PHYSICIAN WELLNESS & WORK/LIFE INTEGRATION

ATTAINING WELLNESS AS A PHYSICIAN
By Chantal Brazeau, MD

PHYSICIAN BURNOUT AND ITS IMPACT ON MEDICAL LIABILITY: AN INTERVIEW WITH MARTIN STILLMAN, MD, JD
Interviewed by Catherine E. Williams & Janet S. Puro, MPH, MBA

ANNOUNCING THE 2019 EJI EXCELLENCE IN MEDICINE AWARD HONOREES
By Janet S. Puro, MPH, MBA

PRIMARY CARE PROVIDER-PATIENT COMMUNICATION TOWARDS HEALTH EQUITY
By Amanda Medina-Forrester, MA, MPH, & Commissioner Shereef Elnahal, MD, MBA
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Welcome to the Winter issue of MDAdvisor—dedicated to the theme of physician wellness and work/life integration. It has been well documented that burnout is a major issue among physicians. According to Medscape’s 2019 National Physician Burnout, Depression & Suicide Report, 44 percent of physicians report feeling burned out. The most common reasons cited for burnout included having too many administrative tasks, working long hours, dealing with technology/EHRs and a lack of respect from administrators, employers, colleagues or staff.

As Dr. Martin Stillman points out in his interview that starts on page 30, there is a correlation between burnout and patient errors, and a real medical liability risk associated with burnout with respect to providing appropriate standards of care in a manner that is well-received by patients. As an advocate for physicians and for patient safety, MDAdvantage will be paying attention to the topic of physician wellness throughout 2019 in a variety of ways, including supporting physicians through providing education and strategies for reducing stress and burnout, as presented in journal articles, podcasts and workshops conducted by experts in the field.

Also included in this issue is a regional legislative update and an article from the New Jersey Department of Health addressing the challenges associated with providing access to primary care for culturally diverse communities. Finally, we proudly introduce to you the 2019 EJI Excellence in Medicine honorees. I hope you will join me in congratulating this year’s award recipients and supporting the Excellence in Medicine Scholarship Fund.

Sincerely,

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Peer Reviewer Acknowledgements

The Editorial Board would like to acknowledge the following individuals who served as peer reviewers of manuscripts submitted for consideration for publication in MDAdvisor in the past year, as well as those reviewers who prefer to remain anonymous. Our reviewers are an important part of the selection process, and provide our authors with valuable insights. We gratefully acknowledge their comments and contributions.

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What’s Happening in Healthcare?

U.S. SPENDS TWICE AS MUCH ON HEALTHCARE AS PEERS

Americans spend more than twice as much on healthcare per person as their peers in developed nations, according to a new analysis from Johns Hopkins Bloomberg School of Public Health. It isn’t because people in the U.S. use more medical services. Instead, it’s because drugs cost more, doctors and nurses are paid better, hospital administration is more expensive and many medical services have higher price tags.

THE PUSH FOR INTEROPERABILITY GAINS NEW URGENCY IN 2019

With most providers having implemented an EHR system to comply with federal Meaningful Use requirements, the government has turned its attention to interoperability. The now renamed program, Promoting Interoperability, will focus attention on using technology to deliver meaningful and actionable data to improve outcomes across the care continuum and at the point of care for populations of patients.
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ATTAINING WELLNESS AS A PHYSICIAN

By Chantal Brazeau, MD

LEARNING OBJECTIVES

AT THE CONCLUSION OF THIS ACTIVITY, PARTICIPANTS WILL BE ABLE TO:

1. Describe current drivers of physician burnout in the healthcare environment
2. Describe at least one strategy for improving personal resilience
3. Describe at least one strategy that can create a culture of wellness in the healthcare workplace
4. Describe a strategy for improving practice efficiency
IN ORDER TO OBTAIN **AMA PRA CATEGORY 1 CREDIT™**, PARTICIPANTS ARE REQUIRED TO ADHERE TO THE FOLLOWING:

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6. Mail the Registration and Evaluation Form on or before **February 1, 2020**. Forms received after that date will not be processed.

**Author:** Chantal Brazeau, MD, Professor of Family Medicine and Psychiatry and Assistant Dean for Faculty Vitality, Rutgers New Jersey Medical School, Newark, New Jersey.

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Physician wellness is a topic that has received increasing attention in recent years.

It has always been important, of course, for physicians to care for themselves so that they can best care for others. But a recent report of burnout in more than half of the physicians in the United States\(^1\) has brought the topic of physician wellness to the forefront.

The term “burnout” was first coined in the 1970s. The most recent large-scale studies, each looking at about 7,000 physicians across the United States, found an average of about 45 percent of physicians had at least one symptom of burnout in 2011, which increased to 54 percent in 2014.\(^1\)

Burned-out physicians mean burned-out care. Burnout has been associated with more medical errors as perceived by physicians, less careful prescribing habits and less satisfying doctor–patient relationships.\(^2\) In addition, burnout can lead to more turnover of physicians in practices, hospitals or organizations and physicians going part-time or retiring early—which is costly to organizations and disrupts the continuity of care for patients.\(^2\) Burnout can lead to depression, and it is an independent risk factor for physicians thinking about suicide.\(^2\) Burnout as a work-related syndrome

Burnout is not a mental health diagnosis—it is a work-related syndrome that can be explained in three parts that can exist to varying degrees in an individual person.

**The first part** is emotional exhaustion—feeling depleted, like you have nothing left to give.

**The second part** is depersonalization—going through the motions at work, being so robotic that you view patients as just another problem to solve, rather than seeing them as people. Depersonalization can also mean feeling cynical about and removed from the work you do.

**The third part** is a decreased sense of personal accomplishment—no matter how well you may be doing or how many accomplishments you may have, you just don’t feel good enough or worthwhile.\(^8\)

Various factors drive these elements of physician burnout, including individual coping style and circumstances. However, the extensive number of physicians reporting burnout has led experts to look at organizational factors in the work environment and within the healthcare system\(^5\) as the main drivers of the current burnout epidemic.

Physicians report administrative burden is the top work-environment factor contributing to burnout. For example, physicians have been faced with increased demands for documentation for reimbursement, quality management monitoring and certification maintenance.\(^10\) Electronic health records (EHRs) are designed to support comprehensive documentation, but are not necessarily designed to be user friendly.\(^11\) It has been recently estimated that for each hour of patient care, there are two additional hours of related administrative work. This is time-consuming, leading physicians to log in from home at the end of the day to complete charts and other administrative requirements. Time on the computer during the medical visit itself can also erode meaningful face-to-face quality time that physicians spend with their patients.\(^10\)

To reduce physician burnout, it is clear that organizational factors at work and within the healthcare system must be addressed.\(^5\) Some factors, such as documentation requirements for reimbursement, need to be attended at the national level. For example, the Centers for Medicare and Medicaid Services is working to simplify the evaluation and management coding system to reduce provider burden.\(^12\) National professional organizations, too, are weighing in as this process evolves.\(^13\) Some medical specialty boards are simplifying requirements for Maintenance of Certification.\(^14\)

**Three Domains of Professional Fulfillment**

As these larger systemic changes take place, physicians can proactively work to maintain personal wellness and promote professional fulfillment within their local work environment. One methodical approach for supporting physician wellness is to address the following three domains of professional fulfillment: personal resilience, culture of wellness and efficiency of practice.\(^15\)

**Personal Resilience**

Approaches for improving personal resilience—the ability to thrive despite adversity—can be divided into three categories: self-care, self-awareness and work–life integration.

**Self-care** includes the basic, but necessary, elements of exercise, good nutrition and adequate sleep. It also includes activities that offset the body’s stress response, such as relaxation techniques, mindfulness meditation, breathing techniques, disciplines such as yoga or tai-chi, or any activity or hobby that has that effect for an individual. In particular, mindfulness meditation has been shown to be effective in physicians.\(^16\)

**Self-awareness** is multifaceted. Aspects include awareness of one’s personality traits and feelings and knowledge of what is...
most meaningful at work. Common traits in physicians include a heightened sense of responsibility, a tendency to doubt and be critical, and a tendency to feel guilty. Although these traits are helpful and important in medicine, they can be draining if they are taken to an extreme. For example, one wants a physician to be critical of the literature and double-check test results, but being overly self-critical can be demoralizing. A physician needs to be mindful and aware of these traits and maintain a healthy balance.

Noticing one's feelings is another component of self-awareness. Physicians are taught to remain calm and objective in the face of chaos; they are exposed to tragedy and joy in people's lives, and often go from one high-stress situation to another, without time to notice what they feel or to process the emotional impact. Being aware of these feelings and seeking a venue in which to share them is a healthy way to maintain resilience. Mindfulness need not be achieved only during formal mindfulness meditation, but can be done informally in simple moments of awareness during day-to-day experiences. A second or two to appreciate the patient in front of us, a few slow breaths taken before the next meeting or patient session, or a moment to think about a grateful patient can be helpful and remind us of what is most meaningful at work.

Work-life integration can be challenging. One approach is to have a schedule that integrates personal and work activities so that family and personal matters are not simply getting leftover time after work. For example, formally scheduling family or hobby activities on one's calendar may prevent a physician from putting them on hold until the workload improves. When possible, paying for assistance with household chores can help make the time at home more focused on relationships or on more meaningful home activities (keeping in mind that a chore for one person can be fun for another).

