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Managing millennial physicians

Keith A. Reynolds

As the physician shortage gets worse, experts say the health care system needs millennial physicians to shore up the workforce. At the same time, as millennials are seeking changes to the day-to-day operations of the system, they're driving a much larger conversation about what health care should look like.

Ted Epperly, M.D., president and CEO of Family Medicine Residency of Idaho in Boise, sees the millennial generation of physicians as a way to refill the ranks but warns that all physicians aren't equal. It will take more than one millennial to fill the hole left by a retiring baby boomer doctor, he says.

"The data on this are that for every retiring baby boomer physician, it'll take about 1.7 millennial replacements," Epperly says. "The reason isn't that they're not as capable, it's that they're not willing to put in the 80-hour workweeks."

Andrew Hajde, CMPE, director of content and consulting at Medical Group Management Association (MGMA) in Englewood, Colorado, says the health care system is reaching a point where millennial physicians are becoming the only ones left to pick up the slack of retiring baby boomers and Generation Xers before Generation Z comes of age. "I think you have to learn to work and integrate (millennials) into your system," Hajde says.

Millennial physicians are simply different from the generations of doctors who have preceded them, which can pose challenges for physicians seeking to fold them into their practices as doctors. These challenges include different attitudes toward work-life balance, technology and mentoring.

Work-life balance and purpose

Although some pundits may decry millennials' love of avocado toast and their shunning of certain industries, Epperly says he believes they are bright and creative physicians who aren't afraid to put in the labor. However, their philosophy is diametrically opposed to his own generation's views on work. "They want to do (the work) quickly, efficiently and effectively, but then they want to hand it over to the next capable and accountable person so they can then get to the rest of their lives," he said.

A survey of final-year medical students performed by national physician search and recruitment firm Merritt Hawkins found that new doctors are taking their desire for more free time into account when evaluating employment

opportunities.

Natasha Bhuyan, M.D., is a family physician and regional medical director with One Medical in Phoenix, and she is a millennial. In her role with One Medical, she speaks to many millennial physicians, and what sticks out to her about the cohort is their desire to be fulfilled by practicing medicine.

Unlike previous generations, though, millennials don't base success on hours spent in the office or number of patients seen, Bhuyan says. "They're measuring success based on fulfillment of purpose, developing meaningful relationships with patients, having time to connect with patients, (improving) their behaviors and (seeing) health results and outcomes change," she says. Millennial physicians are less interested in starting their own practice and prefer employment with a physician organization aligned

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with their values, according to Bhuyan.

Hajde spent years managing group practices and says that this move from starting a practice may be due to the increased emphasis on avoiding burnout. "They see some (individuals) – not (only) physicians but (also) those with different jobs and careers across the board – struggling with burnout and other things when they try to take on too much at one time," he says.

Millennial physicians are less interested in being the prototypical "cowboy" doctor, seeking to take care of all a patient's needs but are more interested in being members of a team in which each member has their role, with the combined goal of offering the patient high-quality care, Bhuyan says.

Technology

Experts say millennial physicians are more comfortable with technology than other generations. Cristy Good, MPH, MBA, CPC, CMPE, a senior industry advisor with MGMA in Denver, says technology is a key marker in the generational divide in practices. Although some older physicians may be reluctant to use newer technology, or have resisted technology in general, millennial physicians are looking for tools that increase communication. Additionally, where older physicians may have stuck with paper charts and were used to discussing things in staff meetings, millennial physicians were using an electronic health record in medical school and believes communication among colleagues can be handled in quick emails and text messages.

With many millennials not having experienced a world without the widescale integration of the internet, Epperly says younger physicians are extremely tech savvy and won't even look at working at a practice where the technology isn't current.

Bhuyan says that although millennial physicians are indeed looking for better technology integration, they aren't seeking technology just for the sake of it; they're looking for technology that allows them to practice at the top of their license without getting burned out. "We want technology that enables us to have a career that's professionally rewarding and takes out all those inefficiencies and administrative burdens in the system that tend to drive that burnout," she says.

Hajde says millennial physicians must be cautious, as too much communication technology can turn patients off because of the lack of personal contact with their physician. "As newer physicians come into the field using technology, we have to be really careful to maintain that relationship with the patient," he says. "They need to look at them when they're seeing the patient, not stare at the computer screen."

Feedback and mentoring

Epperly says the key things millennial physicians need are feedback and mentoring, which are different from the needs of Gen Xers. "They see the value of picking a senior person's brain to help them be more efficient and more effective," he says.

