

Being Well in Emergency Medicine: ACEP's Guide to Investing in Yourself

Edited by Rita A. Manfredi, MD, FACEP and Julia M. Huber, MD, FACEP



American College of
Emergency Physicians®

ADVANCING EMERGENCY CARE 

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Dedication

We would like to dedicate this living electronic book to emergency physicians, past, present, and future, in the Wellness Section and on the Well-Being Committee and to all the ACEP staff members over the years who had the foresight to recognize the importance of wellness in the longevity and resilience of doctors who dedicate their lives to the unknown patients who arrive through the doors of the emergency department.

Rita Manfredi, MD, FACEP, Chair, Wellness Guide Subcommittee, 2014-2017

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FOREWORD

In the mid-1990s, as emergency medicine was in the early years as a specialty, the American College of Emergency Physicians (ACEP) developed a Personal and Professional Well-Being Task Force and formal ACEP committee in order to examine emergency physician well-being. This Committee's booklet, "Wellness for Emergency Physicians," became the first professional resource for emergency physicians to address our needs in all stages of our careers, explore the stressors specific to our specialty, and provide guidance for coping mechanisms and wellness planning.

In 2004, the Well-Being Committee updated its text, "Wellness Book for Emergency Physicians," and the current Well-Being Committee is very proud to present the 2017 version. Now more than ever, emergency physicians are called upon to be flexible, resilient, and self-sacrificing. The changes in the field of medicine in general are not for the fainthearted, and emergency medicine is no exception. As emergency physicians, we are rising to the unique challenges that advancement in technology requires, and together, we are all looking for ways to adapt and stay well throughout our careers so we can best serve our patients, our communities, and our families, while continuing to take care of ourselves.



INTRODUCTION

What is wellness and why do we care? It is difficult to write about wellness because it sometimes sounds so trite, especially to emergency physicians. But we all know, on some level, just how necessary it is. As human beings we all hope to be well, but wellness is more than just the absence of sickness. Many people and organizations have attempted to define wellness. The World Health Organization has distilled wellness to “a state of complete physical, mental, and social well-being.” The National Wellness Institute sees wellness as an evolving process in which a person achieves his or her full potential.

Our goal here is to show emergency physicians what wellness is and why it is so important. What constitutes wellness for one emergency physician can be different from what another emergency physician needs to be well. But there are some universal elements to wellness that affect each physician. The elements are interconnected and contribute to how we live. However, each emergency physician may choose to prioritize these in a different way.

We can think of wellness as a wheel with separate spokes. Each spoke is critical for the wheel to keep turning. Similarly, wellness is multidimensional. By looking at wellness this way we can see how these elements are interconnected and contribute to how we live.



Being Well in Emergency Medicine: ACEP's Guide to Investing in Yourself



THE WELLNESS WHEEL

The Seven Spokes of the Wellness Wheel

1. The Occupational Spoke

Are you happy as you travel to your shift at the hospital? Think about what gives you satisfaction when working in your ED. For the moment, discard all the negatives and think what positives there may be about your department. Is it the people, the system, the setting that gives you satisfaction? Do the procedures energize you? Is it the interaction with patients that is satisfying? Are you challenged by figuring out why a patient is so seriously ill? Discover what makes you happy to be in the ED. Think about the warm blankets from the blanket warmer—don't they always make everyone happy? The myriad "need to fix" departmental issues will always be present. The key is to balance them with the enjoyable aspects of your job. You will have to find those positives because human nature naturally gravitates to what is wrong first, rather than to what is right.

2. The Emotional Spoke

Emergency medicine is rapid-fire and stressful. How many of us take the time to understand what we are experiencing and feeling? Our mode of operation in the ED is singularly fast-paced. There is little time to contemplate why we feel angry at the "patient in room 5" or why we are annoyed with the consultant we spoke with on the phone. As emergency physicians we have to acknowledge what we are feeling, rather than deny our emotions. We may be annoyed with contrary consultants or difficult patients, but we have the power to choose how we will behave and manage these feelings. Optimism and maintaining satisfying relationships with others are key to wellness.

3. The Physical Spoke

Exercising enough, eating well, getting adequate sleep, and paying attention to the signs of illness and getting treatment when needed play a big role in physical wellness. Emergency physicians who are in good physical shape will reap the psychological benefits of greater self-esteem and self-control.

4. The Financial Spoke

Being financially secure is a key component to your effectiveness as an emergency physician. Part of financial wellness is to develop a plan by establishing goals such as providing for your family, paying your monthly bills, planning for your children's education, and creating a nest egg that provides for a comfortable retirement and future travel. You can measure your progress and be confident of the result.

5. The Spiritual Spoke

What gives you meaning and purpose in emergency medicine? Is it the art of helping and healing? The spiritual dimension will be characterized by times of peaceful harmony interspersed with rocky times of disappointment, doubt, and fear. In emergency medicine, every day we have these experiences which cause us to adapt and bring meaning to our existence.

6. The Social Spoke

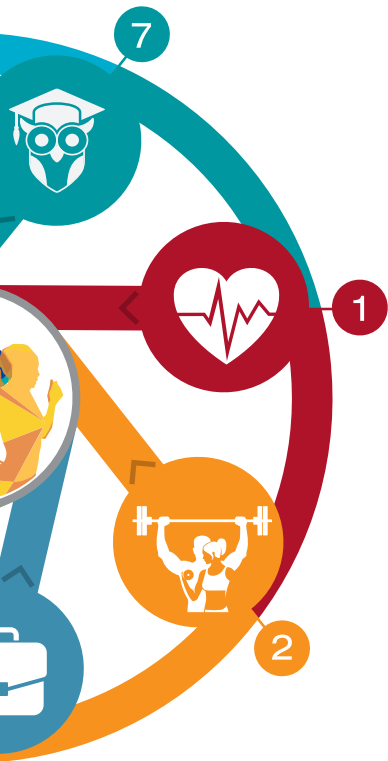
How are you relating to others in the ED and in your life outside the department? Developing effective relationships with colleagues, patients, friends, and our families indicates social wellness.

7. The Intellectual Spoke

As our specialty continually changes and evolves, having an open mind in emergency medicine is critical. Sharing what you know with others in the ED can be stimulating and serve as a way to challenge yourself.

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THE EMOTIONAL WELL-BEING SPOKE

Happiness and Resilience in the Life of an Emergency Physician

By Rosanna Sikora, MD, FACEP, Laura McPeake, MD, FACEP, and Arlene Chung, MD

Emergency physicians are some of the most amazing and resilient physicians in all the specialties. What makes them so? Is it our constant trips to the greatest heights of human behavior followed by the most devastating lows of tragedy followed by a return to the heights again that makes us know happiness and resilience better than any other specialty? We must first understand a little about general happiness and resilience to understand how to better find this place of higher living. We have provided some thoughts about happiness and resilience, followed by a very nice case study of these concepts put in action. References are provided to assist the reader with further study of this topic.

The opposite of depression is not happiness, but resilience.

Engagement and meaning appear to be the strongest contributors to living a happy life.

You can strengthen happiness and resilience by practicing.

Resilience is a choice to weather a storm and make the best of it. It is a skill to be learned and nurtured.

What is happiness for an emergency physician? Cooperative patients? Interesting cases? Collegial consultants? Efficient supportive staff? Wonderful nurses? More than this?

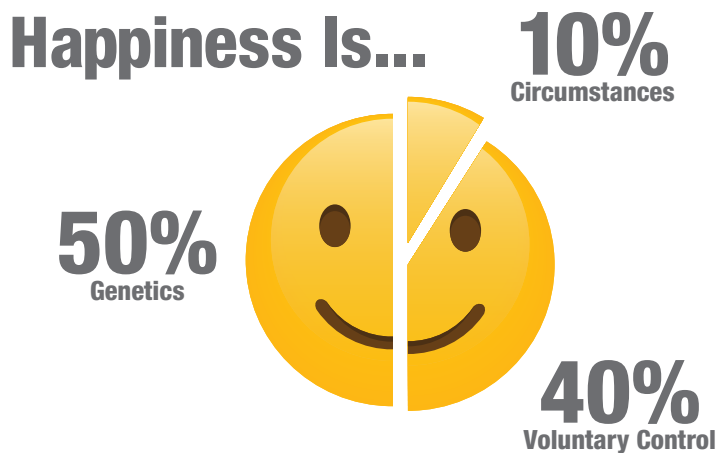
Happiness is sometimes thought of as “The Good Life.” It is so much more than a single entity. Happiness is more than the presence of joy and pleasure and not only the absence of suffering.

We know that happiness is probably not the attainment of a great station in life. When we start an emergency medicine residency, we are all possibly in a state of ignorant bliss. As we

progress through our training we see that emergency medicine is chock full of successful intubations and central lines and exciting resuscitations. But, emergency medicine is also accompanied by mind- and body-numbing hours and hours of clinical work, on-call duties, and fatigue. We are happy, but we are unhappy, too.

We realize that happiness is not just the procurement of some object. Rather, happiness is a subjective state of well-being. We seem to know it when we see it. Seeing it makes it more attainable. How can we open our eyes more often?

Happiness is real and can be measured. We all possess a happiness sensor—a meter of our own daily positive emotions and a feeling that life is worthwhile. We can accurately report happiness. Martin Seligman, a leading researcher in positive psychology and author of *Authentic Happiness*, describes happiness as having three parts: pleasure, engagement, and meaning. Moment to moment, we may have good feelings, or pleasure; however, *engagement and meaning appear to be the strongest contributors to living a happy life*. Therefore, each individual easily controls a large portion of happiness. Seligman has said that genetics accounts for 50% of our happiness—the natural lark vs. the sour lemon is only 50% controlled by genetics! Circumstances in our lives, such as health, account for 10% of our happiness. The final 40% of our happiness is under voluntary control and involves the degree to which we engage in a meaningful life.



Engagement in meaningful activity really appears to be the root cause of happiness. We can choose to find meaning in our lives on a daily basis. Viktor Frankl, a prominent Jewish psychiatrist and neurologist, stated this even more succinctly in his 1946 book, *Man's Search for Meaning*. In revealing the horrendous stories of life in Nazi concentration camps he notes, "Everything can be taken from a man but one thing, the last of human freedoms—to choose one's attitude in any given set of circumstances, to choose one's way." He also stated, "Happiness cannot be pursued; it must ensue. One must have a reason to be happy." This concept is advanced in current happiness literature, which points out that just because we graduate from an emergency medicine residency or happen to land a "dream" job, we are not guaranteed happiness. We must choose what is most meaningful in our lives along the way to be happy.

Viktor Frankl leads us to a better description of happiness and one that would serve us well in our daily stresses as emergency physicians. He touches the concept of resilience. Peter Kramer, who is the author of *Against Depression* and *Listening to Prozac*, has stated that the opposite of depression is not happiness, but resilience. Strengthening resilience is what appears to be the direction for dealing with burnout and will ultimately lead to happiness and joy in spite of our oftentimes difficult work situations.

Where do we find this resilience? In the eyes of a grateful patient? From the support of our family? Do we find it in the praise we might occasionally hear from a colleague or superior? Do we find it when we look at our team in the ED; the nurses, techs, secretaries, and other doctors who work together to make something bigger and greater than if we all stood alone? Resilience is there for all of us; we just need to tap it.

The following is a short example of resilience in a real life scenario. See if you can find examples in your practice and life of the same sort of resilience. By opening our eyes, we see the beauty of human spirit and reward ourselves with happiness.

Long-time emergency physician, Dr. Silien, is regarded by many of his colleagues as a mentor and an example of unfailing grace and humor under pressure. We recount a typical Dr. Silien story during sign-out, where he reports:

“So this is a 57-year-old male with chest pain that seems atypical to me.

“Initial work up negative.

“Benign EKG, no other risk factors.

“Once his labs come back, discharge him with follow up tomorrow in ASYSTOLE clinic.”

It takes a minute for his joke to set in. We all chuckle and look at each other knowingly.

This case underlines the uncertainty with which we all live. It is a lesson in resilience, seeing something alarming and being able to be tougher on the other side of it because you were able to face it. Despite all the blows that time has thrown him, Dr. Silien has weathered every diagnostic dilemma, near miss, and adverse outcome with poise and a little gentle humor. He really cares and recognizes that this won't always save him or his patients from possible disaster, but most of the time it will see him through. He subconsciously copes by using narrative reflection, atypical humor, and peer discussion. He has the ability to take a hair-raising situation and weave it into a comforting blanket that has us all rolling on the floor laughing.

The truth is that every moment we practice emergency medicine is an exercise in either resilience or burnout. Recall the terrible moments after pronouncing a patient dead who had walked into your emergency department a few hours earlier. We can let our emotions overwhelm us and become brutally self-critical, or we can repress all feelings and risk them spilling over later and affecting our family, friends, and physical and mental health. Both paths lead down the road to burnout. Or, we could hunt for a silver lining—a learning opportunity, a lesson in compassion, or even a chance to contemplate our own mortality.

That *ability to take something positive away from any situation, no matter how difficult*, is resilience. And since we, as emergency physicians, are in the business of embracing stressful situations, we must learn how to be resilient.



We have all grown tired of talk about burnout. We realize we are flirting with it every day. Consider resilience and burnout as existing on opposite ends of a spectrum of wellness. By countering burnout, we create resilience, the ability to weather anything that comes through the door. Stanford researcher Christina Maslach and her colleagues have defined burnout as a triad of emotional exhaustion, inefficacy, and depersonalization. Resilience emerges from counteracting each of those facets resulting in rejuvenation and connection with others.

We have developed specific strategies to help build resilience in the practice of emergency medicine. Most of them are likely to help, and we encourage you to start using them today.

Writing a journal or recording oral narratives.

Transforming traumatic experiences into cohesive narratives, such as the many colorful stories shared by Dr. Silien, changes them from potentially damaging emotional memories into opportunities for growth. Observe and note your coworkers and patients for inspiring behavior. This can be done by verbally recording your thoughts onto your cell phone or a hand-held recorder after your shift on the ride home. Journaling, writing articles, and informal storytelling are other ways to transform a negative experience into a positive one.

Meditation or mindfulness exercises.

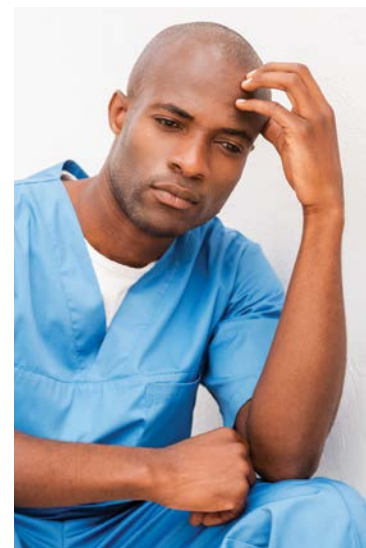
The ability to find inner calm and limit emotional reactivity to situations has a profound impact on personal well-being and results in significantly lower burnout rates. Mindfulness can be as simple as taking in a deep breath and exhaling very slowly, resulting in a parasympathetic charge of feeling peaceful and settled. You can do this between patients or as you enter each new patient's room. Making this a lifelong practice helps you to see the forest through the very large tree that your patient may have driven into.

Peer mentoring.

Recently, the field of critical incident management has moved away from the unwieldy critical incident stress debriefing (CISD) model toward focusing on psychological self-assessment and peer mentoring, thereby formalizing something that the more resilient among us have known for years. Discussing stressful events with a supportive and empathic colleague is some of the best medicine that we have, and if our emergency medicine atypical humor is involved, all the better. Humor is a great coping strategy.

Niche development.

Research has demonstrated that physicians who have developed a niche within emergency medicine have lower rates of burnout, better career longevity, and more career satisfaction. Niche does not have to be research. It can involve serving on local or national committees, volunteer work, mentoring, teaching, or exploring the medical humanities, such as writing, painting, and photography. It may even be in the form of fellowships in palliative medicine or sports medicine.





Education.

Teaching can extend well beyond precepting medical students and residents at university hospitals. Physician assistants, nurses, technical staff, and EMS personnel can all benefit from your experience and knowledge. You can educate your community and your patients. Remember, our title of “doctor” derives from the Latin verb meaning “to teach.”

Personal coaching.

Develop a mission statement and a career plan. Find a support network to help you to connect to what you value most—both in your career and in your personal life—and to help you achieve your goals. This can take many forms, including personal organization, time management courses, and learning to say “no” to obligations outside your mission statement.

Focus on empathy.

Empathy is the essential cure for depersonalization. It is the ability to understand and feel another person’s perspective. Multiple resources for building empathy exist, including books, workshops, and podcasts. Connect with your family, friends, and co-workers outside of the fluorescent lights of the emergency department.

Take care of your own needs.

We need to take care of ourselves before we can care for others. It is easier to be resilient with a full night’s rest and a body that’s been fed with proper nutrition. Remember to MOVE your body: “A jog a day keeps depression away.” Make time for what you enjoy. Place it on your calendar and treat it like a shift.

Limit stressful downtime.

The old adage “work hard, play hard” may actually work against you. Know your limits and balance your high-stress activities with low-stress activities. When we unwind with horror films, and when our vacations become death-defying adventures, we begin to live in a permanent state of adrenergic arousal, which can cause us to remain detached from our feelings and prevent emotional processing, thereby worsening symptoms of depersonalization.

Resilience is the choice to weather every storm and make the best out of every situation. It is not something we are born with, but a skill to be developed and consciously nurtured. The more we understand ourselves and the more we open the discussion about wearing down in emergency medicine and the value of personal wellness, the better equipped we are to engage in the daily practice of resilience.

RESOURCES

Authors exploring happiness and resilience:

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THE EMOTIONAL WELL-BEING SPOKE

Compassion Fatigue: Can You Care Too Much?

By Julia Marie Huber, MD, FACEP

Compassion Fatigue is a state experienced by those helping people or animals in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it can create a secondary traumatic stress for the helper. The bad news—most emergency physicians readily recognize signs of compassion fatigue in themselves. The good news—we now know how to identify and combat its negative effects. The problem is that most of us will not take action until we reach a tipping point. We hope that the following vignette will spur you to action and mindful health

“At the beginning of summer, I sat my family down at the dinner table and said, ‘Listen: All you kids are off school for the summer. Dad and I will be working and that means you all can now water the plants, do the laundry, and take out the garbage. Someone needs to help cook dinner. You all need to put away your own toys and activities.’ Everyone nodded in unison, and volunteered for specific tasks. My social experiment had begun. Week one was okay; just a little mess, and some dry plants. By week two, the living room was filled to the brim with cardboard box creations, some dead or dying plants, and the garbage stank. My eight-year-old stepped into the kitchen one evening and pulled open the cabinet holding the garbage. ‘This stinks!’ she shouted at me. ‘That’s right; and now you can please take it out,’ I responded. And, finally, change began.”

Paradoxically, in the wellness literature, there is so much negative terminology. As emergency physicians we read about how as a cohort we are “fatigued,” “burned out,” work in a “toxic”

environment, and we spend our lives aggressively compensating for it. To turn this around we may need to open the cabinet door to unload some “trash” in order to create a healthy environment and decide what to do next, as individuals as well as collectively, without “sliming” one another in the process!

Definitions and Terminology

Compassion fatigue and burnout: I see these words intertwined whenever I read about physician well-being when, in fact, they are distinct entities, albeit with similar symptomatology and parallel interventions. Burnout, a term presented by Christina Maslach in 1982 and referenced by Francoise Mathieu, refers to an overall sense of emotional exhaustion, depersonalization, and reduced personal accomplishment. It is primarily job related and affects a broad spectrum of workers. Compassion fatigue is also known as vicarious traumatization. In *The Compassion Fatigue Workbook*, Francoise Mathieu states, “Compassion fatigue refers to the profound emotional and physical exhaustion that helping professionals and caregivers can develop over the course of their career as helpers. It is a gradual erosion of all the things that keep us connected to others in our caregiver role: our empathy, our hope, and, of course, our compassion—not only for others but also for ourselves.” It is “the cost of caring for others in emotional pain,” is an “occupational hazard,” and a “cumulative process.” Some providers lose all empathy during this process and report feeling a fundamental shift in their world-view. I have noticed that many authors use these terms interchangeably, but these distinctions are worth noting and exploring.

Signs and Symptoms

There are many lists of symptoms of compassion fatigue to be found on the internet and in other publications such as compassion fatigue workbooks, and although the key concept is loss of empathy, the signs and symptoms are similar to those experienced in the setting of burnout. Although this is not comprehensive, take a quick glance at this list from John-Henry Pffifferling, PhD, and reflect on your current situation:

- Abusing drugs, alcohol, or food
- Anger
- Blaming
- Chronic lateness
- Depression
- Diminished sense of personal accomplishment
- Exhaustion (physical or emotional)
- Frequent headaches
- Gastrointestinal complaints
- High self-expectations
- Hopelessness
- Hypertension
- Inability to maintain balance of empathy and objectivity
- Increased irritability
- Less ability to feel joy
- Low self-esteem
- Sleep disturbances
- “Workaholism”



To this list, I would personally add, “gallows humor that clears a room within minutes, unless, of course, all the others work in a similar setting.” My husband refers to this as “ER humor,” and from his perspective, it gets worse when I have had a really challenging shift in the ED. You may wish to add some of your own red flag behaviors to this list and use them as a personal gauge. If you think you don’t have any red flag behaviors, ask your loved ones; it may come as a relief to them to help you flesh out the list. .

Risk Factors

As emergency physicians, we are all at risk for compassion fatigue in addition to burnout. Some of us are at higher risk than others, however. Consider the following risk factors for compassion fatigue, taken from Martha Teater’s and John Ludgate’s workbook *Overcoming Compassion Fatigue: A Practical Resilience Workbook*.

- The secondary trauma was an act of human cruelty
- Longer exposure to the trauma of others
- Multiple stressors in the caregiver’s personal life coinciding with the secondary trauma
- A personal trauma history
- Lack of social support
- Habitual self-negativity
- Working in isolation

...studies suggest that upward of 60% of experienced caregivers display some elements of compassion fatigue

Self-Assessment: The ProQOL Test

A number of studies suggest that upward of 60% of experienced caregivers display some elements of compassion fatigue. A commonly employed tool is the Professional Quality of Life or “ProQOL” self-assessment test (www.ProQOL.org), which is readily available online courtesy of researcher Beth Stamm who, by the way, also has a very rich bibliography on this website. This test is widely used and referenced. It encompasses both burnout as well as compassion fatigue, but allows you to assess what she refers to as “compassion satisfaction,” or the pleasure you derive from being able to do your work well. The website provides scoring information. I took the test in less than five minutes, and found it straightforward and quite easy to score. It would be helpful to see studies that directly involve using this assessment tool to analyze emergency physicians; my internet search came up empty in this regard.

Tools and Solutions—At the Personal Level

Raise your virtual hand if you “already know” you need to sleep more, eat more nutritious meals, and balance your life by being mindful and practicing meditation. How do you bridge the gap between knowing about self-care and getting into action? Here is what I would suggest as a series of exercises, rather than feeling like you have to drink kale smoothies.

Write it down. Look at the lists above every day for the next few weeks. Which symptoms are the most prevalent? Are you experiencing them at work or just following a shift? Do you have any risk factors that contribute to your loss of empathy? Make a note of how long it takes you

to bounce back from a shift and which symptoms bother you the most. You may start seeing other patterns or symptoms of stress; add these on so you can flag yourself more quickly.

