PHYSICIAN BURNOUT: A CALL FOR UNITY

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DISCLOSURES

I do not have any relevant financial relationship disclosures

LEARNING OBJECTIVES

- Definition and statistics on physician burnout
- Contributing factors
- Review of the evolution of physician burnout
- Solutions to physician burnout

PHYSICIAN BURNOUT: DEFINITION

A condition in which physicians lose satisfaction and a sense of efficacy in their work

PHYSICIAN BURNOUT: ASSOCIATED WITH

- Higher incidents of medical errors
- Lapses in professionalism
- Loss of enthusiasm for work
- Feelings of cynicism
- Low sense of personal accomplishment
- Learning difficulties
- Problematic Alcohol use
- Suicidal ideation

SIGNIFICANCE

Physicians experiencing burnout are more likely than their peers to exit their profession by leaving their practice, retiring early, or reducing their work hours.

PHSYICIAN SHORTAGE

- The Association of American Medical Colleges (AAMC) projected a shortage of up to 139,000 physicians by the year 2033.
- This is an increase from the AAMC's 2019 report, which projected a shortage of up to 121,900 physicians by 2032.

ETIOLOGY OF PHYSICIAN BURNOUT

"FACTORS AFFECTING PHYSICIAN PROFESSIONAL SATISFACTION AND THEIR IMPLICATIONS FOR PATIENT CARE, HEALTH SYSTEMS, AND HEALTH POLICY" (2013)

A study conducted by the American Medical Association in conjunction with the RAND Corporation confirmed the demoralization of physicians because of EHRs interfering with their ability to provide quality medical care to their patients

(Friedberg, Mark W., Peggy G. Chen, Kristin R. Van Busum, Frances Aunon, Chau Pham, John Caloy eras, Soeren Mattke, Emma Pitchf orth, Denise D Ingram Quigley , Robert H. Brook, F. Jay Crosson and Michael Tutty . Factors Af f ecting Phy sician Prof essional Satisf action and Their Implications f or Patient Care, Health Sy stems, and Health Policy . Santa Monica, CA: RAND Corporation, 2013. https://www.rand.org/pubs/research_reports/RR439.html.)

“A CRISIS IN HEALTH CARE A CALL TO ACTION ON PHYSICIAN BURNOUT”(JAN. 2019)

Major Contributor to physician burnout :

“dissatisfaction and frustration with EHRs”

(Ashish K. Jha, MD, MPH, Andrew R. Iliff, MA, JD, Alain A. Chaoui, MD, FAAFP, Steven Defossez, MD, EMHL, Maryanne C. Bombaugh, MD, MSc, MBA, Yael R. Miller, MBA, A Crisis in Healthcare: A Call To Action On Physician Burnout, Partnership w ith the Massachusetts Medical Society, Massachusetts Health and Hospital Association, Harvard T.H. Chan School of Public Health,and Harvard Global Health Institute, January 2019, 4, http://www.massmed.org/News-and-Publications/MMS-New sReleases/Physician-Burnout- Report-2018/.)

"THE INFLUENCE OF ELECTRONIC HEALTH RECORD USE ON PHYSICIAN BURNOUT: CROSS-SECTIONAL SURVEY" (JULY 2020)

Conclusion: This study suggests that the use of EHRs is a perceived contributor to physician burnout.

Tania Tajirian, Vicky Stergiopoulos, Gillian Strudwick, Lydia Sequeira, Marcos Sanches, Jessica Kemp, Karishini Ramamoorthi, Timothy Zhang, Damian Jankowicz J Med Internet Res 2020 (Jul 15); 22(7):e19274

HISTORY OF EHR IMPLEMENTATION

INSTITUTE OF MEDICINE

CHARTER : EXAMINE POLICIES RELATED TO THE HEALTH OF THE PUBLIC

ADVISORY ROLE :TO THE FEDERAL GOVERNMENT ON PROBLEMS IN THE FIELDS OF MEDICAL CARE, RESEARCH, AND EDUCATION

INSTITUTE OF MEDICINE COMMITTEE ON IMPROVING THE PATIENT RECORD IN RESPONSE TO INCREASING FUNCTIONAL REQUIREMENTS AND TECHNOLOGICAL ADVANCES (AKA THE IOM COMMITTEE)