CULTURE OF WELLNESS

Physicians are typically viewed as leaders, and thus, they can normalize and model wellness behaviors with their colleagues, co-workers or clinical team members. At the organizational level, support for wellness should include regular measurement of well-being and work fulfillment. A culture of wellness should be more than hosting wellness fairs. It is about how the organization or the practice is run and the values that the leadership projects.

The leadership in an organization should be encouraged to support provider wellness efforts for many reasons. Implementing strategies for improving provider wellness can help the organization save money, improve the quality of care provided to patients, improve morale and maintain satisfied providers. Additionally, a sincere commitment to addressing wellness can foster trust between administrators and providers.

A number of activities can create a culture of wellness. These include regular meetings in which team members have a voice to improve the work environment, recognition of successes, meetings with time for people to share meaningful personal or professional successes, peer support or formal mentoring and gatherings for affinity groups (e.g., women, minorities, physicians with particular clinical or research interests). Providing the opportunity for judgment-free discussion groups in which physicians of all backgrounds can freely share and reflect about work experiences has also been shown to reduce burnout and can give a powerful message that wellness is supported in the work environment.

Physicians who are employers or supervisors can promote a culture of wellness. This can be done through sensitive planning of staff/physician deployment by being mindful to help employees spend at least 20 percent of their time on activities that are meaningful and are a good fit for them while balancing the needs of the practice or organization. Flexible scheduling for those who need it, as well as direct and compassionate feedback about areas that need improvement, also contributes to wellness.

EFFICIENCY OF PRACTICE

Working in an efficient clinical practice with well-organized work flows and team members who work well together and perform at the top of their license is certainly more satisfying than practicing in a chaotic, uncoordinated clinical environment. This domain of wellness often appears more difficult to attain to many physicians who do not feel they have control over their practice setting or over wellness issues impacted by the larger, national healthcare system.

A recommended approach is to hold a meeting or focus group with the clinical team about the work flow, giving every team member a chance to provide ideas for improvement. Then the team can select one achievable change to improve the work flow or the functioning of the practice. The team should then meet again to review outcomes. This is a quality assurance process, or plan-do-study-act cycle, that focuses on practice efficiency centered on the wellness and satisfaction of the providers and clinical team members. The American
Medical Association has a website called STEPS Forward that provides information (and continuing medical education credits) about physician well-being. This site offers several practice initiatives that can help a physician save time and improve efficiency, such as implementing an expanded rooming protocol or pre-visit laboratory tests or even managing the EHR in-box. These approaches and others have been used successfully in clinical practices to improve providers' joy in practice.

The wellness of physicians is an essential part of providing excellent quality care to patients. Wellness initiatives include developing important resilience strategies that physicians can do for themselves, as well as participating in organizational interventions that promote a culture of wellness and an efficient, more satisfying clinical practice. Physicians can join in all these initiatives to attain, improve and maintain their resilience and wellness.

Chantal Brazeau, MD, is Professor of Family Medicine and Psychiatry and Assistant Dean for Faculty Vitality at Rutgers New Jersey Medical School, Newark, New Jersey.


1. Which of the following outcomes has not been shown to correlate with physician burnout?
   a. Less careful prescribing habits
   b. Suicidal thoughts
   c. Early retirement
   d. Lower cost to organizations where physicians work
   e. Less satisfying doctor-patient relationships

2. Burnout is a mental health diagnosis.
   a. True
   b. False

3. Which of the following is not an aspect of physician burnout?
   a. Depersonalization
   b. Emotional exhaustion
   c. Increased confidence in your abilities as a physician
   d. Decreased sense of personal accomplishment

4. Physician burnout can be addressed only at the personal level, and not at the organizational level.
   a. True
   b. False

5. Physician burnout has been linked to an increase in reports of medical errors.
   a. True
   b. False

6. Resilience means remaining unaffected by stress or discomfort.
   a. True
   b. False

7. Being highly self-critical is not an essential trait for practicing safe medicine.
   a. True
   b. False

8. Providing physicians more vacation time is an essential element of creating a culture of wellness.
   a. True
   b. False

9. The use of electronic health records has been associated with a reduction in stress in the practice environment.
   a. True
   b. False

10. Which of the following is the number one work environment factor that physicians report as a contributor to burnout?
    a. Size of practice
    b. Patient load
    c. Academic or research responsibilities
    d. Administrative burden
ATTAINING WELLNESS AS A PHYSICIAN

REGISTRATION & EVALUATION FORM
(Must be completed in order for your CME Quiz to be scored) Deadline for Response: February 1, 2020

REGISTRATION FORM

First Name Middle Initial Last Name Degree

Address

City State ZIP

Phone Email Address Specialty

ANSWER SHEET Circle the correct answer.

1) A B C D E 2) A B 3) A B C D 4) A B 5) A B

Number of hours spent on this activity ______ (reading article and completing quiz)

I attest that I have read the article “Attaining Wellness as a Physician” and am claiming 1 AMA PRA Category 1 Credit.™

Signature Date

EVALUATION Completed by □ Physician □ Non-Physician

1. The content of the article was: 
   Excellent___ Fair___ Good___ Poor___
2. The author's writing style was: 
   Excellent___ Fair___ Good___ Poor___
3. The graphics included in the article were: 
   Excellent___ Fair___ Good___ Poor___
4. The stated objectives of this program were: 
   Exceeded___ Met___ Not met___

Was this article free of commercial bias? Yes □ No □

If not, why not

Please share your name and contact information so that we may investigate further.

Participant Name __________________________ Telephone/Email: __________________________

5. Will the knowledge learned today affect your practice: Very Much___ Moderately___ Minimally___ None___
6. Based on your participation in the CME activity, describe ways in which you will change the way you practice medicine.

   □ Yes Describe__________________________________________________________

   □ No Why Not___________________________________________________________

   □ N/A Were you the wrong audience for this activity?______________________

7. Did this CME Activity change way you know about:
   • Current drivers of physician burnout in the healthcare environment. Yes □ No □
   • Strategies for improving personal resilience. Yes □ No □
   • Strategies that can create a culture of wellness in the healthcare workplace. Yes □ No □
   • Strategies for improving practice efficiency. Yes □ No □

8. Based on your participation today, what barriers to the implementation of the strategies or skills taught today have you identified?

   __________________________________________________________________________

Suggested topics for future programs:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Legislative Update

By Jon Bombardieri

Health-related legislation continues to dominate discussions throughout the country. On the East Coast, the following pieces of legislation seek to improve healthcare for all.

NEW JERSEY

Senate Bill No. 3201, The Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act: When Governor Phil Murphy signed an out-of-network law on June 1, 2018, some applauded the new administration for ending the nearly decade-long struggle to define how insurers pay out-of-network doctors for services. Others believed the law heavily favored insurance companies and took negotiating power away from out-of-network doctors. While awaiting more definitive regulations from the Department of Banking and Insurance, which have yet to be issued, critics and supporters of the law have accused each other of attempting to manipulate the process in their favor.
New Jersey Medical Marijuana Update

According to the New Jersey Medical Marijuana Program Registry, New Jersey has 38,000 patients and 1,530 caregivers participating in its medical marijuana program, and this number continues to grow. On December 17, 2018, the New Jersey Department of Health (DOH) announced that six companies had been selected to apply for permits to open new medical marijuana dispensaries. Two applicants were chosen in northern, central and southern parts of the state, ensuring patients have local access to pain-relieving medicine.

Before receiving approval to grow medical marijuana, the selected applicants now must pass background checks, provide evidence of a dispensary location and municipal approval and comply with all regulations under the Division of Medical Marijuana, including safety and security requirements.

The 146 applications were reviewed by a six-person committee consisting of four DOH representatives and one each from the Departments of Agriculture and Treasury. The committee members’ expertise includes medical marijuana, alternative treatment center (ATC) regulation, lab testing, plant science, diversity and procurement. Before scoring the applications, committee members received implicit bias training from the state’s Chief Diversity Officer to ensure an impartial selection process.

Connecticut

Substitute Senate Bill No. 302.

Expansion of Telemedicine:

Connecticut has taken another step toward expanding the meaningful use of telemedicine in connection with treatment of mental health and substance use disorders. Senate Bill 302, signed by Governor Dannel Malloy and effective July 1, 2018, allows providers to prescribe controlled substances via telemedicine for the treatment of psychiatric disabilities or substance use disorder, including medication-assisted therapy. The law reverses Connecticut’s previous prohibition on prescribing Schedule I, II or III controlled substances via telehealth technologies.

The law benefits Connecticut patients with mental health or substance use disorder issues, allowing these individuals to obtain better access to quality care. Industry advocates have applauded the Legislature and the Governor for this change. Connecticut’s substance abuse treatment providers can now incorporate controlled substances into their therapies, which are an important and clinically significant component of these specialties.

