We all remember that moment: our first day of medical school. In my case, I felt like that short white coat and the accompanying ceremony, filled with pomp and promises, was the reward for all the hard work I’d put in throughout high school and college. There was hope and excitement. It was all new, and I was ready for the challenge! I couldn’t wait to use my new stethoscope, cure my first disease, and take the first steps transitioning from Mr. Knight to Dr. Knight. What an honor; it almost brought me to tears. That was 20 years ago.

Things have changed—not just for me, but for most of us. American physicians are reeling. So many of our peers are unhappy, anxious, and scared for the future of the careers they fought so hard for. Recently, The Daily Beast labeled our vocation “the most miserable profession.” Why?

It’s hard to measure physician misery, something we’ll call burnout for the remainder of this series. An unwritten rule in the culture of medicine is that it’s taboo or thought of as weak to talk about our own problems. It’s a paradox: the doctors who suffer the most often speak-up the least.

Still, a recent Medscape “Physician Lifestyle Report” showed us that half of all plastic surgeons are burned out, and the numbers are rising. What’s worse, the same report signaled that between 10-12 percent of dermatologists and plastic surgeons rank as “severely burned out,” meaning that they’re contemplating quitting altogether.

A more recent Mayo Clinic Proceedings from December 2015 verified that more than half of US physicians are burning out, an almost 20 percent increase over four years. Even more daunting, the same report noted an 80 percent increase in suicidal ideation among doctors over the same time period. According to the Washington Post in 2014, nearly 400 doctors commit suicide annually.

Two plastic surgeons in my community took their own lives within the last year.

In this two-part series, we’re going to identify the signs of physician burnout and define the factors that lie behind this silent epidemic. I know this article is disheartening, but I hope it is illustrative.
In the fall, we’ll look at some tough choices we all need to make to tackle burnout and fight for our careers, our families, and our health.

I. “I'M OVERWHELMED! WHAT HAPPENED TO MY LIFE?”

This may surprise you: Dermatology and plastic surgery are unique in that most of us remain in independent small practices. We shoulder the heavy burden of federal bureaucracy more than our peers in other specialties. Our practices groan under the regulatory tsunami created by the ACA, HIPAA, MIPPA (PQRS), HITECH, and many other innocuous sounding acts.

The first edition of “The Federal Register,” a compilation of every regulation issued by each federal executive agency, was published in 1936. It was sixteen pages long.

Last year’s Register set a record at almost 82,000 pages. Among these pages, according to the Competitive Enterprise Institute, are 3,378 final rules and regulations, 545 of which have a direct impact on small businesses. These rules serve to encumber business owners, frighten hard-working doctors, and wrap our careers in red tape.

For those of us who accept insurance and perform higher-complexity procedures like Mohs surgery, there is significant anxiety over newer acronyms like VBM and MIPS. These are not abstract concepts. They will be here in a few years, and no one knows what that will mean for our careers.

Most us were forced to adopt EHR. Signing notes and pathology reports used to take five minutes. In talking to physicians, most say it now takes hours every night after clinic to perform the same task, routinely requiring them to stay at their offices until late in the evening, missing dinner and time with their families. Yet, the majority of doctors I speak with claim that EHR actually hampers patient care. In tandem, doctors find that staffing their clinic is much more difficult in the EHR era. Fleming, Culler et al reported in 2011 that “end users” of EHR (physicians and clinical staff) need an average of 134 hours per employee to prepare for use of their system, at an implementation cost of $162,000 for an average five-doctor group.

Meaningful Use and PQRS measures swarm around us like flies, irksome and serving no purpose. It’s become obvious to me that these requirements impede patient safety. I’ve labored over our SOPs for years. Now, my important guidelines get diluted by long, complicated, redundant electronic tasks that make us jump through arbitrary hoops placed there by bureaucrats. Stretched paper thin, how long until your staff misses something important?

Recently in Washington, DC, I sat down with a legislative aide for a local congressman and I was detailing how bureaucracy and regulation were driving independent doctors out of practice. Cutting me off mid-sentence, he said, “You know Dr. Knight, the insurance industry has been in my office every week for the past decade. The hospital groups and the trial lawyers, too. Where were you?” I was stunned. The answer, of course, is that I was caring for my patients. It’s hard to lobby Congress when you’re keeping 12-15 hour days at your medical practice.

Most doctors I speak with feel defenseless against the bureaucratic forces bearing down upon them. We spend our days going from exam room to exam room to OR, isolated from the rest of the world. Our families don’t eat unless we’re at the grindstone. Doctors have no opportunity to hobnob with our legislators over lunch or rounds of golf.

