News, Information, and Advice for Family Medicine Residents

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Physician Wellness Gains National Focus

From staff reports

A soul-searching report in the November/December issue of *Annals of Family Medicine* looks at the mental health challenges faced by U.S. physicians, namely the higher incidences of depression, burnout, and suicide seen in physicians versus the general population.

The report, entitled "Physician Wellness: Changing the Culture," notes that at least 400 physicians commit suicide

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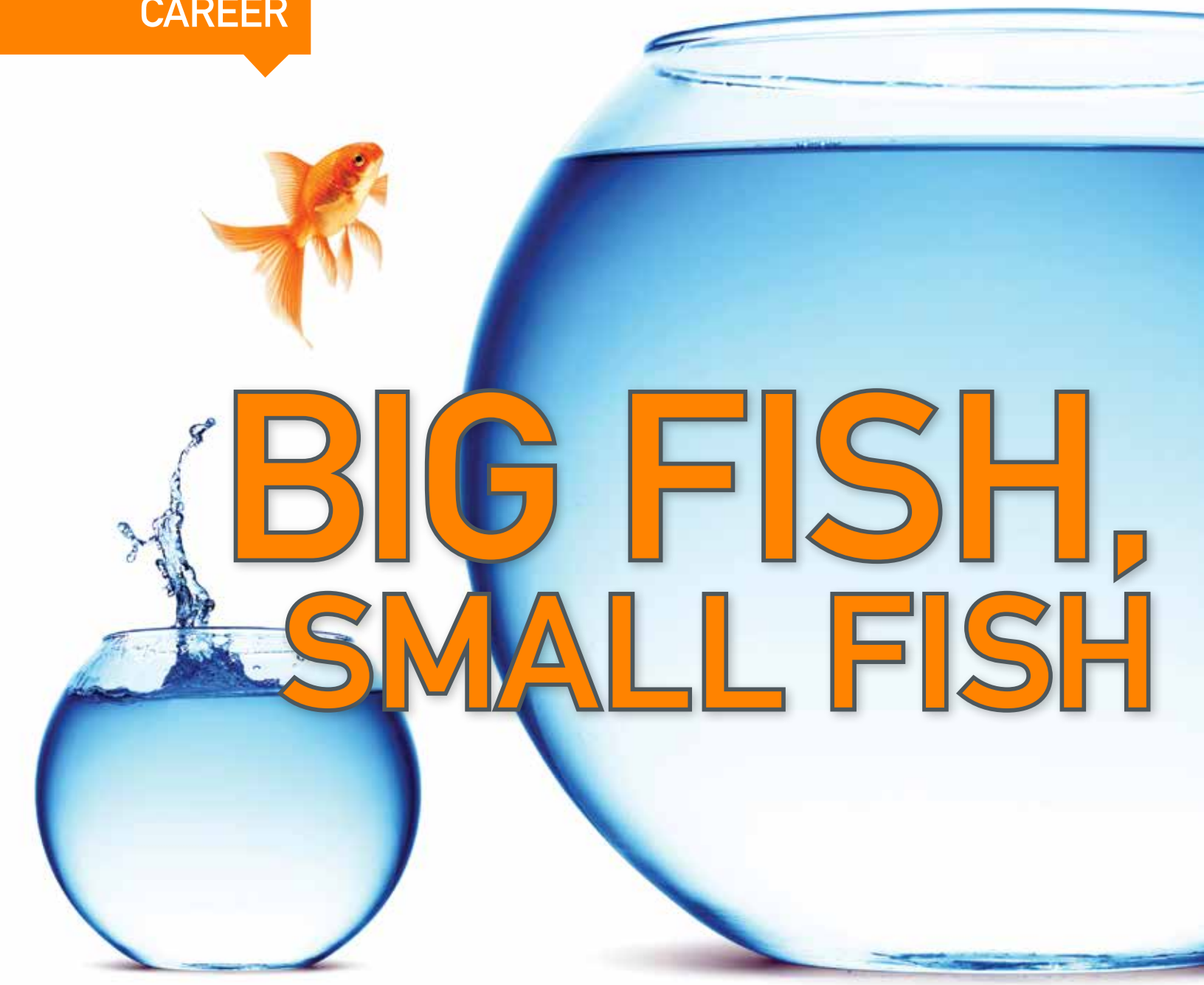
annually and that many "suffer in silence" with depression, substance abuse, emotional exhaustion, or decreased sense of accomplishment. Numerous studies have shown that burnout alone leads to decreased quality of care and patient safety.