1. Setting a guideline for payment for care.

The current law does not dictate what a procedure costs, leaving it up to doctors and insurers to debate. The Lagana-Gopal bill would use guidelines from FAIR Health, a national, independent not-for-profit, that were established following a review of out-of-network reimbursement methodologies to determine a minimum reimbursement. Doctors and insurers can still debate the cost, based on a variety of other factors, such as where the procedure is performed and the expertise of the doctor, but FAIR Health would provide a starting point.

2. Establishing arbitration rules.

The current law calls for baseball-style arbitration, which means a third-party can choose only one payout amount between the originally billed amount and the insurance payout amount. However, the law also says that for a claim to go through arbitration, there must be a difference of $1,000 between those amounts. If the difference is less than $1,000, doctors have to accept what the insurers determine is fair-market value.

The Lagana-Gopal legislation establishes an arbitration system for out-of-network healthcare services provided in certain emergency and inadvertent situations that result in payment disputes between health insurance carriers and healthcare providers. The bill removes the requirement that the difference between the carrier’s and the provider’s final offers must be not less than $1,000 for the dispute to proceed to arbitration.

The change is an attempt to make the original bill more representative of the services provided.

3. Determining what actually is a surprise.

Over the years, many feel a major flaw in the reimbursement system has been that one doctor in a group setting could be out of network although the other doctors participating in a procedure—and the setting itself—could be in network. The Lagana-Gopal legislation asks for the Department of Banking and Insurance to better define “inadvertent” out-of-network care. The sponsors hope to have the legislation moved in the first part of 2019.
Delaware

Senate Bill No. 227. An Act to Amend Title 16, Title 18 and Title 29 of the Delaware Code Relating to Primary Care Services:

This bill, sponsored by Senator Bryan Townsend (D) and signed into law in August 2018, requires individual, group and state employee insurance plans to reimburse—or pay—primary care physicians and medical professionals as much as Medicare does for the next three years.6

Supporters say this increase will help keep doctors in the field of primary medicine and in Delaware as the medical system braces for a possible shortage of primary care physicians in coming years.7

This Act promotes the use of primary care through the following requirements:

1. Creating a Primary Care Reform Collaborative under the Delaware Health Care Commission
2. Requiring all health insurance providers to participate in the Delaware Health Care Claims Database
3. Requiring individual, group and state employee insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants and other front-line practitioners for chronic care management and primary care at no less than the physician Medicare rate for the next three years

Despite the demonstrated value of primary care, access to primary care for Delawareans has become increasingly difficult because insurance reimbursement rates fail to support an adequate infrastructure. The national average for primary care spending for an insurance plan is between 6 and 8 percent of the insurer’s total medical expenditures. Studies recommend, and some states are actively implementing, a 12 to 15 percent spending rate to have an effective system. Delaware’s average insurance spending on chronic care management and primary care is between 3 and 4 percent. Nationally, insurance reimbursement for primary care averages between 120 and 140 percent of Medicare rates. In Delaware, the commercial market reimburses independent primary care at rates as low as between 65 and 85 percent of Medicare rates.7 (Reliable data regarding insurance spending are difficult to obtain due to a combination of contractual restrictions and an absence of mandatory healthcare price transparency requirements applicable to commercial plans in Delaware.)

This Act simultaneously enacts short- and long-term solutions to strengthen the primary care system in this state. At the same time, the Primary Care Reform Collaborative and the Delaware Health Care Commission are studying long-term recommendations that would require insurers to reimburse for chronic care management.

District of Columbia

D.C. Law 22-75. Defending Access to Woman’s Health Care Services Amendment Act of 2018:

This bill, approved by Mayor Bowser, amends the District of Columbia Health Occupations Revision Act of 1985 to allow pharmacists to prescribe and dispense certain contraceptives pursuant to established protocols.8 This bill also amends the Women’s Health and Cancer Rights Federal Law Conformity Act of 2000 by adding the following provisions:

- Insurers are required to cover certain healthcare services without cost-sharing.
- Insurers are required to authorize dispensing up to a 12-month supply of a self-administered hormonal contraceptive prescribed and dispensed by a licensed pharmacist.
- Certain employers are provided with a religious exemption from, or accommodation for, the coverage of contraceptive products and services.
- Insurers are required to provide information regarding coverage to enrollees and potential enrollees.

Maryland

Health Coverage through penalty charge:

Marylanders without health insurance would be required to pay a state penalty that can go toward purchasing coverage, under legislation to be introduced in 2019 by state Senator Brian Feldman and Delegate Joseline Peña-Melnyk.9

Under the proposal, anyone in the state who reports not having quality health insurance would be required to pay a penalty, similar to the federal mandate that will end in 2019 under changes to the Affordable Care Act. However, unlike the federal plan in which the collected penalty money goes into a general pool used to cover everyone, Maryland’s proposal would allow the collected funds to go toward purchasing a health insurance plan for that individual.

Nearly 80,000 Marylanders would be eligible to gain coverage through paying the state penalty, according to a report from the U.S. Agency for Healthcare Research and Quality and the Maryland Health Services Cost Review Commission.9
Rhode Island is following states such as New Jersey, California, Florida and New York that have passed comprehensive laws on balance billing.

Jon Bombardieri is a Partner at CLB Partners, LLC, in Trenton, New Jersey.

1 Lagana, J., & Gopal, V. (2081, November 26). Senate, No. 3201; State of New Jersey 218th Legislature. www.njleg.state.nj.us/2018/Bills/S3500/3201_I1.HTM.
In recent decades, medical schools have acknowledged the positive impact that diversity has on the learning environment, on the research we undertake and most importantly, on the patient care we provide. We have also seen that the benefits of diversity, unleashed through inclusion, foster greater creativity and innovation. However, the attainment of diversity—the very thing we desire—presents its own set of challenges for us as physicians.

A TAPESTRY OF LIFE EXPERIENCES
New Jersey, like the nation, has experienced a tremendous growth in the diversity of its population with 31 percent of New Jersey households (2013–2017) speaking a language other than English at home. The state’s physician workforce is also diverse, ranking highest in the nation in the number of international medical graduates who may also be non-U.S. born and complete residency training in the state.

Given this rich collage of physicians, it is vital that any wellness strategy avoid a one-size-fits-all approach and takes into account the tapestry of life experiences that our colleagues bring to the everyday care of their patients and to the training of our students and medical residents. Our journeys extend far beyond our professional training and include our social identities of race/ethnicity, gender and sexual orientation, as well as our cultures and traditions.

Physician Burnout & Dimensions of Diversity
By Maria L. Soto-Greene, MD, MS-HPEd, & Sangeeta Lamba, MD, MS-HPEd

BURNOUT VARIABILITY IN GENDER AND RACE
Along with our journeys, we have different experiences of burnout. Women physicians have higher odds than men of being burned out and lower odds of being satisfied with or perceiving control over their work lives. A recent Medscape report found high and varying rates (46 to 56 percent) of burnout among physicians of a variety of ethnic backgrounds. The numbers are only a part of the whole story. Through the experiences of our diverse colleagues, we develop an appreciation for the burden experienced by these groups in the practice of medicine.

Think about the burden that comes with the lack of validation that a woman or an African American physician experiences when carrying out daily responsibilities. It is not uncommon, still today, that when a woman physician approaches a new patient, it is assumed that she is not the doctor. The plight for African American physicians and trainees continues as they are relegated to questioning their legitimacy. In his book, *Black Man in a White Coat*, Dr. Damon Tweedy shares the tremendous range of emotions he felt as a first-year student when upon returning...
to the lecture hall after a break. His professor asked why he was there if he was not the maintenance man. He recounts the experience of the devastation, frustration and embarrassment of a Latino colleague when he was mistaken for the parking attendant despite his professional celebratory attire. Similar stories are shared by other “minoritized” physicians.

Recent social media blogs and articles highlight this added burden, sharing feelings and statements such as:

“I AM a doctor.”

“I am not an interpreter.”

#ILookLikeASurgeon

Stereotypes, assumptions and biases remain the kryptonite of physicians who identify as being diverse and different. For some, even the white coat does not provide full protection from such biases that we assume may automatically come with the power and privilege of being a physician.

THE IMPACT OF MINORITY BURDEN

As we explore strategies for addressing physician burnout, we need to consider the impact of this “minority burden.” These types of daily, negative interactions have been called “microaggressions” or “death by a thousand cuts.” Microaggressions are those everyday verbal and non-verbal slights, snubs or insults, whether intentional or unintentional, that send hostile or negative messages to the target persons based solely on their marginalized group membership. Microaggressions include statements such as the following:

“You speak English well.”
“But where are you really from?”
“You are so different than the others.”

A recent WebMD survey showed that nearly 70 percent of Black and Asian physicians report hearing biased remarks. These microaggressions may have a cumulative effect with the impact on physical health and somatic symptoms leading to migraines and heart disease, as well as on mental health leading to increased levels of depression.

Any physician wellness strategy should leverage our rich identities and incorporate awareness so that we do not contribute to stereotypes, biases and assumptions. If we take the time to get to know each other, we can begin our journey toward mitigating unconscious bias and in turn, the effects it has on well-being. Physician discussion groups and affinity groups, such as those for women physicians, can be an ideal venue in which to openly and respectfully discuss the good and difficult experiences related to diversity in healthcare settings as part of wellness initiatives within an institution or practice. Together, we can achieve the type of work environment that fosters wellness through inclusion.
Maria Soto-Greene, MD, MS-HPEd, is a Professor of Medicine and Executive Vice Dean at Rutgers New Jersey Medical School (NJMS). Sangeeta Lamba, MD, MS-HPEd, is a Professor of Emergency Medicine and Associate Dean for Education at Rutgers New Jersey Medical School.