-STUDY FOCUSED ON IMPROVING PATIENT MEDICAL RECORDS

-RESULTS: "PROMPT DEVELOPMENT AND IMPLEMENTATION" OF WHAT WE NOW KNOW AS ELECTRONIC HEALTH RECORDS

1991 IOM COMMITTEE CONCLUSIONS:

-COMPUTERIZATION WOULD:

- IMPROVE PATIENT RECORDS AND THE MANAGEMENT OF HEALTH CARE DATA

-COMPUTERIZATION OF PATIENT RECORDS WERE ESSENTIAL TO THE HEALTH CARE SYSTEM OF THE U.S.

COMPUTERIZED BASED PATIENT RECORDS

EFFICIENT MEANS OF OBTAINING QUALITY AND QUANTITY PATIENT DATA TO :

- DEVELOP CLINICAL PRACTICE GUIDELINES,
- EFFECTIVENESS IN RESEARCH,
- CONDUCT HEALTH SERVICES RESEARCH,
- SUPPORT QUALITY ASSURANCE,
- SUPPORT UTILIZATION MANAGEMENT

IOM COMMITTEE (1991)

-ADOPTION EHRS WOULD ULTIMATELY LEAD TO A :

"MORE CARING, MORE SCIENTIFIC, AND . . . MORE COST-EFFECTIVE HEALTH CARE SYSTEM."

IOM COMMITTEE (1991)

EHRS WERE A ". . . KEY INFRASTRUCTURAL REQUIREMENT TO SUPPORT THE INFORMATION MANAGEMENT NEEDS OF PHYSICIANS, OTHER HEALTH PROFESSIONALS, AND . . . LEGITIMATE USERS OF AGGREGATED PATIENT INFORMATION."

BARRIERS TO ADOPTING COMPUTER-BASED PATIENT RECORDS

FACTORS RECOGNIZED AS DRIVING RESISTANCE TO ADOPTING EHRS

-THE MONETARY COSTS OF IMPLEMENTING AND MAINTAINING AN EHR SYSTEM,

-LACK OF PRODUCTIVITY GAINS OR RETURNS ON THE INVESTMENT

FACTORS RECOGNIZED AS DRIVING RESISTANCE TO ADOPTING EHRS

-ANY SAVINGS OR MONEY TO BE HAD WITH EHR ADOPTION WOULD FLOW BACK TO HEALTH INSURANCE COMPANIES OR PAYERS

-THE LACK OF STANDARDS, VENDOR VOLATILITY, AND RISKS OF CHANGES NEGATIVELY AFFECTING PHYSICIAN WORKFLOW

FACTORS RECOGNIZED AS DRIVING RESISTANCE TO ADOPTING EHRS

PHYSICIANS PERCEIVED ANY “EXTERNAL ATTEMPTS AT INSTITUTING CONTROLS AS AN ASSAULT ON ITS AUTONOMY

IOM COMMITTEE (1997)

-THERE IS NOT, NOR IS THERE LIKELY TO BE, A SINGLE CPR(COMPUTER BASED PATIENT RECORD) PRODUCT THAT MEETS ALL THE NEEDS OF A PROVIDER ORGANIZATION.

-THEREFORE, ORGANIZATIONS SEEKING CPRS FACE SIGNIFICANT CHALLENGES IN INTEGRATING VARIOUS SYSTEMS TO ACHIEVE THE FULL FUNCTIONALITY THEY NEED.

IOM COMMITTEE (1997)

-CPR DIFFUSION GOES FAR BEYOND TECHNOLOGY WITHIN AN ORGANIZATION AND RELIES AT LEAST AS MUCH ON A CHANGE IN CULTURE THAT REQUIRES MOTIVATED, EDUCATED LEADERSHIP WITHIN INSTITUTIONS

IOM COMMITTEE (1997)

CHALLENGES:

-BUILDING THE REQUISITE INFRASTRUCTURE,

-OPTIMIZING THE AVAILABLE TECHNOLOGY (INCLUDING INTEGRATING VARIOUS SYSTEMS)

IOM COMMITTEE (1997)

CHALLENGES:

-ADDRESSING ORGANIZATIONAL CULTURE AND CHANGE ISSUES

- CONFRONTING FINANCING AND POLICY ISSUES.

