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- **Lauren Cohen** | 215-351-2623 (Phone) | lcohen@acponline.org
You found the perfect practice. So, you ask, “When can I start?” Slow down – it’s not that simple. Practice type and location are only 2 of the decisions you will have to make before considering a contract, and there’s more to negotiating an employment contract than salary. The quality of the group you will be joining, the style of the practice, and how your compensation and other benefits are calculated are even more important considerations than salary.

Keys to both professional and personal happiness lie within that all-important decision to sign on the dotted line. Because the employment contract defines the conditions of employment and can therefore greatly affect future professional satisfaction and personal happiness, a physician needs to carefully read and fully understand every aspect of the employment agreement. And in this era of value-based payment, hiring a competent attorney who understands physician compensation and employment is worth every dime you spend. That said, below are some high-level considerations to ponder before going into contract negotiations with your future employer.

Finding the Right Practice

Start by considering the type of practice in which you want to work and your preferred geographic location. You can tap into a number of resources to find the best practice opportunity. When looking for a position outside your immediate geographic area, check professional publications or contact physician recruiters. Your local hospital or personal network of colleagues, teachers, or medical school and residency training alumni may also be excellent suppliers of information. Many web sites, including ACP, have search tools for career opportunities, allowing searches by specialty, type of practice, and location.

**Practice Type:** Decide what type of practice would best suit your needs. Types of practices include solo, small, medium, or large group, value-based, corporate or hospital-owned, hospitalist or outpatient, single or multi-specialty, rural or urban, academic or independent, and government-based.

Listing the characteristics, advantages and disadvantages of each type of practice can be a good starting point.

**Location:** When deciding on a practice, consider living environments, such as the local school system, churches, availability of leisure activities, and proximity to the hospital. The cost of living, crime rate, and transportation system may be personal priorities as well.

**Practice Culture:** After finding a suitable employment opportunity, there are subjective issues to consider. You should learn everything possible about the practice’s culture and values by observing the practice and meeting its owners, employees, and patients. We recommend asking colleagues unaffiliated with the group about its reputation. And of course speak with as many physicians in the group as possible, including recent hires as well as long-term employees or partners.

**Financial Health:** Practice stability is very important when deciding on long-term employment. Consider the practice’s age, expenses, revenue, debt, and financial future. If the financial health of a prospective employer is shaky, working conditions may be poor. Probably the only way to get this information is to ask directly about some key financial indicators, such as payer mix, days in accounts receivables, or staff turnover rates.

**Compensation:** The most obvious issue on the mind of anyone seeking employment is compensation. Although salary may be negotiated during the hiring process, the compensation methodology is usually not negotiable. Most compensation arrangements are based on individual productivity (usually measured by charges, revenue, or RVUs or some combination thereof), with incentives for meeting quality and cost metrics, and/or individual productivity less expenses, with multivariable incentive bonuses tied to payer or employer objectives. Other key factors include hours, paid personal and educational time off, payment for call or ER coverage, committee work, and other non-patient care activities. With accountable care organizations and complex health system or corporate ownership, it is important to get legal review.

The Art of Negotiating

The goal of negotiation is to get to a win-win situation, not to win at the expense of the other party. Thus, you should know what you want and what is minimally acceptable. Although you must be realistic, it is very important that you negotiate for any terms you feel are truly essential to job satisfaction, despite concerns that you may be pushing hard. A fear that hard feelings might develop even before employment begins sometimes inhibits physicians from saying what’s really on their minds. Neither you nor a prospective employer will be well served if you accept a position and then are miserable because of terms you failed to negotiate. Being forthright without being abrasive or unrealistic is essential to the process. You should be creative and flexible in negotiations, since experts agree that it is unrealistic to expect everything on your ‘wish list.’ The best time to negotiate the best deal is during the honeymoon period right after the group has made you an offer, thus it would be ideal to have your attorney lined up ahead of time.
Tips for Negotiating Your Contract

• Gather information and be prepared. Find out as much information about the practice in advance as you can. What questions can you anticipate from them? What do you want to know? Determine what you want to accomplish.

• Treat people with respect. From the receptionist to the partners, show courtesy and consideration. It creates a great first impression.

• Negotiate from the perspective of mutual benefit and fairness. Whenever you are seeking a modification to the contract, explain why. If it could benefit patients or the practice, point that out. Always have logical reasons for what you want and why you are asking for it.

• Set priorities. Before you come to the table, review, list, and rank critical factors. What is negotiable? What is not?

• Develop a strategy. Consider how you will obtain your most important points. Which other points are easy for the practice to offer or concede? Start with an easy point to negotiate. Get a feel for the process and the others involved. Tackle your hardest issue midway and conclude with light ones.

• Return to unresolved issues after most of the bargaining is done. At that point, added pressure to find common ground creates a greater bargaining base for both parties, especially in this era of too few primary care physicians.

• Get it in writing. When you negotiate a change in the contract, make sure that change is in writing and not simply a verbal agreement. Any changes should be incorporated into the contract itself.

Understanding Contract Terms

Even if you employ an attorney or a professional consultant to help with the negotiation process, the decision to accept the opportunity lies with you. Here are a few terms and benefits the contract should address before you sign on the dotted line. Some terms that are important to watch out for are:

• Salary
• Benefits (health, dental, vision, disability, leave, etc.)
• Ownership/Partnership
• Outside Activities
• Duties and Requirements
• Restrictive Covenants
• Non-solicitation Clauses
• Term and Termination
• Gap/Tail Insurance
• Assignability

Should I Use a Third Party?

An employment contract may be the most important financial decision you will make and any misunderstandings can cause painful consequences. Thus, the cost of hiring an attorney is normally money well spent. Because the contract has usually been carefully crafted by the group’s attorney to protect their interests, you should consider seeking legal counsel to review the contract as well. Your colleagues or the local/state medical society or bar association can recommend experienced health law attorneys. Lawyers can help find potential conflicts and will suggest alternative contract language. However, it’s important to understand what you are signing since you are the one who will have to comply with its provisions thereafter.

Conclusion

Contract negotiations can be exciting as well as frustrating. Signing an employment contract is not only an important financial decision but can also affect your personal comfort, family, professional compatibility, and career enjoyment.

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The federal government is pushing physicians to get up to speed on the addiction crisis facing the U.S. As of June 27, 2023, clinicians applying for or renewing their registration with the Drug Enforcement Administration (DEA) must certify that they’ve completed training on the treatment and management of patients with opioid or other substance use disorders. This will be a one-time requirement, according to a public letter from the DEA.

Any organization accredited by the Accreditation Council for Continuing Medical Education (which includes ACP—see sidebar for resources from the College) can provide the training, the DEA said. The new details, released in late March, sent clinicians scurrying to their continuing education providers for help.

For more information on how physicians can meet the requirement and improve their knowledge of substance use disorders, ACP Internist recently spoke to Anika A. H. Alvanzo, MD, MS, FACP, an addiction medicine physician and managing partner of Uzima Consulting Group LLC in Baltimore.

Q: What’s new about this requirement?
A: I would always refer you back to the DEA requirements. The DEA is requiring eight hours of training related to substance use disorder treatment. What is different than some of the previous requirements? There was not a requirement for addiction-related training unless you were going to be prescribing buprenorphine. For physicians [in that category], there were eight hours of training that were required, and that training was specific to recognition and treatment of opioid use disorder. For nurse practitioners and physician assistants, the DEA required 24 hours total of additional training. This training requirement is broader, inclusive of opioid use disorder but also other substance use disorders.

Q: So it will apply to a much larger group of clinicians?
A: According to the DEA, it’s going to be applicable to prescribers who are looking to renew their DEA license. If you’re in practice, are actively prescribing, and are looking to renew your DEA license, then it’s going to be applicable.