A few months ago, our estate attorney sent me a newspaper clipping from the Washington Post. She wrote at the top, “This sounds about right, I’m sorry.” It was an op-ed by Charles Krauthammer. Many of you probably know that Charles had a diving board accident during his first year at Harvard Medical School that left him paralyzed. He finished, took his psychiatry residency at MGH, but abruptly left medicine a few years later stating that he had, “chosen the wrong vocation.”

He wrote that upon attending his fortieth medical school reunion, he noted “an undercurrent of deep disappointment, almost demoralization, with what medical practice had become.” His classmates felt, “an incessant interference with their work, a deep erosion of their autonomy and authority, a transformation from physician to provider.”

We come in early and rarely get home before 7pm thanks to our new EHR programs. We go to bed exhausted and wake up tired and anxious, not ready to face the day ahead. We break even or make less every year, despite working harder, thanks in large part to unfunded government mandates that accomplish nothing.

It’s a recipe for burnout.

II. “I’M AFRAID OF MY PATIENTS”

I had dinner the other night with my neighbor, a well-liked plastic surgeon with more than 25 years experience and great skill.

I was surprised to hear him say how difficult it had become to find patients to perform surgery on. “Most patients,” he said, “come to me as a fourth or fifth opinion, beat me up over price, or skewer me over my online reviews.” One patient with obvious body dysmorphic disorder bashed him on the internet after he declined to perform surgery on her. She wrote something like, “this arrogant **** is too full of himself, I hope he breaks his fingers.”

Another colleague of mine, an orthopedic surgeon, was devastated when a patient alerted him to this one-star
For us, our careers and identities are interwoven. If someone complains about your restaurant’s tasteless hamburger on Yelp it’s a far cry from being called quack, jerk, or worse online for all to see. It hurts!

gem, “I didn’t know the D in MD stood for ******** ” (I’ll leave this to your imagination).

You can’t make everyone happy all the time. It’s a fact of life. Only 10 years ago, we could have shrugged off a rare unreasonable patient and moved on. Those days are gone. Now, anyone with an axe to grind (even non-patients and competitors) can broadcast negative reviews, often anonymously or under pseudonyms, across multiple domains without fear of retribution.

Many doctors I speak with allude to the same theme—a disconnection from their patients for fear of public rebuke or simple schoolyard mockery. One physician described this as existing in a “niceness bubble,” afraid to say anything that could be upsetting or controversial in any way.

There’s a reason that we took that white coat ceremony seriously, the same reason that we still call retired physicians “Doctor.” For us, our careers and identities are interwoven. If someone complains about your restaurant’s tasteless hamburger on Yelp it’s a far cry from being called quack, jerk, or worse online for all to see. It hurts!

Of course, there’s always the tangible risk that your phones will stop ringing because of a negative online review. Most doctors admit that this affects their medical decision making at the bedside. Are we more likely to give that patient the antibiotics they’re demanding but don’t need? Operate on a terrible surgical candidate because they’re upset they “came all this way to see you for nothing?” Smile through a 30-minute dissertation regarding 35 chief complaints—all of them somatic—in the middle of a packed clinic?

We find ourselves saying things to patients that we could have never imagined just a few years back, pandering for positive reviews. Sometimes even asking for them.

By now, we’ve all heard the adage “the solution to pollution is dilution.” At our office, we’ve employed various strategies toward this goal, ranging from little cards we give patients to “please review us” tear-offs for appointment reminders. There is no shortage of vendors that profess to have mastered the online review space. They haven’t.

Despite the calls from advocacy groups over the unfair/shady practices of online rate-your-business review sites, there are no changes on the horizon. Private companies are in no hurry to disclose their algorithms for the placement of positive/negative reviews and explain why certain reviews get suppressed. You don’t make money by rating doctors for free; some filmmakers have accused online ratings companies of outright extortion, suggesting they run a “mafia-style protection racket.”

Time will tell if these efforts, and last season’s South Park episode “You’re Not Yelping,” will resonate with consumers. My guess is no. My oldest friend, a well-educated bankruptcy attorney, wouldn’t think of visiting a restaurant, dry cleaner, or even doctor without checking the reviews first.

Are some doctors jerks? You bet! We all know someone who could benefit from empathy training.

But in researching this paper, one of our colleagues told me something that resonated: she feels as though her patients have become her enemies. She described constant anxiety in her practice, fretting that behind the next door lies a viper ready to strike at even a hint of dissatisfaction.

Today, medical/surgical outcomes are less important than “patient satisfaction.” This often means giving patients whatever they want and adopting a veneer of sugary sweetness.

We deal with important problems, and it took decades to learn our craft. Not getting it perfect in the era of “asymmetric rewards” can mean a lawsuit or board complaint. Not killing the patient with kindness at every turn, by every employee in your office, can lead to excoriating online personal attacks.

It’s heart breaking, and a leading cause of burnout.

