TOP NEWS

02 New Medical Society Serves Entire Metropolitan Area
THE IDEA OF ONE COMMUNITY MEDICAL SOCIETY HAS BEEN TALKED ABOUT AND DREAMED OF FOR MANY YEARS, AND ITS TIME HAS ARRIVED
By Michael L. O’Dell, MD and Angela Bedell

09 Physicians Urged to Use County-Based Prescription Drug Monitoring Program
PROGRAM NOW COVERS 77% OF MISSOURI POPULATION; CLAY COUNTY JOINS
By Jim Braibish, Kansas City Medicine

FROM THE Editor

04 Burnout is a Warning Sign for the Profession
PHYSICIANS FACE “MORAL DISTRESS” AS EXTERNAL PRESSURES INFLUENCE PATIENT TREATMENT
By Michael L. O’Dell, MD, Editor, Kansas City Medicine

Editorially SPEAKING

06 Residency: Training for Burnout
LONG HOURS, LOW PAY, HIGH-STAKES ENVIRONMENT
By Charles W. Van Way, III, MD, Editor Emeritus, Kansas City Medicine

Features

18 Advocating for Patient Safety in Anesthesia
AS NATIONAL ASAPAC CHAIR, MARK BRADY, MD, LEADS HIGHLY SUCCESSFUL FUNDRAISING CAMPAIGN
By Jim Braibish, Kansas City Medicine

Annual MEETING 2017

10 Meeting Summary and Photos

13 Lifetime Achievement Award: Richard Hellman, FACP, FACE

15 Friend of Medicine Award: State Sen. Jim Denning

16 Member Awards
• PATIENT AND COMMUNITY ADVOCATE AWARD: SHEILA MCGREEFY, MD
• INNOVATION AWARD: SUKUMAR ETHIRAJAN, MD
• RISING STAR AWARD: JOANNE LOETHEN, MD, MA

Physician WELLNESS

21 Introduction

22 Charting a Course to Physician Wellness
THREE-PRONGED APPROACH CAN INCLUDE INDIVIDUAL STRESS MANAGEMENT, REALIGNING PRACTICE RESPONSIBILITIES AND WORKFLOWS, AND PHYSICIANS LEADING THE CHANGE IN HEALTH CARE
By Bruce Bagley, MD

25 Using a Strengths-Based Approach to Improve Engagement and Reduce Burnout
INSTITUTIONAL CULTURE IMPROVED BY IDENTIFYING AND UTILIZING THE STRENGTHS OF EACH DEPARTMENT MEMBER
By Miranda M. Huffman, MD, MEd, and Lindsay T. Fazio, PhD

27 The Missouri Physicians Health Program: A First Response for Victims of Burnout
By Robert Bondurant, RN, LCSW

30 Promoting Resident Wellness in Graduate Medical Education at the University of Kansas Medical Center
ANNUAL SURVEY OFFERS INSIGHT INTO STRESSORS AND GUIDES SUPPORT SERVICES FOR RESIDENTS
By Gregory K. Unruh, MD

ON THE COVER: At the signing of the final merger documents joining the Kansas City Medical Society and the Wyandotte-Johnson County Medical Society, during the Nov. 16 Annual Meeting, are, from left, Joshua Mammen, MD, KCMS 2017 president; Angela Bedell, KCMS executive director and Wy Jo administrator; and Gregory Unruh, MD, Wy Jo 2017 president.
The Kansas City Medical Society and the Wyandotte-Johnson County Medical Society have joined forces! At the Nov. 16 annual meeting, Presidents Gregory Unruh, MD, and Joshua Mammen, MD, PhD, completed a long-awaited merger into one organization, effective at the beginning of 2018. Befitting the metropolitan-wide organization, the leadership of the two groups retained the name Kansas City Medical Society (KCMS). The idea of one community medical society has been talked about and dreamed of for many years, and its time has arrived. KCMS now welcomes members from the Kansas counties of Jackson and Wyandotte and the Missouri counties of Cass, Clay, Jackson and Platte.

The Wy Jo Medical Society will remain as an entity to elect a trustee to the Kansas Medical Society board. Through an agreement of membership reciprocity, all Wy Jo members will be Active members of KCMS in 2018. The KCMS dues structure will continue to offer individual membership and corresponding membership through medical staff and groups choosing to belong as an organization.

The societies exist to form a community of physicians. As a membership organization, we provide advocacy, leadership and innovation for medicine in Kansas City. Both the Wy Jo Medical Society and KCMS have had subsidiary charitable organizations. These organizations, along with MetroCare, have legally merged to form one entity: the KCMS Foundation. This new Foundation will house the charitable care (MetroCare and Wy Jo Care) and public health promotion efforts of the medical societies. It is structured as a charitable 501(c)(3) subsidiary of KCMS.

STRUCTURE

The KCMS structure was reworked to permit and encourage more opportunity for members to engage with the Society and Foundation. A Board of Directors functions as an Executive Committee, setting policy for the CEO. The names of those serving in 2018 and their positions accompanies this article. Much of the energy and service of the Society will lie in the Leadership Council, where matters such as leadership, advocacy and education will be discussed.

Angela Bedell serves as executive director and CEO of the new KCMS and leads the staff, now headquartered at PlexPod locations in Westport and Lenexa. Both addresses will appear on the KCMS letterhead.

As a member, several services are provided to you. You will receive this journal Kansas City Medicine as our regular publication. The Advocacy Chairs for Kansas and Missouri and Advocacy Committees will monitor and intercede in legislative and regulatory matters at both the state and local levels. The Society will continue its support of community health efforts, such as Tobacco 21 and immunization efforts. New efforts for educational programs for both the science and business of medicine will be undertaken.

The organization will retain its strong relationship with the Kansas Medical Society (KMS) and the Missouri State Medical Association (MSMA). Both state societies played key roles in facilitating the creation of this new physician community. Those who are members of the KMS or MSMA should continue their memberships. The new KCMS encourages all of its members to join and be active in the appropriate state society. As to which state society to join, that is at the individual member’s discretion after evaluating the location of their practice or residence and any particular benefits KMS or MSMA might offer to the practice.

The merger of the Foundations is a truly exciting part of this effort. Hannah Rues has been hired as the associate director to lead the charitable care programs, reporting to KCMS CEO Angela Bedell who also serves as foundation director. We owe many thanks to the Health Care Foundation of Greater Kansas City and the REACH Healthcare Foundation for encouraging this Foundation merger and supporting the efforts. Our Foundation has a good working relationship with Northland Health Care Access to complete our metropolitan-wide efforts.

THANKS TO MANY

The past several months of work by many for our new society are now to be celebrated. Two organizations, each more than 130 years old, have worked hard to honor their heritage while organizing for today. Early in this process, Jerry Slaughters, Kansas Medical Society executive director, encouraged the group to “look in the windshield, not the rear view mirror.”
This required 18 months of late-night meetings, writing new bylaws, developing a new governance structure and much heavy-lifting. Hard work was put into developing governance for today’s health care environment. The transition team consulted Jamie Orlikoff, who leads governance training for the American College of Healthcare Executives, to incorporate best practices into our leadership models, while making certain that the correct balance of Kansas- and Missouri-based physicians was included. The transition team went as far as to include representation by county and by employed and independent practice physicians.

Particular thanks go to the presidents and past presidents serving during the integration efforts: Drs. Sheila McGreevy, Greg Unruh, Mark Brady, Josh Mammen, Steve Salanski and Michael O’Dell. Thank you for your leadership and continuing to serve through this effort! Many others—too many to be named—also worked very long and hard on this effort and our thanks to each of you. (2)

Michael O’Dell, MD, editor of Kansas City Medicine, is chair of the Department of Community Family Medicine at the University of Missouri-Kansas City, and associate chief medical officer of the Truman Medical Centers Lakewood campus. Angela Bedell, CAE, is executive director and CEO of the new Kansas City Medical Society.

THE NEW KANSAS CITY MEDICAL SOCIETY BOARD OF DIRECTORS 2018
Joshua Mammen, MD, PhD, President
Gregory Unruh, MD, Past President
Mark Brady, MD, President-Elect
Carole Freiberger-O’Keefe, DO, Secretary
Christine White, MD, Treasurer
John Hagan, III, MD, Chair, Governance
Scott Kujath, MD, Chair, Patient Advocacy
Scott Roethle, MD, Chair, Physician Advocacy – Kansas
Casey Rives, MD, Chair, Physician Advocacy – Missouri
Jim Wetzel, MD, Chair, Strategic Planning
Michael O’Dell, MD, Editor, Kansas City Medicine
Sheila McGreevy, MD, At Large
Stephen Salanski, MD, At Large

THE NEW KANSAS CITY MEDICAL SOCIETY FOUNDATION EXECUTIVE COMMITTEE
Scott Kujath, MD, Chair
Sheila McGreevy, MD, Chair-Elect
Stephen Salanski, MD, Vice Chair
Amy Falk, Secretary-Treasurer
Terry Rosell, PhD, Chair, Project Access programs

New Medical Society Governance Structure
Burnout Is a Warning Sign for the Profession

PHYSICIANS FACE "MORAL DISTRESS" AS EXTERNAL PRESSURES INFLUENCE PATIENT TREATMENT

By Michael L. O’Dell, MD, MSHA, FAAFP, Editor, Kansas City Medicine

The dream of reason did not take power into account.
~ Paul Starr, The Social Transformation of American Medicine

This issue of Kansas City Medicine addresses physician burnout. Doctors who are burned out describe emotional exhaustion, feeling cynical or calloused about patients and being unhappy with their work. Sadly, over 50% of physicians are now experiencing burnout symptoms.1 Physicians in other countries experience burnout, and the culture of medicine undeniably factors into the development of such feelings. However, the rapid rise of such symptoms, especially in the United States, seems to point to something new beyond the traditional medical culture. Many think that burnout is on the rise due to factors associated with medicine losing its status as a profession.