After looking at your personal symptomatology, *develop your own personalized “self-care” list* and prioritize the actions. Base this list not on what you think everyone would recommend you do but on what specifically works for you. My personal list includes eating ample amounts of chocolate and reading great literature, even if it means sleeping less. As I said, this list is for you!

Develop a personal meter such as a scale from 1 to 10, and look for patterns. Which symptoms are the most pernicious? If you were to eliminate just one or two of them, what would your life look like and by when? What about this is important to you? What do you risk losing if you decide to continue with the status quo? What would it take you to go up just one notch on your own compassion satisfaction score?

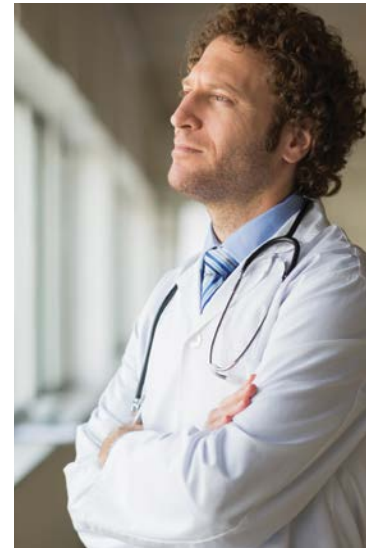
Make a decision to look for support. Do you need professional help in order to rediscover meaning in your job and life and regain a sense of compassion for your patients and for yourself? Do you need to see a psychiatrist to treat depression or addiction? If your family or friends are expressing concern, that should be enough of an indicator to get professional help. Are you a healthy person wishing to seek change through professional coaching, or is it time to form a peer support group?

Debriefing. Don't slime or get slimed! There are two kinds of debriefings, formal and informal. The formal type is scheduled and is referred to as critical incident stress debriefing; you may refer to your human resources department for further information on how your institution facilitates this process. The more informal types of debriefing happen on the fly... at change of shift, in the doctors' lounge, at the holiday party, or even on the kids' soccer field. Although this can be therapeutic for the person sharing, we can at times “slime” the recipient by not asking them permission to disclose sometimes graphic information, which can then leave them, in turn, suffering from vicarious trauma. Mathieu recommends the four step process of “LID,” or “low-impact disclosure,” which involves increased self-awareness of when and how you spontaneously debrief (or slime!) others, providing the recipient with fair warning of what you are doing, obtaining the recipient's consent to engage at that level, and then limiting the amount of graphic information provided.

Tools and Solutions—At the Organizational Level

What can managers do? Regularly check in with staff rather than waiting for them to approach you, engage in your own self-care program, strive to stay positive, and avoid stigmatizing staff who are suffering from compassion fatigue or other stress-related issues (adapted from Teater and Ludgate, *Overcoming Compassion Fatigue*).

What ACEP is doing? The Well-Being Committee has updated the Wellness Guide, available electronically on the ACEP website. “Wellness Week,” started in 2016, strives to highlight the organization's commitment to well-being in all members and emergency departments throughout the country.



What can residencies do? Provide a lexicon of wellness early on in residency, as well as identify issues such as compassion fatigue and burnout; provide workshops that facilitate the creation of a personal self-care “toolbox” to turn to both during and after residency in order to support a continued commitment to personal well-being.

Conclusion

As emergency physicians, we have made a conscious choice to step in and care for people and face challenging and sometimes painful circumstances. It is a privilege and, at times, can be a burden. Writer and internist Dr. Danielle Orfi, in her book *What Doctors Feel* sums this up best:

“For physicians, sadness is part of the job.... Integrating sadness while still being able to function and give of yourself is necessarily a work in progress. It is something akin to two coils spinning. The coil of sadness never stops—there is always awareness that your patients are suffering and the memory of the patients you’ve lost. The other coil is the engine of what you are giving to your new patients, the investment in their lives and health. Nobody desires grief in one’s life, yet wise and experienced clinicians will tell you that they’d never want that coil to disappear. It keeps alive a necessary appreciation of medicine, of what it means to have the privilege of entering other people’s lives.”

At the end of the day we realize that the very instincts that drove us to a career in emergency medicine are also the factors that make us vulnerable to compassion fatigue—our desire to help others, our ability to run toward trouble when everyone else is running away. We don’t want to lose that gift, but we need to find ways to temper and channel the stress. Our goal must be to create a healthy emotional workspace. Creating a balanced professional life requires time and effort—we owe it to ourselves, our colleagues, and our patients.



RESOURCES

<http://www.proqol.org/Bibliography.html>

A detailed research bibliography that goes up to 2010 that provides very extensive background. This website also has the Professional Quality of Life or ProQOL test for compassion fatigue, burnout, and compassion satisfaction.

<http://www.compassionfatigue.org/pages/reading.html#articles>, Compassion Fatigue Awareness Project.

<http://www.compassionfatigue.org/pages/HuggardMedicalEducation.pdf>, Compassion Fatigue: How Much Can I Give?

<http://www.compassionfatigue.org/pages/Top12SelfCareTips.pdf>

Self-care tips that are helpful; consider sharing them with your group or other colleagues.

<http://www.sciencedirect.com/science/article/pii/S1877042812014516>

Secondary trauma stress in medical students.

<http://www.sciencedirect.com/science/article/pii/S0099176708002882>

Prevalence of secondary traumatic stress in emergency nurses; this is a very small sample but worth a quick look since it is germane to our field.

<http://www.aafp.org/fpm/1998/0700/p71.html>

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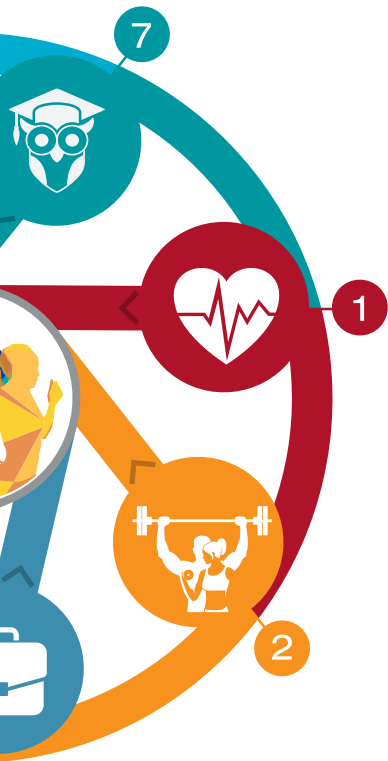
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THE EMOTIONAL WELL-BEING SPOKE

When Emergency Medicine Wears You Down: Talking About Burnout

By Dennis Hughes, DO, FACEP and Amy Betz, MD

Burnout has been common in emergency medicine. Now is the time to turn that around!

A casual observer would likely think that emergency medicine, despite its “exciting” attributes, would not be a great cause of burnout, given the emergency physician’s ability to walk out the door and leave it all behind when the shift is over. While it is true that we can walk out the door, leaving it all behind is harder. The myriad forces at play during the time on shift negate much of the benefit of being able to leave at shift’s end. “Expect the unexpected,” or “the only consistency is inconsistency,” are descriptors commonly applied to emergency medicine. This loss of control can be a constant drain, particularly on individuals who historically have been in enough control to have made it successfully through the rigors of pre-med, medical school, and residency education.

In the practice of emergency medicine, most, if not all, emergency physicians’ actions are under scrutiny (unlike, say, an outpatient practitioner who may practice most of his/her professional life independent of any direct oversight). The practice of emergency medicine occurs in the clearest of fish bowls in medicine. Everyone has an opinion on how the case last night could have been handled. In addition, ever-increasing patient loads, meeting satisfaction measures, working with difficult consultants, rotating schedules and shift work, demanding patients, not practicing “real emergency medicine” (safety net primary care), ED-unfriendly electronic health records, as well as the expected barrage of emergent cases with their demands, can lead one to feel burnt out (Whew! Even writing this list is distressing!!).

According to a recent *JAMA Internal Medicine* study, emergency physicians are at the top of all specialties, with over 65% of respondents reporting burnout. Burnout is pervasive across the board in medicine, affecting one out of three physicians at any given time. Not surprisingly, *burnout among physicians as a group is considerably higher than any other working group in the United States.*

Burnout Happens at All Stages of an EM Career

Burnout can happen to anyone, at any time, but it appears to be less of a problem early in one's emergency medicine career than it is as time in practice progresses. Mid-career (generally defined as 10 years to 20 years post residency) is the time in which burnout reaches its peak. After more than 20 years post residency, emergency medicine physicians still experience high rates of burnout, much higher than in the early career, but still less than during the mid-career years.

One could posit that emergency medicine self-selects those whose personality is best suited for the demands of the job, and that this leads to immunity from the myriad stressors. Results of Myers-Briggs personality assessments suggest that no predominant personality trait exists among practicing emergency physicians. That is not to say that all are equally suited to the job, but many adapt and overcome their innate theoretical disadvantages and function very well.

In April 2014, ACEP released the results of a survey in which members listed the top 5 pressing issues in their personal lives as well as the top 5 pressing issues in their professional lives. *Maintaining a balance between personal life and work was the number one issue in all career stages* with the exception of those who had practiced emergency medicine for over 30 years, and in that group it was still number 2. Professional issues revolved around the pressing and never-ending need to continue to improve and develop clinical skills and keep current with new technology.

Burnout Has Many Different Appearances

Burnout can manifest in many different ways. The famous quote from former Supreme Court justice Potter Stewart (regarding pornography), "I know it when I see it," applies particularly when it is one's peers who are seeing the effects of any given physician being pulled in too many directions while the physician in question is unaware of what is happening.

What are some of the manifestations of someone headed toward burnout? Several years ago, Christina Maslach developed quantifiable measurements of three general areas that are associated with burnout: emotional exhaustion, depersonalization, and personal accomplishment. This is the same instrument that is used for the annual burnout survey administered at the Wellness Booth during the annual *ACEP Scientific Assembly*. The scores of the members who completed the survey from 1999 to 2012 indicated that personal accomplishment was high (a favorable result), but both depersonalization and emotional exhaustion were in the middle range (less favorable). The survey results are limited by the numbers of members who completed it (and note that it was not scientifically administered or controlled), but suggest that as a specialty we need to continue to be vigilant regarding burnout.



Recognizing Burnout

Burnout can be insidious—just like putting the frog in the room temperature water and then slowly turning up the heat until the unsuspecting frog is cooked! Consequently, emergency physicians may find themselves far down the path to burnout before they realize it. This can stem from having trained in the medical education process that values autonomy, the need to always be right, selflessness, and putting the patient's needs paramount. There has historically been very little preparation in taking care of the caregiver or valuation of self-compassion.

Symptoms of burnout include:

- Fatigue, even with adequate sleep
- Work dissatisfaction
- Forgetfulness
- Sadness
- Irritability
- Increased physical illness
- Flagging job performance
- Difficulty with concentration
- Avoiding personal interaction
- Bored with work
- Dreading shifts in the ED
- Reduced participation in social activities
- Feeling like work is a dead-end proposition

In many cases, increased incidence of substance abuse ensues, and even attempting to assuage one's feelings by buying more “toys” is not uncommon. These symptoms hold true across age, gender, and time in practice demographics.

Ways to Prevent and Address Burnout

As with any condition, prevention is the first action to reduce the likelihood that one gets caught in the burnout trap. Although many residency training programs now include some discussion of the issues within their curricula, most practicing emergency physicians are not likely to have an awareness of the importance of self-care. Like a prowler in the night, burnout can come and steal your humanity if you are not constantly vigilant and constantly prioritizing self-compassion and care.

The emergency medicine group at Stanford has instituted a novel program to ward off burnout: Innovative Program Stanford, Aug 20, 2015, <https://is.gd/9YxXYA>.

One approach proposed by Dr. Kevin R. Campbell (adapted from Spickard A Jr, Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist physicians. *JAMA*. 2002;288(12):1447-1450) involves protecting time for some personal reflection. Most of us do this in some form, albeit unconsciously, but it is important to be regularly in touch with and to consider life goals and values.

Additional ways to cultivate self-care and resilience include:

- Identify sources of joy (both personal and professional).
- Weave sources of joy into your daily fabric of life.
- Engage in some form of spiritual activity (not necessarily organized religion).

- Cultivate connections with family, friends, co-workers.
- Protect time off.
- Carve out time for stillness and calm.
- Exercise regularly (activity that gets one moving and increases heart rate can be extremely cathartic).

Within the confines of the work place and organization, find ways within the limitations of emergency medicine that allow for feeling empowered and less at the will of others:

- It is ok to say “no” to the extra committee or extra shift.
- Make sure that when you say “yes” you really mean it and feel good about it.
- Set personal limits.
- Learn to delegate tasks that you have felt compelled to do.
- Identify a mentor whose values regarding work-life balance resonate with yours.
- Find someone not only to emulate but strategize with, and draw inspiration from that person during difficult times.

Some of these approaches may require discussion with the other members of your group, which can be eye opening for all involved.

Dike Drummond, MD, (www.thehappy.md.com) suggests the analogy of the “energetic bank account.” Unlike a real bank account, where the currency is money and once you are at a zero balance, the account cannot be used, the energetic bank account can be in the negative and still function (for a time). In his model, there are three accounts: physical energy, emotional energy, and spiritual energy. Each of these must be recharged and kept in the positive balance to prevent burnout. His website has several short videos that discuss his theories and simple methods to help both prevent and recover from burnout. Simple techniques such as the “squeegee breath” can help with the minute-to-minute stressors while on the job.

Preventing burnout is vital to your personal health and the health of emergency medicine.

It is crucial that the emergency medicine community increase its awareness of burnout prevention, as well as promotion of self-care and resilience. There are good physicians who are unaware of the concept and seemingly blind to the effects of being unwell; they press on with their professional and personal lives until divorce, a medical mistake, or other untoward event destroys their life. Emergency medicine cannot afford to lose members to a condition that is preventable.

The key is to figure out where one’s center point is and then find a way to balance life and work, employing strategies to get one there. It is not going to be one-size-fits-all. Just as many personality types are represented in emergency medicine, there will be myriad individual techniques for burnout prevention. The commonality is to anticipate that we all are at risk and to avoid getting stuck in the “definition of insanity” paradox: doing the same thing over and over and expecting different results.



RESOURCES

The following represent many resources to help prevent, identify, and address burnout in oneself. These resources may be of assistance at any point on the continuum of an emergency physician's career. Some of these links are propriety and have very valuable free material but may have costs associated as one gets deeper into the program.

Videos

SGEM (Skeptics Guide to Emergency Medicine, part of FOAM network): YouTube video on burnout—top 5 tips; somewhat satirical but true. <https://www.youtube.com/watch?v=ERxBCxe-BdA>

Code Lavender—holistic care rapid response mostly for staff (as well as some patients) at Cleveland Clinic. http://www.huffingtonpost.com/2013/12/02/the-amazing-way-this-hosp_n_4337849.html

Physician Burnout-Four Main Causes—The Happy MD. www.thehappyemd.com.
<https://www.youtube.com/watch?v=k1ouwQXcCtQ>

How to Identify and Prevent Doctor Burnout.
<http://www.msnbc.com/morning-joe/watch/how-to-identify-and-prevent-doctor-burnout-522922051925>

Authors and Speakers

Rachel Naomi Remen. Healing the Heart and Soul of the Health Professional.
<http://www.nicabm.com>.

Wayne Dyer. I Can See Clearly Now. Excuses Be Gone. Found on <http://www.drwaynedyer.com> (written and audio formats). Dr. Dyer has authored numerous books, audio CDs, and DVDs relevant to this topic.

Beleruth Naperstek. <http://belleruthnaperstek.com>. Many very inexpensive CDs and MP3s with material for wellness and preventing burnout.

Shawn Achor (keynote speaker at ACEP 2014 Scientific Assembly). www.goodthinkinc.com. TED talk and materials that inspire achieving happiness.

Articles

Walker G. Emergentology: Burnout: It's all about weird hours, challenging patients and high stress. *Emerg Med News*. 2013;35(3):7-8.

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Lamothe M, Boujut E, Zenasni F, Sultan S. To be or not to be empathic: the combined role of empathic concern and perspective taking in understanding burnout in general practice. *BMC Fam Pract*. 2014;15(1):15. (A study that explores the interaction of cognitive and affective empathy in positing an explanation for burnout in general practice. They discovered that deficits in perspective taking skills may be a risk factor for burnout and that higher skill in perspective taking and empathic concern may be protective.)

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Essays

Sotile W, Sotile M. *The Resilient Physician: Effective Emotional Management for Doctors & their Medical Organizations*. Chicago, IL: AMA Press; 2002.

Sotile W, Sotile M. *The Medical Marriage*. Chicago, IL: AMA Press; 2000. (Navigating the particular challenges posed by physician marriages.)

Sotile W, Sotile M. *Letting Go of What is Holding You Back*. Chicago, IL: AMA Press; 2007.

How to live the balanced life. *Real Simple Magazine*. Jan 2014. (Helpful tips on work/life, work/family, exercise/diet, etc.)

Montross C. *Falling into the Fire: A Psychiatrist's Encounters with the Mind in Crisis*. Penguin Books. 2013. (A psychiatrist perspective on how her work with patients in crisis triggers her own emotions, and personal challenges and growth.)

Shilian D, ed. *Lessons Learned: Stories from Women in Medical Management*. Tampa, FL: ACPE Publications; 2013.

Why I left medicine: a burnt-out doctor's decision to quit by Diane Shannon.

<http://commonhealth.wbur.org/2013/10/why-i-left-medicine-a-burnt-out-doctors-decision-to-quit>.

(An essay on one physician's decision to quit medicine. It can provide a bit of insight and the commentary that follows the article allows for reflection.)

Websites

www.Kevinmd.com. A social media site that deals with many issues relating to physicians. There are many articles that deal with burnout as well as ongoing dialogue. See: Why are physicians burning out? Michelle Finkel, MD, May 4, 2013; Burnout: The perfect storm of physician stress. Karen S. Sibert, MD, August 5, 2013.

<http://www.zdoggm.com>. This site primarily allows a cinematic outlet for frustrated actor/physician Zubin Damania, MD, and has commentary on burnout and other common physician frustrations. It is also beyond hilarious and is good for a laugh when things are rough.



THE PHYSICAL WELL-BEING SPOKE

Food, Fitness, and Physical Health

By Christina Miller, MD, FACEP, Marc L. Pollack, MD, PhD, FACEP, Frani S. Pollack, MS, MSW, RD

Optimizing physical and mental health is a key strategy for emergency physician longevity. Health and well-being can be maintained throughout a career in emergency medicine not only by careful attention to signs and symptoms of fatigue, stress, and burnout, but also with emphasis on self-care.

By focusing on wellness and taking care of ourselves, we can have satisfying and long careers and serve as role models for our emergency physician colleagues. Taking time to optimize one's health is essential in emergency medicine and begins with the conscious decision to maintain a healthy lifestyle. Excellent health starts with our daily habits, and leads to increased energy and stamina, improved sense of well-being and optimism, and enhanced longevity—all essential factors for a thriving and vital career in emergency medicine.

You Are What You Eat

What we eat affects us on every level—from the nutrients that can be directly incorporated into our cells, to the amount of energy we have, maintaining optimal weight, and aging with grace and good health.

Although there has been much confusion with appropriate diet over the years, there is a convergence of evidence that points to unprocessed food as being superior to that which is processed. The more real, whole foods people consume, and the less processed and packaged foods with artificial colors, flavors, and preservatives, the healthier people are. Food is meant to nourish and sustain us, and this is dependent on the nutrient density of the foods we choose. *The most nutrient dense foods, in descending order are vegetables, fruits, legumes, whole*

grains, and nuts and seeds. The more we fill our plates with these nutrient-packed foods, the healthier and more energetic we become.

The US government has also made changes to reflect this; the Food Pyramid has given way to the new Choose My Plate in 2011. The Choose My Plate clearly displays that the meal should consist of at least 50% vegetables and fruit, 25% protein source, and 25% unrefined carbohydrate. This is a significant change. Refer to the website <http://www.choosemyplate.gov> for more details.

Further clarification and detailed guidance for a healthy meal can be found at the Healthy Eating Plate, as put out by the Harvard School of Public Health. Again, half the plate is vegetables and fruit (with emphasis on vegetables, as these have been shown time and again to be the most protective against disease and promoting healthy aging); one-quarter plate of healthy protein, with emphasis on lean protein and plant-based protein, including legumes, nuts, and seeds; and one-quarter plate unrefined grains. Please see the website <http://www.hsph.harvard.edu/nutritionsource/healthy-eating-plate/> for more information.

These healthy eating plate recommendations are a result of multiple studies showing that people who eat the most vegetables, fruits, with unrefined carbohydrate and lean proteins (including plant-based sources) have improved health and age better.

Although we are concerned with aging well and longevity, healthy eating goes way beyond that. In fact, reducing sugar and artificial chemicals in foods and eating more unrefined plant foods, leads to increased energy, mental clarity, and even improved mood. This information is critical for emergency physicians who work demanding shifts on a regular basis and need to know how to eat to optimize performance and well-being.

As the performance of an athlete can be enhanced with proper nutrition, the energy, stamina, and mental clarity of an emergency physician can also be improved with good nutritional choices.

Work in the emergency department is often busy and stressful, lending itself to quick meals, fast foods, and sweets in the break room. Try instead to eat slowly and listen to the satiety signals, even in the midst of a chaotic ED shift. Do not use food as a stress reducer or misinterpret stress/anxiety feelings as hunger. Try to get in a good, well-balanced meal with healthy protein, complex carbohydrate, veggies and fruit before your shift. Also, make time for a meal or snack break during the shift by bringing in healthy, real foods in a cooler that you can access at any time.

As an example, here are some quick and easy snack ideas:

- Cut vegetables (tomatoes, carrots, broccoli, celery, sugar snap peas, etc.) with or without hummus (extra protein in the hummus leads to increased energy and satiety)
- Fresh fruit (with or without peanut butter, almond butter, or other nut butter)
- Whole grain bread with peanut or almond butter, sliced fruit (banana, apple)
- Fruit and vegetable smoothie (add spinach, frozen or fresh fruit, nuts/seeds, etc.)
- Hot-air popped popcorn, kale chips, trail mix
- Whole grain pita pockets or whole grain bread with hummus, lettuce, tomatoes, bean sprouts, lean protein



Emergency Medicine Requires Total Fitness and Well-Being

The successful practice of emergency medicine requires a high degree of mental and physical fitness. A busy shift can be both physically and emotionally exhausting. These physical and emotional demands are more noticeable as we get older and during times of personal stress or illness. Careful preparation will allow emergency physicians to “weather the storm” of the demanding shifts. If you find all or most of your shifts physically or emotionally draining, a critical reassessment of your job and life situation is warranted.

In addition to a nutrient-dense diet, maximal health and well-being require physical fitness, relaxation and relieving stress, quality sleep, and involvement with family and friends in the community. It is when we address all these areas of our lives that we can achieve our full health and well-being potential.

Physical fitness, including planned and regular exercise, can be adapted to fit any lifestyle. You will not only be better prepared for the busy shift but will look and feel better and maintain appropriate weight. Regular aerobic exercise will enhance your cardiovascular and respiratory fitness. In addition, an aerobically fit emergency physician will not suffer as much from the physical fatigue often associated with a busy ED shift. In general, during aerobic exercise, you want to maintain your heart rate at 60% to 85% of your age-adjusted maximum heart rate. There are several ways to monitor this in today’s techno world, such as heart rate monitors, iFit bands, and rough calculations, such as 220 minus your age.