Stay tuned for upcoming podcasts and workshops on

Physician Wellness & Work/Life Integration
A funny thing happened on the way to the courthouse. No, it didn’t. Nothing funny ever happens on the way to the courthouse. There is always unexpected traffic, and when you finally make it to court, there is no parking, you can’t find the right courtroom or your attorney and your dream of coffee before a day in court is crushed. And this is the good part of your day. Undoubtedly, being named in a lawsuit, having to appear at a deposition or attending a trial is going to have an impact on your efforts to achieve a stress-free balance between your professional and personal lives.

According to Kevin B. O’Reilly, the News Editor for the American Medical Association, the life-disrupting ordeal of having to juggle one’s professional and personal lives while attending to a lawsuit is not an uncommon occurrence in the medical profession. O’Reilly notes that more than one out of three physicians will have a medical liability lawsuit in their career, and by age 55, one out of two doctors will be sued. The fact that close to 90 percent of medical malpractice cases that go to trial (as opposed to being settled or dismissed) are won by the defense when there is little evidence of medical negligence does little to comfort a physician the day he or she receives notice of a lawsuit. Reading a document that alleges your care injured a patient can be traumatizing and adds an additional level of stress to a profession in which more than half of its participants experience professional burnout.

Peter Grinspoon, MD, a Contributing Editor to the Harvard Health Blog, describes burnout among physicians as decreasing satisfaction and decreasing enthusiasm for work with increasing detachment, emotional exhaustion and cynicism. Although he stresses that the causes of physician burnout are complex, he relates them in part to “increasing workload, constant time pressures, chaotic work environments, declining pay, endless and unproductive bureaucratic tasks required by health insurance companies that don’t improve patient care, and increasingly feeling like cogs in large, anonymous systems.” Grinspoon also mentions looming lawsuits as an additional cause of stress; he specifically cites the problem of circling “[p]arasitic malpractice lawyers.” In addition, studies have correlated medical errors with physician burnout and decline in quality of life.

Whether or not the underlying claim in a lawsuit can be linked to a doctor’s well-being or quality of life, the additional stress or anxiety that litigation brings is the last thing that a healthcare provider needs.

Stand Up and Be Proactive

A lawsuit should not derail the personal and professional stability you have accomplished. There are ways to help minimize a lawsuit’s impact on your life.

REMAIN CALM. Panic can cause irrational thinking and possibly irrational actions. For example, when a physician first becomes aware of a lawsuit, a hasty review of records might reveal inadequate documentation. The day-to-day stresses of work combined with the trauma of getting served with a lawsuit may result in an attempt to fix the records. With an electronic health record, changes are difficult, if not impossible, without adding an addendum. With handwritten notes or orders, although changes can be made, they should not.
Fortunately, there are safeguards that should ease panic—you have medical professional liability insurance. You will likely be provided a lawyer whose career has been spent defending healthcare providers, and most importantly, you have your experience as a physician. When I represent doctors at a deposition, I always remind them that they know more about medicine than anyone else in the room. A doctor may lose sight of this fact when panicking in the face of a malpractice claim, but it is one of the most important things to remember throughout the litigation process.

**SET ASIDE TIME.** There are only 24 hours in a day, and using those hours wisely is difficult. Physicians, in particular, must be deliberate with their time because how it is spent has a direct effect on someone else’s life. Therefore, adding time to an already hectic schedule to deal with activities related to a lawsuit is not easy. The lawsuit’s demands on your time can be frustrating and can make a doctor resentful about taking time away from patients or family. However, giving the lawsuit appropriate attention is critical to your defense. The first meeting with your lawyer will set the wheels of your defense in motion. There is a mutual exchange of information. You as the doctor have the opportunity to explain the underlying medicine, and your lawyer has the opportunity to explain the litigation process. If you feel anxious or rushed, the time spent will not be helpful for you or your lawyer. If, however, the few hours necessary to meet with your lawyer are carefully planned in your schedule, the meeting will feel like time well spent.

**PREPARE.** There is no dispute that any additional demand on a doctor’s time is more than an annoyance. Nevertheless, the benefit of being prepared far outweighs the risk in failing to properly prepare. Doctors are skilled at succeeding and excelling under pressure. Taking time out of a busy day or away from the things you enjoy to prepare for a lawyer meeting, deposition or trial may, at times, seem trivial. Physicians do far more difficult things every day. However, it is important to understand that...
preparation for the activities associated with a lawsuit can change the outcome of a case. For example, having your lawyer provide you with information from the record that you may have overlooked or forgotten about before you sit for a deposition can impact how you, as a witness, will perform. It is disconcerting to be taken by surprise at a deposition by something in the record, and it may negatively affect how you answer questions during the rest of the deposition. If a doctor is perceived as being well prepared and knowledgeable about the case during the discovery phase of litigation, it can change how the plaintiff’s attorney perceives the case in terms of its credibility and value. Taking the time to prepare early in the litigation process is invaluable moving forward.

**ASK FOR SUPPORT.** Don’t keep the experience a secret from people in your life (spouse, life partner, work partners/colleagues and office manager/staff). The time commitment and additional stress of communication and frequent exchange of information with your attorney make it necessary for other people to know what is happening. Trying to keep the process a secret will make it more difficult to be involved. It is stating the obvious to say that a doctor’s job is demanding. A lawsuit takes those demands to another level, and keeping the lawsuit a secret may add unnecessary feelings, such as shame or embarrassment, to the equation. Given that one out of two physicians will be named as a defendant in a lawsuit by the time he or she is 55 years old,¹ being sued for malpractice does not make you a member of an exclusive club. It is more likely than not that friends and colleagues have gone through the same experience and could be great resources for you to gain knowledge about the process or to just blow off some steam.

In addition, don’t sacrifice your personal life and joys. If you are preparing to meet your lawyer for the first time, getting ready for your deposition or even preparing for trial, the last things you should give up are the things that make you happy. Whether it is spending time with your family, going for your morning run or even doing charity work you love, those are the very things that will help you put your best foot forward under the duress of a lawsuit. I represented a doctor who traveled overseas every year with a medical charity organization. It was an annual journey she treasured but planned to cancel to prepare for a trial. Knowing that getting away was perhaps important for preparing herself mentally, we were able to assure her there would not be a conflict. If she had made this sacrifice, it may have negatively impacted her performance at trial. With some notice and planning, the litigation process should not prevent you from continuing to do the things you love.

**DON’T FORGET YOUR PURPOSE.** The vast majority of doctors I represent became doctors to care for their patients. This may be the single most important fact to remember throughout the litigation process. Continue with your practice and move forward, and treat your patients with the same care and commitment that you did before you received notice of a claim. This remains your number one priority.

Certainly, a lawsuit is an unwanted disruption in your life and practice. However, you can proactively reduce the degree of stress a lawsuit causes if you take advantage of the tools already in place, set aside the time necessary and don’t let the process change who you are or how you take care of patients.

By understanding what you can expect during the course of the litigation and by cooperating with your attorney to properly prepare, you can directly influence how your case is handled and perceived, and ultimately, minimize the disruption the case brings to your life.

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ANNOUNCING THE

2019 EJI
Excellence in Medicine
AWARDS
The **Edward J. Ill Excellence in Medicine Awards®** are awarded annually to honor those exemplary physicians and leaders whose dedication to medical care, education, research and public service have significantly impacted the delivery of healthcare in New Jersey and around the nation. This 80-year-old event debuted in 1939 and has been sponsored by MDAdvantage Insurance Company since 2003.

The mission of the EJI Excellence in Medicine Foundation is to promote and encourage excellence in medical care and healthcare for the citizens of New Jersey. The Foundation is committed to recruiting and retaining medical talent in New Jersey. Profits from this annual event will be dedicated to the Excellence in Medicine Scholarship Fund; significant scholarships are provided to medical and healthcare students who represent the values of the Foundation and intend to practice in New Jersey. The Excellence in Medicine Scholarship Fund brings the mission of the event full circle. By acknowledging the accomplishments of physicians and scientists in the prime of their careers, we are also inspiring our students to strive to make their own unique contributions.

This year’s awards dinner will be held on Wednesday, May 1, 2019, at Park Château Estate and Gardens in East Brunswick, New Jersey. To order tickets, participate as a Scholarship Honor Roll member, place an ad in this year’s awards journal or make a direct contribution, please contact the Edward J. Ill Excellence in Medicine Foundation at 609-803-2350 or visit www.EJIIawards.org.

**Stephen Garrett, PhD,** is Associate Dean of Student Affairs of the Rutgers School of Graduate Studies and Associate Professor, Department of Microbiology, Biochemistry and Molecular Genetics, Rutgers New Jersey Medical School (NJMS).