Bhuyan says millennials have also changed the forms that feedback and mentoring can take. The model is no longer just a senior physician transferring everything they know to the junior physician. "I like to think of mentorship like coaching: How do we coach physicians to reach the top of their potential and beyond? How do we push individuals beyond what they think is their best?" she says.

Bhuyan adds that millennial physicians should have a hand in guiding their own development and mentoring, and practice managers should be willing to place them into higher roles within the practice.

Keith A. Reynolds is the editor of Physicians Practice®.

Would you go to a doctor like you?

Neil Baum, M.D.

Several years ago, I was over 45 minutes late to see a patient who was also a good friend. When I entered the exam room, he was livid and said, "Neil, would you go to a physician like you?" Not getting the drift of his question, I asked him, "What do you mean?"

He said, "Would you go to a doctor who keeps a patient waiting for 45 minutes for a routine appointment?" I said that I wouldn't like to wait for the doctor. He then told me he didn't appreciate it, either, and that he wanted a copy of his records and would take his urologic care elsewhere, with a doctor who respected his time. No matter how many apologies I offered and promises not to be late again, his mind was made up, and he left the practice for a new physician.

I was devastated and decided I would not let this happen again and was going to develop a patient-centric practice. I

began by developing moments of truth (MOT) analysis. The first MOT is not when the doctor is eyeball-to-eyeball with the patient. I identified interactions between the practice and our patients. I tried to make those interactions as positive as possible for the patients. Instead, the first MOT is usually the telephone.

We now have a script on each phone that asks the receptionist to smile and be enthusiastic, as the smile can be heard on the other end of the line. We have a small mirror in front of the phone to encourage the receptionist to smile. Now the receptionist can receive feedback that they are smiling. That is where most patients develop their first impression of the practice.

The receptionist identifies the practice and then gives their name, as there should be no anonymity. Each caller wants to know to whom they are speaking. Finally, the

To streamline the visit, the receptionist suggests that the patient complete the demographic information and the health questionnaire before coming to the office.

receptionist tries to personalize the call by using the caller's name several times during the conversation. After all, the most important word in the human language to us is the sound of our own name.

The receptionist also directs the patient to the practice website, which contains a map with directions to the office, suggestions for parking, and information about the physicians. The receptionist emphasizes the importance of the patient obtaining authorization from their primary care physician (PCP), and failure to have this authorization will significantly delay their visit to the office. The receptionist tries to find out the purpose of the visit and will suggest that the patient review the educational material on the website related to why the patient is seeking an appointment.

For example, suppose the patient is referred by a PCP for an elevated prostate-specific antigen (PSA) level. In that case, we include information about PSA testing, which also discusses free\total PSA, an explanation and indications for an ultrasound and prostate biopsy. Now the patient is educated about their problem before their visit.

To streamline the visit, the receptionist suggests that the patient complete the demographic information and the health questionnaire before coming to the office. This avoids the patient spending 20 to 30 minutes to complete those forms and impacting the schedule. Patients are told that completing the forms in the comfort of their homes will facilitate their visit and make it possible for the doctor to see them at their appointment.

The receptionist informs the patient about their responsibility of paying a co-pay and that they will be responsible for the entire bill if they have not met their deductible. This avoids the sticker shock when the patient receives a large bill when they complete the doctor-patient encounter.

Finally, the website mentions what instructions are necessary for their first visit. For example, if the patient will be asked to provide a urine specimen upon arrival in the office, they should consume extra fluids to facilitate this lab test. This avoids the typical scenario of patients going to

the restroom before they come and having to wait 20 to 30 minutes for them to hydrate to provide the specimen.

The next MOT is the time spent in the reception area (not the waiting room) and the time in the exam room, waiting for the physician. We have tried to reduce time in the reception area by engaging the patient in the exam room before the medical assistant or physician enters the room. New patients taken to the exam room will watch a 5- to 7-minute video of the practice that introduces the doctor and the office staff. This way, the patient meets the physician and other staff members involved in their care.

Finally, we suggest closing the loop and surveying the patient after leaving the office. This is important to understand the patient experience, identify any problems that occurred and provides you with an opportunity to correct them so you can have continuous improvement and increase patient satisfaction. This improves your online reputation, if the patient goes to review sites and comments on their experience with your practice.

