Laying down my stethoscope

A family doctor ruminates on physician burnout and dreams of a health care revolution.

BY ANNE LIPPIN, MD

People ask me if I’m going back to “work” anytime soon. After I completed residency in 2000, I signed a contract for three-quarters time with one of the major health care organizations in the Twin Cities. I had my own dedicated RN—this sounds possessive, but I assure you, I was hers, too. Full-time status was considered to be 28 face-to-face hours per week. That didn’t include the hours spent on phone calls, charting, paperwork, prescription refills, etc.

I worked one week out of every eight in the hospital, loving the interaction with our clinic’s patients and the hospital specialists with whom I’d trained. I took overnight call about three times a month, sometimes more. Those nights were rough, often with little sleep and hours spent at the hospital.

I dictated my patient visits and handed the tape to our transcriptionist. The notes were filed in the chart in reverse chronological order. The paper-bound story of a patient’s medical life.

When my son was born in 2005, we were up to 34 face-to-face hours as the expectation for full-time employment. Benefits were dependent on your FTE (full time equivalent) status. I was my own transcriptionist at that point. We had transitioned, painfully, to an electronic medical record. Physicians were encouraged to develop “dot phrases,” generic pre-fab chart note chunks, that could be plunked into anyone’s note and tweaked as necessary. It’s like calling paint-by-number “art.”

We were paid on “production,” how much revenue we generated for the organization. “Work Relative Value Units” or wRVUs is the technical term.

RNs were a hot commodity by that time, sequestered into specialized roles like Coumadin management and phone triage. Providers (we were mostly physicians with a couple of nurse practitioners) worked with medical assistants, some of whom floated to different clinic sites.

So when our son was born, my husband and I each had uncoordinated, independent, overnight call schedules. I asked for some time away from call with a concomitant decrease in pay. The organization turfed the question back to my colleagues. They declined. I can understand it—if I didn’t take call and the organization offered no support, the burden fell upon my partners.

I gave my notice. But the organization contractually required 90 days. Eventually, the 90 years/days were up. I wanted to continue working for the organization in urgent care sporadically, but that meant I couldn’t cash in on the physician retention benefit plan. I worked in urgent care twice and haven’t worked for money since. We are fortunate. We can make it on one income. Last time I checked, “full-time” was considered to be 38 face-to-face hours per week. That still doesn’t include phone calls, charting, paperwork, prescription refills, etc. Part-time employment is not allowed unless you were grandfathered in. Patient visits are scheduled at 20-minute intervals. Yes, you’re expected to do a complete physical exam in 20 minutes on that 64-year-old three-pack-per-day hypertensive, dyslipidemic diabetic who just moved here from Florida and arrives with an oxygen tank and a wheelchair. Providers work with whatever medical assistant is assigned to the patient care team for that day.

“When are you going back to clinic?” you ask.

After the revolution.

Physicians and mid-level providers are the way health care organizations make money. Presidents do not generate revenue. CEOs do not generate revenue. Nurse managers do not generate revenue. When organizations find themselves in tough times financially, they whip the doctors. Work more! See more patients! Get us more money!

Pay-for-performance is a particularly devious form of torture. Your pay is docked if your patient’s blood sugar control isn’t perfect or if their blood pressure isn’t within certain parameters. Physicians are held personally responsible for patient outcomes. On one level, of course this is appropriate. Physicians must practice ethical, up-to-date medicine. On another level, I can’t control
whether my patients actually take their medication, follow my exercise advice, or smoke right before their appointment.

What would a revolution look like? Here are my thoughts:

• Make appropriately trained medical scribes available to all providers. Physicians shouldn’t be typing their notes. This is an unbelievable waste of the specialized knowledge of the sole income generators in a health care system.
• Transition to a single-payer, universal health care system. You can’t imagine the convoluted mess of human resources necessary to support our idiotic patchwork-payer system.
• Allow part-time employment and build in support for life circumstances (illness, leave, surgery, birth, family emergencies).
• Reward thinking specialties (family medicine, internal medicine, pediatrics), not just procedure-driven specialties (gastroenterology, surgery, etc).
• Make medical school free. I graduated from med school in 1997 with $60,600 of debt. I paid most of it off during residency. The average medical student today graduates with $170,000 in debt. And we wonder why there is a shortage of primary care docs.
• Study upper-level administrative pay and figure out a rational approach.
• Create an economic environment where it’s possible for a family to live on one average income.

• Give some control back to docs. If I want 45 minutes for a complete physical, let me have it. I know I won’t be paid as much. So be it.
• Make pay dependent on the quality and complexity of care as well as production. But figure out the right ways to measure quality.
• Off-load providers. Providers should only be doing provider-level work. This sounds arrogant to some, I realize. Gee, the poor doctor doesn’t want to room her own patient. In terms of office efficiency, though, this is the only system that makes sense. Develop protocols for refills, triage, rooming, updating chart info AND FOLLOW THEM. PharmDs can do a lot of medication management for chronic disease.

There’s a lot more to the revolution. And I have a headache.

In short, it’s great that attention is being paid to physician burnout and stress. However, the answers lie not in fixing the physicians, making them more “resilient,” but in fixing the health care system that’s burning them out.

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