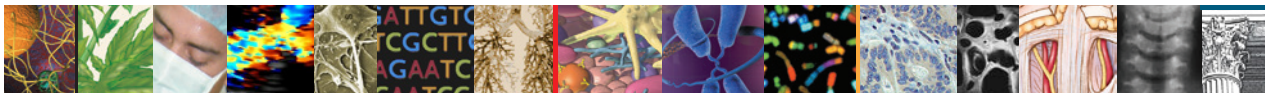

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

MARCH 23, 2017

Kathryn

David Muller, M.D.

On Wednesday, August 17, 2016, at about 5:15 in the morning, Kathryn, one of our fourth-year medical students, ended her life by jumping out of her apartment window. She was found minutes later by a small group of surgical interns who were headed to the hospital to attend rounds for their patients. One of her classmates, on his surgery subinternship, was with them. They began an effort to resuscitate her that continued, and ultimately ended, in our emergency department (ED). The classmate who had participated in the initial resuscitation efforts called Kathryn's father as soon as she arrived in the ED to let him know that something terrible had happened. By the time her father called back, the resuscitation efforts were over and his daughter was dead.

In the hours that followed, our school was rocked by waves of anguish, anger, and frustration, guilt, fear, and profound sadness. Our new first-year class woke up that morning expecting to attend day 3 of medical school. As dean for medical education, I, along with my team, had spent most of orientation talking to them about well-being and self-care, the human side of medicine, and the importance of balancing social good with scientific progress and clinical excellence. We reinforced their expectations of a school that would care for them as people and teach them to do the same for their patients. Given all the anticipation, nervous energy, self-doubt of those first few days and the bravado required to survive them, I can't imagine what it must have felt like to be introduced to medical school with a suicide.

The next 48 hours were a whirlwind. We put 24/7 emergency mental health services in place, had two town-hall–type meetings for all students and one with the first-year class, we worried about copycats, communicated with parents and alumni, and tried to process the feelings of guilt at not having done enough to prevent something like this from happening.

At the meetings there were students who publicly expressed their rage at not feeling adequately supported, at being ignored when they had been working so hard to provide us with feedback and suggestions, at knowing that they and their friends were also struggling with depression, anxiety, and suicidal ideation. There were also many students who privately expressed their gratitude for a school that they believed made

extraordinary efforts to support their well-being, delivered on its promises, and was constantly striving to improve. Kathryn's closest friends gathered at a vigil that first evening to share memories and experiences of her brief but very full life.

I spoke to Kathryn's parents soon after she died and stayed in touch with them throughout the first few days. The day after Kathryn's death I accompanied her mother to the medical examiner's office so that she could identify her daughter's body. Afterward, she asked if we could travel uptown to see Kathryn's apartment. An hour later, I found myself standing silently in the doorway to Kathryn's room, staring at the open window, sensing its terrifying allure, and trying hard not to imagine what it must have felt like to take that final step out.

Kathryn's mother was distraught. I had mentally prepared myself for all sorts of scenarios: a total breakdown, angry accusations and finger-pointing, a shocked numbness. Instead, through her tears she asked me questions that I hadn't expected at all: How are the other students? How are her roommates? How is everyone at the school coping with this?

I don't know where she found the presence of mind to think about anything other than her unspeakable loss. I am also humbled when I think of all the people, students in particular, who approached me to ask how I was doing, or sent e-mail messages expressing their concern for me and for the other members of our administrative team.

"How are you?" used to be the day's most mundane question, something to say when you couldn't think of any other way to pass the time in the elevator or acknowledge someone passing by in the corridor. Now, it took on extraordinary meaning and usually ended with a hug or eyes brimming with tears, an outpouring of love, compassion, and empathy. "How are you?" tightened the bonds of our intimate community of teachers, students, and staff.

Countless colleagues from around the country sent us documents and data, and they shared personal experiences of coping with suicides of medical trainees, as well as heartfelt condolences and good wishes. Scores of our students offered to volunteer their time and expertise to help enhance our support and resources. We have convened a task force charged by our dean that will address some important gaps. What else can we do to improve student well-being? How can we eliminate the stigma of asking for help? How much staffing do we need to expand access to mental health care? Why don't we implement an opt-out policy that sets an expectation for every student and resident to have an annual mental health assessment?