Fears of the loss of professional status are not new. Kansan and later HHS Deputy Assistant Secretary for Health Ralph Reed, MD, asked the following question in 1987: “Can our society possibly benefit from the non-medical management of treatment and care?”2 Dr. Reed’s question was a rhetorical one, and he could not see any such benefit. Paul Starr, in his magnificent 1982 book, The Social Transformation of American Medicine, reminds the reader that American medicine has not always been viewed as a profession and recently has lost much of credibility in self-governance.3 Starr further describes increasing corporate control of medicine as: “Emerging developments now jeopardize the profession’s control of markets, organizations and the standards of judgment.” Stephen Shortell in 1983 describes the influence that exudes from administrative decisions on clinical decisions thought reserved for the medical profession.4

But how does the loss of professional status and increasing corporate control result in burnout? That might seem a rhetorical question to most readers, but it allows exploration of the concept of “moral distress” and the accompanying harmful effects on the individual.5 The entirety of the June 2017 JAMA Ethics is devoted to this topic of moral distress. Physicians, in service to their patient, now consider not just proper diagnosis and treatment. They also ask if the plan adheres to myriad external pressures such as: Does it meet quality guidelines? Is the treatment available on the formulary? If a referral is needed, is the preferred consult in the narrow network?6

“The repeated set of constraints and compromises leaves a sincere physician concerned about whether the care that has been delivered is truly best for the patient, or whether it has been made acceptable only to those intruding on the patient-physician relationship.”

As Paul Starr stated in the opening of his book, “The dream of reason did not take power into account.”9 Medicine’s basis to be a profession lies in reason, knowledge, procedural skills and our rules of behavior. Power is inherent in our lives and can be at once good and evil, useful and destructive, thoughtful and ill-mannered. Democratic societies often are at odds with meritocratic professions. Medicine is certainly at odds with U.S. society over cost and access, among other matters.

Finding our share of power will be necessary to re-professionalize medi-
FROM THE Editor

Cine. This gain of our share of power will involve educating ourselves about the political process, lobbying, being savvy about regulatory processes and even taking on more leadership roles in large organizations. But even more importantly, it will involve taking care of ourselves and our burnt-out colleagues, bringing us all to the empathic and caring behaviors that are in the rules of behavior for our profession. After all, ultimately our moral power comes from how well we care for and treat our patients.

Your Editor,
Dr. Michael O’Dell

Michael O’Dell, MD, MSHA, FAAFP, is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine, and associate chief medical officer for the Truman Medical Centers Lakewood campus. He can be reached at Michael.ODell@tmcmed.org.

REFERENCES


2. Reed RR, Evans D. The deprofessionalization of medicine. JAMA. 1987; 258(22), 3279–3282.


EXCLUSIVE OFFER FOR KCMS MEMBERS

Save Up to 25% on Medical Malpractice Insurance Rates

Kansas City Medical Society has partnered with the Keane Insurance Group to offer members significant discounts up to 25%* on medical malpractice insurance rates. Members can benefit from great rates, with coverage from a national carrier with an A.M. Best “A” (Excellent) rating and access to award-winning risk management CME activities.

Contact Tom McNeill to learn more. 816.474.4473 | tom.mcneill@keanegroup.com

A.M. Best “A” (Excellent) Rating  Award-Winning Risk & CME Solutions  40 Years of Strength and Stability  24/7 Access to Claims and Risk Mgmt

*K Program available to physicians in good standing with KCMS. Discounts subject to underwriting approval.

KANSAS CITY MEDICINE 5
Don’t talk to me about adjusting. I don’t want to become adjusted to a bad system.

~ Paraphrase of remark by Barbara McAneny, President-Elect, AMA, 2017

There is much current hand-wringing about physician burnout. We now have task forces, committees, surveys and learned articles. We don’t have Congressional investigations, but that’s coming, as sure as taxes. And yet, we all know the source of our frustration. It’s our toxic work environment. There’s only so much we can do to adapt to 12-minute clinic visits, excessive paperwork, intrusive oversight and execrable technology. The word “execrable,” by the way, stems from the Latin word for “putting under a curse.” Right on.

But what about our residents? Those wonderful young folks, who are helping us today, and will be putting us out to pasture tomorrow? Are they going to bring fresh blood into the system, and re-invigorate American medicine? We’re training them to be our successors, to be sure. Are we training them to be our salvation?

Well, no. In fact, we aren’t even training them to tolerate the system we’ve got. Perhaps that’s why so many students and residents are all up for single-payer medicine. Compared with what they have to live with, even Canada looks better and better. Or so they think. But I digress.

Let us begin with students. There are at least four problems. First, medical school has always been high pressure. Tragically, my own medical school class had a suicide within two weeks. Medical students still kill themselves. Second, medical students are high achievers, driven by their parents and themselves to succeed. Even small failures can be devastating. Third, we don’t let up. Grade point average. Three USMLE exams. Residency match. Abusive residents. Grumpy faculty. And fourth, money, money, money. The average student graduates with $200,000 debt. They’ve acquired a mortgage, but they don’t have a house to live in.

And then, they get to be residents. At least, they’re now doctors. OK, residency has always been challenging. But I recall vividly, looking back on my intern year and commenting that I’d rather do that for four years than be a medical student again. Remember, this was in the day of 110-hour weeks. It was still highly rewarding, no matter how much work it was. Since 2003, residents have been limited to 80-hour work weeks. With less frequent call! Still rewarding, but much more livable, eh? Well … Sort of.

80-HOUR WORKWEEK: CONSEQUENCES

The 80-hour workweek has indeed solved some problems. Residents have fewer nights on call, and get more sleep. Some of them even have a social life. Back in the day, there were programs in which residents were on call, at home or in the hospital, all the time. Every other night was considered pretty reasonable. No longer. Even every third night call, although “legal,” will exceed the 80-hour limit. The most demanding surgical programs are every fourth night, with some exceptions. However, the lighter call schedule means fewer residents to cover the service each night. When a resident is on call, he or she works the whole night.

Then, there is the dreaded hand-off. Residents not on call must leave their patients under someone else’s care. Handing patients off to another resident for the night or the weekend introduces its own stresses, on both physicians. Also, it affects patient care. In surgical programs, fewer nights on call may mean fewer operations and less experience. Residents often reach the end of the program feeling they need more training. Before the work-hour limits, 25% of general surgery graduates took post-residency fellowships. Now, 75% do so.
PRESSURES ON RESIDENTS

Residents share the same sort of harassment that plagues all physicians. The electronic health record is still execrable (hey, when I find a good word, I use it). In multi-hospital programs, residents may have to learn three or four execrable EHRs (see?). Oversight is still intrusive. Residents have to limit their work hours, and they frequently have to do so by compromising patient care. Or else they just lie on their timesheets. Did I mention that? Yes, residents have to fill out timesheets. Every week. In detail. In some places, they have to “card” in and out of the hospital. Sounds like we’re telling them that they’re really factory workers.

Like a factory worker, a resident might be fired. From a faculty standpoint, it’s very hard to fire residents. But from a resident’s standpoint, the risk is always there. It’s a terrible threat, because the consequences are devastating. Even a 1% possibility is demoralizing and stressful.

And examinations. Everyone has to take yearly “in-training” examinations. These are supposed to be for “evaluation.” Except that if scores are too low, a resident may be kicked out of the program. All of this leads up to the very high-stakes Board exam(s) at the end of training. You thought exams were over with that M.D.? Think again.

Many residents take further fellowships. That means applications, interviews, competitive matches. Maybe moving the family to another city. That’s if the resident is foolish enough, or brave enough, to start a family. Consider: You’re $200 grand in debt, you’re working 80 hours a week, you’re making $10-$15 an hour, and your employment status is year-to-year. Who wouldn’t want to get married and start a family? Did you fall in love with another resident? Then the two of you can be $400 grand in debt when you start out! And remember, the interest accumulates.

Of course, residents are supposed to be “resilient.” Now, resilience is a very good quality in a healthy personality. The sort of individual who gets through college and medical school usually has that quality in spades. But even the stoutest rubber band will break if it’s stretched far enough. And we do a whole lot of stretching. If the resident seeks mental health services, will that affect their later career? Licensing? Employment? Better to tough it out.

STUDIES SHOW EXTENT OF BURNOUT

Burnout among medical residents is not a terribly well-studied problem. There have been a few studies. A Dutch review from 2007 found 19 articles in the literature, of which 5 were of moderately good quality. The reported rate of burnout symptoms ranged from 18% to 82%. In a 2002 survey of 415 American internal medicine residencies, Collier, et al., found depression symptoms in 35% of residents, with indicators such as dehumanization and cynicism in still others. Goebert, et al., in a study of residents and students at six centers, found depressive symptoms in 21% of residents. A French survey of general surgery residents published in 2017 indicated a 52% rate of burnout symptoms. Yes, burnout is a problem in Europe, as well as in the U.S. We can conclude that both medical and surgical residents are subject to burnout, perhaps about as much as physicians in general. Putting it more harshly, our training programs are failing to protect residents from burnout and depression.

There have been a fair number of articles from individual centers promoting this or that coping strategy. Most of these papers say their strategy works. Or appears to work. In general, if a program recognizes and tries to deal with the problem, the residents will benefit. However, there is little consensus on best practices. The truth is, if we don’t know how to manage burnout in practicing physicians, then we probably don’t know how to manage stress in residents.

