HARJOT SINGH, M.D. PRESENTS

DO YOU RECOGNIZE THE *FIVE DANGEROUS TRENDS* THAT THREATEN A DOCTOR'S CAREER?

AND ONE THING YOU CAN DO TO STOP WORRYING ABOUT THEM AND BE SUCCESSFUL.

A SPECIAL REPORT BY:

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DO YOU EVER...

- Do you ever feel like there are changes happening in healthcare that you have no control over?
- Do you think you are losing autonomy over your job and career?
- Would you like to get power back in your profession?
- If you agree with these statements, read on.
- In this special report, you will learn about trends in healthcare from two perspectives- the business of medicine and the practice of medicine. And how these changes could be causing harm to you, and what you need to do to undo the problems, even create an advantage for you.
- In the last 15 years, the accelerated change in medicine has created unforeseen and unexpected trends. These shifts were visible before, but the pandemic has laid them bare like a storm uproots a tree and shows the undersides. If you are in a leadership position, you should realize that all of this is bad not just for a doctor's success and wellbeing, it also creates obstacles for a leader.
- First of all, change is continuous and is the only constant we know.

Like Bill Gates said,"We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten." Even a crisis like a pandemic is not unforeseen, it's only a change at a macro level, and it happened fast.

So read along to the next page for the five trends from the last 15 years that you should be absolutely aware of.

1. Unproven practices in the business of medicine:

You already know that majority doctors are employed now. And the percentage is only going up each year. This is like the new way of being for a doctor.

Here's what is going on - with the increase in the number of employed physicians, a class of non-clinical leaders has emerged who are a few steps removed from clinical work. And they have much shorter tenures than an average doctor's workspan in a workplace. E.g. On average, a healthcare CEO's tenure is about 5 years. Their priorities are different given the financial storms the organization goes through. Again, this isn't a bad thing.

Then what is the problem?

The situation is that all of these changes have created a need for how to manage and lead employed doctors. Doctors are waking up in this brave new world unprepared. And so far, the majority of the efforts in the name of leading or managing doctors have been about controlling them. This is the norm in the corporate world but a totally new experience for doctors. Like in the rest of the corporate world, top-down leadership and management ideas are being applied. As Jeffrey Pfeffer describes in his book, Leadership B.S., the leadership development enterprise is enormous with billions of dollars, thousands of books, and hundreds of thousands of blogs and talks. Yet, we have not seen worldwide employee burnout, and disengagement numbers budge in the last 5 decades. The same half-baked leadership and management ideas are used to lead and manage doctors. All of this is done in a way that sounds scientific on the surface because data is gathered.

Patient satisfaction scores are the best example to understand this phenomenon. The original idea was, and yes it was just an idea, that higher patient satisfaction would result in better patient outcomes, lower costs, and improve care quality.

Consider the following:

A. An original investigation in a JAMA article from 2012 by Fenton et al shows that it resulted in exactly the opposite - higher inpatient care use, higher healthcare and drug expenses, and to rub salt in the wounds- higher mortality.