The successful practice of emergency medicine requires a high degree of mental and physical fitness.

Significant Benefits Have Been Seen With a Minimum of 150 Minutes of Aerobic Exercise Per Week

One hundred fifty minutes of aerobic exercise per week can be achieved with five 30-minute sessions, or broken down in any way that works for you. If you cannot exercise 30 to 45 minutes in one session, you still get the same benefit if you exercise for shorter periods broken up into two or three sessions in a day. Do what feels right for you. Start slowly, and gradually increase your exercise time while working towards achieving and maintaining your target heart rate. You can start with walking, swimming, or biking, and progress to running, spin classes, aerobic classes, hiking, etc. No need to go to a gym for this—get outdoors and find what suits you.

What is the best aerobic exercise?

It’s any program that gets you moving and that you do regularly. It is usually something you enjoy, something easily accessible, and something that is compatible with any physical limitations you might have. Prior to starting a regular aerobic program, an evaluation for occult coronary artery disease is appropriate. Evaluate your cardiac risk factors and seek an objective medical evaluation (not a hallway conversation with your buddy). You know where exercise-induced chest pain or injuries can get you.

Resistance training is another aspect of a personal fitness plan. Lifting weights, pulling on bands, or using your own weight keeps muscle mass and tone high and has a positive effect on

bone density and joint function. Increasing your muscle mass also increases bone mass, and helps prevent osteoporosis. It will also increase your overall metabolic rate and will reduce body weight. Starting a resistance program should involve a sports trainer, physical therapist, online education, or an instructional class to ensure proper technique and prevent injuries.

High-intensity interval training (HIIT) classes are popping up all over, and serve as a great way to get in both aerobic and resistance training in a short time. Studies are confirming more and more benefits from this type of workout, from weight loss and improved muscle mass, to lengthening of telomeres on DNA, which is associated with longevity and disease resistance. And further benefits include group fun and motivation, as well as the advantage of a shorter workout. If you haven't already, check with your doctor to see if HIIT classes are safe for you, and see about a class near you.

Flexibility and balance are further components of a personal fitness program. The key to flexibility is stretching. Proper stretching keeps the muscles supple, prepares you for movement, and helps you make the daily transition from inactivity to vigorous activity without undue strain. Stretching should be slow and gentle and not painful. It can be done alone, or as part of a yoga or other program. It can be done in groups, or at home with a DVD or YouTube video. Again, proper technique is essential to prevent injuries. An excellent book on stretching by Robert Anderson is listed at the end of this chapter.

How do you begin a fitness program? How do you exercise regularly with rotating shifts and all your other life commitments? Getting started and staying motivated is difficult, even for regular exercisers. One strategy is to insert exercise time into your schedule as a required event, like an ED shift, not an optional activity. Write it on your calendar, just like you would a meeting.

Fitness Shorts

Need motivation? Here are 25 tips from trainers on how to keep it fresh in and out of the gym. You got this! <http://ow.ly/WhsFR>.

“Exercise is a lifestyle, strength=self-sufficiency.” 10 things you communicate to your daughters by working out. <http://ow.ly/Whthe>.

Boost your immune system—work out! Regular exercise strengthens the immune system and helps fend off illness. <http://ow.ly/Whupm>.

Regular exercise keeps your brain as well as your body young and nimble. Aerobic fitness improves cognitive functioning. <http://ow.ly/WhuFJ>.

Will run for beer? Exercise and alcohol consumption appear to be linked. <http://ow.ly/Whv1T>

Being “mindful” and “present” during exercise helps increase satisfaction and compliance. <http://ow.ly/WhvKW>.

Pressed for time? Try the Scientific 7-Minute Workout and Advanced 7-Minute Workout. <http://ow.ly/WhwCW>, <http://ow.ly/WhwR4>.



Make Time to Preserve the Only Body You Have

Self-care does not have to be boring, inconvenient, and time-consuming. Setting time aside to exercise, prepare healthy food, unwind, and sleep can become habits included in your busy life.

Food prep can be done on days off with leftovers (frozen or refrigerated) for future meals. Taking a few extra minutes to put together real, whole foods to enjoy can make the difference between an energizing and a sluggish shift. Remember, a sugar high will lead you to crash and fatigue will set in, and as this is not the goal, try to avoid sugary foods on shift.

As for exercise, all physical activity is helpful, although more strenuous activity does have benefits. Make a list of all physical activities you enjoy, such as walking the dog or throwing a Frisbee. Commit yourself to these enjoyable activities for at least 30 minutes per day. Take a look at your weekly schedule and block out times you plan to exercise. Exercising when you first wake up is often convenient and prevents daily events from interfering. Be sure to warm up properly as your muscles will have been at rest while sleeping. Whether you like to work out in the morning or after a shift, be sure not to exercise within 1 to 2 hours of bedtime.

Aerobic exercise raises your metabolic rate for several hours after exercise, which can make falling asleep difficult.

Many emergency physicians find exercising after a shift an excellent way to wind down and rejuvenate themselves. You can also squeeze in bits of exercise throughout your day, such as using stairs instead of elevators or parking farther away from your destination.

Once you are involved in regular fitness activities, you may need incentives to maintain your program. These incentives may include goal setting, working out with a friend, keeping a daily log of accomplishments, or rewarding yourself with a treat such as a massage, new bicycle, or a workout clothes.

Aging is Not a Disease

As emergency medicine matures into an established specialty, the range of ages of emergency medicine practitioners reaches parity with other specialties. There are many more “older” emergency physicians in full-time practice than there were 20 years ago. Even though we do not necessarily look forward to getting older, it is inevitable. After all, what is the alternative?

You can postpone and even avoid many of the negative aspects of aging by taking care of your mind and body. The aging physician can expect alterations in vision and hearing that can affect the ability to practice medicine. Even seemingly minor abnormalities, such as the ability to ambulate, sit, or stand can have a significant impact of the ability to practice emergency medicine. Cognitive changes will have a profound effect on the ability to practice medicine and are the most difficult to cope with for the practicing physician. The emergency physician is required to suture, auscultate, reduce dislocations, and perform other procedures that may become more difficult as we age.

Rotating shifts become much more difficult after the age of 40 and are the leading cause of older emergency physicians leaving emergency medicine practice. An alteration in practice may

*You can postpone
and even avoid
many of the negative
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mind and body.*

become necessary as these changes occur. A loss of muscle mass commonly occurs with aging and is primarily due to an increasingly inactive lifestyle. An active lifestyle and regular fitness program will maintain muscle mass and tone and physical strength and avoid an increase in adipose tissue. Regular visual and audiometric screening will permit continued high-level sensory function. Physical and cognitive limitations are inevitable and planning for practice limitation and retirement are advisable.

We all want to practice successfully for as long as we can. Paying attention to our nutrition, our fitness, and our capabilities as we age will help us thrive at work and at home.

As emergency physicians, we have extremely demanding lives. A single shift necessitates that we have high energy, stay on the move for long days and nights, think clearly and precisely, and maintain enthusiasm and a positive attitude. Oftentimes, we must dig deep within ourselves to find the energy to continue, and push long past our state of fatigue. Our lifestyle choices can make the difference between a healthy, long career, and a truncated one filled with dissatisfaction, illness, or burnout.

The choice is ours, and the decision starts with us. Don't we owe it to our patients, our partners, and especially ourselves, to take the best care of ourselves we can?

RESOURCES

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THE PHYSICAL WELL-BEING SPOKE

SLEEP! Emergency Medicine and Sleep: Are They Compatible?

By Patti Van Leer, MD and Rita Manfredi, MD, FACEP

You have just finished an overnight shift and are driving home after you have stayed in the ED an extra hour to complete your notes. It was a difficult shift with one STEMI, a bad child abuse case, a trauma resuscitation that did not go well, and an over-abundance of abdominal complaints necessitating multiple rectal exams. You are 100% exhausted. You come to a stop in a line of cars at a red light and must have drifted off to sleep for a few seconds because you now have an angry driver from the car ahead of you at your window screaming, “You hit my car! Have you been drinking?” Your overnight shift is turning into an overnight nightmare!

As emergency physicians we are shift workers and have to develop strategies to accommodate the disruptions that occur with shift work. How do we prevent such episodes as the one above from occurring?

To start, let's look at your current situation. Answer the following 3 questions and choose the answer with which you identify most:

In anticipation of an overnight shift, my sleep plan of attack is:

- A. What plan? I can sleep whenever and wherever. I can sleep until 6 pm if I want to!
- B. I try to take a nap before the overnight shift but it never works.
- C. I try to sleep until at least 3 pm the day after an overnight, but I find myself awake at noon and exhausted but unable to fall back asleep.
- D. What plan? I have two kids and administrative duties. An overnight is just a missed night of sleep.

On a typical overnight shift I find myself:

- A. Ready for anything!
- B. Inserting a caffeine IV while taking shots of espresso.
- C. Fading around 4 am and desperately pacing to stay awake.
- D. Wondering how comfortable the stretchers are for napping.

Working overnight shifts is:

- A. The best thing about emergency medicine.
- B. A necessary evil.
- C. An impossible task.
- D. Easier when you are younger.

If most of your answers were As, you are lucky and you are kind of a freak of nature. Are you interested in joining our practice? We always can use more “night people.” If you answered mostly Bs, Cs, and Ds, read on. There are some strategies you can use.

Shift work sleep disorder (SWSD) is common in people who work nontraditional work hours. It is defined as difficulty sleeping and excessive sleepiness due to a noncircadian-based schedule. Some people with the disorder have an increase in accidents or work-related errors and increased irritability. While most of us do not have true SWSD, we probably all can identify with some aspects of the disorder.

Multiple studies have shown that night shifts are hard on the body in other ways. Studies suggest that people who work nights are at an increased risk of developing breast cancer, metabolic syndrome, and type 2 diabetes (<http://www.ncbi.nlm.nih.gov/pubmed/21355031>). One study has determined that short-term memory is most affected by both overnight and day



shifts (<http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2011.01254.x/full>). Anecdotally, a 32-year-old female physician has commented that her husband has diagnosed her with “decision fatigue” after she arrives home from an overnight shift, citing that she has difficulty making small decisions such as what to eat or drink.

Be selfish with your sleep. Let family and friends know that you are out of commission until a certain time and request that they avoid texting or calling during your sleep times.

The good news: there are ways to combat the evils of night shifts. We will make a few suggestions here, but we'd also like to hear from you about the strategies that you have found helpful.

#1 Sleep

This one seems obvious, but sleep needs to be a priority. The day after an overnight is not the best time to have your cleaning lady running the vacuum in every room of your house. Don't schedule a meeting in the middle of your daytime sleep and assume “I'll be okay.” Be selfish with your sleep. Let family and friends know that you are out of commission until a certain time and request that they avoid texting or calling during your sleep times. Put a sign on the door that says, “Day Sleeper, Do Not Disturb and Do Not Open the Door.”

#2 Darkness

Our bodies want to sleep when it is dark. Create a dark, quiet place for daytime sleeping. Think about installing black-out shades on your windows to create nighttime. Unplug the phone and use ear plugs. One overnight attending from the Bronx in New York City wears black-out goggles on his way home from work to avoid seeing the bright sun and throwing off his sleep cycle. (Just to paint a picture: this man is 6'5” riding the subway home during morning rush hour in a hooded sweatshirt and black, metal goggles.) You can wear sunglasses home instead of black-out goggles.

#3 Schedule

A schedule that bounces from day to night then night to day without a second to breathe is going to be hard for anyone. Some emergency physicians bundle their night shifts together while others find that having night shifts randomly throughout the month is better. You should experiment with both strategies and find which best fits your biorhythm.

#4 Reward for Working Night Shifts

It is possible that some people just can't do night shifts. One emergency medicine program just implemented a policy wherein employees do not have to do nights in the third trimester of their pregnancy. Many EDs do not require physicians over a certain age to do night shifts. One hospital in the northeast has shortened the night shift from midnight to 6 am so that the overall impact on sleep is less.

Certain medical and psychiatric conditions are also affected by overnight shifts, such as seizure disorder and depression. Does your practice have specific guidelines for who is not required to work night shifts? This is a discussion that should take place. Many departments offer supplemental compensation for night shifts.

The reality of emergency medicine is that night shifts are not going to disappear. Further, most hospitals are trying to stay fiscally sound 24/7. The general population is working a less traditional 9 am to 5 pm business schedule 7 days a week, leading more and more people to work nontraditional hours in the future. We will need to know how to treat this disorder, not just for ourselves but for our patients.





THE PHYSICAL WELL-BEING SPOKE

Well-Being Tips for Scheduling Shift Work*

By Thomas Benzoni, DO, FACEP, Serena Baqai, DO, Mark Meredith, MD, FACEP, and Hal Thomas, MD, FACEP

Shift work does not have to cause dissatisfaction within our specialty if we have the tools to use it to our advantage.

“To sleep, perchance to dream: ay, there’s the rub.” —Shakespeare, Hamlet

Introduction

Emergency medicine is a high-stress specialty. Not only do we not control what comes through the doors, we give up control of the time of day when anything might present. This anticipation of stress adds to emergency physician stressors. Our ability to cope with stress varies with the time of day and the duration of the exposure to that stress. Although we agree (by our specialty choice and the ethics undergirding it) to not mitigate the input side of the stress, we can moderate our response to it. Thus, control of our personal lives and work structure is vital to the well-being of our patients and ourselves.

Control What We Can

What is a fair schedule? The first response may be that all members of a group or hospital staff should have the same number of days, evenings, nights, weekends, and holidays. The reality is that administrative responsibilities within the group or outside personal responsibilities can make that impossible.

Emergency medicine shifts run 24/7/365; birthdays, holidays, weekends—all the same. Standards and routines of care do not vary by the level of the sun; however, the rhythm of our lives is linked to the diurnal variation of the sun. This is a vital anchor. We cut that anchor chain by having to work rotating shifts.

The adverse effect of constantly rotating shifts is the single most important reason given for premature attrition from the specialty. We are out of sync with the sun and the rest of society because of the work we do. People see us in flip-flops and beach shirts when they are working and think emergency medicine is a great lifestyle; it is not their fault they were sleeping while we worked.

There are many biological and social problems associated with rotating shifts. Physical problems include:

- Increased stress-related peptic ulcer disease (8 times greater than the general population)
- Increased cardiovascular mortality¹
- Increased divorce rate
- Chronic fatigue
- Excessive daytime sleepiness
- Difficulty sleeping at night/normal hours
- Increased substance abuse
- Increased depression (15 times greater than the general population)
- Increased incidence of accidents.

Many of the recent major disasters attributed to human error (Exxon Valdez oil spill, Three Mile Island, Bhopal chemical plant explosion, Chernobyl), occurred on the night shift, when alertness is at its lowest point.

Circadian Rhythms

To understand and mitigate sleep cycle problems, a basic knowledge of intrinsic rhythms makes comprehension and solutions more available. Circadian is the most basic rhythm.

Circadian comes from two Latin words: *circa* meaning “about,” and *dia* meaning “day.” It refers to the bodily rhythms that vary throughout the day in a periodic fashion. These rhythms have been recognized since the times of Aristotle and Hippocrates. Many bodily functions exhibit circadian rhythms, from the best known sleep/wake cycle to all of the vital signs. As we become capable of more precise measurements, more and more circadian cycles are being recognized. Even bone length has been found to exhibit a circadian periodicity.

Most circadian rhythms have both an endogenous component (regulated by an internal clock located in the supra-chiasmic nucleus of the hypothalamus) and an exogenous component.² The exogenous component comprises various time or environmental cues called *zeitgebers*. One of the most powerful *zeitgebers* is the light/dark cycle.

The adverse effect of constantly rotating shifts is the single most important reason given for premature attrition from the specialty.

Temperature is one of the most studied of the circadian rhythms and exemplifies the effect of both endogenous and exogenous factors. People with a diurnal (work during day, sleep at night) orientation have a peak temperature about 4 pm and a trough about 4 am. During the day people are up using muscles, generating heat, and eating, which produces heat as food is metabolized. During the night not only is muscle use decreased, but one doesn't eat. Subjects kept in a so-called steady state, forced to remain in bed but awake and fed the same amount of calories each hour, still exhibit the same temperature curve but with dampened periodicity (peaks and troughs do not differ by as much). In day-shift workers, the endogenous and exogenous components of the circadian rhythms tend to complement each other and work in harmony. Night shift workers pit the endogenous and exogenous components against each other.

One important finding about the internal "clock" is that it runs on a 25-hour day, not the expected 24-hour day. Subjects who are isolated and removed from all *zeitgebers* will predictably go to bed an hour later each "day" and sleep an hour longer into the next day. Why this is so is unknown. It is postulated that this allows the body to adjust depending on the season and other external considerations. This 25-hour day explains why it is so easy to stay up later during holidays but so hard to get back on a work schedule rising earlier. It is also why traveling from east to west is much easier (where one adapts by staying up later and sleeping in) than vice versa. *This is the basis for recommending a clockwise shift rotation, which takes advantage of this natural tendency to stay up later and later.*

One important finding about the internal "clock" is that it runs on a 25-hour day, not the expected 24-hour day.

Sleep Primer

In order to understand the effects of shift work and how to best schedule any 24-hour operation, some understanding of sleep is necessary. Little is known about normal nocturnal sleep, but even less is known about the sleep of those who must attempt to sleep during the day and work at night. Although it is not clear how much sleep is actually necessary for optimal health, there is evidence that very long natural sleepers and very short sleepers have increased mortality.³

Physiology.

Sleep is divided into several stages based on electroencephalogram (EEG) criteria. *Stage I* is the initial part of any sleep episode lasting 10 to 15 minutes. Most subjects when awakened from stage I will deny being asleep at all. *Stage II* accounts for the largest portion of sleep (50%), yet it is the least understood of all sleep stages, because it is the matrix from which all the other stages proceed. Sleep stages are typically studied by selectively depriving a subject of that particular stage and observing the results. Attempts to selectively deprive a subject of stage II sleep results in total sleep loss because it is impossible to enter other stages without going through stage II. Stage II is the stage least likely to be made up after a period of sleep deprivation, and the most likely to be increased with the use of sedative hypnotics. *Stages III and IV* are now collectively termed slow wave sleep (SWS); the only difference between the two is the absolute number of delta waves recorded on the EEG. In contrast to stage II, stages III and IV are the most constant from individual to individual and most consistently made

up after a period of sleep deprivation. SWS is thought to be important for bodily repair. It is the stage during which growth hormone is secreted during normal sleep. The single most important determinant of SWS is the length of time since the last sleep episode; it is not as subject to circadian factors. Rapid eye movement (REM) sleep is the best known sleep stage. During this time the body is completely paralyzed and loses its thermoregulatory properties. This is the main time when dreaming occurs, which is thought to be important for psychological adjustment and development. Unlike SWS, REM is highly influenced by circadian periodicity.

Normally, these stages cycle throughout the night in periods of about 20 minutes (remember this), with relatively more SWS alternating with stage II in the earlier part of the night, while REM sleep dominates during the latter part of a sleep episode.

Many things can alter this sleep architecture. Drugs are an important cause of altered sleep patterns; caffeine causes a more rapid than normal cycling between stages, while alcohol suppresses REM sleep. Sedative hypnotics (with the possible exception of zolpidem) will result in greater total sleep time but will almost exclusively increase stage II sleep (which may not be particularly restorative). Noise, even if it doesn't awaken one, will alter sleep cycles.

Circadian placement (when during the solar cycle) of sleep is also very important. Daytime sleep is typically 1.5 to 2 hours shorter than the nocturnal sleep period. REM and to a lesser extent stage II are the most shortened. The night-shift worker must contend not only with the expected circadian trough of energy and alertness but also with sleep deprivation from the poor quality of daytime sleep. Many shift workers develop a near obsession with sleep.

Sleep duration is an often forgotten concept. In general, sleep occurs in 1.5-hour cycles (not precise and with individual variation) in 4 sections. Thus, a nap of 20 minutes is better than one of 30 minutes but not as good as a 45-minute nap. A solid nap of 1.5 to 3 hours can restore 6 hours of function. While working nights, physicians should find 6 hours of sleep during the day to suffice.

Social/Domestic Factors.

The social effects of rotating shifts on the worker and the worker's family are also important. The general population is coupled to the solar cycle of activity in daylight and sleep in moonlight. Thus, society engages in behaviors that directly undercut the well-being of the night-shift worker (into whose hands they place themselves in times of need). Neighbors mow lawns, people make phone calls, families carry on activities, all while the night-shift worker is trying to recover/restore herself. Other industries have demonstrated greater productivity and increased job satisfaction by applying circadian principles to scheduling.⁴

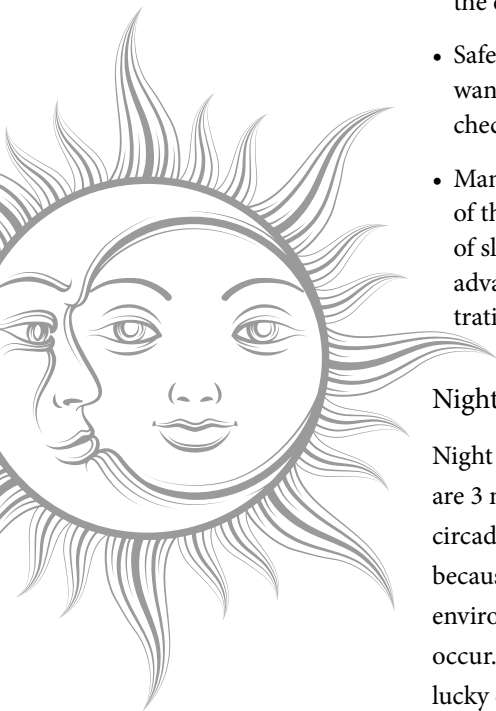
The risk of "drowsy driving" is increasingly recognized. Sleep deprivation has been equated to driving while intoxicated (PBT=0.16) and over 1,000 fatal motor vehicle crashes yearly are attributable to falling asleep behind the wheel.⁵ Commuting home after a night shift is recognized as a major risk factor for motor vehicle crashes. Providing a place for a post-shift nap before driving home is a best practice.



Scheduling Strategies

How best to schedule a department is one of the most important issues for adaptation to shift work. There is no one best schedule; each group must find what works best. Many factors must be considered including the census and acuity of the department, individual group member's preferences, group size, part time help, etc. There are a few basic principles:

- Shift start time and shift length depend on the group's sense of taking care of its members. Taking care of the emergency physician will allow the emergency physician to take optimal care of patients. Creativity is useful here. Perhaps a shift start time of 0600 to 0800 may not be the best for the group.
- Family counts. They are the emergency physician's support system. Family is where the emergency physician goes for healing and restoration. Putting the support system first lets the emergency physician succeed.
- Safety counts. Once the first 2 priorities are addressed, the cognitively enabled manager wants as few handoffs as possible. Thus, a natural place for a shift change is the nadir of check-ins.
- Management: At the management level, the best way to secure your position and take care of the patients is to take care of the emergency physician employees/partners. In matters of sleep, it is critical to take care of night shift personnel. The day shift workers have all the advantages of working during the daytime where there is plenty of ancillary and administrative support.