We’re still training competent residents. We are not, as has been suggested, training future workers in the medical factory. But we are getting somewhat closer to that than we may find comfortable. One thing is certain: Our current medical students and residents will be the core of the profession in the next 10 to 15 years. The more we can keep them happy and mentally healthy, the better our profession will become. And right now, we’re not doing that very well. Among nearly all specialties, we need to begin a
serious conversation on how we can stop burning out our residents even before they get into practice.

Charles W. Van Way, III, MD, is editor emeritus of Kansas City Medicine and is emeritus professor of surgery at the University of Missouri-Kansas City. He can be reached at cvanway@kc.rr.com.

REFERENCES
2. Prins JT, Gazendam-Donofrio SM, Van Der Heijden FMMA, Van De Wiel HBM, Hoekstra-Weebers, JEHM. Burnout in medical residents: a review. Medical Education. 2007; 41:788-800.
5. Chati R, Huef E, Grimberg L, Schwarz L, Tuech JJ, Bridoux V.

Physicians Urged to Use County-Based Prescription Drug Monitoring Program

PROGRAM NOW COVERS 77% OF MISSOURI POPULATION; CLAY COUNTY JOINS

By Jim Braibish, Kansas City Medicine

The county-based prescription drug monitoring program (PDMP) launched in 2017 across Missouri continues to grow.

Currently, 55 counties and cities across the state have enacted authorizing legislation. They encompass 77% of the state population and 90% of health care providers, according to Teesha Miller, director of the PDMP for Jackson County.

In the Kansas City area, Clay County has joined Jackson County and the cities of Kansas City and Independence in participating in the program. The PDMP, based at the St. Louis County Department of Public Health, now has over 4,900 users statewide including physicians, pharmacists and dentists. The system receives an average of 1,250 patient searches each day.

Miller said an exciting new development is that health systems soon will have the opportunity to mass register their providers in batch form. “This will streamline the process for large systems and hopefully increase utilization,” she said. This feature is expected to be in place by the end of the first quarter of 2018.

In addition, work continues to connect the PDMP to other state systems that use the same Appriss platform, including Kansas’ K-TRACS PDMP. Stephen Salanski, MD, KCMS past president, said, “The Kansas City Medical Society strongly encourages all physicians to sign up for the county-based PDMP. We are very glad to finally have this program available. It is extremely important for physicians to utilize the PDMP to help reduce patient addiction to opiates.”

GOVERNOR’S NEW STATE PDMP IS LIMITED

In late July, Missouri Gov. Eric Greitens signed an executive order to establish a state PDMP. However, the Missouri State Medical Association (MSMA) and others said the program does not go far enough.

“Governor Greitens’ plan is a law-enforcement action,” said Sam Page, MD, the St. Louis County councilman who has championed the county-based PDMP. “Under the governor’s PDMP, pharmacy benefit managers will voluntarily report data to the state Department of Health, and this will be reviewed by the Bureau of Narcotics and Dangerous Drugs (BNDD) for suspicious subscribing patterns.” He added that physicians will not have access to any data.

“In fairness to the governor, his options were limited without the support of the state legislature,” Dr. Page continued. “Legislation for a state-operated PDMP has been killed in the Missouri Senate for several years.”

ENROLLING AND USING THE SYSTEM

Physicians are encouraged to register for the county-based PDMP and then check it as clinically appropriate when prescribing opioids. The registration website is: https://missouri.PMPaware.net.

(Net, not “PDMPaware.”)

The registration process is brief and requires uploading of credentials such as medical licenses. Physicians may also designate staff members to have login credentials for the PDMP.

Under the PDMP, pharmacies are required to report to the PDMP database all Schedule II, III and IV controlled substance prescriptions dispensed in the participating jurisdiction. Physicians can check the database for the patient’s history of Schedule II-IV prescriptions. The system will provide a “Potential Doctor Shopper Alert” for any person who has obtained controlled substance prescriptions from three or more providers and filled them at three or more pharmacies over the past six months.
ANNUAL MEETING CELEBRATES
THE NEW MEDICAL SOCIETY

Members of the Kansas City and Wyandotte-Johnson County medical societies gathered to celebrate the new Kansas City Medical Society at the Annual Meeting on Nov. 16 at the new University of Kansas Medical Center Health Education Building.

The 2017 presidents of the respective societies commented on the merger. “Many thought this wouldn’t happen and couldn’t happen. Tonight we celebrate that it has happened,” said Gregory K. Unruh, MD, Wy Jo 2017 president. “We believe we can be stronger speaking with one voice for physicians in the metro area.”

Joshua M.V. Mammen, MD, MPH, KCMS president, added, “We’re merging two tremendous organizations with long histories. Two organizations are coming together as one unified voice speaking for physicians and patients. I encourage everyone to be part of this.”

The evening culminated with signing of the documents making official the merger of the medical societies, as well as the merger of the affiliated charity care foundations, MetroCare and Wy Jo Care.

Marna Courson, MetroCare board chair, said, “This will expand the reach of both organizations to meet the tremendous needs in our community. We will now be able help more people become healthier.” She also thanked the Health Care Foundation of Greater Kansas City and the REACH Healthcare Foundation for their support of costs associated with the foundation merger.

KCMS AWARDS WERE PRESENTED TO:
• Richard Hellman, MD, FACP, FACE, Lifetime Achievement Award
• Kansas State Sen. Jim Denning, Friend of Medicine Award
• Sheila McGreevy, MD, Patient and Community Advocate Award
• Sukumar Ethirajan, MD, Innovation Award
• Joanne Loethen, MD, MA, Rising Star Award

See profiles of the 2017 honorees starting on page 13.
Missouri State Medical Society President Warren Lovinger, MD, right, brought gifts for the medical societies. From left, KCMS Executive Director Angela Bedell; Wy Jo President Gregory Unruh, MD; KCMS President Joshua Mammen, MD; and Dr. Lovinger.

Carolyn Loethen and Joanne Loethen, MD

Stephen Salanski, MD, and Michael Seward

Staff members and friends of Hellman & Rosen Endocrine Associates celebrate the Lifetime Achievement Award given to Richard Hellman, MD, front row second from left.

Kansas State Rep. Kathy Wolf Moore; Bridget McCandless, MD; Al Biggs, MD.
Endocrinologist Richard Hellman, MD, FACP, FACE, has been a leader and innovator in the practice of diabetes care and also in the areas of patient safety and performance measurement both locally and internationally. Throughout his 50-plus years in medicine, he has emphasized a patient-centered approach, utilizing a team to support the physician to achieve the best results for the patient. He has helped advance medical knowledge through service with national and international organizations and publications.

For these accomplishments, the Kansas City Medical Society honored Dr. Hellman with its Lifetime Achievement Award, presented at the Annual Meeting on Nov. 16.

TEAM-BASED COMPREHENSIVE DIABETES CARE

Dr. Hellman founded his practice, Hellman & Rosen Endocrine Associates, in 1981 as the first comprehensive diabetes care program for adults in the Kansas City area. He previously was associate professor and director of endocrine programs at the University of Missouri-Kansas City School of Medicine, joining the faculty in 1973. He remains with the School of Medicine today as a clinical professor and associate director of the endocrine fellowship program.

“It is well-accepted that a person with diabetes needs to be well-educated in self-care, but no one physician or other health care provider will have the time or resources to assist the patient to this extent” Dr. Hellman said. “Teamwork is needed, and the highest priority was to have a team with a special interest and expertise in diabetes care. I developed a team, composed of dieticians, nurse educators and a clinical psychologist, and as the lead physician I took the responsibility for both educating the team and building the teamwork so the group meshed smoothly in this difficult task.”

Hellman & Rosen today employs a 21-person multidisciplinary clinical team, which is led by the two senior physicians (Dr. Hellman and Howard Rosen, MD) and three nurses who have worked together as a functioning team for more than 25 years. Avin Pothuloori, MD, brought his special talents to the practice in 2016 and has become an important part of the team. The practice provides to its patients ongoing educational assessment and dietary counseling, in individual and group sessions, as well as psychological counseling services and ongoing support. Dr. Hellman believes in creating a culture of safety—checking on each other’s work to reduce medical errors and providing ongoing education for the entire clinical team.

Dr. Hellman had realized the value of teamwork in medicine many years earlier. Following two years of residency at the University of Kansas Medical Center, he joined the U.S. Air Force in 1968 and in 1969 was assigned as commander of a 12-bed hospital in northern Japan. “As the only physician for eight months of my stay, I learned quickly that nurses were eager to help extend the services that I could offer. So I developed algorithms to guide their activities and teaching programs to help them perform their tasks,” he recalled.

DIABETES RESEARCH

After starting his private practice, Dr. Hellman continued extensive research activities in connection with his practice. In 1990, he set up the Heart of America Diabetes Research Foundation, a nonprofit foundation funded strictly by private donations. The foundation does not seek public grants to avoid competing with university researchers. This foundation has provided support for many of his research and educational endeavors.
His first major work was the landmark diabetes outcome study which was published as the lead cover article in Diabetes Care in 1997. Describing the study, Dr. Hellman said, “This was the first diabetes outcome study, a prospective cohort study with risk-stratification, to show that a comprehensive approach to diabetes care, with intense education and therapy, could reduce death rates and kidney failure rates.”

That study was followed two years later with data presented at national meetings on patient safety and medical error reduction, and this data was the first that showed the importance of these strategies in diabetes care, he said. This work was subsequently published in the online version of Harrison’s Textbook of Internal Medicine, and has been widely cited in the literature.

Dr. Hellman has authored or co-authored over 40 scientific articles on diabetes, quality, safety and outcomes, and has given dozens of lectures to national and international conferences.