The issue is top of mind at many national organizations, according to authors Katy Kirk, MD, MPH, and Steven R. Brown, MD, FAAFP. They outlined efforts by ACGME (a symposium in 2015 and a new CLER focus area on the issue), AAFP (a multi-organization summit on the topic), and the Family Medicine for America's Health initiative. They also noted the Society of Teachers of Family Medicine's inaugural Twitter chat in February focused on physician wellness.

"Although there may not yet be consensus on how to improve physician well-being, many national organizations, including those in family medicine, are now urgently seeking gains," the authors wrote. "Improvement is imperative for the health of our profession, our specialty, and our nation." ■



BIG FISH, SMALL FISH

GEOGRAPHY, SUPPORT, AND SIGNIFICANT OTHERS INTEGRAL TO THIS KEY, EARLY-CAREER DECISION

By Richard Quinn

It's a question that's been posed to family medicine residents forever: Would you rather be the big fish in a small pond or a small fish in a big pond?

Well, there's no right answer.

Reid Blackwelder, MD, former president of the American Academy of Family Physicians (AAFP) and the director of undergraduate medical education at East Tennessee State University's Kingsport Center, says that three main factors play into the decision. So while family physicians leaving residency will likely find job offers easy to come by, they should consider geography, available supports, and what, if anything, their significant other feels about the choices.

You can get a real disconnect if you want to be a big fish in a little pond, but your significant other doesn't want to be in a little pond.

"It's really critical that anybody else who is part of that decision making has a say in the big fish/little fish kind of discussion," Dr. Blackwelder says. "You can get a real disconnect if you want to be a big fish in a little pond, but your significant other doesn't want to be in a little pond."

The significant other is the first level of support physicians have during and after leaving residency. Beyond that, having the ability to lean on fellow physicians, nurses, assistants, and professional organizations like the AAFP can help shape physicians' outlook.

In addition, how residents have been trained informs what they are prepared to be. Dr. Blackwelder says how much physicians are exposed to team care during residency influences how content they would be as a big fish. Conversely, physicians preferring the little fish stature might feel at ease in a more personalized setting, working under a veteran practitioner who can guide them through the complicated waters of contracts, insurance companies, and patient relationships.

"Healthcare delivery and healthcare payments are transforming at a very rapid pace, and we haven't really prepared our residents to handle that as smoothly because they're already dealing with the challenges associated with being responsible as a physician," he says. "I think medical education is beginning to look at approaching this differently and exposing our residents to a different approach."