All these questions will have to be addressed, and the answers incorporated into whatever plan we propose to implement. But in my opinion they will fall far short of addressing one of the root causes of this national epidemic of burnout, depression, and suicide[1]: a culture of performance and achievement that for most of our students begins in middle school and relentlessly intensifies for the remainder of their adult lives. Every time students achieve what looks to the rest of us like a successful milestone — getting into a great college, the medical school of their choice, a residency in a competitive clinical specialty — it is to some of them the opening of another door to a haunted house, behind which lie demons, suffocating uncertainty, and unimaginable challenges. Students bravely meet these challenges head-on while we continue to blindly ratchet up our expectations.

From their very first shadowing experience to their first foray in the lab; from high school advanced-placement courses and college admissions tests to grade point averages and the Medical College Admissions Test (MCAT); with helicopter parents, peer pressure, violins and varsity soccer, college rankings, medical school rankings, medical licensing exams, and the residency Match, we never let up on them — and it's killing them.

At Icahn School of Medicine, we will significantly enhance mental health and well-being resources for our students. But we have also committed ourselves to a genuine paradigm shift in the way we define performance and achievement. We must minimize the importance of MCAT scores and grade point averages in admissions, pull out of school ranking systems that are neither valid nor holistic, stop pretending that high scores on standardized exams can be equated with clinical or scientific excellence, and take other bold steps to relieve the pressure that we know is contributing at least to distress, if not to mental illness, among our students.

I recognize that all of us — students, parents, pre-medical and post-baccalaureate programs, undergraduate and graduate med-

An audio interview with Dr. Stuart Slavin is available at NEJM.org

ical education, the Association of American Medical Colleges, the U.S. Medical Licensing Examination, and the American College of Graduate Medical Education — will have to band together if we want to change this culture. I believe it is imperative that we do so before another precious life is lost.

Published with permission from Kathryn's family.

Disclosure forms provided by the author are available at NEJM.org.

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Breaking the Stigma — A Physician's Perspective on Self-Care and Recovery

Adam B. Hill, M.D.

My name is Adam. I am a human being, a husband, a father, a pediatric palliative care physician, and an associate residency director. I have a history of depression and suicidal ideation and am a recovering alcoholic. Several years ago, I found myself sitting in a state park 45 minutes from my home, on a beautiful fall night under a canopy of ash trees, with a plan to never come home. For several months, I had been feeling abused, overworked, neglected, and underappreciated. I felt I had lost my identity. I had slipped into a deep depression and relied on going home at night and having a handful of drinks just to fall asleep. Yet mine is a story of recovery: I am a survivor of an ongoing national epidemic of neglect of physicians' mental health.

In the past year, two of my colleagues have died from suicide after struggling with mental health conditions. On my own recovery journey, I have often felt branded, tarnished, and broken in a system that still embroiders a scarlet letter on the chest of anyone with a mental health condition. A system of hoops and barriers detours suffering people away from the help they desperately need — costing some of them their lives.

Last year, I decided I could no longer sit by and watch friends and colleagues suffer in silence. I wanted to let my suffering colleagues know they are not alone. I delivered a grand-rounds lecture to 200 people at my hospital, telling my own story of addiction, depression, and recovery. The audience was quiet, respectful, and compassionate and gave me a standing ovation. Afterward, hundreds of e-mails poured in from people sharing their own stories, struggles, and triumphs. A floodgate of human connection opened up. I had been living in fear, ashamed of my own mental health history. When I embraced my own vulnerability, I found that many others also want to be heard — enough of us to start a cultural revolution.

My years of recovery taught me several important lessons. The first is about self-care and creating a plan to enable us to cope with our rigorous and stressful work. Personally, I use counseling, meditation and mindfulness activities, exercise, deep breathing, support groups, and hot showers. I've worked hard to develop self-awareness — to know and acknowledge my own emotions and triggers — and I've set my own boundaries in both medicine and my personal life. I rearranged the hierarchy of my needs to reflect the fact that I'm a human being, a husband, a father, and then a physician. I learned that I must take care of myself before I can care for anyone else.