PERFORMANCE IMPROVEMENT

Another area of interest for Dr. Hellman has been performance measurement and improvement. Since 1997, he has been active with the American Medical Association-convened Physician Consortium for Performance Improvement, serving on its executive committee from 2003 to 2015, and as vice chair from 2012 to 2015.

“Initially, our goal was to introduce the house of medicine to performance measurement as both a science and a method of improving quality of care. Our first years were spent identifying gaps of care and developing tools to help correct these in an evidence-based way,” Dr. Hellman said. During that time, the consortium worked with 74 specialty societies and many specialty boards.

Committed to performance measurement as part of a lifelong learning and self-improvement process, Dr. Hellman commented, “I remain steadfast in my belief that the value of performance measurement should be primarily to improve clinical outcomes and it should be physician-led.” However, he believes that the effort to use performance measurement as a basis for reimbursement (“pay for performance”) has been unsuccessful and should not be used, as it often distracts from the most important use, which is improving clinical outcomes.

“I remain steadfast in my belief that the value of performance measurement should be primarily to improve clinical outcomes and it should be physician-led.”

SPECIALTY ACTIVITIES

Dr. Hellman has been involved extensively with the American Association of Clinical Endocrinologists. He served as 2007-08 president of the AACE and was a board member from 1999 to 2009.

Of his tenure in AACE leadership, he said, “I was proudest of my successful efforts to introduce the need for endocrinologists to consider patient safety and reduce medical errors in the care of diabetes and other endocrine conditions.” Another accomplishment he noted was reaching out to many endocrine and diabetes societies throughout the world, and encouraging more sharing of ideas and expertise.

In 2016, the AACE presented Dr. Hellman with its Outstanding Clinical Endocrinologist Award, given in recognition of dedicated and compassionate care, exceptional knowledge and expertise in the field of clinical endocrinology, and active advocacy of AACE’s mission in both professional and public environments.

He also devotes time to many professional journals in endocrinology. He is a member of the editorial board of Diabetes Care, the founding editor of the AACE patient safety exchange website, endocrinology section editor for Internal Medicine World Report and manuscript reviewer for a number of others. He was honored as a distinguished reviewer by Diabetes Care for 2014, 2015 and 2016.

Locally, Dr. Hellman was Kansas City Medical Society president in 2000. He received the KCMS Innovation Award in 2015 for his accomplishments.

CHOOSING MEDICINE AND ENDOCRINOLOGY

Growing up in the Bronx and Mount Vernon, N.Y., Dr. Hellman remembers being fascinated with the brain and human psychology since his youth. At age 12, his interest in medicine was sparked by a dermatologist who treated him. “He showed me how compelling the practice of medicine could be as a lifelong endeavor,” Dr. Hellman said.

“My interest in diabetes developed shortly after- (continued on page 17)
Kansas State Sen. Jim Denning (R-Overland Park) has worked on behalf of Kansas City-area patients and physicians for nearly 25 years as a member of the Kansas Legislature and on the provider side as CEO of Discover Vision Centers. He was recognized with the 2017 Friend of Medicine Award at the Kansas City Medical Society Annual Meeting. The award goes to a non-physician for outstanding service to medicine.

Sen. Denning’s signature accomplishment has been passage in 2014 of the Predetermination of Health Care Benefits Act calling for greater transparency in expected out-of-pocket costs to patients. The bill requires, starting July 1, 2017, that health plans give the patient and provider an estimate of coverage before a treatment or procedure is performed. This includes the expected payment to the provider and the patient’s cost share including deductible, coinsurance and copayment.

A native of Great Bend, Kan., Sen. Denning obtained his bachelor’s degree in finance from Fort Hays State University. After working in banking for several years in Dallas, he became CEO/CFO of the Dallas Eye Institute. In 1993, Mr. Denning and his wife Marearl returned to Kansas to join Discover Vision Centers as its founding CEO. During the next 17 years, he led Discover to become one of the largest privately owned medical groups of ophthalmologists and optometrists in the United States. Discover has 14 ophthalmologists and 22 optometrists who take care of 800 patients per day from offices located throughout greater Kansas City.

In 2010, Mr. Denning was elected to the Kansas House of Representatives, and then was elected to the Kansas Senate in 2012. He currently is Senate majority leader and chairman of the Select Committee on Education Finance, the Confirmation Oversight Committee, and the Kansas Public Employees Retirement System Subcommittee. He retired as Discover CEO after his election to the Legislature, but remains with the company as a board member and vice president of business development.

Sen. Denning has been involved in the local community as well as the national and international community. He has served on many local boards including Independence Chamber of Commerce, Commerce Bank Advisory Board, State Ambulatory Surgery Society Association, Metropolitan Medical Society Legislative Committee and Regional Specialty Providers. He was a finalist in the Ernst and Young Entrepreneur of the Year program.

He has written numerous articles and book chapters on the business of health care. Mr. Denning has been involved in various clinical trials including ones that helped to develop the mathematical nomogram used in LASIK surgery and a bifocal type of technology implant used in cataract surgery.

In receiving the award, Sen. Denning said, “The Kansas City Medical Society does a fantastic job of promoting quality medical care while providing leadership and innovation for physicians. Through all of this work, patients benefit from receiving the best of care. I am honored to be selected to receive such a prestigious and exclusive award.”
Joanne Loethen, MD, MA, a second-year resident in internal medicine and pediatrics at the University of Missouri-Kansas City, believes in the importance of organized medicine to the future of the profession.

Dr. Loethen (her first name is pronounced JOAN-ee) has been chair of the Missouri State Medical Association (MSMA) Resident & Fellow Section since 2016. She also serves as a delegate to MSMA. During medical school at Michigan State University, she was active in the American Medical Association as a delegate from Michigan’s student section and an alternate delegate from the state’s main delegation. She has also served as UMKC program delegate to the American Academy of Pediatrics.

“Organized medicine is a critical voice in shaping the future of health care change,” she said. “As physicians, we are called upon to lead and advocate. Residents and fellows bring a unique perspective and innovative ideas to the table.”

A native of St. Thomas, Mo., located just south of Jefferson City, Dr. Loethen earned her undergraduate degree in nutrition and fitness from the University of Missouri-Columbia. She obtained a master’s in exercise physiology from MU, then worked as an exercise physiologist for several years before starting medical school.

About the Rising Star Award, she said, “What an honor it is to receive this award, especially given the notable accomplishments of previous recipients and the many KCMS early-career physicians who are worthy of such an award. I’m grateful to KCMS and its members who have been influential mentors. I am excited to be part of an organization that continues to do great things for the Kansas City area.”

Sheila McGreevy, MD, has dedicated much of her career to serving low-income, uninsured patients.

Sheila McGreevy, MD, has dedicated much of her career to serving low-income, uninsured patients.

From 2003 to 2011, she was medical director of Duchesne Clinic in Kansas City, Kan., a safety-net clinic for patients who could not otherwise afford care. She practiced at the clinic until 2013 when she joined the faculty of the University of Kansas Medical Center as an assistant professor of internal medicine.

She helped found Wy Jo Care in 2006, through which physicians donate care to low-income patients. She is Wy Jo Care’s medical director and a member of the board of directors.

In addition, Dr. McGreevy was the president of the Wy Jo Medical Society in 2015 and has been an executive committee member since 2012. She has been a member of the transition committee planning the Wy Jo-KCMS merger along with the merger of the Wy Jo Care and MetroCare foundations.

She served on the Community Advisory Committee of the Health Care Foundation of Greater Kansas City from 2008 to 2014. She is a graduate of the Creighton University School of Medicine.

On receiving the KCMS award, she said, “It is an honor to receive this award. All I do, really, is help provide a framework for the wonderfully generous physicians of Kansas City to donate their time and expertise, helping our neighbors who otherwise do not have access to health care. It is these volunteer physicians who deserve the credit. It is my privilege to work with them.”
SUKUMAR ETHIRAJAN, MD
Innovation Award

Sukumar Ethirajan, MD, has been providing patient-centered oncology care in the Kansas City area for the past 24 years.

To deliver a more personalized, holistic experience for patients, he started a concierge practice, Dr. E.T’s Concierge Care, in 2016. One of a handful of concierge oncologists in the nation, he integrates traditional cancer therapies with genomics and other personalized medicine.

Recognizing the ethical issues involved in genomic medicine, he has become active in the Center for Practical Bioethics and serves on its board of directors. In July 2017, he gave a presentation to a CPB forum on the benefits and concerns of genomic medicine.

Dr. Ethirajan also sees patients at Kansas City Urology Care. From 2011 to 2015, he practiced with the Sarah Cannon Cancer Institute at Menorah Medical Center. Previously, he was with Kansas City Cancer Center for 11 years.

He served as Kansas City Medical Society president in 2004 and was a founding member and board vice-chair for MetroCare prior to its merger with Wy Jo Care. He has served on the boards of the REACH Healthcare Foundation and the Health Care Foundation of Greater Kansas City. He was the vice chair of the Midwest Institutional Review Board for HCA Midwest Health for eight years, and a member of the Kansas City Blue Cross and Blue Shield Health Collaborative. In oncology, he is a past president of the Kansas Society of Clinical Oncology and has been a member of the American Society of Clinical Oncology clinical practice committee.

About the award, Dr. Ethirajan said, “The Medical Society’s history is studded with various innovative programs which have helped benefit the greater Kansas City area for 132 years. In accepting this award, it is my honor and privilege to be a part of the society’s tradition.”

For more about Dr. Ethirajan and his concierge practice, see the feature in the next issue of *Kansas City Medicine.*

LIFETIME ACHIEVEMENT AWARD
(continued from page 14)

wards, fueled by the fact that two of my first cousins developed type 1 diabetes. The care of diabetes involved both cutting-edge science and a very humanistic side. At the time I started, many people with type 1 diabetes would die before they were 40 years old, and the complication rates in type 2 diabetes were abysmal,” he continued.