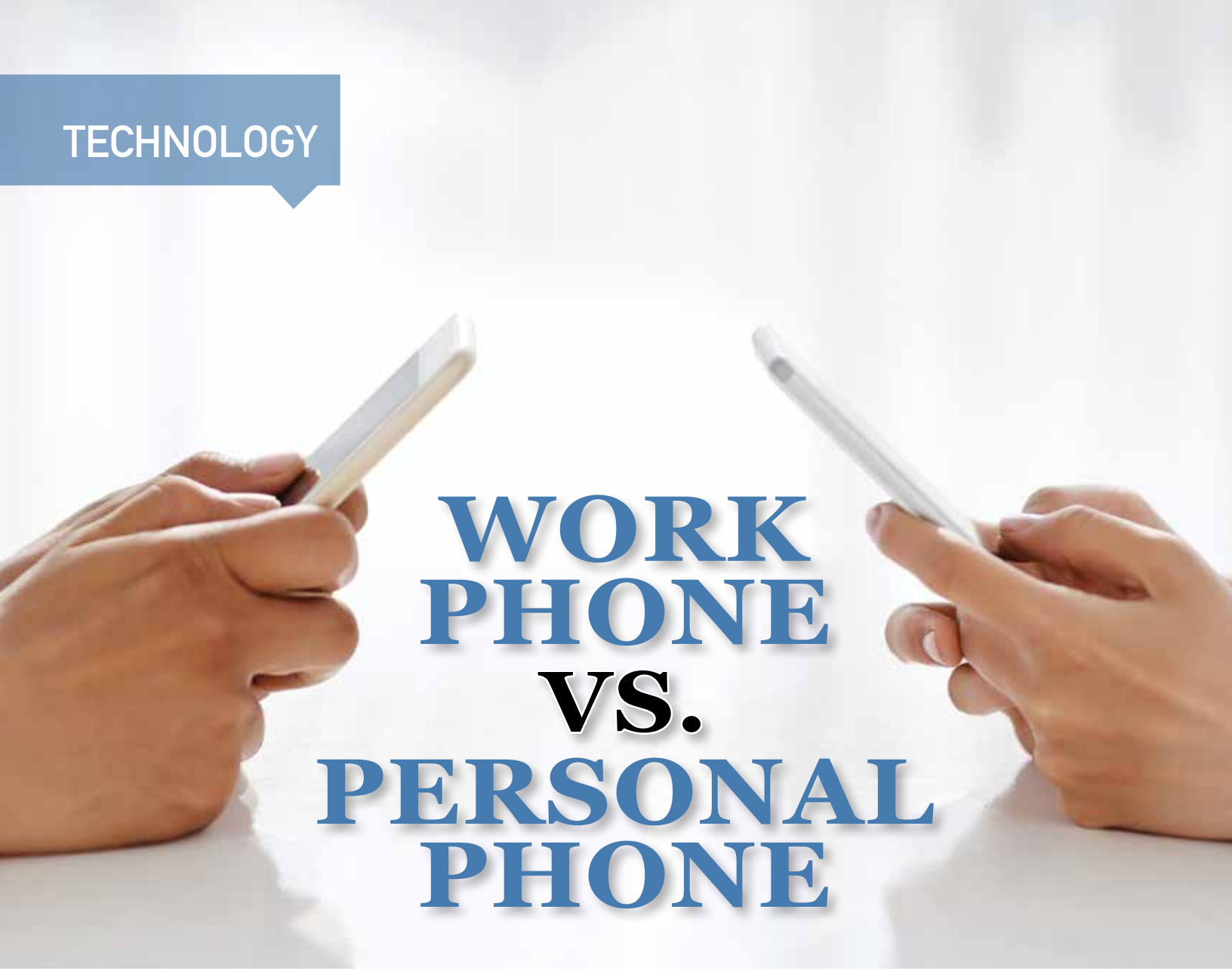
In years past, it was a badge of honor to serve as a single physician in private practice. Now, many physicians feel that isolating themselves is counter to what is essential to being successful. Dr. Blackwelder, who once served as the solo practitioner in 1,400-resident Trenton, Ga., said he would approach the situation much differently today.

"If I were going to do it now, I would go there knowing that even though I'm going to be the only physician, there's a pharmacy, there's a physical therapist, there's an EMT station," Dr. Blackwelder says. "I would make sure I would go out and connect with those other groups. I don't want to go and be the big fish in that little pond. I want to go and see if I can get several of the fish to be about the same size, and that way, we can run together without being afraid that one fish is going to eat the other."

And whatever size fish doctors choose to be, remember your patients see you as the biggest fish they know.

"That level of responsibility is very powerful, and I often use the word 'sacred,'" Dr. Blackwelder says. "I believe that is one of the things that people who go into whatever their practice is are often a little bit surprised by, and it can be overwhelming because if you think, 'I just want to be a little fish,' and you suddenly realize that, to those people, you're everything."

Richard Quinn is a freelance writer in New Jersey.



WORK PHONE VS. PERSONAL PHONE

THE DECISION TO INTEGRATE OR KEEP DEVICES SEPARATE ISN'T AS EASY AS IT SEEMS. FOR FAMILY PHYSICIANS, IT LIKELY IS PERSONAL PREFERENCE

By Candace Mitchell

Work cellphones are great—until you go a few months carrying around two cellphones and think, "Wouldn't it just be easier if I integrate them?" Well, not so fast.