Q: Is there anyone who is exempt from the requirement?
A: The letter does have a list of certain people who are exempt. I would refer readers to the DEA letter for the full list of exemptions. Certainly the first group are going to be practitioners who are specialty-trained in addiction, whether they’re addiction medicine specialists or addiction psychiatrists. They’re exempt by virtue of their training and their board certification. Practitioners who previously completed the training for prescribing of buprenorphine and were X-waivered are also exempt.

One of the other groups is anybody who graduated from a medical school or nurse practitioner or physician assistant school within five years and can document that their curriculum included at least eight hours of training in this area. This, I think, speaks to the need for medical schools to really look at revising their curriculum so that their graduates, when they graduate, are already equipped with knowledge of how to screen, diagnose, treat, and appropriately refer patients with substance use disorders. We would hope they are all already doing this.

Q: For physicians in practice, what types of training are available?
A: There are a number of different continuing medical education opportunities available. I’m a member and a board member of the American Society of Addiction Medicine (ASAM), and ASAM has some phenomenal training for people who are considered novices, with respect to treatment of addiction, all the way through people who are specialty trained. There are other organizations that also provide continuing medical education in the area of substance use disorder treatment. I would advise people to not only look at national resources but look at state-specific resources that may speak more to regulations and requirements where they are practicing and serving patients.

Q: While physicians are meeting these requirements, are there particular skills they should try to learn?
A: We know that there’s no segment of society that’s spared from addiction. Whether people recognize it or not, people with addiction are in their practices. And so, No. 1, be able to recognize and identify the presence of not only an addiction, because ideally we want to catch somebody before they progress to an actual use disorder, but unhealthy use of substances—how to appropriately assess where somebody is along that continuum, then how to treat, and also how to recognize when the person’s severity of illness may be beyond their ability to treat and they need to refer to specialty-level treatment, an addiction medicine specialist or an addiction psychiatrist. It’s also important to know what are the co-occurring medical and psychiatric conditions that may present along with a substance use disorder and how to recognize those and treat or appropriately refer.

Q: Do you have any other advice for physicians on meeting this requirement and improving their addiction care?
A: Read the DEA letter, and then get familiar with resources...
or education about addiction and also treatment of addiction. They need to know what's available in their own communities: Who are the addiction medicine specialists in their community? Start forming those networks and partnerships and collaborations so that when they do have somebody whose substance use disorder has exceeded their ability to manage, they have that existing relationship with an addiction medicine specialist.

One of the things I also want to highlight is that just as there are health inequities in other areas of medicine, health inequities exist within addiction as well, with respect to racial and ethnic disparities in access to treatment. Providers need to be aware of that and working towards creating a practice that is looking to mitigate and eliminate those disparities. ASAM has online educational modules as well as policy statements on racial justice in addiction medicine.

ACP offers a wide variety of CME activities that will count toward the new DEA requirement of eight hours of training on substance use disorders.

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Well-being resources from ACP

Interactive Multimedia
- **ACP Pain Management 7: Opioid Use Disorder.** This interactive training module provides background information necessary to support clinicians in their care for persons with opioid use disorder (OUD), including persons with coexisting chronic pain. 5 CME.

Video
- **X-Express: The ABCs of Prescribing Buprenorphine.** This highly practical one-hour video course provides an overview of the role buprenorphine plays in the management of OUD. 1 CME.

Podcasts
- **Evidence-Based Care of Substance Use Disorders.** In this episode of Annals On Call, Robert Centor, MD, MACP, discusses current thinking about the appropriate treatment of patients with substance use disorder with Dr. Stefan Kertesz. 1 CME.
- **Opioid Use Disorder.** In this episode of Annals On Call, Dr. Centor discusses the care of patients with opioid use disorder with Dr. Jessica Taylor. 1 CME.
- **5 Pearls on Stigma in Opioid Use Disorder.** In this episode of Core IM, the team discusses how language can contribute to increasing or decreasing the stigma surrounding OUD, as well as physicians' potential lack of ability to apply culturally relevant approaches to substance use disorder treatment and management. 1 CME.
- **Underuse of Thiamine in Patients With Alcohol Use Disorder in the Intensive Care Unit.** In this episode of Annals On Call, Dr. Centor discusses the underuse of thiamine in critically ill patients with alcohol use disorder with Dr. Michael Donnino. 1 CME.
- **The Breadth of Addiction Medicine.** This episode of The DEI Shift explores the broad and timely topic of addiction with Dr. Chwen-Yuen Angie Chen. 0.5 CME.

Annals in the Clinic
- **Alcohol Use.** Unhealthy alcohol use—the consumption of alcohol at a level that has caused or has the potential to cause adverse physical, psychological, or social consequences—is common, underrecognized, and undertreated. For example, data from the 2020 National Survey on Drug Use and Health indicate that 7.0% of adults reported heavy alcohol use in the previous month, and only 4.2% of adults with alcohol use disorder received treatment. Primary care is an important setting for optimizing screening and treatment of unhealthy alcohol use to promote individual and public health. 1.5 CME.
- **Opioid Use Disorder.** OUD is a treatable chronic disorder with episodes of remission and recurrence characterized by loss of control of opioid use, compulsive use, and continued use despite harms. If untreated, OUD is associated with significant morbidity and mortality. Buprenorphine and methadone reduce fatal and nonfatal opioid overdose and infectious complications of OUD and are the first-line treatment options. Physicians have an important role to play in diagnosing OUD and its comorbidities, offering evidence-based treatment, and delivering overdose prevention and other harm reduction services to people who continue to use opioids. Interdisciplinary office-based addiction treatment programs support high-quality OUD care. 1.5 CME.
- **Care of the Patient Using Cannabis.** The past two decades have seen a revolution in legal access to cannabis, driven largely by activists and business interests. As a result, the population of cannabis users nationwide—especially daily users—has grown significantly. An estimated 4.5 to 7 million persons in the United States now meet criteria for cannabis use disorder annually. This article focuses on the effects of cannabis use, intoxication, and withdrawal while also reviewing the developmental pathways of cannabis use disorder as well as evidence-based pharmacologic and psychosocial treatments. 1.5 CME.
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How to fight impostor phenomenon

High-achieving individuals, like physicians, often think they don't deserve their success, and this can lead to higher rates of burnout.

By Jennifer Kearney-Strouse

Physicians tend to be high performers, but many think they don't deserve their success. That can lead to higher rates of burnout, a recent study found.

In the November 2022 Mayo Clinic Proceedings, researchers compared rates of impostor phenomenon, or the belief that one's success is undeserved rather than a result of hard work and ability, in a survey of 3,116 U.S. physicians and a probability-based sample of the U.S. population. Physicians were more likely than those in other professions to report impostor phenomenon, and higher rates were associated with higher odds for burnout and suicidal ideation. In a multivariable analysis, physicians were also more likely to endorse the statement, “I am disappointed at times in my present accomplishments and think I should have accomplished more.”

Study coauthor Colin P. West, MD, PhD, FACP, a professor of medicine at Mayo Clinic in Rochester, Minn., recently spoke to ACP Internist about the findings.

Q: What prompted this study?
A: We've been studying burnout for two decades, and that led to an explosion of interest and understanding of its prevalence and its impact on physicians and the medical system as a whole. We continue to explore how burnout relates to many other factors and experiences. We've looked at things like burnout and other mental health diagnoses such as depression or suicidal ideation, and we and colleagues at other institutions have looked at burnout and self-valuation. This was really an extension of that interest. The idea that [impostor phenomenon] can affect high-achieving individuals, like physicians, who commonly experience feelings of doubt and guilt and uncertainty in their work, and how that might relate to other aspects of distress, like burnout, was something that we thought would be of interest.

