**Bold conversations: Elephant in the exam room**

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Hi there. It's doctor Nicole. I'm excited to share my presentation from the twenty twenty four PI conference entitled The Elephant in the Exam Room, what your doctors wish you knew. In this very vulnerable and transparent presentation, I had an opportunity to share my personal and professional challenges as well as the challenges of many physicians and healthcare providers as we manage this conflict between wanting to provide the most appropriate, high quality, excellent care that you deserve in the context of a severely broken healthcare system. I hope that you enjoy it and we look forward to your feedback.

It is my absolute honor and pleasure to be here with you today. And I'm gonna start by being very vulnerable and gonna be vulnerable throughout this entire presentation. But when Megan and the team at IDF asked me to give this talk, there was some reticence on my part because over the last two or three years that I've worked with IDF, I've had to amazing opportunity to learn so much more about primary immunodeficiency. As a pediatrician, it's something that, you know, we don't see. As you all know, we don't see many cases of this in practice.

And so I've learned so much and I've had so many opportunities to talk with many of you before the conference. Certainly, during this conference I've said at lunch tables and dinner tables and and then the amazing documentary that we all watched last night. And so there's been this red sense on my part because I know the struggles and the challenges and the journey that you all face and I know the frustrations that you have with doctors and yet I'm being asked to basically tell you how our life sucks. So bear with me. You know, this I do wanna say this is not meant to be a great session, and certainly this is not meant to minimize in any way all of the challenges that you all face.

But ultimately, my hope is that we can all connect on a heart to heart level so that you understand us better and that my colleagues and I understand you better. So I'm gonna start with the question. What do you know about your doctor? So I like each of you in the room. Think about the last doctor that you saw.

And if I were to run a contest right now and say, lineup in the center, if you could tell me three things about that last doctor that you can't find on their website or on a physician directory. How many of you would be able to get and I don't have any gift cards or any domain. But, okay, I see quite a few hands. That that is absolutely reassuring. The reality is that many of us don't really know much about our doctors.

There's a lot that we as physicians keep hidden in our hearts and in our minds for lots of reasons that we're going to be talking about today. So the reality is that I wouldn't be on this stage talking with you. Meghan shared that I have my own company as a professional

health advocate. I am a pediatrician. I no longer practice clinical medicine.
I guess that's another disclaimer for this talk. But I literally wouldn't be here on this stage if it wasn't for a doctor's appointment. And it wasn't just any doctor's appointment. It was literally the doctor's appointment that completely changed my life and that changed my entire professional career trajectory. And it was my dad's doctor's appointment.
And so this is my dad. His name was John. He's pictured there on the screen on the left. And in twenty ten, fourteen years ago, my dad had a lot of chronic medical conditions and pretty much it was this perfect storm and everything got worse as health started to rapidly decline. And my two older sisters who were pictured on the ends of that picture in the upper right, We had to rather abruptly jump in and begin caring for our dad.
And it was like an episode of undercover boss. It was frustrating. It was angering. It was challenging. And I would like to say, and I believe this is true, that I was a very empathetic physician before my caregiving journey, but I can tell you that I learned so much while caring for my dad and being on what I call the other side of the step scope and just being in those medical appointments.
And so the three of us were taking care of our dad, and we struggled a little bit like caregivers often do. And then ultimately, we decided to kind of assign roles based on our areas of expertise. And so me being the doctor and the family, I became the one that was in charge of overseeing his medical care. So practically, what that meant is that I would go to his medical appointments. I would go try to sit at his bedside when he was in and out of the emergency department, which I'm four he was a lot.
When he would be hospitalized, I would be at the bedside there as much as possible. I was communicating with members of his medical team. And ultimately, what I found over and over again is that I had to advocate very, very fiercely for my dad. And so going back to this doctor's appointment that changed everything. When I first started going to with my dad to the hospital, to the emergency department, I didn't share what I did for a living because I didn't think that that should have been important.
And so there was one day early in the caregiving journey where I accompanied my dad to see his cardiologist. And he knew his cardiologist well. They had a rapport. He had been seeing this this doctor for probably over ten years. And so this was my first time though, accompanying him to the appointment.
So we get to the office and as you all are well aware, and you've experienced many times. It's crowded. Everybody's running behind. We check-in at the front desk. We sit down in the waiting room, which was quite full.
And his appointment time comes and goes, and we're still sitting and waiting. And then eventually, we're taken to the back, to the room, and then we wait a little bit longer. And then his doctor comes in, and the appointment goes really quickly. And before I know it, the doctor is getting up and heading to the door. But there were like four or five significant