Night Shift Scheduling

Night shift scheduling has as many points of view as it has discussants—if not more! There are 3 main methods: never rotate shifts, rotate blocks of shifts, and pseudo-random. From a circadian perspective, the alleged gold standard is never to rotate shifts. (This is problematic because the constant night shift worker still has circadian rhythms and, in a non-aware environment (one that thinks it has found “the solution” so stops paying attention) errors will occur. Additionally, this constant night shift worker still pays with all the risks above. A group lucky enough to find someone who will work permanent nights should work hard to retain him or her and make sure that the compensation is adequate.

A nocturnist is a hospital-based physician who only works overnight. -Wikipedia.

Without a permanent night worker or nocturnist, the best shift rotation, *from a circadian perspective*, is to have group members work a long string of nights: 4 to 6 weeks. The idea is that each person can group together their nights for the year and only need to shift their circadian rhythms twice, once onto nights and once back again. Everyone in the group will work exclusively nights for that one period, but have 10 to 11 months of the year when they will only work an occasional night, on the night person's shift off. It is thought important for those working long strings of nights to stay up even on their nights off so as not to lose their hard-won night orientation. Whether this re-orientation really occurs or if the worker simply habituates is unknown.

The other strategy is to work as few consecutive nights as possible, ideally one. The idea is to never reset your circadian rhythms but to maintain a constant diurnal orientation. This strategy of “randomness” may be a good long-term solution. Groups that have done this for several decades have good long-term retention and low rates of injury and disability. This method transfers much of the cognitive load onto administration/management, ensuring sufficient rest periods. However, as administration has command of assets, this is not an unreasonable expectation.

IDEA – Shift change times. Consider changing the shift at 2 or 3 am. This allows providers to get some sleep during the normal sleep hours. This is not as helpful with 12-hour shifts.

IDEA – Shorter night shifts. Consider implementing 10-hour day shifts, 8-hour evening shifts and 6-hour night shifts. Utilizing this strategy does not create more night shifts.

In some cases per diem or part-time staff might be a solution. If you can find part-time or per diem staff to work the less desirable shifts, then this will take the burden off the full-time members. The pros and cons of per diem and part-time staff are numerous. It is wise to consider that per diem and part-time staff may not have the same commitment to the group and the facility that the full-time staff have.

Age or tenure opt-out policies.

Some groups have developed policies that allow members to opt out of night shifts based on the provider’s age or years with the group or some combination of the two. Find out if this policy is “all or nothing” or has a tiered response. Providers may opt out of nights completely when they qualify. Alternatively, the policy may reduce the number of night shifts required as a provider has more years with the group. This solution requires that the group have members of various ages and tenure, otherwise all members could opt out leaving no one to work the night shifts.

Which solution or blend thereof is used depends on local values, administrative support, and group dynamics. The only wrong solution is staying with one that grinds through people.

Shift Length

Another major decision for any group is how many hours in a row to work.⁶ Traditionally, most groups have worked two primary shifts of 12 hours each, with additional double coverage shifts of varying lengths as needed. There is a trend to shortening the primary shift. Many believe that patient care improves with a better rested, more alert physician. There is also the



ability to enjoy recreational pursuits even on workdays with shorter shifts. Circadian principles are much more easily applied with 8-hour shifts. If a group adopts a system of many nights in a row, shorter shifts are an advantage.

The major advantage to 12-hour shifts is having one-third more calendar days off completely free of hospital responsibilities. It is important to be clear that there are not more hours off, just fewer days that have to be worked. Those with a long commute are likely to favor longer shifts as well as those lucky enough to reliably get 2 to 3 hours sleep on each night shift. As physicians age or as patient census and acuity increase, most find shorter shifts more appealing. Patient care is probably improved with shorter shifts as there is a cognitive load to working; this cognitive fatigue is found around hour 7.^{7,8}

Other scheduling strategies for groups to consider are to change shifts at different times. Some groups start at 0400, changing every 8 hours. This system works well in high-acuity settings where physicians are using their full training. Anchor sleep (sleep during those critical times for REM) is preserved. Each shift has a negative aspect to it: getting up for 0400 is tough, noon is busy, 2000 is nights. If longer shifts are desired, overlap times should be done by the day workers (paying for this time.) Adding double coverage for low acuity cases smooths out the transition times.

Patient care is probably improved with shorter shifts as there is a cognitive load to working; this cognitive fatigue is found around hour 7.

Shift Differentials

Most other industries pay a differential for night work. Groups of all sizes are beginning to reward night shifts in different ways, particularly monetarily. Even in the health care field, most nursing staff receive a differential for night shifts. It is well established that working night shifts becomes more difficult as one ages and increases the potential for errors. Older group members who don't tolerate nights well often gladly "pay" extra to those younger members who are more tolerant of nights and less secure financially. It is relatively easy to devise a reimbursement system whereby the night shift pays relatively more and other shifts proportionately less. In other industries, this helps retain valuable workers who would otherwise prematurely retire as night shifts become increasingly burdensome. Some groups reward night shifts in other ways such as fewer total shifts and/or fewer weekend and holiday shifts. Non-monetary incentives for working nights should also be considered such as decreased administrative duties. There are innovation centers (Stanford, others) looking at other values.⁹

Individual Strategies

There are also many individual strategies to help you adapt to shift work. Awareness of sleep physiology can inform these. It begins with working for an institution that is willing to invest in scheduling innovation.

Dark and cool are needed to foster REM sleep; a sleep room at home is a must. Entering the sleep room while it is still dark out preserves the elevated melatonin levels that foster restorative sleep. Staying in the room, sleeping in dark and silence (leave the smart phone outside!) will permit 6 hours of solid rest.

Room design is a special area. Best is a below-ground bunker, soundproofed (See Amazon “soundproofing”). Being below ground dulls the neighbor mowing the grass and promotes a 55°F temperature. Additionally, the lack of light means no night shades. Soundproofing absorbs any other arousal signals and eliminates the need for earplugs. Second-tier adaptations involve earplugs and eye and window shades. A non-starter is a regular bedroom in the busy center of an active house.

There are also individual sleeping strategies that can be used. A split sleep period is a technique involving sleeping for 3 to 4 hours immediately before and 3 to 4 hours immediately after a night shift. The rationale is that at least part of each sleep episode is during the circadian period when sleep is expected. There is a technique that can be used after a series of night shifts that is essentially a compromise to switching to a diurnal orientation. One stays up until 3 or 4 am and then sleeps until 10 or 11 am. That way one gets some time to socialize but doesn't completely lose a nocturnal orientation. Naps are problematic.¹⁰ Regularly scheduled naps can be effective, and some industries with multiple workers on night shifts include time for naps in their shift design. In general, however, random unscheduled naps serve to hinder adaptation (making it harder to get proper sleep during the planned sleep period) and do not increase alertness or improve mood.

Exercise can help in adapting to shift work. Not only does exercise improve general mood but it also promotes alertness on night shifts (if not too strenuous). It has been shown to increase circadian adaptation also. Aerobic exercise immediately after awakening, no matter which shift one is working, is most effective. Exercising within 2 hours of intended sleep time delays the onset of sleep, likely through activation of adrenergic mechanisms.

What About Medications?

Pharmacology may be considered. Night workers should not routinely use sedative hypnotics; they are very addictive and, while they do increase total sleep time during the day, they do not hasten resetting of rhythms to night shifts or improve alertness during the night.¹¹

Shift workers nearly universally use caffeine. It can increase alertness but also alters sleep architecture when used within 4 hours of a planned sleep period. Stop consumption of caffeine within 4 hours of going home to decrease time to restful sleep.

Another alerting agent of proven benefit is modafinil and, more recently, its isomer armodafinil.¹² They belong to the broad family of amphetamines but are thought to have very low abuse potential. They have not proved to be significantly more alerting than higher doses of caffeine (500-600 mg) but may have fewer side effects. However, there have been numerous examples of non-addicting medicines shown, over time, to be problematic.

Alcohol induces sleep, but decreases REM sleep, which is already diminished during daytime sleep periods.

Another pharmacological agent which holds promise is melatonin. It is a hormone secreted nightly by the pineal gland in response to darkness. Melatonin is a sedative, promoting REM

Exercise can help in adapting to shift work. Not only does exercise improve general mood but it also promotes alertness on night shifts



sleep. It has been shown to hasten resetting of circadian rhythms to local times. Several studies of jet lag have shown significant improvement with the use of melatonin. Careful timing of melatonin has also been shown to be helpful for shift workers. Bright light of greater than 3,000 lux can also hasten resetting of circadian rhythms.¹³ Bright lights during the nights will increase alertness on the night shift and rapidly convert circadian rhythms by suppressing melatonin. Bright light in the early morning (5 to 7 am) can hasten adaptation back to days by phase advancing one's rhythms and allowing earlier night sleep. This is problematic when the night shift ends during daylight hours and the night shift worker drives home bathed in sunlight. This exposure resets the clock to daytime, eliminating adaptation to nights and destroying restful sleep that day. Ramelteon, a selective melatonin receptor agonist, has proved to be a useful long-term hypnotic agent, although its use for daytime sleep is untested.¹⁴

Conclusions and Summary

- Shifts should be scheduled, whenever possible, in a manner consistent with circadian principles. For most settings, scheduling isolated night shifts or relatively long sequences of night shifts is recommended.
- Overly long shifts or inordinately long stretches of shifts on consecutive days should be avoided whenever possible. In most settings, shifts should last 12 hours or less. Schedulers should take into consideration the total number of hours worked by each practitioner and the intervals of time off between shifts. ACEP strongly recommends that practitioners have regularly scheduled periods of at least 24 hours off work.
- Rotating shifts in a clockwise manner (day to evening to night) is preferred. This applies even when there are intervening days off.
- Night shift workers' schedules must be designed carefully to provide for anchor sleep periods, and those workers' daytime responsibilities should be held to an absolute minimum. Groups should consider various incentives to compensate those working predominantly night shifts.
- Schedules for emergency physicians should take into account factors such as ED volume, patient acuity levels, non-clinical responsibilities, and individual physician's age.
- A place to sleep before driving home after night shifts should be provided.

Shift work is a necessary fact of life for emergency physicians. Emergency physicians must be mindful of the importance of their well-being and acknowledge the adverse effects of shift work. Administratively, this includes making rational schedules from a circadian perspective. Individual strategies should also be employed to guarantee good sleep hygiene and decrease potential interruptions. There is a reason that fewer jets fly at night, and it's not the jets.

*Material for this chapter is based largely on an ACEP Policy Resource and Education Paper, "Circadian Rhythms and Shift Work," developed by members of the Well-Being Committee in 2010 as an adjunct to the ACEP Policy Statement, "Emergency Physician Shift Work"; however, the authors have added and updated information as needed to reflect current understanding.

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THE OCCUPATIONAL WELL-BEING SPOKE

So You Wanted To Be an Emergency Physician . . . Now What?

Early Career Planning and Longevity

By Elaine B. Josephson, MD, FACEP and Susan Bañuelos, MD

Innovative Program Stanford, Aug 20, 2015, <https://is.gd/9YxXYA>.

Planning what to do post residency is very exciting and filled with wonderful possibilities. But it can also be somewhat intimidating, stressful, and time-consuming. Although the switch from resident to attending physician literally happens overnight, the planning for it starts almost as soon as residency begins. Decisions about fellowship training and early sign-on bonuses are now common among junior residents. When deciding what you want to do as your first “grown-up” job you should take into account various factors including family, location, fellowship vs. no fellowship, academic vs. community, and a strategic plan if the first job does not work out. There are no right or wrong answers, but honesty counts. The more you reflect on what’s important to you—family, paying down debt, a good work-life balance—the better choices you will make.

Family Influence

Immediate and extended family needs and desires play an extremely important role in the decision-making process. If you have a family and your spouse is planning to work, remember that he or she must be able to find employment as well. If you have children, you will want to consider the quality of the schools in the area, access to child care, and whether living close to other family members is important to you. Make time to have fun, spend quality time with your family and friends, and go on vacations. Ensure that you make family and friends a priority; it is very easy to let work life interfere with your family and personal relationships.

Location

Location is likely going to be one of the most important decisions you will have to make during the career planning process. You will have to choose where you want to live and what type of work setting (urban, suburban, rural, or international) is best for you. You may decide to work as an independent contractor, try a locum tenens position, or join an already established group. Take time to think about geographic locations. Where in the country would you like to practice? Where do you see yourself living? Do you have any flexibility in your choices? Keep in mind that your selection of location may affect your ability to do a specific fellowship. Be sure to investigate the attending physician salary ranges for that particular area, as they vary in different parts of the country.

Once you decide on a location, research the emergency departments in that area. Which practice settings (trauma center, tertiary care center, transplant center, etc.) are hiring? For each potential place of employment, collect the following information: annual emergency department census, shift total per month, percentage of day and night shifts, number of physician coverage hours per shift, and total coverage hours of allied health personnel (ie, nurse practitioners, physician assistants) per shift. Most importantly, make sure you will be able to afford to live in that area on your salary. Investigate for each location the state malpractice risk and liability.

Fellowship Decision

If you are considering a fellowship, first determine what type of fellowship and what your plans are post fellowship training. Examples of emergency medicine fellowships include research, EMS, medical toxicology, ultrasound, academic, administrative, pediatric EM, critical care, hospice and palliative medicine, sports medicine, clinical informatics, and wilderness/disaster medicine. Not all fellowships are ACGME accredited, so do your research. One of the main differences between ACGME vs. non-accredited fellowships is that ACGME fellowships offer the availability of a Board Certification exam. Other differences may include financial compensation and your ability to moonlight. When determining whether you are willing to do a non-accredited fellowship it is important to determine the value of the training, the access to future mentors, and further employment options.



If you are looking for a research-based career, fellowships are often recommended in the area you plan to study. Keep in mind that many federal research grants are generally given to physicians with formal training or those with extensive prior research in the subject.

If your interests, however, lean toward academics, the path for fellowship training is less clear-cut. If you decide to do a fellowship, realize that emergency medicine fellows may work clinically as part-time faculty and are therefore paid a part-time faculty or fellowship salary. After clinical duties, the remainder of time is spent in the specialty training. Expected clinical time will depend on the funding source.

Academic vs. Community

Once you have decided if you do or do not want to pursue a fellowship, it is necessary to determine if you want to practice in an academic or community setting. The private sector will most likely pay more than academic. However, academic positions will generally offer better benefits and job security. Academic medicine affords the rewards of teaching students, residents, paramedics, colleagues as well as constantly improving medical education. If you decide to take an academic position, pitfalls to be aware of are programs that offer major leadership positions immediately out of residency (Caution: something is wrong here!) or, taking a position at an academic institution with no leadership or growth opportunities.

Comparing Salaries and Benefits

Most residents these days will have multiple job offers and comparing these offers gets tricky. Emergency physicians can be independent contractors or employees of a private group or hospital. Take the time to fully understand the business model and compensation of any offer you are seriously considering. Often it is difficult to compare benefits (ie, the advantage of a 401K vs. traditional pension). Does your salary seem high because you are asked to pay your own malpractice and health insurance premiums? Ask questions and consult a professional if you don't fully understand how the model works. Be honest with yourself about your current financial situation and your own financial habits.

Take the time to fully understand the business model and compensation of any offer you are seriously considering.



Independent Contractor vs. Hospital or Group Employee



You are self-employed.

There are usually no benefits. These must be purchased for yourself and your family.

Check if the independent contracting firms offer malpractice insurance.

Independent contractor status offers maximum flexibility with scheduling shifts (the more shifts you work the more you make).

If you don't work, you will not have a stable paycheck (ie, there is no maternity leave, vacation pay, etc.).

There are tax benefits to being self-employed (many common expenses are tax deductible).

You may be required to pay a self-employment tax.



Academic Institution

All taxes and deductions are paid by hospital.

Benefits are automatically provided by the hospital (eg, health insurance, basic life insurance, and basic disability insurance).

Stable contract.

Teaching/research opportunities.

Lifelong personal learning.

Often lower salary.

Limited tax deductions.

Hospital Employee

Hired directly by the hospital administrator.

You negotiate your own individual contract.

You are not responsible for billing/collecting, contract-maintenance, or administrative duties.



All members in the group are equal and all decisions are made with a group consensus in terms of operating decisions.

The corporate group holds the contract with the hospital and employs physicians to fulfill the contract.

The practice's hospital contracts can be lost with the hospitals.

Depending on the size of the group, some will provide health insurance, basic life insurance, and possibly basic disability insurance.

Ownership/partnership potential.

Comparable salary and tax benefits of an independent contractor with the benefits of a hospital employee.

The group revenue and expenses determine your ultimate income.

If the First Job Doesn't Work Out

Residency directors estimate that 60% to 70% of graduates will switch jobs within the first 2 years of graduating from residency. One of the main reasons for the high turnover rate is the lack of preparedness when deciding on that first job. This is especially important since many large groups are offering sign-on bonuses even before residency completion. Some are offering money now, often for a 3-year or longer commitment later.

Several reasons cited for job turnover include shift work, workload pressures, consultant conflict, financial compensation, and malpractice issues. These concerns need to be considered before accepting any job. If you find that you are not quite satisfied with your first job at the 2-year mark, know that this is happening to many of your colleagues who have recently graduated from residency. Figure out what questions you wished you had asked before you took your current position and get answers to those questions when deciding on your next job.

Seek Out a Wise Mentor

Whether choosing an academic or community-based position, finding a good mentor is invaluable in planning your own career path. Think about where you want to be in 10 years and seek out individuals who have achieved that success. Ask your mentors about how they got there and what choices they would make or not make again. Find out who mentored your mentor! When you do get a job offer discuss the pros and cons with your advisors. Develop a plan not only for the next year but also for 5 to 10 years in the future.

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THE OCCUPATIONAL WELL-BEING SPOKE

All Things Retirement

By Richard M. Goldberg, MD, FACEP, Shay Bintliff, MD, FACEP, and Gloria Kuhn, DO, FACEP

Transition to Retirement

The members of the Well-Being Committee hope that this section is helpful to retirees, both prospective and actual. Each subsection is formatted to provide basic background information, with references and linkages included for access to authoritative sources. We welcome your suggestions for modifications or additional materials to be included in the future. Enjoy the ride!

Any transition must be seen in the context of your life's journey. So, ask, "Why?" Why is this happening? And why now? Transition is the difficult process of letting go of an old situation, suffering the confusing nowhere of in-betweens, and launching forth again in a new situation. It is a natural process of disorientation and reorientation that marks the turning point in the path of growth. It is part of the natural process of self-renewal that we all will face.

There are three primary stages to this process, an understanding of which can benefit the prospective retiree: 1) an ending, followed by 2) a period of confusion and distress, leading to 3) a new beginning.

Phase 1: An Ending

Every transition begins with an ending. We have to let go of the old thing before we can pick up the new—not just outwardly—but inwardly, where we keep our connections to the people and places that act as definitions of who we are. People will congratulate you on your new life, but you may go through a period of mourning for the loss of the old life.

This letting go can be very hard! Our self-image is defined in part by the roles and relationships we have had, and we seldom realize how much we identify with the circumstances of our lives. Think back on how you coped with other endings. Perhaps you have experienced the loss of a pet, a friend, a parent, or another loved one. Recall those feelings and thoughts—they can sometimes be reactivated in this phase.

Phase 2: A Period of Confusion and Stress

This can be a time of emptiness, more like a “neutral zone,” before life resumes a pattern and new direction. It is important to anticipate and accept the sudden sense of loss of direction should it occur, understanding this phase as a prelude to renewal.

Here are some practical suggestions for discovering meaning in the “neutral-zone” experience:

- Begin a log of “neutral-zone” experiences as a means of examining the process of renewal.
- Consider taking this time to write an autobiography. Why? Sometimes it is only in seeing where you have been that you can know where you would like to be headed.
- Most importantly, think of what would be un-lived if your life ended today.

Phase 3: A New Beginning

The final phase—a beginning! As stated earlier, we come to beginnings only at the end. It may help you navigate this final completion phase by recalling the important beginnings in your own past. Examples: The decision to become a physician; meeting your significant other; moving to a new home, etc. You probably already know that new beginnings are difficult, requiring adjustments to long-established ways of thinking and relating to others. You may also recall that new beginnings are opportunities to create growth in your life, as new aspects of yourself emerge.

*People will
congratulate you
on your new life,
but you may go
through a period of
mourning for the
loss of the old life.*

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Healthy Aging—Diet For the Mature Emergency Physician

Dietary Guidelines for Americans, published every 5 years by the Departments of Agriculture and Health and Human Services, provides authoritative advice on promoting health and reducing risk for major chronic diseases through proper diet, <http://www.health.gov/dietaryguidelines/>. The *Dietary Guidelines for Americans, 2010*, released on January 31, 2011, emphasizes three major goals for Americans:

- Balance calories with physical activity to manage weight.
- Consume more of certain foods and nutrients such as fruits, vegetables, whole grains, fat-free and low-fat dairy products, and seafood.
- Consume fewer foods with sodium (salt), saturated fats, trans fats, cholesterol, added sugars, and refined grains.

Balancing calories to manage weight

- Prevent and/or reduce overweight and obesity through improved eating and physical activity.
- Control total calorie intake to manage body weight. For people who are overweight or obese, this will mean consuming fewer calories from foods and beverages.
- Increase physical activity and reduce time spent in sedentary behaviors.
- Maintain appropriate calorie balance during each stage of life.



Individuals should meet the following recommendations as part of a healthy eating pattern while staying within their calorie needs.

- Increase vegetable and fruit intake.
- Eat a variety of vegetables, especially dark-green and red and orange vegetables and beans and peas.
- Consume at least half of all grains as whole grains. Increase whole-grain intake by replacing refined grains with whole grains.
- Increase intake of fat-free or low-fat milk and milk products, such as milk, yogurt, cheese, or fortified soy beverages.
- Choose a variety of protein foods, which include seafood, lean meat and poultry, eggs, beans and peas, soy products, and unsalted nuts and seeds.
- Increase the amount and variety of seafood consumed by choosing seafood in place of some meat and poultry.
- Replace protein foods that are higher in solid fats with choices that are lower in solid fats and calories and/or are sources of oils.
- Use oils to replace solid fats where possible.
- Choose foods that provide more potassium, dietary fiber, calcium, and vitamin D, which are nutrients of concern in American diets. These foods include vegetables, fruits, whole grains, and milk and milk products.
- Reduce daily sodium intake to less than 2,300 milligrams (mg) and further reduce intake to 1,500 mg among persons who are 51 and older and those of any age who are African American or have hypertension, diabetes, or chronic kidney disease.
- Consume less than 10% of calories from saturated fatty acids by replacing them with monounsaturated and polyunsaturated fatty acids.
- Consume less than 300 mg per day of dietary cholesterol.
- Keep trans fatty acid consumption as low as possible by limiting foods that contain synthetic sources of trans fats, such as partially hydrogenated oils, and by limiting other solid fats.
- Reduce the intake of calories from solid fats and added sugars.
- Limit the consumption of foods that contain refined grains, especially refined grain foods that contain solid fats, added sugars, and sodium.
- If alcohol is consumed, it should be consumed in moderation—up to 1 drink per day for women and 2 drinks per day for men.