Q: The study mentions low self-valuation as a potential reason for impostor phenomenon. Can you describe that concept?
A: Low self-valuation is this idea that people are very hard on themselves and value their own needs less than the needs of others. The challenge in medicine, of course, is this is part of our social contract, this is part of our professionalism—that the needs of our patients come first. That can be internalized so that it becomes something that's true in every aspect of our lives, where even outside of our interactions with patients, we don't do as well in our own self-care efforts.

Physicians are among the most self-critical people out there. That can be constructive sometimes, when it really challenges us to always be striving for the best on behalf of our patients, but it can be destructive as well, when we never give ourselves the grace of saying, “Oh, yeah, you actually do need to take a breath, you actually do need to nurture your own life and your own interests and the things that are important to you, as a human being who deserves to have those things be prioritized.” That's where low self-valuation comes into this.

Q: Your study found that impostor phenomenon was more common in some groups, including women. Do you have any thoughts on why and whether other groups might be at risk?
A: It's a great example of hypothesis-generating findings. Something we write about in the paper is this idea that impostor phenomenon can be thought about in a couple of different ways. One is intrinsically, within each individual, is there a tendency to think maybe you don't belong, and do we bring that as part of our individual personality to our life experiences? But the other part of this that is really important not to lose sight of is that there are also messages that come from outside the individual. What is it about the environments within which women are working that is sending them the message over their entire lives and their careers that maybe they don't belong, maybe they're not here on their own merits? Then we start overlapping into underrepresentation and discrimination and bias, and that leads us to ask what we know about other groups that get messages, culturally and structurally, that they are "less than."

We didn't have a large enough sample size in this particular study to provide meaningful insights on racial and ethnic groups, for example. That's an important study that needs to be done. My hypothesis is that much like we saw for women, other disadvantaged and underrepresented groups historically in medicine are going to have the same issues, because they've been told for decades that they're less than, that they don't belong, and that becomes internalized. That then speaks to a responsibility across medicine for us to reverse that.

Q: How can medicine as whole begin to address impostor phenomenon?
A: We need to be aware of how we think about ourselves and how we think about our colleagues so that we stop putting ourselves down, stop putting those around us down, and turn that into a shared support environment, where in our local spheres of influence, we don't tolerate dragging people, and when we see other people tearing others down, we don't accept it. We don't just stand idly by. That's one
broad approach to how we try to solve this idea of people not feeling like they belong, like they're just waiting to be found out. We need to help people acknowledge that lots of people feel this way, and we need to support each other collectively, because we need it, and our patients need it. We’re not at our best when we’re distracted by these feelings, and we need people to be able to be their very best in medicine for their patients.

Q: Are medical schools starting to address this issue more systemically?

A: There's a lot of history in medicine of not acknowledging that we’re human, that we are going to deal with difficult situations, and that they’re going to be stressful. The historical training mindset was along the lines of, you have to basically put on a stone face and not let it get to your core. We’re increasingly understanding that that is counterproductive. You’re going to be affected by these feelings in medicine at some point in your career, no matter who you are, and hiding them, suppressing them, walling them off like an abscess is not healthy. By having more open discussions about these issues in medical school, in residency training, even in practice, we normalize these feelings, we destigmatize these feelings. They become OK to talk about.

By talking about this and realizing that everyone is in it together and should support each other, it creates a team that shores each other up for what is, no question, a demanding and stressful career. That’s the kind of mindset I see medical schools starting to shift more to: a team-based, community-oriented kind of learning environment. But we have such a long way to go, and there are still people who get left behind in that or are uncomfortable trusting that that openness about what they’re feeling will truly be honored as something that will be used to support as opposed to harm them.

Q: How can individuals guard against impostor phenomenon?

A: One of the first things that I recommend to people, even when I’m talking about burnout and distress more generally, is to honestly take stock of your own experiences. I talk with residents sometimes who may be struggling with feeling like everyone else seems so accomplished and knows the answers on rounds while they are scrambling and always feel like they’re a step behind. To me, that’s the beginning of impostor phenomenon, this feeling of “Oh, I’m not as good as everybody else. I don’t belong here.”

What I ask residents or students to do in those cases is step back. First of all, don’t lose sight of what you have accomplished. Think about what being a physician says about your academic experiences, about your service in the community, all of the things we select people for. In medicine, we have to give ourselves the permission to appreciate our accomplishments in a way that sometimes I think we resist, because it almost feels arrogant, but it is part of self-worth. Step back and think, “OK, let me remind myself of my credentials. What have I accomplished? What have I overcome to be here? What challenges make me proud?” It’s OK to be proud of those things.

So many of us are fearful of being viewed as arrogant that we are self-deprecating to a harmful fault. I think there’s a balance. I don’t think people should tell themselves that they’re great at things that they’re not, but what I’m advocating for is honest self-appraisal. A lot of this is about being able, individually, to listen to that internal signal of strength.

We also need to have the support of our systems around us. When we see our colleagues feeling a bit low, we need to remind each other that “Hey, you know what, look what you’ve accomplished already. Pretty cool. I admire you and your commitment. I’m here for you.” If we do that for each other, I think that’s a big step forward toward building supportive cultures in medical training and practice, which would be incredibly helpful.

Q: Are there other take-home messages from your study?

A: The first point is there’s so much more that we have to learn about how all of these different aspects of human experience and physician experience interrelate, and this is just one more small step to building that deeper understanding. Our paper identifies relationships that are important, and they should serve as a launching point for further research to dig into what other underrepresented groups experience, and which solutions move from being plausible to actually working.

The second is just an emphasis on, as we’ve proposed for physician well-being more broadly, really taking responsibility from a system standpoint, from an organizational standpoint, and not putting the solution to impostor phenomenon on the individual. It’s just not helpful to tell the individual without system support, “Hey, just think more highly of yourself.” That can make them feel good for five minutes, and then they get back out into their practices, onto the wards, into their lecture sessions, and they start feeling pummeled and doubtful again. We have to have learning and working environments within which people can thrive, and that sense of community, that sense of mutual support for growth, is something that we really have to challenge ourselves to foster, so that it becomes part of our professional norms.

From ACP Internist, May 2023
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Culture in health care is a nebulous concept and can be tricky to define, but Patrick P. Kneeland, MD, put it simply. “Culture is no more than how we behave with each other over time,” he said at the Society of Hospital Medicine’s CONVERGE conference, held in late March in Austin, Texas. “And what’s cool about that is we can control that, to a great extent,” whether leading a team, being a teammate, or interacting with patients.

People almost universally want certain qualities in their leaders, colleagues, and physicians, mainly trust, listening, and loyalty, said Dr. Kneeland, who is vice president of medical affairs and lead for advanced care and extended care at DispatchHealth, a high-acuity home health care provider based in Denver.

“We all have a sense that we want to be operating in a psychologically safe space, where our voices are listened to and where people care about us as humans,” he said.

Such spaces are environments where clinicians feel comfortable in interpersonal risk-taking, Dr. Kneeland explained. “That’s really important when we’re thinking about solving the complex problems that all of us have to solve on a daily basis. … Ultimately, most of us desire to get to a point where we’re in a learning organization that’s continuously striving to improve,” he said.

During the talk, “From Surviving to Thriving in a Changing Healthcare Environment,” Dr. Kneeland and ACP Member Read G. Pierce, MD, offered three high-yield strategies to cultivate a thriving work environment.

1. Ask powerful questions.

As a leader, colleague, or individual, try to ask powerful questions, including during the most stressful moments of your workday, rather than making statements, Dr. Kneeland said. “We like to think of this as turning to wonder,” he said. “Most people experience [being asked] truly open-ended questions that are nonjudgmental as being a positive form of communication, versus a statement.”

Asking a question in this way requires that you don’t already have an expected answer in mind, Dr. Kneeland said. Example questions to ask in an annual performance review might be, “Can you tell me something you’re really energized about in your work right now?” or “Can you tell me something you’re struggling with in your work right now?”

