apply casts, or be your first assist in any procedure or surgery.

LPNs. New York State licenses practical nurses. New York State Education Law §6902 states that you may task an experienced and able LPN with responsibilities of: case finding, health teaching, health counseling and providing supportive and restorative care under the direction of you or your RN, NP, or PA. LPNs are most commonly employed bedside in the hospital or nursing home settings, and there are many New York laws and regulations about what an LPN can and cannot do. In general terms, New York State Office of Professions states that it IS okay for your LPN to perform the following tasks, if they are trained and competent to do so: administer medication, vaccines, and blood; observe, measure, record, and report patient data; perform clinical procedures, such as urinary catheterizations, oral or tracheal suctioning, sterile dressing changes, and starting a peripheral IV; supervise unlicensed care staff; and identify patient goals for possible inclusion in a patient's care plan. It IS NOT permitted for you to allow an LPN to perform any task for which they are not trained and competent, perform any nursing diagnosing, develop or make any changes to care plans, or triage.

RNs. New York State licenses registered nurses. New York Education Law §6902 permits you to employ RNs to perform "nursing diagnoses" and "nursing treatment" to your patients. These are NOT the same as a physician medical diagnosis or treatment. RNs do not make medical diagnoses or prescribe medical treatments or drugs. There are many other New York laws and regulations about what an RN can and cannot do. New York State Office of Professions states generally that it IS okay for your RNs to engage in "case finding, health teaching, health counseling and providing care supportive to or restorative of life and well-being." But RNs must carry out medical regimens only as prescribed by a licensed physician, NP or PA. It IS NOT permitted for you to allow an RN to diagnose and treat in any manner that is inconsistent with the medical regimen you established for a patient, or perform an activity in which the RN is not trained and competent. The following are examples of activities it IS okay for an RN in New York to perform, but only while physically working with a physician and when prescribed by a physician, NP or PA: identification and addressing of patient health problems and unmet patient care needs, development of nursing care plans, bereavement counseling, ostomy care, medication administration, wound care, health screening of early signs of disease or risk factors, health teaching, making referrals, and emotional support to patients and their families.

NPs. You may have NPs included in your medical practice, or you may be collaborating with one or more NPs at other locations. In New York State, a nurse practitioner is an RN who has completed advanced nursing education (usually a master's or doctorate degree) in a nurse practitioner specialty area AND is certified

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by the New York State Education Department in that specialty area: Adult Health; Family Health; Gerontology; Neonatology; Obstetrics; Oncology; Pediatrics, Perinatology; Psychiatry; School Health; Women's Health; Holistic Care; and/or Palliative Care. Additional limitations and rules apply for NPs in the following settings: Acute Care, College Health, Community Health, and Holistic Care, and Gynecology. An NP must be competent and engage ONLY in the specialty area of practice in which the nurse practitioner is certified. Within these strict limits, on a day-to-day basis, an NP does not necessarily have to be part of your medical practice. NPs do not require direct physician supervision over them or co-signatures of their charts or records. But all NPs must have an active physician "Collaboration" in operation. If you are a collaborating physician to an NP, you and the NP must be collaborating on the same specialty area for which you are experienced and they are certified.

New York State Education Law provides for two NP physician Collaboration options. First, all NPs must establish a relationship with a collaborating physician, with whom they maintain active communication and have written practice agreement and protocols. This can be in your practice or at another location. You, as the collaborating physician, must review the NP's charts at least once every three months, and may not enter into written practice agreements with more than 4 NPs who are not located on the same physical premises as you. Second, since 2015, New York State's Nurse Practitioners Modernization Act states that NPs having more than 3,600 hours of qualifying NP experience can elect to either continue that collaborative physician relationship with its written practice agreement and protocols, OR have "collaborative relationships" with one or more qualified physicians or licensed health care facility physicians. If you are in a "collaborative relationship" with an NP, New York State Education Law states that you and the NP must communicate with each other by phone, electronically, or in writing to exchange information to provide comprehensive care or make referrals. There is no requirement under this second option that you as the physician review the NP charts every three months, or have a written collaborating agreement with protocols, but you as the physician must complete a qualifying "Attestation." An NP under either option may continue to see patients even if you, as a collaborating physician, are on vacation or even out on a leave of absence or illness, as long as you remain available for communication as needed. In the case of a prolonged absence by a collaborating physician, it is recommended that you identify an alternate resource person for the NP. There are other rules and regulations concerning NPs.

