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This issue of *Maryland Medicine* is devoted to the blaming of physicians and physician burnout.

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- **The Pilloried Physician**
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**CORRECTION: Volume 17, Issue 2**

The article in Volume 17, Issue 2 about MedChi’s legislative accomplishments during the 2016 Maryland Legislative Session incorrectly stated that physicians who have dispensing licenses may now delegate the task of dispensing to Physician Assistants and Nurse Practitioners. House Bill 752 (Chapter 116) (Physicians – Prescriptions Written by Physician Assistants and Nurse Practitioners – Preparing and Dispensing) clarifies the practice that physicians who have a dispensing permit can dispense medications prescribed by physician assistants working under a delegation agreement with them or by a nurse practitioner working with the physician in the same office setting. The task of dispensing remains with the physician. It is simply that the physician can dispense the medication prescribed by a physician assistant or nurse practitioner as outlined above.
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Accountability: Rediscovering Joy in Medicine

As the outgoing president of MedChi, I must first thank you for the honor of having been chosen to serve. The perspective gained at the tip of the spear is unique. To truly be responsible to my profession in a way that is shared by only 167 Maryland physicians over the centuries is an enormous gift. In a word: accountable. Yes, I cared about the practice of medicine; I cared a lot. I love my art, I spend my free time reading about disease, worrying about my patients’ well-being, and talking to legislators. In my personal life, I sometimes ignore things I shouldn’t, putting the practice of medicine first. This year, I realize that, in many ways, I’ve been but a bystander.

I used to rattle off the party line. I knew physicians were special and worked extra hard and experienced more deeply. I knew we were the leaders of health care delivery and we were doing virtuous work. After all, I’ve given nearly everything to becoming a doctor—my youth, my enthusiasm, my dreams, my financial security, my health, and sometimes even my joy. I knew we deserved our spot at the top of the health care pile.

This year, representing us, I’ve confronted everything I’ve ever known to be true about physicians. I’ve been challenged on every facet of our professional truths. I am now waking up to a modified truth. Yes, we are all these things; we are important leaders. However, we have become so tired, so beaten, so reactionary, that as leaders of the health care team, we are losing our followers. A leader without followers…is a lonely person indeed.

Surely we don’t want to continue making the same mistakes. We want to be the thought leaders and respected as the final authority in the health care team. We want patients to admire us, and we want nurses to want to work with us. We want our boundaries to be respected and our work to be revered. Why does this old reality seem to be slipping faster and faster through our fingers? The tighter we grasp our unique plight, the more elusive it becomes.

MedChi’s mission to serve patients, physicians, and the public health has been unwavering. How could we be losing ground? Maybe competition, budgets, time, and circumstances have caused our stumble, but what of passion, accountability, and courage? Are we truly walking the walk?

Leadership can’t be given. Leadership is a discipline that is learned. Most important, leadership is earned. In less complicated times, there weren’t questions about physicians as leaders; we were unique in our knowledge and dedication. Our work was noble and mysterious. Today, regulation, transparency, technology, and competition are changing our environment quickly. Change is hard. A profession of change management has evolved to usher people through difficult times. Physicians are skilled, intelligent, and proud and are slower than many to accept help. Like caged animals, we rattle the bars, bearing our teeth at anyone who would try to help us through these difficult times. It is time to accept the constant evolution of health care, accept help, open our minds, and learn to be leaders.

Physicians are burning out and leaving medicine at an alarming rate. We are telling our children to become anything but physicians, if not with words then by our actions. How many children of physicians say how much they respect their parent but wouldn’t want that life? We lament the loss of fraternity in the medical staff lounge, the loss of private practice and of private patients. We look for early retirement, and jump to administration and part-time work to relieve us of the clinical burden. We lead teams in title, but do not have the time or the training to be intentional in this effort. We stand behind our science and our dedication. Our work was noble and mysterious. Our pain isn’t greater. We don’t deserve respect and followers because we suffer. Our inevitable success as leaders; we were unique in our knowledge and physically. How often do we mock the new work hour restrictions, giving a hard time to all the physicians who train in this system as we chuckle over our spinal stenosis and failed marriages as a badge of a career well spent? We brag about the nights we don’t sleep or even make it home. We are not well. We’ve given up our own dreams for that of being ‘The Physician’. We have forgotten that the most important element of an excellent physician is his or her humanity. The world holds us to a super-human standard, and we have embraced her vision and made it real.

It is time to take back our humanity. It is time to understand what it means to lead by example and intention. We must pursue leadership skills as a discipline of our craft. We must walk in a path deserving of followers, prioritize our own health, and seek joy. We scoff at such questions as “Do you have a best friend at work?” and mental health days. We text instead of listening and get “paged out” of meetings thinking we are being tricky. We are truly demonstrating arrogance: “I am too important to listen like normal people.” We are no longer accountable to the nobility of the great art of healing. We are lost.

My awakening in serving this year confirmed that a smile matters. It signals the spark of accountability that opens the door for leadership deserving of followers. Our inevitable success as leaders and healers requires that we become accountable to ourselves in ways we haven’t yet considered. Our pain isn’t greater. We don’t deserve respect and followers because we suffer. Every human walks in his or her own path. Pain is universal, but so is joy. I am in love with being a healer. There is no greater honor. I will continue to learn to lead, and I will share my knowledge and hopefully people will believe in me and follow. I will choose joy. It starts with a smile, honoring our humanity, and trying together to heal the world. In this, we might just heal ourselves. Namaste.
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John Cenerazzio - Program Director
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It seems that often the best thing I do
Sometimes it is serious; sometimes not.
who are worried about this pain or that.
an orthopaedic surgeon, I see many people
worries, their concerns, and their fears. As
our compassion to help patients with their
profession to pay it forward and do good
the suffering. We entered this noble
MedChi, Sir William Osler, we physicians
To paraphrase a previous president of
Indeed, it is all our careers in medicine.
I met a stranger in the night whose
lamp had ceased to shine.
I paused and let him light his
lamp from mine.
A tempest sprang up later on,
and shook the world about.
And when the wind was gone,
my lamp was out.
But back came to me the stranger —
his lamp was glowing fine.
He held the precious flame,
and lighted mine.

This poem by Lon Woodrum was
recited weekly during my childhood as the
beneficence for our Friday night services
at my summer camp. It impressed upon
me how we are all connected, and that it is
important to pay it forward.

During my high school years, I was
terrible at languages. On my final report card
of senior year, I found a “D” as my final grade
in French. I sought out my French teacher to
thank her, as we both knew I didn’t deserve
that high a grade. Her answer was, “I did
something good for you; now you go and do
something good for someone else.”

These introductions to paying it
forward led me to my career in medicine.
Indeed, it is all our careers in medicine.
To paraphrase a previous president of
MedChi, Sir William Osler, we physicians
are bound to heal the sick, and alleviate
the suffering. We entered this noble
profession to pay it forward and do good
for someone else. We use our training and
our compassion to help patients with their
worries, their concerns, and their fears. As
an orthopaedic surgeon, I see many people
who are worried about this pain or that.
Sometimes it is serious; sometimes not.
It seems that often the best thing I do

for patients is to reassure them that the
discomfort they feel is not so foreboding
as they fear. Yes, some will need surgery;
some just need exercises and physical
therapy. But to get them to know that
their physician is there with them is often
one of the more important things I do.

I take on this role as the 169th President
of MedChi because of my desire to pay it
forward. Not only do we physicians have
an obligation to our patients, we have an
obligation to each other. This House of
Delegates of Maryland consists of those of
us who have a sincere desire to make things
better. I have often said in my office that the
way to make things 100 percent better is to
make 100 things 1 percent better. We all
need to take the time to make 100 things 1
percent better. Taking the time to do the “one
little thing extra” goes a long way to improve
our overall well-being. Your presence at a
meeting is important. Your contribution to
the Center or the PAC is important. Your
encouraging a young physician to join and
participate in MedChi is important. It is in
these small acts that we are strengthened 1
percent at a time.

So what do we need to accomplish
this year? As some of you know, I am intensely
motivated to try to get people connected
to the dealings of MedChi in Baltimore
and Annapolis. Meetings that take an hour
or more to drive to and back are a huge
impediment to connecting physicians to
MedChi. Using the Zoom technology can
be a tremendous boon to engage and connect
our physicians. The Friday Lunch and Learns
can be a webcast. I want physicians from the
Eastern Shore, Western Maryland, Southern
Maryland, and even as far off as Montgomery
County to be able to participate in meetings
and have valued input and feedback without
having to lose extra hours away from their
families.

We also need to keep the legislative
process strong and vibrant. By using the
Zoom technology, more physicians can
participate in the Sunday calls and Monday
meetings. More knowledgeable physicians
will better engage with their legislators in
Annapolis, not only at our county visits
but also throughout the year. We are here
today setting our legislative agenda and
determining MedChi policy for the year. I
want each and every one of us to be able to
go out from here and engage with legislators.
As I have written many times in Maryland
Medicine, the time spent between sessions
is almost as valuable as the time during the
session, as those relationships are vital to
advancing our agenda.

As the leaders of medicine in Maryland,
we all need to be intimately involved in the
political process. It has been said, “If you are
in medicine, you are in politics.” Each and
every one of us needs to contribute, not only
time and effort, but financially. Even though
the presidential election is upon us, the
Maryland legislative elections are looming
two years from now. The Maryland Medical
PAC needs funding to aid in our legislative
efforts year in and year out. I expect each
and every one of us to make contributions in
both time and money.

We physicians in Maryland are generally
well informed as to what is happening to
medicine. I was recently in another state
and I found myself explaining to one of
their delegates what SGR was and why it
needed to be changed. I don't think any of
our physicians would need that explanation.
Medical policy is complex, to be sure. I
admit that, other than Gene, intimate and
extensive knowledge of the Waiver is in
short supply. Our communication and
outreach programs will continue to educate
all of us to navigate the difficult path to the
future of medicine.