Dr. Garrett received his PhD degree in 1986 from The Johns Hopkins University, where he was a Scholar of the Natural Sciences and Engineering Research Council of Canada, and then completed a post-doctoral fellowship in microbial genetics at Princeton University. After finishing his post-doctoral training, he joined Duke University Medical Center as an Assistant Professor in the Departments of Biochemistry and Molecular Cancer Biology in 1989, where he remained until he came to NJMS in 1997. Between 1989 and 2007, when he shut down his lab to assume a position within the School of Graduate Studies, Dr. Garrett carried out NIH- and American Cancer Society–supported studies on the mechanisms of cell growth regulation and ion homeostasis and was awarded a Junior Faculty Award from the American Cancer Society in 1992.

Throughout his career, Dr. Garrett has been committed to student education, lecturing in more than 20 individual medical and graduate courses and designing and/or directing seven courses. Reflecting his commitment to education, Dr. Garrett was appointed Assistant Dean of Curriculum of the School of Graduate Studies in 2009, where he directed the design and development of courses contributing to the PhD and master’s programs. Within the NJMS curriculum, Dr. Garrett has directed the main infectious disease course within the preclinical curriculum for the past seven years and has lectured in the course for 20 years. More recently, Dr. Garrett played a major role in the development of the first-year medical course Foundations of Body Systems, which incorporated basic-science components from first- and second-year medical courses and was essential to the adoption of the New Jersey Medical School Organ System–based curriculum in 2014.

Along with his contributions to course direction and design, Dr. Garrett has served on a number of graduate and medical committees dedicated to education, including the Pre-Clinical Curriculum Committee and the Committee on...
Academic Programs and Policies of NJMS. For these efforts, Dr. Garrett has received multiple Golden Apple awards, the Excellence in Teaching Award and the Faculty Organization Teaching Award. In 2010, he was made a member of the Stuart D. Cook, MD, Master Educator Guild.

Dr. Garrett’s current position as Associate Dean of Student Affairs and Vice Chair for the NJMS Student Affairs Committee follows a long career of advocacy, including service as the inaugural Director of the Molecular Cancer Biology PhD graduate program at Duke, Director of the Microbiology and Molecular Genetics PhD graduate program at Rutgers NJMS, Program Director of the Rutgers SGS master’s program and Campus Program Director of the Alfred Sloan Foundation–funded Minority PhD Program.

**OUTSTANDING MEDICAL EDUCATOR AWARD**
Presented to a medical educator who has made an outstanding contribution to graduate or undergraduate medical education in New Jersey.

Bonita F. Stanton, MD, is Founding Dean, Hackensack Meridian School of Medicine at Seton Hall University, and President, Academic Enterprise, Hackensack Meridian Health, and holds the Robert C. and Laura C. Garrett Endowed Chair for the School of Medicine Dean. Under her leadership, the School of Medicine matriculated its first class of students on July 9, 2018.

Dr. Stanton earned her medical degree at the Yale University School of Medicine, completed her pediatric residency at Rainbow Babies and Children’s Hospital (Case Western Reserve) and received her Pediatric Infectious Disease Fellowship training at Yale University School of Medicine.

During the period of 2002 to 2016, Dr. Stanton served as the Vice Dean for Research for four years and as the Chair of the Department of Pediatrics and Pediatrician-in-Chief at Children’s Hospital of Michigan for 10 years. She had served for three years as Chair of the Department of Pediatrics, West Virginia University and as Division Chief of General Pediatrics at the University of Maryland’s School of Medicine for 11 years. Before that, she lived and worked with her family in Bangladesh for five years, where she served as a health consultant to the World Bank and a research scientist for the International Center for Diarrheal Diseases Research.

Dr. Stanton’s career has been focused on improving the health of under-represented minorities and disenfranchised populations. She has been continuously funded by the National Institutes of Health for 25 years. While at the University of Maryland, she was the Principal Investigator (PI) and Director of the federally funded Center for Minority Health Research. Her research in the United States and the Caribbean has been concerned with health issues of urban youth, and her work overseas has similarly focused on vulnerable populations, including women (Bangladesh), migrant populations (China) and rural African youth (Namibia). In addition, she served as the Medical Director of Yale University’s School of Medicine Hill Health Center, delivering healthcare to the urban poor in New Haven and as the Director for the Urban Volunteer Program, a community-based research and service program directed to the health of Bangladeshi women and children living in the slums of Dhaka, Bangladesh.

She has consulted for numerous national and international groups, including the World Bank, the Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), UNICEF and USAID, on issues related to urban health, HIV/AIDS transmission in youth, maternal child health, vaccines and health services research. She has been an author of more than 300 peer-reviewed articles and has served as an editor of Nelson Textbook of Pediatrics, along with many other journals and books. Among many local, national and international advisory roles, she was a member of the Advisory Board of the National Institutes of Health’s Fogarty International Center and was President of the Association of Medical School Pediatric Department Chairpersons.

**OUTSTANDING HEALTHCARE EXECUTIVE AWARD**
Presented to an executive in a healthcare-related organization or field who has demonstrated exceptional leadership in the enhancement of patient care and medical practice in New Jersey.

Gary S. Horan, FACHE, is President and Chief Executive Officer of Trinitas Health and Trinitas Regional Medical Center since 2001.

Mr. Horan has extensive experience in healthcare leadership among hospitals in New Jersey and New York. Before coming to...
Trinitas, he served for 11 years as the President and CEO of Our Lady of Mercy Healthcare System, Bronx, New York, and he has held senior leadership positions with New York University Medical Center, St. Vincent’s Hospital and Medical Center of New York and JFK Medical Center in Edison, New Jersey. Mr. Horan earned his MA degree in Healthcare Administration from the George Washington University, School of Government and Business.

Among his many professional and civic appointments, Mr. Horan is past Chairman and current Vice Chairman of the Board of Governors of the Greater New York Hospital Association and a past Chairman of the Hospital Association of New York State. He currently serves as Chairman of the Board of the Catholic Healthcare Partnership of New Jersey and is a member of the Board of Directors of the New Jersey State Chamber of Commerce. Mr. Horan is a past Governor of The American College of Healthcare Executives. He is a past member of the Board of New Jersey Hospital Association and is currently Chairman of the New Jersey Hospital Association HealthPAC Board of Directors. Mr. Horan is a member of the Union County College Board of Governors and is a member of the Board of Directors of SOAR! He is also a member of the Board of CrimeStoppers of Union County.

**EDWARD J. ILL PHYSICIAN’S AWARD®**

Presented to a New Jersey physician for dedication and extraordinary service to the profession and to the citizens of the state.

Roger K. Strair, MD, PhD, is the Chief of the Division of Blood Disorders, Rutgers Cancer Institute of New Jersey, and Professor of Medicine at Rutgers Robert Wood Johnson Medical School.

Dr. Strair graduated from Albert Einstein College of Medicine and completed his hematology/oncology internship, residency and fellowship at Harvard Medical School, Brigham and Women’s Hospital. Dr. Strair held a faculty position at Yale and then joined what is now the Rutgers Cancer Institute of New Jersey in 1993 as a Founding Member.

Dr. Strair is an expert in hematologic malignancies and related diseases and works closely with colleagues across all disciplines at the Cancer Institute, at other national and international institutions and in the community to develop new treatments designed to improve the care of patients with acute or chronic leukemia, lymphoma, Hodgkin lymphoma, multiple myeloma, myelodysplasia or other blood/immune-related diseases. Dr. Strair is the author or co-author of more than 55 peer-reviewed publications and works as part of a basic, translational and clinical research team that has successfully developed a variety of new investigator-initiated treatment approaches currently being studied in clinical trials at the Cancer Institute.

**VERICE M. MASON COMMUNITY SERVICE LEADER AWARD**

Presented to an individual who has personified, led and provided the vision for an organization, and to the organization served, for extraordinary commitment to improving the health and welfare of the citizens of New Jersey.

David S. Kountz, MD, MBA, will accept the Verice M. Mason Community Service Leader Award on behalf of the Hackensack Meridian Health. Dr. Kountz serves as Professor of Medicine and Founding Associate Dean for Diversity and Equity at Hackensack Meridian School of Medicine at Seton Hall University, Co-Chief Academic Officer and Vice President for Academic Diversity at Hackensack Meridian Health and Vice President, Academic Affairs, at Hackensack Meridian Health Jersey Shore University Medical Center.

Dr. Kountz earned his MD at SUNY/Buffalo School of Medicine and his MBA at Georgian Court University. After residency at Hahnemann University Hospital in Philadelphia, Pennsylvania, Dr. Kountz was a member of the faculty at Hahnemann, Temple and Robert Wood Johnson Medical Schools before joining Jersey Shore University Medical Center in 2007.

Dr. Kountz has been responsible for advancing the academic mission of the medical center and establishing community outreach programs with local schools and colleges. Mini-Medical School, initiated at Neptune High School in 2013 and now held in collaboration with Monmouth University, is an annual six-week event designed to inspire high school students to consider careers in the health professions. Since inception, more than 500 students...
have completed the program. In 2014, it was a recipient of the School Leader Award from the New Jersey School Board Association. Dr. Kountz also oversees a summer pipeline program at the medical school for students underrepresented in medicine.