After studying mathematics at New York University, he obtained his medical degree from Chicago Medical School. He is a member of Alpha Omega Alpha, and in 2009 was the recipient of Chicago Medical School’s Distinguished Alumnus Award. He completed internship and residency in internal medicine at the University of Kansas Medical Center, followed by a fellowship in endocrinology from 1971-1972. He then joined the UMKC faculty.

ON RECEIVING THE LIFETIME ACHIEVEMENT AWARD

In accepting the award, Dr. Hellman said, “It is very special to be honored by the medical community that has been my professional home for nearly all my 50 years in medicine. I do not believe I would have achieved the professional goals that led to this award without the help and support of so many friends and colleagues.”

As is evident with his extensive resume of service, Dr. Hellman believes in the importance of volunteerism. “Our responsibility as professionals should include advocacy for others, for our patients, and for the physicians and clinical teams that support patient care. I have a hard time saying ‘no’ when the proposed effort has merit,” he said. “Volunteerism and service are part of the fabric of our society.”

As is evident with his extensive resume of service, Dr. Hellman believes in the importance of volunteerism. “Our responsibility as professionals should include advocacy for others, for our patients, and for the physicians and clinical teams that support patient care. I have a hard time saying ‘no’ when the proposed effort has merit,” he said. “Volunteerism and service are part of the fabric of our society.”
Advocating for Patient Safety in Anesthesia

AS NATIONAL ASAPAC CHAIR, MARK BRADY, MD, LEADS HIGHLY SUCCESSFUL FUNDRAISING CAMPAIGN

By Jim Braibish, Kansas City Medicine

Shawnee Mission Medical Center anesthesiologist Mark Brady, MD, FASA, has been providing national leadership to help his specialty attain their major goal in public policy, which is ensuring that patients continue to have access to safe, high-quality physician-led anesthesia care by an anesthesia care team.

For the past three years, he has chaired the national Political Action Committee of the American Society of Anesthesiologists (ASAPAC). He spearheaded a campaign that raised more than $2 million during the year ended Sept. 30, 2017, one of the highest totals for any medical specialty and exceeding that raised by the American Hospital Association’s PAC. After Dr. Brady’s term ended in October, he was succeeded as national chair by James B. Kelly, Jr., MD, of Saint Luke’s Anesthesiology Specialists.

For Dr. Brady, “ASAPAC is the political voice of physician anesthesiologists and provides us a mechanism to advance our health care safety and quality initiatives.”


Dr. Brady said, “The administration of anesthesia is a complex and technically demanding medical procedure and requires a physician who has extensive medical education. Physician anesthesiologists are highly trained medical specialists who have 12,000 to 16,000 hours of clinical training in anesthesia, pain and critical care medicine.”

“Physician anesthesiologists’ medical education covers the entire human body and all of its systems, preparing them to evaluate, diagnose, treat and manage the full spectrum of medical conditions and patient needs,” Dr. Brady continued. “Because of their superior education and training, physician anesthesiologists provide the highest quality and safest patient care before, during and after surgery.”

In 2016, the ASA successfully reversed a Veterans Administration proposed rule that would have compromised the safety of VA’s surgical anesthesia services. The proposal would have revised longstanding VA policy to move from physician-led models of anesthesia care to nurse-only models of care. Dr. Brady described the effort. “Mobilizing veterans, their families and physicians, we were able to deliver more than 100,000 comments about the importance of maintaining safe anesthesia care for those who serve our nation. We are pleased that VA’s leadership preserved the highest standard of care for our nation’s Veterans.”

Dr. Brady visits Washington, D.C., several times a year and joins in meetings with elected officials and other policymakers.

Additionally, he has led ASAPAC’s annual fundraising campaign kickoff at the ASA annual meeting in October. The kickoff is followed by targeted outreach campaigns to “champions” and key contacts who support the Society’s advocacy efforts. Key contacts at the state level...
Advocacy

include 100 state PAC grassroots representatives and the 14-member executive board.

“We have state competitions including raising the most money, highest participation rate, most improved, and residency programs at 100% participation,” Dr. Brady said.

Physician anesthesiologists complete extensive training in pain medicine during residency, uniquely qualifying them to manage acute pain and chronic pain utilizing various treatment options, including the safe use of opioids. The opioid abuse epidemic is a major concern. “Physician anesthesiologists have an important opportunity to help address the opioid issue,” he said.

Dr. Brady has served on the national executive board for six years and previously was a grassroots representative from Kansas for six years. In other professional service, he was 2016 president of the Wyandotte-Johnson County Medical Society and currently is a member of the Kansas Medical Society board of trustees. He also is immediate past president of the medical staff of Shawnee Mission Medical Center.

Why advocacy? “Being involved in advocacy outside of patient care is key for physicians. Physician anesthesiologists must be patients’ advocates in and out of the operating room. We’ve got to continually advocate to policymakers for the well-being of our patients,” Dr. Brady commented. He added, “We also need to train and educate young physicians about high-quality care—as well as the lasting impact of being involved and taking action. This is critical to ensure future patients’ access to safe, high-quality care.”

“When seconds count, physician anesthesiologists save lives and oppose any policies that eliminate patient-centered, physician-led anesthesia care and jeopardize patient safety,” Dr. Brady said.

For more information on advocacy issues, the ASA website is www.asahq.org.

PATIENT SAFETY (continued from page 9)

Children's Mercy is partnering with the Kansas City Fire Department to integrate its electronic health record system into the documentation systems local EMS agencies use for capturing patient information.

The integration enables hospital caregivers to gain timely and efficient access to critical patient information that local first responders gather in the field or during transport. It also enables EMTs and paramedics to receive feedback on the hospital outcomes for their patients.

Cerner and Austin, Tex.-based ESO Solutions are working with Children's Mercy on the integration.

Children's Mercy, EMS Share Data

Researchers at the Stowers Institute for Medical Research have published the first comprehensive analysis of the dynamic gene expression within single migrating cells from the neural crest, a highly invasive cell population that contributes to nearly every organ during human development. Two of the most aggressive forms of cancer, pediatric neuroblastoma and melanoma, are derived from neural crest cells.

In a study published online in the journal eLife, the researchers identified a molecular signature of approximately 1,300 genes differentially expressed in an aggressive subset of migrating neural crest cells termed as “trailblazers” in a vertebrate model system of development. These genes appear to play a critical role in migration and may be part of a broader molecular signature of cell invasion in a number of phenomena.

“We found molecular diversity in the gene expression profiles of neural crest cells, as they migrated through different microenvironments of the developing chick embryo,” says Paul Kulesa, PhD, director of imaging at the Stowers Institute and senior author of the study. “But one special subset of cells, the trailblazer cells, appear to possess a unique ensemble of genes that enable them to forge ahead, breaking down the extracellular matrix, responding to directional signals, and sending guidance information back to the rest of the cells to follow suit.”

Molecular Signature of “Trailblazer” Neural Crest Cells Gives Insight Into Human Development and Cancer
Roy Jensen, MD, Named 2017 Kansas Citian of the Year

Roy Jensen, MD, director of the University of Kansas Cancer Center, was honored by the Greater Kansas City Chamber of Commerce as 2017 Kansas Citian of the Year, the region’s highest civic honor.

“Dr. Jensen is passionate in his fight against cancer, and his leadership has brought front line cancer research and treatment to our region,” says Joe Reardon, president and CEO of the KC Chamber. “His work has directly saved lives in Kansas City and is contributing to the betterment of our entire Kansas City region.”

Born in Kansas City, Kan., Dr. Jensen returned to the area in 2004 to direct the University of Kansas Cancer Center. In the eight years that followed, he guided the Cancer Center to become a National Cancer Institute (NCI) designated cancer center, one of only 69 in the United States.

Dr. Jensen also widened the network of local treatment options through the creation of the Midwest Cancer Alliance, connecting the KU Cancer Center with a network of community-based oncologists and cancer care professionals throughout Kansas and western Missouri, leading to better access to cutting edge clinical trials for those in the region.

This past summer, the Cancer Center’s designation was renewed, and its score upgraded from excellent to outstanding. NCI also announced an 11 percent increase in funding for the center. Now, KU Cancer Center is pushing for NCI’s most prestigious title: comprehensive cancer center designation, of which there are only 46.

Physicians Form Clinically Integrated Network

About 1,600 physicians from three health systems along with a group of independent physicians have joined to form Centrus Health Kansas City, a physician-led clinically integrated network (CIN).

Included in the CIN are the employed medical groups of North Kansas City Hospital, Shawnee Mission Health and The University of Kansas Health System, along with independent physicians including the Kansas City Metropolitan Physician Association. Centrus officials said this collaboration across health systems is unique among CINs.

Centrus Health has formed a partnership with Blue Cross and Blue Shield of Kansas City (Blue KC) on an accountable care organization (ACO) and has applied for Medicare certification as an ACO. More than 90,000 patients who are on Medicare and Blue KC employer-based insurance could be affected by the network, officials said.

The network website is http://centrushealth.com.

Saint Luke's to Acquire Six Mosaic Life Care Facilities

Saint Luke’s Health System is assuming ownership of six Mosaic Life Care clinics in the Northland area of Kansas City. The affected locations are in Highland Plaza, Parkville, Platte City, Smithville, Burlington and Shoal Creek.

As part of the transaction, Saint Luke’s will acquire the Mosaic Life Care physicians and office staff at each facility and anticipates little or no impact to employees, which should result in a seamless transition of care for current patients. Saint Luke’s and Mosaic Life Care anticipate the change of ownership to be completed by the end of April 2018.