The famous philosopher, Garrison
Keillor, has said, “Be well, do good work,
and keep in touch.” Using social media, we
do get to keep in touch. I know that many of
us are neophytes in this arena, but we
have seen this fall the power (for good or
continued on page 8
for ill) of a Tweet. We all have a circle of friends and colleagues. By resending items from @MedChi or @MedChiPresidents, and resending MedChi Facebook posts, we help shape the conversation surrounding medicine, whether it is about the Waiver, MACRA, physician wellness or burnout, the opioid crisis, Medicaid funding, sugar free kids, or end-of-life care.

Another looming problem is what has been called “burnout.” The system is finally getting to us. It gets harder and harder to keep up every day with our EMRs, the messages, the rules, the regulations. We get tired. We get stressed. We get depressed. Sometimes we want to end it all. We need to identify these symptoms before they get overwhelming. We are in this together. Yes, the Center has programs for physicians who are impaired. But we need to identify these problems even before they get that far, and offer help and solutions.

Dr. Buckley began to bring some relaxation or “wellness” techniques to our meetings, and that certainly has been a start. A recent survey revealed that close to 55 percent of physicians would take advantage of some sort of stress relief program. We need to explore this further and establish safe ways to relieve stress before physicians become impaired or take ultimate steps.

There are many people I need to thank who have helped me along the way. Of course, my dear wife and partner, Ann Sablosky, has been there with me from high school and college. My children: Paul is here today, Ellen is working as a nurse in Oncology at the University of Pennsylvania, and Harry is joining us via a Zoom meeting, since he is at the South Carolina HOD as a medical student presenting a policy paper on Medicaid expansion. My practice partners have allowed me the space to pursue the crazy hours needed to do this. My office staff puts up with the changes I need as I cancel office hours for a meeting, somehow making it all work. It will probably only get worse this year. I am especially grateful to the previous presidents who have taught me and mentored me along the way: Tyler Cymet and Brooke Buckley for showing me the ropes, and to Bruce Smoller, Brian Avin, Harry Ajrawat, Willarda Edwards, and others for showing me how to negotiate the complexities of MedChi. And I need to especially give a shout out to the tireless staff of Montgomery County Medical Society and MedChi, without whom none of this can ever happen. Dianne Briggs got me started on this journey many years ago, and Susan D’Antoni has helped me continue to succeed. Cathy Johannesen, Lawrence Almengor, Sharon Kirk, and others are instrumental in keeping everything running. Steve Johnson, Gene Ransom, and Debbie Sciarabassi are the glue that keeps it all together.

I began today with a story about a tempest and a flame. I urge all of you to carry the precious flame of medicine. Pay it forward by being involved at multiple levels, at your county, at MedChi, and at the AMA.

Be well, do good work, and keep in touch.
MedChi’s Tradition of Promoting Physician Health

MedChi’s tradition of promoting physician health can be traced back to its inception in 1799. The Society has a history robust with stories of physicians helping physicians with practice and personal issues. MedChi has a long history of helping physicians with impairment. A landmark American Medical Association study, titled The Sick Physician, explained:

“It is a physician’s ethical responsibility to take cognizance of a colleague’s inability to practice medicine by reason of physical or mental illness; including alcoholism or drug dependence... Accountability to the public through assurance of competent care to patients by physicians and other health professionals is a paramount responsibility of organized medicine.”

We have been working to achieve accountability to the public and to protect and help physicians with impairment issues for years.

Defining Impairment

• In 1973, the AMA Council on Mental Health published a landmark study, The Sick Physician, estimating that 3.2 percent of physicians suffer from alcoholism, 2 percent from drug abuse, and 1.3 percent from other mental disorders.

• An impaired physician is one whose ability to practice medicine, with reasonable skill and safety, is impaired because of mental illness, substance or physical disability. (AMA, 1973)

• More recent data estimate that 12 to 16 percent of physicians suffer from alcoholism, drug abuse, or emotional or mental disorders, a rate similar to the general population.

The Maryland Physician Health Program (MPHP)

The MedChi commitment to public health is well represented by the Maryland Physician Health Program (MPHP). MedChi established the MPHP in 1978 as a volunteer committee to help colleagues with issues that may interfere with their personal or professional lives. Today, the program is stronger than ever and has actually been divided into two physician programs—the Physician Health Program and the Professional Rehab Program. The group is working on adding services for other non-physician clinicians in a third program.

“MedChi established the Maryland Physician Health Program in 1978 as a volunteer committee to help colleagues with issues that may interfere with their personal or professional lives.”

MPHP assists physicians and physician assistants in a confidential, private setting to address issues that may potentially impact their ability to practice medicine. The program assesses and refers participants to clinically appropriate treatment, helps the participant develop a rehabilitation plan, provides case management to facilitate progress with the plan, and provides advocacy on behalf of the client when needed. The program also provides education and outreach to the medical community regarding physician impairment and available services.

MPHP is not affiliated with the Maryland Board of Physicians. The Program meets HIPAA compliance standards. Federal and state laws ensure the confidentiality of practitioners referred to the program. Program records are non-discoverable and confidential to the extent covered by law. Exceptions to confidentiality include evidence of imminent harm to self or others through good-faith assessment by program staff, medical emergencies, court-ordered disclosures, and the State of Maryland mandated reporting requirements regarding child abuse and neglect.

The types of concerns encountered by the MPHP include:

• Alcohol abuse and alcoholism
• Chemical dependency
• Mental or emotional health
• Physical and cognitive impairment
• Behavioral issues
• Legal issues
• Sexual misconduct/boundary
• Stress

The Maryland Professional Rehabilitation Program

The Maryland Professional Rehabilitation Program for physicians, physician assistants, and allied health providers licensed by the Maryland Board of Physicians has been established at the direction of the Maryland Legislature for professionals who are in need of treatment and rehabilitation for alcoholism, chemical dependency, or other physical or psychological conditions, and who have been referred by the Board for services. The program is designed to facilitate access to treatment and rehabilitation services. It offers information, evaluation, and referral for treatment. Staff is available to provide or arrange presentations on topics related to substance abuse and mental health. MedChi, through the Center for a Healthy Maryland, has had a contract to provide these services for the last seven years.

The two programs are separate and distinct, but both are set up to help physicians who face an impairment issue. If you or someone you know needs help, I urge you to contact MedChi today. That action could save a life.
If you are Dispensing Medications you are now Required by law to complete CME.

Effective July 2013, if you are dispensing medications you must complete Continuing Medical Education credits on dispensing to apply for your permit.

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MedChi and The University of Maryland School of Pharmacy have collaborated to develop content to meet your needs. Introducing Physician Dispensing in Maryland: An Educational Series. We have made the process easy for you with the launch of three online modules:

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Additional modules will be coming soon to support your efforts to be fully compliant.

ACCREDITATION STATEMENT
Activities were planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society, and The University of Maryland School of Pharmacy. MedChi is accredited by the ACCME to provide continuing medical education for physicians.
This issue of *Maryland Medicine* is devoted to twinned and intertwined topics: the increasingly insidious blaming of the physician community using some legitimate, and some very spurious, measures and physician burnout. We set out, actually, to present two topics of current interest, but recognized rather quickly that there is a very intimate connection between the two.

Burnout is characterized by exhaustion, lack of involvement, enthusiasm, or motivation, feelings of intense and easily triggered frustration, fatigue, cynicism, and anger. Its causes are protean, and occupational burnout is often found in the helping professions.

It has been around as long as humans have, but its study generally began in the 1970s. As a psychiatrist, I have been involved in one way or another in the treatment of hundreds of patients who would be typified as “burnt out.” We tend, however, to group these patients by diagnosis and offer treatment on a broad spectrum from medication to social change and psychological “strengthening.”

The incidence of “burnout” is increasing, and coincident with the accelerating changes in the way physicians work, are paid, and are gratified. We see more and more physicians as patients and an increasing dissonance between the expectations of the practitioners of medicine and the reality of today’s practice world.

As I was working at one of those stressors, CME, I came across a module devoted to burnout. There were two almost diametrically opposed viewpoints expressed by the two main speakers of the module. The first was an exposition of an increasingly frustrating practice world and spoke of the increasing incidence, prevalence, and virulence of this dysphoric and destructive syndrome. The second, by a neurologist, premised the fact that physicians were still very trusted and revered and that there was no such thing as burnout, or at least shouldn’t be.

It was clear that both authors had a point. The environment in which we find ourselves is rather a paradox and somewhat bipolar. We are respected by our patients, but our frustration with the framework of practice is also very much in play. We are asked to work long hours, and we generally like interacting during those long hours with our patients and help in solving their problems. That’s why we signed up. As we all know, it’s “all of those other things.”

So what is the difference? If long hours and tremendous demands and expectations are and have been a part of our lives since long ago, what is different, if anything now? What is promoting what are generally accepted as rapidly accelerating rates of burnout?

Physicians were once fully in charge of themselves. The concept of the loss of the locus of control is probably responsible for at least a good part of higher rates of burnout.

The effect of stress on humans is a complicated business. It involves the strength of the stimulus (devious demands of insurers, for instance) as well as the health of the receptor (the psychological health and history of the physician on whom the stress is worked). How long has the stress been applied, how trapped are we, how insulated against financial losses are we in case we need to exit this workplace, and many more factors come to bear almost mathematically to determine how supply is our response, and how much reserve we have.

The expression of the solution of the equation is the syndrome we call burnout…. loss of efficiency, anger, fatigue, depression, anxiety, dysphoria, and more.

There is, in fact, a standard curve that expresses output versus stress…it is an inverted “U.”
These types of problems may interfere with the safe practice of medicine, or the effective operation of your practice or institution, and have the potential to result in legal and disciplinary actions, which may even affect licensure status. Most importantly, these issues can be addressed through early and appropriate assessment and treatment. Do not wait to seek assistance, because the greater the delay the higher the risks.