concerns that my dad had expressed to me on the drive there, none of which my dad brought up during this appointment.
And so I have been sitting quietly just trying to listen and take notes. But at this point, I intervened and I said, you know, hey, and I started to go through this list of concerns that my dad had, concerns that I had. And I watched the doctor's face go from smiling and being kind of welcoming to like literally annoyed, I could see anger behind his eyes, and and quite a bit of frustration. And he essentially ignored my concerns and continued to progress towards the door Until in a moment of frustration, I explained to him that I was a physician. And everything changed.
He literally his face softened. He walked back to the to the exam room. He sat down. He leaned in. And he was much more interested in my in my concerns.
We had a whole dialogue. And while that particular experience went well for my dad, it was a pivotal moment for me because one, it showed me that my ability to advocate for my dad was largely dependent on my role as a physician. And that frankly made me very angry because I know that most patients and most family caregivers don't have someone in the family who happens to be a medical doctor. Fast forward, that's what ultimately led to me leaving clinical medicine and becoming a professional health advocate. But when I tell this story and I tell this story often, I usually tell it from the family caregiver perspective.
My anger how I felt being dismissed and ignored. And as I was preparing for this talk, for the very first time I reflected on what that experience may have been like for the doctor, how must he have been feeling that day knowing that he had a full waiting room that he was running twenty, thirty plus minutes behind, that likely each room that he walked into, there was a frustrated patient, maybe a frustrated family member like myself. How many emails might he have had in his inbox? Waiting to be answered. How many prior authorizations which we've been hearing a lot about this weekend might have been waiting for him?
And then on a personal note, what might have been going on in his personal life might have had a death in the family made, I mean, he had been dealing with a child who's struggling in school. And so I say all that just to say that there are lives, that all of us are living outside of the examination room. And I'm thankful that during this talk, I had this opportunity to really start to reflect on some of the challenging experiences that I've had and to really start to examine them from the other perspective. So I want to talk with you a little bit about this medical journey, what it takes to become a physician. So that's me.
That was in May of nineteen ninety seven on the day that I graduated from medical school. And behind that bright smile was this sense of accomplishment. I have finished four years of college. I have finished four years of medical school. I have matched in my number one choice for pediatric residency at Till international in DC, and my future looked incredibly bright.
But this is also me. So two years prior to graduating from medical school, I was a newly

wed, and I was a new mom. And my daughter had neonatal sepsis and had to stay in the neonatal intensive care unit for seven days for IV antibiotics. The picture in the upper left is my mother-in-law and myself visiting my daughter. On day seven, when she was discharged, instead of going directly home, we stopped at Georgetown University Hospital where my mom, who's pictured on the right, was in the hospital for complications from leukemia.

On the lower left, you see me in the first few weeks of caring for my newborn daughter as a medical student trying to manage the demands of mothering, breastfeeding, sleep deprivation, all while studying for finals and studying for my board exam. And then unfortunately, on my daughter's two month birthday, my beautiful mother passed away. So the bottom line is that that's my story, but every one of your physicians has their own story. So this path to becoming a doctor is extremely long. It's eleven, twelve, thirteen, fifteen years depending on what specialty you go into.

And yet, we undertake this journey because the overwhelming majority of us, and I know this is not how it seems, but I promise you, the overwhelming majority of us really do care. And we really do enter this profession so that we can help so that we can make a difference. And so we endure a sleepless night and all the tests and studying and all the things that take place during this journey because we believe that as exhausting as the journey was, there's this profound belief that our future is gonna be better. Like on the other side of this, is something amazing. We're finally gonna get a chance to make a difference in our patient's lives and in the lives and in the lives and health of our community.

But the reality when we finish is that those bright eyed bushy tail moments turn into this reality that this is not really what we signed up for. And in fact, we find ourselves practicing in this very broken healthcare system punctuated by things like abbreviated healthcare visits and prior authorizations, and all of these external forces that every day prevent us from providing the very care that we chose to in the first place. And honestly, most of us have this look on our face. Like, what in the world is this? What did I sign up for?

How do I live the life? And how do I have the career that I dreamed of? In my case, since I was seven or eight years old. So in order to really understand how we got here, we really need to kind of go back. So I'm just going to do a very brief walk through of the history and the evolution of healthcare in the United States.

So if we go back to the seventeen hundreds, eighteen hundreds, that was a time when not that everything was perfect, but medicine was much more personalized. Everyone had one doctor who typically knew them very well. A lot of that care was provided in the home through house calls. And so the doctors really got a chance to not only get to know the patients for whom they care, but the patient's families. It wouldn't be uncommon from one doctor to not only take care of the family, but maybe the entire town depending on where you lived, and so perhaps you would worship with your doctor.

Maybe you've run into the doctor regularly in the grocery store. Your kids and the doctor's kids probably went to school together, played sports together. And what happened is as we started to move into the 1800s, medicine became more formalized, which was a good thing. There was a more emphasis on medical training and emergence of more medical schools practices and and and things with related to science became more well known and so we stopped, you know, doing things like blood letting and leaches and there started to be more scientific evidence involved in medicine. And with that, the care started to shift from individual doctors to more shifting towards hospitals.