Other Resources

- Consumer Reports on Health: This is a monthly, independent, non-profit publication with reviews on topics such as nutrition, exercise, and aging as well as related goods and services. <http://www.consumerreports.org/health/>
- CDC Healthy Aging Podcast Series. Offers podcasts on a variety of health-related topics. <https://www2c.cdc.gov/podcasts/browse.asp?c=180>

Basics of Financial Planning for the Pre-Retirement or Retiring Emergency Physician

A broad outline of the subject will be presented here. A comprehensive discussion of financial planning is beyond the scope of this publication. Most physicians will benefit from the services of a certified financial planner to deal with the complexities of retirement financial and estate planning. The American College of Emergency Physicians website refers readers to the Financial Planning Association* www.fpanet.org for introductory publications. Also provided are listings of local certified providers. www.plannersearch.org.

I. Financial Planning—A Timeline*

- Ages 20s to early 30s:
 - try to save 10% of income
 - join employer's retirement plan
 - use IRA or other vehicles if employer has no plan
 - if self-employed, use 401 (k), SEP or similar plans
- Ages 30s through 40s:
 - save at least 10% of income
 - have adequate health and life insurance and emergency fund
- Ages 50s and 60s:
 - boost savings to 20% or more
 - maximize tax-deferred contributions
 - begins shift into lower risk investments
 - begin focusing on retirement lifestyle
 - calculate realistic retirement resources
- Retirement:
 - determine how much money to withdraw each year
 - determine which accounts to withdraw from
 - invest more conservatively but don't abandon stocks
 - hold 2 to 3 years living expenses and cash equivalent
 - develop estate plan

The American College of Emergency Physicians website refers readers to the Financial Planning Association® www.fpanet.org for introductory publications.

II. Estate Planning: The Four Fundamental Tools*

Select a team of professionals to include a Certified Financial Planner who specializes in long-term care, a lawyer, an accountant, and a life insurance underwriter to help with planning issues. Regardless of the size of your current estate, you generally should have as a minimum four estate planning tools: a will, a durable power of attorney, a living will, and a medical power of attorney.

A will: a legal document that details where you want your estate's assets to go and who is going to oversee the execution of the will. It also may state who is to care for your minor children. Without a will, the laws of the state will determine what happens to your estate's property.

A living will: an individual's written declaration of what life-sustaining medical treatments he or she will allow or not allow in the event the individual becomes incapacitated.

Durable power of attorney: allows you to designate a representative, such as your spouse or adult child, to perform certain actions for you should you become ill, incapacitated, or otherwise unable to manage your affairs. Without a power of attorney, your spouse or other loved one would have to go through the delay and expense of seeking approval from the court to carry out needed financial transactions.

A medical durable power of attorney (or health care proxy): authorizes a person to make medical decisions on your behalf, ideally to carry out what you've specified in your living will.

*Adapted from: Financial Planning for Life Events (<http://www.plannersearch.org/financial-planning>) with permission from the Financial Planning Association, Denver, Colorado.



III. Medicare Basics

Medicare is a national social insurance program, administered by the US federal government, currently using about 30 private insurance companies across the United States. Medicare guarantees access to health insurance for Americans aged 65 and older who have worked and paid into the system, for younger people with disabilities, for people with end-stage renal disease and those with amyotrophic lateral sclerosis. Medicare has four parts.

- **Medicare Part A:** covers inpatient hospital stays, including semiprivate room, food, and tests. Also covered are brief stays for convalescence in a skilled nursing facility, as well as hospice care, if certain criteria are met.
- **Medicare Part B:** covers 2 types of services, medically necessary services and preventive services. Medically necessary services are services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice. Preventive services are health services intended to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best. You pay nothing for most preventive services if you get the services from a health care provider who accepts assignment. Examples include:
 - [Clinical research studies](#)
 - [Ambulance services](#)
 - [Durable medical equipment \(DME\)](#)
 - Mental health (in/out patient)
 - [Getting a second opinion before surgery](#)
 - [Limited outpatient prescription drugs](#)



- **Medicare Part C (Medicare Advantage Plans):** these plans, like an HMO or PPO, are run by Medicare-approved private insurance companies. They include Part A, Part B, and usually other coverage like Medicare prescription drug coverage (Part D), sometimes for an extra cost.
- **Medicare Part D:** a prescription drug option run by Medicare-approved private insurance companies.

Services not covered by Medicare: If you need certain services that Medicare doesn't cover, you'll have to pay for them yourself unless you have other insurance or you're in a Medicare health plan that covers these services. Examples include:

- Most dental care
- Eye examinations related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Long-term care

Applying for Medicare. The Initial Enrollment Period is a 7-month period that begins 3 months before the month of the 65th birthday, includes the birthday month, and ends 3 months after the birthday month. You must sign up at that time. You will need to decide if you want original Medicare—Part A and Part B (B is optional) or a Medicare Advantage Plan (Part C). Then decide if you need drug coverage (Part D). This is sometimes included in Part C plans. Finally, consider whether or not you need to add a Medicare supplemental insurance plan. “Medicare Basics” is a helpful tool, available at <http://www.medicare.gov/pubs/pdf/11034.pdf>.

IV. Social Security Basics

You can apply for Social Security benefits as early as age 62 and as late as age 70. The longer you wait for benefits, the greater the monthly benefits. For example, by waiting until age 65 to start taking benefits, your annual benefits increase by more than 6% over the sum you would receive at age 62.

In applying for benefits, you can either schedule an appointment at the local Social Security office or online at www.ssa.gov. Benefit payments begin about 4 months after your application is submitted.

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www.ssa.gov. The government social security website.

Social Security Benefits — Do Your Homework by Scott M. Kahan, CFP. Strategies for obtaining benefits. <https://is.gd/W3MFPw>

Resources for Emergency Physicians in Pre-Retirement/Retirement Years

Sports, Fitness, and Exercise

National Senior Games Association sponsors competitive events in a wide variety of sports. Participants must be 50 years or older. Competitions are now staged at state and national levels, with summer and winter games. Website: www.nsga.com.

2011 Physical Activity Guidelines for Americans. Developed with health professionals and policy-makers in mind, the Physical Activity Guidelines describe 1) a total amount of activity per week that allows people to design their own way of meeting the Guidelines and 2) a range of physical activity options. A special section is included for older adults. Website: <http://www.cdc.gov/physicalactivity/everyone/guidelines/olderadults.html>.

The American Volkssport Association. A nonprofit organization whose goal is to promote physical fitness and good health by encouraging all people, regardless of age, to exercise in noncompetitive, stress-free programs. Included among the programs are noncompetitive walking, swimming, bicycling, and cross-country skiing events. Each event has a pre-marked scenic trail and/or measured distance designed to appeal to all ages. Website: www.ava.org.

National Institute on Aging. Provides articles and other general information on how exercise can help you live a longer, healthier life. Website: <http://www.nia.nih.gov/HealthInformation/Publications/>.

US National Park System and Recreational Areas. Information is available on national parks, historic sites, and monuments across the country. National Park Service, 1849 C Street, NW, Washington, DC 20240. Phone: 202-208-3818. Website: www.nps.gov.

Retirement Planning

US Department of Health and Human Services, Commission on Aging. This agency provides a variety of booklets with pre-retirement counseling services. Phone: 202-619-0724. Website: www.hhs.gov.

US Department of Labor. Taking the Mystery Out of Retirement Planning. Online version includes interactive worksheets for each chapter. www.dol.gov/ebsa/publications/nearretirement.html.

CNN Money. Retirement Planning and Savings Plans. Strategies and advice, including retirement calculators, www.money.cnn.com/retirement/.

Senior Citizens Health Insurance Counseling Program. This organization helps seniors evaluate their health care needs and options. This is a free service provided by the National Association of Life Underwriters. Phone: 703-276-0220. Website: www.nahu.org.

Consumer's Guide to Insurance. This nonprofit organization provides guidance on a variety of insurance options. Website: www.life-line.org.

Educational and Travel Opportunities

Auditing seniors. A large number of state and city universities allow seniors to audit their courses free of charge or for a nominal sum. Check with your local institutions.

The Earthwatch Institute. Participants volunteer to go on scientific research projects. Worldwide in scope. Phone: 800-776-0188. Website: www.earthwatch.org.

Elderhostel (Road Scholar). A non-profit organization that provides one- and two-week educational programs in more than 2,000 colleges, universities, research stations and other educational institutions worldwide. Classes are a blend of lectures, cultural events, local exploration, and social activities. Phone: 800-454-5768. Website: www.elderhostel.org.

The Smithsonian Institution. This program presents a wide variety of educational opportunities including cultural activities, public outreach programs, performing arts, lectures, films, and courses. Phone: 202-633-1000. Website: www.SI.edu.

Chautauqua Institution. This institution provides summer weekends and one-week programs for seniors. They present a wide variety of educational programs, workshops, evening entertainment, and recreational activities. Phone: 800-836-ARTS. Website: www.chautauqua-inst.org.

Osher Life-long Learning Institute. This organization offers a large variety of courses (credit and non-credit) at more than 100 colleges and universities across the country. Website: <http://www.osherfoundation.org/index.php?programs>. Phone: 415-861-5587.

Association of Graduate Liberal Studies Programs. This organization offers master's degree programs in a variety of liberal studies. Website: <http://www.aglsp.org/>. Phone: 919-684-1987.

Health

American Heart Association: Provides a variety of reports and brochures covering all types of heart disease. They also provide guidelines for preventative care. Website: www.americanheart.org. Phone: 800-AHA-USA1.

Consumer Reports on Health: This is a monthly, independent, nonprofit publication with reviews on topics such as nutrition, exercise, and aging as well as related goods and services. The cost is \$24 per year. Website: www.consumerreports.org/health.

National Institute on Aging: This is a government agency providing free publications on many areas of health and aging. Website: www.nia.nih.gov/HealthInformation/Publications/.

National Heart, Lung, and Blood Institute (NHLBI): Provides a variety of materials relating to cholesterol, blood pressure, obesity, asthma, and sleep disorders. Website: www.nhlbi.nih.gov/.

CDC Healthy Aging Podcast Series: A newly established program offering podcasts on a variety of health-related topics. Website: www.cdc.gov/aging/publications/podcasts.htm.

US Dietary Guidelines, 2015-2020. A publication of the US Department of Agriculture. Website: <http://www.cnpp.usda.gov/dietaryguidelines.htm>.

Organizations Providing Services for Seniors

Social Security Administration. Provides information on Social Security Programs, Medicare and Medicaid benefits, as well as local senior programs and activities. Website: www.socialsecurity.gov. Phone: 800-772-1213.

National Institute on Aging. Provides many free publications on a variety of health and aging-related issues. Website: www.nia.nih.gov.

State Agencies. Each state has an Office on Aging that provides information for all matters relating to the needs of seniors. They also provide senior discount programs.

National Senior Service Corps. A national network of projects that place older volunteers in assignments in their communities. Website: www.seniorcorps.org.

US Department of Health and Human Services Healthcare Financing Administration (HCFA). This agency is responsible for administering the Medicare Program and assists with all matters and questions relating to the program. Website: www.hhs.gov. Phone: 877-696-6775.

American Association of Retired Persons (AARP). A non-profit organization providing a variety of services to seniors including insurance, travel, pharmacy, and educational resources. Website: www.aarp.com. Phone: 888-687-2277.

Volunteer Opportunities

Project Hope. This organization offers volunteer opportunities in more than 30 countries. They can accommodate emergency physicians for assignments lasting from a week to a year. Website: www.projecthope.org. Phone: 800-544-HOPE.

Doctors Without Borders/Medecins Sans Frontieres. Recipient of the 1999 Nobel Peace Prize, this organization is involved in more than 70 countries. They seek emergency medicine physicians willing to volunteer for a minimum of six months. They prefer physicians with knowledge of tropical medicine or foreign languages or previous field experience. Website: www.doctorswithoutborders.org. Phone: 212-679-6800.

Senior Corps. This organization links people over the age of 55 with organizations that need their services. They include such services as mentoring, coaching, or contributing to job skills and expertise in community projects and organizations. Programs include the foster grandparent program, senior companion program, and RSVP—a program that matches volunteers with organizations needing their particular skills and availability. Website: www.seniorcorps.org.

American Medical Association, Senior Physician's Group. Provides resources for physicians to remain active in medicine if they consider late-career transitions. They have an extensive database of opportunities for volunteers, both in the United States and overseas. They also provide linkages to Locum Tenens opportunities. Other benefits include travel programs and an AMA publication for senior physicians. Also offered are insurance programs and a wealth of written material on financial planning, emotional aspects of retirement, and healthy lifestyles. Website: www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/senior-physicians-section.page?

Volunteers in Medicine. Begun in 1994, this organization utilizes retired physicians to provide clinic care to serve the needs of uninsured patients. There are now multiple clinics across the country. Website: www.volunteersinmedicine.org.

Reach Out. A national program to support physician's wishing to provide care for the underserved. Website: <http://www.rwjf.org/pr/product.jsp?id=17588>. Phone: 877-843-7953.

General Resources

Senior Information Network. This is a national senior resource guide with links to AARP, Social Security Administration, National Council on Aging, and Centers for Medicare and Medicaid Services. Its database provides a wealth of information about local senior resources as well. Website: www.info4seniors.net. Phone: 770-934-8320.

Kiplinger's Retirement Report. One example of a monthly publication with wide-ranging reviews on topics such as finance, travel, and health. Cost is \$59.95 per year. Website: www.kiplinger.com/. Phone: 202-887-6491.

ING Retirement Services. One example of a financial institution offering retirement financial planning. Website: www.ing.us/retirement. Phone: 855-873-5288.

Directory of retirement communities, and active adult communities. Website: <http://www.retirementliving.com/>.



THE OCCUPATIONAL WELL-BEING SPOKE

Electronic Medical Records: Surviving and Thriving with Them

By Thomas Benzoni, DO, FACEP and Rita Manfredi, MD, FACEP

Electronic Medical Records (EMRs) are, at times, a source of angst for practicing emergency physicians. Why should this be, given the great promise they hold? And how do we keep our sanity amidst all the insanity?

A Brief EMR History

Not many decades ago, a patient's medical record resided on a 5-by-8-inch card in a filing cabinet in a general practitioner's office. That was good enough for all concerned, until more people wanted to access that record. Insurance companies, government officials, statisticians, and many others wanted the data the general practitioner possessed. With the coming of the Internet, the electronic medical record was born. The result was more useful data but also more extraneous information: more signal and more noise with a less easily located patient history.

What is the function of the EMR as it currently exists? The EMR is more of a billing record and less of a clinical record. By keeping this perspective in mind, one can stay sane and keep a frame of reference. The EMR evolved from billing sheets, where the physician circled the positive findings and "Xed" off the negatives. The markings were tabulated and mapped on a 1 to 5 scale. Thus, the more circles and Xs on the paper chart, the higher the points and the more revenue generated.

The EMR software that evolved, which was intended for billing, was less than successful in documenting patient care. It is no secret that EMRs are a source of stress to physicians, some to the breaking point. This significant contribution to wearing down physicians needs to be addressed. How do we, as emergency physicians, navigate our way through such challenges?

Remember Your Mission

A standard, reference point is needed: Remember why we are in the ED—the patient. We are reminded daily that we care for patients; so caring for the patient is the solution. Patients are about their stories, and those stories must stay central to our work. So how do we preserve this essential function of testimony and information transmission? The same way it has always been done. Listen to and document the patient's story. So how can we cope with the stresses the EMR causes?

Start with the Patient

- **Etiquette.** Sit down in the patient's room. There's a reason the computer is called a laptop. Face the patient over the top of the screen so that you can see the patient's face and eyes.
- **Learn keystroke shortcuts.** This will let you look at the patient while your fingers get that old document or lab. Don't know your software shortcuts? This may be the time to meet with your super-user in the department. Look at <http://www.makeuseof.com/tag/windows-8-keyboard-shortcuts/>.
- **Have a document page open.** Take your own shorthand notes on the computer while you talk to the patient. (You can acknowledge the computer's presence; patients will understand.)



Adapt to the Technology; It's Not Going Away

Exploit some of the other tech tools available to put the EMR back in its cage.

- **Pick up the Dictaphone.** Use Dragon dictation software, save a simple .wav sound file to the record (comes bundled with any modern OS), or use Google Speak. Dictate a short summary note. Skip the pre-set templates and just talk or type:
 - Why the patient came to the ED
 - What you found
 - What you did
 - What you want the patient to do
- **Hire a scribe.** There is a huge literature base on this topic, clearly showing that a scribe will pay for him/herself. Hospital won't do it for you? Then, hire one yourself. You can afford it and you can't afford to let this stuff drive you crazy!
- **How do you handle the software that you must use during the visit?** Go mobile. If the hospital won't buy a tablet, get one yourself. You may need to remote in from within your own facility, but it's worth it.



- Make a Favorites file that is useful and arranged the way you think. (Therapeutic Drug class? Chief complaint? Odd or critical workups? Special tests that are buried in the mass of entries?) Store what you need to remember for treatment of hyperkalemia in one place. Chest pain is just begging for its own directory.
- Use Macros/shortcuts/pre-configured order sets. These repetitive functions are the real strength of using a computer. Invest the time to set up your own Macros. Copy or share ones developed by your colleagues. Your Information Technology staff or department Super-user is there to assist you, and it will only cost you a sincere “Thanks!”
- Keep your common tests in the root directory of the favorites file; CBC, basic electrolytes, urinalysis, etc. (Optimally, a modern EMR would push your most common tests to the top, but that’s a future topic.)
- Use a laptop or a Computer on Wheels (COW) and load the PACS onto it to bring the radiology study to the bedside. Patients love to see the images, and it’s a major time saver for you.
- Learn how to access a graph of lab results. A line showing the downward trend in the hemoglobin for a GI bleed is much faster than trying to explain numbers.
- Show off your knowledge of past events by having prior visit dates and diagnoses pulled up on your screen.

What if you still are frustrated with computers? Be optimistic. The software someday will catch up to your expectations. Or you can design your own program. Be sure to share your EMR coping strategies with others, especially the new doc joining the department. EMRs are here to stay and we are the ones who will need to transform them so they benefit both the clinician and the patient.

As Jack Welch said, *“Control your own destiny or someone else will.”*





THE OCCUPATIONAL WELL-BEING SPOKE

When You Are Being Sued: Litigation Stress

By Arlene Chung, MD

Surveys consistently rank fear of medical malpractice as one of the top professional stressors for physicians. Having been trained to expect perfection from ourselves and our peers, we don't handle accusations of fallacy well. One of the biggest differences between medicine and other professions (law, engineering, business) is that where other professions see occasional errors, failures, and periodic lawsuits as inevitable, "the cost of doing business," physicians see it as a personal attack. Our siblings and friends who practice in other professions don't understand why we take it so hard. Our yoke of perfection is highly developed; it's not likely to change soon. In order to survive, we need to educate ourselves about what to expect and how to deal with the "inevitable" malpractice case. Our longevity and success depend on being able to handle this unpleasant, stressful professional reality.

Introduction

Back in the day, as a newly-minted intern starting my residency in emergency medicine, I remember one of my venerated senior attending physicians saying to me at the end of a long night shift, "You have an exactly 100% chance of being sued during your career. So stop worrying about it."

Of course, that did almost nothing to reassure me.

Although the statistics don't actually bear out a 100% risk of litigation, the threat of a malpractice claim is real for emergency physicians. A study conducted by the American

Medical Association found that more than 42% of physicians across all specialties have been sued at least once and more than 20% report being sued two or more times.¹ The number and frequency of claims varies quite a bit among the specialties in this report, with the surgical subspecialties ranking high on the list and pediatricians and psychiatrists at the bottom. Malpractice rates in emergency medicine hovered near the average, at about 8% per year. Disconcertingly, however, over 75% of emergency physicians over the age of 55 had experienced malpractice claims, while nearly 50% of emergency physicians of all ages reported experiencing at least one claim.

Residents can be sued too. A study in the *Journal of the American Medical Association* estimated that residents have been named in approximately 22% of lawsuits.² In most cases, they are named as codefendants with the attending physician on the case and may be held to the same standards of care. Although the attending is usually determined to be ultimately responsible for the care of the patient, malpractice lawsuits become part of the resident's permanent professional record should the claim result in payment.³

Fear of Litigation

The looming specter of malpractice casts a long shadow, even affecting physicians who haven't been served. Many physicians in a variety of specialties admit to practicing defensive medicine—referring to the practice of performing a diagnostic test or treatment that primarily serves the function of protecting the physician against possible future litigation, rather than being in the best interests of the patient's health. Emergency physicians in particular practice in an information-poor, high-risk, technology-rich environment that lends itself to defensive decision-making. This inevitably leads to increased costs and a greater rate of false-positive findings that adversely affect patients. Unfortunately this culture has become so engrained, that even with tort reform, physicians continue to practice defensively.⁴

Merely the threat of being sued may contribute to decreased career longevity. One study found that emergency physicians cited malpractice and litigation stress as one of the top three reasons for burnout and a desire to leave the field.⁵ Furthermore, as this study and many others have found, physicians who report high levels of burnout are also more like to retire early.

What to Expect

(Adapted from: Coping with the Stress of Being Sued. *Fam Prac Manag.* 2001;8(5):41-44.)

Summons. The summons is often the first clue that a physician is being sued. Normal reactions range from shock to disbelief to outright denial. This is usually followed by several weeks of feelings of depression, anger, loss of control, and even physical illness. These feelings may occur even if the physician involved does not believe that any negligence actually occurred. In these initial stages, it is important to learn about the details of the litigation process and work closely with a lawyer. Physicians should also recognize that emotional turmoil is normal and avoid excessive self-blame, which can be detrimental to both morale and the ability to take corrective action when necessary.

Emergency physicians in particular practice in an information-poor, high-risk, technology-rich environment that lends itself to defensive decision-making.

Discovery. Following the summons, discovery begins. During this period, information about the case will be gathered from both parties. Depositions will be requested, in which the defending physician must respond to verbal questions from the plaintiff's attorney under oath. Physicians should expect frequent interruptions to their schedules during this time and also expect to feel surges of guilt, self-blame, anger, and isolation each time they are called to revisit the case for questioning. This is all normal. *Even though physicians should heed the legal advice not to discuss the details of the case with others, it is acceptable and frequently therapeutic to talk through the feelings experienced during a lawsuit with close friends and family.*

Trial and Settlement. Once all of the relevant information has been gathered, both sides will need to come to an agreement on whether or not to settle or proceed to trial. Whether or not the physician was at fault does not determine the decision to settle. Multiple factors contribute to this decision, including how well the case could be defended in terms of the documentation in the medical record, available witnesses, and possible juror sympathy toward the defendant. Approximately 6% of all lawsuits eventually proceed to trial. Physicians may find that facing the defendant and his or her family exacerbates feelings of guilt and shame. Living in the public eye if the case proceeds to trial can also intensify these feelings. During this time period, physicians should rely on the same coping strategies used in the months leading up to the trial. This can also be a helpful time to carefully and objectively examine any acknowledged mistakes and construct a plan of action. If mistakes go unaddressed, they can create doubt and lack of confidence in clinical skills for many years following, regardless of the outcome of the trial.

Aftermath. For as long as 2 years following the conclusion of a lawsuit, physicians report continued feelings of job strain, shame, and doubt. They may be plagued with persistent negative memories, cynicism, burnout, and a desire to leave the specialty. Taking an active role in malpractice prevention can be one method of dealing with these feelings. Improving communication skills, chart documentation, or administrative issues can decrease the incidence of litigation and provide a constructive outlet for negative energy. Throughout this time, it is important to continue to maintain a life balance and close social support networks.