The second lesson is about stereotyping. Alcoholics are stereotyped as deadbeats or bums, but being humbled in your own life changes the way you treat other

people. An alcoholic isn't a bum under a bridge or an abusive spouse: I am the face of alcoholism. I have been in recovery meetings with people of every color, race, and creed, from homeless people to executives. Mental health and substance-abuse conditions have no prejudice, and recovery shouldn't either. When you live with such a condition, you're made to feel afraid, ashamed, different, and guilty. Those feelings remove us further from human connection and empathy. I've learned to be intolerant of stereotypes, to recognize that every person has a unique story. When we are privileged as professionals to hear another person's story, we shouldn't take it for granted.

The third lesson is about stigma. It's ironic that mental health conditions are so stigmatized in the medical profession, given that physicians long fought to categorize them as medical diagnoses. Why do medical institutions tolerate the fact that more than half their personnel have signs or symptoms of burnout? When mental health conditions come too close to us, we tend to look away — or to look with pity, exclusion, or shame.

We may brand physicians who've had mental health conditions, while fostering environments that impede their ability to become and remain well. When, recently, I moved to a new state and disclosed my history of mental health treatment, the licensing board asked me to write a public letter discussing my treatment — an archaic practice of public shaming. Indeed, we are to be ashamed not only of the condition, but of seeking treatment for it, which our culture views as a sign of weakness. This attitude is pervasive and detrimental — it is killing our friends and colleagues. I've never heard a colleague say, "Dr. X wasn't tough enough to fight off her cancer," yet recently when a medical student died from suicide, I overheard someone say, "We were all worried she wasn't strong enough to be a doctor." We are all responsible for this shaming, and it's up to us to stop it.

The fourth lesson is about vulnerability. Seeing other people's Facebook-perfect lives, we react by hiding away our truest selves. We forget that setbacks can breed creativity, innovation, discovery, and resilience and that vulnerability opens us up to personal growth. Being honest with myself about my own vulnerability has helped me develop self-compassion and understanding. And revealing my vulnerability to trusted colleagues, friends, and family members has unlocked their compassion, understanding, and human connection.

Many physicians fear that showing vulnerability will lead to professional repercussions, judgment, or reduced opportunities. My experience has been that the benefits of living authentically far outweigh the risks. When I introduced myself in an interview for a promotion by saying, "My name is Adam, I'm a recovering alcoholic with a history of depression, and let me tell you why that makes me an exceptional candidate," I got the job. My openly discussing recovery also revealed the true identity of others. I quickly discovered the supportive people in my life. I can now seek work opportunities only in environments that support my personal and professional growth.

The fifth lesson is about professionalism and patient safety. We work in a profession in which lives are at risk, and patient safety is critically important. But if we assume that the incidence of mental health conditions, substance abuse, and suicidal ideation among physicians is similar to (or actually higher than) that in the general population, there are, nevertheless, many of us out there working successfully. The professionals who pose a risk to patient safety are those with active, untreated medical conditions who don't seek help out of fear and shame. Physicians who are successfully engaged in a treatment program are actually the safest, thanks to their own self-care plans and support and accountability programs.

Instead of stigmatizing physicians who have sought treatment, we need to break down the barriers we've erected between our colleagues who are standing on the edge of the cliff and treatment and recovery. Empathy, unity, and understanding can help us shift the cultural framework toward acceptance and support. Mentally healthy physicians are safe, productive, effective physicians.

The last lesson is about building a support network. My network has been the bedrock of my recovery. You can start small and gradually add trusted people, from your spouse and family to friends, counselors, support groups, and eventually colleagues. Then when you fall flat on your face, there will be someone to pick you up, dust you off, and say, "Get back out there and try it again." A support network can also hold you accountable, ensuring that you remain true to your own personal and professional standards.

Without question, my own successful recovery journey has made me a better physician. My newfound perspective, passion, and perseverance have opened up levels of compassion and empathy that were not previously possible. I still wear a scarlet A on my chest, but it doesn't stand for "alcoholic," "addict," or "ashamed" — it stands for Adam. I wear it proudly and unapologetically.

An audio interview with Dr. Stuart Slavin is available at NEJM.org

When a colleague dies from suicide, we become angry, we mourn, we search for understanding and try to process the death . . . and then we go on doing things the same way we always have, somehow expecting different results — one definition of insanity. It's way past time for a change.

