EDITORIAL

Balancing Burnout, Burden Reduction and Appropriateness

By Philip A. Baer, MDCM, FRCPC, FACR

Scenes from my office recently: A patient of mine is transitioning to another rheumatologist closer to where she lives. She said she would miss me, particularly because of my help in obtaining WheelTrans for her (a mobility service for those with disabilities). Could I do one last thing for her, and fill out her disability tax credit (DTC) form? Unfortunately, the answer had to be no, as the criteria for the DTC are more stringent than for mobility assistance.

The next patient arrived with a bright red envelope perched on the seat of her walker. Given we were meeting in January, that could have been a card for our office for New Year or Lunar New Year. But it was not. Instead, I was presented with a form from a small country thousands of kilometers away, asking me to stipulate that my patient was still alive. Reminiscent of old Canadian passport applications, only certain professionals could be trusted as guarantors. Now there are a lot of fraudulent supercentenarians apparently,[1] but my patient was only in her 70s. I laughed when I saw that both a signature and an office stamp were required; yes, I have one of those from 30 years ago, but most doctors probably don't anymore.

Rheumatology used to be called "The Happiest Specialty."[2] Now studies say we have high levels of burnout, even surveys conducted at the Maui winter rheumatology conference![3] My inbox and medical social media feeds are deluged with links to articles on burnout, burden, and forms. Reading it all is dangerous to one's mental health. As a result, our Editorial Board decided that the *Journal of the Canadian Rheumatology Association (CRAJ)* theme issue on the topic should focus on wellness rather than burnout, to put a more positive spin on the issue.

Everyone seems to agree burnout relates to systemic issues. So, we are now engaged in burden reduction. *The Medical Post* mentioned a burden reduction committee in British Columbia, and Doctors Nova Scotia made the news with their survey on how much time doctors spend on administrative tasks. Even the Canadian Federation of Independent Business (CFIB) has taken up our cause, given the importance of health care to businesses, and the fact that most medical practices are small businesses. One appeal of larger corporate and investor-run medical clinics is their claim to handle the business side, leaving doctors free to concentrate on medical practice. Of course, the forms burden still falls on physicians. At the Ontario Medical Association (OMA), we have a Forms Committee taking up the challenge, with our own Dr. Jane Purvis highly engaged as a member.

The other side of the burden coin is the issue of appropriateness. We are all familiar with inappropriate test ordering of ANAs[a], RFs[b], anti-CCPs[c], ENAs[d], and imaging such as knee MRIs[e] when plain X-rays have already demonstrated osteoarthritis (OA). Choosing Wisely Canada is working on the matter, but based on the referrals that come through my office, they have a lot of work to do to achieve their goals. Our standard provincial lab requisition has tried a different approach, with some tests moving from ordering by ticking a box to having to write or type out the lab test name to order it. That apparently works for tests such as TSH[f] and ferritin. For a couple of tests, namely PSA[g] and Vitamin D levels, there are tick boxes to designate the test as appropriate and government paid, or as uninsured and billed to the patient.

Speaking of MRIs, a recent blog by Dr. Sohail Gandhi, ex-OMA President, mentioned that to order an MRI as a GP (general practitioner), he had to fill out an MRI appropriateness form in addition to the MRI requisition.[4] He didn't seem to mind, but that is the battleground between burden and appropriateness that we are all facing.

Other examples of that battle: sending me a referral note with the one word "arthritis?" reduces burden on the referring doctor, but increases the triage burden on the consultant. Sending a hundred pages of duplicated lab results with the referral might also reduce the burden on the GP ("just fax them the whole chart"), but the burden at our end is no less. And what about one of my most common referral sources who doesn't know how to attach documents to their referral letter? We have become experts at merging various categories of imaging tests and lab results into a single document as a result.

The latest office skirmish in the war on burden: I saw a patient a few months ago for knee OA. Injections were given, and I told the GP that the patient could be referred to an orthopedic regional assessment clinic (RAC) if knee replacement surgery was desired in future. The RAC requires a specific referral form (burden). Recently, I received a document from the regional home care service with an updated knee X-ray, my last note, and a blank RAC referral form. The implication was clear: the GP had made a referral, but the key form had not been

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completed. My choices: fax the document back to the GP or to home care, stating that the GP needs to complete the form (burden reduction for me, burden increase for GP). Or, since it is a mutual patient, and I had suggested the orthopedic referral, and I have completed the RAC form many times, and it autopopulates much of the required info from my electronic medical record (EMR), I could take care of it myself and feel I had done my good deed for the day. So, I completed the form and sent it to the proper place. But I also noticed that the patient must bring a CD[h] of their knee X-ray to the appointment (burden and cost to patient). So, I closed the loop by calling the patient. Much to my surprise, she told me she already had an appointment at the RAC next week! Conclusion 1: The GP must have completed the proper referral form eventually. Very unclear why I would then be sent a blank referral form. Conclusion 2: calling our current state of affairs a healthcare "system" is laughable.

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Glossary:
[a]ANA: antinuclear antibody
[b]RF: rheumatoid factor
[c]anti-CCP: anti-cyclic citrullinated peptide
[d]ENA: extractable nuclear antigens
[e]MRI: magnetic resonance imaging
[f]TSH: thyroid-stimulating hormone
[g]PSA: prostate-specific antigen
[h]CD: compact disc

References:
1. Newman SJ, Supercentenarian and remarkable age records exhibit patterns indicative of clerical errors and pension fraud. bioRxiv preprint doi: https://doi.org/10.1101/704080.
2. O'Dell J. The Happiest Specialty: Rheumatology Is #1! *The Rheumatologist*. Available at *https://www.the-rheumatologist.org/article/the-happiest-specialty-rheumatology-is-1*.Accessed March 1, 2023.
3. Tiwari V, Kavanaugh A, Martin G, Bergman M. High Burden of Burnout on Rheumatology Practitioners. *J Rheumatol*. 2020: 47(12):1831-1834. doi: https://doi.org/10.3899/jrheum.191110.
4. Gandhi S. Moving Procedures to IHFs is a Step in the Right Direction (January 17, 2023 entry). Avaialble at *https://justanoldcountrydoctor.com*. Accessed March 1, 2023.

Attend the ORA Annual Scientific Meeting!

By Sandy Kennedy, Executive Director, Ontario Rheumatology Association

Join us on May 26-28, 2023, at the Kingbridge Conference Centre in King City for the ORA Annual Scientific Meeting. The theme of this year's meeting is **Progress + Promise: Advancing Care in Rheumatology**. The meeting will enable participants to engage in both clinical and scholarly activities with the objective of improving the quality of care in Ontario for patients with rheumatic diseases.

Dr. Janet Pope has assembled an incredible line-up of speakers once again, including international and local talent. Enjoy learning sessions with international speakers, such as Dr. Atul Deodhar, Dr. Georg Schett, Dr. Cynthia Cooper and Dr. Eduardo Mysler. Some of our local speakers include Dr. Zain Chagla, Dr. Stephanie Garner, Dr. Amanda Steiman, Dr. Rae Yeung and more!

ORA Ontario Rheumatology Association

Visit the ORA website at **www.ontariorheum.ca** to learn more! See you there!

Sandy Kennedy
Executive Director, Ontario Rheumatology Association