This strategy can also be applied during rounds by leadership. Dr. Kneeland described a system in which a patient-safety leader visits a frontline unit and asks for two things that are going well and one that has room for improvement. In a study published in March 2018 by The BMJ Quality & Safety, health care workers who received more feedback in this way reported significantly better leadership, teamwork, safety, emotional exhaustion, burnout, and work-life balance than those who received less. “This is correlative, for sure, but a pretty interesting breadth of impact from a single behavioral change that’s actually pretty simple. And it’s really about a powerful question,” he said.

A more common example of a powerful question is to replace asking a colleague “How are you?” with “Hey, it’s been a tough six months. How’s it going?” said Dr. Kneeland. Asking in this way is “a little step beyond social and normative versions of that question,” he said.

Physicians can also ask themselves powerful questions. “Folks may have heard in the past about a concept called Three Good Things, and this is about asking ourselves a question as we’re getting ready to go to bed for the night, for example, what were three good things that happened in my day today?” Dr. Kneeland said. Data show that if done for 14 consecutive days, this practice works as well as or better than a selective serotonin reuptake inhibitor for mild to moderate depression, he noted.
2. Listen reflectively.
Once you're in the habit of asking open-ended questions, try to practice active listening, said Dr. Pierce, who is chief of hospital medicine and associate chair for faculty development and well-being at Dell Medical School at the University of Texas at Austin. “So I’m going to listen to the other person, and I’m going to convey interest,” he said.

But people usually skip a useful next step, reflective listening, Dr. Pierce said. “Before I do anything else—before I solve the problem, make a suggestion, ask a follow-up question, make a comment about the leadership of the organization—I’m going to summarize briefly what I [heard] from the person who’s speaking,” he said.

Reflective listening is simple, but it’s not easy, especially given time pressures and physicians’ role as “fixers,” Dr. Pierce noted. “We want to move the conversation forward because we think we have a handle on the problem or the concern, when the reality is that, particularly for us as humans, our emotional experience of work and life is complex,” he said.

“The first thing that may come out of our mouth (and the second and third thing) may not actually be the whole story.”

This is especially true in interactions with patients. “Anybody had that experience where you’re interviewing a patient, it’s like 10 minutes in, and the real issue comes up?” Dr. Pierce said. “You would’ve missed it if you cut the interview short.”

Letting people feel heard doesn’t just have a powerful impact on culture; it can also affect outcomes, said Dr. Pierce, adding that reflective listening can even help with clinical problems such as low back pain. “Listening is not a passive thing we’re doing,” he said.

3. Recognize and respond to emotion.
When in conflict, try to see the emotion in the other person and address that emotion before moving on to solutions, Dr. Kneeland said. That may sound basic, but it’s quite difficult to do, he added.

That’s because people are wired to respond in the moment, especially when under stress, by getting defensive, throwing somebody under the bus, providing data or a technical solution, or avoiding the situation altogether, he said. “We live in a high-pressure, very complex world most of the time. And in that world, our brains, for biological and evolutionary reasons, like to do one of these things,” Dr. Kneeland said.

Try to buck your evolutionary urges by recognizing what emotion the person is experiencing and responding to it before moving forward, he advised.

Dr. Kneeland shared PEARLS as a helpful acronym for doing this, which comes from the book “Communication Rx”: Partnership (“How could we walk through this together?”), Empathy (“I imagine that has been very difficult for you”), Apology/Acknowledgment (“I am so sorry I don’t have better news”), Respect (“You have worked very hard on this project”), Legitimization (“Anyone who has gone through this would be angry”), and Support (“How can I most effectively support next steps?”).

He added that naming the emotion is also useful (“I am sensing quite a bit of anger”).

“This is helpful for me to have in my toolkit, particularly when I’m not showing up at my best,” Dr. Kneeland said. “It’s been super helpful just to have some ideas for those moments.”

He called out legitimation as a particularly powerful component. “Just legitimizing what the other person experiences in the world … and you’re not agreeing with any of the details; you’re just saying that’s a normal human reaction,” Dr. Kneeland said.

Adopting these behaviors in difficult conversations can improve your energy levels in addition to your interactions. “At the end of the day, I’ve got a container of [limited] energy … so if I can leave that interaction in a better place than if I were to get defensive, throw someone else under the bus, avoid, and then think about it all day, I’m going to have a little bit more energy for the next interaction, because there’s going to be other important ones that day,” Dr. Kneeland said.

“A little bit of an investment up front actually saves me a lot of backend energy.”

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ACP Resident/Fellow Member David J. Savage, MD, PhD, was halfway through his residency at the Cleveland Clinic in March 2020 when, suddenly, it was time to learn telemedicine from scratch.

“Up until that point, I had never done a virtual visit at all,” he said. “And I would say, by and large, the faculty members, just a handful of them were doing some form of virtual visits.”

Despite the novelty of telemedicine, internal medicine programs recognized the immense, immediate need to deliver patient care safely from a distance. “We, just like everywhere, had canceled a lot of our ambulatory clinics while we were figuring out what to do with COVID, and … we were scrambling as a program to figure out how we could continue to keep residents seeing patients, since everybody was going to be virtual,” Dr. Savage said.

Across the country, the volume of virtual visits soared. Prepandemic, Johns Hopkins Medicine in Baltimore did 50 to 80 telemedicine visits a month across ambulatory services, said ACP Member Brian Hasselfeld, MD, medical director of digital health and telemedicine, during the C. Wesley Eisele Lecture on the future of telemedicine at Internal Medicine Meeting 2022, held in April in Chicago.

“In March of 2020, obviously, all of that changed, and by April, May, and June, we were nearing 100,000 outpatient telemedicine visits across our footprint—over 1,000 times increase in a period of 60 days,” he said.

The trend remained stable through 2020. During that year, the overall number of Medicare visits conducted through telehealth in the U.S. grew to 52.7 million, a 63-fold increase from about 840,000 televisits in 2019, according to an HHS report published in December 2021.

Since then, telemedicine use has leveled off but still hovers above prepandemic figures. In 2021, about 20% of total ambulatory visits at Johns Hopkins were conducted via telemedicine, according to Dr. Hasselfeld.

As policymakers continue to assess regulatory issues, medical educators and residents continue to refine the best ways to teach and learn telemedicine.

Pros and cons

Prior to the pandemic, telehealth was a blip on the radar in medical education, said ACP Member Ryan Jelinek, DO, during an ACP Telemedicine 201 webinar in January. “[It] never really garnered much significant attention amongst medical educators, given the higher-yield competing priorities that it was up against within such jam-packed curricula,” he said.

Telemedicine appears to be here to stay. However, more than one year into the pandemic, a survey of residents at Accreditation Council for Graduate Medical Education (ACGME)-accredited training programs in the Minneapolis/St. Paul, Minn., region found that only 15% reported any formal training around the provision of care via telehealth, according to results published in July 2021 by Telehealth and Medicine Today.

“I suspect that this finding is consistent in many academic medical centers across the country. … Many medical education programs either didn’t have the capacity or bandwidth to develop curriculum or have yet to prioritize the creation of strategies to properly train learners in telehealth,” said Dr. Jelinek, coauthor of the study and medical director of telemedicine and access for the department of medicine at Hennepin Healthcare.

A big reason why there has been such limited education
on telehealth up to this point relates to a lack of guidance or expectations from governing organizations within academic medicine, he noted. “Without this, many programs did not feel that telehealth education was something that warranted prioritization among the vastness of internal medicine training,” Dr. Jelinek said.