If you integrate your work cellphone and personal cellphone, your iPhone or Galaxy S7 becomes a work phone—and vice versa. The decision also gets tangled up with another question physicians often face: Should physicians give a patient their cellphone number?

"Throughout medical school, there's rarely, if ever, a situation where somebody says, 'Hey, you should really give your patients your phone number,'" says Kimberly Becher, MD, a family physician in Clay

County, W.Va., and a past member of the American Academy of Family Physicians (AAFP) Board of Directors. "Nobody encourages you to do that, which creates this weird barrier where we feel like we shouldn't."

Avoid Delay

If a patient has your personal phone number or if your work phone is integrated with your personal phone, a patient can call you and (most likely) immediately get you on the phone with no delay. Early career physicians should ask themselves, "What level of direct contact and 24-hour availability do I want with my patients?" It's a tough choice, and once you make it, that habit will be hard to break.

"If I have a patient who is either really sick or end-of-life…I don't want that delay," says Dr. Becher, who says she provides her cellphone number to almost every patient when they get to end of life.

Chances are you constantly carry your personal device; however, that may not be the case with your work phone. Delays often surface when a patient with a medical issue calls your office (the old-fashioned way). If it's an emergency, your office connects you immediately.

"There are situations where the existence of a work phone gets in the way of me being able to talk to the patient as quickly as I feel like I need to…but not everybody wants people to be able to immediately access them," Dr. Becher says.

Security

If you're giving your patients your cellphone number (work or personal), you're enabling them to possibly text private information to your cellphone. Having a separate work phone might mean an extra layer of security to protect you from HIPAA violations. Integrating your work and personal devices would require this extra level of security on your personal, too.

"I have my phone password-protected; I wouldn't if I didn't communicate with patients on it," Dr. Becher says. "Even just having their names, that identifies them as one of my patients."

Keeping your work and personal phones separate also protects your private information in the event that your company would need to access your work device.

If your work phone is completely separate, your personal information is kept private and safe in more extreme situations when your company may need to wipe the hard drive on your work device, a *Forbes* article points out.

> If I have a patient who is either really sick or end-of-life…I don't want that delay.
>
> —***Kimberly Becher**, MD, a family physician in Clay County, W.Va.*

Work-Life Balance

There's a lot to be said for being able to put down, or even turn off, your work phone if you're not at work and not on call. Dr. Becher says one of the only times she wishes she could put away her work phone is when her child is pitching baseball.

"[It is] one of those moments where you don't want to be distracted," she says. "You don't have that luxury when you have somebody that you know is pretty critical that might be contacting you. I still feel like I have to sit there and hold my phone, just in case." ■

Candace Mitchell is a freelance writer in New Jersey.

AMA Seeks Tax Code Change for Student Loan Forgiveness, More Mental Health and Addiction Training

From staff reports

AMA announced new policies from its 2016 Interim Meeting, including an effort to assist medical practices with loan forgiveness and adoption of mental health and addiction treatment in physician training programs, according to a release.

AMA supports eliminating the tax liability on employers who offer student loan forgiveness for physicians working in underserved areas. The current tax code requires such funding to be considered ordinary income, according to the release, and therefore is a tax liability.

With new studies showing 60% of mental illness treated by primary-care physicians and half of all primary-care visits in the U.S. concerning behavioral health comorbitities, the AMA is advocating "incorporation of integrated services for general medical care, mental health care and substance-use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings," according to the statement. AMA also is supporting payment for such efforts in clinical care settings.

"The new policies adopted today will further our mission to create the medical school of the future by ensuring future physicians are prepared to quickly adapt to the changing healthcare landscape and provide care to patients, populations and communities as soon as they enter practice," AMA board member Jesse M. Ehrenfeld, MD, said in the release.

AMA delegates also voted to work with the Liaison Committee on Medical Education, the Association of American Medical Colleges, and other governing bodies to implement programs early in medical training to promote the development of leadership capabilities. ■