Joy Revisited

Jean Antonucci, MD

If we want joy in practice, we're going to have to try a different approach.

Things can seem pretty dismal in primary care these days, so plenty of folks have been offering advice on how to reinvigorate the joy of practice. Some have said we should slow down, pray, be mindful, or use laughter. Others have said it is more about how we run the office, so we should reduce our overhead (e.g., empty our own trash) and work to the top of our license (e.g., let someone else empty the trash).

I have a solo practice with a few staff that I use in innovative ways. I work in the third poorest county in a state that is 30th in per capita income. Over the last eight years my income has risen, and though I cannot make what an employed (i.e., subsidized) doc makes, I do OK. My quality is good and costs are low, and I spend a lot of time with my patients. I measure, tinker, and redesign continuously. I have a cool practice. I might have joy. Except.

Except that if we really want joy in the practice of a very tough job, and if we want to encourage young people to join us, then we need a better job and the tools to be successful.

Except that without simple, meaningful metrics for primary care, we end up reporting hundreds of meaningless measures (such as how many emails we have recorded and can pull out as a separate searchable data set), which don't help the systems we work in but make us work with two hands tied behind our back.

Except for the nonsense of coding and documentation requirements. Why are we grateful for transitional care codes that make us remember moderate versus high complexity, visits at 7 versus 14 days, and, oh, hold the bill for 30 days? How can we prevent readmissions if we are never told our patients were in the hospital?

Except for the varied information systems with multiple passwords that change every 90 days and support that can only be accessed through a real person who left at 4 p.m.

Except for the lack of interconnectivity between those information systems.

Except for the barriers created by CDC rules about vaccine transfers between practices.

Except for manufacturers whose medications come in 10-dose vials only, so we waste nine doses because the medication, once used, is less potent at 30 days.

Except for specialists who will not schedule when we call but grade our referral information instead.

Except that we work in a non-system where money is always in the room and often prevents patients from getting what they need.

But we are not even amazed anymore. We are inured to absurdities, and learned helplessness prevails.

To restore our joy, we need deep change, and we need to be the ones to make it. Instead of making nice because our work is relationship based, we need to speak up. Let's advocate for systems that work without us having to find workarounds or spend Sundays to learn them. Let's tell our employers to manage panel sizes and improve access, and stop heading us to burnout. Let's insist on small teams that design their work together. Let's reject more check boxes in less time. Let's help independent doctors to share data so they can have a voice. Let's recognize that many of them are innovative and nimble and deserve support, not criticism. Let's focus on meaningful measures like access, cost, and patient experience. Let's stop getting stuck on form versus function. Isn't it about the patients?

A friend recently reminded me that transformative change does not occur absent a supportive environment. Doctors must "take back the night" as the women's movement said. It is time to expect accountability, not from us to measure the minutes it takes to pick up the phone, but from the powers-that-be to enable us to have the time to talk to the person on the other end. It just doesn't matter who empties the trash. FPM

About the Author

Dr. Antonucci, a family physician, is in solo practice in Farmington, Maine. She wishes to acknowledge L. Gordon Moore, MD, for his mentorship and permission to borrow key phrases. Author disclosure: no relevant financial affiliations disclosed.

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