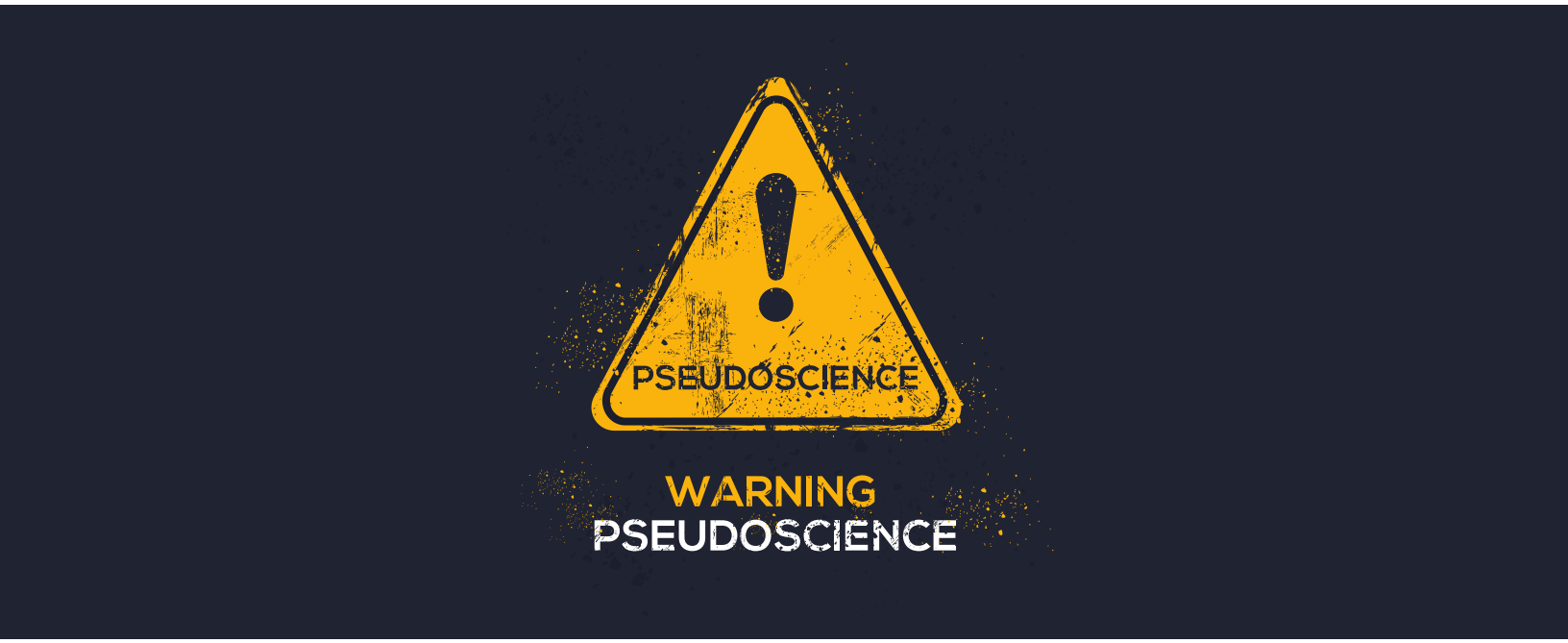
B. Later review studies confirm that there are many other factors besides just what a doctor does. On top of that, these surveys are not cheap.

C. An article in Medical Economics from 2019 by Rosenfeld shows that the patient satisfaction surveys may promote job dissatisfaction, attrition and even inappropriate clinical care among some physicians. Not only are scores not necessarily accurate at identifying negligent or incompetent physicians, according to the American Journal of Medicine, they do not correlate with better patient outcomes. They are also biased

against women and minorities.

Has anything changed in the healthcare leadership world with these studies ? No. Giving these scores fancy acronyms, and collecting data doesn't make them scientific. Every undergrad statistics student knows that data is only good if it is valid i.e. if it measures what it says it will measure, and reliable i.e. if it is replicable, and consistent. These scores are neither. They are corporate pseudoscience. Of course, doctors should not act like jerks with patients but right now the patient satisfaction scores are used to jerk doctors around- it's about command and control.

Another example of a bogus study touted as an established standard - the well-known Makary study about medical errors being the third leading cause of death. It is like a meme now, and is consistently one of most oft-quoted and referenced articles. It says that about 62% of all hospital deaths are caused by medical errors.



Whole Healthcare executives' national meetings have been dedicated to this. Calls have been made to redo malpractice laws to prevent medical errors- basically asking for more doctors to be sued and for more money. Yet, more rigorous studies show the number to be between 3.6 to 4.2%.

Did that change anything? No.

Again, we should continue our work on quality and preventing medical errors is one of them. But the programs based off of these kinds of "studies" don't serve that purpose. They only serve to intimidate and control doctors that further alienates them. They fuel mistrust of doctors and this kind of bogus information is misused in the media.

Here's the risk in all of this. It's not that these attempts are annoying or frustrating, or that they have been proven to be harmful. But the real risk is that if this trend continues, there are even more crackpot ideas around the corner. Ideas that sound good on the surface, and justified using bogus data - mere pseudoscience. Without doctors in operational leadership roles this trend is going to be hard to tackle.