EXECUTIVE ORDER 13335 (APRIL 27, 2004)

-PRESIDENT GEORGE BUSH ISSUED EXECUTIVE ORDER (EO) 13335

-EXECUTIVE ORDER 13335 ESTABLISHED THE OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH AND INFORMATION TECHNOLOGY (“ONCHIT”)

THE OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH AND INFORMATION TECHNOLOGY ("ONCHIT")

- - ONCHIT provided "leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care

2006 STUDY ON ADOPTION OF MEDICAL RECORDS BY PHYSICIANS NOTED:

"[c]ollectively, the medical community's social mechanisms that influence adoption decisions view EHRs as a potential threat to professional autonomy. This may be particularly true among physicians in small practices who value the freedom and autonomy they provide."

(Ford, Eric W et al. "Predicting the adoption of electronic health records by physicians: when will health care be paperless?." Journal of the American Medical Informatics Association : JAMIAvol. 13,1 (2006): 106-12. doi:10.1197/jamia.M1913. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1380189/)

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH AND INFORMATION TECHNOLOGY ("ONCHIT")

THE ONCHIT RELEASED THE FEDERAL HEALTH INFORMATION TECHNOLOGY STRATEGIC PLAN FOR 2008 TO 2012 ON JUNE 3, 2008 FOR ADVANCING PRESIDENT BUSH'S VISION OF AMERICANS HAVING ACCESS TO ELECTRONIC HEALTH RECORDS BY 2014

PROTECTING RECORDS, OPTIMIZING TREATMENT, AND EASING COMMUNICATION THROUGH HEALTHCARE TECHNOLOGY ACT (THE PRO(TECH)T ACT) 2008

-AUTHORIZED THE ONCHIT AND SET OUT ITS OBJECTIVES,

-PROVIDED FUNDING TO BE USED AS INCENTIVES FOR ADOPTING HEALTH INFORMATION TECHNOLOGY (“HIT”)

-

THE PRO(TECH)T ACT) 2008

-SET OUT STANDARDS FOR TESTING, DEVELOPMENT, APPLICATION, AND USE OF HIT,

-PROVIDED FOR HEALTHCARE INFORMATION PRIVACY PROTECTIONS

THE GREAT RECESSION

-THE LONGEST ECONOMIC CRISIS SINCE WORLD WAR II, BEGAN IN DECEMBER 2007 AND ARGUABLY ENDED IN JUNE OF 2009

-THE BURSTING OF AN 8 TRILLION DOLLAR HOUSING BUBBLE HERALDED THE GREAT RECESSION, AS HOMEOWNERS SOLD THEIR HOMES, DEFAULTED ON THEIR LOANS, OR CUT BACK ON SPENDING

AMERICAN RECOVERY AND REINVESTMENT ACT ("ARRA") MANDATE (2009)

-$789 BILLION DOLLAR ECONOMIC STIMULUS PACKAGE

-SIGNED IT INTO LAW ON FEBRUARY 17, 2009

AMERICAN RECOVERY AND REINVESTMENT ACT ("ARRA") MANDATE

-GOAL OF SAVING AND CREATING THREE TO FOUR MILLION JOBS

-FEDERAL MANDATES MODERNIZING HEALTH CARE, IMPROVING SCHOOLS, MODERNIZING INFRASTRUCTURE, AND INVESTING IN CLEAN ENERGY TECHNOLOGIES OF THE FUTURE

AMERICAN RECOVERY AND REINVESTMENT ACT ("ARRA")

OKLAHOMA SENATOR TOM COBURN, (FAMIILY PRACTICE PHYSICIAN):

-STIMULUS BILL WAS "90 PERCENT SOCIAL POLICY AND 10 PERCENT ECONOMIC POLICY."

- ". . . THIS "SOCIAL POLICY" WILL BE COUNTERPRODUCTIVE TO THE GOALS OF UNIVERSAL ADOPTION OF HEALTH IT BECAUSE IT WILL MIRE THE HEALTH CARE SYSTEM IN NEW BUREAUCRATIC RED TAPE."