Dr. Kountz has authored more than 100 peer-reviewed publications, book chapters, editorials and abstracts. In 2002, Dr. Kountz was elected to the Stuart D. Cook, MD, Master Educator Guild of Robert Wood Johnson Medical School.

**WILLIAM C. GAUSE, PHD**

**OUTSTANDING SCIENTIST AWARD**
Presented to an individual or individuals who have made important contributions leading to advances in treatment.

William C. Gause, PhD, is Senior Associate Dean for Research at Rutgers New Jersey Medical School, as well as Director of the Rutgers Biomedical and Health Sciences (RBHS) Institute for Infectious and Inflammatory Diseases (i3d) and Director for the New Jersey Medical School (NJMS) Center for Immunity and Inflammation (CII). He is a tenured Professor of Medicine.

He earned his PhD in 1986 in Immunology, Biochemistry and Physiology from Cornell University and then joined the National Institutes of Health as a research fellow from 1986 to 1989. In 1989, he joined the faculty of the Department of Microbiology at the Uniformed Services University, where he served until 2004, becoming a tenured professor and Director of the Molecular and Cell Biology Graduate Program. He joined NJMS in 2004 as the Senior Associate Dean for Research and University Professor of Medicine. In 2006, he also became the Director of the interdepartmental Center for Immunity and Inflammation, and in 2016, he was appointed as the Director of the RBHS Institute for Infectious and Inflammatory Diseases.

Dr. Gause has published more than 100 papers in prestigious scientific journals, such as *Science, Immunity, Nature Medicine, Nature Materials, and Nature Immunology*. He has been continuously funded by the NIH since 1985. His work is highly cited and is focused on elucidating macrophage activation during parasite infection, including characterization of a macrophage phenotype that triggers anti-inflammatory and wound healing pathways. His studies have revealed novel immunoregulatory molecules and host-signaling pathways that may have therapeutic potential. Dr. Gause has recently been awarded a patent on the use of parasite products to activate the host-immune response to enhance tissue repair.

At NJMS, Dr. Gause has overseen the expansion of the research mission that has included creation of new research cores and highly productive research centers and institutes. They now serve as a catalyst for cutting-edge research and for fostering independent research programs by junior faculty. In this capacity, with the support of the Dean and the Chancellor, Dr. Gause has spearheaded a recent surge in recruitment to NJMS of outstanding faculty actively engaged in research.

**JACK MORRIS**

**PETER W. RODINO, JR., CITIZEN’S AWARD®**
Presented to a citizen or group of citizens of New Jersey who merits recognition for distinguished service in advancing and promoting the health and well-being of the people of our state.

Jack Morris is President and CEO of Edgewood Properties and Chairman of RWJBarnabas Health Board of Trustees and Robert Wood Johnson University Hospital Board of Directors. He also serves as a Board member of the Robert Wood Johnson University Hospital Foundation, and is a partner in the Hard Rock Hotel and Casino in Atlantic City, NJ.

Mr. Morris was born in New Brunswick, New Jersey, and spent most of his youth in Highland Park. He started Jack Morris Construction, specializing in the construction of custom homes at the young age of 18 years. In 1992, Jack Morris and his wife, Sheryl, formed Edgewood Properties, which is responsible for the development of residential and commercial properties throughout the United States.

Mr. Morris has served as a Board Director of the New Jersey Builders’ Association. He has been named an honoree by Spectrum for Living Foundation and has been honored by and is a Silver Life member of the New Jersey Policemen’s Benevolent Association. He participates in many other charitable organizations, such as Make a Wish.
MDADVANTAGE CONGRATULATES THE 2019 EJI EXCELLENCE IN MEDICINE SCHOLARSHIP RECIPIENTS

FERNANDO ARIAS
Rutgers Robert Wood Johnson Medical School – Class of 2019

NICOLE CALTABIANO
Rowan University School of Osteopathic Medicine – Class of 2019

JODIE KUNKEL
Rutgers School of Health Professions, Physician Assistant Program – Class of 2019

A. MICHAEL LUCIANI
Cooper Medical School of Rowan University – Class of 2019

CHRISTINA MCARDLE
Rutgers School of Dental Medicine – Class of 2019

MORIT SEGUI
Rutgers New Jersey Medical School – Class of 2019

ROBERT VAGUEIRO
Seton Hall University School of Health & Medical Sciences, Physician Assistant Program – Class of 2019

Janet S. Puro, MPH, MBA, is Vice President of Business Development and Corporate Communications at MDAdvantage Insurance Company of New Jersey.

To participate in this year’s event by purchasing tickets, an Honor Roll sponsorship or an ad in the awards journal, call 609-803-2350 or visit www.EJIAwards.org.
Access to primary care has been a long-standing concern among culturally diverse communities. In 2017 in New Jersey, overall, 79.2 percent of adults had a personal doctor or healthcare provider; however, this access varied among racial and ethnic groups with Hispanics, Blacks and Asians having considerably less access to a personal provider (65.2 percent, 78.2 percent and 77.6 percent, respectively) compared to Whites (84.2 percent). The Healthy New Jersey 2020 goal is to have our primary care providers reach 90 percent of our residents.

Certainly, access to healthcare services should be available to everyone, regardless of income, education, age, racial or ethnic group, sexual orientation, religion or any other defining factors. However, one significant barrier to healthcare access is lack of cultural awareness, sensitivity and communication from the healthcare provider. Patients who are culturally or linguistically different have worse health outcomes and difficulty following medical advice and are less satisfied with their healthcare experiences than patients who do not have communication barriers.

This issue is of particular importance in NJ where one-fifth of our residents are foreign-born and nearly one-third speak a language other than English at home. Of those, only 60 percent feel they speak English very well. Diverse populations bring different attitudes, expectations, beliefs and communication styles to each health encounter. Therefore, to be successful, health professionals must be sensitive to these complex issues.

### USE EFFECTIVE CULTURALLY AND LINGUISTICALLY APPROPRIATE COMMUNICATION

Improving cultural and linguistic appropriateness is not a one-time learning experience, but an ongoing journey. It is important to know your patients’ diverse backgrounds, language preferences, cultural identities and perceptions of health and illness. Then, with culturally and linguistically appropriate communications, you can build the kind of trust that facilitates patient empowerment of self-managed care.

To improve access to healthcare, the U.S. Department of Health and Human Services (HHS) Office of Minority Health developed the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. The Guide to Providing Effective Communication and Language Assistance Services is the tool grounded in these standards that provides detailed direction on culturally and linguistically appropriate communication and services. This guide can be found on the U.S. Department of Health & Human Services, Think Cultural Health website at https://hcbsig.thinkculturalhealth.hhs.gov.

Below are a few strategies from this Guide to remember when caring for your culturally diverse or communication-needs patients:

1. **Know your patients’ language preferences.** With an awareness of language differences in verbal and written communication, you can become a more effective communicator with patients who have limited English proficiency (LEP).

2. **Use language assistance services.** Individuals with communication needs include those with LEP and those who are deaf or hard of hearing. Communication errors, such as prescription labels written in English given to non-English-speaking patients, can have negative and even life-threatening consequences. Examples of language assistance services include interpretation of oral communication and translation of written documents, signage and symbols for wayfinding. These services should be provided to patients at no cost.

3. **Use culturally appropriate nonverbal cues.** An awareness of cultural differences in nonverbal communication contributes to effective communication. Following the patient’s lead, use culturally appropriate nonverbal cues, such as gestures, facial expressions, eye contact and body language that show you are interested in what the patient has to say.

4. **Use effective written communication.** Your written communications should use plain language that is easily understood by the patient the first time it is read. This will ensure that all patients, despite various literacy and health literacy levels, can understand the content. Many important materials need to be available in multiple languages, depending upon your patient population. It is also very important to use written symbols, such as letters and numbers, as well as pictures and graphics.
Effective communication and language assistance services help you do your job more successfully because they help you fully understand your patients’ health conditions. These services also ensure that your patients can follow your health recommendations and therefore, rate their care as satisfactory.10, 11, 12, 13

**RESOURCE FOR DIVERSITY INFORMATION**

The U.S. Department of Health and Human Services has developed a useful electronic learning program entitled *Think Cultural Health* for physicians, physician assistants and nurse practitioners.

This program offers many resources, including videos, toolkits and fact sheets, for further information about health disparities, health equity and health resources in other languages.

The resource is available on the HHS website at https://cccm.thinkculturalhealth.hhs.gov.

As a physician and the Commissioner of the Department of Health and as the Executive Director of the New Jersey Office of Minority and Multicultural Health, we want residents to get the care they need to stay healthy; for that to happen, they need healthcare that takes into consideration their cultural backgrounds. We hope you will take time to refresh your cultural competency skills and those of your staff. Culturally competent health workers not only respect cultural differences but also incorporate them into the entire patient-care and program-planning process. To improve health outcomes for all residents, we need to ensure we are advancing cultural and linguistic sensitivity and health literacy across the state.

