Overcoming Burnout: Dr. Amy Fogelman's Journey from Primary Care to Expert Witness and Physician Advocacy Transcript

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Podcast Introduction and Guest Background

Welcome to the Doctors Making a Difference podcast, where we help physicians to be empowered with the tools they need to be successful in medicine, in finance, and in life.

Join us as we highlight doctors and other professionals around the world who are making a difference. Today we have as our guest, Dr. Amy Fogelman. I'm excited to have Amy as a guest.

She gave me permission to call her Amy. I am delighted to have her as a guest. She is a primary care physician who was highlighted in a Boston Globe article.

She sent it to me, so I'm going to read the exact title. Their lives are awful. More doctors are quitting medicine, citing burnout. and workplace issues.

And it's an important thing to kind of talk about medicine burnout and what we can do. And Amy has a very interesting story and I hope you'll find it as interesting as I have.

And I'm looking forward to the conversation. So Amy, would you mind introducing yourself to our audience? Sure. Hi, thanks for having me. So my name is Amy Fogelman.

I grew up in the Boston area. I went to medical school in Boston and did my training here as well in internal medicine. And then I went on to practice primary care at Mass General for about a decade.

And then more recently at a small private practice in the Chestnut Hill area. In 2018, I started a company now called High Rock Experts. where I connect medical professionals to attorneys and I teach medical professionals how to be expert witnesses.

So thank you for having me. Oh yeah, that's a long journey in a very short little nutshell. You kind of describe this journey from a busy practicing physician and then working in a smaller clinic and then eventually leaving the clinical practice of medicine and moving more toward expert witness work.

Yeah. As we get into that a little bit, I want to talk a little bit more about that journey. You worked in a hospital system for a number of years. What was your practice like?

What did you do? I was a primary care doctor for 2000 plus patients in the Boston area, in the urban Boston area, very generalized practice of adults.

I had a lot of extra projects at Mass General that I was involved in. A lot of opioid policies were kind of my thing that I fell into that was super fun.

I also taught residents and medical students and all these other extra little projects that I was doing when I was at Mass General. In the article, it said something about being part-time, and I wasn't sure if it was part-time all the way through or if…

Yes, and it became more and more part-time as I went through. I started out, I think, six sessions, which eight sessions is full-time, and then kind of every year I would…

Burnout, Commute, and Leaving Clinical Practice

go down another session, but I would keep myself busy with all of these other projects I was working on that some of them I would get reimbursed for, most of them I didn't.

So what ended up happening, and I'll tell you a little bit about the article actually, because I think this will inform our discussion, which is that this reporter called me.

And they said, oh, your former patient said that you would be a really good person to talk to. I want to write this article about physicians that are leaving medicine.

I have to tell you that this is something that I hid about myself. I agonized over this decision. I was embarrassed about this decision. So I listened to that voicemail.

I was like, do I call her back? What do I do? I don't know. And then I just decided, you know what, this may help another person. And so I called her back and I told her my whole story of burnout, which I can certainly share with you.

And it was just shocking how much this resonated with so many people. I heard from people that I knew, people who I didn't know, who just said, oh my gosh, like, I totally hear you.

I totally feel you. I've been there. And so all of a sudden this thing that I kind of tried to hide and pretend like it didn't happen was a very, very active, obvious part of my history.

So it's a little weird like talking about my past without sharing that big elephant in the room. So yeah. I think it's interesting. And one, it's almost like a tongue in cheek sort of a joke when they're like, oh yeah, I work part-time.

I only work 40 hours. And that's classic. Honestly, we talked before we hit record, I'm a primary care doctor in rural Idaho. I would love to only work 40 hours.

That sounds like a dream. I mean, it sounds like a part-time job, but that's ridiculous to the rest of the world. Part time is fewer than 40 hours, maybe 20 hours, maybe 32 hours, but it's very, very hard to achieve that in a busy primary care practice because you have to do so many things.

And I always tell my staff, it's not just the patients we see, that's actually the minority of the work. It's all the other stuff. It's the prior authorizations and the coordination of care among various specialists.