AMERICAN RECOVERY AND REINVESTMENT ACT ("ARRA")

SENATOR COBURN :

- DOCTOR-PATIENT RELATIONSHIP ALTERED
- DECISIONS ABOUT THE USE OF MEDICAL TECHNOLOGIES, TREATMENTS, DRUGS, AND PROCEDURES BEING BASED ON CONTROLLING COSTS RATHER THAN THE INDIVIDUAL PATIENT AND DISEASE PROCESSES.

AMERICAN RECOVERY AND REINVESTMENT ACT ("ARRA")

MANDATE SPECIFIC TO HEALTH CARE:

-HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT

-THE "HITECH" ACT

HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT

IMPLEMENT AN ELECTRONIC HEALTH RECORD ("EHR") FOR EACH PERSON IN THE UNITED STATES AND THE DEVELOPMENT OF A NATIONWIDE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE THAT WOULD ALLOW FOR THE ELECTRONIC USE AND EXCHANGE OF INFORMATION

EHR ADOPTION

-IN 2001, STUDIES INDICATED ONLY 18.2% OF OFFICE-BASED PHYSICIANS WERE USING ANY EHR SYSTEMS

-IN 2008 EHR ADOPTION INCREASED TO 42%

EHR ADOPTION

-AFTER THE PASSAGE OF THE HITECH ACT IN 2009, THE NUMBER OF PHYSICIANS AND HEALTHCARE ENTITIES ADOPTING HEALTH INFORMATION TECHNOLOGY SIGNIFICANTLY INCREASED TO 85.9% IN 2017.

-COMPLETE ADOPTION OF EHRS BY PHYSICIANS HAS NOT OCCURRED TO THIS DAY.

PHYSICIAN FOUNDATION SURVEY DOCUMENTING THE EVOLUTION OF PHYSICIAN BURNOUT

2008 PHYSICIANS FOUNDATION

-79% OF PHYSICIANS BELIEVED THERE WAS A SHORTAGE OF PRIMARY CARE DOCTORS IN THE U.S.

-49% INDICATED THAT OVER THE NEXT THREE YEARS THEY PLANNED "TO REDUCE THE NUMBER OF PATIENTS THEY SEE OR STOP PRACTICING ENTIRELY."

2008 PHYSICIANS FOUNDATION

-90% OF PHYSICIANS INDICATED TIME DEVOTED TO NON-CLINICAL PAPERWORK

-67% STATING THAT LESS TIME WAS SPENT PER PATIENT AS A RESULT OF THE NON-CLINICAL PAPERWORK

2008 PHYSICIANS FOUNDATION

-60% OF PHYSICIANS WHO WOULD NOT RECOMMEND MEDICINE AS A CAREER

2010 PHYSICIANS FOUNDATION STUDY

-86% OF PHYSICIANS BELIEVED THEIR VIEWPOINTS AS PHYSICIANS WERE NOT REPRESENTED TO POLICY MAKERS RESPONSIBLE FOR HEALTH CARE REFORMS.

2012 PHYSICIANS FOUNDATION STUDY

-OVER 84% OF PHYSICIANS BELIEVED THAT THE MEDICAL PROFESSION WAS IN DECLINE.

- 82% OF PHYSICIANS BELIEVED THEY HAD LITTLE INFLUENCE ON THE DIRECTION OF HEALTHCARE OR ABILITY TO EFFECT CHANGE

2010 PHYSICIANS FOUNDATION STUDY

-74% OF PHYSICIANS INDICATED THEY WOULD CHANGE THEIR CURRENT PRACTICE STYLE

-40% OF PHYSICIANS STATED THEY WOULD NO LONGER PROVIDE PATIENT CARE IN THE NEXT ONE TO THREE YEARS AND INSTEAD WOULD OPT FOR RETIREMENT, NONCLINICAL HEALTHCARE JOBS, OR NON-HEALTHCARE RELATED JOBS

2012 PHYSICIANS FOUNDATION STUDY

-92% OF PHYSICIANS INDICATED THAT THEY WERE NOT SURE WHERE THE HEALTH SYSTEM WOULD BE IN THREE TO FIVE YEARS AND HOW THEY WOULD FIT INTO THE SYSTEMS