**Amanda Medina-Forrester, MA, MPH, is the Executive Director of the New Jersey Office of Minority and Multicultural Health. Shereef Elnahal, MD, MBA, is the Commissioner of the New Jersey Department of Health.**


PHYSICIAN BURNOUT
and Its Impact on Medical Liability
An Interview with  

Martin Stillman, MD, JD

Martin Stillman, MD, JD, is a physician, lawyer and a mediator who has a particular interest in mediating conflict within healthcare and understanding and minimizing physician burnout. He is a practicing internist at Hennepin County Medical Center in Minneapolis, Minnesota, where he also serves as the Mediation and Conflict Resolution Officer, an Assistant Chief for the Department of Medicine and Assistant Director of the Institute of Professional Worklife. Additionally, he is an Associate Professor of Medicine at the University of Minnesota Medical School and teaches about medical error, medical malpractice, disclosure of unexpected patient outcomes and the risk management aspects of physician-patient relations and communication. Recently, Dr. Stillman responded to questions posed by Catherine Williams and Janet Puro on the topic of physician burnout and its impact on medical liability risk.

MDADVISOR: AS A PHYSICIAN WHO ALSO HAS A LAW DEGREE, HOW DID YOU BECOME INTERESTED IN THE TOPIC OF PHYSICIAN BURNOUT?  
Stillman: I have had an interest in the intersection of medicine and the law for a long time, and more recently, this has included mediation. In my role as Mediation and Conflict Resolution Officer at my hospital, I work to reduce and mediate conflict between providers or groups of providers so that they can move forward in a productive way and ultimately, deliver safer patient care. In this work, physician burnout had been an issue that continued to come up, and I developed an interest in educating others about burnout and burnout reduction.

MDADVISOR: HOW DO YOU DEFINE PHYSICIAN BURNOUT?  
Stillman: Physician burnout is usually the result of some sort of prolonged stress that leads to a number of significant implications. This can include higher rates of depression, fatigue and anxiety. In some physicians who are burned out, there is a higher rate of substance abuse, increased incidents of sleep disturbances, broken relationships and even increased rates of suicide. Physician burnout can also appear as a loss of interest in and enthusiasm for work as well as increased frustration and emotional exhaustion. All of this in turn can lead to decreased empathy for patients, as well as a decreased sense of personal worth and professional accomplishment.

MDADVISOR: IN YOUR EXPERIENCE, WHAT IS THE MAGNITUDE OF PHYSICIAN BURNOUT, AND HOW DOES IT DIFFER FROM BURNOUT EXPERIENCED IN OTHER TYPES OF CAREERS?  
Stillman: One thing we know is that burnout among U.S. physicians continues to be on the rise and is higher than in other career areas. A major study in 2014, led by Dr. Tait Shanafelt out of the Mayo Clinic in Rochester, Minnesota, looked at physician burnout compared to the general population. In that study, 49 percent of doctors were burned out, compared to 28 percent of the general U.S. working population. Thus, burnout was actually 75 percent higher in doctors. Additionally, the rates of emotional exhaustion were roughly 43 percent for physicians, compared to 25 percent in the general population, and 36 percent of the doctors were satisfied with their work-life balance compared to 61 percent in the general U.S. working population. That study begins to get at the magnitude of the issue and the increase we are seeing in physician burnout. Additionally, this same study looked at physician burnout comparing data from 2011 to the findings in 2014. Physician burnout had increased in every specialty measured. This study begins to get at the magnitude of the issue and the increase we are seeing in physician burnout.
**MDADVISOR: WHICH PHYSICIANS ARE MOST AT RISK FOR BURNOUT?**

**Stillman:** In general, some of the front-line specialties, such as emergency medicine, family medicine, internal medicine and pediatrics, have a higher occurrence of burnout. The data also support the conclusion that mid-career physicians appear to be at increased risk, compared to physicians in the early and late stages of their careers. We also know that women appear to be affected by burnout more than men. But I say these generalizations with some warning. Part of the problem with calling out a few areas or specialties is that it may suggest these are the only areas that have burnout, where other specialties don’t. That is simply not the case. Sometimes, the measurements show that the difference in physician burnout between specialties is minimal. So the concern I have in naming a few specialties as the hardest hit is that it can detract from the global issue of burnout affecting many if not all areas of practice.

**MDADVISOR: HOW IS BURNOUT MEASURED?**

**Stillman:** When researchers look to measure burnout, they rely primarily on three well-accepted self-assessment tools. One is the Mini Z Burnout Survey. The second is the Maslach Burnout Inventory, and the third is the Professional Fulfillment Index (Physician Wellness Survey). These tools vary in length, with some being more in-depth than others. Sometimes, there is an advantage to using a shorter survey that is easier to fill out, which may result in higher participation when you’re looking at a large department or hospital. At the same time, sometimes it is more helpful to collect the in-depth information that a longer survey allows. Currently, a study is underway that is trying to evaluate how a score on one self-assessment tool compares to the scores on the others, which will be helpful.

**MDADVISOR: HOW DOES PHYSICIAN BURNOUT IMPACT THE RISK OF MEDICAL ERRORS, AND ULTIMATELY, PATIENT CARE?**

**Stillman:** This is a question that is currently and understandably receiving much attention, and to some extent, debate. Many studies look at the impact of burnout on patients retrospectively, where physicians are asked to rate their level of burnout after an error occurs. When these metrics have been used, multiple studies have suggested that there is a correlation between increased burnout and increased levels of patient errors. Some feel that when you have a retrospective self-reporting method for medical errors, it is not necessarily a true measure of errors that may or may not have occurred. But despite some of the concerns of retrospective analysis, I believe that when concerns are raised about physician burnout, legitimate patient safety flags are raised.

There have been other studies in which researchers looked at levels of burnout in inpatient nurses as a predictor of patient satisfaction. The results showed that as nurse burnout increased, patient satisfaction decreased. This tells us a lot about liability risk. Although the studies didn’t look specifically at medical errors, risk managers know that, in general, unsatisfied patients are a higher liability risk when substandard care becomes an issue. And as I noted, physicians with burnout have higher rates of depression, fatigue, anxiety and substance abuse, as well as less empathy for patients. When all of this is in play, it is reasonable to recognize that there is a real medical liability risk associated with burnout with respect to providing appropriate standards of care in a manner that’s well-received by patients.

**MDADVISOR: WHAT ARE SOME STRATEGIES OR BEST RECOMMENDATIONS TO DECREASE PHYSICIAN BURNOUT?**

**Stillman:** It is difficult to identify one global answer for reducing burnout because the solution really depends on what is driving the burnout in a particular practice, clinic or hospital. You need to take the time to evaluate and identify the drivers of stress in your particular setting. For example, if taking too much work home is a big driver of burnout and electronic health records are taking a good deal of the physician’s time, then scribes may be of benefit. At the same time, we have seen that scribes alone don’t just take the burnout away. For example, if a clinic practice still feels chaotic, and there is not good values alignment with clinical leadership, stress and burnout will likely remain.

Sometimes, finding a break in the middle of a clinic session, like a designated time for catch-up, can be helpful. In the hospital setting, it is helpful to identify issues with the physicians’ support systems that are impacting a physician’s time, control and stress level, such as social work, pharmacy, physical therapy support, etc.

Additionally, when people have at least 10 percent of their work time devoted to a work activity they feel particularly passionate about, it can have a protective impact against burnout. That doesn’t mean the physician is going to get 10 percent of his or her time off. Rather, if someone has a particular area of interest within which they like to practice, fostering that passion even one half day per week can make a substantial difference in reducing physician burnout.

**MDADVISOR: DO YOU HAVE AN EXAMPLE OF A SUCCESSFUL WORKFLOW STRATEGY THAT HELPED REDUCE PHYSICIANS’ STRESS?**

**Stillman:** I have one example that I like to share because it was pretty straightforward. There was a clinic where...
new patients were being scheduled at the end of the day. Some of the patients were relatively straightforward, and of course, some were not. When new patients presented who needed more time, it disrupted the end of the physician’s day, making it difficult to get home for dinner or to pick up a child from daycare. It was an end-of-day disruptor that was stressful because control over one’s schedule was lost. The scheduling template was then changed to have new patients come in earlier in the afternoon. Ultimately, stress was significantly reduced among the providers in this particular clinic by making a fairly easy schedule change. It wasn’t about seeing fewer patients, but about seeing them at a different time that made all the difference.

MDAdvisor: What can healthcare organizations do to improve burnout and stress?
Stillman: The first thing that they can do is recognize that burnout is real and includes physicians and other types of healthcare workers. I have seen that starting to happen in a positive way over the past five to ten years. Now it is much more common to go to meetings of all specialties and have some sort of educational session addressing burnout.

In addition to the humanitarian aspect of reducing burnout, a valid business model supports paying attention to burnout. We know that physicians with burnout often look to work less. Additionally, they tend to leave their practice earlier than non-burned-out physicians, and increased turnover is a real expense for an organization. In fact, it is estimated to cost a healthcare organization a minimum of $250,000 when someone leaves. That’s not referring to the hiring cost alone, but additional factors such as the productivity loss associated with a vacant position, ramp-up time for the oncoming physician, etc. The bench is not so deep in certain areas of medicine that when a physician leaves, another can just pick up where the departing physician left off.