2. Unproven practices in practice of medicine -

This one is sneaky. But the methodology is the same as the first one above. Good intentions touted as a scientific standard that becomes a practice guideline, that controls the hands of a doctor. It ignores that "the road to hell is paved with good intentions." This is a real trend and is not letting up.

Have you heard of the opioid epidemic ravaging the country? And you already know how it started. When I was applying for my California License in 2005, we were mandated to do pain management CME hours before the license could be issued. Later on, I remember clearly where I was when I heard the host on an NPR program on my car radio discuss how heroin was making a comeback and what that was leading up to. You know that these mandated CME and guidelines and practices did not solve the problem of chronic pain management. They set off a chain of events that continues to cause patient deaths and malpractice lawsuits, and is a common cause of patient dissatisfaction, and public mistrust.

You may ask, is this kind of dangerous mandating really a trend?

Think of the EMR mandate that permanently changed how medicine is practiced. The implementation did not include workflow studies, or sufficient training. The interoperability was never planned. On top of that, EMR's are susceptible to ransomware attacks. In March 2022, there were 43 data breaches reported to the Dept of HHS Office of Civil Rights. All the while, the EMR acts like a glorified cash register, while doctors' click fatigue increases with each new update. Doctors spend two thirds of their time documenting, many spend pajama time at home doing charting. This has led to lower physician engagement and higher burnout, and higher turnover. Yet, has any vendor ever been held accountable for this? No.

The opposite is also true. This is a story not often told.

Let me tell you about one of the most evidence-based mental health treatments and what we are doing to it. This particular intervention has many benefits - improve physical health, mental health, lower hospitalizations due to physical or mental causes, lower cost of care, and reduce Psychiatrist shortage. The new data only shows how effective it is and we have known this for over 15 years. It is supported by NIH, AHRQ, and AAFP as the gold standard of mental health treatment in primary care. Do you know what this magic pill is? It is called Integrated Behavioral Health where the Psychiatrist works with primary care providers to treat patients reaching a far bigger number of patients. With all this evidence, and support, you'd think we would have it implemented nationally by now. The reality is that very few places have been able to have it long term. Why? Lack of reimbursement. The model has clinicians spend time doing activities that are not considered "clinical

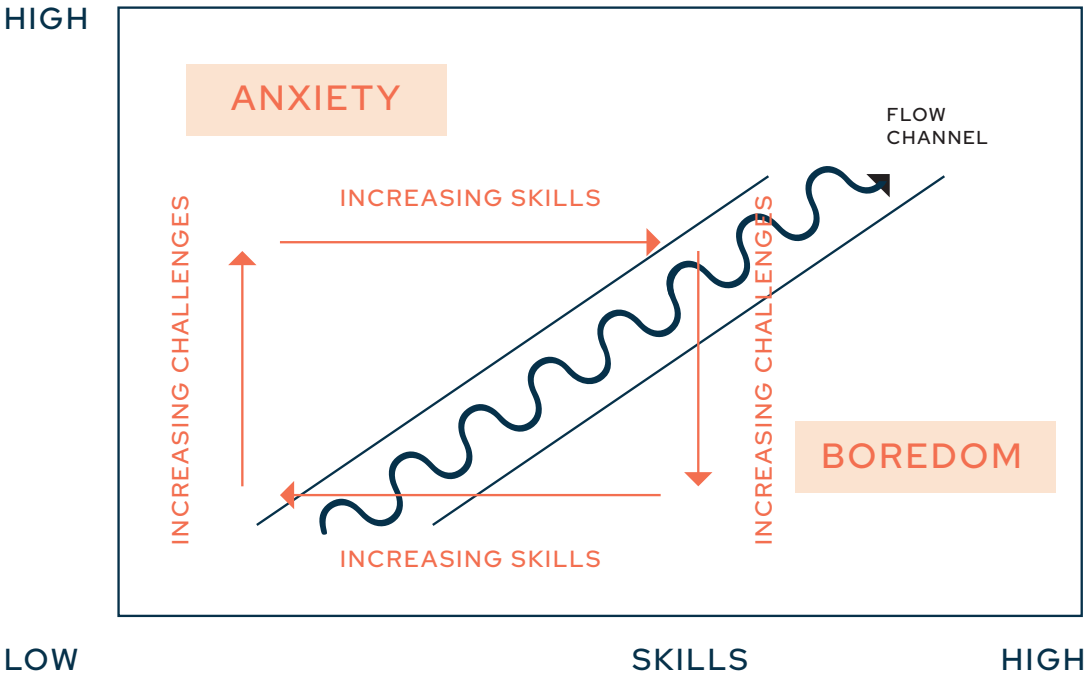
care". There is another fallout from this- we don't have clinical workforce trained in the model either due to lack of availability of training sites. So an evidence based practice that is good for the doctor, good for the patient, and good for the whole healthcare can't be implemented because of leadership failure.
All of this is the rise of pseudoscience in the practice of medicine - an idea is presented as good, and implemented before any rigorous vetting is done, or implementation is planned, while the actual evidence based care is ignored like an orphan.