- 60% OF PHYSICIANS INDICATING THAT RETIREMENT WOULD BE AN IMMEDIATE OPTION IF THEY HAD THE FINANCIAL RESOURCES

2012 PHYSICIANS FOUNDATION STUDY (FOCUSING SPECIFICALLY ON EHR'S)

-69% OF PHYSICIANS INDICATED IMPLEMENTATION OF EHRS

-31% INDICATED EHRS EITHER HAVING NO EFFECT OR IMPROVEMENT ON THE QUALITY OF CARE IN THEIR PRACTICES AND DID NOT FORESEE ANY IMPROVEMENTS INTO THEIR MEDICAL PRACTICES IN 2012

2012 PHYSICIANS FOUNDATION STUDY (FOCUSING SPECIFICALLY ON EHR'S)

- 10% OF PHYSICIANS INDICATED EHRS DECREASING THE QUALITY OF CARE IN THEIR PRACTICES
- 4% OF PHYSICIANS INDICATED EHRS HAD DECREASED THE QUALITY OF CARE BUT ANTICIPATED AN EVENTUAL IMPROVEMENT

2014 PHYSICIANS FOUNDATION STUDY

- 85% of physicians surveyed had adopted EHR, up from 69% in 2012
- 46% of physicians indicated EHRs detracted from their efficiency
- 24% of physicians indicated EHRs improved their efficiency
- 69% of physicians indicated they experienced a lack of clinical autonomy with their decisions sometimes or often compromised

2016 PHYSICIANS FOUNDATION STUDY

- Questions regarding physician burn out were incorporated into the survey.
- 49% of physicians indicated they often, or always experience burnout
- Multiple factors reviewed as contributing to physician's burnout. The primary two noted to be regulatory/paperwork burdens and erosion of clinical autonomy

2018 PHYSICIAN FOUNDATION SURVEY

-50% of physicians indicated they often, or always experience burnout

-45% of physicians still in training reporting they are burned out

2018 PHYSICIAN FOUNDATION SURVEY

- Top three reasons for “feelings of burnout, low morale, and pessimism about the future were” Electronic Health Records, Regulatory and insurance requirements, and loss of autonomy

2020 PHYSICIAN FOUNDATION SURVEY

- 61% of Primary Care physicians often have feelings of burnout
- 57% of Specialists often have feelings of burnout

2020 PHYSICIAN FOUNDATION SURVEY

- Nearly 1 in 4 physicians (22 percent) know a physician who has committed suicide.
- 26 percent of physicians know a physician who has considered suicide.
- 15 percent of physicians know a physician who has attempted suicide.

2020 PHYSICIAN FOUNDATION SURVEY

- 43% of Physicians 46y/o or older would like to retire within the next year
- 21% of Physicians 45y/o or younger would like to retire within the next year

2020 PHYSICIAN FOUNDATION (COVID IMPACT)

- 8% of physicians closed their practices as a result of COVID-19.
- 4% of physicians plan to close their practices within the next 12 months.
- 4% indicated that they will not return to their practices due to COVID-19 health risks.

2020 PHYSICIAN FOUNDATION (COVID IMPACT)

- 16 percent of the physician workforce, or approximately 134,000 physicians, may change their practice patterns in such a way as to at least temporarily disrupt continuity of patient care, by changing practices, by no longer treating patients or by working temporary (locum tenens) assignments.

2020 PHYSICIAN FOUNDATION (COVID IMPACT)

The majority of physicians (86 percent) do not believe the virus will be under control until after January 1, 2021.

SOLUTIONS TO PHYSICIAN BURNOUT

THE QUADRUPLE AIM (MODEL DEVELOPED TO OPTIMIZE HEALTH SYSTEM PERFORMANCE)

-Improve the patient care experience

-Improve the health of a population

- Reduce per capita health care costs

-Improved clinical experience (The idea is that without an improved clinical experience on the provider side, the three other patient-centric aspects won't reach their full potential.)