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Adopting Innovations in Care Delivery — The Case of Shared Medical Appointments

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Transformative innovations in care delivery often fail to spread. Consider shared medical appointments, in which patients receive one-on-one physician consultations in the presence of others with similar conditions. Shared appointments are used for routine care of chronic conditions, patient education, and even physical exams. Providers find that they can improve outcomes and patient satisfaction while dramatically reducing waiting times and costs.[1] Patients benefit from interacting with their peers and hearing answers to questions that may be relevant to them. Doctors avoid repeating common advice, which improves their productivity and enables higher-quality interactions with individual patients. Increased system capacity reduces waiting times even for patients who opt for traditional one-on-one appointments. Shared appointments have been used successfully for over 15 years at the Cleveland Clinic, in the Kaiser Permanente system, and elsewhere.

Shared service delivery isn't a new concept. Group interventions are common for primary prevention (e.g., encouraging smokers to quit) and secondary prevention (e.g., helping patients with chronic obstructive pulmonary disease to avoid complications). Group-based programs such as Alcoholics Anonymous and Weight Watchers allow people to acknowledge that they have a problem and start working toward solutions. PatientsLikeMe connects patients to peers with similar conditions. Mental health support groups — for people with depression or anxiety, for example — are common. Yet these interventions are rarely led by doctors.

Given the effectiveness of group interventions, why aren't doctors routinely using them to treat physical and mental conditions? We believe four crucial components are missing: rigorous scientific evidence supporting the value of shared appointments,[2] easy ways to pilot and refine shared-appointment models before applying them in particular care settings, regulatory changes or incentives that support the use of such models, and relevant patient and clinician education. Such enablers are necessary for any highly innovative service-delivery model to become standard.

First, like most delivery models, shared medical appointments aren't easily amenable to randomized, controlled trials. Patients like to decide for themselves how they'll see their doctor. And unlike a study drug and identical placebo, shared and one-on-one appointments differ visibly from one another.

In the social sciences, randomization is often impractical. Researchers can't randomly provide schooling to some children and deny it to others to estimate education's effect on earnings. Social scientists have cracked this selection problem by exploiting sources of "random" variation in the treatment variable. For example, whether a child's birthday falls before or after an arbitrary cutoff date often determines the age at which he or she can enter first grade. This policy creates random variation in years of education among children who drop out after the compulsory schooling

period, permitting analysis of the effect on earnings of an extra year of education.[3]

Similarly, in health care, researchers can't randomly assign hospitals to adopt or refrain from adopting electronic medical records (EMRs), and a correlation between EMR adoption and improved outcomes doesn't imply causality. But economists have taken advantage of a source of random variation in EMR adoption — state medical privacy laws — to show that EMR use reduces infant mortality.[4]

Contextual knowledge enables customization of care delivery. Shared medical appointments at a poor, inner-city health care facility will look different from those in a wealthier suburban setting: the two facilities might have different no-show rates, require different communication approaches, and need to address different opportunities for patients to make lifestyle choices. In-depth observational studies and use of patient-reported outcome measures that can highlight subtle contextual variation will allow health systems and individual physicians to tailor shared appointments to specific patient populations.

Although experimentation is more complicated outside the laboratory, innovative providers of "high-touch" services find ways to perform pilot studies of new delivery models or conduct simulations. Intuit, a U.S. company that provides tax software, traditionally relied on high-paid advisors to answer customers' questions. One year, two Intuit employees suggested setting up a website where customers could answer each others' questions — a seemingly cavalier idea, given that clients can be jailed for filing their taxes incorrectly. Yet Intuit found a way to test this idea in a narrow submarket where there was little chance of contaminating its brand. The website was a success and is now available nationally, with features to minimize liability risk. It has essentially allowed Intuit to change the boundaries of its service — what the provider, the client, or another entity does to solve a client's problem.[1]

Shared medical appointments change the boundaries of health care services because fellow patients, rather than only the doctor, can provide information and support. The Aravind Eye Hospitals network in India is experimenting with shared appointments for glaucoma. Aravind first tested the concept without disrupting clinic workflow by offering shared counseling to patients who were waiting between tests during their regular glaucoma appointments. Seeing its potential, they ran two pilots with a doctor on a weekend, gathered feedback, and refined the concept. They then introduced shared appointments on Friday afternoons, when their workload was lightest.