There are many additional laws and rules about the use of PAs, Medical Assistants, LPNs, RNs and NPs, the presence of their names in your patient records, and your reimbursement rates. Every licensed, certified, and registered professional in your practice has ongoing education, testing, and malpractice insurance and recertification credentialing requirements. If you have specific questions, you should consult with a knowledgeable source and clarify your own responsibilities. Relying on your employees and mid-levels alone to set their own credentialing, treatment or schedule boundaries is not appropriate. In all cases, mid-levels and other support staff with whom you work or collaborate become your responsibility on different levels. They are not physicians. All are justly limited by you in their ability to perform patient care: by your physical presence or availability for supervision or collaboration, by any limitations you set for them over patient care, by your assessment of their experience and competency, and by your areas of knowledge, training and expertise.

A Message From the President…

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fellow invitee of President Obama's Patient Centered Outcomes Research Institute in Washington DC. We have collaborated on several projects aimed at leading social justice and positive culture change within medicine and health care more broadly. I have appreciated Dr. Bensadon's ability and willingness to cut across disciplinary siloes and ability to bring psychology and medicine together. This has included clinical roles in family medicine, internal medicine, and geriatric medicine, and as Associate Director of the internal medicine residency program's geriatrics and palliative care rotation at Florida Atlantic University. He recently assembled a team of psychologists and physicians (myself included) as Editor of a collaborative text titled Psychology and Geriatrics: Integrated Care for an Aging Population (Elsevier) and was selected 1 of 15 national geriatrics leadership scholars by the American Geriatrics Society (AGS) and Association of Directors of Geriatric Academic Programs (ADGAP). Most recently he launched an independent clinical practice focused on primary care psychology and geriatrics and has been heavily involved in leading physician wellness initiatives for two county medical societies in Florida, a major reason I solicited his contribution to our newsletter.

References

1. Shapiro L. Quality care, affordable care : how physicians can reduce variation and lower healthcare costs. Phoenix, Maryland: Greenbranch Publishing; 2014.

2. Baker N WJ, Resar RK, Griffin FA, Nolan KM. Reducing Costs Through the Appropriate Use of Specialty Services. 2010.

3. Fuchs VR. The doctor's dilemma – what is "appropriate" care? *N Engl J Med* 2011; **365**(7): 585-7

4. Partnership NP. National Priorities & Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum, 2008.

George Baumler, M.D. ~ 1/11/2018

Bertram Portin, M.D. ~ 1/13/2018

Milford Maloney, M.D. ~ 2/9/2018

Welcome New Members!

Sarah Cairo, M.D., Pediatric Surgery

Brian D'Arcy, M.D., Cardiovascular Disease

John Fitzgerald, M.D., Diagnostic Radiology

John Huebschmann, M.D., Anesthesiology

Lisa Kozlowski, M.D., Cardiology

Katharine Morrison, M.D., OB/GYN

Crystal Nunez, M.D., Pediatric Critical Care

Mary Rykert-Wolf, M.D., Family Medicine

Paul Updike, M.D., Internal Medicine

Physician Burnout: A Culture Clash of Psychology & Medicine

Benjamin Bensadon, Ed.M, Ph.D

In a 2016 *JAMA* essay titled "Healing Physicians," addiction psychologist Lisa Merlo conveyed her deep empathy for distressed physicians and described her numerous clinical interventions.[1] Given that physicians commit suicide nearly twice as often as the general public, I called her to learn more and hopefully help. In our 2-hour conversation she shared that while some readers were supportive, many were angry, calling into question her credibility. Why? *Because she is not a physician.*

Sadly, I was not surprised. I have documented similar examples in a collaborative text advocating better psychologist-physician collaboration.[2] One psychologist described being ordered to avoid interviewing a patient that the physician assumed would be embarrassed by a psychologist visit. The psychologist saw the patient anyway and was later thanked by the physician who hadn't realized the patient was acutely suicidal, with a firearm and plan. Another psychologist reported physician colleagues refused to refer to him as Doctor until one day he correctly detected a normal pressure hydrocephalus diagnosis that they missed. My own experiences have been similar. A chief medical resident I'd mentored called me about a patient he revived while others had called the code, assuming the patient died. The resident described deep satisfaction seeing patient extubated, and months later in the hospital, confided privately that his confidence to continue compressions was due to a conference presentation he and I gave about death and medical training. When I relayed this to faculty leadership with hopes of integrating further and replicating similar outcomes, they were annoyed and offended. One asked why I was taking credit, another stated I should feel lucky to have even attended the conference. None acknowledged the life saved. None acknowledged that the resident was empowered. Instead, they focused resentfully on me. Why? I cannot be certain, but I believe in part, *because I am not a physician.*