And so now, we have in the nineteen hundreds this modernization of the healthcare system. And with that came an influx of evidence and science and also technology. So as you can imagine, when we start to have more technology that drives the cost up. And so as the cost come up, now we start to have a situation where it's really too high for an individual to just be able to pay a doctor or a hospital. So this is when we see the emergence of the insurance companies, and I hope there are no insurance companies in the room because I just yeah.

You all know. So insurance I'm not saying insurance is a bad thing. Because again, with the cost of healthcare, it's beyond what most of us would be able to pay out of pocket. But what happened when we had the introduction of insurance companies is that, ultimately, there was a middleman placed between the doctor and the patient. And so what started out as what were called fee for service plans where doctors were paid and hospitals were paid based on the care that they provided.

Then in the 1960s, we had the introduction of Medicare and Medicaid And then when we got to the nineteen eighty, something called managed care came into the picture. And as the title implies, the purpose of this was literally to manage the care that we all receive. And so the bottom line is that the primary goal was to restrict care and to manage the cost of care. And so this is where we have things like prior authorizations, primary care providers that went from being the person who cares for you to the gatekeeper, the person that decides what kind of care you get, whether or not you get a referral to a particular specialty. We have provider networks where the insurance company decides who you can see?

Are they in this particular network? And we have things like like all the other challenges that you all are much more familiar with than than I am. And so where we are now as a result of all of those developments is that healthcare is a business. And as you know, the primary purpose of any business is to maximize profit and to minimize loss. But when you put that model in healthcare, it creates a long list of mismatched incentives And ultimately, you all, the patient, the family members, and us, the doctors get caught up in the middle.

So the result of all of these innovations and technology and health insurance is that we have things like abbreviated patient visits. And so you all probably know that the average duration of a physician visit in twenty twenty four, they say is fifteen to twenty minutes. That

has not been my experience. I would say it's more like eight to ten minutes. It's of you, they're seeing specialists, you're probably getting a little bit more time.
But the point is that these visits are incredibly short. And the reason that the visits are incredibly short is that we have been turned into workhorses where there is an expectation that we just see more and more and more patients. Ten minutes, fifteen minutes, even twenty minutes is not long enough to even begin to scratch the surface of the the concerns that many of you come to us with, let alone, it's enough time for us to really develop a relationship and a rapport with each other. Does anyone know what RBUs are in the room if you all heard of RBUs? Anybody.
You gotta see a couple of hands. So RVs are directly related to the shortened business. RVs stands for relative value unit. And without going into a lot of boring detail, the RVU is used as a system of measurement for physician reimbursement. And it started with Medicare, but at this point, it's trickled into all of the commercial payers.
And so there is a value that is assigned, a numeric value, that is assigned to doctor visits. There's a numeric value that's assigned to procedures, And this value is based on the amount of time that the physician spends in the room. It's based on the complexity or the presumed complexity of the visit. It's based on the location and it's based on malpractice expenses. And all of these things get put together into these formulas that are way above my pay grade.
And ultimately, you get this RVU. But the problem is, this relative value unit is not only used to calculate physician reimbursement but it's used to calculate physician productivity. And so you may or may not know this, but in your doctor's offices, your doctors are being held to standards. And there are some practices where they have guidelines. They will literally tell the physicians These are the RSUs that you should be accomplishing, and that dictates that these are the number of patients that you need to be able to see every single day.
And so there are certain situations where doctor salaries are tied to these RSUs I have close friends and colleagues who have been fired because they weren't meeting the RVUs, but there is no RVU for the time that I take to sit down and give you a hug after you've shared something difficult about your disease or about your personal life. There's no RVU to measure the connection that should be happening in the examination rooms between doctors and patients. There's no RVU if I as I'm leaving the room, you bring up another concern like I did with my dad's doctor that's incredibly important And so maybe that appointment looked like it should have been ten minutes, but in fact it really is thirty or forty. I'll never forget when I first started medicine, like literally I just finished my residency training program. I was so excited to start my new job as a pediatrician And I had the privilege of having a couple of days with the doctor who I was replacing, who was more senior, and she was retiring from the practice.
And so I arrived on a Monday morning, a few maybe ten, fifteen minutes before the patients

would get there. And she brings me into this exam room and she starts to go through this list of things that she thought I needed to know so that I would survive and and be a great doctor. And one of the first things she told me is, never sit down. And I'm looking at her, like, what? She's like, never sit down.

If you sit down, it's gonna take up too much time, and and you're gonna be in that room too long, and we have a lot of patience that we have to see every day. And I'm listening to this woman who, you know, I admire because she was like twenty years my senior and I'm listening to her tell me not to sit down in the exam room where I'm supposed to be connecting with my patients. Now keep in mind, I'm right out of training. So again, I have all of these ideals. I have all these ideas about how I'm gonna serve my community.

And this woman is telling me not to sit down. Now I'm happy to say I did not follow that advice, but the reality is that I did sit down. I did talk to my patients and their parents. And guess what? I was always behind.