This changed with the 2021 ACGME updates, which incorporate digital health as a milestone for internal medicine, he noted. The milestones state that Level 1 learners should be able to identify the required components for a telehealth visit, Level 2 learners should be able to perform assigned telehealth visits using approved technology, Level 3 learners should be able to identify clinical situations that can be managed through a telehealth visit, Level 4 learners should be able to integrate telehealth effectively into clinical practice for the management of acute and chronic illness, and Level 5 learners should be able to develop and innovate new ways to use emerging technologies to augment telehealth visits.

“With this guidance in place, it’s clear that this is a field of medicine that has gained prominence and is worthy of the attention of internal medicine educators,” Dr. Jelinek said.

In addition to following ACGME guidance, he recommended that educators train learners in the importance of telehealth from a patient-centered lens. “Many studies published over the past two years have shown great support and patient satisfaction with these virtual modalities of care delivery,” Dr. Jelinek said. “With this, there is also a growing body of evidence to support the efficacy of virtual care centered around patient outcomes and cost savings.”

Despite telehealth’s potential to improve longitudinal care, trainees and educators have faced many challenges with virtual modalities throughout the pandemic. In one study that surveyed 95 internal medicine residents in August 2020 in New York City, only 2% believed the patient received the same level of care when comparing telemedicine visits with in-person visits, according to results published in February 2021 by PLOS One. The survey showed that 83% of residents preferred in-person visits during their training, 65% thought the telemedicine experience will affect their future career choice, and 67% would prefer to have less than half of their visits be telemedicine in the future. No respondents thought patients were always comfortable discussing their medical conditions over the phone, and 74% agreed that telemedicine visits increase the chance of patients being lost to follow-up.

Lead author and ACP Resident/Fellow Member Chia-Yu Chiu, MD, who was a third-year resident at the time of the study, offered a few potential reasons why residents may not be so keen on having a tall telemedicine workload in the future. First, he said, since telemedicine curricula are not well established, residents may feel rushed into using the technology or otherwise poorly prepared. “Language barrier is also a problem, and another thing is the lack of physical examination,” Dr. Chiu noted.

His study is one of the first to document telemedicine from an internal medicine trainee perspective, said Dr. Chiu, now a second-year infectious diseases fellow at the University of Texas Health Science Center at Houston. (Jacob Quinton, MD, MPH, FACP, Chair of the ACP Council of Resident/Fellow Members from 2020 to 2021, led a survey study on resident and fellow perspectives on COVID-19’s impact last year, although it doesn’t principally address telemedicine; results are pending publication.)

“My study’s conclusion is that we are not ready for telemedicine,” Dr. Chiu said. “We need more supervision, and we need to have a good protocol.”

**Working out the kinks**

Educators and trainees may have been unprepared for telemedicine visits when the COVID-19 pandemic hit, but more recently, programs have made inroads in designing effective curricula.

One model is the four quadrants of telehealth teaching, developed by Ben Li, MD, MBA, and Julian Genkins, MD, ACP Resident/Fellow Member. These include facilitating learning, optimizing logistics, building skills, and innovating, explained Pamela Vohra-Khullar, MD, FACP, during the ACP webinar.

To facilitate learning as an educator, promote learner engagement by explaining the benefits of telemedicine, and encourage independent problem solving, as telemedicine requires creativity, she said. As with teaching in general, it helps to be kind and understanding and to admit your own weaknesses, since telemedicine is new for everyone, Dr. Vohra-Khullar said.

Optimizing logistics, on the other hand, can be a more complicated matter. “I probably spent the first few months of the pandemic just working on this part to try and perfect some things,” said Dr. Vohra-Khullar, who is an assistant professor of general internal medicine at Emory University in Atlanta.

She recommended meeting in person with trainees if possible, exchanging cell phone numbers, and identifying colocation procedures (e.g., the learner and preceptor are colocated in person, with the patient remote). While the level of supervision will vary based on the learner and the preceptor’s comfort level, be sure the learner knows how to ask for help during a virtual visit (e.g., secure messaging, texting, muting the call and speaking by phone), Dr. Vohra-Khullar recommended.

Building skills is the “real crux of the teaching,” she said. Teaching after a telephone visit should focus on proper phone communication skills (i.e., empathetic, no jargon), triage skills, and counseling patients about self-management, while teaching after a video visit should review bedside manner (i.e., working with others who are virtually present, setting up the camera), the virtual physical exam, and counseling about COVID-19 public health measures, Dr. Vohra-Khullar noted.

Innovation, the final quadrant, can include repurposing highly effective tools for in-person learning for virtual formats, such as simulation labs, said Dr. Jelinek. “Training learners on how to tackle some of the more common connectivity issues the patient might have in a simulated environment is a great way to help improve efficiency and comfort around these types of issues that most learners have never received any training for in the past,” he said.

Indeed, medical educators should test their virtual visit platform out first, according to the “T” in the TELEMEDS framework, presented in a March 2021 article published...
by JMIIR Medical Education. The rest of the mnemonic recommends that medical educators evaluate their schedule, lay out an agenda, establish visit rules, modify their speech, encourage patient engagement, demonstrate positive nonverbal communication, and summarize next steps.

But back in March 2020, such frameworks weren’t readily available to scrambling internal medicine residency programs. As the Cleveland Clinic tried to figure out how to properly train its residents in virtual visits, program leaders tapped the three residents in the Clinician Educator Track for help.

“They said, ‘Is this something you can help us with? Because we need to come up with something pretty quick,’” said Dr. Savage, who was a second-year resident in the track at the time and is now a second-year hematology/oncology fellow at Scripps Health in San Diego.

Word had gotten out that the residents had started thinking about creating a telemedicine curriculum just one month prior to the pandemic. “At the time, we didn’t have a whole lot; we just had a lot of brainstorming, and so that’s what really spurred us to start working hard on it,” he said.

The team finalized the curriculum in five weeks. It included introducing a formal training program for residents, creating a resource guide for different video communication tools, and training preceptors to supervise care. The majority of residents who responded to a preparticipation survey had no prior telemedicine experience and expressed only slight comfort with the modality. In a span of 10 weeks, residents performed more than 2,000 virtual visits; 64.9% of those who responded to a postparticipation survey said they had acquired new knowledge as a result.

Dr. Savage said that he initially envisioned doing a capstone project during residency, not designing a telemedicine curriculum during a pandemic. “But it ultimately turned into this, and this was the most impactful, meaningful thing that I never could have imagined coming in,” he said.

Soon after designing the curriculum, Dr. Savage moved with his spouse across the country and started his third year of residency in August 2020 at the University of California, San Diego. He was surprised to see similar progress in telehealth at a different residency program.

“Everybody was doing exactly what we had talked about at a brainstorming session six months prior, where it seemed like, ‘Well, maybe in five years we could be doing this,” Dr. Savage said.

He attributed that innovation solely to the pandemic, noting that newer trainees seem to be much better prepared for telemedicine visits due to exposure in medical school.

“It felt so new and so abrupt and so futuristic to be doing it in real time as the pandemic started, but now, people are getting exposure further down in the education pipeline. They come into residency or fellowship, and it’s just kind of part of their standard workflow,” Dr. Savage said. “I feel like [the pandemic] just catapulted the way we do ambulatory health care forward by years.”

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ACNP: ACP’s Career Connection 2023 Summer Career Guide
With declining job satisfaction, growing burnout, and ongoing staff shortages, hospital medicine has never experienced such a challenging time for physician turnover as now, said Alan Hathcock, MD, MPH, FACP.

Since it’s so hard to keep hospitalists (and so expensive to replace them), he likens physician retention to a mountain summit. "We need to figure out why some people fall or stop climbing," said Dr. Hathcock, CEO and medical director of Northern Colorado Hospitalists, a hospitalist group based in Fort Collins.

By knowing what makes hospitalists stay or leave, hospital leaders can encourage them on their career expeditions, he said during his talk at the Society of Hospital Medicine’s CONVERGE, held in late March in Austin.