These examples illustrate the understandably strong collective identity that bonds physicians. But they also reveal the dangerous impact of an environment where exposure to trauma and stakes is high; tolerance for emotional support is low; and anything less than perfection can be deadly. In this setting physicians' psychological needs are generally undetected, denied, or ignored. Even when recognized, these needs are rarely acknowledged due to fear, perceived stigma, and a toxic training model in which conformity is encouraged, revealing one's own vulnerability is not, and emotion is often perceived as a liability.[3,4] Physicians know this is nothing new and live in a culture of ignoring their own well-being.

But in a nation where currently, physicians reportedly manage burnout by committing suicide between 300-400 times a year, and medical error ranks 3rd in all-cause mortality,[5] the urgent need for crisis intervention is inarguable. But so is the acute stigma of and resistance to needing an intervention. So what can be done?

Burnout

Like most psychological syndromes, burnout is hard to diagnose until the process has already begun. Visible evidence of maladaptive coping behavior (e.g., substance misuse) often signals there is a problem.[6] Psychologist Christina Maslach has examined and measured burnout for more than 25 years,[7] and her assessment tool (Maslach Burnout Inventory) is now ubiquitous in medical training. Consistent with the climate described above, she defines 3 primary components of burnout—emotional exhaustion, cynicism, and inefficacy—and prescribes increased civility and respect as evidence-based solutions.[8] Recently academic physicians have called for the same.[9]

Wellness

Though these solutions are conceptually straightforward, implementation remains difficult. Why? Physician discomfort with psychology is common. Psychologists themselves have largely failed to articulate their role. "Wellness" is nonetheless being promoted as an antidote to burnout by academic medicine.[10] The wellness movement was actually pioneered by pediatric psychologist Emory Cowen, who shifted away from *reactive* focus on "fixing" deficits and psychopathology to proactive emphasis on primary and secondary prevention, by targeting resilience.[11] But in a healthcare system where psychologists and physicians rarely cross paths, this differential is missed, wellness is poorly

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NEW AMA Podcast Series Helps Physicians Navigate Difficult Conversations

For many physicians, having difficult conversations with patients is a part of daily practice. That's why the American Medical Association recently launched a new podcast series, AMA Doc Talk, which features physicians' eye-opening encounters with patients and their real-world solutions and insights. Inspired by research and feedback from physicians, topics range from talking with patients who don't heed your medical advice to helping patients manage the challenges of chronic disease. The interview-style series is hosted by Dr. Rajesh S. Mangrulkar, associate dean for medical student education, University of Michigan. We invite you to listen to episodes of AMA Doc Talk, rate us and subscribe at Apple Podcasts or Stitcher.

Thank you to all of the Erie County Legislators, Representatives, and Member Physicians for your participation in our Legislative Breakfast, January 19th, 2018

Physician Burnout…

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defined, and interventions run the gamut from yoga, tai chi, and meditation, to psychotherapeutic interventions such as cognitive behavioral therapy and 24/7 access to confidential telephone counseling. I have tried to differentiate this in psychiatrist-dominant physician wellness committees, and suggested that lecturing physicians about exercise and nutrition, or worse, purporting to teach them how to be "happy," is misguided, ineffective, and offensive. Alternatively, cultivating physicians' own resilience and supporting their efforts to survive a broken system that incentivizes poor, incomplete care, mandates overwhelming bureaucratic administrative burden, and increasingly sacrifices training and knowledge to contain cost ("value"), can help.

Evidence

Where's the proof? Given burnout's humbling, emotional nature and healthcare's longstanding disciplinary siloes, medical journals publish data quantifying the problem more frequently than solutions reliant on psychological intervention. But this may be changing.[12] While popular media more openly addresses physician mental health and psychologists' efforts to assist, Stanford has hired a physician Chief Wellness Officer to guide their WellMD program[13], and Mayo Clinic has developed a department of Psychiatry and Psychology, focused on integrated patient care and healthcare worker resiliency training.[14] Importantly, Mayo's Department is explicitly named Psychiatry and Psychology as opposed to the more standard (generic) "Psychiatry and Behavioral Sciences." Willingness to directly reference psychology by name makes it clearer to understand, "safer" to discuss, and clinically, easier to integrate.