And that's the middle of the night phone call because we can't get something worked out or checking with people after a clinic or going and doing rounds in the hospital on someone that you admitted during the day.

on and on and on. It's interesting that you were able to cut back a little bit over the years. You found yourself eventually not before. Well, I cut back, but I was still like spinning my wheels.

I had very young kids at home. My commute was awful and I would leave at five o'clock in the morning because I wanted to be the most efficient that I could possibly be.

So I didn't want to hit any traffic. So I'd go in there, pre-chart for hours in the practice. Then I would leave after I saw my patients in the afternoon or in the evening.

And I would get home and I would do more charting. I would be answering messages. And this is what I talked about in the article, but I was like holding it together at work, but I was like not holding it together at home.

I was incredibly moody. It was really tough. And, you know, I had all of these other projects that I was doing that were also taking up a lot of time that I finally said, you know what, this commute is killing me.

All of these other projects are killing me. Let's make it more simple. And I said, I'm just going to do clinical work, and I'm going to do it closer to where I live so I have less of a commute.

But surprisingly, what I found out was that it was all of those other projects that I was doing that was keeping the burnout a little bit at bay. That's what I was getting the joy out of.

Plus, I had all these patients that I had known for 10 years that trusted me that I wasn't fighting with them to get them to agree not to prescribe the antibiotic for their URI because they trusted me.

And then all of a sudden, I go to this new practice where the patients don't know me or I'm just another doctor. They have had a huge turnaround on their doctors, so they're very distrustful of anybody.

And I realized, oh shoot, I liked all those other projects. That was the fun part. And arguing with patients over what their deductible was and how I code their annual exam so that they don't have to pay their labs.

That was becoming a lot of what I was doing. And I just was getting more and more and more burnt out until finally I couldn't take it anymore. Well, I think this podcast goes to a lot of people of different stages.

We've got people that are medical students and some that have been in practice for 40 years. Everybody can probably relate with the idea of burnout and became a buzzword.

Everybody talked about burnout, but when you've been through it, and I think most people have spent some time in it, it's so frustrating. You're no longer fulfilled.

You feel like you can't give enough. You feel like everything else in your life is too much and you just feel stressed and worried and burned out. And like you said, you have to find some fulfillment in something else or find a way to make it work.

You did try. So what eventually led you to say, I can't be in this anymore. It was my husband who was worried about me. And he said, because the only thing I ever learned how to do is to be a doctor.

I didn't realize there were any other option. I mean, I was doing expert work. I didn't realize though that that could be a career. I had no clue that there were all these other options.

And my husband said to me, Amy, you don't need to do this.

Finding a New Path Through Coaching and Career Exploration

And he said, just stop. And I thank him for that. If he hadn't said that, I don't know what would have happened, honestly. And he recommended, he said to take six months off.

and I ended up meeting with a coach. I thought about for the first time in my life, you know, what gives me joy? What part of my job or what things am I really good at?

What things am I not so good at, but really give me fulfillment that I'm willing to work hard at? And I met with probably hundreds of physicians who were doing non-clinical jobs out there.

And I thought I had to get another degree in order to do that. I thought I needed to get an MBA. And the first person that met with me, his name is Graham Gardner.

He was one of my chief residents when I was a intern. And he said to me, no, you don't need to get an MBA. And he gave me a whole primer on all the different jobs that there are out there, and a list of people to meet that had gone through our same residency program.

And then I started meeting with people, asking them what they loved about their job, what their day-to-day work was like. And it was just eye-opening.

And then I realized I wanted to open my own business and be an entrepreneur, which I never could have in a

million years predicted. It's interesting to think about that whole journey.

Cause I've talked to lots of people on the podcast and just in my own circles of people who feel that same frustration, what you're describing, just like I'm going through this motion again and again and again.

And really what I'm doing is arguing against insurance or playing that. I love my patients. I'm happy to care for people who want to get better. But I find it so frustrating.