Bottom line: I find it interesting that the golden rule that was given to us over 2000 years ago still applies to today's health care delivery. We all need to answer the question: Would we like to be treated by someone the way we are treating our patients? If the answer is no, we make the changes to give each patient a positive health care experience, or the same experience we would like to have when we require health care.

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Bipartisan legislation introduced to ban selling health and location data

Rachel V. Rose, JD, MBA

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which had the U.S. Department of Health and Human Services (HHS) modify certain standards on August 14, 2002, established parameters for certain types of marketing and the sale of protected health information (PHI). Found at 45 CFR §§ 164.501, 164.508(a) (3), the HIPAA Privacy Rules provides individuals with certain privacy rights and important controls over how their PHI is used and disclosed. As HHS iterates on its website, “(w)ith limited exceptions, the rule requires an individual’s written authorization before a use or disclosure of (their PHI) can be made for marketing. So as not to interfere with core health care functions, the rule distinguishes marketing communications from those communications about goods and services that are essential for quality health care.”

There are different applications of marketing, and the one that constitutes the disclosure of PHI “in exchange for direct or indirect remuneration, for the other entity or its affiliate,” requires the express written consent of the individual patient, which must be prominently placed on the HIPAA authorization form and give the patient (or the patient’s legal representative) the option of opting out of the sale at any time. And, depending on the nature of the relationship between the covered entity, business associate and/or subcontractor, a business associate agreement.

In 2018, the HHS Office for Civil Rights announced a \$100,000 settlement with Filefax, Inc. – a company that once provided storage and disposal services for medical records – for allowing an unauthorized person to remove PHI, leave it unsecured outside the facility and attempting to sell the PHI without the patient’s express written authorization. The take-away: It’s illegal.

Fast forward to June 2022, in light of *Roe v. Wade* being overturned, privacy rights that have been protected under the 14th Amendment of the U.S. Constitution under an individual’s “zone of privacy” are at risk. A bipartisan group of senators introduced the Health and Location Data Protection Act, which, if passed, may mitigate the effects of *Roe v. Wade* being overturned and would fill a significant gap in U.S. privacy law. The data broker industry brings in \$200 billion a year. Three of the key features of the bill are as follows:

Ban data brokers from selling or transferring location data and health data. The bill forbids data brokers from selling or transferring location data and health data and requires the Federal Trade Commission to promulgate

rules to implement the law within 180 days while making exceptions for HIPAA-compliant activities, protected First Amendment speech and validly authorized disclosures.

Ensure robust enforcement of the bill’s protections. The bill empowers the Federal Trade Commission, state attorneys general and injured persons to sue to enforce the provisions of the law, allowing for remedies, such as damages and injunctions, to stop any illegal practices.

Provide funding to the Federal Trade Commission to act. The bill provides \$1 billion to the Federal Trade Commission over the next decade to carry out its work, including the enforcement of this law.

In the meantime, HIPAA’s Privacy Rule coupled with the 14th Amendment’s zone of privacy may be a solution. Individual states have also begun to follow California’s lead and pass legislation similar to the California

Ban data brokers from selling or transferring location data and health data.

Consumer Privacy Act. Regardless of an individual’s stance on abortion, all Americans should take issue with companies – whether medical device companies, big tech companies or data brokers (among others) – selling or disclosing information without the express written consent of the person in a manner that does not constitute a contract of adhesion. Rare situations, such as a grand jury subpoena, exist for the government to directly request such information without violating a person’s individual Constitutional rights, which is why both substantive and procedural due process exist. It is critical that patients are aware of their rights and that companies are aware of what’s legal and have adequate compliance programs in place.

Rachel V. Rose, JD, MBA, advises clients on compliance, transactions, government administrative actions and litigation involving health care, cybersecurity, corporate and securities law, as well as False Claims Act and Dodd-Frank Whistleblower cases. She also teaches bioethics at Baylor College of Medicine in Houston. Rose can be reached through her website, www.rvrose.com.

Trusts 101 for physicians: Part one

Ike Devji, JD

Trusts can be effective and important legal tools, but they are not all the same and they are not universally interchangeable. We examine some of the trust law basics and terms every successful physician should know when evaluating their own legal planning needs.

What is a trust?

For the purposes of our discussion, a trust is a formal, binding, legal document that allows an individual to create and transfer title to property or value of any kind to the control of another for the benefit of a third party.