Based in St. Joseph, Mosaic Life Care operates a 352-bed hospital there along with a comprehensive health care organization serving northwest Missouri. Mosaic Life Care retains ownership of its clinics in Kearney and Excelsior Springs in the metropolitan Kansas City area.

Burnout is increasingly being recognized as a serious concern among physicians. According to a study led by burnout expert Tait Shanfelt, MD, 54% of physicians experienced at least one symptom of burnout in 2014. This represents an increase of 9% over just three years prior. The specialties with the highest rates of burnout are internal medicine and emergency medicine. Residents and students are impacted as well.

The Quadruple Aim recognizes that a healthy, energized, engaged and resilient physician workforce is essential to achieve the national Triple Aim goals of higher quality, more affordable care and better health outcomes.

In this section, Kansas City Medicine offers insight from local experts on preventing burnout and maintaining wellness.

- **Bruce Bagley, MD**, presents a three-pronged path to physician wellness based on his work with the American Medical Association in professional satisfaction and practice sustainability.

- At the UMKC Department of Family and Community Medicine, a program has been implemented to capitalize on physicians’ strengths to improve personal development and teamwork. **Miranda Huffman, MD, MEd**, and **Lindsay Fazio, PhD**, explain the program.

- **Bob Bondurant** from the Missouri Physicians Health Program describes their perspective on burnout and how they can help physicians who are affected.

- **Gregory K. Unruh, MD**, associate dean for graduate medical education at the University of Kansas Medical Center, discusses their program to promote resident wellness.

Earlier in this issue, see columns on burnout by editor Michael O’Dell, MD, and editor emeritus Charles W. Van Way, III, MD.

---

Whether we are in the clinic, at the hospital or at medical meetings, there seems to be a lot of buzz about physician burnout. The conversation quickly turns to the clunky EMR, excessive administrative burden and the chaotic work environment as root causes of physician discontent. What are the issues surrounding the current wave of physician burnout and what can YOU do about it?

In this article, we will explore: 1) The broad context of the changing health care landscape and the implications of the trend toward value-based payment; 2) The individual physician’s responsibility to guard against burnout; 3) The organizational responsibility to improve the work environment for physicians; and 4) The role of physician leadership at all levels to bring about adaptive change and reduce the risk of burnout.

It was only 10 years ago that the smartphone was introduced … now most of us are seldom separated from one. The news cycle, once measured in days, has morphed into a continuous flow of information. In our everyday lives, we are connected, monitored, tracked and measured in ways that were unimaginable just a few years ago. Stress from the pace of life and the demands of the job affect people from the C-suite to front-line employees in a broad range of occupations resulting in burnout, turnover and early retirement.

The medical profession is certainly not insulated from these same life stresses. Add to this general chaos the fact that there are major changes to the payment environment, changing expectations about how we go about our work of caring for patients and uncertainty about the future organization, finance and delivery of health care … no wonder many physicians are feeling overwhelmed, overworked and emotionally exhausted.

Recent surveys indicate that over one-half of all physicians report some symptoms of burnout. The rate of physician suicide is higher than in the general population. Typical symptoms include physical and/or emotional exhaustion, depersonalization and loss of empathy, and feelings of loss of efficacy as a physician. Physician burnout can lead to decreased patient satisfaction, an increase in errors, a higher likelihood of malpractice actions, more physician and staff turnover and increased rates of drug and alcohol abuse.

The push from the Centers for Medicare and Medicaid Services (CMS) and commercial insurers to move from fee-for-service or volume-based payment to “value-based” payment has generated a lot of confusion and a general reluctance for physicians to let go of a payment system they know—only to replace it with some fuzzy ideas about global payments, capitation, population health and team-based care. The fact remains that most physicians are still paid primarily on a fee-for-service basis and are driven by relative value unit (RVU) incentives, leaving many feeling like they are constantly running on a “hamster wheel.”

The American Medical Association has established “professional satisfaction and practice sustainability” as one of its three strategic priorities. This work includes: research into the prevalence and causes of physician burnout; engagement with health system leaders to address the organizational factors; and advocacy to improve EMR functionality and lower administrative burden. Research at the Mayo Clinic and elsewhere shows that effective organizational strategies can reduce the levels of physician burnout, physician turnover and the prevalence of physicians cutting their clinical load by working less than full time.

What can be done? We suggest a three-pronged approach that includes individual responsibilities, organizational responsibilities and physician leadership.

**INDIVIDUAL RESPONSIBILITIES**

Some would say that the main problem is susceptible individuals in a high-stress environment; but with more than half of all physicians experiencing some symptoms of burnout, clearly the level of stress is too high and must be addressed. Individual physicians can be trained to improve resilience and reduce stress, but to assume that this is the sole solution is terribly shortsighted. As part of an overall strategy, some organizations have offered training in “mindfulness,” yoga and other relaxation or stress reduction techniques.

We recommend that physicians take some time to reconnect with why they went into medicine in the first place, focusing on the personal and professional satisfaction that results from helping others live healthier, happier lives. It is also important to re-evaluate your own...
personal goals and how you are spending your time and energy. Looking at family time, exercise, healthy eating, income expectations, professional development and time for personal development or spirituality … most of us would have to admit that we are feeling a little out of balance. A conscious effort to realign our priorities can go a long way to reducing stress. Physicians who have regular interactions with their peers (ideally with food and drink in a casual atmosphere) to discuss the stress that is related to patient care and health system change have reduced rates of burnout symptoms and improved resilience.

ORGANIZATIONAL RESPONSIBILITIES

The current work environment in front-line medicine is often chaotic, frustrating and inefficient … leaving patients, staff and physicians thinking there must be a better way. Organizational leaders have a responsibility to facilitate changes in the work environment, promote team-based care and realign incentives to reduce the risk of physician burnout. High rates of burnout represent an existential threat to health care organizations through reduced quality, productivity and professional satisfaction resulting in costly turnover among all health care professionals.

The enculturation of training for a career in medicine has instilled in most of us a tremendous sense of self-reliance for clinical decision making and in dealing with stress. As students and residents, we were expected to just deal with whatever came along and not complain. Emotional exhaustion, anxiety and depression were considered signs of weakness and seldom discussed openly or addressed by the larger community of our peers. Fortunately, times have changed and health care leaders now see the need to measure levels of burnout and actively intervene to improve the work environment for physicians.

The AMA and many other medical professional organizations have emphasized the need for practice transformation as a critical piece of reducing work-related stress. Team-based care is not just about working together with others, but rather a critical look at how we do our work and a strategic distribution of the tasks to all members of the team related to individual skills and abilities. As currently implemented, electronic medical records and associated workflows are inefficient and require an inordinate amount of physician time and effort. In part, this was caused by trying to computerize existing workflows and documentation to support billing rules. Health information technology must be reframed as a “platform for office redesign.” We live in a digital world that offers the opportunity to connect with and care for patients in a more efficient, reliable and continuous way.

When organizational leaders create a culture that actively addresses basic human needs, structural inefficiencies and support for physician and staff well-being, professional satisfaction improves for all. Specific actions include such things as:

1. Designate a leader and/or workgroup for staff wellness;
2. Identify and rectify process inefficiencies especially related to the electronic medical record workflow;
3. Strategically redistribute patient care work to the entire team with an emphasis on reducing the clerical burden on physicians;
4. Eliminate financial incentives that over-emphasize volume of work over quality and time for compassionate care.

PHYSICIAN LEADERSHIP

In many health care organizations, financial considerations and incentives have dominated the culture, resulting in poor alignment with professional values and clinical considerations. Collaborative physician leadership is critical at every level of the organization from the clinic to the C-suite to ensure that it remains a clinical, patient-centered enter-
Physician Wellness

prise. Progressive physician leaders view change as an opportunity to improve current systems and processes. They clarify and communicate a vision for the future and enable positive, adaptive change through an iterative process.

Physician leaders engage their peers, helping them understand the need for change and enabling adaptive change by aligning resources, incentives and systems with patient care goals. Organizations should identify positive physician leaders and support them through training and progressive management responsibilities.

Teaming up to improve the quality of care we provide, taming the practice work environment, and taking responsibility for the overall diagnostic and therapeutic efficiency of our clinical work are worthy goals for all of us. The result will be less physician burnout, better outcomes for patients and lower total cost of care with enhanced practice revenue.

Bruce Bagley, MD, is senior advisor for professional satisfaction and practice sustainability to the American Medical Association. Based in Leawood, Kan., he served as president and CEO of TransforMED, a wholly owned subsidiary of the American Academy of Physicians, from 2013 to 2015, and previously was AAFP medical director for quality improvement from 2003 to 2011. He practiced family medicine for 28 years in Albany, N.Y., and was AAFP president in 1999-2000. He can be reached at bruce.bagley@ama-assn.org

ADDITIONAL RESOURCES

American Medical Association STEPS Forward.
This is an online program to assist practices of all sizes in specific areas of office transformation. The modular design of this program allows physicians and their office staff to select and prioritize improvement projects. www.stepsforward.org


Four Physicians Join Shawnee Mission Health

Shawnee Mission Health recently welcomed four new physicians: Suzanne Ozbun, MD, family medicine, will see patients at Shawnee Mission Primary Care-Prairie View Medical Building. A graduate of the University of Kansas School of Medicine, she completed her family medicine internship and residency at the Research Family Medicine Residency Program.

Matthew Butler, MD, cardiology, will see patients at Shawnee Mission Cardiovascular Associates on the Shawnee Mission Medical Center campus and at Ransom Memorial Hospital in Ottawa, Kan. A graduate of the University of Kansas School of Medicine-Wichita, he completed his internal medicine residency at the University of Kansas Medical Center. He completed his cardiology fellowship at the University of Florida Shands Medical Center. Most recently, he served as an invasive cardiologist at Cardiovascular Consultants of Kansas.