MPHP helps with:
- Alcohol/chemical dependency
- Mental or emotional health
- Stress
- Physical or cognitive impairment
- Disruptive behavior
- Boundary violations/Sexual misconduct

During these increasingly difficult times for physicians, it is essential to know who to turn to for professional assistance with potentially career-ending problems. MPHP is a private, confidential, non-disciplinary program that advocates for the health and well-being of all physicians and other allied health professionals who are licensed by the Maryland Board of Physicians to safeguard the public. MPHP is HIPAA compliant, and protects the confidentiality of participant records as set forth under state and federal law. MPHP is administered by the Maryland State Medical Society’s 501 (c)(3) affiliate, the Center for a Healthy Maryland, and is separate from the Maryland Board of Physicians. MPHP satisfies the Joint Commission requirements to be able to identify and assist physicians with health and behavior problems, and to have a process to identify and manage matters of individual physician health that is separate from the medical staff disciplinary function.

For a confidential consultation for you or a colleague who may benefit from our help, please call 800-992-7010 or 410-962-5580.

We need your support! Please consider making a tax-deductible contribution to the Maryland Physician Health Program. For more information visit www.healthymaryland.org or call us at 800-992-7010 or email phpinfo@medchi.org.

Call MPHP First!
Too little anxiety, and there is poor motivation and poor performance. Too much anxiety produces an extinguishing of efficient production. Many physicians are pushed into the latter category, working under many demands and unreachable benchmarks. Add to this the constant drumbeat of criticism and lack of rewards, a dollop of frustration with insurers and a jigger of plaintiff’s bar to the mix, and you have a stew worthy of the name “burnout bisque.”

There are programs, such as the MedChi program devoted to the physician in crisis. Unless, however, our medical societies, our legislators, our officials, and, most important, we ourselves, concentrate on retrieving the lost locus of control, we will continue to stew and simmer as the lobster pot gets slowly hotter.

This issue addresses the topic of physician burnout in an era in which we are blamed for much, have had much of our autonomy surgically cut from us, and are expected to be perfect in our work. In “The Pilloried Physician,” our own Barton Gershen, MD, documents the genesis and propagation of the “blame” culture. In “Finding the Joy in Medicine,” articles by Steven Bialick, DO; Christi Hay, MD; Jattu Senesie, MD; and Joseph W. Zebley, MD, present more personalized dimensions to the problems of practicing and living our lives in an environment increasingly hostile to the control of our practice. Articles from Richard Colgan, MD, and David L. Stewart, MD, of the University of Maryland, detail the problem from the perspective of teachers of our future physicians and the academic approach to stress. Christine Sinsky, MD, of the American Medical Association, discusses how we can keep from letting the stress of today’s practice environment from seeping into the care of our patients in “AMA Guide to Moving Forward in the Battle Against Burnout.”

As always, we invite your comments, criticisms, and kudos in the form of letters to the editor or requests to submit pieces for review by our editorial board.
In Act One of “Fiddler on the Roof,” Tevye and his wife Golde gaze lovingly at their eldest daughter Tzeitel, who has just wed Motel the tailor. Sadly, Tevye and his wife sing:

“Is this the little girl I carried,  
Is this the little boy at play?  
I don’t remember growing older,  
When did they?  
When did she get to be a beauty,  
When did he grow to be so tall?  
Wasn’t it yesterday when they were small?”

Our daily lives are recorded in slow motion, but our compressed memories are replayed at fast-forward speed. Which of us has not experienced that time-warp? Your daughter’s graduation from high school? Your son’s wedding? Your thirtieth medical school reunion? Where did the years go? Where were you when all that happened?

Within the past few years, physicians have slowly awakened to find themselves trapped within an impenetrable cobweb of regulations, prohibitions, barriers, and restraints. We have discovered that the vocation, which we so enthusiastically entered, has become a target of reproach and condemnation. Our skills are now questioned, and our professional authority has waned. No longer are we esteemed as “physicians” or “doctors,” we have been reclassified and placed within an amorphous category known as “health care providers,” which includes nurses, pharmacists, chiropractors, optometrists, EMTs, acupuncturists, homeopaths, naturopaths, Ayurvedic workers, faith healers, aroma therapists, and more.

Physicians have been blamed for the rising costs of medical care, charged with spending too little time with patients, and censured for indifference to their concerns. Within the last year, we have even been accused of responsibility for the third-leading cause of death in the United States—medical errors!

When did this hostility to physicians develop, and when did our authority begin to decline? Like the growth of children, or the change of seasons, our status has diminished by degrees, and our influence abridged imperceptibly. The beginning of those transformations was, however, well recorded.

It began at the Harry Truman Library in Independence, Missouri, on July 30, 1965. President Lyndon Baines Johnson sat behind a desk and signed H.R. 6675, creating a federal health insurance policy for seniors, known as the Medicare Act. The recipient of the first Medicare card was retired President Harry Truman himself, who had been an early advocate for universal health insurance.

The initial response from physicians was antipathy and fear that this legislation would lead to “socialized medicine.” However, over time physicians have become more comfortable with Medicare, recognizing its value for elderly patients with decreased incomes. On the other hand, economists worried from the start that Medicare might bankrupt the nation, if it were not constrained in some way. Their fears were not unwarranted.

In 1966, the first full year of Medicare, there were 19 million participants. Medicare consumed 4 percent of the federal budget, and cost the U.S. taxpayers $31 billion dollars. In 2015, the Medicare population had grown to 50 million people, and Medicare expenditures had risen to 15 percent of the federal budget, costing taxpayers $540 billion dollars. (If one adds the Medicaid population of 11 million people, total health care cost rises to 27 percent of the budget.) From the beginning, it was obvious that the Medicare population would continue to grow, and the associated increase in medical expenditures would have to be constrained. The federal administrators began to focus on physicians as the solution to this pending economic catastrophe. Their reasoning was simple: (1) physicians were paid on a fee-for-service basis, and (2) physicians were responsible for ordering all ancillary tests and referrals to other physicians. Therefore, controlling the behavior of practicing physicians should result in a reduction in the rate of Medicare spending.

Thus began a labyrinth of federal programs, none of which were completely successful, leading to a morass of systems, strategies, confusion, and a dictionary of new acronyms. Physicians and their staffs had to become familiar with such bewildering terminology as

- HMO, IPA, CAH, OPPS, VBC, CPC+, PQRS, PQRI, HER, OSHA, PTN, SGR, APM, PCMH, APRN, IPO, CLIA, CORF, E/M, HIPAA, EIN, MSA, PPO, NPI, “MEANINGFUL USE,” CAM, COBRA, POS, NCCI, MA, HAC, EOB, HER, MOC, MACRA, etc.

As federal decrees multiplied, restrictions escalated, reimbursements fell, and physicians began to close their offices. Many obtained employment in huge medical affiliations or hospital groups. Predictions are that only one third of all U.S. physicians will remain in private practice by 2017. With their loss of autonomy, physicians also began to lose some of their traditional status as leaders within the health care community. Unfortunately, many medical and specialty societies failed to challenge objectionable federal policies, choosing diplomacy rather than confrontation. The result has left individual physicians struggling to cope and feeling abandoned.
One of the more troublesome requirements decreed by the government has been the ubiquitous establishment of electronic health records (EHR), to replace conventional paper documents. The concept is admirable, but its implementation has become a nightmare for physicians and their staffs:

1. Software companies have designed electronic health records that are dissimilar and frequently unable to communicate with hospitals or other physicians’ offices. This has clearly thwarted a major reason for implementing electronic health records, and has become a source of great frustration;

2. The cost of EHR systems is considerable, averaging $30,000 per year to maintain, and often exceeding $100,000 annually.

3. Physician data entry is laborious, and has usurped much of the time spent during patient interviews. Hiring scribes to facilitate record management—a method employed by some physicians—causes a further layer of complexity and expense to office practice.

4. Finally, and most important, patients often detest the EHR because it has expropriated their physician’s time, taking his or her attention away from them and placing it on a keyboard.

The government has further decreed that EHRs be used to authenticate the quality of care provided by the physician at each patient encounter. The criteria used to assess “quality” are problematic and disputable, and—whatever their virtue might be—documenting them requires a great deal of time. A recent survey reported that physicians spend at least three hours per week, and their staffs spend at least fifteen hours each week simply devoted to filling out forms on the “quality” of that encounter. A September 6, 2016, article in the *Annals of Internal Medicine* revealed that for every one hour of patient time, the average physician spends two hours on paper work related to that encounter.

I reviewed some of the questions designed as indices of “quality measures,” and found it difficult to understand how fulfilling them would enable someone to distinguish an instance of superior medical care from one of mediocre or average care. I then sought to discover which department, committee, or individual had designed those evaluations, but was unable to unearth that information. A search for the bureau or division that scrutinizes the answers and ranks the “quality” of each service also proved futile. To paraphrase Winston Churchill, it is a riddle wrapped in a mystery inside an enigma. Of course, we are dealing with government agencies.

In response to the diminishing number of primary care physicians, as well as to the urgings of some health groups, many states have legislated major changes in health care. Currently, twenty-one states and the District of Columbia license full clinical status to Nurse Practitioners. These nurses have total responsibility for patient management, including the authority to prescribe medications, without doctor supervision. After an average six years of training, they have become de-facto primary care physicians. It seems likely that the number of states that grant such licenses will ultimately increase.

The erosion of physicians’ prestige was accelerated in 2001 by publication of a document titled “To Err is Human,” in which it was alleged that medical errors cause 40,000 to 90,000 deaths per year in the United States. The authors of that article did no original research, relying instead on older studies whose validity is questionable. Nevertheless, “To Err is Human” immediately became the inviolable, canonized proof that American physicians were at best substandard, and at worst iniquitous. Furthermore, to sustain this opinion, a May 2016 *British Medical Journal* article concluded that deaths from medical errors had actually grown to 250,000 annually, representing the third leading cause of death in the United States. This allegation was unhesitatingly accepted by the majority of news media, and disseminated to the world. One heard few dissent from organized medicine.

As a result of unending accusations, frustrations, impediments, and disappointments, physicians have become depressed, angry, and dissatisfied with the practice of medicine. They feel justifiably victimized, and many are ready to leave the profession. A study in 2014 revealed that 60 to 80 percent of physicians feel they are experiencing burnout, and 45 percent plan to retire or completely change their practice model.