- The person who creates and funds a trust is known as a “grantor” or “settlor.” If there is more than one, they are known as “co-grantors” (i.e., husband and wife as co-grantors).
- The trust is under the control of an individual known as a “trustee.” If there is more than one trustee serving at the same time, they are known as “co-trustees.”
- The trustee manages the trust in accordance with the terms it provides, most commonly for the benefit of a third party, known as the “beneficiary.”
- There may be one or more beneficiaries, and some trusts name ‘primary’ and ‘contingent’ beneficiaries (i.e., wife leaves estate to her husband as primary and to her 3 children as contingent beneficiaries, if he predeceases her).

There are also cases where one may create and fund a trust for their own benefit, during their own lives, as opposed to those created solely for the benefit of third parties. These are referred to as “self-settled trusts” and are commonly seen in various forms of asset protection trusts, including both those used by successful, high-risk professionals, such as doctors, and those for Medicaid asset protection planning.

Trust situs – jurisdictional issues

The term “situs” refers to the jurisdiction and choice of law selected for the trust. Trusts may be established under the law of your state, another U.S. state or the laws of a foreign nation (offshore). Different jurisdictions may have significantly different laws, taxation and compliance requirements, including the asset protection benefits they provide.

1. Offshore trust, aka International Asset Protection Trust or
 2. Domestic Asset Protection Trust, established in one of 19 states that specifically allows
- Some special purpose asset protection trusts don’t rely

on specific creditor protection laws at all, but rather on other well-established legal principles, including arm’s length sales transactions (i.e., you sell an asset to a trust for fair market value) and gifts to trusts that are considered “completed gifts” by the IRS for tax purposes, where you permanently relinquish title and control.

The myth of trust secrecy

Any asset protection plan or planner that uses the term “secret” should be a glaring red flag and most likely avoided. There is no such thing as secrecy in the law (as opposed to privacy, which does exist and can be a trust benefit), and any plan that relies on assets being held in a trust, LLC, etc., that you hope isn’t found will also require your willingness to actively lie to conceal it. Why? Because an experienced litigator will simply ask you under oath in discovery, deposition, a debtor’s exam, etc., to disclose, “any trust, partnership, corporation, foundation or similar device that you are a grantor, trustee, beneficiary, officer, member or director of.” You’ll either answer honestly, or you’ll be committing perjury.

As desirable as privacy is, it is not a substitute for careful drafting, compliance and the right choice of jurisdiction, all of which can lead to a trust being effective and defensible, even when you disclose it to an adverse party.

Two key trust terms: Revocable and irrevocable

These are key terms in any trust, and understanding them is especially important to those who are using any trust as part of an asset protection plan. Fortunately, their usage in the law is plain-English usage. A revocable trust can be revoked at any time up until your last breath, allowing you to change the trust details, including the trust’s assets, and beneficiaries. As such, a revocable trust is defective against your creditors and liabilities during your lifetime. An irrevocable trust, on the other hand, makes a permanent transfer of assets away from yourself to the trust so the assets are trust property and not available for your personal or professional liability.

Ike Devji, JD, has practiced law exclusively in the areas of asset protection, risk management and wealth preservation for the past 16 years. He helps protect a national client base, with over \$5 billion in personal assets, including several thousand physicians. He is a contributing author to multiple books for physicians and a frequent medical conference speaker and Continuing Medical Education presenter.

Messy moments: That's not the way we do things here

Nance Goldstein, Ph.D., M.Sc., ACC

That's not the way we do things here!

You've asked a clinician in your care group to do something differently. That person objects. You've heard it before: "That's not the way we do things here!" You may see anger or frustration in the other's face.

What would you like to happen here?

You decide your own intention. Possible directions here include the following:

1. Persuade them to do it, even when you aren't around. That means they must want to do it. You need their buy-in. They may agree because it's valuable for patients or themselves.
2. Energize them so they see something for themselves in successful change and feel your support.
3. Show you understand what this means for them and their workday. It's a lot more successful than anger or reprimands.