Even though physicians should heed the legal advice not to discuss the details of the case with others, it is acceptable and frequently therapeutic to talk through the feelings experienced during a lawsuit with close friends and family.

Medical Malpractice Stress Syndrome

There are real physical, mental, and emotional costs to being sued as a physician. Medical malpractice stress syndrome (MMSS)^{6,7} shares many of the features of post-traumatic stress disorder. Victims suffer psychological distress, often manifesting as anxiety and depression, and may also experience physical symptoms such as the development of a new physical illness or exacerbation of a pre-existing one, such as diabetes or hypertension. Physicians with MMSS report feelings of isolation, negative self-image, irritability, and difficulty concentrating. They may experience insomnia, fatigue, or hyper-excitability. They may be prone to compulsively over-ordering tests on patients and consider changing careers. Physicians with MMSS may resort to self-medication with alcohol or recreational drugs and in extreme cases may contemplate—or complete—suicide.

Not everyone named in a lawsuit will ultimately suffer from MMSS. However, almost all physicians will experience at least some depression, anger, shame, and feelings of isolation. This is independent of whether or not there was any physician negligence, real or imagined.

A bit of advice; don't make big life-changing decisions while dealing with a malpractice suit. You may be enticed to quit your job, sell the house, and move to Hawaii. Resist the impulse—the lawn isn't greener next door—it's artificial grass.

Coping Strategies

Knowledge is Power. Demystification of the legal process goes a long way toward mitigating anxiety. Discuss the anticipated steps with a representative from your risk management department, your lawyer, or experienced colleagues. Read published books and journal articles on the topic. The American College of Emergency Physicians offers a number of webinars and other resources on its website. See below under “Resources on Litigation Stress” for links to specific sites.

Support Networks. Although you should not discuss any details about the case itself with anyone aside from your legal counsel, this does not mean that you must keep complete silence about the issue. It is important to share any feelings of guilt, shame, depression, and anger with trusted friends and family. This will protect against feelings of isolation by preventing withdrawal into yourself or your work (a review of case law shows that no physician has ever been called to testify against another physician for discussing how they are feeling—just avoid the case details).

Confidential Peer Counseling. Many risk management groups offer confidential peer counseling networks. Often conducted over the telephone, physicians can anonymously contact another physician who has also been sued in the past. This not only provides a means of sharing emotions with a truly empathic individual, it also serves as another means of learning more about the litigation process and what to expect.

Mental Health Professionals. It can be useful to seek treatment from a licensed mental health professional and most certainly if you feel persistent depression, guilt, hopelessness, thoughts of self-harm, or any of the symptoms consistent with MMSS. They can provide emotional support and a safe space for brainstorming effective coping strategies and prescribe medications if necessary.

Malpractice Prevention. Taking an active role in your own malpractice prevention can be immensely therapeutic. Better patient-physician communication skills and demonstration of empathy has been shown to decrease rates of litigation.⁸ Many courses exist to improve these skills in physicians. Similarly, continuing education on documentation, conducting a root cause analysis, and understanding administrative structure can also be effective in preventing future lawsuits.

If you have read this far, you hopefully realize that while malpractice claims are unwanted, stressful, time consuming, and expensive, they are not the worst things that will happen to us during our professional lives. Being equipped to handle the unexpected and knowing where to turn for help and support is critically important. We owe it to ourselves and our peers to be able to respond to the threat of a lawsuit in a measured, thoughtful manner.



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THE OCCUPATIONAL WELL-BEING SPOKE

Toxic Exposures in the ED: From Infectious to Interpersonal

By Mary Warlaumont, MD, Peter Peloquin, MD, and Arlene Chung, MD

Unlike many of our colleagues who sit in cozy offices or the growing number of people who have the option of working from home in their pajamas (I call them the beautiful people), we as emergency physicians are physically immersed in our jobs the second we walk in the emergency department door. Our job responsibilities require us to look, listen, touch, hear, smell, speak, and communicate with patients and coworkers who are often scared, exhausted, or both. While it is exhilarating to be so intimately involved, our practice leaves us exposed to several infectious and interpersonal toxins. For instance, have you ever been stuck by a bloody needle from a patient with unknown HIV/AIDS or hepatitis status? Have you ever had to undergo post-exposure prophylactic treatment? Or have you ever been harassed by uncooperative, disruptive, or combative patients or family members? Have you ever interacted with toxic consultants, whose unprofessionalism and/or incompetence left you frazzled and distracted for the rest of your shift? If you have experienced any of these, then you know the physical and mental strain that healthcare-associated exposures can bring to providers in the emergency department.

Infectious Exposures

Let's start with infectious exposures. Despite our best efforts, they still do occur, many times in situations that are fully preventable. Improper personal protective equipment, carelessness with sharps or soiled garments, and rushing through procedures are all modifiable factors that may help to reduce exposures.

Primary prevention is the most important aspect in preventing infectious disease transmission in the hospital setting. All health care workers should use standard precautions (clinical practices and personal protective equipment), including gowning, eye protection, and appropriate gloves, at all times of potential exposure. In addition, when an exposure does occur, health care management systems should work to improve safety in the health care setting.

Post-exposure. First things first. If you are exposed or feel like you may have been exposed to infectious material, take a deep breath. You are not the first person with this problem. Remember, skin wounds should be cared for with soap and water. Mucous membranes should be flushed with water. There is no evidence for antiseptic use, but they are not contraindicated. Bleach or injection of disinfectants or antiseptics is not recommended.

After exposure, it is important to follow your hospital's protocol for reporting, evaluating, and treating exposures. All source patients should be tested for HIV and hepatitis B and C if penetrating exposure occurs with blood, semen, vaginal secretions, cerebral spinal fluid, or synovial, pleural, peritoneal, pericardial, or amniotic fluids. If the source patient's status is unknown, the patient should be informed of the incident and required testing. Access to post-exposure care for the health care provider should be available 24/7, and all exposures should be reported immediately, as post-exposure care is most effective early on. If the source patient is negative for HIV and hepatitis B and C, no baseline testing or further evaluation for the health care provider is needed.

Hepatitis B exposure. Hepatitis B transmission rates vary depending on the state of the carrier but range from 1% to 37% for needle sticks contaminated with hepatitis B virus. Hepatitis B can be transmitted through indirect contact from source patient to the health care provider, although less commonly than through direct contact.

All providers exposed to hepatitis B virus should be vaccinated if they are not already. Hepatitis B immunoglobulin may be indicated. If so, it should be initiated within 24 hours and is normally completed within 7 days. See the Centers for Disease Control and Prevention (CDC) website (below) for recommendations.

Hepatitis C exposure. The hepatitis C transmission rate is less than that for hepatitis B. The seroconversion rate for hepatitis C virus (HCV) is 1.8% (average), more commonly from hollow-bore needles. Mucous membrane, non-blood transmission, and non-intact skin exposure transmission are very rare.

No vaccination for hepatitis C is currently available. There is currently no indication for anti-HCV immunoglobulin or post-exposure antivirals. Therefore, recommendations for post-exposure are aimed at early identification and possible treatment options.

If the source patient is HCV-positive, the health care provider should obtain baseline testing for anti-HCV and ALT activity, as well as follow-up testing per hospital protocol. It is not necessary to modify sexual practices or refrain from becoming pregnant or stop breastfeeding, but the provider should refrain from donating blood, plasma, organs, tissue, or semen. In addition, no change in patient care is needed.

After exposure, it is important to follow your hospital's protocol for reporting, evaluating, and treating exposures.

HIV exposure. Not exactly time to break out the champagne, but there is some good news: the HIV transmission rate is even less than that for hepatitis B or C. Blood exposure to percutaneous membranes has a transmission rate of 0.3%, and blood exposure to mucous membranes has a rate of 0.09%. Intact skin transmission is uncommon. Several factors affect risk of transmission: device visibly contaminated with blood, procedure involving needle directly placed into artery/vein, deep injury/hollow-bore needles, and transmission from a patient with terminal illness.

As with hepatitis C, there is no vaccination available for HIV. However, there is a brief window of time for post-exposure antiretroviral therapy (especially within 24 hours). Post-exposure prophylaxis (PEP) is usually completed in 4 weeks. After 72 hours, reevaluation with results of the source patient's HIV status is completed, and if the source patient is found to be HIV-negative, PEP is discontinued. Of note, there is a prophylaxis failure rate, and close monitoring is required for drug toxicity. Also, the health care provider should seek medical attention for any acute illness during the follow-up period, as this may signify acute HIV infection or drug reaction.

Interpersonal Exposures

Working in the emergency department is like no other job. Patients and their family members are often literally having the worst day/night of their lives. Fear, confusion, and impatience are palpable. In addition, coworkers and consultants can become quickly frustrated, distracted, and uncooperative when work-load demands escalate. This next section identifies common examples of abrasive interpersonal exposures in the emergency room and how to deal with them as a medical professional.

Toxic Patients and Family Members

If you have never been a patient, then it may be difficult to understand how frustrating and embarrassing a visit to the ED can be. Usually, patients are not allowed to eat, drink, urinate, or defecate when they want to. Most healthy people I know would have some problems with this. But now imagine that you also feel ill, are too hot or too cold, and have no idea what the plan is or whom to ask. Despite the best intentions from patient representatives or ED staff, unfortunately, this is how many patients feel when they come to an ED. They are disoriented, anxious, and often plain scared. And it is not surprising that a few of these patients become increasingly agitated as their time in the ED increases or as their confusion worsens. Some patients bear that anxiety in silence, while others will lash out with violent verbal or physical attacks on the health care provider.

ED physicians are at risk of mental and physical injury from agitated patients or family members. Verbal assault can leave a physician feeling distracted, abused, or angry. Physical attacks on a provider can produce similar results and make it that much more difficult to continue seeing patients. While it may be difficult to avoid such behavior from disgruntled patients, there are several steps to help cope with these toxic interactions.

If you have never been a patient, then it may be difficult to understand how frustrating and embarrassing a visit to the ED can be.

Prevention. Many toxic encounters with patients and their family members can be prevented with a few simple steps. First, if a patient or family member appears overtly agitated or upset, *approach the person in a nonjudgmental manner and ask what the problem is.* Often, they want nothing more than a blanket, a new urinal, or to locate their wallet which fell on the ground. If the concern is more complicated, take a minute or two to try to resolve the conflict because it will likely save you time and energy to confront the problem rather than let it linger.

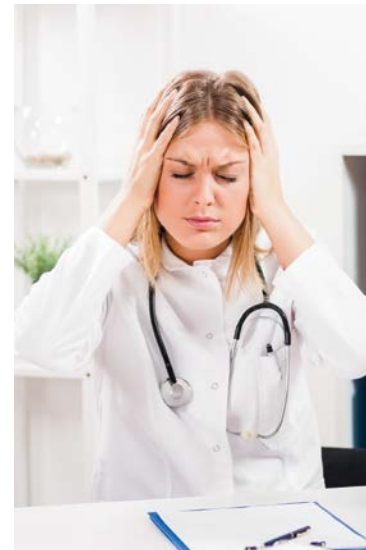
Self-preservation. If a solution cannot be easily achieved or if the patient/family member is inconsolable, contact the appropriate ED staff including nursing staff, patient representatives, or security. Move away from the agitated party for your own safety. An attack that leaves the health care provider injured directly affects medical care for all other patients in the ED, so take the appropriate steps to stay safe.

Toxic Consultant

Despite our vast medical knowledge and training, there are many patients in the ED who require consultants. Medical and surgical consultants provide an invaluable service to emergency physicians when patient care requires procedures or knowledge outside the scope of emergency medicine training. But remember, we are consulting them and giving them work. These priceless individuals are not sitting around waiting for us to call. Instead, they are very busy doctors with their own schedules and patients who are interrupted by our consults. Imagine if you were paged to come to OBGYN for an intubation, or consulted for a central line in the MICU during a busy ED shift. This is the life of a consultant, and with perspective, one can understand the difficult nature of their profession. It is our responsibility as ED professionals to utilize consultants appropriately and in a professional manner.

However, sometimes conflicts still occur. Consultants may not respond to a page for what seems like an eternity, or they may disagree with our care plan or they may even refuse to cooperate or take the consult if they feel we are managing a patient incorrectly. Aargh! Naturally, tensions will rise, and the interactions can become toxic. In truly toxic interactions, tempers erupt, and passive-aggressive behavior or even personal attacks may occur. Ultimately, professionalism and patient care are compromised, making these interactions completely unacceptable in the ED or any medical setting.

Prevention. As in dealing with toxic patients or family members, toxic interactions with consultants are best handled by preventing them from occurring in the first place. *There are several options available to an emergency physician to prevent these conflicts, but none more important than effective communication.* Proper communication starts immediately by making sure to clearly convey the reason for the consult and to answer any and all questions in a respectful and professional manner. Saying “thank you” at the end of a call is completely appropriate and may even expedite the consultant’s response leading to expedited patient care. Later, if a conflict arises, directly address the conflict and actively seek ways to resolve it. *Escalating the situation will only delay adequate patient care.* Also, be decent. Your consultants are overworked and exhausted just like you. Don’t berate them for taking 10 whole minutes to respond to your page, and don’t be offended if you have to repeat yourself two or three times. Give them a place to sit at your computer.



Make this a team effort. Showing a little kindness is ultimately the right thing to do and can only expedite appropriate care for your patient and foster good relations between consultants and the ED.

Self-preservation. OK, so the situation has become sour. Despite your best efforts, the consultant won't respond to your pages, refuses to see the patient, or is acting completely unhelpful or unprofessional. What then? Is it time to get mad? While getting upset may seem like the easiest course of action, it will almost certainly make things harder for you. If you feel yourself getting upset, walk away, take a deep breath, meditate, count to 10, walk outside for a moment, or vent to trusted coworkers. Do whatever you need to do to stay collected and keep things in perspective. Remember, you are a professional doctor working to provide the best care for your patients, and if this consultant won't help you, simply move on and protect yourself from this toxic situation so that you can continue to provide optimum care to all of the patients in the ED. When you are ready and calm, re-contact the service and ask for a different consultant, or contact the attending physician covering the specialty, or call your department chair. Do not exhaust yourself over this one situation; you owe that to yourself and your patients.

While being supported by colleagues at work is important, the positive exposures from patients and their family members are what ED physicians cherish most.

Perspective and Positive Exposures

Perspective is needed to survive in every ED. We work in a largely uncontrolled environment. Unlike other colleagues sitting in carpeted offices, emergency physicians are on duty in the place where actual emergencies happen. Things are bound to get hectic, tensions will rise, arguments will happen, and mistakes will happen. Despite all your best efforts, you are not perfect and you will make mistakes. You may forget to order something for one patient, forget to review an x-ray for another patient, misdiagnose another patient, or lose your cool with a consultant. This does not mean you are a bad person, but just a person who happens to work in an inherently chaotic environment who occasionally makes mistakes. Nothing more. Holding yourself up to unobtainable standards is unrealistic and unhealthy. So give yourself a break, and go see that next patient because that patient needs a good doctor like you!

Another important way to stay motivated is by focusing on the positive exposures that you encounter every day in the ED. Coworkers who are happy to see you, or kind words from a patient representative or supervisor should not be discounted as routine. These people are your friends and colleagues and they would not be saying these things if they did not care about you or feel you are a good doctor.

While being supported by colleagues at work is important, *the positive exposures from patients and their family members are what ED physicians cherish most.* Remember, these people are likely experiencing one of the worst days in their lives. So when a patient's family member thanks you for help taking care of her frail grandmother, or when that same grandmother with urosepsis smiles and grasps on to your hand, don't forget this moment. By taking away their fear and giving them a plan you are not just doing your job; you are causing healing to occur. You are a being hero. They will never forget you. If fully appreciated, these moments provide emergency physicians with the energy and perspective needed to deal with all other exposures and encounters in the ED.

Another Toxic Exposure in the ED: Violence

There she was. I was sitting across from her in the police room in the ED. The room was no larger than 8 x 8 feet. There was a cop on either side of her and her hands were in cuffs. She was about 5'5" and was wearing a navy blue jump suit similar to the kind that mechanics wear. And she had heavy black lace-up work boots on... the ones with steel toes.

I had been called to the police room to medically clear this psych patient, who looked pretty calm just sitting there between two policemen. I was 5 months pregnant at the time because I remember how glad I was to sit down to interview this patient. She didn't yell. She wasn't swearing. She didn't slobber and spit at me.

I started my interview... and in the next instant felt the toe of her steel-reinforced boot crashing into my chin. I must have known that something was about to happen because I tucked my chin down just in time, so that her boot missed my neck and larynx and knocked into my jaw.

The police instantly jumped on her and had her on the ground. I stood up and walked wobble-legged out the door and in a wavering voice said, "I think the officers need some help in there."

Welcome to the world of violence in the ED. This patient didn't curse me out or throw a punch; she just decked me... without warning. Looking back, I realize how fortunate I was that she didn't get her boot in where she could have fractured my larynx and gravely injured or killed me.

*...more than 75%
of emergency
physicians
experience violence
in the ED at least
one time per year*

The violence that we encounter in the ED may not be as dramatic or physical as the example above, but it occurs to all of us almost every day. Did you know that more than 75% of emergency physicians experience violence in the ED at least one time per year? Research shows that most of the attacks on health care workers are by patients or visitors, occur in the patient's room, and consist of yelling, pushing, shouting and grabbing.

We are not the only providers targeted in the ED. Over 70% of our nursing staff has encountered physical or verbal abuse, occurring mostly between 11 pm and 7 am, and when nurses were triaging, restraining patients, or performing invasive procedures such as venipuncture or Foley catheter placement.

Violence in the ED: How can we anticipate it? What can we do to prevent it?

Recognizing potential violence may be fairly easy but sometimes the clues can be subtle.

Threatening stances such as clenched fists, pacing, talking to oneself, or using loud insistent verbal language are all physical clues that an episode may be imminent.

If there is any history that the patient or visitor has had previous violent episodes (especially if unprovoked) or currently is exhibiting symbolic acts of violence or threatening to be violent, then this information must be taken very seriously.

Diagnoses associate with violence. Patients who are acutely intoxicated or withdrawing pose a risk for acute escalation. Also those with acute mania or schizophrenia, organic brain syndrome, personality disorders, and epilepsy have shown a predilection for acute violent episodes.

Violence occurs at night. If you are working the overnight shift, then be aware that this is the shift classically associated with violence.

Strategies for de-escalating potentially violent situations. Most importantly, your department should offer training to physicians and nursing and security personnel so that potentially violent patients can be identified and attended to before they act. Health care providers should show a calm, caring demeanor, maintain a safe distance from the patient, and not shout at the patient or respond to threats. It is critical that your actions not be interpreted as aggressive and that you acknowledge the violent person's feelings. Try to limit eye contact.

Security officers and closed-circuit 24-hour surveillance are critical in every ED. Often a "show of force," with several security guards approaching the patient, is enough to diffuse the situation. If not, then security personnel should be trained in the process of "taking down" and safely restraining a patient to gain control. Unobtrusive "panic buttons" should be placed in strategic locations in the ED. Access into and out of the ED should also be controlled. Identification badges or coded wrist bands for patients and visitors also are necessary to keep track of who might be in the department.

Our exposure to violence will occur in the ED. How we respond to this toxic exposure will determine the outcome. We have the tools to diffuse the situation. We just need to learn to use them effectively.



Important Points

- Prevention is key to avoiding health care–related infectious and interpersonal exposures.
- Take appropriate measures based on hospital protocol when exposed to infection.
- Use direct communication to diffuse toxic interpersonal encounters.
- Escalating the situation will only delay adequate patient care.
- Take measures to protect yourself, if communication fails.
- Keep perspective: You are human and will make mistakes.
- Appreciate the positive exposures in the ED.

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For a perspective on the emotional stress of an infectious disease exposure, please watch the YouTube video titled “Jane Aston on the emotional costs of needlestick and sharps injuries in the health care industry” at <https://www.youtube.com/watch?v=nD28cPFtr1E>.

For additional tips on how to deal with difficult patients or family members, please watch “How to deal with a rude patient or family member” at <https://www.youtube.com/watch?v=0k2fdH-9f0w>.

For a perspective on how to limit the stress associated with difficult consults and consultants, please watch the YouTube video titled “The discomfort zone: A guide to managing difficult consultations at <https://www.youtube.com/watch?v=eJnXJFRBkow>.

TED talks: Brian Goldman: Doctors make mistakes. Can we talk about that?

https://www.ted.com/talks/brian_goldman_doctors_make_mistakes_can_we_talk_about_that#t-764151.



THE OCCUPATIONAL WELL-BEING SPOKE

When a Physician Becomes Impaired

By Preeti Jois, MD, FACEP, Douglas Char, MD, FACEP

Physician Impairment—it sounds serious, scary, something to avoid. It’s often defined as something extreme, terminal. I’d rather view it as the lack of or opposite of “physician wellness.” Most of us don’t lack “wellness,” we just don’t experience enough of it in our daily lives. We are out of balance. Like most chronic disease states (hypertension, kidney disease, obesity), impairment and wellness are at two ends of a continuum. When we are caring for ourselves, feeling positive, we recognize it as wellness. When we are stressed, overly tired, and overwhelmed, we risk becoming impaired. Each of us has a personal threshold and we move back and forth along the continuum over time. It’s only when we find ourselves stuck on the negative side that we describe it as impairment.

Good stress has its place:

- It allows us to focus.
- It increases our efficiency.
- It energizes us temporarily.

Not all stress is bad. We recognize that tension in certain settings, such as level 1 traumas and codes, allows us to step it up, focus, and become more efficient. Short periods of “situational stress” are recognized by most emergency physicians as being part of the routine work environment. We have learned techniques that allow us to turn off the stress switch, stepping back from the turmoil and anxiety. All of us are guilty of allowing stress to build up to an unhealthy level from time to time. Hopefully when we recognize this, we step back and address the issues—turning down the thermostat and engaging in activities that nudge us toward the

healthier “wellness” side of the continuum. Impairment occurs when we fail to recognize that we are in trouble, or when we are unable to find mechanisms to reduce our life stress. That is when we risk becoming impaired. One way to gauge how we are doing is to take the Adult APGAR test (see page 125).

Dr. John W. Travis introduced the Illness-Wellness Continuum in 1970.

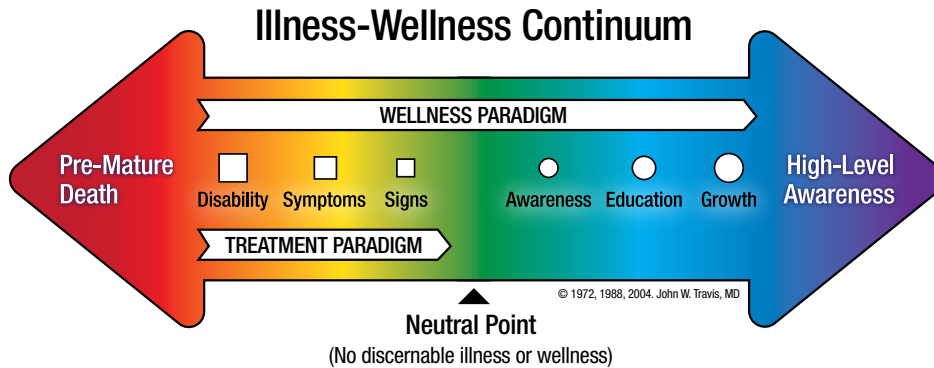


Figure. Illness-Wellness Continuum

© 1972, 1981, 1988, 2004 by John W. Travis, MD, Reproduced with permission from *Wellness Workbook: How to achieve enduring health and vitality*, 3rd edition, by John W Travis and Regina Sara Ryan, Celestial arts, 2004. www.wellnessworkbook.com.