Sarah Mingucci, DO, and John Moon, MD, will open Shawnee Mission General Surgery Consultants. Dr. Moon most recently worked as a surgeon specializing in general and advanced laparoscopic minimally invasive surgery at Southern California Permanente Medical Group and robotic and advanced laparoscopic minimally invasive surgery at Mission Surgical Clinic. He earned his medical degree from Louisiana State University and completed a general surgery residency at State University of New York-Brooklyn; he also completed a fellowship in bariatric and advanced laparoscopic minimally invasive surgery at Staten Island University Hospital. Dr. Mingucci is a graduate of the Kansas City University of Medicine and Biosciences. She completed an osteopathic traditional rotating internship at the University of Missouri-Kansas City; a general surgery residency at the Virginia Tech Carilion Clinic General Surgery Program; and a general surgery residency at the Cleveland Clinic South Pointe Hospital General Surgery Program.

Ozbun
Butler
Mingucci
Moon
Burnout, generally defined as a combination of emotional exhaustion and depersonalization, is common among U.S. physicians, affecting as much as 50% of practicing physicians at any point in time. Burnout affects patient satisfaction, the safety of the health care environment, and physician retention. In addition, burnout is associated with development of depression and physician suicide.

Efforts to address burnout often focus on promoting personal resilience through improving work-life balance or developing strategies to promote resilience. While individual behaviors certainly play a role, institutional culture can impact wellness as well. At the University of Missouri-Kansas City Department of Community and Family Medicine, we have been working to change the culture surrounding professional well-being using strengths-based coaching.

Beginning in January 2016, all faculty, residents, and administrative support staff were asked to complete the Clifton StrengthsFinder assessment. The Clifton StrengthsFinder is based on principles of positive psychology. It is an assessment tool managed by Gallup and completed online that allows users to identify their unique talents. Access to the assessment tool may be obtained either by purchasing the tool directly from the Gallup website or by purchasing one of several books, including StrengthsFinder 2.0.

**USING THE STRENGTHSFINDER ASSESSMENT**

The results of these assessments were shared broadly, by developing and posting a summary document highlighting our individual strengths. In addition, signs were posted outside offices listing everyone’s top five strengths.

An outside consultant familiar with both the StrengthsFinder assessment and academic departments led an educational session for faculty and administrative support staff that detailed the 34 strengths. Using tools available for purchase through the Gallup organization, faculty learned more about their strengths and their co-workers’ strengths. The faculty members also explored the “dark side” of their own strengths, those characteristics of a strength that could also be damaging or otherwise troublesome. Through the sharing of each other’s strengths, the faculty learned more about what their colleagues could contribute to the organization. We began having discussions about how to use an understanding of someone’s strengths, which could lead to a more effective working relationship.

After this initial session and providing department faculty with the information, two faculty with additional interest in the tool performed similar training sessions with residents.

In addition to using strengths for personal development and interpersonal relationships, discussions of strengths were used to promote effective teams. For faculty, this meant that makeups of various committees were analyzed to ensure an appropriate balance of strengths. Residents began each inpatient rotation with discussions about how they could use their strengths to improve team functioning to maximize patient care.

We have used this understanding of our various strengths in multiple ways. For example, we know a committee charged with a task will benefit from including someone with “Responsibility” as an identified strength to keep everyone on task, along with someone with the strength of “Ideation” for brainstorming sessions. We have some faculty with “Futuristic” strength who can see where we are going and some with “Context” strength who can reflect where we have been. When exploring a potential solution to a problem, those with “Context” describe the historical experience while those with “Futuristic” strength foreshadow. Previously, there was tension between these two divergent viewpoints as one group looked forward and the other reflected back, often not seeing the collaborative value of the two perspectives.

Our strengths-based enhancement program was started due to a recognition that some faculty were less engaged
with program activities. The goal was to show faculty how they could contribute to department activities using their unique skillset.

To evaluate the effectiveness of the StrengthsFinder exercise, faculty completed the Maslach Burnout Inventory (MBI) and the Area of Worklife Survey (AWL) both prior to starting the strengths-based intervention as well as six months afterward. Each individual was shown their personal results from the MBI and AWL compared to literature and department averages. In addition to discussion of individual and department areas of concern, education was provided on burnout to normalize the experience of burnout and discussion of its symptoms and consequences. A summary of the data was shared with all faculty, and is shown in Table 1.

The strengths-based intervention has been only part of department-wide efforts to address burnout, including more frequent tracking of burnout levels and establishment of processing groups. We continue to work on helping all department members use their strengths to achieve their personal goals.

We believe that similar programs to improve team dynamics in health care settings have the potential to be effective in a wide variety of situations. Gallup has multiple resources for individuals to learn more about the StrengthsFinder tool as well as information on certified coaches. This is a preliminary report on this approach to enhancing physician engagement. 😊

Miranda M. Huffman, MD, MEd, is associate professor and vice chair of education in the Department of Community and Family Medicine at the University of Missouri-Kansas City. She can be reached at 816-404-7119, huffmanmm@umkc.edu.

Lindsay T. Fazio, PhD, is a former faculty member in the Department of Community and Family Medicine at the University of Missouri-Kansas City. She currently teaches behavioral science and professionalism in the Northshore Family Medicine residency program, and provides psychological services to patients. She can be reached at lindsayfazio@gmail.com.

REFERENCES

It is appropriate that this article is written for physicians in the Kansas City, Missouri area. It is here that the foundation for the Missouri Physician Health Program was laid.

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

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

This new development came to the attention of a Missouri anesthesiologist, Don McIntosh, MD, who practiced in Kansas City. He had a strong interest in helping troubled colleagues, and thus in the mid 1970s, introduced the concept of showing compassion to his colleagues by initially offering his services as a one-man program. Later, in concert with the Missouri State Medical Association, a statewide program was initiated in the mid-1980s. Dr. McIntosh was part of the leadership that provided oversight for the fledgling program.

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

The gold standard that was implemented was five years of monitoring.

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

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

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

BURNOUT: A FUNDAMENTAL ISSUE

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

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

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

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

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

_A popular term for mental or physical energy depletion after a period of chronic, unrelieved job-related stress characterized sometimes by physical illness. The person suffering from burnout may lose concern and respect for other people and often has cynical, dehumanized perception of people, labeling them in a derogatory manner._3

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

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

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

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

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

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

Before we begin you must understand that burnout is not actually a problem. Let me explain.

Problems have solutions. When you apply a solution to a problem, what happens to the problem? It goes away ... yes? So often physicians come to me asking “What is the one thing I can do to lower my stress levels and make burnout go away?” Notice how this request presumes burnout is a problem that has a solution. When you can’t find that “one thing,” many doctors simply slide back into their old work habits and give up on the possibility that things could be different.

In reality, burnout is a dilemma. It does not have a solution, because it is not a problem in the first place.

Dilemmas are perpetual balancing acts. You are “between the horns of a dilemma,” taking specific actions every day, week and month to maintain the balance you seek. You address a dilemma with a strategy, not a solution.

By its nature, a strategy has multiple parts and in order to maintain balance you have to be measuring how you are doing in some fashion.

The fundamental question at the heart of preventing burnout is this: What is your burnout prevention strategy and how are you measuring your effectiveness?” The horns of the burnout dilemma are the amount of time and energy you put into your practice on one side and your ability to maintain a positive energy balance and your desired quality of life on the other.

Dilemmas are very common in health care. Here are just a few examples: burnout, your compensation formula, the best care at the lowest cost, your call schedule, your accounts receivable, work-life balance, and EMR.

From this point forward, we will be discussing tools to lower stress by increasing your efficiency at work and decreasing the time it takes to complete the tasks of your practice. One way to measure your effectiveness in this effort is to track the amount of time between your last patient leaving the office and you getting home—with your charts done.

Each tool is a potential component of your personal burnout prevention strategy. You may be utilizing some of these already. If so, make sure you read the Power Tips for that technique. As you read, take note of the tools that seem simplest to implement or feel most attractive to you. I will be giving you implementation pointers at the end of the article.

Remember nothing changes unless you change your actions. This is an active learning process.4

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

MPHP: YOUR FIRST RESPONDER

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

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

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

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

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

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

REFERENCES
All physicians are focusing on current literature describing the risk of burnout in our profession, well described almost 40 years ago. The American Medical Association (AMA) and all major specialty societies have honed in on the issues of a stressful career and what can be done to intervene and assist physicians in their navigation. It appears that physicians demonstrate a higher rate of burnout than other professions and other similar age group cohorts of the general population. Other research has shed light on the pervasive and frightening statistics around physician substance abuse and physician suicide, which some would argue are a result of untreated burnout.

Defining the problem is one part of the issue and there are many researchers in the field. Some early studies were authored by psychologist Herbert Freudenberger, PhD, who has worked in substance abuse, and social psychologist Christina Maslach, PhD, who developed the Maslach Burnout Inventory (MBI) Human Services Survey. It is very commonly used to survey physicians to assess burnout symptoms.

Tait Shanafelt, MD, of the Mayo Clinic and others recently published longitudinal work around physician burnout and changes in work effort. Many other studies too numerous to cite have shown effects of burnout on caring, quality of care, patient satisfaction, physician turnover and revenue production.

While physicians are becoming more adept at recognizing signs and symptoms of burnout, it seems many physicians are unwilling to participate in surveys or assistance programs. We all know that physicians feel they are super-smart folks who have felt self-reliant in managing their lives and careers and “don’t need any help!” The picture we’re seeing seems to indicate otherwise. Many smart folks are thinking about what we can do to assist and interrupt the cycle.