Literally always ten, fifteen, twenty minutes late, always apologizing. And this system that really was not built for me and for many doctors literally caused me to leave primary care and ultimately transition into hospital medicine so that I could have that freedom and that time to visit my patients multiple times a day, to sit down, to talk to parents. But these are the challenges that your doctors are facing in the examination room. The other challenges that we're facing is the introduction of the electronic medical record. I remember the day when I was working in the hospital that they told us that in a few months, We were gonna be introduced to this amazing thing, the electronic medical record.

It was gonna make our lives better. It was gonna make our patients' lives better. We were told that no longer what we have to go to chart rooms in the basement of hospitals to look for records no longer would patients have to worry about this doctor not having their records that everything would be seamless, everything would be in this amazing computer system, lies, lies, and more lies. The electronic medical record, if you don't know, was built for billing purposes. No matter what they may tell you.

Now, there are some other consequences that are positive, but it was designed so that hospitals and outpatient offices and insurance companies could capitalize and basically capture the things that we do in medical encounters so that they can bill more efficiently. As you all probably know, they don't all talk together. So you could go in a hospital on this side of town. Go in a hospital on this side of town. They have no idea what happened to you over here because this is epic and this is Cerner.

It has been a complete nightmare. And beyond those challenges of this coordination of care and beyond the fact that those they they're not doing what they were told us they were gonna do, the electronic medical record has extended the doctor's work date infinitely. And so we went from having to complete a chart while we were in the office because God forbid, you sneak and put one in your bag and take it home. I've never done that. Never ever.

But now we have this system where all you need is a laptop or an iPad or even your telephone. And not only that, there are so many checkboxes and things, just ridiculous redundancies that are built into the record, things that your doctor is having to do, that have nothing to do with the care that you receive. And so when doctors go home in the evenings and they should be putting their children to bed or they should be at the family dinner table or they should be going to sports events with their kids, they are doing chores. And I've heard doctors tell me they're spending eight, ten, twelve hours a week, the equivalent of an entire workday or more on the electronic medical record. We know that the COVID-nineteen pandemic just rocked literally the entire world.

And of course, we know the impact that it had on patients and on family members, but it also had a very significant impact on physicians who found themselves for the very first time being on what felt like the front lines of a war. Practicing medicine, trying to treat a disease for which we knew very little about in the beginning, not receiving appropriate protective equipment, being told to just suck it up and reused mask. I mean, there were all types of crazy things happening, not to mention witnessing death over and over and over again. Having to be the person to get the iPad, to to call the family so that they could stay that laugh goodbye. And doing it in a system where there were workforce shortages, having to show up, sleep deprived, not eating, not sleeping, not drinking, and then not having an outlet to discuss this trauma, and it was trauma, not having any way to really process the emotions and basically just being told, do more.

And as a black woman physician, I would be remiss if I didn't talk with you about bias and discrimination that positions of color and those with other marginalized identity space in the healthcare system. And so I will never forget and this happened to me over and over again. In the hospital where I spent most of my career, we had badges and it had our name and it had the hospital, but then at the bottom in big, big, big, you all, like big, all caps. It's mindset physician. If you were a nurse, it said nurse.

And in pediatrics, we don't really wear white coats, but I always wore my stethoscope around my neck. And then I had this badge with physician in these big bold all caps. And I would walk into the room and say, hi, I'm doctor Rochester. I'm the pediatrician for today. And I cannot tell you how many times after saying that someone would say, oh, honey, the nurse just walked in.

And that would be a compliment. Because I was also mistaken as environmental services. So I'm there with my stethoscope, my physician badge, and I literally would be asked to take food trays, I've been asked to empty trash, I've been in doctors' lounges where that's supposed to be kind of the safe space. That's where we doctors hang out. That's where we sometimes get lunch or coffee.

And I've walked into doctors' lounges in hospitals all over my state. And watch the eyes of fellow colleagues go from my face down to my badge because they're looking to see, do I