Shouldn’t we be “burned up” rather than “burned out”?

*Note:* In 2015, the AMA launched the “Break the Red Tape” program, bringing physicians and legislators together to discuss “meaningful use” regulations. This year, the AMA has introduced a new website: PhysiciansGrassrootsNetwork.org, an advocacy program for physicians. One hopes the AMA may have finally understood the plight of physicians.

*Barton J. Gershen, MD, Editor Emeritus of Maryland Medicine, retired from medical practice in December 2003. He specialized in cardiology and internal medicine in Rockville, Maryland.*
2016 Survey of America’s Physicians: Practice Patterns and Perspectives

Key Findings

PHYSICIAN PRACTICE PATTERNS ARE LIMITING PATIENT ACCESS TO CARE. MOST PHYSICIANS NOT ENGAGED IN THE LEVERS OF HEALTHCARE REFORM.

Key findings of the 2016 Survey of America’s Physicians suggest a continued struggle among physicians to maintain morale levels, adapt to changing delivery and payment models, and to provide patients with reasonable access to care. Key findings include:

- 54% of physicians rate their morale as somewhat or very negative.
- Only 37% describe their feelings about the future of the medical profession as positive.
- 80% of physicians are overextended or at capacity, with no time to see additional patients.
- 72% indicate that external factors such as third party authorizations significantly detract from the quality of care they are able to provide.
- 27% do not see Medicare patients, or limit the number they see.
- Employed physicians see 19% fewer patients than practice owners.
- 20% of physicians practice in groups of 101 doctors or more, up from 12% in 2012.
- 17% of physicians are in solo practice, down from 25% in 2012.
- 49% often or always experience feelings of burnout.
- 49% would not recommend medicine as a career to their children.
- Physicians spend 21% of their time on non-clinical paperwork, the equivalent of 168,000 physician FTEs not engaged in clinical activities.
- Only 14% of physicians have the time they need to provide the highest standards of care.
- 8% of physicians plan to cut-back on hours, retire, take a non-clinical job, switch to “concierge” medicine, or take other steps limiting patient access to their practices.
- Only 43% have their compensation tied to quality or value.
- Only 44% of physicians believe hospital employment of doctors is a positive trend.
- Only 43% participate in insurance products offered through state/federal exchanges.
- Only 6% indicate ICD-10 has improved efficiency in their practices, while 42.5% say it has detracted from efficiency.
- Only 20% are familiar with the Medicare Access and CHIP Reauthorization Act (MACRA).
- Only 11% of physicians say electronic health records (EHRs) have improved patient interaction, while 60% say they have detracted from patient interaction.
- Only 33% of physicians identify as independent practice owners or partners, down from 48.5% in 2012.
- 55% of physicians participate in the Physician Quality Reporting System (PQRS), 36% participate in an ACO, and 75% participate in patient satisfaction surveys.
- 71% of physicians describe “patient relationships” as the most satisfying aspect of medical practice, while 58% say “regulatory/paperwork burdens.”

It should be noted that physicians are not uniform in their perspectives. Younger physicians, female physicians, employed physicians and primary care physicians are notably more positive about the current medical practice environment than are older physicians, male physicians, medical specialists and practice owners, though the majority of almost all types of physicians suffer from low morale and express doubts about the direction of the healthcare system.

Data derived from a survey of 17,236 physicians conducted for The Physicians Foundation by Merritt Hawkins
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How do Maryland physicians compare?

Is any of your compensation tied to quality metrics? **Maryland is 41st of 50.**
Only 36.2% of Maryland physicians responded their compensation is tied to quality metrics such as patient satisfaction, “citizenship,” and error rates compared to the highest response in Wisconsin (64.1%) and the lowest in Alaska (20.8%).

Would you describe the future of the medical profession as negative/pessimistic? **Maryland is 15th of 50**
67.0% of Maryland physician respondents indicate they feel negatively or pessimistically toward the future of medicine compared to 78.7% (#1) in Wyoming and 51.3% in Minnesota (#50).

Would you recommend medicine as a career to your children or other young people? **Maryland is 19th of 50**
51.9% of physician respondents in Maryland indicated they would recommend medicine as a career to their children compared to 65.3% in Alaska (#1) and 39.8% in Delaware (#50).

How many physicians remain in private practice? **Maryland is 29th of 50**
30.2% of the Maryland respondents indicated they remain in private practice, compared to South Dakota (#1) with 45.9%, and Vermont (#50) with 7.8%.

How familiar are physicians with MACRA? **Maryland is 15th of 50**
57.8% of Maryland respondents said they are very unfamiliar or somewhat unfamiliar with MACRA, compared to #1 Oregon (66.0%) and #50 Wyoming (33.3%).

Where are physicians not seeing Medicare patients? **Maryland is 26th of 50**
12.9% of Maryland respondents do not see Medicare patients, compared to #1 Nevada with 22.5%, and #50 South Dakota 2.9% not seeing Medicare patients.

Where is physician morale the highest & the lowest? **Maryland is 15th of 50**
49.5% of physician respondents in Maryland indicated their morale is very or somewhat positive compared to the highest morale in Nebraska (58.3%) or the lowest in Texas (38.8%).

To what extent do you have feelings of professional burnout in your medical career? **Maryland is 9th of 50**
50.5% of physician respondents in Maryland indicated they often or always have feelings of burnout compared to 60.4% of the physicians in Alaska (#1) or the lowest burnout reported in Montana of 31.9% (#50).

Data derived from a survey of 17,236 physicians conducted for The Physicians Foundation by Merritt Hawkins. 1.8% of the respondents identified Maryland as their practice location (approx. 310). For complete survey results, go to http://physiciansfoundation.org or contact Susan D’Antoni at MCMS at 301.921.4300 or sdantoni@montgomerymedicine.org.
Through resiliency in sickness and health, my osteopathic education has given me the chance to explore the intimate connection between the mind, body, and spirit.

— Steven Bialick, DO

I was able to identify the three core values I needed in a work environment — a strong doctor-patient relationship, access and accountability, and passion.

— Christi Hay, MD, MPH

It never occurred to me that it was appropriate to reflect on my own needs to change the paradigm and include myself among the people who deserved my care.

— Jattu Senesie, MD, FACOG

Spending twenty relaxed minutes with patients rather than five or ten hurried minutes, and learning about the social and economic determinants of their health brings back the joy.

— Joseph W. Zebley III, MD, FAAFP
The Magic Jar of Human Connection

Steven Bialick, DO

Human anatomy would suggest that our brains are complex, intricate, diverse organs, different from person to person. But a peek inside most brains—yours included—shows there’s something we all share: hurt. At some point throughout our existence on this earth, we all experience pain. Whether physical, emotional, or psychological, we have all sustained injuries. And they hurt. To get through that hurt, we rely on support. Support from our friends, support from our family, from music, from reading, from listening. We rely on the strength of human connection. We rely on our resiliency.

Like most medical students, my first clinical experience witnessing a doctor break bad news in a patient encounter was unforgettable. I watched a Stage 4 Colon Cancer diagnosis swallow the 53-year-old patient and his wife like unexpected children standing in the ocean under too big of a wave. It was four years ago, but I still remember the details of that moment—the noises, the silence, the lightning, the shadows, the fear, the numbness, the hopelessness, the helplessness. As a medical student, the flood of emotions was overwhelming, yet tolerable. But as the patient’s son, it was crippling.

My dad has wrestled four years of surgery, chemotherapy, and radiation; our family has been his light. I realized quickly that his fight is fueled by our success. As such, I became steadfast on achievement, doing everything I can to boost his pride to strengthen his morale. While studying for medical school and serving as the family therapist, I also took on leadership roles, received scholarships, authored journal articles, and created community service projects that I knew he would be proud of—things he could discuss and brag about to his friends, distracting him from terminal illness.

But as he became weaker with metastasis to his spine, brain, liver, and lungs, our family began to crumble on the sidelines. Seeing our family break down because of his condition made my dad even sicker, which made the family even more distraught. It became a vicious emotional cycle. I needed to bring back hope, and the holistic approach to patient care that sits at the heart of my osteopathic education allowed me to do it. In order to effectively treat my dad, I had to treat our family. We needed something to look forward to, something to spark a smile everyday despite the darkness.

And to do this, I had to share our story.

So on Father’s Day, my sisters and I got in touch with everyone who is or has been a special part of my old man’s life. We clued them in about our struggle and asked for their help. We had these people send in notes of encouragement, their favorite memories, sports highlights, or photos with my dad. The response was overwhelming. We received over 360 messages from people near and far, new and old, who have been grateful for or inspired by my relationship she had with my mother and me. As I entered high school, I set out to become a physician, which for me was a very structured path. I was a strong math and science student in high school, which served me well in college as a pre-med student at Stanford University. I graduated with a human biology major and decided to go to graduate school in Ann Arbor, Michigan. I graduated from the University of Michigan School of Public Health, trained as a health educator. My public health training exposed me to the systems of health care and how they impact communities and individuals. From Michigan, I traveled to Charlottesville, Virginia, to attend medical school at the University of Virginia and then Washington, D.C., to complete a pediatric residency at Children’s National Medical Center. These academic milestones are familiar for most practicing physicians.

How does an academic pediatrician become the owner of a medical start-up practice that incorporates easy access to the physician, comprehensive care, and house calls? In my search for the perfect job, I discovered that I had to create my ideal work environment. I decided that I wanted to be a pediatrician when I was ten years old. I loved my pediatrician in Oakland, California, in the Kaiser Permanente Health System. She was a great role model, and I really liked the relationship she had with my mother and me. As I entered high school, I set out to become a physician, which for me was a very structured path. I was a strong math and science student in high school, which served me well in college as a pre-med student at Stanford University. I graduated with a human biology major and decided to go to graduate school in Ann Arbor, Michigan. I graduated from the University of Michigan School of Public Health, trained as a health educator. My public health training exposed me to the systems of health care and how they impact communities and individuals. From Michigan, I traveled to Charlottesville, Virginia, to attend medical school at the University of Virginia and then Washington, D.C., to complete a pediatric residency at Children’s National Medical Center. These academic milestones are familiar for most practicing physicians.