The risk with the rise of pseudoscience in the practice of medicine is that the doctors who are happy to be practitioners, and are not willing to be in leadership positions are left vulnerable to the changes made to their practice without their input. That in turn leaves the patients and entire healthcare vulnerable to the whims of these changes. Only a doctor trained in leadership and in an administrative role can do the damage control and protect themselves and their colleagues.

3. Ignoring a doctor's needs in the workplace:

Every doctor has needs in a workplace.

A quick review of human needs is in order. The founder of Positive Psychology, and ex-president of American Psychological Association, Martin Seligman has summarized this the best in his evidence based PERMA model. Human thriving and wellbeing consists of five components - Positive emotions, Engagement, positive Relationships, Meaning in life, and Achievement. It is easy to see that all five are needed in all parts of life. However, in the workplace, engagement with work is the foundation of flourishing at work. The other four don't exist if you are disengaged or burned out at work. You can read about this in detail in my chapter "How a physician feels engagement, how a leader enhances it" in the book Enhanced Physician Engagement by Healthcare Administration Press 2021. (You can have the chapter for free on my website.) Briefly, engagement is one of the most positive aspects of human experience. To understand it the most tested model is Flow by Cziskentmihalyi. It is the optimal balance between challenges and skills at work. If the challenges are high, and skillset is low, it causes anxiety. This can be seen in the case of a new graduate. And if challenges are low and skillset is high, it results in boredom. Many mid-career physicians feel like they are languishing instead of feeling flow.



Engagement is the opposite of burnout. Overwhelming data shows how they are connected to employee effort, retention, and turnover. It costs anywhere from $100k- 1 million or more to recruit just one doctor.
So you would think that healthcare organizations would be falling over each other trying to engage doctors.
Here's the reality- a story that has unfolded since 2016.
According to MGMA, in 2017, 21% of organizations had a staff engagement program to reduce burnout. In 2018, the number was 19%. But since then, we have had the pandemic and you might hope that the number should have skyrocketed, and you would be dead wrong. In 2021, only 14% of healthcare leaders have a formal plan or strategy to reduce physician burnout.
If you were to grade a student who got 14% in an exam, what grade would you give?

An F.

And the number is looking for a bottom to hit.