really belong there? I had a friend, a physician colleague the other day who happens to be a black woman, and she told me about this story that happened to her a couple weeks ago where she drove into most hospitals have a physician's parking lot. So she drove into the physician's parking lot. She parked their car.
She's mining her own business, walking into the hospital. And this doctor approaches her and said, how did you get to park here? And so she shows her him, her physician badge, and then just proceeds to walk into the hospital. I wish I could tell you that these were rare incidents, but unfortunately, they're not. The last thing I'll share about this is that in my career as a pediatric hospitalist, when we were on call at night, we would be responsible for the cute little babies in the newborn nursery, as well as the pediatric patients that were admitted to the hospital unit.
And probably about, I'll say, six, seven, maybe seven, at the most eight years ago, I was on call one night, and I received in our sign out, which is like a document where the doctors kinda sign out to each other. I received and signed out that there was a baby in the nursery whose father had said that he only wanted doctors with blonde hair and blue eyes to take care of his baby. I have dark hair, I have brown eyes, And I was the only pediatrician for that entire hospital for the night. And I'm having to manage this this anxiety about what what if something would have happened to his baby. Now thankfully, the baby was fine.
But these are just I mean, I have stories for days. I'm not gonna share them, but It's just to show you that for those of us with marginalized identities on top of all of the other challenges that I've spoken about, these are other challenges that your doctors are facing. And so we are in this system where we have literally taken an oath to do no harm. And that is our desire. Our heart's desire is to do no harm.
But we're in a system where we watch harm being done every single day. That creates this cognitive dissonance. It creates something that is really hard for me to articulate. And so as we struggle with these ideals and these dreams of how we wanted to practice and these amazing doctors that we wanted to be with this reality, of what we face in the system in which we work. And then we try to make things better.
We go to our supervisors, and we attend meetings, and we sit on committees, and we talk about, like, how things could be better. But what we're told is just work harder. Stop complaining, see more patients. And when we talk about how we want to connect more with patients and some of the ways that that could happen, we are literally told and taught in medical school in residency training, sometimes overtly often covertly that we need to lock up our emotions. We're taught that in order to be a better doctor, you must develop this professional distance.
Between yourself and your patient, that you have to learn how to deliver bad news in a way that, you know, you're stoic. And while that there's some validity to that. I mean, if I were to break down and cry every time I deliver bad news, obviously, that wouldn't make me a very

effective doctor. But in this caring profession, how can you keep your emotions in a place where you want to be caring for your patients and for their family members? But yet, you're working in this system where it really doesn't allow you to care.
And in fact, year after year after year of practicing in this system, you literally find yourself in this place where you do have to start to harden yourself a little bit. You do have to start to turn your emotions off. There was an incident when I was working in the hospital, and many of you probably know what cold blue is. Basically, when you call it cold blue in a hospital, that means that there's someone that is either not breathing or their heart has stopped or sometimes both. And when they call a cold blue, what they're doing is summoning the members of the resuscitation team.
And so in the hospital where I worked, when I was on call or when I was there in the hospital, I was part of the resuscitation team. And of course, nobody, you never want to hear a cold blue, they period, but as a pediatrician, you absolutely don't want to hear pediatric cold blue. When you have cold blue situations and when you're at the bedside resuscitating a patient, of course, in that moment, you really have to kind of block everything out get out of your feelings, and you have to focus on the things that are necessary to bring that patient back to life, and that's what we do. And so on this particular day, there was a pediatric code blue. And I went down with members of my team.
I took a medical student and a resident and there were several other people in emergency room. And unfortunately, we were unsuccessful in this resuscitation event. And what happens in these situations is that you spend ten, fifteen, and in pediatric cases, sometimes forty five minutes an hour trying to bring a patient back. And when you're unsuccessful, of course, you have to talk with the family members. And there's all the things that you have to do.
And then, you're expected to just go back up to the hospital unit and finish taking care of patients. And again, this is this locking away of emotions. And so there was this routine and I had seen it model for me and I had unfortunately done it myself where you do these things, you have this horrible, traumatic event You share information with the patient and family and then you put on your stowage face and you get back on the elevator and you go back to your hospital unit and you walk into that next room and you talk to the patient and family as if nothing ever happened. In this particular day, for whatever reason, I wasn't able to do that. And so, you know, we we finished the the process and my medical student and my resident and I turned to leave the emergency room.
And while I was in there, I was able to hold it all together. But as I open up the door to leave, to go back upstairs to the pediatric unit, I just I started crying, and it started with a single tier. And then I could I could tell, like, they were about to be a lot more tiers. And I had to make a decision in that moment with my trainees. Do I excuse myself and go into the bathroom and get all my tears out and then come and pretend and let them see this, you

know, perfectly put together attending?
Or do I let them see this humanity I chose to let them see me cry. And I was conflicted by it, but we got on the elevator and I'm wiping my eyes and then they began to cry. And instead of going back to business as usual, we went into our team room and we spent about forty five minutes debriefing on what had happened. Not the medical complexities of the medications that we gave or the quality of our chest compressions, but we sat in that room and we just talked about what it felt like to unsuccessfully resuscitate a child, what it felt like to have that conversation with the patient. I'm just with the with the mother and the father.
And I wasn't sure still if that was the right thing until the next day when I showed up for work. They came to me and said doctor Rochester, thank you. No one has ever talked to us about this. We've never had an opportunity to share. And I'm not sharing this story with you to pat myself on the back.
I'm sharing this story with you to tell you that that was a rarity. That that is not the norm. That we do these horrible things and these great things and we experience so many challenges, but we are expected to be robots and machines. But but in fact, we're we're humans. And so in this system, you have a couple of choices.
You can either as a physician willfully comply so that you fit in or you can fight and fight until your edges are so worn down that you eventually fit into that round pig or you can leave. And of course, we can't all leave, but if you stay, you ultimately become as broken as the system in which you practice. So what does that look like for us? Physicians? It looks like burnout.
And so I'm gonna step over here for a moment so I can tell you some statistics. So you may be aware that burnout in the physician community is incredibly high. And just so you know, the burnout is a psychological syndrome that emerges as a response of chronic unrelenting workplace stress. And burnout is defined by three parameters. The first is emotional exhaustion this idea that I just cannot do this anymore.
The second is depersonalization. And this is important because this is this phenomenon where you feel like does my doctor even have a heart? That's part of burnout. This process where you literally have to start well, you don't have to, but you separate your emotions from your intellect. And it's a coping mechanism to allow you to survive.
And then the third element is a sense of ineffectiveness. And a lack of accomplishment. And so despite all of the things that we have to do to become physicians in burnout, we get to a place where we start to wonder, does this even matter? Am I even making a difference? And so there was a twenty twenty four survey conducted by Medscape on physician burnout and depression.
And what they found is that in the majority of specialties, fifty to sixty percent of physicians reported burnout. Sixty three percent of emergency medicine physicians, fifty three percent