That part just kind of leaves you empty. The part that leaves you fulfilled is when you help somebody. You know, when you say this person had a problem and I knew the solution or they were going through something that really even wasn't a great solution, but I was able to walk them through that.

I mean, you go home and say that was a hard day, but I did something very meaningful and very important. trying to find the balance of those two is super hard.

And so it's interesting, you talked to people, like you said, a whole bunch of doctors that had been in practice or had modified what they did. What do you think gave them the courage and you the courage to make a change or to pivot or shift into something a little bit different?

I think my husband gave me the courage. I just want to go back a second and just say this explicitly because I do think it may help some people in your audience.

I think when I had left Mass General, if I had at that point decided to open a practice and own it myself, do direct primary care, I think that I would have found fulfillment in that.

because you're absolutely right. It's the insurance issues. It's the butting heads with patients. It's being an adversary with the patient. That's the worst.

Like we're supposed to be on the same team. And so I think had I done that when I wasn't so burnt out, it would have kept me in clinical medicine longer.

And what ended up happening is that I moved into this practice that just made the burnout speed up because there were so many things about it that were out of my control.

And I really ceded that control. And I think had my husband not told me to stop, I can see why physician suicide rate is so high. Because I think you feel like you're stuck, you feel like there's no other options, and you don't know what to do.

And I just want to say to any of your listeners who feel like they're stuck, they are absolutely not stuck. There's ways to get your family insurance that are not through your job.

There are ways to make money that are not getting a paycheck from a hospital and don't despair. Okay. So I want to say that explicitly because I was in a bad place and I needed a break.

You know, and it's interesting how you said that your husband was the one that intervened in your case, but he just kind of gave you permission to do what you needed to do.

You needed to step away and re-examine. And maybe in an alternate universe, you would have started a direct primary care. You would have gone in a different direction.

You would have focused on some of those that helped build you and stayed in clinical practice. You found. expert witness work, which is also very important, very adjacent to medicine.

But I think all of us need the permission to step back. And so if you need permission, you got it from the podcast here, permission granted. Take the time, take the minute to step back and look and see what fulfills me and what

doesn't.

Because I love my patients. I truly do love my patients. I have the practice like what you had in those first 10 years. I have a relationship of trust.

I love those patients. I am happy to do things for them, but I don't like being a widget in the machine. And sometimes on those days when you've been going like crazy, I tell my wife, I've been the doctor about 2000 today.

I just like nothing. I've just been going full speed and I didn't even have time to enjoy the moments that were tender or were awesome. Cause I was so far behind and had three people, you know, always kind of meeting me at that moment.

And it's fulfilling, but. It's so much more fun to be a doctor when you are doing it because you love the patients and when you don't have these huge productivity things and I don't know.

So in the podcast, we talk quite a bit about how to achieve financial independence and regain autonomy and what are some pivots and shifts you can do to find medicine fulfilling.

And if you find yourself burned out and not able to stay in medicine, what else can you do? Because we certainly can't have every doctor leave clinical practice.

We won't have any doctors. But at the same time, you have to find a way to do it so that your life is meaningful and fulfilled. Doctors are pretty vulnerable, like you said.

Absolutely. So I want to hear the rest of your journey. So, you know, you went through this, you realized after your six month break and talking to all the different folks that there was other stuff.

How did you finally decide, okay, I'm a primary care doctor, but I actually have quite a bit of expertise and I can work on this expert witness angle, because a lot of people would feel nervous or feel like I'm only me.

I can't be more than I am. And so I'm curious how you arrived at that. All of us can be expert witnesses, your clinical Acumen is what makes you an expert.

An expert witness is just someone who simply explains the medicine to the judge and the jury because they don't understand it. That's it. You just translate it.

I had done expert witness work through the years. My husband is an attorney, and he also would ask me over the dinner table advice all the time about his cases.

He doesn't do medical malpractice, but there's still medical facts that integrate themselves into all different types of cases. And it was during my break that one of his colleagues was asking me, hey, Amy, could you do this thing for me?