A Doctor’s Standard Career Path — And The Path I Chose

Christi Hay, MD, MPH

After all of that training, my goal was to work in an academic setting, which I did for approximately eight years. I saw patients in a busy clinic and was a preceptor for pediatric residents, medical students, and physician assistant students. I developed and executed health education programs, created a reading room in the clinic, and chaired the clinic community advisory board. I loved my job, but something was missing. I was restless and unsettled. I interpreted this feeling as a need to change jobs.

I joined a traditional private pediatric practice as an alternative to academia. In the private practice I loved the families, but the business of medicine was very frustrating. A sick visit was a ten-minute appointment, and a well visit was fifteen to twenty minutes. As a medical student and resident there is a strong emphasis on medical histories. As medical trainees we are often told that 80 to 90 percent of the information a physician needs to make a diagnosis comes from a thorough medical history and exam. The limited time spent with a family made it difficult to address all their issues. There was a strong emphasis from management to see as many patients as possible, with twenty to twenty-five patient visits a day being a typical workload. There were also challenges with office logistics, such as bringing patients back to exam rooms in a timely fashion and medical assistant training. After several years in a busy and stressful private practice, I decided that the work environment was not a good fit for me. Again, I was restless and unsettled. I interpreted this feeling as a need to change jobs.

I loved my career choice as a pediatrician, but I didn’t love the realities of practicing medicine. This misalignment of expectations forced me to question my core professional values. I determined that I needed to work in an environment that valued strong doctor–patient relationships, access and accountability, and passion.

The doctor–patient relationship is the foundation of providing quality medical care. I believe it is important for my patients to know my professional style and me as a person. It is important to me that my families know where I am from, where I was educated, and my professional preferences. I want to know my family’s personal preferences and their health beliefs. A strong doctor–patient relationship helps me cre-

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How a Type A Found Her Plan B

Jattu Sennesie, MD, FACOG

The Burnout

At the time I retired, I would have said I stopped practicing medicine because I hated being a physician. Six years after the fact, I now realize that the issue was that I had become disconnected from the essence of what made being a physician purposeful for me. Ironically, it took leaving clinical practice for me to rediscover that connection.

When I stopped practicing, I knew I didn’t enjoy my life as a physician and thought that altering my external environment would bring me a greater sense of well-being. My previous attempts to bounce back from burnout included taking a three-month sabbatical, altering my work schedule, and moving to a new neighborhood. Unfortunately, those strategies didn’t yield the expected results.

Rather than rethinking my outside-in approach to achieving fulfillment, I decided to make a bigger, more dramatic change. I considered getting more specialized training in a fellowship, looking for a different practice, or leaving medicine altogether. My eventual choice to retire was based on the acknowledgment it no longer felt worth it to me to be a physician. I decided there had to be a better way for me to help other people be well while maintaining a sense of well-being for myself.

What I struggled for years to identify was what made the endless tedious tasks associated with the current health care system dwarf my joy so much. How had my dream career become not worth it to me? Eventually I determined that I had been basing my approach to being well on a flawed fundamental belief. Being good at school doesn’t automatically translate into being good at life, especially when that educational system teaches one to neglect personal well-being.

The Myth

There is a certain story that many of us physicians tell ourselves about how our lives are supposed to work. We are convinced that perfectly following a pre-determined path into a career of caring for others guarantees satisfaction. It seems logical that a life that adheres to external expectations will yield internal fulfillment. Personal well-being doesn’t automatically translate into being good at life, especially when that educational system teaches one to neglect personal well-being.

Next, make sure your contract is enforced and be clear with any providers, physicians, nurses, and others) and their patients supports them. Ten years ago, I was burning out as well. Faced with the disintegration of a medical group, but left with nearly 3,000 patients who depended on me, at age fifty-seven I was ready to retire. I no longer really needed the money. I needed to either quit my practice (i.e., retire) or do something else. I elected to try a third path. I decided to evolve my high volume practice, of running on the hamster wheel, depending on E & M codes (Evaluation & Management CPT codes), fighting with the insurers over nickels and dimes, to a different model. Although we have seen a groundswell of so-called DPC practices (Direct Primary Care) since 2006, ten years ago there were few models. Either a physician dropped insurance altogether, as there are so many penalties if one balance bills a patient, or became a servant of the insurance industry. One reasonable choice existed for my practice. I opted to join a national program that holds the maximum number of patients in a family or internal medicine practice to 600 and requires an annual fee for the members who join the practice.

I also was able to provide scholarships for 10 percent of my patients and thereby keep those patients who could not afford the annual fee. Unfortunately, when you go from 2,700 souls to fewer than 600, there are many who cannot be served. After many pangs of conscience, I felt it was better to serve 600 people well with good thoughtful care rather than stop altogether.

Spending twenty relaxed minutes with patients rather than five or ten hurried minutes, and learning about the social and economic determinants of their health brings back the joy. Integrating my skills in mental health counseling and general health counseling with the somatic skills and procedural skills I learned in residency has allowed me to regain and even expand my scope of practice. Again, this helps bring back the joy of practice.

Working with a team of health providers by continuing to attend patients at home, in the nursing home, and especially in the hospital, has allowed me to feel comfortable working by myself with only loose coverage arrangements. I do not answer to an executive or to bean counters, and I would never go back to being a wage slave, a clinical mule on a treadmill, under the lash of a nurse manager. Joy comes when a provider regains clinical as well as financial independence.

Here are my thoughts.

Each person must find his or her own path; however, no physician should assume he or she will be obligated to work for a hospital corporation or a corporate group. Nonetheless, with high debts, many young physicians are afraid to go out on their own, even though an entrepreneurial spirit will suit everyone who is not in government service. If you do decide to work for someone else, first sit down with an attorney and lay out your needs and demands for quality of life, and not only work and life balance, but also quality of work balance. Next, make sure your contract is enforced and be clear with any clinical supervisor that your responsibility is to the patient, not the hospital, the group, or the corporation.

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The Magic Jar of Human Connection ...  
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brings him and the emotional pain the cancer brings us, we've been able to find joy through the power of human connection. People came together to share their good thoughts in order to take away our hurt. Through resiliency in sickness and health, my osteopathic education has given me the chance to explore the intimate connection between the mind, body, and spirit.

Reaching deep within that mind, body, and spirit allows us to uncover the resiliency that lives inside, and sharing it with those on the outside allows us all to cope. The power of writing is immeasurable. Born in written language is a relationship between an author and a reader. This relationship provides an outlet to express emotion and gives us the magic to tell and share stories. As the reader, you've become part of my story, and we've become part of each other's resiliency. And only together, we can get through the hurt. Steve, Bialick's essay is reprinted from Inner Strength: Osteopathic Medical Students Reflect on Resiliency, a collection of essays by osteopathic medical students. Each essay is a story describing in detail a moment of struggle experienced by the writer during his or her journey to becoming a physician.

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A Doctor's Standard Career Path ...  
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ate realistic health plans for my families. I know whether a family can administer a medication three times a day versus twice a day, or whether a family will use a nebulizer machine versus an inhaler. Such a relationship ultimately improves the well-being of my patient and makes the medical experience pleasant for everyone involved.

I believe that families want one person who is easily accessible to be accountable for the well-being of their child. The mother of a patient of mine called me to tell me her son had abdominal pain. She thought he was coming down with a stomach bug and just wanted to check in about his condition. After reviewing his medical history with her on the phone, I decided that he needed to be seen. I drove to their home and determined that her son probably had appendicitis and needed to go to the emergency room. The patient was taken to the ER, diagnosed with an appendicitis, had surgery and was back home within twenty-four hours. A life-threatening condition was identified and managed accurately and efficiently because the patient had direct access to a provider.

I am passionate about managing the health issues of children and adolescents. I enjoy keeping children healthy and thriving. I also enjoy managing ill children and working with families to get their child back to baseline health. I am happy to research pediatric topics and read the pediatric literature. I truly believe it is an honor to work with families and children.

Once I was able to identify the three core values I needed in a work environment—a strong doctor-patient relationship, access and accountability, and passion—I was able to write a business plan. I needed a small practice, direct access to the patient with minimal staff, and lots of time to discuss issues. In 2011, I started Palisades Pediatrics, an intentionally small practice with direct access to me by phone, office, and home. Honestly, I was reticent to incorporate home visits into my business plan. Did families want a doctor in their home? How would families respond?

To my pleasant surprise, families have been very receptive to home visits. Families enjoy receiving care for their child with minimal disruption in their daily routine. I appreciate seeing the home environment and how it may impact my patient's health. Palisades Pediatrics allows me to be my authentic self at work. This authenticity is a freedom I have not previously experienced in the workplace. I am free to provide care using my professional style and judgment. I am free to schedule patients for time slots that I feel allow me to deliver quality care. I am free to research and provide health education materials for my patients that I believe will enhance their pediatric health experience. I am free to counsel families about their medical issues on a daily basis.

Palisades Pediatrics allows me to align my professional training and expectations with medical practice, and has resulted in a renewed professional enthusiasm. I am no longer restless or unsettled at work. Simply stated, I am very happy. I encourage all physicians to consider the core values they need in the workplace and work toward finding the right work environment.

Christina Hay, MD, is a pediatrician practicing in Washington, D.C. She can be reached at drhay@palisadespeds.com.

How a Type A Found Her Plan B ...  
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place of true fulfillment. I was looking exclusively externally and neglecting many of the internal signals directing me toward self-care and personal well-being. I didn't realize that a truly satisfied life requires balancing external expectations and internal insights.

The Truth

During the long process of becoming a physician I had lost sight of what actually drew my spirit to doing this kind of work. I love connecting with people in ways that help them be better. At the same time, I have always found maternal-fetal physiology and reproductive endocrinology to be fascinating. I also enjoy being physically active. Working as an obstetrician-gynecologist seemed like the perfect career to combine my interests in a way that would continuously feed my mind, body, and spirit.