of OBGYNs, fifty three percent of oncologists, fifty one percent of pediatricians, fifty one percent of family medicine doctors, And while I don't have numbers for immunologists and pulmonologists, I would dare say that they're up in those those same numbers as well. So in addition to burnout, there is a huge amount of mental stress and actually mental illness, mental health challenges among physicians such that fifty two percent of physicians in a recent study reported experiencing a great deal of stress. Twenty four percent almost one in four of your physicians have clinical depression. Twenty six percent of physicians have an anxiety disorder.

Ten to twelve percent of physicians will develop substance use disorder during their lifetime. And three hundred to four hundred physicians die each year by suicide. That's the equivalent of an entire medium to large medical school class just being gone each and every year. And as if these statistics aren't sad enough, what you also need to know is that physicians are often not being treated for their mental illness. So these numbers are absolutely underreported because there is a stigma.

We know universally there is a stigma associated with mental health or mental illness. But specifically in the physician community, these things have to be reported when we apply for jobs, when we apply for licensure. When we apply to be in network for insurance companies. And so unfortunately, there are physicians who are suffering, who don't even feel that they can receive care from the very profession in which they practice, because they worry that it might lead to them actually losing their job or not being able to get a job. And then there's the debt.

And so as I mentioned, there's, you know, eight, eleven, fifteen years Many of us have educational debt as a result of this journey. So seventy three percent of medical school graduates have educational debt. Ninety one percent of black medical school graduates have educational debt. And as of May of this year, the average US position has almost two hundred and seven thousand dollars in education debt. Seventeen percent of medical school graduates have more than three hundred thousand dollars in educational debt.

And the reason I bring up debt is that you may be saying, well, if it's so bad, just leave. You know, go do something else. And in many professions, that is a reality. You you you you go to school for something. You begin in that career, you realize, isn't really what I thought it was gonna be and you pivot to something else.

But when you have three hundred thousand dollars in educational debt, it makes it a little bit difficult to to lead that profession. However, there are some who do that, and so we know that we are in the midst of the great resignation, not just in healthcare, but really throughout all professions. For good reason, because people are just getting sick and tired, people are being fed up, and they're tired of having to make these difficult decisions between their career and their family, between their career and their well-being. So there was a study done by Mayo Clinic a couple of years ago and they had twenty thousand

respondents. These are physician responded.
And what they found is that one in five of those physicians who responded to the survey said that they will likely leave their current practice within two years. One in three said that they plan to reduce their hours. Within the next twelve months. So I don't know about you, but I'm concerned about who's gonna be there to take care of me. But this is this is one of the many realities.
And so outside of all of these workplace stressors and challenges that I've shared with you, If we go back to where we started, your doctor has all personal challenges as well. They may be dealing with divorce. They may be dealing with cancer or other chronic diseases in themselves or in their spouse or in their partner or their children or other family members. They likely have experienced death and loss in their family. They may have aging parents. They may have significant financial challenges. And all of this is what's going on in that examination room. And then there's impact on you all. And so this was me. And my well, this is this is how I felt in that appointment with my dad.
You know, this is the impact on our patients and families. We have these short visits. We're not connected to you all. We're brushing you off. We're ignoring you.
And so you all are appropriately angry. You're frustrated. You're not getting the care that you need and you deserve. We know that there's medical gaslighting, particularly in the PI community. We know that you are being seen by doctors who are not taking your your concern.
Seriously, We know that there are biases, even that physicians have against their patients. And so we just are all in this broken, broken system where you all aren't getting what you want and need, and we're not getting what we want or need either. And so while modern press would have a belief that it's us versus them, doctors versus patients, what I really want you to understand is that we're on the same team. It's really, in my opinion, doctors and patients versus the evil healthcare system. And it definitely feels like we are losing.
But I am an eternal optimist and no matter what happens, I am always gonna be team hope I believe that through conversations like this and through many other things that there are ways that together, we can begin to combat all of these challenges that I've been talking about. And so I want to spend the last few minutes before we go into Q and A talking about solutions. What can we do about this problem? I believe that at the core of all the problems that I just spoke to you about is a lack of empathy. We know that empathy is really your capacity to understand and vicariously experience the challenges, the attitudes, the beliefs, the concerns of others.
And at the core of where we are now is a lack, frankly, a lack of empathy. There is a huge empathy gap that has allowed us to put profits over patients that have allowed us to prioritize things that really have nothing at all to do with being a good doctor, nothing at all to do with providing the care that all of you need and deserve. And so how do we begin to