He categorized physicians’ reasons for leaving as pull and push. Factors that pull physicians away include family needs, such as a spouse accepting a job elsewhere, or wanting to live in a different location, Dr. Hathcock said.

As for what pushes them out, he said the top factors are an undesirable schedule (especially working nights and weekends), compensation below the market rate, mismatched culture and values, work-life imbalance, administrative burden, and—most of all—bad managers.

"People do leave bad managers across every industry," Dr. Hathcock said. "This is something that everybody in this room needs to take to heart … and you’ve got to fix that, if you have that problem."

The key is to find the “sticky factors” that can inspire physicians to stay the course. "I promise you, there’s a lot you can do," said Dr. Hathcock. He offered the following 10 tools to increase physician retention, which his group has identified and refined over the past 20 years.

1) A shared mission.

Most hospitals have mission statements, but each hospital medicine group should also have a more specific one, he said. Group leaders should sit down with the team in person and ask the following questions: Who are we? What is our purpose? Why do we do what we do? Why should a physician want to be on our team?

Once you have these answers, a mission statement naturally develops, he said, and if you’re lost for where to start, high-quality patient care is always a cornerstone. But the work doesn’t end there.

"We review and revisit our mission statement every January. We just made some big modifications this year on it. That’s how important it is for us. … If everybody knows they’re working towards that same mission, it really promotes retention," Dr. Hathcock said.

2) The right people.

Retention starts with hiring physicians who believe in the group’s mission, he advised. To do that, review all parts of the recruiting and hiring process and thoughtfully consider who first contacts the applicant, the structure of the interview day, questions to ask, which references to call, and how to manage follow-up. "If you spend time on the front end, you avoid problems down the road," said Dr. Hathcock.

3) An onboarding program.

Physician turnover peaks in the first years of practice, reaching as high as 25% in the first three years compared with less than 5% among those practicing for more than 10 years, according to a 2022 study in the Journal of General Internal Medicine (JGIM). “You want people to set their routes, and you’ve got to set them early,” Dr. Hathcock said.

The onboarding process, which starts the moment a contract is signed, creates lasting impressions, he said. “Most people don’t think about … how they say, ‘Hey, welcome to the team.’ What are the next steps? Do they outline those? Is it a smooth process, or is it incredibly bumpy?”

Ease new physicians in by limiting their workload and pairing them with a mentor for the first year, Dr. Hathcock said. "We cap their services. We try to offload difficult patients—especially [for] some of the newer docs," he said,
adding that new hires also enjoy no night shifts for the first three months. New hires should also know who to call when there's a problem, and it can also help to pair each one with a more experienced physician (aka an orientation liaison) for the first couple of days for extra support, he said. Then, throughout the first year, different leaders should check in about important items, from the new employee’s biggest concerns to how their family is adjusting.

4) Culture.
In the 2022 JGIM study, 96% of millennial hospitalists rated culture of practice as important in choosing and remaining at a hospital medicine group.

Groups should encourage and incentivize a culture of helping, as well as invest in their hospitalists’ growth and health by offering professional development and wellness programs, he said. They can also build a culture of psychological safety by encouraging dissent, as well as having zero tolerance for toxic, unprofessional behavior, Dr. Hathcock said. “There's an old parable that ‘One drop of oil poisons the well,’ and it will.”

5) Scheduling and staffing fundamentals.
It’s tough to master scheduling and staffing, especially coming out of the pandemic, but it’s essential, he said. Dr. Hathcock recommended asking physicians about the biggest pinch points for them in the scheduling process and targeting these issues in small pilots, reworking any kinks with input from the group before broad expansion.

He also recommended standardizing the process for requesting time off, as well as using a flexible scheduling model that creates backups for sick calls and surge calls. “If people don’t get their requests, generally, and the schedule has no flexibility, they’re going to leave. I promise,” Dr. Hathcock said. “And if people are overloaded with too many patients, they’re going to leave. Guaranteed.”

6) Continuous process improvement.
Always keep an eye on daily procedures, and be sure to ask for feedback on them, he recommended. “You’ve got to figure out a cadence for getting feedback from your group that’s monthly, weekly, annually, but you need to do it,” Dr. Hathcock said.

This means being in a constant state of revision and refinement. “You have to make sure that a broken process has attention and that you work through it. That’s what people want to see,” he said. “It may not be fixed today, but people have to be seeing that you’re working on fixing processes.”

7) Clinical excellence.
Care quality is the foundation on which to build everything else, so set high clinical standards in recruiting and consider rewarding quality care with bonuses, Dr. Hathcock advised. “You have to have a clear, unwavering focus on high-quality patient care and professionalism.”

This goes beyond metrics like mortality, medical errors, readmissions, and other patient outcomes that every group prioritizes. “If you’re on the wards and people are not being kind to the nurses, the ED staff, that all trickles down to not taking care of that patient well,” he said.

8) Flexibility.
The importance of adapting to change has been a difficult lesson of the pandemic, Dr. Hathcock said. “We need more contingency plans, we need more flexibility built into our processes like hiring, clinical, HR,” he said. “We’ve got to be nimble and agile now in our process like we never had to do before.”

For each new initiative Dr. Hathcock’s group launches, leaders walk through the Kotter model of change with the operations team to figure out the best strategy. “Change management and messaging is very important in that model, and I would encourage you to think about how each step of that is communicated, what kind of feedback you’re getting from your docs and providers during the change, and then how you message it throughout the change process,” he said.

9) Compensation.
Fair compensation is integral to hiring and retaining physicians, Dr. Hathcock noted. “Given the already-high level of compensation to physicians that we already pay, it’s unlikely that more money is going to mitigate burnout and a lot of the problems,” he said. “But it has to be competitive.”

Offer an attractive compensation package, relative to benchmarks, and don’t underestimate the value of benefits, Dr. Hathcock recommended. “People … sometimes have a very old way of thinking about benefits, meaning ‘I’ve got a retirement [plan] and I’ve got health insurance.’ But there’s a lot of things you can do,” such as wellness benefits, stipends, sabbatical programs, a gym membership, and parental leave, he said, adding that it’s best to review compensation annually.

10) Leadership from the frontline.
Dr. Hathcock noted that in the Marine Corps, the Mustang Officer is someone who started out in the ranks of soldiers before becoming a commissioned officer. “Leaders in health care, we can be the Mustang as well. … It seems to lend a little bit of trust and credibility, whenever you’re a clinician that rises to leadership,” he said.

But even nonclinician leaders can learn from the frontlines. “Go to that frontline, learn about the processes, so that people know that you understand them,” Dr. Hathcock said. “And that’s your lens as you move forward and you make decisions with your team. … Be visible. Don’t just sit in your office, please; go talk to people, but don’t interrupt their day.”

Hospitalist programs may have additions and modifications to these strategies, Dr. Hathcock noted, but he encouraged leaders to put in the work to keep their physicians climbing, “because the view from the top of the physician-retention mountain is beautiful.”

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Open Payments marks its ninth anniversary this year, but many physicians still may not be entirely aware of how this CMS program applies to them. In short, any transfer of value from industry to clinicians above specific thresholds is reported by the payer (aka the reporting entity) and made public each June.

Before CMS releases the yearly report, though, there’s an opportunity to review, affirm, dispute, and correct the information. *ACP Internist* recently talked to Veronika Peleshchuk Fradlin, director of the Division of Transparency Projects in the Center for Program Integrity Data Analytics & Systems Group, to learn more about the program, including why physicians may want to make timely review of their data a priority.