However, over time, the balance in my mind, body, and spirit connection skewed far toward the mind and disrupted my overall well-being. My mind told me my purpose was to help other people get and stay well. As good as this explanation sounds on paper, in reality I got more caught up in the grind of completing tasks than in the development of healing relationships. I became so cerebral in the development of healing relationships. I became so cerebral in the sight of what actually drew my spirit to doing this kind of work. I loved connecting with people in ways that help them be better. At the same time, I have always found maternal-fetal physiology and reproductive endocrinology to be fascinating. I also enjoy being physically active. Working as an obstetrician-gynecologist seemed like the perfect career to combine my interests in a way that would continuously feed my mind, body, and spirit.

Rather than connecting with patients, I became more focused on getting through the appointments on my schedule. When my body needed a break to rest or eat or pee, my mind told me other people’s expectations superseded my physical well-being, and I powered through. These were the standards of behavior to which I had become accustomed during my medical training. It never occurred to me that it was appropriate to reflect on my own needs to change the paradigm and include myself among the people who deserved my care.

When I moved into the non-clinical world, I initially approached developing my Plan B with the same externally focused mindset that I used to craft Plan A. Thankfully, when I was working as

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I hope this is helpful. I have found my joy again. I plan to keep practicing to some degree into my seventies. I have thoroughly enjoyed the last decade of my professional life, and I look forward to working with another young enthusiastic internist or family physician who wants to get off the hamster wheel.

Joseph W. Zebley III, MD, FAAFP, is a family medicine physician in Baltimore, Maryland. He can be reached at josephzebley@icloud.com.

Experiencing symptoms of burnout in ostensibly low-stress work environments helped me realize that it’s not just the toxic system that prevents physicians from being well. Many of us are so disconnected from what is truly well for us that we don’t even recognize toxicity when we are in the midst of it. Considering our well-being as individuals is essential if we are going to effect the systemic changes necessary to improve the current health care environment.

It was this realization of a need for self-care advocacy among physicians that led me to start my company Essence of Strength. I speak and write about self-care to increase awareness of how essential this concept is, especially in the lives of altruistic high achievers. Through individual coaching and workshops, I teach physicians how to implement the practical self-care strategies that support personal and professional achievement and well-being. My goal is to help my fellow physicians trust the same gut instinct used in treating patients to help them make the proper choices for their own well-being.

Jattu Senesie, MD, FACOG, former OB/GYN and current personal trainer and professional life coach at Essence of Strength, LLC, in the greater Washington, D.C., area. She can be reached at jattu@essenceofstrength.com.

Finding the Joy Again ...

I hope this is helpful. I have found my joy again. I plan to keep practicing to some degree into my seventies. I have thoroughly enjoyed the last decade of my professional life, and I look forward to working with another young enthusiastic internist or family physician who wants to get off the hamster wheel.

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DocbookMD has now made it easier than ever to engage and communicate with your non-physician colleagues in a new feature to our app called Care Team. With Care Team, physicians can invite members of the patient care team to join them on DocbookMD to communicate in a secure, fast and efficient way through their mobile device. Now, all of those caring directly for patients can share messages and images like X-rays, EKGs and images of wounds or rashes wherever and whenever they need to. Simply download the app from either the App Store or Google Play and start building your Care Team.
A Life in Medicine

“\textit{To prevent disease, to relieve suffering and to heal the sick — this is our work.}”

—William Osler

Richard Colgan, MD

Physicians coming upon tough times is nothing new. What likely is new is the impression of many of us that today’s current stressors, strife, and difficulties in practicing medicine are unique to our times. Regardless, we must keep what is special about our vocation in focus.

Our Work

What we do for a living is a blessing that only rarely is available to others who want to serve mankind. MedChi’s former president and internationally renowned medical educator, William Osler defined our work clearly. We are here “to prevent disease, relieve suffering and to heal the sick.”1

A life in medicine is not without its stressors. In describing what our vocation involves to medical students, a physician who had been out more than thirty years once urged me, “Don’t sugar coat things.” I don’t intend to. None of us are blind to today’s stressors. The toll that many years of training and late nights on call had on us was just the beginning of what is truly the hard work of what we do, day in and day out. In the decades prior, it used to be a badge of honor to never be home, always be at the hospital. Now, most would likely see this as purely foolish and shortsighted. So how do we get there from here?

Perhaps one step is to admit that a life in medicine is demanding and stressful. The next step could be the realization that it has been stressful and demanding to physicians for centuries.

The Obstacle Is the Way

We need to rethink how we think of things. A great read on this topic can be found in Ryan Holiday’s recent release \textit{The Obstacle Is the Way,}2 This light read is based on some of the teachings of Roman Emperor and Stoic Philosopher Marcus Aurelius (121–180 AD), who said, “The impendunt to action, advances action. What stands in the way, becomes the way.” In his landmark work, \textit{Meditations,} Aurelius wrote about the philosophy of service and duty. Like William Osler, he championed the need to find and exhibit an inner peace or equanimity when confronted with crisis. What’s this got to do with me, you might ask? We are the captains of our fate, and the only ones who can turn adversity into advantage.

A Quest for Work Life Balance: An Impossible Dream?

For us to feel better about ourselves, we have to understand what needs attention. Despite being an astute observer of others, this may be more challenging when it comes to our own health. Doctor, perhaps you could use a second opinion? From your spouse, significant other, or physician, for example? Having someone you can talk to at work, developing a routine, perhaps of taking the lunch break you often miss and socializing with a coworker, can be part of what is missing in your life.

Such reasoning may have been behind Osler’s admonition that physicians go to medical meetings. Besides being updated on the latest advances in medicine, you can learn how others deal with the rigors of our profession.

You might also consider relaxing and using another part of your brain to explore activities you once enjoyed. Being involved in your community, volunteering to serve a cause you believe in, or taking the art or music class you’ve always dreamed about may help you rediscover a passion that has been forced to take a back seat to a life in medicine. Perhaps you have always wanted to read some of the great works of literature. Osler ritualistically went to bed at 10 p.m. and spent the next hour reading nonmedical classics, including Don Quixote and \textit{Meditations,} by Marcus Aurelius.

Remember what you told your patient yesterday: exercise is good for you. It is! When was the last time you worked out? A regular exercise regime can help battle anxiety and feelings of depression, reduce body fat, and lower blood pressure. As an added bonus, you can enjoy the uplifting sensation of an increase in endorphins. While we know the benefits of exercise, many of us do not take the time to make it a part of our lives. If you want to overcome the inertia of inactivity, pick SMART goals that are specific, measurable, attainable, relevant, and time-limited. Consider working out with a friend or coworker. Finally, don’t be discouraged if you cannot find 150 minutes per week. Start slow. If you don’t have half an hour in your day, try finding brief periods for a brisk walk instead. Short periods of intense physical activity, at full effort, have also been shown to be helpful.

The Fellowship of Those Who Bear the Mark of Pain

Albert Schweitzer wrote, “We belong to a fellowship of those who suffer.” We feel pain too. Physician wellness is up to us. Like our patients, but certainly not as severely, we also suffer. We suffer physically from lack of exercise, inactivity, obesity, and often neglect our own health. We suffer emotionally as well. In the course of caring for those who are sick, we ourselves fall victim to an equal incidence of depression and, even more so, addiction. Depression is more common in medical students and residents, with 15 to 30 percent screening positive for depressive symptoms.3,4
Numerous efforts are taken by faculty at the University of Maryland School of Medicine to promote mental health and prevent illness. In their first week of school, incoming medical students learn from Assistant Professor and Director of Student Health, James Baronas, MD, how to access mental health professionals at the Student Counseling Center (University of Maryland Baltimore), which also hosts monthly wellness events. Physician impairment and wellness is discussed throughout the medical school curriculum, including the positive effects of treatment. Associate Professors Christopher Welsh, MD, and Ann Hackman, MD, from the Department of Psychiatry, educate students about good self-care, basic wellness practices, and when to seek assistance with symptoms of anxiety and depression. Substance abuse is addressed, to include a visit by a physician who is in recovery. Medical student Jennifer Bai has taken the lead in convening a panel about wellness, inviting people from various stages of their medical career to talk about their personal experiences and how they have dealt with work-related stress.

We often do not want to burden others with the fact that we are fighting a pervasive sadness, or may maximize the number of alcohol drinks we take to lighten the load. If you find yourself struggling emotionally or with alcohol or other chemical substances, you can confidentially contact MedChi’s Maryland Professional Rehabilitation Program. Or, again, reach out to your physician.

As physicians, many of us do a poor job of looking after our own well-being. If this article encourages you to do nothing else: pick up a phone today and make an appointment to see your physician, or find one, if you do not have one.

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References
“Physician Heal Thyself”

“The physician will hardly be thought very careful of the health of his patients if he neglects his own.”

— Galen 130-200 A.D.

The process of becoming a physician takes commitment and hard work. The typical physician may be twenty-eight years of age with a minimum of twenty-three years of education, as he or she starts a career associated with increasing stress and tremendous demands and rewards. Physicians’ careers have ongoing tension created by the competition between work and personal life. Our work is stimulating and rewarding and may include such areas as clinical practice, research, or community service. Our personal life includes important goals and needs of family, other relationships, individual health, and well-being. Some physicians are able to balance the competing forces of career and personal life effectively, while others may struggle during certain periods of life or may never be able to strike a balance conducive to personal health or a productive medical career.

This article looks at the ongoing competition between career satisfaction and personal life satisfaction for physicians; stress that results when balance between the two is upset and proven methods that help maintain balance and well-being. The topics discussed are often what we prescribe for our patients. Please read, reflect, and enjoy before you say, “Oh this is soft stuff.”

Stress has been implicated in a spectrum of health problems ranging from common conditions (e.g., headaches, obesity, mood, forgetfulness, and family or interpersonal relationship problems) to traditional illness (e.g., diabetes, heart disease, depression, and premature death). Our personality, learned coping behaviors, and available support systems all have major impact on how we prevent or relieve stress. Every day physicians help patients acknowledge and address the effects of stress on the ability to combat illness or maintain health. As physicians we have unique sources of stress associated with the demands of clinical care, government regulations, the business of medicine, and the needs to address issues in our personal lives. The competition between career needs and personal life may be a great source of stress for us. We often are unable to acknowledge and address the effect of stress on our ability to maintain our health. Recently, some organizations have even started to look at physician well-being as an important metric for the quality of care received by patients.