bridge this empathy gap? I think that one of the main ingredients to the solution is curiosity. I believe that curiosity is our superpower.
It is literally the thing that drives us to want bigger knowledge, deeper knowledge. Curiosity starts with us asking questions. It starts with us asking those probing questions to why? You think about when you were a little kid and you were always like why? Are those of you that have kids?
You make a statement. But why? And then you try to answer that question. But why? That's the only way that we're going to fix this challenge is to begin at asking those why questions and to really approach each other with a genuine sense of curiosity.
Curiosity is what allows a physician to truly get at the root of why their patient has missed the last two or three appointments. Or why they stop taking a particular medication. Curiosity is what will allow you to begin to think about, well, why is it that my doctor's always running late? Or why did that appointment get canceled at the last minute? Is it that there may have been a challenge in my doctor's family?
You know, it's frustrating when you get that call and they say, hey, I'm really sorry, but your your doctor's out today and you're not gonna be able to come in. But have we ever stopped to think, why couldn't that doctor be in today? You know, did they have some issues, some challenge with themselves or with their family members? So I believe that curiosity is at the core. And a few years ago, I had the honor and privilege of giving a TEDx talk And in that talk, I shared a lot about the challenges that I've shared with you, not from the doctor point, but from the caregiver perspective.
And one of the challenges that I issued to my physician and healthcare provider colleagues in that top was something that I coined a ninety second encounter. With regard to curiosity and empathy in the ninety second encounter, essentially, what I propose is that what if at the beginning of every patient encounter that doctors and patients spent just ninety seconds getting to know each other on a heart to heart level. As a doctor that could look like me asking you, hey, where did you go on vacation last year? Or what's going on in your life? What's exciting?
What challenges you? What's keeping you up at night? What's the best book that you read in the last year? And it goes both ways so you all can participate in the ninety second encounter as well. So for you all, it might be saying, hey, you know, how how are things going?
If you know they have kids, how's your daughter doing? It's it's really just getting beyond the what brings you in today and you all going down, you know, your list of concerns. But before we get into the purpose of that visit. What would it look like for us to engage in just human conversation and human connection? And so I wanna encourage all of you to try it.
It actually can be quite disarming. In a good way. And so if you have a doctor that's like rushing into that appointment and they're not making eye contact with you, maybe they

have a frown on their face, imagine looking at the doctor and saying, hey, doctor Jones, you look like you're having a really rough time today. How's everything going? And you'd be surprised.
I've done it. I've actually done this. You'd be surprised how that frown, you know, kinda melts and the doctors looking up because we're not used to people, you know, patient's family members asking us how we're doing. And so I just encourage you all to really begin to find ways to connect with your doctor. I can guarantee that he or she or they will appreciate it.
And it's not to say that this burden is on you because again, we have a lot to work, a lot of work to do on our end. But I just genuinely genuinely believe that as we work persistently and earnestly to bridge that empathy gap, that we can really begin to make this healthcare system better. I'm not waiting on the system to fix itself. It probably won't happen in my lifetime, but I truly believe that the solutions to many of these problems are right here in the room. And so I wanna go back to that question that I asked you.
And as I share with you, we all wear a mask. With the version of the doctor that you see in the exam room is likely not the true version of the doctor. And so hopefully, you can still hear me. Hi, everyone. My name is doctor Nicole Rochester.
I'm a board certified pediatrician. I attended Johns Hopkins University, the University of Maryland School of Medicine. I own a company called Your GPS doc where I help patients and family caregivers navigate the healthcare system. I'm a HealthEquity consultant and a proud medical advisor for HealthEquity for the immune deficiency foundation. Hi, everyone.
My name's Nicole. I was afraid of the dark and until I was nine years old and slept with a night light. One of the things on my bucket list is to be a mascot for sports team. Probably not full time, but just for the day. And I recently went through a very painful and traumatic divorce.
And I'm in the process of healing and reclaiming my joy. It is very very nice to meet you. Thank you. I

Thank you so much to doctor Rochester. I also feel we may have a t z in the making here from your comment. Always looking for someone to to BRTZ. But with that being said, we have just a a little bit of time at the end for some questions, some appreciation, some thoughts for doctor Rochester. We have one mic runner in the audience right now.
If you guys wouldn't mind raising your hand, and we'll get to many as people as possible.

Go ahead.