Although firms routinely use simulation to preview how new delivery models will affect productivity and waiting times, simulation as a substitute for experimentation is underused in care delivery. When designing Terminal 5 at Heathrow Airport, British Airways used simulation to model how the number of self-service check-in kiosks would affect waiting times at manned check-in desks. Similarly, simulation can show how the number of weekly shared appointments at a clinic will affect waiting times even for patients attending traditional one-on-one appointments.

With any new delivery model, regulation and participation incentives influence uptake. E-learning allows universities to expand their reach, but professors may balk at new teaching methods. To address their hesitation, some universities reward faculty for developing online content. Clinicians managing shared appointments can often charge payers for each patient at the same hourly rate used for one-on-one appointments. Advertising this incentive should increase uptake.

But even with adequate incentives, providers worry that patients may reject new care models. Once there is solid evidence supporting shared appointments, regulators can make them standard for certain conditions, while allowing one-on-one appointments for individual patients as needed. Sweden has implemented substitution of generic for brand-name drugs, but providers can request reimbursement for brand-name versions for specific patient needs. Single-payer systems or government insurance programs could use a similar approach for encouraging shared appointments. Charges for shared appointments could then be adjusted in order to distribute the savings they generate between payers and providers.

Finally, patient education could stimulate interest in shared appointments. Businesses that can profit from changes in customer behavior invest in client education. Even for mundane tasks such as using automated checkout machines at the grocery store, offering initial assistance accelerates

adoption. Education can also help clients adjust to new delivery modes and locations. Offering a single trial of a service — such as a new type of fitness class — can dramatically influence a potential customer's adoption.

When altering an interaction as unstructured and personal as a doctor visit, patient education is critical. Many patients may hesitate to participate in a shared appointment for their annual physical, imagining that they would meet fellow patients in their underwear. In fact, in a typical shared physical for female patients at the Cleveland Clinic, the doctor performs pelvic and breast exams and discusses test results with each patient in private. The remainder of the appointment is conducted as a shared appointment. By sitting in on shared appointments as unbilled observers, patients can experience for themselves the less tangible benefits of peer interaction.

Doctors also need education. Large health care organizations could experiment with new care models and invite doctors within their system to observe and learn.

Indeed, these needs apply to all new delivery models: to accelerate their adoption, we will need to embrace new strategies for collecting evidence on their outcomes; find safe, quick, and cheap ways to experiment; offer incentives to providers; and educate stakeholders.

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Patient Inducements — High Graft or High Value?

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In May 2016, Uber announced a partnership with the Southeastern Pennsylvania Transportation Authority (SEPTA)[1] to provide discounted ride-sharing services to "bridge the first and last mile gap" and encourage people to ride the regional rail system. It was a potential win for all — increased ridership for Uber and SEPTA, decreased traffic and pollution. The partnership was lauded for testing an innovative way to advance social goals.

Contrast this partnership with one that might be arranged in health care. For instance, a partnership between a health system and a ride-sharing service to provide free rides for patients with transportation barriers might help elderly patients with disabilities or those with limited transportation options get needed care.[2] However, it might be illegal.

Two federal laws prevent health care providers from using inducements to increase demand for care or encourage selection of one provider over another. Under the Anti-Kickback Statute, no provider or institution receiving federal dollars can offer anything of financial value that may increase referrals for either their publicly or privately insured patients. Violators risk criminal penalties and substantial fines per kickback under the Civil Money Penalty Law. That law allows some incentives for care, a "nominal value exception" of no more than $15 per item or $75 per year per patient. Triggers for investigating fraud have a low threshold: increasing referrals doesn't have to be the primary reason for providing the service or good — it just needs to be one possible reason or consequence.

But two recent changes in health care invite new thinking. First, these laws were enacted when health care financing largely involved patients who receive care, physicians and hospitals who provide care, and insurance companies (and the government or employers behind them) who pay for care. The same stakeholders exist today, but rearrangements in how the money flows have changed who is at financial risk for what. For example, as the financial risk for care is redistributed toward providers with bundled payment and readmission penalties, it makes less sense to retain harsh penalties for inducing patients to seek care.