Medical schools and graduate training programs have attempted to mitigate institutional sources of stress through curriculum reform or duty hour limitations for trainees. Such efforts grew from a need for patient safety and trainee health. The “Association of American Medical Colleges Personal Well-Being Survey” showed well-being varied by student subgroups. For example, women respondents had higher stress scores than men. The University of Maryland School of Medicine routinely participates in activities required for accreditation that collect information about the impact of stress on our trainees. The university, school, and clinical departments use feedback, campus counseling, mentoring, interest groups, and curriculum topics to improve trainee well-being.

We now have reached a point at which young physicians are entering the clinical workforce having experienced different career indoctrination and with unique beliefs about maintaining balance between career and personal life. The young physician may find that health care organizations and group practices have not evolved to support the same system of beliefs regarding work life balance. As a result, a young physician may be dissatisfied and stressed earlier in his or her career than was true for more senior colleagues. The potential for stress is not simply a function of having worked for a long period of time or of feeling worn out or burned out.

Physicians should expect stress to be a part of their career and lives. We take this clinical approach with our patients and help them realize that stress cannot always be avoided but it can be anticipated and managed. The key to this approach is the act of a patient visiting a physician for a health-related concern. Many of us are familiar with the well-known Oslerism, “A physician who treats himself has a fool for a patient.” This is a humorous statement, yet studies have shown that physicians often neglect seeing a physician, self-treat, or inappropriately curbside colleagues for treatment. Our business and political colleagues understand that people are the most valuable resource for their professions. Often leaders in other disciplines are required to see a physician yearly. Many of us perform executive physicals in our offices. Physicians should appreciate that we are a valuable resource to society and our families. Our patients do not own all illness. Our profession works best when physicians have a personal physician whom they access in the traditional manner. Having a personal physician may be the only action that a physician needs to take to decrease stress and maintain health and well-being.

Physicians fail to see common reasons for increased stress in their lives, which can be addressed. The etiology of stress may be our clinical knowledge base, time management, or work place structure not providing needed support. These topics often are addressed by professional societies or continuing medical education. We should not underestimate how continuing medical education decreases stress by addressing such matters.

We manage stress with coping skills developed throughout our lives. The challenge is managing stress with skills supportive to health. Negative skills can reduce stress but not support the balance between personal and professional life. We should periodically do an inventory of our coping mechanisms for negative skills. Smoking, yelling, over eating, caffeine consumption, driving too fast, and alcohol consumption are examples of such skills. Positive coping skills should include strategies that have been shown to reduce stress, such as physical activity, relaxation, social engagement, family time, and personal time. We should choose specific activities that best fit our personality or align best with our personal goals. Becoming a swimmer or writing poetry may be very stressful for someone without such interests. How we decrease stress should be personal.
The importance of health care teams in our daily lives is ever growing. Physicians often find that we are the leaders of teams and are responsible for how a team functions. We find ourselves in the position of giving feedback to team members, and we should be open ourselves to feedback from team members. Such an exchange may give us insight about our coping skills and how we are functioning.

In closing, I return to the importance of a physician having a personal physician. We all are subject to experiencing stress that we cannot effectively manage. The potential for depression, physical illness, and family or personal relationship problems reaching a point at which they impact our career is possible. We all should have a physician with whom we can talk and who helps us maintain optimum health.

References

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Environmental and Self-Oriented Fixes “That Work”

Gail Fisher, MSW

Self-efficacy and control over one’s own destiny—It is important to find islands, areas where one can be in control of one’s work and home life. Research clearly demonstrates that we limit our own selves far more than a situation may warrant.

The ability to check in with colleagues throughout the day—validation, consultation, feedback.

Being aware of the positive (and thereby fulfilling) challenges that the day brings.

Engaging in diversions and hobbies that stretch one’s interest outside of the medical setting. Absorbing and meaningful outside interests that vie for your attention. Spontaneity. Surprise colleagues and yourself with the unexpected—snacks, silliness, notes of support.

Willingness to expand life commitments as demands may dictate.

Touching base with colleagues who have a positive outlook. They too have dissatisfactions, but they do not want or need to complain constantly.

Take quick “Stress Breaks” throughout the day (meditation, breathing, music, reflection, newspaper, stretching).

Remember that no experience is wasted, and an experience might be incorporated into next steps.

Most important is SELF-CARE. You are a priority!

Gail Fisher, MSW, is president, Resources for Change, in Bethesda, Maryland. She can be reached at gailfisher@resourcesforchange.com.
AMA Guide to Moving Forward in the Battle Against Burnout

Christine Sinsky, MD

At a practicing physician, you may be aware of the disturbing statistics indicating that more than half of U.S. physicians experience some sign of burnout (54 percent according to Shanafelt et al’s 2015 study). The men and women on whom health care is dependent are running out of reserve.

High rates of physician burnout cannot be good for patients. Care from discouraged or demoralized physicians is not optimal. Burnout is associated with an increase in medical errors, a decrease in empathy, and diminished patient satisfaction. Additionally, physician burnout is associated with higher malpractice risk, reduction of work effort to part time, or leaving the profession altogether.

The impact of burnout extends beyond the office. Physician burnout is associated with serious consequences for physicians’ home lives, including increased alcohol and drug use, higher rates of disruptive behavior, higher divorce rates, and higher rates of suicide.

What is Causing Burnout?

The issues that cause physicians to lose joy in their work include:
- documentation,
- in-basket messages,
- prior authorizations,
- insurance forms, and
- EHR tasks (e.g., order entry)

What Can Be Done?

Burnout can be caused by time-pressure, workflow, and inefficiency. Advice on how to beat burnout is similarly rooted in these capacities.

Improve workflow efficiency. Small changes are often the best places to start when thinking about transforming your practice to increase efficiency and therefore reduce burnout.

Proactively schedule patients for future visits. Pre-visit planning involves proactively scheduling patients for future appointments at the conclusion of each visit, as well as arranging for pre-visit laboratory testing. Pre-visit planning can save a practice time and money; one study showed that after implementing pre-visit laboratory testing, estimated savings from improved practice efficiency were $25 per visit.

Expand rooming and discharge protocols. Clinical support staff can perform medication reconciliation, update past medical history, provide immunizations, and arrange for preventive services, thereby allowing the physician to spend more time directly interacting with the patient and family.

Implement team documentation. Staff members assist by documenting visit notes, entering orders, and queuing up prescriptions in real time alongside the physician and patient. Team documentation has been shown to save approximately ninety minutes of physician time for every four-hour-long block of clinic time, improve cycle time (i.e., time from patient check-in to check-out), reduce staff costs per wRVU (work relative value unit) generated, and improve patient, staff, and physician satisfaction, and result in better quality and financial outcomes.

Looking Forward: What Can We Do Together?

While burnout is a pervasive problem in medicine, there is reason to look forward with optimism. The AMA has brought together expertise from around the country to create STEPS Forward, a series of free, online practice transformation toolkits (https://www.stepsforward.org/). These resources will help guide your practice transformation, so that you can work smarter, not harder. There are currently forty-three modules on topics including improving workflow, strengthening culture and leadership, and engaging patients and families. Not sure where to start? There is a brief practice assessment tool you can work through with your team on the Steps Forward website to direct you to the modules best suited to your needs.

At the individual level, the Maryland Physician Health Program helps physicians and physician assistants address personal issues that may affect their ability to practice medicine. The program refers participants to treatment options, and provides case management and a rehabilitation plan.

Burnout is a multifaceted problem, as are the solutions. At the AMA, one of only three strategic focus areas is improving professional satisfaction and practice sustainability. Improving joy in practice is a key priority for the entire organization.

The AMA, along with many other organizations, is adopting the Quadruple Aim. The Quadruple Aim adds the goal of improving the well-being of physicians and clinical staff to the original Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

Patients need physicians who spend most of their time on work for which they are uniquely qualified. Improving career satisfaction in medicine is a shared responsibility. By recognizing that professional well-being is a shared responsibility among physicians, institutional leaders, administrators, technology vendors, and policy makers, I believe we can find lasting solutions.

A single physician or individual clinic cannot solve these problems, but collectively, multiple stakeholders can make a significant impact. Patients deserve to receive care from nurses and physicians who are not running out of reserve, but who instead come to work each day empowered and supported by technology, policy, and effective and efficient teams.

References


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The Numbers Game

Barton J. Gershen, MD
Editor Emeritus

A certain logic puzzle asks: “If the maximum number of hairs on a human head does not exceed 6,000,000, would it then be true that in the city of New York there must be at least two people with exactly the same number of hairs on his head?”

Numbers, digits, figures, tallies, amounts.

Our world is flooded with figures, deluged with digits, and nameless by the numbers.

But we are dysfunctional without them. From the sieve of Eratosthenes to quantum mechanics we depend on numbers to comprehend our universe—as well as to buy groceries.

Some 4,000 years ago in the land between the Tigris and Euphrates rivers the Babylonian culture arose. (The area was known as Mesopotamia since it was Greek mesos: “between” + Greek potamos: “river,” that is in the valley between two rivers. Potomar may be found hidden in the word hippopotamus: “river horse.” Greek hippos: “horse” as in hippodrome, a place to run horses. Also, in the contraction Greek philo: “to love” + hippos, which yields the name Philip: “one who loves horses.”)

One of the remarkable inventions of Babylonian culture was the abacus, a device that could perform sophisticated calculations. An abacus had parallel strings onto which were threaded colored pebbles. These could be moved rapidly along a row, each string representing numbers in the tens, hundreds, or thousands. Calculation and the calculus evolve directly from the abacus, a reference to those small stones on each string that were used for computation. (Latin, calculus: “a stone or pebble,” which in turn derives from calx: “limestone,” as in calcium.)