Hi, doctor Rochester. My name is Rebecca Schultz from New Hampshire, and I have an eighteen year old son with a primary immune deficiency. And I also have chronic medical

conditions. First thing I want to say is thank you. Your talk was fantastic.
Yeah. Thank you so much. I'm sure a lot of us can relate, but we my son and I both spend a lot of time at doctor's appointments. And we face a lot of what you mentioned. Doctors are rushed they don't have time to answer all of our questions or any of our questions in and out.
We can sense the minute they sit down. They're just looking at their computer typing. Sometimes they don't even look at us. Sometimes they don't even, like, touch us or examine us. Mhmm.
It's all about just putting stuff in the computer, and we leave frustrated. So I love the idea of the ninety second encounter. Do you have other practical ideas that you can give us, all of us. Besides the ninety second encounter, things we could do to prepare for appointments or during the appointments that can help make appointments and treatment go better.

Absolutely. Well, thank you for your kind words and I love this question. When there there are a lot of things that you can do to kind of counteract this idea of these ten, fifteen minute appointments, particularly for those of you with, you know, lots of challenges and like you said, concerns that are not being addressed. I think one of the main things you can do is to prepare ahead of the visit. As I shared with my dad, that appointment, you know, there were probably five or six things.
And in reality, while I was frustrated, the doc it really didn't have enough time to address the five or six concerns. And so prioritizing your concerns is extremely important. Thinking about that one or that those two things that, you know, if nothing else, you're gonna get those one or two things addressed during the visit, and and writing them down because I found that when we're in these medical appointments, the whole way there, like, look my dad, you may know exactly what you want to say, you may know exactly what your concerns are, but then something weird happens when you get in the exam room, especially if you're met with negative energy, and all of that kind of goes out the window. And so writing down what those concerns are and having them top of mind in front of you is is also extremely helpful. If you find yourself being dismissed as you're trying to address those one or two concerns, you know, again, it's sometimes naming it.
And so, you know, saying, doctor Rochester, you seem like you're rushing. And I know that you're really busy, but I this is very, very important to me, and I'd really appreciate it if you would slow down for a minute. So that we could talk about it. I mean, we don't we don't hear those words often, and I can guarantee that when you say it, I mean, some doctors may get a little, you know. But but I think most will just they'll realize like, oh my gosh. She's right. You know, I'm rushing. I'm disconnected. Let me just slow myself down. So sometimes it may be helpful to provide a reminder to your doctor and to name the behavior that you're seeing, you know, in a way that's compassionate and respectful.

The the other thing that I think is important and you all do this extremely well, but just this idea of advocating for yourself, sometimes that may look like you doing it. Sometimes it may look like having a friend or a family member someone that you can trust in that appointment because particularly if you're not feeling well, you really shouldn't have to be unwell and simultaneously fight for your doctor to be listening and to do the things that you that you need them to do. And so I think it's incredibly important to have a buddy, an advocate with you, whether it's the doctor's office. Certainly, when you're in the emergency department, if you're in the hospital stay, I hate to say this, but there are a lot of things that fall through the cracks. And despite that electronic medical record that we talked about, there are things in there that are inaccurate.
There's information that gets copied forward. So the previous provider saw it. They copied it. They put it in their note because again, these notes take so much time. And so having somebody at your bedside that can say, no, that's not right.
That didn't happen or no, this is her doctor. No, that's not the medication that she takes anymore. Those things can be incredibly helpful. You're welcome.

Good morning, doctor Rochester. How are you? My name is Alice Drennan. I'm from Houston, Texas. I'm a CVID patient for fourteen years.
And I wanted to share a testimony about what you're saying between the connection of doctor and patient. I have doctor [] in Houston for the last fourteen years. He diagnosed me with CVIT. Now working in the legal field, I knew that helping myself and him connect is by emailing him once a month if I had any difference in my infusion. Or any side effects or any infections.
And this gradually started decreasing because, again, he was not only my doctor, he began being my advocate. During COVID, he wasn't an a doctor. He was a friend to me. That connection goes a long way, and I spoke to him two weeks ago, my six month checkup. And he said, miss Drummond, I have to let you know that I'm retiring in September.
I said, no, you're not. You know, I'm a little. And I said, By the way, how are the grandkids? And I started naming the grandkids. And then I said, well, your birth is coming up in August. And he turns around and he says, you know too much about me. I said, doctor h, I've been with you for fourteen years. We've been together through your divorce, through your depression, through your new marriage, through your grandkids, you didn't have any of that when I first met you. And he says, you're right. I wish all my patients were like you.
Wow. So I want to thank doctor Harrison and all the immunologist doctors. For opening up to us patience, but we have to be the first ones to step in. I believe in my opinion, but my hats are off to you for sharing this information that is it's a hard talk to talk about opening up about your feelings. I never felt anything about my doctor going through these things.

So it's definitely going to be a change or life change it for me moving forward with my new doctor in the future. So thank you so much.

Thank you, Alice

We have another round of applause for doctor Rochester. And then just recognizing, as as my friend mentioned in the audience, the the amount of vulnerability it took for her to come here and then share this story with you and we all have our gratitude for the the space of the journey to respond this morning.