Your chosen career is the first step to being able to focus on wellness. There are some stressors that we have a modicum of control over.

Learning to Identify Stressors in Emergency Medicine

Your chosen career is the first step to being able to focus on wellness. There are some stressors that we have a modicum of control over. Appreciating the complexity of work relationships and developing skills in conflict resolution are proactive ways of reducing our stress levels. What coping mechanisms do you rely on to get through the shift, the day, and the week? While it's ideal that we develop wellness habits during training (*Wellness for EM Residents*), it's never too late to embrace new behaviors that reduce stress.

Once stress is present, how we deal with it matters. Each of us reacts to stress differently. Some of us become more assertive, vocal, engaged (we have something to prove). Others retreat into quiet introspection, isolation, self-doubt (fearful of what others might think of us). The cause of our distress may be acute, sudden—a medical error, or unexpected outcome (second victims), a threatening lawsuit or impending litigation (medical malpractice stress syndrome) or traumatic event (mass casualty, shooting, disaster) that in its most severe form leads to the development of post-traumatic stress disorder (PTSD). Our distress may build slowly over time due to our daily repeated exposure to suffering and sense of helplessness. This build up is often unappreciated until it suddenly becomes overwhelming (compassion fatigue). When the joy of being a physician is gone, we talk about experiencing burnout.

In all of these situations, caregivers often experience a predictable constellation of physical and emotional symptoms. We feel exhausted, restless, sad, and angry at the same time. We replay events over and over, we can't concentrate and may be unable to perform routine clinical

procedures or experience decision-making paralysis. In short, we are not our “usual selves.” Many times we sense this change, but often others notice this change before we recognize it in ourselves. Given our clinical training and professional imprinting, we often resist naming or acknowledging our lack of wellness— “impairment.” In taking on a mantle of responsibility, we refuse to accept that we are imperfect and susceptible to the same shortcomings that we so readily identify in our patients. If we are to be of any use to ourselves, our colleagues, and our patients, we have to be open to the idea that emergency physicians deserve support and caring when we become or are at risk of becoming impaired. It’s time we committed as much time and effort to wellness as we do to everything else in our professional lives.

Physician Impairment

Most formal policies or guidelines define physician impairment narrowly; “impaired” means under the adverse influence of alcohol or any narcotic or drug; or, mentally unable to reason, communicate, or perform medical services in a safe and professionally acceptable manner or carry out any duties, assignments, or requirements of the emergency physician.

Types of Physician Impairment

- Physical Illness – cognitive changes, cancer, chronic illness and aging
- Mental Illness – depression, addiction, personality disorders, the “disruptive physician”
- Boundary violations and unprofessional behavior
- There are multiple aspects of impairment: too many hours, improper work-life balance, chemical dependency, poor interactions with other physicians/consultants/staff, depression, obesity, health issues, to name a few. A physician can be impaired for many reasons. Impairment runs the gamut from ignoring self-care to being unable to function at a professional and personal level. How can you prevent impairment? If you or someone you know is impaired, how do you deal with and treat the issue?

Physician impairment is an important issue because of the potential negative impact on the physician, his or her family, other physicians and staff, and patients. If impaired physicians undergo appropriate treatment and aftercare, most can successfully return to work

Warning Signs of Impairment (rarely does someone demonstrate all these signs)

- Performance deteriorates
 - Inconsistent work quality and lowered productivity. Spasmodic work pace, deteriorated concentration, signs of fatigue
 - Increased mistakes, carelessness, errors in judgement



- Poor attendance and absenteeism
 - Absenteeism and lateness accelerate, particularly before and after weekends
 - Multiple complaints of flu, stomach distress, sore throat, headache, or other vaguely defined illnesses
- Attitude and physical appearance changes
 - Details are often neglected, assignments handled sloppily
 - Others are blamed for the individual's own shortcomings
 - Colleagues and supervisors are often deliberately avoided
 - Personal appearance and ability to get along with others deteriorates
 - Colleagues may show signs of poor morale and reduced productivity, often because of the time spent "covering up" for the substance abuser
- Health and safety hazards increase
 - A higher than average accident rate emerges
 - Careless handling and maintenance of machinery and equipment
 - Taking of needless risks in order to raise productivity following periods of low achievement
 - Disregard for safety of colleagues
- Domestic problems emerge
 - Complaints about problems in the home and with the family increase. There is talk of separation, divorce, delinquent behavior in children
 - Financial problems recur with frequency



It is impossible to note all the behavioral symptoms that may occur in this process of deterioration or to define precisely their sequence and severity. They may appear singly or in combination, and they may very well signify problems other than substance abuse.

Areas where physician impairment may become apparent:

- Work-life balance
- Clinical interactions/patient relationships
- Chemical dependency
- Obesity, lack of attention to personal fitness/health issues
- Depression, isolation/mental health issues
- Loss of previously employed coping skills

What should be done if you suspect impending impairment?

If you sense that you are stuck in an unhealthy situation, seek out help. Talk to a trusted colleague, your personal physician, or a religious/spiritual counselor. If you are reading this, you already realize that you are not alone—welcome to the epidemic of self-doubt and unhappiness. Reaching out is difficult, and just like our patients, it may take a number of false starts before we connect—but it's the best and hardest thing you can do.

If you suspect that a colleague is suffering, don't remain silent.

By expressing interest, support, and caring, you may be the one to give the extra nudge that this individual needs to take the first step in seeking help. When we identify a mental health issue or struggle in a patient, we routinely seek out professional help for that individual—yet somehow we feel unqualified to do the same for our peers. Is there a risk that our colleagues will react negatively or deny that they need help? Sure, just like with our patients. These reactions don't stop us from doing the right thing for our patients; they shouldn't deter us from taking care of our most important resources—each other. Our colleagues who are suffering may not thank us, but then again rarely do our patients, and that doesn't stop us from trying. Many states have special programs to assist physicians in trouble. Many of these services are confidential and can be implemented without risking loss of licensure. Check with your state medical board.



Recommendations for Successful Interventions

- The intervention should be conducted by a team, not an individual.
- The team leader should be experienced in interventions.
- Team members should be educated about interventions and treatment possibilities.
- It is important to collect and evaluate as much data as possible prior to the intervention.
- Presentations during the intervention process should be focused on facts.
- The team should include only members whose attitudes are conducive to the objective tone of the intervention.

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THE OCCUPATIONAL WELL-BEING SPOKE

Overcoming Second-Victim Syndrome: The Impact of Medical Errors and Unexpected Outcomes on Emergency Physicians

By Douglas Char, MD, FACEP

“Do you remember that patient from the other day...?” These are the words every emergency physician dreads hearing. Your mind starts racing and you start to replay the entire case in your head. Questions of self-doubt and uncertainty come charging back.

Medicine is by its very nature an imperfect science. All of us make mistakes; we are human. However we’ve been indoctrinated to feel shame and guilt when mistakes or unexpected events occur. *Primum non nocere* (first, do no harm) is a mantra we’ve all dutifully ingrained in our souls. Yet adverse events occur in 33% of all hospital admissions. David Hilfiker first described this “yoke of perfection” in his 1984 *New England Journal of Medicine* editorial.¹ Even with our technological advances, it is estimated that errors affect patient outcomes 10% of the time.

- Despite our best efforts errors will continue to happen—we are human.
- Emotional responses that accompany recognition of an error are natural, predictable, and common.
- Medicine has traditionally ignored the suffering of second victims.

Albert Wu defined “second victims” as health care providers who are involved in an unanticipated adverse patient event, a medical error, and/or patient-related injury and subsequently become victimized. The provider can be traumatized by the event. Frequently, these

individuals feel personally responsible for the patient outcome. Many feel they have failed the patient, second guessing their clinical skills and knowledge base. Wu describes the “sickening realization of making a bad mistake.” Providers feel singled out and exposed. “You agonize about what to do, whether to tell anyone, what to say. Later the event replays itself over and over in your mind. You question your competency but fear being discovered.”²

Common responses to medical errors and unanticipated events include the following:

- Anxiety
- Frustration
- Guilt
- Fear
- Anger
- Embarrassment.

In emergency medicine, we often cover up our insecurity with dark humor or false bravado and point out the irony of the event. We realize that we were never trained to deal with these situations, and most have not developed the skills necessary to navigate this emotional minefield.³ We now know that errors are common. Ninety-eight percent of residents have experienced a serious event (78% of senior medical students), yet many are hesitant to disclose the error. One large study by Waterman asked those who had experienced a medical error to describe their distress. More than 40% noted loss of confidence in their ability, insomnia, job dissatisfaction, or damaged reputation, and over two-thirds were concerned about future errors.⁴ A related study found that those who reported an error scored lower on quality of life and higher on burnout and depression surveys. Their ability to cope with these setbacks was directly proportional to the level of reassurance they received and opportunities for learning. The negative effects lingered. At 6 months, 17% said they were still affected. One study discovered that 16% of surgeons had entertained suicide in the preceding three months.

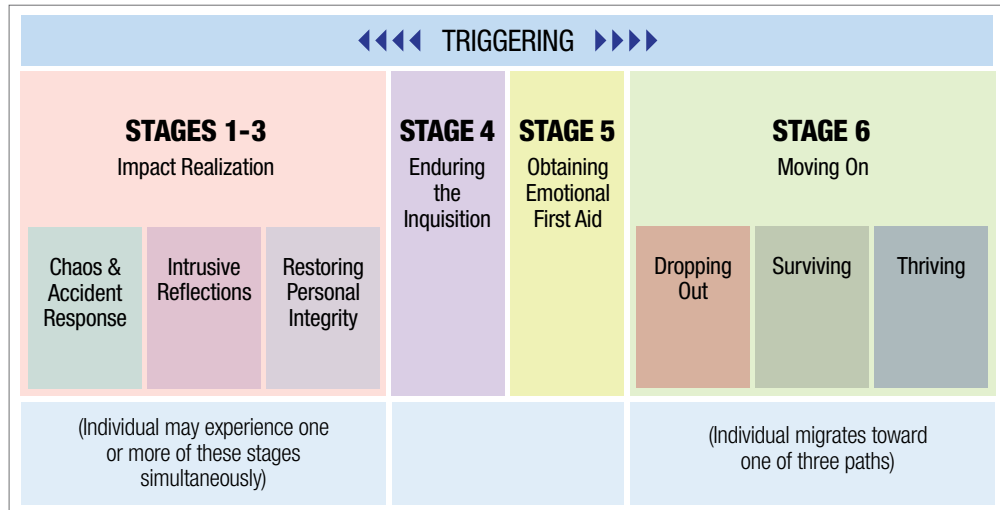
What second victims desire after an event:⁵

- Information about the event and process going forward
- Formal emotional support
- Time off duty to process the event
- Opportunity to discuss ethical concerns
- Prompt debriefing.

Sue Scott at the University of Missouri Columbia has described six stages that most second victims experience: the impact of realization (stages 1-3, chaos and accident response, intrusive reflections, restoring personal integrity); enduring the inquisition (stage 4); obtaining emotional first aid (stage 5);⁶ and finally, stage 6, moving on (one of three trajectories; dropping out, surviving, or thriving). Shelly Luu, a surgeon, describes three phases; the Kick, the Fall, and the Recovery.⁷ Immediately after the event, well-described psychological

*Medicine is by
its very nature an
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All of us make
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human.*

and physical reactions related to sadness, fear, anger, and shame occur. There is an increase in blood pressure and heart rate, muscle tension, rapid breathing, appetite disturbance, and difficulty concentrating. The fear of losing one's job and the financial consequences of unknown outcomes permeate one's thoughts. Over the short term, this can lead to a form of PTSD in the most extreme situations, and over the long term, if unaddressed, can lead to compassion fatigue.



Resilience is the capacity to cope with stress and stressors within one's environment and the ability to interact in a manner to promote personal well-being.

The way to combat these negative responses is by developing resiliency in providers. *Resilience is the capacity to cope with stress and stressors within one's environment and the ability to interact in a manner to promote personal well-being.* The most desired outcome is to remain a trusted member of the health care team. Henry Harlow's 1970 studies of orphaned monkeys found that affection was more sought out under stressful conditions than food or "necessities." Social support is of value in and of itself and directly influences biological processes. This is the basis for the success of peer support teams.⁸

In collective cultures (such as medical teams, ICU staff), the group is committed to supporting its members, and the individual expects that his/her needs will be anticipated and cared for without having to request support directly; however, the individual is discouraged from bringing forth personal problems that might impose on and burden the group. In such a setting, sharing personal problems (error reporting) might cause an individual to lose face or affect relationships negatively. What is needed is implicit support through presence and shared activity. It's what most of us crave when we are in this situation.

Peer support assists second victims in multiple ways:⁹

- Overcoming the culture of invulnerability
- Reducing shame and blame
- Limiting isolation by normalizing the situation
- Encouraging self-care.

Organized support programs now exist in a number of medical centers. At the University of Missouri, a three-tiered system is in place. Tier I promotes basic emotional first aid at the local or departmental level. Reassurance and/or professional collegial critique of cases by unit leaders and colleagues/peers suffices (team members receive basic awareness training). Tier II provides guidance and nurturing by specially trained peer supporters imbedded within high-risk departments. These peer supporters provide one-on-one crisis intervention, mentoring, debriefings, and internal resources, such as patient safety experts for support during the aftermath of an event through an institutional investigation. Tier III professionals include chaplains, social workers, psychologists, and psychiatrists who ensure prompt access to professional counseling support and guidance.

Colleagues are encouraged to talk with involved providers, to let them know that they are still valued and trusted. The goal is to reassure their peers and acknowledge that this has happened to them as well. The top priority is to avoid the awkward silence that was so common in the past. There is no ideal peer supporter. Those who strive to build community, have available time and energy, are approachable, listen well, and are broad minded tend to be choice individuals for this important role.

Washington University Medical Center took a slightly different approach. Nurses and hospital staff have access to a three-tier system based on the Scott model. Physicians were thought to be less open to this type of group sharing—surveys reflected a desire for more one-to-one confidential sharing. At this institution, physician supporters (not trained professional counselors) reach out to colleagues who have experienced a medical error or unanticipated outcome. The focus is on how the individual physician is doing after the event. Physician supporters stress that the emotions the provider is experiencing are normal and predictable, and that with time, many of the negative attributes will resolve. When looking back at how this service has been utilized, it was found that the most common reason for initiating peer support wasn't a medical error but an unanticipated patient outcome or personal crisis. The vast majority of the time (60%), local support at the floor or unit level was all that was required. An additional 30% of victims made use of one-to-one confidential off-line meetings (the physician model). Approximately 10% of individuals were so traumatized by the events that they required referral to professional counselors. A high priority for Tier II peer supporters was to know when referral to formal counseling is indicated.

By proactively seeking out providers after a medical error or unanticipated clinical outcome, these programs hope to reduce physician distress and direct involved providers onto a trajectory toward recovery instead of allowing them to suffer and beat themselves up. Today's regulatory atmosphere means that formal safety investigations must occur, but hopefully those involved in these adverse events will be better able to handle the stress in a healthier and more productive manner than in previous generations.

By proactively seeking out providers after a medical error or unanticipated clinical outcome, these programs hope to reduce physician distress.

Barriers to implementing second victim support programs:

- Lack of formal structures
- Reluctance of individuals to use support services
- Fear of loss of professional respect
- Ineffective reporting systems
- Stigma of seeking out assistance.

We must change our mindset to one that embraces wellness and longevity. Success will require a transformation in culture from seeing assistance as a sign of weakness to one of strength. There is growing recognition that clinical environments where professionalism is not embraced, and where supporting behaviors are not demonstrated, result in increased medical errors, adverse events, and unsafe work conditions. Wellness is about changing this.



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THE OCCUPATIONAL WELL-BEING SPOKE

Post-Traumatic Stress Disorder 101: A Primer

By Richard M. Goldberg, MD, FACEP

Post-traumatic stress disorder (PTSD) refers to a prolonged, sometimes permanent abnormal emotional reaction to a critical incident. Critical incidents include any traumatic events that have sufficient emotional power to overcome the usual coping abilities of people exposed to them. Emergency physicians are potentially exposed to many such events, including line of duty deaths, multi-casualty/disaster/terrorism incidents, and significant events involving children.

Diagnostic criteria for PTSD include the following features and symptoms, present for at least one month:

- exposure to an extremely stressful or traumatic event to which one has responded with fear, helplessness, or horror
- a continual re-experiencing of the event in thoughts, dreams, or daily life
- avoidance of any stimuli associated with the event
- symptoms of hyperarousal, including insomnia, irritability, difficulty in concentration, hypervigilance, and increased startle reactions¹

Associated symptoms may include loss of memory of important aspects of the event, loss of interest in activities previously enjoyed, feelings of detachment and estrangement from others, sleep disturbances, and loss of emotional control. Studies of the biologic mechanisms of PTSD have found alterations in brain regions such as the amygdala and hippocampus that are

associated with fear and memory, as well as changes in hormonal, neurochemical, and physiological systems involved in coordinating the body's response to stress.²

Treatment Options

Counseling

Important components of treatment include the provision of education and a feeling of safety and support. Specialized treatment techniques are often helpful. These include: exposure therapy (helping patients confront painful memories and feelings), cognitive therapy (helping patients process their thoughts and beliefs), anxiety management, and interpersonal therapies (helping patients understand the ways in which the traumatic event continues to affect relationships). Group therapy may also be helpful in reducing isolation.²

Medications

A number of psychotropic medications have been found to be effective in alleviating the symptoms of PTSD. Serotonin-reuptake inhibitors are considered first-line because they are safer and more easily tolerated. Benzodiazepines have not been demonstrated to be superior to placebo in alleviating symptoms.³

Critical Incident Stress Debriefing (CISD)

CISD refers to structured group meetings that emphasize ventilation of emotion and discussion of other reactions to a critical event. CISD had for many years and been recommended as a primary modality of treatment for PTSD. However, findings from several meta-analyses provide no evidence that psychological debriefing is a useful treatment. While CISD they have some use in the identification and referral of individuals at risk, it is not considered to be a substitute for therapy.⁴⁻⁵

Additional resources are available on the Wellness website of the American College of Emergency Physicians, <https://www.acep.org/wellness/>.

Post-traumatic stress disorder (PTSD) refers to a prolonged, sometimes permanent abnormal emotional reaction to a critical incident.

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THE OCCUPATIONAL WELL-BEING SPOKE

Critical Incidents

By Thomas Benzoni, DO, FACEP, Julia Marie Huber, MD, FACEP

We practice in the most important area of health care, the ED. And every other practitioner, hopefully, thinks the same about their area. Emergency medicine has the special distinction of lack of control by the practitioner. Thus, it is guaranteed that, in a full emergency medicine career, you will have encounters for which you are not prepared and cannot prepare. These situations meet the definition of a disaster, needs > assets. These are *critical incidents*.

These incidents may entail a mass casualty, resuscitation of one of your own medical staff, or a pediatric tragedy. You will encounter difficulty coping; this does not have to be career ending or even career damaging. It can be a growth opportunity; recognition is the beginning.

Once a critical incident is identified (internally or externally; by yourself or someone observing), it is important to recognize and defuse pressures and discordant thoughts. Some of these may be guilt for perceived failure in resuscitation, fear for your own children, fear for your personal safety in its many forms, and a sense of personal failure. The common result of failure to defuse is internalization of these thoughts; they eventually surface as post-traumatic stress disorder (PTSD).

Symptoms of PTSD are (perhaps not) surprisingly prevalent in emergency medicine personnel:^{1,2}

1. Re-experiencing symptoms:

- Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
- Bad dreams
- Frightening thoughts

2. Avoidance symptoms:

- Staying away from places, events, or objects that are reminders of the experience
- Feeling emotionally numb



- Feeling strong guilt, depression, or worry
- Losing interest in activities that were enjoyable in the past
- Having trouble remembering the dangerous event

3. Hyperarousal symptoms:

- Being easily startled
- Feeling tense or “on edge”
- Having difficulty sleeping and/or having angry outbursts

Critical Incident Stress Debriefing (CISD)

Once a critical incident is recognized, prevention of PTSD becomes important. There is considerable uncertainty as to one “best” method, and some “best” methods are proprietary.³ Preparation is considered best; this is why training and drills are important. The first time you meet the “real thing” will not be your first exposure.

Thus, crucial to PTSD prevention (given that you can’t prevent the critical incident except by not being there) are administrative support, personnel training, and open lines of communication. Most institutions will have a CISD team. This team can be activated by anyone within the facility and often from without. CISD had for many years been recommended as a primary modality of treatment for PTSD. However, findings from several meta-analyses provide no evidence that psychological debriefing is a useful treatment. Formal “debriefing sessions” used to be “de rigueur” but have been shown not to be helpful and may actually worsen PTSD.³ So, *prevention* of PTSD on the job is critical. Emergency medicine personnel must feel they are backed up in the job with which they are entrusted and are given the tools to carry out that job effectively. When “failure” inevitably occurs, support must be shown instead of blame. This must be practiced on a routine basis; “the beatings will continue until moral improves” doesn’t work.

Once PTSD is present, formal professional help is indicated. This is not a problem one can talk a partner through. Comprehensive treatment is needed.

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RESOURCES

- **American College of Emergency Physicians**, Emergency Medicine Practice Department, PO Box 619911, Dallas, TX 75261-9911, 800.798.1822
- **International Critical Incident Stress Foundation**, 5018 Dorsey Hall Drive, Suite 104, Ellicott City, MD 21042, www.icisf.org
ICISF hotline to request a debriefing team in an emergency situation: 401.313.2473.

...it is guaranteed that, in a full emergency medicine career, you will have encounters for which you are not prepared and cannot prepare.



THE OCCUPATIONAL WELL-BEING SPOKE

Diversity and Inclusion in Emergency Medicine

Douglas Char, MD, FACEP, Julia Marie Huber, MD, FACEP

The population of the United States is growing more, not less, diverse, particularly in terms of race. Why is this important to emergency medicine and physician wellness, in particular? There are three main reasons why we (a collective of physicians) should care:

1. The patient population is changing, and our ability to care for new demographics effectively is predicated on our ability to understand and adapt so that we can provide culturally appropriate medical care.
2. Health care providers (our colleagues) are becoming more diverse, and our ability to work and function in teams that are racially, sexually, ethnically, socioeconomically, and culturally diverse is important – an expectation! We must ensure that our workplace culture is inclusive and welcoming to all.
3. Despite good intentions, our implicit and, at times, explicit biases impact how we interact with patients, families, ED staff, and peers. These biases can be seen as unintentional slights, cultural ignorance/naiveté, but also episodes of microaggression or harassment.