III. “NO ONE CARES ABOUT MY EXPERTISE”

If you spend a good portion of your time treating skin cancer and accepting insurance like I do, you probably feel a disconnect between the quality of your practice compared with what you’re paid. In some states, Florida included, it’s suddenly normal for private insurers to pay doctors less than what the government pays—sometimes far less.

It’s a broken system when the best surgeon in town gets paid the same as the worst surgeon in town for the same work. Imagine the title partner in the law firm down the
street billing the same hourly rate as the most inexperienced junior associate, mandated by federal statute?
The lack of a free market in American healthcare means that, if you accept insurance, we can’t use price as a tool to help control our businesses. How many of us are offering a Ritz Carlton experience but get paid Howard Johnson rates by our patients’ insurance companies? The only way to grow your business in this model is to do it in volume like a discount warehouse shopping club. Of course, we’re not selling paper towels and sport socks. As volume goes up, quality goes down; many of us find this simply unacceptable. Our patients would, too.
So, like our peers who practice only cosmetic surgery, we offer services that pay cash. This trend has been fortified by the remarkable sudden popularity of in-office cosmetic procedures. According to ASPS data, cosmetic minimally-invasive procedures have increased 158 percent since 2000.
If you’re reading this article, you know the colossal overhead cost associated with owning and maintaining high-priced laser/cosmetic surgical equipment. You understand the astronomic acquisition and inventory costs of fillers and neurotoxins. You’ve spent countless hours mastering your technique, taking weekends away from your family seeking extra training. You demand safety and desire happy patients.
But it’s no secret that our services are increasingly commoditized. On every other street corner, spas and non-core providers offer the same services we do. Sure, many of these clinics are operating at the fringes of (or even outside) the law, but there’s little enforcement. Patients infrequently appreciate the difference between a board-certified physician and a cosmetologist injecting neurotoxin in the back of her salon for a third of what you charge.
Online daily-deal websites further trivialize our services. After all, who wouldn’t want filler at $200 a syringe or 95 percent off their laser hair removal? You can find these offers right next to deals for hot air balloon rides and laser tag.
Pilots saw this change in the 1980s. Anyone who’s seen “Catch Me If You Can” will remember the golden-age of commercial airline pilots. Society viewed them as stylish, larger-than-life heroes. Every child wanted to grow up to be a pilot. They commanded universal respect. Why? You and your family’s life depended on his/her skills and ability.
Today, no one cares who’s in the cockpit. Pilots rarely get a nod from passengers as they exit. They’re seen as an impediment to running on time, blamed for things out of their control (like jamming passengers in the fuselage like sardines), and often mistreated by the companies they work for.
Passengers don’t care who the pilot is, they just want the cheapest ticket, often sold through online bargain websites. Is this our future too?

IV. “WHY BOTHER?”
Most of us remain in private practice, grinding it out day after day, watching as the water table rises closer and closer to our noses. It’s panic-inducing. Suffocating.
We’re universally working longer hours and making due with less. Costs in our sector of the economy far outpace overall increases in the cost of living, alarming economists.
Small business owners form the backbone of our economy, yet we eat last. After running the gauntlet of fee reductions, poor patient collections, astronomic deductibles, overhead expense, payroll, licensure/fees, and taxes, we get to keep whatever is left over at the end.
Physicians are programmed to tackle challenges, and growing your business is no exception. But why would we bother hiring another doctor or open a new satellite office when most of us pay pass-through taxes above the corporate tax rate—already thought to be some of the highest rates in the world?
In Florida, dermatologists and plastic surgeons may find part of their business income falling into the top marginal federal tax rate, almost 40 percent. If you live in states that levy significant regional taxes, like California and New York, the rate can be more than 50 percent.
Then we pay property, excise, payroll, capital gains, sales, and a bevy of other taxes.
Despite shouldering the heavy weight of regulation, paying the overwhelming majority of taxes, and creating jobs that keep our communities strong, there’s often not a lot left over at the end of the month to help sustain our families.
Alarmingly, according to the 2014 Medscape “Physician Lifestyle Report,” 69 percent of dermatologists and 58 percent of plastic surgeons reported minimal savings to unmanageable debt.

V. NOT AS BLEAK AS IT SEEMS
Heraclitus wrote, “You cannot step twice into the same river.” Put in a more modern way, “Nothing endures but change.”
Every generation of American doctors has faced challenges that seemed insurmountable. In 1965 the New York Times proclaimed that doctors could be crushed under the weight of “M-day.” In the 80s and 90s we endured HMOs, capitation, and hospital consolidation.
As our world changes around us, we’ll learn to adapt and we will thrive. But it’s going to take effort, and we’re going to have to make some tough choices.
One thing is certain: we have to de-stigmatize physician burnout and put it in the spotlight.
In the second part in this series, coming in the fall, we’ll look at ways we can fight burnout—protecting our physical health, our mental wellbeing, our families, and our futures as physicians.