Also, when an organization recognizes that it is worth reducing burnout, it can develop a wellness plan and decide what the action items are going to be. This can be accomplished with a relatively modest infrastructure. A wellness committee can be formed with representatives from different areas within the organization, and they can begin by measuring baseline degrees of burnout among the physicians. The costs to get something going are fairly modest. Some of the survey tools don’t cost anything. They can then be analyzed, and the results can be distributed. That information is crucial to identifying the specific areas that need to be improved. Some institutions have implemented a Chief Wellness Officer to oversee the work, which puts the subject on the radar screen and helps to make changes to get things done.

Recognizing physician burnout as an issue does not change the financial demands of hospitals and healthcare institutions and I don’t think that working to reduce burnout and pursuing financial stability are mutually exclusive. Successfully reducing burnout often comes down to listening to physicians and having them be part of generating solutions to address the stresses that they’re living. The fear that the only way to reduce burnout is to have physicians work less isn’t the answer. Physicians aren’t afraid to work hard. Rather, it’s about fixing how physicians work and the environments in which they practice that can make a significant difference.

MDAdvisor: What resources are available to someone interested in developing a wellness program for his or her organization?
Stillman: There are many resources available. The American Medical Association has a STEPS Forward program, which has a number of modules that can be followed to assist in developing more specific ways to reduce burnout. The Institute of Professional Worklife at Hennepin Health System or others doing this work can assist with program development when organizations want to take some more concrete steps. I also encourage any physician or provider who feels the need for immediate help due to burnout to contact a healthcare provider or a crisis line because, for some, the risk of self-harm among burned-out physicians is real and concerning.

MDAdvisor: What might risk managers and even medical liability insurance carriers do to address the concern of physician burnout and its associated liability risks?
Stillman: Perhaps carriers can help drive the effort to reduce burnout by encouraging their insureds to obtain measurements in physician burnout and develop an action plan to address it depending on what they find. This could help in identifying possible troubled areas or practices before potential medical errors or disruptive interactions take place. The good news is that the goals are aligned for insurance carriers, risk managers and physicians when it comes to reducing burnout: To have fulfilled providers deliver standard of care medicine in ways that are well received by patients. Reducing burnout allows the best chance for this to happen.

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The term work-life balance sounds so quaint. Seems simple, right? Just find a healthy balance between how hard you work and how much you play. How much time you spend consumed with professional responsibilities and how much time you dedicate to family, friends and leisure activities. But, like most things in life, sometimes the more appropriate axiom is “Easier said than done.”

In my leadership and communication coaching with physicians of all stripes, as well as with others in various professions, the issues of burnout, work-related stress and shortage of time always come up. I’m not a fan of giving cookie-cutter lists of things to do that somehow will magically make life more manageable and stress free. Instead, after thinking long and hard about this topic and working to find a better balance myself between what I do professionally versus what I do in my downtime, I’ve come up with a few practical, realistic and valuable tips for physicians striving to do the same.

**THINK IMPACT, NOT ACTIVITY.**

Consider how much time we spend in often unproductive, repetitive and “why am I here?” meetings. Sure, I know you can’t get out of every meeting, but the question is: Why do we spend so much time in meetings that are not very impactful? A meeting is an activity that too often is not strategic, much less productive. Instead, meetings consume
some clients tell me that of their list of 10 items, are not as important as you think, even if they consume also to the key stakeholders in my professional and personal at the meetings you are attending and opt out of those that are not essential. Further, if you are leading meetings, make sure those meetings are goal-oriented, engaging and focused and add value to those who attend. The point is, a meeting should have impact, and if it doesn’t, it is merely a time-consuming activity.

PRIORITIZE YOUR TO-DO LIST.
My executive coaching clients and those in my leadership seminars often tell me that their to-do list never gets shorter. I get it. Once again, we often value how much we do (activity) versus how much what we do really matters (impact). Some clients tell me that of their list of 10 items, they did only seven or eight of them, which often stresses them out and makes them feel that they have fallen short. If you find yourself feeling this way, look at your list of 10 to-do items and ask yourself these questions: Of these 10 items, which two or three matter most—not just to me but also to the key stakeholders in my professional and personal orbits? What items will have the greatest impact, and which of those have to be done today because of some self-imposed or organizational deadline? Simply put, be more strategic about your to-do list. You will find that many items are not as important as you think, even if they consume massive amounts of time. Doing this will not just create less stress, but will also give you the time to focus on the life part of the work-life balance.

BE PRESENT.
Recently, I was telling my wife, Jennifer, an anecdote about something that happened at work. While I was sharing what I thought was an interesting story, she turned to one of our kids and asked if they had done their homework yet. I said, “Jen, I was just in the middle of telling you a story that I thought was important.” Her response was totally understandable: “I can listen to you and still do other things at the same time.” Jennifer is not alone. We all multi-task, including yours truly. But if we routinely find it difficult to be present for our family or for our colleagues, it is likely we’ve created a work-life imbalance. My wife often tells me how frazzled she feels with everything she has to do, both professionally and personally. The result: Like so many of us, she is not truly present when communicating with others. Stress and anxiety are often the product of feeling like we are never really mentally in one place because we are thinking about many things at one time. But when we are not present, we often don’t truly understand what is being said to us, much less why it is being said. The byproduct often is miscommunication and misunderstanding, confusion and unintended arguments that start with, “I thought you meant…” This is especially dangerous for physicians when dealing with patients, their family members, nurses and staff where literally someone’s life may be on the line.

My advice to relieve this stress—which will take practice and persistence—is to work to be more present in all of your interactions, both professionally and personally. When you do, the message that you intend to send is more likely to be the one that is received. You will waste less time clarifying or, worse, arguing, and your relationships will become more fulfilling as others feel that you care enough to pay attention to what they are saying.

LEARN TO SAY “NO.”
Physicians and other top-notch professionals don’t like to say “no” when asked to do something. We are often flattered that someone wants us or needs us. We want to be helpful and supportive of many causes, organizations and colleagues. But if we don’t learn to strategically say “no” to certain requests for our time, energy and expertise, we will once again overload our schedules with activities that add to our levels of stress and frustration while upsetting our work-life balance built on the value of impact. Saying “no” does not make you less of a top physician or physician leader. Sometimes, it is the smartest decision that you can make, particularly if you are up front about why at this particular time you are going to have to pass. Again, think strategically and think impact over activity. Think: “I can’t create more hours in a day or days in a week, but I can use the limited time I have in a much healthier, productive and efficient fashion.” This kind of thinking won’t eliminate or solve all of your issues of stress and frustration or help you achieve a perfect work-life balance, but it will make a big difference. It certainly has for me.

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Turning Dissatisfaction into Joy
By William Davis
Emerging Medical Leaders Advisory Committee Member

“I’m not,” I replied, glancing gloomily at the floor.

“Oh, well. Hopefully, it’ll get better!”

Our small talk continued for another few minutes before our session of Healer’s Art began. Healer’s Art is an elective course offered at more than 70 medical schools in the United States. To my knowledge, it is typically offered during the preclinical years, conceived as a “vaccination” against the various negative ideations that pile up as a medical student gains clinical experience, many of which are believed to be associated with burnout. Topics include grief, acceptance, wonder and awe, and loss. However, my institution offered the course in the first half of the third year.

The session leader began: “I want you to take these cards and write about a time that you felt wonder, a sense of awe, something that maybe you couldn’t completely understand.” The index card’s light blue lines mocked me as I stared blankly at them, unable to recall an appropriate instance. Oh well. My relative lack of sentimentality was one of the reasons I had elected to enroll in the course. As the Phillies are trying to demonstrate, the easiest way to improve is to take one’s biggest weakness and turn it into at least something neutral.

After we broke into small groups, we shared what we had written. I gave voice to the random scribbles on my card. When the stammering stopped, I remarked, “I’m sure I’ve noticed these things; it just isn’t something that I spend a lot of time thinking about or trying to remember. So for the next two weeks, I’ll try to write them down as they happen or something like that.”

I kept my resolution. Sort of. I didn’t report back about my endeavors the next session, because we moved on to another topic.

Before that session began, though, the same colleague asked, “So, has your current rotation gotten any better?”

“Yeah, it really has.”

“What changed?” came the obvious follow-up.

Nothing had, really. The things I did not enjoy about that rotation were exactly the same. But seeking moments to appreciate, walking into each day with a belief that around any corner could be a moment producing wonder, awe or something pleasantly just out of reach spoke those moments into existence. This, in turn, created joy and a positive experience. The Healer’s Art course not only made my labors less laborious but also made me better at fulfilling them.

My experience is not unique. At the end of the course, we were asked to write brief blurbs relating one thing that we hoped to remember. The final compilation of those responses is littered with similar ideas: “May I celebrate the small successes.” “Help me find colleagues who find the absurdity and humor.” “Enable me to be a friend to my patients and colleagues.”

Although taking the course earlier in my curriculum may have provided these benefits at an earlier point in time, I suspect that the magnitude of these benefits would have been diminished. Although the course was initially conceived to be prophylactic instead of an acute intervention, experiencing some frustration first magnified the effects of the course. Obviously, it is too soon to tell whether these effects will persist for the duration of my career. But at this moment, I can confidently say that by experiencing dissatisfaction with my work, I was able to discover joy. And should I find myself in the same situation several decades from now, I will have a stronger belief that I can do so again.

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