Could you review? And it was like a aha moment.

Expert Witness Work and Building High Rock Experts

Wait, I could do this for other people and get paid. So I started out doing more background work, and then I realized that as a primary care physician, you know, a lot of what we do is connect people.

Probably not you as much. In a place like Boston, where there's a zillion subspecialists, a lot of what we do is connect people to the subspecialists around us.

And so what I realized that there was a need for was a connector. So that's what I do. I connect attorneys to expert witnesses. I created a Facebook group to do that.

And then I realized that just because you're a fabulous primary care doctor doesn't mean that you know the foggiest thing about how to do expert work.

So I created a course to teach people how to do it. And it just all evolved from there. It's been so much fun. I love using different skills that I haven't used like since junior high, using my creativity, using art, like when I create my social media post.

on Canva. These are fun skills that I never really got to use as a doctor, thinking about things in such a big picture way. And I also love that I'm helping doctors.

And you and I had talked about this a little bit before we started recording, but I just want to say that some people feel like, oh my gosh, expert witnesses, you guys are the devil.

You're so bad because you think about getting sued and the lawsuits that are not fair. And I will say this, my underlying message when I do everything I do through high rock experts is to integrity and being clinically accurate.

And that's what I teach. So anytime that you're reviewing a case, you look at the records and you make the opinion based on what the records show. So, most of the time, when you're reviewing cases for plaintiff attorneys that are thinking about suing a doctor, you're saying like, yeah, you know, this bad thing happened, like, that's too bad, but there's not any medical malpractice here.

And if you have the trust of the attorney, they're going to say, oh, thanks a lot, and they will not file that case. If all of our listeners say, no, no, no, I don't want to do expert work because they're the devil, then what you're going to be selecting experts that you wouldn't want to review those cases who may just say what the attorneys want them to say.

So it's really important to have credible, ethical experts doing the work. That's a good point. I can think of a couple of lawsuits that I've been part of.

They name everybody that's ever touched the patient for anything. I was actually really thankful. If I can think of one, I think the expert witness helped everything because if you're going to be sued, you'd rather be sued by a firm that does a ton of it and they kind of know.

what actually is valid and what's not, because this was a totally invalid case. And we were really thankful that an expert witness came and said, well, this is what was done.

These are the objective data points. And it was not malpractice. The patient was not satisfied with the surgical outcome, which is understandable. But the understandable thing is that if you do enough cases, somebody's going to have a negative outcome, but it wasn't for negligence.

It wasn't for Poor timing is just the patient didn't like it. And they went to a law firm that, you know, say, well, yeah, we can for sure do that. But instead of reviewing the case properly, they filed everything and went forward with it.

And so I was very thankful for an expert witness that came through and just said, these are the objective data points. They weren't on our team. They weren't on their team.

They just simply were. This is the objective case. I can see what you're saying. It does make you feel like I don't want to betray my colleagues or something like that.

But on the other hand, you do want someone that is going to give an objective review and say this is actually the case. There was negligence here or this is the standard of care or not.

Correct. And then we could talk about the standard of care. The definition is a legal definition and it actually is very forgiving for physicians. And a lot of experts who just do this without getting training don't quite understand what that means.

Like I've read reports. by experts and they think that the standard of care means the best care or ideal care or what the guidelines say. But the standard of care is what more likely than not or more than 50% likely someone would do in a similar or same circumstances to defend it.

So we're talking 50%, you know? And so it's not like what we talk about at M&M rounds, you know, where you're like, why didn't you do that? This is a much lower bar.

But I will just say on the other hand, if there was truly medical malpractice, this is in our country how we make the patient whole. And it is important that we keep sometimes our medical boards don't do enough to get rid of physicians and nurse practitioners and someone who are not following good medicine.

And so sometimes it is really important. I don't know if you ever listened to the Dr. Death podcast, but that's an example. I did listen to that. Yeah, that's an example where, you know, because of so many medical malpractice tort reforms, they were sort of hamstrung.