Future Solutions

In a healthcare system plagued by uncertainty, some physician leaders from organized medicine have attempted to formally normalize physician needs and limitations, and advocate for teamwork. Former CMS administrator Donald Berwick has recommended abandoning the notion that physicians can and must be completely self-sufficient,[15] and AAMC CEO Darrell Kirch, has more specifically identified psychologists' role in helping physicians manage, as system-induced risk of burnout continues to rise.[16] Though important steps, as corporatization of care persists, the traditional culture of medicine described above will remain a risk factor for physician burnout. But a genuine mentality shift that counters the longstanding artificial separation of psychology and medicine may enable us all to unite as a buffer.

In medicine, what has traditionally been dismissed as "touchy feely," is now a matter of life and death.

References

1. Merlo LJ. Healing Physicians. *JAMA*. 2016; 316(23):2489–2490.

2. Bensadon B. *Psychology and Geriatrics: Integrated Care for an Aging Population*. Elsevier; 2015.

3. Shapiro J. Perspective: Does medical education promote professional alexithymia? A call for attending to the emotions of patients and self in medical training. *Acad Med* 2011;86(3):326-332.

4. Gaufberg EH, Batalden M, Sands R, Bell SK. The hidden curriculum: what can we learn from third-year medical student narrative reflections? *Acad Med* 2010;85(11):1709-1716.

5. Makary MA, Daniel M. Medical error-the third leading cause of death in the U.S. BMJ 2016;353:i2139.Zeidner M, Saklofske D. Adaptive and maladaptive coping. In M Zeidner & NS Endler (Eds.) Handbook of Coping: Theory, Research, Applications. (pp 505-531). New York: John Wiley & Sons.

6. Maslach C, Schaufeli WB, Leiter MP. Job burnout. *Ann Rev Psychol* 2001;52:397-422.

7. Maslach C, Leiter MP. New insights into burnout and health care: Strategies for improving civility and alleviating burnout. *Med Teach* 2017;39(2):160-163.

8. Leape LL, Shore MF, Dienstag JL, Mayer RJ, Edgman-Levitan S, Meyer GS, Healy GB. Perspective: a culture of respect, part 2: creating a culture of respect. *Acad Med* 2012;87(7):853-858.

9. Mayo Clinic Physician Well-being Program. http://www.mayo.edu/research/centers-programs/physician-well-being-program/overview

10. Cowen, EL. The enhancement of psychological wellness: Challenges and opportunities. *Am J Comm Psychol* 1994;22:2, 149-179

11. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet* 2016; 5(388):2272-2281.

12. Stanford WellMD. https://med.stanford.edu/news/all-news/2017/06/stanford-medicine-hires-chief-physician-wellness-officer.html

13. Werbeburg BL, Jenkins SM, Friend JL. Improving resiliency in healthcare employees. *Am J Health Behav* 2018;42(1):39-50.

14. Berwick D. Era 3 for medicine and healthcare. *Jama* 2016;315(13):1329-1330.

15. Kirch DG, Ast CE. Health care transformation: The role of academic health centers and their psychologists. *J Clin Psychol Med Settings* 2017;24(2):86-91.

…Like most psychological syndromes, burnout is hard to diagnose until the process has already begun…

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Mr. Turner is a nationally known speaker, entrepreneur, author and activist, who has authored multiple books, videos, speeches, and training programs. He has been recognized through The University of Chicago, TEDx, Integrating Woman Leaders Foundation, Fox News Radio, NCAA, and several other outlets. A few of his recent Keynote Presentations Include: "Be Humanity: The Challenge to be More Human", "Why it Might Be Time to Rethink (MOST) Everything You Believe about Diversity." Mr. Turner is also the author of "Raising Supaman" which gives parents, students, and educators tools & strategies to increase student's access to higher education.

Monday, May 7, 2018

5:45 P.M. – Vendor Display & Cocktail Reception

6:45 P.M. – Call to Order and Dinner

Statler City, 107 Delaware Avenue, Buffalo, NY

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NO SHOW POLICY: Refunds will be made if cancellation is confirmed no later than Monday, April 30, 2018
QUESTIONS: Emily McMullen, 716-852-1811 ext. 102, mcmullene@wnydocs.org

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