FRAMEWORK FOR IMPROVING JOY IN WORK:

“A CRISIS IN HEALTH CARE A CALL TO ACTION ON PHYSICIAN BURNOUT” (JAN 2019)

- Support proactive mental health treatment and support for physicians experiencing burnout and related challenges
- Improved EHR standards with strong focus on usability and open APIs (Application Programming Interfaces)
- Appoint executive-level chief wellness officers at every major health care organization

“A CRISIS IN HEALTH CARE A CALL TO ACTION ON PHYSICIAN BURNOUT”

The recommendations presented reflect a broad recognition of the inadequacy of individual coping strategies in response to burnout in favor of systemic and institutional reforms to mitigate the prevalence of burnout

(Ashish K. Jha, MD, MPH, Andrew R. Iliff, MA, JD, Alain A. Chaoui, MD, FAAFP, Steven Defossez, MD, EMHL, Maryanne C. Bombaugh, MD, MSc, MBA, Yael R. Miller, MBA, A Crisis in Healthcare: A Call To Action On Physician Burnout, Partnership w ith the Massachusetts Medical Society, Massachusetts Health and Hospital Association, Harvard T.H. Chan School of Public Health,and Harvard Global Health Institute, January 2019, 4, http://www.massmed.org/News-and-Publications/MMS-New sReleases/Physician-Burnout- Report-2018/.)

"THE INFLUENCE OF ELECTRONIC HEALTH RECORD USE ON PHYSICIAN BURNOUT: CROSS-SECTIONAL SURVEY" (JULY 2020)

There should be a focus on combating physician burnout by reducing the unnecessary administrative burdens of EHRs through efficient implementation of systems and effective postimplementation strategies.

Tania Tajirian, Vicky Stergiopoulos, Gillian Strudwick, Lydia Sequeira, Marcos Sanches, Jessica Kemp, Karishini Ramamoorthi, Timothy Zhang, Damian Jankowicz J Med Internet Res 2020 (Jul 15); 22(7):e19274

ARE THESE THE REAL SOLUTIONS TO PHSYCIAN BURNOUT?

- Mental Health Counseling
- Measuring and improving physician well-being
- Asking "What matters to you?"
- Improving JOY IN WORK
- Make a visible commitment to improving the well-being of clinicians

- Improve baseline understanding of challenges to clinician well-being
- Raise visibility of clinician stress and burnout
- Elevate evidence-based, multidisciplinary solutions

ADDRESS ROOT CAUSE OF BURNOUT

LOSS OF AUTONOMY

PROPOSAL FOR GETTING OUR AUTONOMY BACK:

Create Standards of Medical Ethics and Rules of Professional Conduct

WHAT OTHER PROFESSION REQURIES AUTONOMY TO PRACTICE?

Lawyers

THE PARALLEL UNIVERSE BETWEEN PHYSICIANS AND LAWYERS: EDUCATION

PHYSICIANS

- Doctor of Osteopathic Medicine or Doctor of Medicine (D.O./M.D.)- The D.O./M.D. degree is the postsecondary medical degree necessary to sit for the state medical board exams and practice as a physician in a U.S. state
- Board Certification: is a mark of distinction. It indicates the education that he or she has undertaken beyond the minimal standards and competency requirements in a chosen specialty
- Fellowship

LAWYERS

- Juris Doctorate (JD) - The JD is the initial, post-secondary law degree necessary to sit for the bar examination and practice as a lawyer in a U.S. jurisdiction
- Esquire (Esq)- A title reserved for licensed attorneys; JD's who have passed their bar examination
- Master of Laws (LL.M) - The LLM serves as a secondary degree for lawyers who have achieved their JD and passed the bar exam, and who are interested in a focused, specialized course of study in a specific topic of law

ETHICAL STANADARDS

PHYSICIANS:

- Many different medical ethics guidelines are available from:
- American Medical Association (AMA
- American Osteopathic Association (AOA)
- American College of Physicians (ACP).

MEDICAL ETHICS

- The AMA CODE: The AMA code is of historical interest since it originates from the world's first medical ethics code (written in 1847) intended to function at a national level.
- In 2016, the AMA advertised its updated 2016 code as "designed to meet the ethical challenges of medical practice" and as "the medical profession's authoritative voice."
- However, the first page of this code states that the code only contains opinions and is "not intended to establish standards of clinical practice."

MEDICAL ETHICS

The AOA Code:

- The American Osteopathic Association (AOA) Code of Ethics is a document that applies to all physicians who practice osteopathically throughout the continuum of their careers, from enrollment in osteopathic medical college/school through post graduate training and the practice of osteopathic medicine. It embodies principles that serve as a guide to the prudent physician. It seeks to transcend the economic, political, and religious biases, when dealing with patients, fellow physicians, and society. It is flexible in nature in order to permit the AOA to consider all circumstances, both anticipated and unanticipated.