And so this guy just sort of kept on going, kept on going. So there is an important place for medical malpractice cases. No, it's interesting. And like you said, I was interesting just thinking what you said at the beginning.

I think you said, I love this. I find it engaging. This is fun. And that's a change. It's a big change from what you were describing as you tapered off of the medical side.

And it sounds like your initial practice, you had such rapport with your patients that. And you were involved in some projects and that kept you really pretty engaged, but the commute was terrible.

And when you went to this other one that was, you were just sort of a cog in the machine and you were doing a lot of work without necessarily getting a lot of fulfillment.

It left you feeling unfulfilled and you didn't say words like love and you didn't have these positive, warm, fuzzy feelings for that. Yeah, totally. Like I remember.

I would have to remind myself to find out what the patient's eye color was and stare into their eyes so that I could feign empathy because I was so much of a shell of myself.

It was really bad. Oh my goodness. I think everybody listening can relate because everybody's been in that spot at one point or another where you feel like I am a shell.

I don't know how to do it. And then the biggest answer that I think you've given us really an excellent example of is find a way forward. And if you find yourself suicidal and finding yourself really at that low level, I mean, absolutely get help, just like we would tell our patients if you're really in that level, get the help you need.

But the ability to shift and pivot and change, modify, et cetera, is something that's within your power. And the other thing, like you pointed out, as a physician, you actually have quite a bit of broad training in a lot of different things.

And you become kind of an expert in human interactions and Health is integrated into everything about the human experience. And as a physician, especially where you've done it for a few years, you really do have a lot of expertise in a lot of stuff that you may not realize.

I think it's interesting, Amy, you have found a way forward and you found a way to use a skill that's so adjacent to what you already learned.

The Role of Expert Witnesses and Medical Malpractice

And now you're able to just magnify this and be a great help to lots of people. So pretty cool experience. Thank you so much. Yeah. Jump back with me for a minute as we talk about this.

So. Healthcare is broken in a lot of ways. The system seems to value productivity and RVU production and code efficiency and all those kinds of things, which you would expect a robot, like I joked before, to be able to just have all that.

What the lived experience of patients and physicians is that usually you want to go in and When I'm a patient, when I need help, I want my doctor to be a hundred percent interested in my outcome.

And if I'm a doctor and I'm showing up with the patient, I want that all to be about what's best for this patient at this moment. And not to have all these external things informing like how many minutes can I spend with the patient?

Do I need to talk about this thing? Are we going to up code this to get this extra? CPT code involved in this or like you brought up, somebody comes in for a Medicare wellness visit and they only want to be billed for the Medicare wellness.

He only comes in once every two years, despite having 18 problems. And he's a really nice guy. But it's the challenge is we live in this constrained system where we have to kind of abide by all these external factors.

And they weren't designed by physicians or if they were, it can't be physicians that are in practice. As you've reflected back on that, what do you think is working in medicine and then what's not?

And then specifically, do you have any ideas of what we could do to make it better for those who come after us? I think what's working is that there are amazingly empathetic, smart, caring physicians out there.

I have some of them caring for me and my family members. And so the workforce, the physician, you guys, you're there. And it's beautiful. and the training that you have, the empathy that you have, the number of really difficult things that you hold as a burden because you are there with your patients, that makes you such a strong advocate for patients going forward.

So that's what's working. I think what is not working, as you alluded to, is the administrative overhead. I don't quite know when physicians ceded control of everything to this huge giant monolith of administrators, but that was a mistake.

And I think in trying to rein in cost, The only way that anybody is thinking about doing it is by chipping away at the visit. The insurance companies are giving less money for each visit, which then gives less money to the physicians.

Let's get rid of these administrators that have huge salaries and let's have the physicians take back control. I don't know how that would work, but I just see that as being the way forward.

My observation also is the same thing. Just in the time of my career, which I guess has been about 15 years, the administrative burden has increased dramatically.

The amount of time we spent on prior authorizations and asking permission to do what's the right thing for the patient has really increased in my practice.