Address their anxiety or fear

1. Start with acknowledgement and appreciation. Tell them something you've seen them do well. Appreciate a quality they bring to the work and the group.
2. Tell the resister you'd like to understand how they feel about the way "X" is done now. Acknowledge those feelings, genuinely, whatever it is.
 - "It's understandable..." or "I bet others feel the same..."
3. Ask whether there is anything they dislike or wish we did better in "X."
4. Ask how they'd solve the situation. They'll have ideas!
5. Find out what they really care about from any solution. This helps you find out where they can tap their own courage.
 - "Are there principles that matter to you enough that you'd be willing to try a solution that honors those principles?"
6. Tell the person you'll think about what they said.
7. It helps you to know what got in the way of their suggesting the possibilities before. Ask and listen carefully to the answer, particularly the emotions behind the words.
8. If you know the person well enough, tell them you've seen them use wisdom, courage, carefulness or something positive in their work in the past. Offer your confidence that this capacity and experience from the past will help them make this transition now.
9. Acknowledge that it does require courage, or at least curiosity.
10. Explain how you'll support them through whatever

change is made. You're there for them if questions or problems arise. Assure them you'll check in with them soon.

What does this do for you and your practice?

Health care is more complex, uncertain and turbulent than ever before. These conditions inevitably cause distress. People were already stressed, but turbulence ratchets up discomfort.

The resistance may be coming from fear: Will I be able to do it? Will it make the rest of my job harder? They must give up the familiar, comfortable ways of doing things. They're already rushed like crazy to do necessary tasks.

Anxiety and distress also jeopardize care reliability and safety. Addressing the emotions underneath resistance is the best way forward. Emotions (not logic) drive our behavior. The perceived threat must be reduced or removed. People need reassurance, support and psychological safety. They need information and support so they see how they can do it with ease. They need to know they don't have to be perfect. They want to know you'll continue to value and support them.

We are always threatened by status. Our brain is always scanning: Is this person more important than I am? Less important? Imposing changes sends the signal that individuals have no say and no control over their work. This threat is magnified for individuals in groups with histories of being ignored, excluded or considered lesser. Anxiety or anger rises because it triggers old bad feelings. You can soften the resistance and increase the sense of safety by knocking down the high, hard walls of rank between you.

- The more you talk together and show you value their thoughts, concerns and hopes, the more you remove the bricks in the wall between you.
- The more people feel on the same level as you with the problem and potential solution, the more you reduce the discomfort or fear of the change.

- The more you talk with them about how you can accommodate their concerns, the more they relax about what's coming.

Your approachability and reassurances also help them feel included. You make a critical shift from "I'm here to judge and blame you," to "I'm here to support you. If you have a problem, it's our problem." They'll be more likely stay in the game despite discomfort.

Nance Goldstein, Ph.D., M.Sc., ACC, partners with physicians as a leadership coach to find ways through today's tough times and enjoy medicine more

How to do away with the broken health care system

Colin Zhu, D.O.

According to Visier, the first quarter of 2021 and 2022 saw the highest increase in resignations among individuals of age 40 to 60 years or those with more than 10 years of experience. If you are thinking that this is only limited to business owners, restaurants or retailers, then you had it wrong. Physicians who felt the rage of COVID-19 are also suffering.

Let's get things straight. How do we deal with this broken system? Will physicians still get out of this trap?

Private practices are being swallowed up

Before the pandemic, the number of independent practices continued to drop. Even today, more and more physicians are on the verge of extinction. There are two reasons: rising compliance costs and changing reimbursement models.

We know how everyone is affected by the COVID-19 pandemic, so "financial capacity" comes in. As per personal activity intelligence, between January 1, 2019, and January 1, 2022, influential health organizations bought more than 36,000 medical offices. This is 38% higher than corporate-owned practices. Doctors thought that as they join more prominent corporations rather than being practice owners, they would have more flexibility and enjoy other benefits.

Patients suffer in broken systems

Health care systems strive to accumulate more significant market share. In return, patients get higher prices for every service they need. But the question is: Are you sure doctors' salaries will change, too?

The Health Affairs study shows a physician's salary decreases after a hospital acquires its practice. In addition, doctors employed by large conglomerates are often prohibited from referring patients to providers outside their health system. As a result, if a specialist with knowledge on a particular health problem is not part of the referral network, the patient may be unable to visit them. It's no wonder patients report lower satisfaction rates when they receive hospital care in markets with higher concentration levels.

It doesn't have to be this way. You don't have to play the game.

I believe the future of private practice is bright. Although many in the industry see indicators as heralding the extinction of private practice, it can still be leveled out and may be reversed. Here are some ways you can leverage being a private physician rather than being employed.

- Learn how to avoid frequent private practice stumbling blocks.
- Learn how to expand your patient panel.
- Create an appropriate environment for your private practice team.
- Your private practice is only as effective as the counsel you receive.