MEDICAL ETHICS

The AOA Code:

- The AOA has formulated this Code to guide its member physicians in their professional lives. The standards presented are designed to address the osteopathic and allopathic physician's ethical and professional responsibilities to patients, to society, to the AOA, to others involved in health care and to self.

MEDICAL ETHICS

- American College of Physicians (ACP) Code:
- Medicine, law, and social values are not static. Reexamining the ethical tenets of medicine and their application in new circumstances is a necessary exercise.
- It reflects on many of the ethical tensions in medicine and attempts to shed light on how existing principles extend to emerging concerns. In addition, by reiterating ethical principles that have provided guidance in resolving past ethical problems, the Manual may help physicians avert future problems.

MEDICAL ETHICS

American College of Physicians (ACP) Code:

- The Manual is not a substitute for the experience and integrity of individual physicians, but it may serve as a reminder of the shared duties of the medical profession.
- The Manual raises issues and presents general guidelines. In applying these guidelines, physicians should consider the circumstances of the individual patient and use their best judgment.

MEDICAL ETHICS

Given the lack of definitive ethical standards and premises, let alone a hierarchy or algorithm for prioritizing them, physicians often still face great challenges in achieving satisfactory solutions to ethical challenges for themselves, their patients, and other parties involved.

(Young M, Wagner A. Medical Ethics. [Updated 2019 Mar 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2019 Jan-. Av ailable from: https://www.ncbi.nlm.nih.gov/books/NBK535361/)

ETHICAL STANDARDS

LAWYERS:

- Model Rules of Professional Conduct (MRPC):
- All fifty states and the District of Columbia have adopted legal ethics rules based at least in part on the MRPC
- -Many states allow the MRPC to be used as evidence of the general standard of care in liability actions and rules of conduct regarding conflicts of interest may be consulted in deciding disqualification motions

MODEL RULES OF PROFESSIONAL CONDUCT

PROVIDE LAWYERS WITH A MEANS OF MAINTAINING THEIR AUTONOMY AND ESTABLISHING A STANDARD OF CARE

THE FOLLOWING SLIDES DEMONSTRATE EXAMPLES OF THE THE MRPC THAT MAY BE APPLICABLE IN THE MEDICAL FIELD

CLIENT CONFIDENTIALITY

[8] A lawyer's responsibilities as a representative of clients, an officer of the legal system and a public citizen are usually harmonious. Thus, when an opposing party is well represented, a lawyer can be a zealous advocate on behalf of a client and at the same time assume that justice is being done. So also, a lawyer can be sure that preserving client confidences ordinarily serves the public interest because people are more likely to seek legal advice, and thereby heed their legal obligations, when they know their communications will be private.

CLIENT CONFIDENTIALITY

MRPC 8

- A lawyer's responsibilities as a representative of clients
- …a lawyer can be sure that preserving client confidences ordinarily serves the public interest because people are more likely to seek legal advice, and thereby heed their legal obligations, when they know their communications will be private.

PROFESSIONAL JUDGEMENT

[9] In the nature of law practice, however, conflicting responsibilities are encountered. Virtually all difficult ethical problems arise from conflict between a lawyer's responsibilities to clients, to the legal system and to the lawyer's own interest in remaining an ethical person while earning a satisfactory living. The Rules of Professional Conduct often prescribe terms for resolving such conflicts. Within the framework of these Rules, however, many difficult issues of professional discretion can arise. Such issues must be resolved through the exercise of sensitive professional and moral judgment guided by the basic principles underlying the Rules. These principles include the lawyer's obligation zealously to protect and pursue a client's legitimate interests, within the bounds of the law, while maintaining a professional, courteous and civil attitude toward all persons involved in the legal system.

PROFESSIONAL JUDGEMENT

MRPC 9

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PROFESSIONAL JUDGEMENT

MRPC 9

- These principles include the lawyer's obligation zealously to protect and pursue a client's legitimate interests, within the bounds of the law, while maintaining a professional, courteous and civil attitude toward all persons involved in the legal system.