**Q:** Briefly, how does Open Payments work?

**A:** The Open Payments Program is a national transparency initiative administered by CMS and mandated by the Affordable Care Act. It requires certain pharmaceutical companies and device manufacturers, referred to as reporting entities, to report any payments or other transfers of value they make to covered recipients, who are physicians, teaching hospitals, and certain nonphysician practitioners. The Open Payments System is a very large database where the data from the industry is collected. The same database supports a prepublication review and dispute period, during which covered recipients have an opportunity to look at the data that was reported about them before it becomes published on the CMS Open Payments website. The system has been refined multiple times since its inception, most notably in 2021 to include nonphysician practitioners, such as advanced practice nurses and physician assistants, as mandated by the SUPPORT Act of 2018.

**Q:** What types of payments are reported?

**A:** There are three broad categories: general payments, research payments, and ownership and investment interest records. Research payments are, as the name indicates, related to research activity or a formal research agreement or protocol. General payments can be things like travel honoraria or any type of education funds that are not specifically tied to a research study. Ownership and investment interests are not exactly payments, but financial information about the investments of covered recipients or their immediate family members in entities defined as applicable manufacturers or GPOs [group purchasing organizations] under the Open Payments Program.

**Q:** How small a payment gets reported?

**A:** There is a reporting threshold for individual payments and an aggregate reporting threshold for the year. These thresholds moved up to $116.35 or higher, they must be reported even if the individual payments were below the $11.64 threshold. It’s important to note that these thresholds are being applied to the reporting entity, so the reporting requirement is on them. Physicians and other covered recipients need to know these thresholds so that they can identify any payments during data review that didn’t meet them but were still reported.

**Q:** Why is it important for physicians to review the data?

**A:** One good reason for physicians to review their data is that it will become public and visible to patients and other stakeholders. Patients may see data on the site and ask their physician about it, and physicians may not even be aware of some payments, particularly related to conference attendance or similar events that they may not consider a transfer of value. That’s what’s in it for the physicians. It’s also important that the Open Payments data is accurate and clear and accessible to the public. We want to make sure the data is as valid and reliable and timely as it can be for public use.

**Q:** When is data posted and available for review?

**A:** It’s a standard timeline on a yearly cycle. Industry collects the data for the duration of the calendar year and reports it to CMS between the start of February and March 31, our statutory reporting deadline. After that, every spring between April and May, there is a 45-day period, basically April 1 to mid-May, when the data is available for providers to review within the Open Payments System before it becomes publicly available.

The Open Payments System is available through the CMS Enterprise Portal, and registration is required. CMS maintains a covered recipients webpage that provides step-by-step instructions about how to access the Open Payments System and how to register. Once registration is complete, the provider will be able to see the data and take any actions on it, including filing a dispute, if necessary.

It’s best to handle reviews and disputes right after the data is reported for the first time and before it becomes publicly available. It’s also a good way to ensure as speedy a resolution as possible. If there are any issues, inaccuracies, questions, that is when reporting entities have the resources available and are monitoring any disputes or inquiries about the data.
Physicians should mark their calendars for April as a reminder to see if any relevant payments have been reported. They can also sign up to receive reminders from CMS about the review and dispute period via its Open Payments listerv. After the 45-day review and dispute period ends, the reporting entities have an additional 15-day period to make any changes or modifications to the data before publication.

Q: If a physician notices a mistake within that initial 45 days, is it generally corrected before the data is made public?
A: For the most part, reporting entities are responsive to disputes within that first 45 days and the additional 15-day resolution timeframe. It is the reporting entity who needs to make the correction. CMS does not take part in the process other than providing the software platform.

Q: What happens if a dispute is not resolved at the end of that 60 days?
A: The data goes public, and it’s marked as disputed, and it can be corrected later. If the dispute is resolved at a later time, the updated data point will be reflected in the next publication or data refresh. The initial yearly publication of the data takes place by the end of June each year, and a refresh happens once a year in January.

Q: If a physician finds a mistake in publicly posted data, what’s the process for correction?
A: We know that a number of covered recipients only look at the data when it becomes public, and then try to take action on it. The data remains available within the Open Payments System for review and dispute until the end of the year in which it was published. If a covered recipient notices an error on the Open Payments website before the end of the calendar year of that initial publication, they can still register and log into the Open Payments System and dispute the data there. In that case, we would go through the normal process and it would be updated in the next applicable publication year.

If they notice an error after the data is no longer available in the Open Payments System for review and dispute, they would need to contact the reporting entity directly. The legislation does require reporting entities to correct the data as soon as they learn of any omissions or inaccuracies, and the database supports that functionality year-round. CMS is not alerted to inquiries that happen outside of the Open Payments System, and CMS does not make any modifications to the data received. The compliance burden is entirely on reporting entities.

Q: How common are disputes and mistakes?
A: The dispute rate is very low, less than 1% of the data. The mistake rate is harder to pinpoint, because not everybody reviews their data prepresentation. We hope the low dispute rate reflects a low mistake rate as well, but it’s impossible to know without broader participation of the provider community in the review and dispute process.

More information about Open Payments, including an overview, reporting timeline, and FAQs, is available. Covered recipients can register for data review, learn how to review data, and find additional resources. ■

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**ACP’s Career Connection Summer Career Guide 2023**

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Sanjay Saint, MD, MPH, MACP, knows what it takes to be a great teaching attending, not just from experience, but from research on some of the country’s top medical educators.

“The word doctor is derived from the word docere, which in Latin means ‘to teach,’” he told attendees during his session at SHM Converge. “Our role as physicians is to teach patients, to teach family members, to teach each other, to teach ourselves. And so we thought studying physicians and how they taught would be very appropriate.”

The qualitative study of inpatient teaching focused on general medicine wards throughout the U.S. The researchers asked department chairs and other medicine leaders to identify exemplary, award-winning clinician educators. “We ended up getting 70-plus names from around the country,” said Dr. Saint.

The researchers narrowed the list down to 18 attendings who were diverse in their location, gender, and ethnicity, as well as varying in career longevity, hospital type, and training setting. They then visited each site to interview the educators and study them in their own habitats.

“A physician, sometimes more than one physician, and then a trained qualitative expert—in many cases, it was a medical anthropologist—went on rounds during teaching and sometimes even during other teaching sessions and observed what these individuals did,” said Dr. Saint, adding that the research team also interviewed the study subjects’ learners, 81 current and 43 former.

While some results were published in the December 2017 *Journal of Hospital Medicine*, his talk provided a more comprehensive rundown of the habits of great teaching attendings, many of which he adopted in his own practice, organized into three themes.

**Fostering positive relationships**

The attendings all recognized the importance of developing a teaching team that works well together, and this began on day one of a rotation, Dr. Saint said.

“One of the ways they did this, and this is pretty striking, is that they did introductions,” he said. “They went around the room—it didn’t matter where they were in the call cycle, how busy they were—they spent that 15 minutes or so asking everyone to share just a few things: who they are, where they went to school.”

The attendings then addressed team members by name. “They learned their names and how the team members wanted their names pronounced, and they made sure that they pronounced it correctly,” said Dr. Saint, who is the chief of medicine at the Veterans Affairs Ann Arbor Healthcare System, as well as a hospitalist and the George Dock Professor of Medicine at the University of Michigan.

They also asked trainees what they wanted to get out of their ward time together, he said. Another common practice was to throw in an icebreaker question, asking about team members’ favorite movie, favorite book, or something a little more creative.

“If you had two hours to do anything you wanted, what would that be? Other attendings have said things like, ‘If you have a superpower, please share that with the team,’” he said.

Attendings also used the first day of service to set ground rules and expectations for the rotation. One attending gave learners 10 “rules” describing tasks he likes the team to do during rounds, such as muting or turning off the TV and checking for decubitus ulcers every other day.

Dr. Saint has his own set of expectations for trainees to follow both by the bedside and away from it. “We’re going to treat every veteran as if they are a family member. That requires more work for us, but that’s what we do,” he said.