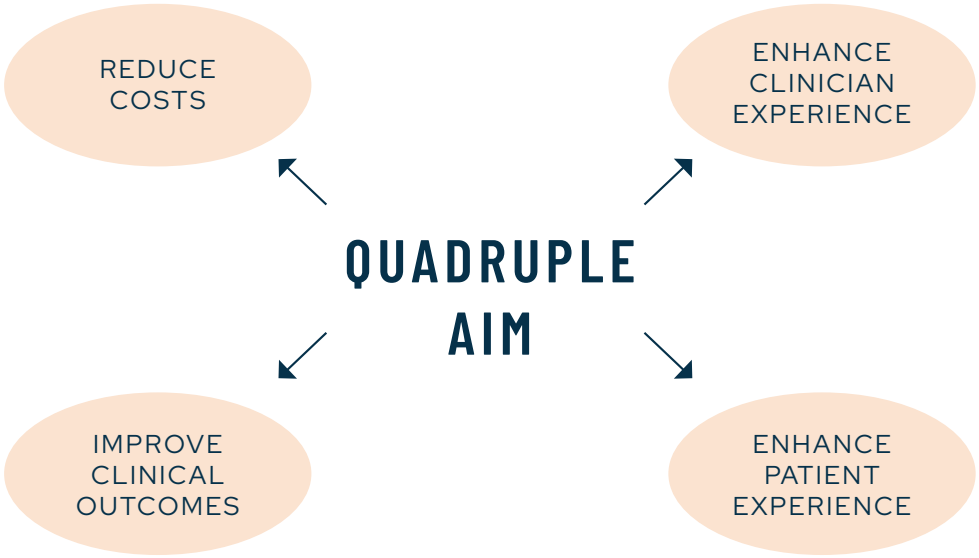
Another interesting tidbit - I have been looking at this one particular number in annual medical school graduation questionnaires. It's like an exit interview all US medical school graduates have. This question first appeared in 2015. It asks about how many students plan to have administrative careers- and the number is always around 25-30%. That means that about 1/4th of medical students already see the need for doctors to be in administration. Did the educational institutions try to address this need? No. This need is not met in

medical school education at this time.

If the doctor's needs continue to be unmet, the risk for you is that it leads to career dissatisfaction, disengagement, and burnout. At any given time, about 55-60% of doctors wish to retire within the next 5 years. About 1 in 3 practices saw a doctor leave in 2021 due to burnout. If you continue to wait for others to take care of you, the jobs are not created with you or your needs in mind. Without a doctor in the driver's seat of their own life, these needs won't be met.

4. Unproven practices in physician development at organizational level:

Something wonderful is happening. With the blessings of IHI and with the support of AMA - there is recognition that triple aim i.e. the three pronged strategy of patient experience, population health, and cost reduction is not enough. We need to include Healthcare workforce wellbeing as the fourth aim, otherwise triple aim cannot be achieved. Even ACGME has mandated resident wellbeing in training programs.



The requirements emphasize that psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. These are absolutely good developments but the problems have appeared when the question has come about how to achieve this fourth aim.
First of all, someone let an idea out that doctors need to be made more resilient. Sounds good? Actually it's a terrible idea- it blames the doctor instead of holding the workplace responsible for the illbeing. Hundreds of non-peer reviewed articles can be found online on the topic. For the last 7 years, countless doctors have gone through resilience training programs. Did the burnout numbers budge? No.

For the first time, probably the only properly done study on the topic published in JAMA in 2020 shows that

doctors have higher resilience than the general population. Did that change anything? No.

And guess what happens when HHS and HRSA ask for RFP's worth $103 million in 2021 to lower physician burnout? The main thrust is to boost physician resilience. And when 103 millions are dangling in the air - you have people line up to write proposals to boost physician resilience. And those proposals will become plans and the plans will become programs and you will be mandated to take part in them.

The only way to tackle these problems is to take charge of your own learning and growth. And learn what evidence based research shows about achieving professional and personal development.

5. Scattered and inconsistent individual growth and development:

This is a big problem and at the root of every other problem.

Let's agree on one thing first. A doctor is a learning and growing being. Very few professionals spend 12-20 years of their life after high school mastering their craft like a doctor does. Many of these years are spent learning hands-on skills 80-100 hours a week. If anything, a doctor is a learning machine. Not learning feels like a fish out of water to a doctor.

After finishing formal training, it doesn't take long before a smart doctor realizes that there were gaps in their training - like the missed rotations in your training. The most common ones are - business of medicine, leadership & career advancement, managing your team, managing your boss, workplace speaking, money, and wellbeing & happiness. That's when the fun begins.

First, the doctor searches for one of these problems online. An avalanche of marketed solutions hits them and buries their browser for an unforeseeable future. As social psychologist Robert Cialdini says in his book, Pre-Suasion, "What is focal appears causal." Whoever has your attention, appears to have the solution. Hyperbole gets your attention - terms like moral injury, institutional physician homicide, and corporate murder of physicians are used. Most of it is in the form of articles that have tactics after tactics that appear to contradict each other.