Digits are numbers, the term stemming from the ancient— and still popular—practice of counting on one’s fingers (Latin, digitus: “finger or toe”). A number consisting of two figures (e.g., 25) is a binary number. One of its two digits is known as a binary digit, the acronym for which is a bit in computer terminology. Eight bits constitute a byte, which is the basis for rating the memory capacity of a computer’s hard disk (e.g., 200 megabytes, or 200,000,000 bytes), or the size of a computer program (e.g., 700 kilobytes, or 700,000 bytes).

Mono is the Greek word for “one.” Its combining derivative is mono, as in monocular. Monogamy (Greek gamos: “marriage”), monograph (Greek graphain: “to write”), monogram (Greek grammata: “letter,” as in grammar and grammatical), and monologue (Greek legein: “to speak”) are also representative examples. A monolith is a figure made from a single stone, such as those at Stonehenge or Easter Island (Greek lithos: “stone,” as in the Paleolithic era, or in nephrolithiasis and lithotripsy). A monolithic philosophy is unyielding and of a single dimension. Mononucleosis inundates the blood stream with white blood cells containing single nuclei (monocytes). A monobactam, such as Aztreonam, is a monocyclic beta-lactam.

The Latin for “one” is unus, as in the words unilateral, universe, and uniform. In our world there appear to be more monos than unis, but the choice keeps us from being too unidimensional or monotonous.

The prescriptive Q.D. stands for Latin quaque die: “every day,” avoiding the need for either Greek or Latin numerals.

Duo is the Latin for “two,” as in duet, dual, and duplicate. The duodenum was thought by early prosecutors to have been twelve finger breadths long (Latin duodeni: “twelve,” which in turn derives from duo + decem: “ten,” that is, two plus ten). The prescriptive B.I.D. comes from the Latin bis (“twice”) in die. The Biceps has two heads (Latin bis + capit: “head”), and a bicuspid valve or tooth possesses two points (Latin: cuspis). Severe aortic regurgitation causes the carotid pulse to become bifurcians (Latin bis + ferio: “to strike,” that is the pulse is M-shaped, striking the finger twice during each systole).

A biscuit is something that is baked twice (Latin bis + coctus: “cooked or baked”). The Germans had a similar name for it: zwieback.

Tri is the Latin for “three,” and yields the combining form tri. The Triceps has three heads, the tricuspid valve three cusps, and a tripod has three feet (Greek pous: “foot”). A Triangle has three angles. Trigonitis is inflammation of the lower, triangular segment of the urinary bladder (Tri + gonion: “angle”). Trigonometry stems from trigon + metron: “measure,” the measurement of three-angled structures. A goniometer is an orthopedic instrument that measures the angle, or range, of motion of a joint. Nitroglycerine is a glyceryl trinitrate, which expands arteries or explodes buildings, depending on your specialty.

In ancient Rome, people often gathered on street corners to gossip and lament their circumstances, not unlike many of us today. In those days, three roads would often converge at a common intersection, which meant that early truants were able to loiter on three street corners at the same time (Latin trivium: “place where three roads connect,” which derives from tri + via: “road”). Thus the place at which those critical discussions were held begot a word which best describes the speakers: trivial.

The Latin “four” is quattuor, in Greek it is tetras. The respective combining forms of each are quadr- and tetra-. A quadrangle is a plane geometric figure with four angles and four sides. A quart (Latin quartus: “fourth”) is one fourth of a gallon, and a quartet boasts four singers. A quarter horse is any breed of horse that reacts quickly to its rider’s commands. These equines are used by cowboys (and “city slickers”) to herd cattle. The name arises from the horse’s ability to accelerate quickly for up to a quarter of a mile.

Something that is said to be “catty-cornered” has four corners, from the French quatre: “four” (i.e., quatre-cornered). Carillons originally consisted of only four bells and were known by the Latin designation quattuor, which later evolved to the French carrignon, and finally to English carillon.
**Quartan malaria** (due to *Plasmodium malariae*) causes four-day intervals of fever, the **quadriceps** is a four-headed muscle, and a **quadruplegic** has paralysis of all four extremities. (Greek *plege*: “stroke.”) **Cycloplegia**, loss of visual accommodation, is due to paralysis of the ciliary muscle. *Cyclo* derives from the Greek *kyklos*: “circle,” and refers in this case to the eye or ciliary muscle, which is round (as in *iridocyclitis*). The infamous **Ku Klux** Klan is also a derivative of *kyklos*, here referring to the inner circle of the Klan.

The Greek word for “five” is **pente**. In Latin *quinque* is “five,” and *quin tus* means “fifth.” In May 1934, a twenty-four-year-old woman in Callender, Ontario, delivered five babies: Emilie, Yvonne, Cecile, Marie, and Annette, each averaging 2 pounds 11 ounces. The Dionnes became the world’s first surviving **quintuplets**. (One hopes that the arrival of the McCaughey septuplets, in November 1997, has permanently eclipsed the old record.)

Ancient philosophers and alchemists believed that the universe was composed of four constituents: earth, air, fire, and water. However, they theorized that there must be a fifth element, the ultimate material from which the heavens were formed. They spoke of this fundamental substance as the *quinta essentia*: the fifth essence. It was, alas, never discovered but has given rise to **quintessence**, a word expressing the consummate manifestation or quality of a thing.

The **Pentagon** has five angles, as well as five sides. A **pentathlon** is an athletic competition with five events (Greek *penta* + athlon: “prize or contest”). The pentateuch comprises the first five books of the Old Testament bible (Greek *penta* + teuchos: “an implement or book”), known to the Jewish people as the Torah. **Pentobarbital** (Nembutal) is named for its five-barbituric acid nucleus. The intravenous anesthetic, **pentothal**, is also named for its methylbutyl appendage, the “thal” resulting from *thio*barbiturate + the suffix “-thal”. **Pentecost** is the fiftieth day after Passover, a Jewish holiday known as Shavuot. In the Christian religion, Pentecost is the seventh Sunday after Easter, consecrating the descent of the Holy Spirit upon the Apostles.

The Latin for “six” is **sex** as in **sextet**. A college **semester** comes from Latin *semestris*: “a six month or half-yearly period,” which in turn results from Latin *sex* + *mensis*: “six months.” (A **mensural cycle** occurs monthly. The word *mensis* ultimately derives from the Greek word for “moon”: *mene*.)

The **sexta hora** in ancient Rome was the sixth hour after sunrise. Since dawn was assumed to be 6:00 AM, the “sixth hour” was 12:00 PM. In southern climates the sun is almost directly overhead at noon, making energetic work difficult. That is how the **siesta**, the Spanish derivative of **sexta**, originated.

The word **noon** also has an interesting history. Originally the Latin term was **nona hora**: the “ninth hour” after sunrise, which would be 3:00 P.M. In the King James Bible, published in 1611, Mark’s account of the crucifixion states: “there was darkness over the land until the ninth hour” (15:33). In the early Roman Catholic Church a daily service was conducted at that hour, and was called the **nones**, a contraction of **nona hora**. During the 12th century, however, this service was moved to an earlier hour. Eventually it was held at 12:00 P.M. thus that hour became the **noones**, or **noon**, hour.

The original Roman calendar had ten months and began with March:

**March** (*Martius*): “of Mars”
**April** (*Aprilius*): “second month”
**May** (*Maia*): the name of an earth goddess
**June**: for the goddess **Juno**, wife of Jupiter
**Quintilis**: fifth month, later renamed for Julius Caesar and called July
**Sextilis**: sixth month, later renamed **August** for Augustus Caesar
**September** (Septem): “seven”
**October** (octo): “eight”
**November** (novem): “nine”
**December** (decem): “ten”

This last term became the basis for our **decimal** system, a **decibel**, a **decathlon**, and a **decade**. Boccaccio’s *Decameron*, written in 1353, was a collection of tales narrated by a group of Italians during ten days of a plague epidemic. In ancient Rome, the victorious army arbitrarily executed every tenth prisoner, a policy known as **decimation**. Today it signifies virtual total annihilation.

The Roman year was only 304 days long, making it quite difficult for farmers who depend upon a solar year, to predict their planting season. In an unsuccessful attempt to rectify the problem, two additional months were added: **Januarius** and **Februarius**, named respectively for the two-faced god Janus, and Febru, the Roman festival of purification. Ultimately, January was assigned to begin each new year, since elected officials took office on the first of that month (even then the world seemed to revolve around politicians). Still the calendar did not operate properly. Therefore, in 46 B.C., Julius Caesar ordered the astronomer Sosigenes to modify the calendar, in order to make it synchronous with the seasons. Sosigenes tried to accomplish the task by including 445 days in that year. The Romans called it the *year of confusion*.

Unfortunately, after all that work, the Julian calendar was still not coincident with the seasons. Thus, in 1582, Pope Gregory XIII formulated an entirely new calendar that did correct the problem. We continue to use it today, and call it the Gregorian calendar.

One may now appreciate why the names of our ninth, tenth, eleventh, and twelfth months are respectively derived from the numbers seven, eight, nine, and ten.

However, there is still that logic problem concerning the relationship between hairs on a head, and the population of New York City. The answer, of course, is yes.

**Barton J. Gershen, MD, Editor Emeritus of Maryland Medicine, retired from medical practice in December 2003. He specialized in cardiology and internal medicine in Rockville, Maryland.**
A Brief History of Health-Care

The House Call

The Office Call

The 1-800 Call

The Conference Call

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YOUR “NO OBLIGATION” REVIEW INCLUDES THE FOLLOWING:

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- Group Life & Disability
- Voluntary Benefits

Property & Liability:
- Medical Malpractice
- Workers Compensation
- Medical Office Insurance
- Employment Practices Liability
- Directors & Officers Liability
- Privacy/Data Breach Coverage
- Bonds (Fiduciary/Fidelity/ERISA)

Personal:
- Life Insurance
- Disability (Individual/Pension/Business Overhead)
- Annuities
- Long Term Care
- Estate Planning
- Retirement Planning
- Auto/Homeowners/ Umbrella Coverage

Med Chi Insurance Agency
The Maryland State Medical Society
1211 Cathedral St. s Baltimore, MD 21201

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