AUTONOMY

[11] To the extent that lawyers meet the obligations of their professional calling, the occasion for government regulation is obviated. Self-regulation also helps maintain the legal profession's independence from government domination. An independent legal profession is an important force in preserving government under law, for abuse of legal authority is more readily challenged by a profession whose members are not dependent on government for the right to practice.

AUTONOMY

MRPC 11

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AUTONOMY

MRPC 11

- An independent legal profession is an important force in preserving government under law, for abuse of legal authority is more readily challenged by a profession whose members are not dependent on government for the right to practice.

AUTONOMY

[13] Lawyers play a vital role in the preservation of society. The fulfillment of this role requires an understanding by lawyers of their relationship to our legal system. The Rules of Professional Conduct, when properly applied, serve to define that relationship.

DISCIPLINARY PROCESS

[19] Failure to comply with an obligation or prohibition imposed by a Rule is a basis for invoking the disciplinary process. The Rules presuppose that disciplinary assessment of a lawyer's conduct will be made on the basis of the facts and circumstances as they existed at the time of the conduct in question and in recognition of the fact that a lawyer often has to act upon uncertain or incomplete evidence of the situation. Moreover, the Rules presuppose that whether or not discipline should be imposed for a violation, and the severity of a sanction, depend on all the circumstances, such as the willfulness and seriousness of the violation, extenuating factors and whether there have been previous violations.

DISCIPLINARY PROCESS

MRPC 19

- Failure to comply with an obligation or prohibition imposed by a Rule is a basis for invoking the disciplinary process.
- disciplinary assessment of a lawyer's conduct will be made on the basis of the facts and circumstances as they existed at the time of the conduct in question and in recognition of the fact that a lawyer often has to act upon uncertain or incomplete evidence of the situation.

DISCIPLINARY PROCESS

MRPC 19

- the Rules presuppose that whether or not discipline should be imposed for a violation, and the severity of a sanction, depend on all the circumstances, such as the willfulness and seriousness of the violation, extenuating factors and whether there have been previous violations.

STANDARD OF CONDUCT

- [20] Violation of a Rule should not itself give rise to a cause of action against a lawyer nor should it create any presumption in such a case that a legal duty has been breached. In addition, violation of a Rule does not necessarily warrant any other non-disciplinary remedy, such as disqualification of a lawyer in pending litigation. The Rules are designed to provide guidance to lawyers and to provide a structure for regulating conduct through disciplinary agencies. They are not designed to be a basis for civil liability. Furthermore, the purpose of the Rules can be subverted when they are invoked by opposing parties as procedural weapons. The fact that a Rule is a just basis for a lawyer's self-assessment, or for sanctioning a lawyer under the administration of a disciplinary authority, does not imply that an antagonist in a collateral proceeding or transaction has standing to seek enforcement of the Rule. Nevertheless, since the Rules do establish standards of conduct by lawyers, a lawyer's violation of a Rule may be evidence of breach of the applicable standard of conduct.

STANDARD OF CONDUCT

MRPC 20

- The Rules are designed to provide guidance to lawyers and to provide a structure for regulating conduct through disciplinary agencies. They are not designed to be a basis for civil liability

THINGS TO THINK ABOUT

THE SOLUTION TO PHYSICIAN BURNOUT

GETTING OUR AUTONOMY BACK

HOW?

ESTABLISHING A STANDARD OF MEDICAL ETHICS AND RULES OF PROFESSIONAL CONDUCT

WHAT DO WE DO NOW?

- Creation of a standard textbook of Medical Ethics and Rules of Professional Conduct

- Medical Ethics and Rules of Professional Conduct become a required class in Medical School

WHAT DO WE DO NOW?

Creation of a Standing Committee on Ethics and Professional Responsibility similar to the ABA charged with interpreting professional standards

WHAT DO WE DO NOW?

Work together (M.D.'s and D.O's) to retrieve the autonomy we need as Physicians to ensure we are able to provide the quality of care we want for all of our patients

CONSIDER THE IMPLICATIONS OF CREATING THIS STANDARD ON MEDICAL MALPRACTICE

PHYSICIAN BURNOUT: A CALL FOR UNITY

THANK YOU

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PLANTE TULSA WORLD 12.4.2017
HE LOOKS LIKE A FUTURE DOCTOR OR LAWYER TO ME.
OR BETTER YET, A COLLEGE FOOTBALL COACH.