Second, it appears that some things look doable but there is a lot of confusion about where to begin. Dr. Google and Dr. Facebook don't help here either. You start to feel like your own worst patients who believe the latest conspiracy theory instead of accurate information.

This two pronged problem leads to inaction, which is pretty sad because everyone deserves success if they are ready for action. It makes you feel like a novice in a world full of masters.

It is important to understand that this is not your fault.

The reality is the new challenges are just a newer version of the old ones with three big differences.

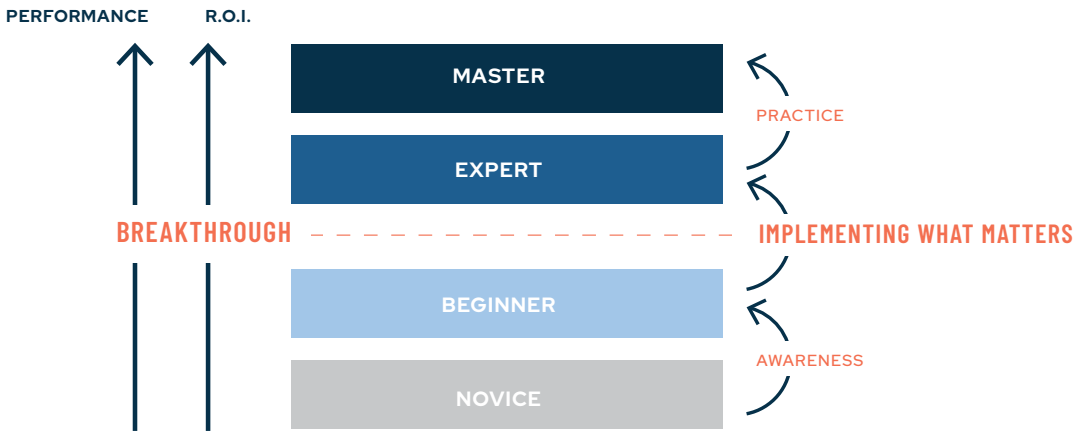
A. In the past, during your formal training there was an endpoint- your degree. Now, your life is an open playing field with seemingly endless possibilities. Being employed, you may let someone else totally define your life, or you can do things to take control back. No matter what you do or don't do, it's your choice.

B. Getting a degree had two levels of learning. Mastering a lot of intellectual information to answer board exams, and going in depth over a smaller skill-set experientially. However, your training creates an illusion of mastery over both domains. Like phenylketonuria. Have you ever seen a case of it? Do you know anyone who has seen a case of it? And think about how much you learned about it in biochemistry. Just because you can answer a question about something in a board exam starts to feel like you know about it as much as something you have done over 100 times. This doesn't work in real life - reading blog articles alone is not going to solve your problems. You have to go out and try, and fail, and learn, and succeed and grow.

C. You had a scaffolding of a system and a process that supported your learning and development. The help was built in with the purpose of helping you become an independent practitioner. The reality is that this is not true independence, it is pseudo-independence, like house cats seem to pretend they are fiercely independent. This tradition of pseudo-independence is against the very thing that helped us survive as a species - interdependence. Stephen Covey in The 7 Habits of Highly Effective People says, "Interdependence is a higher value than independence." Your professional education followed a process. This process isn't about creating a big vague job description like a "Doctor" or a "Leader". Rather it is

based on skill sets and competencies. As you progress by learning, training, and practicing, you go through different levels of expertise.

Think of how classes taught you the didactics, and then there was supervised training, then unsupervised training, and then practice during different rotations. That's what turned you from a novice to an expert. The mastery is never complete because the master starts a new journey all the time.
Just like that, in your quest to master challenges after training you have to go through the similar rungs of a ladder. It doesn't matter what you are trying to master - the business of medicine, leadership & career advancement, managing your team, managing your boss, workplace speaking, money, or wellbeing & happiness. For example, when you use it for developing doctors into leaders (D2L), you get a D2L leadership development ladder that looks like this.