RESIDENT WELLNESS

While lack of wellness or burnout may manifest at any time during a medical career, it appears that residents are vulnerable from different stressors than later-career physicians. These stressors center around the large and seemingly never-ending workload, long hours (despite attempts by the American Council on Graduate Medical Education [ACGME] to regulate this) and inability to control schedules on top of trying to maintain a personal life while often under financial pressures. All of these clash with responsibility and pressure to do the right thing for each and every patient.

Ask residents about work-life balance and they may look incredulously at you and respond, “What work-life balance?” We all know that the practice of medicine is inherently stressful but is it perhaps more stressful during residency? ACGME believes so and has recently focused on this topic at annual meetings and in publications as well as a 2015 ACGME Symposium on Physician Well-Being. ACGME has also mandated changes in the common program requirements to require institutions and programs to address well-being.

KUMC WELLNESS COMMITTEE

To attempt to define the issues in our setting and actively address what we can, we created a Wellness Committee three years ago as a subcommittee of our Graduate Medical Education Committee. The subcommittee has leaders from the Resident Council, other residents and fellows, GME and program director leadership as well as representatives from Student and Resident Counseling Services and our Kirmayer Fitness Center’s leadership. We agreed to focus on anything that we could tie to wellness and categorized our thoughts around...
Physical and mental health.

Physical health is pretty easy to pinpoint and discuss. Strategies to highlight healthy nutrition and address exercise, sleep and fatigue, personal health maintenance and sexual health are pretty straightforward.

When we dug into defining emotional health, our thoughts were wide-ranging. Of course, career choice satisfaction, doing meaningful work, relationships, and a feeling of belonging (community) rose to the top of the list. But we quickly found that residents place importance on academic performance, financial literacy and well-being (debt management), acceptance or lack of acceptance around LGBTQ+, loss of personal schedule control and therefore time management, and relationships with faculty and patients. As you can imagine, any of these topics can generate feelings of well-being or lead to stress. Most importantly, our committee recognizes that these are moving targets for residents and can change daily, weekly, monthly or yearly over a three-to-eight year residency.

ANNUAL SURVEY

At KUMC, over the last three years our Wellness Committee has annually administered a validated over-65-point survey in conjunction with two other academic institutions sponsoring graduate medical education. We have had a phenomenal response rate that can be attributed to residents believing that by studying the issue, we can identify groups at risk and understand trends and effect change. We have had unbelievable support from all residents and resident council leaders.

WHAT THE SURVEYS HAVE REVEALED

- PGY-2s are more stressed and more likely to be burned out than interns (PGY-1s). This was a surprise to us since interns work long hours, have new and great responsibilities, tend to be less efficient, and are learning the ropes. However, as we explored further, we came to understand that in the PGY-2 year, the responsibilities change and in many ways become greater. PGY-2s supervise younger residents and that takes the PGY-2 out of the role of primary caregiver, thereby creating an oversight role while increasing the total number of patients under their care. The buck stops with them! Supervising residents are also likely to take on teaching roles in the clinical or didactic settings, a role they may or may not feel qualified to assume.

- Perhaps, not necessarily validated, the change in style of in-house call plays a stressor role here. ACGME work-hour rules prevent—until a recent change—interns from working longer than a 16-hour shift. Most teams created teams for night shift in-house call for several nights in a row. ACGME rules allow PGY-2s to work 24-hour periods with four-hour extensions as necessary for patient care. This often puts residents on the more traditional, intermittent call schedules, particularly on weekends, and this perhaps creates a different type of sleep disruption leading to more fatigue. It is possible that a week or two of nights, while stressful and disruptive to sleep, might be easier to deal with than the traditional call schedule of every third or fourth night, etc., or taking sleep-disruptive 24-hour calls on weekends.

- We also determined female residents are more stressed and either closer to burnout or burned out. This is consistent with national findings. Literature around burnout has suggested many reasons to which we might look. We have begun to delve into this question with our leadership and focus groups.

- One interesting finding involves the role of the significant other in burnout. We found suggestions in our survey that among our residents, males who live with a significant other and males or females who do not live with a significant other may show less burnout than females who do live with a significant other. My leadership team and female resident leaders laughed me out of the room when I expressed surprise and discussed this with them. They indicated that they were not surprised at all! They suggested this might tie closely to traditional gender roles in our American society—if both the female resident and their significant other are employed outside the home, the female often maintains more responsibility for running the household such as groceries, meal planning, cleaning, laundry, pet care and sometimes or often, financial management. They suggested to me that even if they were not personally
performing these duties, they were still the primary mover in the relationship to assure completion of these tasks. This added to the otherwise hectic life of residency.

- Another weak signal in the surveys comes from those residents who have children. As you can imagine, it’s one thing to go home tired post-call to an empty house and your own schedule vs. going home to an infant or child who needs and demands love and attention (not that a significant other doesn’t!). The survey didn’t cover this in detail, but it appears, happily, that the joys and rewards of raising children seem to mitigate the associated stressors of raising children such as time required for feeding, changing, supervising, baths, bedtime and the occasional illness. However, parent residents clearly state the angst that is created when choosing to spend time with the kid(s) vs. studying, and vice versa. Finding time to prepare for licensing exams and board certification exams adds mightily into the stress.

**ACTIONS**

Identifying the issues now makes it possible to attempt to address them with action plans, and we are working to do so.

For physical health, all residents of course have health insurance and access to primary care physicians either within the medical center or outside. We were easily able to provide programming around physical fitness and we were able to assure all residents had memberships to our on-campus Kirmayer Fitness Center that provides early morning and late evening hours for resident access. It also has all forms of exercise including classes and a new feature, on-demand classes for an individual or groups that do not require a live instructor to be physically present. We also provide bike desks and under-desk elliptical exercisers for programs to access in their work areas. Residents use them while writing notes, and this equipment has been very popular in some programs.

ACGME mandates fatigue mitigation training that we are easily able to accomplish using our experts within the medical center.

Healthy nutrition has been a little more of a challenge given residents’ complex schedules. Of course, food is available 24 hours a day through our cafeteria services, and healthy choices are available at reasonable prices. However, speed of access can still be a challenge at our place for busy residents, and it’s always easier to choose a candy bar and soda over that boring but nutritious salad.

We have now developed programming for our transitioning PGY-2s and our female residents around their specific issues as well as academic and writing services and expert assistance around financial well-being. We rely heavily on our partners in Student and Resident Counseling Services for group discussions and exercises, large group conferences as part of our resident core competency series, and access to online resources through our wellness website. Our Wellness Committee provides monthly newsletters highlighting different areas of emotional health, and among other important topics, the letters have focused on embracing our diverse community and how to effectively and respectfully care for our LGBTQ+ patients. The newsletter shines the light on topics and resources that are available inside and outside our community and online. Some of the TED talks are phenomenal! We also provide an afternoon workshop focused on residents as teachers and wellness early in the PGY-2 year.

Most importantly, if a resident does feel things are going off track, we provide free (GME pays for it), anonymous, confidential access to Student and Resident Counseling Services. They do a phenomenal job of providing psychological and, if necessary, psychiatric services for our residents. We are aware that many residents take advantage of these services and we believe this is extremely important.

In conclusion, we don’t have all the answers but we’re learning doing what we can based on current information. Sometimes just looking at the issues draws attention that helps residents understand they are not alone in the challenges we all face. We’ll continue to study and try to provide a healthy start to our residents’ careers.

Gregory K. Unruh, MD, is associate professor and associate program director in the department of anesthesiology at The University of Kansas Medical Center. He also is associate dean.
P hysician wellness for graduate medical education and ACGME Designated Institutional Official. He can be reached at gunruh@kumc.edu or 913-588-7223.

REFERENCES


STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (USPS FORM 3526)

1. Publication Title: Kansas City Medicine
2. Publication No.: 2473-327x
3. Date of filing: Sept. 11, 2017
4. Issue Frequency: Quarterly
5. No. of issues published annually: 4
6. Annual subscription price: $10-Members; $50-Nonmembers
7. Complete mailing address of known office of publication: Kansas City Medical Society, 300 E. 39th St., Kansas City, MO 64111. Contact person: James Braibish, (314) 570-3532
8. Complete mailing address of the headquarters or general business office of the publisher: Kansas City Medical Society, 300 E. 39th St., Kansas City, MO 64111
9. Full names and complete mailing addresses of publisher, editor, and managing editor: Publisher: Kansas City Medical Society, 300 E. 39th St., Kansas City, MO 64111. Editor, Michael O’Dell, MD, 300 E. 39th St., Kansas City, MO 64111; Managing Editor, James Braibish, 300 E. 39th St., Kansas City, MO 64111
10. Owner: Kansas City Medical Society, 300 E. 39th St., Kansas City, MO 64111
11. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of the total amount of bonds, mortgages, or other securities: None
12. Tax Status: Has not changed during the preceding 12 months
13. Publication title: Kansas City Medicine
14. Issue date for circulation data: Summer 2017
15. Extent and nature of circulation
16. Paid electronic copies: 0
17. This information is printed in the Fall 2017 issue.
18. I certify that all information furnished on this form is true and complete.

Michael O’Dell, MD, Editor.
THE NEW KANSAS CITY MEDICAL SOCIETY
Advancing the health of people in the greater Kansas City area

Serving Jackson, Cass, Clay and Platte counties in Missouri and Wyandotte and Johnson counties in Kansas

• Advocating for physicians with legislators and insurance companies
• Providing educational programs on issues and trends in medicine
• Informing physicians through Kansas City Medicine and electronic communications
• Through the KCMS Foundation, coordinating volunteer specialty care to support area safety net clinics and their uninsured patients.
• Promoting public health initiatives for the region
• Offering venues for networking among physicians