You know, I'm in a rural area. It was me and one receptionist and one nurse. And now we couldn't possibly operate without the clinic has two receptionists.

I have two nurses that do just stuff with me. And we have a prior authorization person that helps with that. And we have a referral person that does all the referral stuff.

And there's a billing department and it expands from there. And all those things are useful and important, but I just look at the administrative burden that has now accompanied medicine at the business of medicine.

And when you look at it, the patient's still receiving pretty good care and the doctors are still giving pretty good care, but it's not like doctors are making more money or patients are getting more care.

I think you're right. We've just added more and more layers of complexity and bureaucracy and billing. And I also don't know when that happened, but I have to believe that a previous generation of physicians maybe had a little bit more autonomy and control.

And weren't so much worried about whether you were meeting an electronic medical record compliance report, or if you were making various insurance companies happy.

So the only answer I've seen realistically is people leave and go to direct primary care, like you observed. But that's also challenging in some respects, because it leaves some of our most vulnerable patients without easy access to care.

So it's a hard challenge. I'm curious, what do you think, if you were a public policymaker, what would you think reflecting on your experience? Well, it's interesting.

In Massachusetts, where I live, the governor just announced that she is getting rid of prior authorizations in Massachusetts.

What Is Working and Not Working in Medicine

So I thought that was very fascinating. I don't understand how that's going to work in practice, but I'm curious to see how that goes. And so I think that there are things like that to think about.

Let's get rid of some of these extra layers and burdens that we put on physicians. Another thing that I see as a real problem, and this is when I was talking about the reimbursement for visits has just gone down in the past 20 years.

And so what ends up happening is that that's why the visit times have gotten shorter. And I don't even think patients are aware how long their visit is.

They just know, oh, my appointment is at 8 a.m. They don't know if their visit is for 10 minutes or 20 minutes or 30 minutes. They just come. But I think that we should tell patients how long that their visits are.

And if patients complain enough to the hospital, I think that, first of all, it would help because they're going to understand why you have your hand on the doorknob when they're talking about the other, oh, by the way, it's always the big issue that they have is, oh, by the way, when you're trying to run out the door to the next patient.

And sometimes those oh-by-the-ways are so important and then you spend another hour with that patient and then you're running behind with your other patient.

Oh, by the way, I have chest pain. You know, that's classic as you're walking around. Correct. Or oh, by the way, you know, my husband is beating me. And so that can be so hard to navigate.

But I think if patients understood how difficult it is for doctors, I think they would have more empathy for us. I know that your patients do because they trust you, because you have a long-term relationship with them, but just in general, patients don't trust doctors anymore.

And it's because they're being rushed. It's because of a lot of issues. And so I think that we need to be more transparent with patients about the limitations that we're under.

And then hopefully that blowback would make it better for us to practice for things like getting rid of prior authorization. These are challenging. And I don't know that we're not going to arrive at the one unified conclusion in one podcast episode, but I think from every level, our hospital administrators and physicians, everybody's existing in this same change.

And it would be instructive to look at. what used to work and what has worked in other countries and just try to make it so that the core experience that you want to work is the patient physician interaction or the surgery where

the physician is doing that for the patient and those healthcare provider to patient experiences need to be the defining thing.

And not the other way around. Sometimes it feels like, you know, and you've seen administrators that have done that before, like easy in, easy out, we'll just hire somebody else.

And I think what we're seeing is the supply chain on physicians who are willing to come in and do that is going to limit. And I think those who come after us are going to say, nope, I'm not accepting that.

lifestyle where you want me to work 60, 80 hours a week, or my part-time job is 40 hours. I think people are going to say, I'm going to reject that kind of side of medicine and I'm going to do only primary care in a direct primary care fashion.

Or you have other people that are just going to find another way. And in some ways, I think that's the only power we have is to vote with our feet. I hope that we can stay in medicine though, because I want to find a way to find that balance.