Don't overlook private practices because you think they won't be around much longer. Instead, consider the independence and cost reductions they can give, and base



your selection on your own situation.

I believe physicians will play an important, growing role in any reformed health care system for all these factors. Of course, things are different and have begun to evolve dramatically for physicians today, but it is safe to say that the sky hasn't fallen yet for those who are in private practice.

Colin Zhu, D.O., is a traveling physician who is board certified in family practice/OMT and lifestyle medicine. He has practiced as a CompHealth locum tenens physician for four years. Additionally, Zhu is an international speaker, author of Thrive Medicine: How To Cultivate Your Desires and Elevate Your Life, podcast host of Thrive Bites, and creator of The THR5 Formula™ Masterclass Series, an online resource for health care professionals and students on learning how to thrive.

Shifting the mindset behind how we practice medicine

Trevor Cabrera, M.D.

Although most in the health care industry have heard of travel nursing, especially during the COVID-19 pandemic, a lesser-known field of medicine is the world of locum tenens. Like travel nursing, locum tenens encompasses physicians, physician assistants and nurse practitioners who work in temporary assignments around the country. A Latin phrase coined by health care staffing agency CHG Healthcare in 1972, locum tenens means “to hold in place of” or “one holding a place.” Contrary to popular belief, this musty Latin term has the potential to spark a larger cultural shift in how we practice medicine in the future.

It’s never easy navigating the workforce fresh out of residency, and with the advent of the COVID-19 pandemic, many pediatricians were faced with a growing paucity of work. As my peers were seeking out jobs in academia, private practice and fellowship training, I drew up blueprints to walk an uncommon path toward exclusive work in locum tenens. From my perspective, jumping into the market of locum tenens was akin to entering an underground society of traveling doctors, targeted at helping to fill gaps in health care throughout the United States.

While my colleagues were settling into their new careers, I was busy obtaining multiple state licenses and preparing to broaden my experiences through working in myriad health care facilities, geographic locations and various practice settings. To deepen my medical experiences and continue down the path of eternal education, I sought out work in some of the most isolated spots in the country. From the desert of New Mexico to the greater plains of North Dakota to the lakes of central Maine – the more I practiced in these rural areas, it became clear that these are the region’s most in need of providers. According to the Association of American Medical Colleges, “Of the more than 7,200 federally designated health professional shortage areas, 3 of 5 are in rural regions. And (although) 20% of the U.S. population lives in rural communities, only 11% of physicians practice in such areas.”

As I traveled from job to job, acquiring new skills, new connections and reaching a level of flexibility that historically doesn’t exist in medicine, it allowed me to appreciate the everchanging landscape of hospital needs and how I could use my skills to help meet them.

Locum tenens work has given me the ability to create my own schedule. Although I could have easily chosen a life of frequent vacations, I instead chose to maximize my work schedule, navigating from one assignment to the next. In February 2020, I sold 80% of my belongings, moved the remainder back to my mother’s house in California and

gave up my home base entirely. With no rent or utilities and most expenses reimbursed by my agency, locum tenens has allowed me to pay off medical school loans at five times the speed of my colleagues, all while quenching my growing wanderlust to travel around the country. In less than three years after residency graduation, I will be loan free – seven years sooner than had I sought public service loan forgiveness.

In 2021, I traveled a total of 320 days across multiple states and hospitals, covering for facilities awaiting permanent providers, clinicians on maternity leave and vacations and physicians who are constantly overworked.

I quickly learned the art of business negotiations, the variations in hospital contracts and the ins and outs of an organization’s infrastructure

I quickly learned the art of business negotiations, the variations in hospital contracts and the ins and outs of an organization’s infrastructure – essentially, the parts of medicine that are often not taught in medical training.

Locum tenens is not for everyone, but it does provide a meaningful alternative to traditional workplace settings in medicine that are prone to provider burnout, constant employee turnover and a loss of focus as to why we went into medicine in the first place. While my peers have found themselves navigating the complexities of a singular job, I have already navigated working in over a dozen hospitals and clinics. I have learned flexibility, fostered exploration and experienced compounding personal and professional growth. Today, I am proud to call myself “The Nomadic Pediatrician” and look optimistically toward the future of locum tenens and where it may take me.

Trevor Cabrera, M.D., is a California-born, Southern-trained pediatrician, with an interest in pediatric oncology, intensive care, neonatology and hospital medicine, who is working as a CompHealth traveling locum tenens provider.