“The second goal is we’re going to learn a ton of medicine. That means we’re going to go home and read … attending included, and then we’re going to come back the next day and share with others some pearls of wisdom. And then the third is that we’re going to find joy. We’re going to do things either during the work day or when we get home to find joy.”

Speaking of life outside of work, the attendings made sure to learn more about their team members on a personal level, Dr. Saint said. “Attendings also felt more comfortable sharing their own life experiences—much more so than I would say my
attendings did when I was in training. And because of what I saw our exemplary attendings do, I feel more comfortable doing this as well,” he said.

The knowledge of what was happening outside of the hospital helped them to build a connection with the team. “One attending starts table rounds with music,” Dr. Saint said. “And the day we visited, he chose ‘The Waiting’ by Tom Petty, and the reason he chose that is one of the interns was awaiting the birth of his first child.”

When engaging with learners, patients, and families, the attendings were fully present, and frankness and honesty were common traits, he said. Given that women are sometimes perceived negatively when being assertive, one female attending gave her team a heads-up that she may look displeased while she’s thinking. “I thought that this was actually very helpful, and I appreciated that kind of honesty,” said Dr. Saint.

Attendings also tended to show vulnerability. “In fact, three of the most powerful words we heard attendings say: I don’t know. And they would say this to learners, they would say this to patients, and they would say this to families. … We heard one attending say, ‘I was wrong.’ They had said something the day before (we weren’t there), and they had to correct themselves while we were there,” Dr. Saint said.

The attendings worked to create a comfortable learning environment where team members could freely express themselves. Several even used nuanced humor to make rounds more informal and more enjoyable, Dr. Saint said.

“Self-deprecating humor often works very well, by poking fun at themselves. … One attending said this to his intern: ‘Talk to me like I know nothing.’ He wanted the intern to explain something to him,” he said. “And then he followed that up quickly with, ‘Thank you for not saying that’s how you always talk to me.’”

The attendings prioritized a safe environment for patient care. “In fact, one attending told us that the patient’s room is a sacred place, and it’s a privilege for us to be in there. And if we don’t earn that privilege, then we don’t get to go there,” Dr. Saint said. “This idea of a sacred place was kind of new and somewhat foreign to us. I had not really thought of it that way until the attending had mentioned this.”

**Patient-centered teaching**

Sir William Osler wrote that “The good physician treats the disease; the great physician treats the patient who has the disease.” It should be no surprise that the exemplary attendings fell into the latter category.

“One way of doing this is to prepare before rounds. … What we saw throughout our study is how much preparation our attendings did for the day,” said Dr. Saint. “They reviewed the medical records either the night before or the morning of, including new admissions.”

They didn’t do this prep work just to make rounds run more efficiently. “They would do this so they could anticipate possible stumbling points, where a test probably should have been done … and therefore could then help coach the team as to why we should do the lumbar puncture, for example, or a CT of the abdomen of this elderly patient with unexplained abdominal pain,” he said.

The attendings also used this opportunity to find pertinent articles to provide to the team. “They tended not to bring Xerox copies of those because … people tend to just kind of let stack them up. Instead, they would send the paper after rounds via email as a PDF,” Dr. Saint said.

The attendings also considered in advance how patients’ cases could enable them to make important teaching points, Dr. Saint said. “I would say this has really become kind of standard of care for attendings to read up about patients before rounds,” he said.

There were a variety of rounding structures. “The more traditional [one] and the one we probably saw the most was outside the room, where the presentation would be made, and then people would go in and most of the time, the attending would direct the interaction with the patient and family,” Dr. Saint said. “Other times would be table rounds, where they would discuss all the patients and then they would go in and see patients and families.”

The presentation styles varied as well, with E-SOAP being the most common. “But that tended to go very long: events overnight, subjective, objective, assessment and plan, and in the subjective and objective, we include all the lab data, imaging, and all the medications,” he said.

Sometimes they saw EAP rounds. “What I’ve actually done in my own style is do EAP rounds: significant events overnight and then assessment and plan by problem, where if there are any issues with the subjective and objective or lab data, that’s part of the assessment and plan by problem,” Dr. Saint said.

Another presentation style came up only once. “That was because a lot of the team members were off, and it was really the senior resident, one intern, and an attending, and that tended to be more colleague-to-colleague,” he said. “So it was more informal; however, the attending still made sure they brought up teaching points that were appropriate to that level of learner.”

Each of these approaches to rounding or presentations can be effective if done purposefully and methodically, Dr. Saint said, adding that this is another spot for thorough introductions.

“We did see all attendings go to the bedside with a team, at least for some of the patients. … They introduced the team, so each team member would say who they are and their role on the team, which helped patients and family members know who they’re speaking with,” he said.

Teaching moments were not restricted to rounds. “One of the things we noticed is that our attendings tended to use all moments to teach because time together is a teaching opportunity,” Dr. Saint said. “So when they would be walking from one patient to the next, when they would be in the elevator, when they would be in the stairwell, they were teaching.”

The attendings tended to be parsimonious with their teaching pearls, however. “They tended to make one teaching point per patient per day,” he said. “They didn’t make too many because that would overload the learners, but one per day was a manageable amount that could be memorable.”

In addition to teaching, the attendings fostered human connection while caring for patients, for example, by sharing feelings with trainees after an unexpected patient death or kneeling by the patient’s bedside, Dr. Saint said. “What else
did attendings do? They helped patients change positions during examinations. If they took off the socks, they put them back on. Humility, a smile, appropriate touch can be very powerful, and our attendings use these things liberally.”

Speaking of a smile, the attendings also tended to smile a lot, as evidenced by pre-COVID-19 attending snapshots Dr. Saint showed to attendees. “This is what they looked like when they walked in, when it was appropriate, in the morning with learners, with nurses, with pharmacists, with patients, with families. And because of mirror neurons, people tended to smile back also.”

**Collaboration and coaching**

Great attendings know that if there’s no stress, there’s little learning. But too much stress and anxiety aren’t conducive to learning either, Dr. Saint said.

“Moderate amounts of stress usually optimize learning or performance, and that’s where our attendings try to be, and they also realize that each learner has a different relationship between learning and stress.”

One of the ways the attendings optimized the amount of stress in the learning process was effective questioning, leading trainees to find their own path to knowledge. As one learner said about an attending, “I don’t know how she does it, but she teaches you without teaching you.”

“What we want to do as physicians is to ask questions, not to question someone. … [The attendings] asked team members to explain their answers to questions and how they make conclusions from a position of curiosity, not from a position of judgment,” Dr. Saint said.

Visual learning aids were also popular with the attendings, including one who brought along his own whiteboard and another who gave trainees handouts that were partially filled out. Another attending asked a trainee to pull up a chest X-ray and walk through it on rounds, he said.

“I thought all of these were terrific ideas, and in fact, I do that now with my iPhone,” Dr. Saint said, such as by showing trainees an electrocardiogram and asking one to name the rhythm and another to describe the treatment. “A learner said [the addition of a visual is] complete night and day in terms of being able to follow along and pay attention and be invested in what’s being taught.”

There were also some less quantifiable aspects of the great attendings. In a review published in the May 2008 *Academic Medicine*, researchers found that two-thirds of characteristics of outstanding clinical teachers were noncognitive. These relationship-based, noncognitive attributes were also key in the current study, Dr. Saint noted.

“A closing thought, and this actually comes from one of our attendings: ‘I think learners have to know that you love being a teacher without declaring it. It has to be obvious. They have to know you care about the craft … the craft of being a doctor,’” he said. “And in fact, that’s what our attendings shared. They were joyful in their choice of careers, and they’ve shown a great deal of gratitude that they could do something and get paid to help learners become the best doctors that they can be.”

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*From ACP Hospitalist, July 2021
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