Because if everybody leaves, you don't have these caring, compassionate, wonderful physicians when you're in need. On the flip side, if you keep grinding everybody into the dust, then you don't have a wonderful workforce that wants to do it because they can't do it.

They can't exist in the current system. And so I appreciate your perspective. You've done this from the inside and now a little bit peripherally adjacent from the outside, kind of looking at it.

Any other thoughts on what you would see change? If you were queen of the world, what would you change? You know, I think there's just so many things, but no, I can't think of anything right now.

How about you? I think number one, I think I would try to limit the need for prior authorizations. I think that is a big deal. So I'm really interested to see what happens in Massachusetts.

And I think I would put a lot more strength of how things are paid to, you know, we talk about quality outcomes, but it can't be this big, huge time constraint thing.

Like just say, this is your patient panel and it probably shouldn't be 2000 people. Your patient panel should probably be, you know, 800 people or something like that for your panel.

And if you're a primary care doctor. And you're in charge of helping with that group and doing whatever it takes and make incentives around outcomes like that.

But don't do it always under the threat of what we're going to pay you way, way, way, way less. Like, because it takes years to become a doctor and it's so expensive.

If you primary care, goodness, if you cut their salaries because they had to go to a lower patient panel, it makes it undoable. The math doesn't work anymore.

You have to be able to derive an income from that. So I think I would just say policy makers need to look at that experience. The incentive thing I actually think is not good.

I think that, yes, we need people to look at our records and make sure that we're practicing appropriately. But I think when there is an incentive, for example, to make sure that your patients have colonoscopies or that your A1Cs are a certain level, what ends up happening in practice, as you know, is that in order to have perfect scores, you end up choosing patients.

Because there's only certain patients who are going to be effective. It's not on the doctor. It's on the patient population. There are certain patients that no matter what you do, maybe the goal with that particular patient is to

get their A1C from a 10.5 to an 8.3. And that's awesome.

If you do that, you're a hero. But that doesn't show when you're getting paid by how your numbers are. And so there's no incentive other than just being a good person if you're being paid that way.

to spend that time with that patient. So what's going to happen is that doctors are going to fire patients that are quote unquote noncompliant. And then the doctors who take on those more difficult patient panels are going to be paid less.

And that's not fair. Well, you're right. And I think the whole system needs to be blown up and started over again. And whatever needs to happen, it needs to be constructed around that experience of patient and doctor and outcome.

And like you say, if everybody came into it perfectly aligned with wanting to help patients, and if that's the defining core of the experience, you have an excellent physician, and patients who are going to get the very most mileage out of it.

That's what you want to be the main core of the system.

How to Follow Amy and Closing Remarks

I don't have all the systemic answers. I'm hoping these conversations will inspire others to look at and say, OK, what can I do as a physician? I'm just me.

I can't fix everything around me, but I can try to make it better. And so I find this inspiring. You have found ways to make your own life better. And you've talked about medicine.

You've talked about your experience. And I think you've given hope to those who might find themselves in trouble or they may find themselves where they're experiencing burnouts.

Thank you again for sharing all that. I really appreciate it. Thank you for reaching out and having this place to discuss these issues. I think it's really important.

Yeah, me too. One of the things I wanted to end on is how do people follow your work or how can they get ahold of you? If someone says, I'm interested in expert witness work, or I just think Amy is a really interesting person and I want to follow along with what she's doing.

How would you refer people to you? Well, I'm on social media on all the major platforms, Amy Fogelman, F-O-G-E-L-M-A-N-M-G. And you can reach me at highrockexperts.it'saplural.com.

Awesome. We'll put it in the show notes. Anybody interested in medical expert work or this realm of medicine, or just to get in touch with Amy and Picker Brain, she would be an excellent resource.

Thank you again, Amy, for taking the time to be with us and keep in touch. Thank you so much. Thank you. Thanks for tuning in to the Doctors Making a Difference podcast.

And thank you for what you do to help your patients and your community. Your work truly helps so many people. We produce this content to help you have the tools you need to stay in medicine and to highlight the amazing work being done by physicians around the world.

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See you next time.