THE LEADERSHIP DEVELOPMENT LADDER

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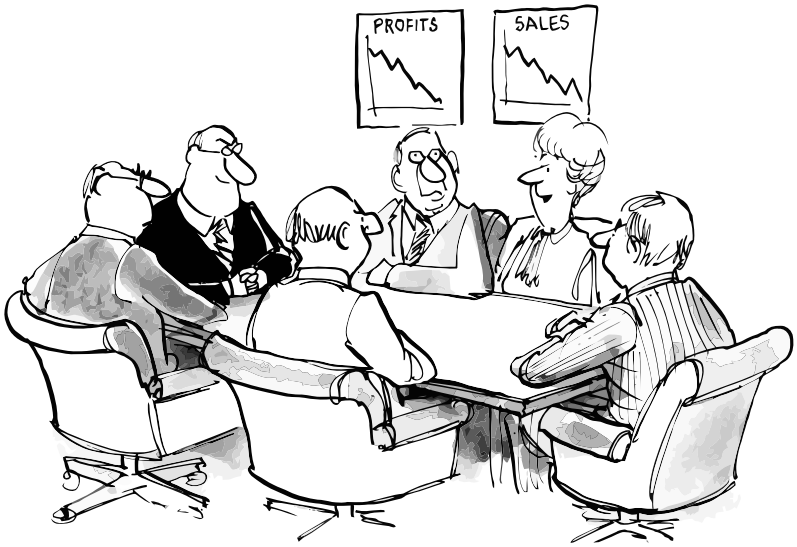
The lower tungs need more structured learning like didactic learning followed by training. And the rungs above need coaching and mentoring and picking new skills to start a new cycle of learning and growth. Do you see the heart right in the middle of the ladder- this journey is emotional & experiential with its ups and downs, and is done only with you bringing your heart into it. When done step by step with help, a doctor moves fast through these levels and then starts the journey all over again to tackle a new problem or a new skill.

Let's take a skill like workplace speaking. Even a toddler can hold a knife and cut but can they perform a surgery? Parents have to run to stop such a toddler wielding a knife. Just like that, anyone can speak but can

they make others listen and change their thinking, or feelings, or actions? First of all, workplace speaking is different from public speaking. Public speaking typically is used to influence feeling, is not interactive, and is over soon. Workplace speaking has to influence action too, is interactive, and facilitative, and has to be done again and again. You need to learn, train, and then practice using coaching.

Using this development ladder, a doctor can master much needed challenges and meet their needs. The main theme of it is to stage the needs properly and help with the next immediate level of growth, the proximal need, also called the zone of proximal development. Not keeping you comfortable but bored, but also not making you overwhelmed and panicked. This just right proximal development, based on your immediate needs, if done continuously, builds confidence, helps you see progress, and brings joy to life. This one shift in your attitude i.e. continuous and proximal growth and development based on your individual needs is the most important step you can take today to turn all the dangerous trends to your advantage. As far as change and trends go, there are three kinds of people. First, who make the change happen, second, who see the change happen, and third who say, "What the hell happened?"



"What if we don't change at all ...
and something magical just happens?"

A change should not be bad or disruptive to you. You may not have control over each and everything happening around you, but you can be prepared. It will help you, and you will help others as well.

Let's take this conversation further and how you can buck these trends and how you can lead for success and live with joy. Email me so we can chart the course about which skill you want to master next.

If you want to share this with your team and group, let's plan an educational event like a lunch and learn.

Email me.

Harjot Singh, M.D. is a keynote speaker and a leadership consultant. He helps leaders and doctors master skills never taught in training so they can lead for success and live with joy. He speaks at national level meetings and in boardrooms across the country on leadership and wellbeing. He also focuses on organizational level change, working with C-suite leaders to design tailored programs especially for workplace wellbeing, engagement, and burnout. Bridging the gap from a technical expert to a leader is what Harjot does best. He is passionate about helping people discover who they really are - like how Yoda helps Luke discover what a powerful Jedi he is. He believes that a mind once expanded never goes back to its old state. A practicing physician, chief of telemedicine at Kingsview Behavioral Health, and faculty at American College of Healthcare Executives, Harjot's work is informed by all three perspectives. He has authored several textbook chapters - the latest one called Enhanced Physician Engagement, 2021, by Healthcare Administration Press.

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