Second, along with these shifts, health systems have had financial reason to develop new approaches to improving outcomes. Services such as providing low-salt food parcels for patients with heart failure and safe housing for patients with addiction — services that would never have been considered under traditional payment models — are now seen as potential ways to avert readmissions and associated penalties.[3] A recent large, randomized trial revealed that financial incentives shared by patients and physicians can lead to substantial improvement in lipid management in patients with high cardiovascular risk.[4] Such incentives are precisely what the relevant statutes were designed to prevent, because they may be seen as inducements to seek services. And yet if it makes sense to pay for the statins that patients need, it may also make sense to offer patients financial incentives to take them. And if those incentives are acceptable because they help achieve the patient outcomes we want, should it matter who pays them?

It might. Even as we recognize that poor medication adherence greatly limits the management of chronic disease, we might worry if pharmaceutical companies began paying patients to take their drugs. Indeed, coupons from pharmaceutical companies that reduce patients' out-of-pocket expenses are prohibited in government insurance programs. What makes coupons unacceptable (even if their use is legal in commercial markets) is that they reduce both patients' incentives to seek value and companies' incentives to make price concessions.[5] We might worry less about such consequences if insurance companies were the ones paying patients to take their medications — because, presumably, they would make such payments only under circumstances of high value.

The same considerations seem relevant for health care providers. If a health system gives free rides to patients for surgical treatment of varicose veins, a payer or a competitor may cry foul because vein stripping is profitable and free rides may induce demand or divert clients. Rather than using profit or unfair competition as the primary metrics, a more socially constructive distinction might be whether the service is high value. If the procedure is indicated and the price is right, as it might be for a screening colonoscopy, what's the problem with sending a private jet? If, however, we are providing colonoscopies at exorbitant costs or to people who don't need them, then offering a transportation inducement seems problematic.

The Department of Health and Human Services adopted a new safe-harbor provision in December that was intended to clarify the rules and permit health care providers to pay for certain forms of ride-sharing services. Though the provision is intended to ease restrictions, it focuses on the cost of the ride, who is eligible for it, and the types of cars that can be sent. It also prohibits marketing the services. What drives the new approach is still concern over inducing demand without distinguishing between high- and low-value care.

Some health systems have avoided the perception of inducement with some logistic gymnastics. The website of Medstar Health in Maryland provides a link to advertise the option to use ride sharing for appointments but probably escapes the anti-kickback statutes by not paying for the rides. Hackensack University Medical Center in New Jersey does pay for rides — but only the rides home, perhaps because a ride to the medical center for specific services might look like an inducement, but a ride away for patients in general might not. In collaboration with Lyft, we are studying the impact of ride-share–based medical transportation on attendance at primary care appointments. Our lawyers advised us that Lyft Plus and Premier are luxury vehicles and therefore prohibited inducements.

Uncertain and overlapping motivations make it hard to judge these programs. Some services and incentives help patients receive high-value care by overcoming barriers they couldn't otherwise surmount. Others may unleash demand for low-value care that generates high profit margins for providers.

So perhaps we should instead consider their ability to achieve what we want to achieve. We believe that if inducements support the receipt of high-value services, they shouldn't be viewed negatively. And if an institution provides transportation, thereby encouraging participation, raising satisfaction, and wooing patients from competitors, that's positive, too — as long as we know that the services being encouraged provide benefit at reasonable and competitive prices. Under these circumstances, we might be applauding inducements, just as people applauded the deal made

between Uber and SEPTA. It's only the fact that we often can't agree on what is high value that makes it easier just to condemn all these strategies as forms of graft. But in doing so, we also limit our ability to test them.

What to do? We could increase the dollar limits, hoping for more high-value inducements and fewer low-value ones. We could judge inducements by who pays for them, reasoning that graft is less likely when inducements come from parties with greater risk sharing. Or we could judge inducements by the kind of care they support — not at the level of each individual service, which might be impossibly burdensome, but by modifying the safe harbors to include broadly categorized high-value services, such as recognized prevention. Any of these approaches seems better than what we have. After all, sweeping prohibitions against patient inducements never really made sense, in our view, because sometimes it's good to get patients to seek care.

Our improved understanding of the forces influencing patient behavior helps us reimagine currently prohibited inducements as tools for driving high-value care, not just engines of fraud or value-empty demand. New considerations could free health care institutions to provide incentives or services with the purpose of improving overall health, even if it means inducing patients to seek care. Applying value-based criteria to inducements is challenging. But so much of health care financing is moving toward value-based assessments — we might as well bring inducements along for the ride.

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