A Changing World

Racial and ethnic minorities comprise 26% of the total population of the United States, yet only roughly 6% of practicing physicians are Latino, African American, and Native American. Patients generally feel more comfortable, exhibiting greater trust and a willingness to follow medical recommendations, with a physician who looks like they do and who shares a similar cultural background. The lack of diversity of health care providers, coupled with limited cultural competency education, continues to produce training and treatment environments

that are biased, intolerant, and contributory to health disparities. These are some of the findings noted in the Institute of Medicine's 2004 report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*.¹

Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. "Competence" implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities.²

Enhancing Cultural Competency (delivering culturally appropriate care)

There are several ways in which clinicians working with multicultural patients and families can contribute to a positive ED experience. An important first step is to be sensitive to patients' cultural beliefs and practices and to convey our respect for their cultural values through the manner in which we communicate with them and deliver their health care. This may require calling for help in interpreting behavior, either from a provider who is from the same ethnic group as the patient or from an expert familiar with the group's language, life-style, and value preferences.³

It is critical that health care providers recognize individual differences and do not participate in "cultural stereotyping." Because people of the same ethnicity can have very different beliefs and practices, it is important to understand the particular circumstances of the patient or family by obtaining information on place of origin, social and economic background, degree of acculturation, and personal expectations concerning health and medical care.

When dealing with patients and their families or health care providers from different backgrounds, we must be sensitive to cultural differences. We should begin by acknowledging that there can be differences between Western and other cultures' health care values and practices. We must show empathy, being sensitive to the feeling of being different, and patience, understanding the potential differences between Western and other cultures' concept of time and immediacy. We demonstrate respect by acknowledging

- The importance of culture as a determinant of health
- The existence of other world views regarding health/illness
- The adaptability and survival skills of our patients
- The influence of religious beliefs on health, and
- The role of bilingual/bicultural staff.

Despite our best efforts, we sometimes get it wrong, and the situation becomes awkward. Our ability to laugh at ourselves and with others is necessary. Our investment in building a relationship with patients that conveys a commitment to safeguarding their well-being builds trust. It takes commitment and practice. Being able to provide culturally appropriate care enhances not only patient outcomes, but makes our professional interactions with patients, families, and peers more meaningful and rewarding.

Patients generally feel more comfortable, exhibiting greater trust and a willingness to follow medical recommendations, with a physician who looks like they do and who shares a similar cultural background.

Looking in the Mirror

The benefits of a diverse medical workforce have been well described, but the percentage of emergency medicine residents from underrepresented groups is small and has not significantly increased. Groups like SAEM's Academy for Diversity and Inclusion, ACEP's Diversity and Inclusion Task Force, ACEP's American Association of Women Emergency Medicine Physicians (AAWEP), ACEP's Emergency Medicine Workforce Section, and ACEP's International Emergency Medicine section all focus on increasing the number of underrepresented-in-medicine (URM) individuals in our specialty. The more we can look like our patients, the better we will be able to care for them.



Every emergency physician should support the common goals of diversifying the physician workforce at all levels, eliminating disparities in health care and outcomes, and ensuring that all emergency physicians are delivering culturally competent care.⁴ If you don't identify with any of the groups that are underrepresented in medicine, you should work to create an inclusive workplace and ensure that professional gatherings are open and welcoming to all who belong in emergency medicine. While it's important to advocate for URM members, it's also important to recognize that those in a position of "privilege" (a term taken from the social justice literature) should not be made to feel guilty about their position or standing. Just as being part of the URM group can be stressful at times, being a white middle-aged male emergency physician can also be stressful for completely different reasons. Walking in each other's shoes will allow all to better appreciate our individual uniqueness.

An Imperfect World

Despite progress, disparities continue both in health care delivery and in the House of Medicine, leading to inequities in advancement and professional opportunities. Discrimination may be based on differences due to age, ability, sex, race, ethnicity, religion, sexual orientation, or any other characteristic by which people differ. Discrimination is not always easy to prove; however, its consequences are quite concrete. Prejudice, on the other hand, involves thoughts, attitudes, insensitivity, and ignorance, not actual behaviors or demonstrable denials of opportunity. Prejudice frequently leads to discrimination.

Physicians and other health care providers may be victims as well as perpetrators of discrimination. Selective mistreatment often undermines the work experiences of individuals who are identified with groups that are the targets of discriminatory behaviors. Sexual harassment remains a real issue. A 2000 survey of more than 3,000 full-time faculty members at 24 randomly selected US medical schools found that about half of the female faculty experienced some form of sexual harassment. Further, the report found that 48% of female academic physicians experienced sexist comments or behavior (compared with 1% of male colleagues), and 30% of female academic physicians experienced severe harassment, including sexual solicitation, threats, or coercive sexual advances (compared with 3% of male colleagues).⁵ Female physicians were significantly more likely than male physicians (53.3% vs 33.6%) to have experienced at least one form of discrimination in the past year.

The proportion of physicians who reported that they had experienced racial/ethnic discrimination "sometimes, often, or very often" during their medical career was substantial among non-majority physicians (71% of black physicians, 45% of Asian physicians, 63% of "other"

race physicians, and 27% of Hispanic/Latino/Latina physicians, compared with 7% of white physicians).⁶ A 2009 joint AMA-NMA survey of 529 respondents found that physicians who self-identified as non-majority were significantly more likely to have left at least one job because of workplace discrimination (black, 29%; Asian, 24%; other race, 21%; Hispanic/Latino/Latina, 20%; white, 9%). Having experienced racial/ethnic discrimination at work was associated with high job turnover (odds ratio 2.7) and poor career satisfaction (minority 45% vs majority 88%), with 40% contemplating a career change.⁷ These incidents can have a substantial influence on career trajectories, potentially threatening retention of a diverse physician workforce, in addition to compromising patient care.

How Should We Respond?

It is important first that we look at ourselves (identify and name our implicit biases). It is easy to tell ourselves that we have no prejudice, be it racist or otherwise, within us. The word racism is an ugly word, and understandably, we do not like applying it to ourselves. We give tacit assent to prejudice and discrimination by letting it go unchallenged. Ignorant attitudes need to be countered, and discriminatory behavior needs to be challenged. Only when we make a conscious effort to point out (often unintended) discriminatory behavior will we be able to end it. Inappropriate behavior should be reported, and it is everyone's obligation to support those who feel discriminated or harassed due to "being different." Most importantly, we need to strive to understand how others are interpreting our words or actions within the context of a multicultural work and professional environment. By doing so, we will reap the benefits of a healthier, more equitable workplace that encourages the professional growth of all.

Diversity and inclusion are everyone's responsibility. We want to live and work in settings where we are valued for our abilities and cherished for the unique cultural attributes we bring to the table, as well as being acknowledged and rewarded for our accomplishments. Physician wellness advocates embrace this lofty goal and encourage us to work toward it.

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Having experienced racial/ethnic discrimination at work was associated with high job turnover and poor career satisfaction (minority 45% vs majority 88%), with 40% contemplating a career change.



THE FINANCIAL WELL-BEING SPOKE

Seven Steps to Financial Serenity: An Introduction to Financial Planning for the Emergency Physician

By Douglas Segan, MD, FACEP and Rita Manfredi, MD, FACEP

Step One: Plan Now, Financial Bliss Later

Do you recall your interview for admission to medical school? Was one of your goals to convince the physician interviewing you that you were a humanitarian? Did you articulate your passion to help care for the medically underserved? Hopefully you still feel that way.

Did you also try to convince your medical school interviewer that the acquisition of money was not all that important to you? Did you feel at that interview that you had to present yourself as someone who was above seeking financial security and wealth? That was then; now you have new priorities. Thankfully, you no longer have to hide the fact that one of your career goals is financial security.

If your goals are to provide for your family, pay your monthly bills, afford your children's education, and create a nest egg that provides for comfortable retirement and future travel, then you need a plan. If you feel as I do, that having the comfort of being financially secure is a key component to your effectiveness as an emergency physician and sound financial planning is an integral factor in your mental and physical well-being, then this article will be a resource to help you achieve that. You need a roadmap and a plan to achieve your financial goals, and the time to start planning one is now.

Financial planning need not be complicated, confusing, and costly. It may be tempting to put it off for another day, but don't kick this can down the road. If you break financial planning down into bite-size steps that are painless, you can achieve your financial goals.

Working in the ED is tough enough, and we should do what we can to reduce the stress on emergency physicians. If we can reduce their financial stress, they will be healthier and more productive. Our patients will benefit if our colleagues are not worried about their own financial health. Financial worries can be distracting and impair your focus, so the aim of this article is to encourage you to commit to taking the path to financial serenity.

I. Financial Planning—A Timeline*

- Ages 20s to early 30s:
 - try to save 10% of income
 - join employer's retirement plan
 - use IRA or other vehicles if employer has no plan
 - if self-employed, use 401 (k), SEP or similar plans
- Ages 30s through 40s:
 - save at least 10% of income
 - have adequate health and life insurance and emergency fund
- Ages 50s and 60s:
 - boost savings to 20% or more
 - maximize tax-deferred contributions
 - begins shift into lower risk investments
 - begin focusing on retirement lifestyle
 - calculate realistic retirement resources
- Retirement:
 - determine how much money to withdraw each year
 - determine which accounts to withdraw from
 - invest more conservatively but don't abandon stocks
 - hold 2 to 3 years living expenses and cash equivalent
 - develop estate plan

*Adapted from: Financial Planning for Life Events (<http://www.plannersearch.org/financial-planning>) with permission from the Financial Planning Association, Denver, Colorado.

Step Two: Become Financially Savvy

Having advisors is a wonderful thing, but this is one area that you cannot totally delegate to others. It is just too risky to turn things over to others and trust that your interests are paramount in their minds. You must learn the lingo and the basics. Thankfully, the number of options that are now available to learn the fundamentals of finance and investing have greatly expanded from the days of just lectures, books, and periodicals.

*That was then;
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goals is financial
security.*

Websites of major financial institutions (banks and brokers) are useful sources of timely financial and investing information if you are able to overlook their ads. One of our colleagues, Dr. James Dahle, has a blog that is an outstanding resource for the physician seeking to become a knowledgeable investor. The archive section has over 500 previous posts that make complex topics manageable. His blogs are often entertaining, and he provides a well-thought-out and careful analysis of numerous financial topics.

Suze Orman is also a well-known financial advisor and writer; she presents very concise guides to understanding finance basics.

Step Three: Live Within Your Means

Most emergency physicians earn an excellent salary that is well-deserved based on the training that the job requires and the challenging nature of the work. If current salary trends continue and you are fortunate enough to have a long and healthy career, your lifetime earnings will amount to an impressive figure. With a little planning, some sage input from ethical advisors, and a modicum of fiscal discipline, your income is more than enough to support a comfortable (but not extravagant) lifestyle, to prepare for a secure retirement, and to be able to weather the inevitable personal financial setbacks that occur in everyone's lives.

Earning a salary that is the envy of most Americans is no guarantee that you will enjoy financial bliss. Physicians are notorious for their ability to burn through a fat paycheck. The recent Great Recession was a sober reminder to many of our colleagues who overextended themselves with McMansions, credit card debt, vacation homes, his and her sports cars and multiple ex-spouses. Even if the economy stays on course, it is prudent to prepare for a change of fortune. The risks of losing your contract or your group's hospital contract or dealing with an unexpected medical problem are persuasive reasons to live within your means, even when the money is flowing in. When you are in the midst of "the good times" is when you should save for a rainy day and for your retirement.

A great and achievable goal is to save 25% of your gross (pretax) income. Set aside as much of this money as you can in those retirement accounts for which you and your partner qualify. There will usually be tax benefits and asset protection benefits for putting this money in your retirement accounts, but more importantly, once the money is in a formal retirement account, you are less likely to spend it.

Step Four: Build Your Team

To be successful in the realm of financial planning, it helps to have a good team in your corner. Finding ethical advisors that charge reasonable fees and are motivated by a fiduciary responsibility to put your goals ahead of theirs can be a challenge. A good way to find these valuable advisors is to ask senior colleagues in the community for the names of experts that they have worked with for decades.

At the minimum, have a CPA on your team. There are few gifts from the federal government, but the smorgasbord of IRA and other retirement plans are a gift from Washington that should be fully utilized. A CPA will help you do this.



A lawyer will help you write your will, assist with real estate transactions, and explain the various options in your state for estate planning and trusts.

An insurance agent that will educate you about the nuances of various policies without pressuring you to buy a particular product is a great asset to help you navigate this critically important marketplace.

There are pros and cons to having a financial planner/advisor. If you don't have the time or temperament to manage your own investments, it may give you peace of mind to have someone else take care of this, but the costs can be substantial and there are often serious conflicts of interests. If you want an advisor without conflicts of interest, consider an independent advisor that charges a straight hourly fee and does not benefit financially from any particular investment that you end up making.

Step Five: Protect Thyself (Insurance)

In addition to medical malpractice insurance, most physicians will need auto and homeowner's (or renter's) insurance. An umbrella policy that supplements these policies provides a great deal of additional coverage at little cost and should be strongly considered.

Disability insurance is advisable for most physicians. This is a complicated product and it is important to do some due diligence to find the right fit for your situation.

Life insurance is recommended if you have family members who are dependent on your income. The range of life insurance choices requires one to do significant homework and to not sign up after the first sales pitch.

Long-term care insurance is appropriate for some physicians and requires careful evaluation of the company and a review of the fine print of the policy.

Step Six: Investing—Simple is Smart

If you like to watch CNBC, read the Wall Street Journal, study the markets, explore various investment options, and play with individual stocks, then by all means, enjoy yourself. But the likelihood that you will beat the averages is remote when even the best financial gurus in the country have difficulty consistently beating a mix of 60/40 of low-cost index funds in stocks and bonds.

The vast majority of investors will be well-served by the following guidelines: 1) keep it simple, 2) stick with very low cost index funds or Exchange Traded Funds (ETFs) from large discount brokerage firms, and 3) block out the noise of the talking heads on the financial shows. Be skeptical of all advice (including this advice). Have some exposure to the US stock market, the bond market, and mix in a little international exposure. The exact mix will vary depending on age and your risk tolerance. Adjust your asset allocation yearly. Don't try to be a market timer. You won't hit a home run every year with this plan, but you won't strike out either. Over the long haul, there is good evidence that this type of investment plan is the wisest course for most investors.



This area is filled with sharks and con artists eager to separate you from your money. Some do it legally (with outrageous fees while providing no added value) and some belong in prison. Rick Ferri, a leading expert on Exchange Traded Funds, warns that “many Wall Street firms exist to make money from you, not for you.” Certainly there are countless ethical and reliable practitioners in the field, but “Doctor, beware.”

Step Seven: Protect Thyself with Asset Protection

In the course of your career, there is a high likelihood that you will become a defendant in a medical malpractice case. Thankfully, there is a very low likelihood that you will lose a suit that is in excess of your insurance limits and face the possibility of turning over your personal assets to the plaintiff and the plaintiff’s attorney, However, the fear of a financially catastrophic outcome in a malpractice lawsuit can be very detrimental to your serenity and impair the joy of working in the ED.

There are simple, legal, inexpensive, and ethical steps that emergency physicians can take now to protect assets from a large civil suit. The October 2012 and February 2014 issues of *ACEP News/ACEP Now* have articles by this author that review some fundamental asset protection steps. The laws concerning asset protection vary from state to state, so this is not an area of the law where one size fits all. For most physicians in most states, the single best asset protection and investment plan is to maximize your retirement plan contributions.

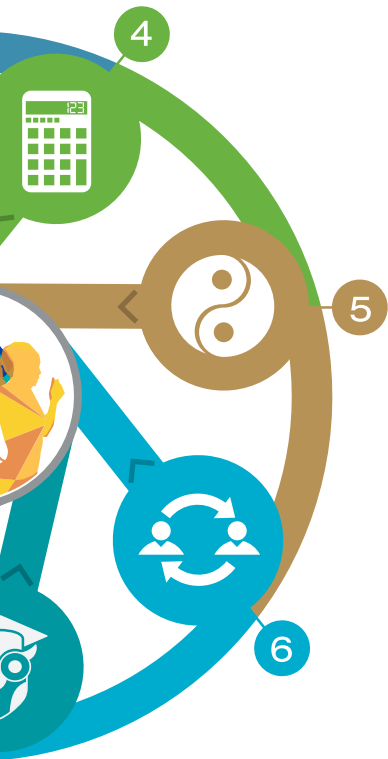
Final Thoughts

Working in the ED is challenging enough without adding the stress of financial worries. If your financial house is in order and you are building up your nest egg so that you will achieve your lifetime financial goals, you will more easily focus on your patients when working in the ED and be able to fully enjoy your time off with family and friends. Your salary is sufficient to achieve your financial dreams. A little planning and some discipline will make it happen.



RESOURCE

Dr. James Dahle, <http://whitecoatinvestor.com> (very helpful and a large source of valuable information)



THE SPIRITUAL WELL-BEING SPOKE

Every Day You Focus

By Jason Fleming, MD, FACEP

Practicing meditation is a skill that already comes naturally to emergency physicians. This is because we exist in a chaotic environment and constantly need to focus and refocus our attention. This focusing/refocusing is actually quite similar to the process of meditation. Practicing meditation can enhance our abilities to focus in the emergency department, making us calmer, more focused, and more effective.

Many people think that meditation is sitting quietly and concentrating. We picture a monastic sage with a peaceful face under a tree. How can this fit in with the chaotic realities that we live every day?

The actual practice of mediation involves focusing the mind, and this *often involves an object or a phrase*. The object used can be an actual article held in the hand, such as a pebble or a pen or a coin. A phrase (referred to as a *mantra*) can also be used and typically is meaningful to the meditator. The mantra can be in any language. We often find more meaning in a mantra that is in our native tongue. Let's briefly discuss how each of these two meditations can be performed.

For an *object meditation*, all that is needed is the object and a willing mind. A timer can be useful; try 2 minutes to start. The object can be held in the hand and focused on as you sit quietly... the shape, curves, edges can be intentionally felt with the fingers and appreciated. When the mind begins to interrupt this moment by naturally drifting to the myriad distractions in our lives, we bring it back to focus on the object of the meditation by intentionally noticing some new aspect of the object... the weight, the texture, the temperature in the hand. Once the chime on your timer signals the end of your object meditation,

intentionally feel gratitude for this brief moment of peace. It matters less what or whom you “thank;” more important is that you *attach the feeling of gratitude to the process*.

For a *mantra meditation*, the actions are the same except the meaningful phrase is substituted for the physical object. Many meditation practitioners use counting beads to keep track of how many times a mantra is repeated. The mantra can be repeated aloud, whispered, or simply repeated silently in the mind. Many practitioners have found value in the act of repeating the same mantra over and over. The mantra acts as the object of focus. When you notice that your mind has begun to wander, bring it back to focus on the mantra you have selected.

Some beginning meditators feel a sense of failure or “doing it wrong” when their mind wanders. On the contrary! This is the mind’s natural tendency. The practice of meditation involves returning the mind to the calm-focus state, rather than feeling any pressure to keep the mind there without straying. The ability to stay in the calm-focused state will grow effortlessly from the practice of centering on the mantra or object.

How can this practice help us in the emergency department? Developing our ability to return our minds to a calm-focus state allows us to switch tasks rapidly and effectively during the practice of emergency medicine and can lead both to decreasing the risk of mistakes and increasing our satisfaction at work.



Practicing meditation can enhance our abilities to focus in the emergency department, making us calmer, more focused, and more effective.



THE SPIRITUAL WELL-BEING SPOKE

Emergency Yoga

By Bryan Balentine, MD, FACEP and Shawn Galin, PhD

The word yoga conjures up various mental images. What flashes through your mind? Or, are you a seasoned veteran of the ancient practice of uniting mind and body—and know pleasure and being at peace with life?

- Finding calmness by breath—so portable and omnipresent
- Help with posture—we all need some help here
- Wherever you are, there you are—noncompetitive improvement in flexibility

Fifteen minutes into my first yoga class, I quickly wondered what I had gotten myself into. I am a fairly open-minded individual and was looking for an alternative way to exercise. We, as emergency physicians, are all keenly aware of the stresses our profession offers, and I am not immune. What could be more relaxing than sitting around in a circle and chanting "Ohmmmm"? I needed a break from the surrounding clinical symphony of alarms, beeps, and interruptions.

After some basic stretches, the small class stood in a circle. The instructor gestured to someone near me who responded with "Sun," as if that was her new name. The person next to me responded with "Moon." It was now my turn. "Uhhh, Bryan," was my response. A few giggles followed in the room. Apparently we were standing in a circle that did not allow everyone to spread their arms then touch their toes at the same time without bumping into a neighbor. Alternating the stretch (Sun and Moon) next to your neighbor prevented "full contact" yoga. I smiled.

Two years later, I developed a deeper appreciation for yoga, flexibility, and a greater ability to simply relax in most situations. I could not remember the last time I could touch my toes but now I can.... and grab the bottom of my feet. From a practical standpoint, my 43-year-old body can hop up from the floor easier after playing with my young children. Clinically, I am more aware of posture while sitting at work. My chair angles at 90 degrees rather than the previous, somewhat reclining position and kyphotic posture. How many patients with back pain do you see a day with surgical histories? I like my spine without scars.

While I benefit from numerous yoga instructors, I spend more time with Shawn Galin, PhD. He is course director for endocrinology at the local medical school and an associate professor of critical care medicine, and he carries a passion for yoga. I learned of his background in medical education just before joining the ACEP Well-Being Committee. After sharing my experiences with him on



how yoga positively impacted me at work and home, we shared articles and research. PubMed reveals almost 3,000 articles on yoga, but our goal in collaboration here is to focus on a few areas that can impact you now whether you are on or off a shift.

The Breath and Stress

As in life, proper breathing is very important in the yoga practice. In fact, the ability to breathe properly and control one's breath can have profound effects on both mental and physical status. When the breath is shallow, a common side-effect of stress, blood is not oxygenated properly. This impairs mental function and promotes physical fatigue. Stress can cause shortness of breath and anxiety. These changes in breath patterns are mediated through the sympathetic nervous system as part of the "fight or flight" response. As you get more anxious, your breathing muscles fatigue and cause even more shortness of breath and anxiety. Thus, stress can create a vicious, perpetuating cycle.

Most yoga classes focus on breathing techniques, or pranayama, that actually helps the practitioner slow down their breath. A recent article in *The Wall Street Journal* entitled "Breathing for Your Better Health" reports that the benefits of abdominal breathing are the direct result of vagal stimulation. Slower breathing stimulates the vagus nerve, which runs from the brainstem to the abdomen. The vagus nerve, as part of the parasympathetic nervous system, is responsible for the body's "rest and digest" activities. In contrast, rapid, shallow breathing is associated with the sympathetic nervous system. The article goes on to report that vagus nerve activity can cause the heart rate to decrease as we increase the length of our exhalations. This is, in part, due to the vagus nerve's release of acetylcholine that slows down heart rate and digestion. This suggests one can actually alter one's physiological response to stress simply by observing one's breath. Taking long deep breaths with *conscious observation of exhalation length can promote vagal stimulation resulting in a sense of calm rather than chaos.*

Taking long deep breaths with conscious observation of exhalation length can promote vagal stimulation resulting in a sense of calm rather than chaos.

Posture

Although meditation and pranayama (breathing techniques) are core components to the practice, yoga is more commonly associated with asanas, or postures. There is a common misconception that people need to be flexible in order to attend a yoga class when, in fact, the opposite is true. The yoga practice is designed to increase both strength and flexibility by synchronizing breath with physical movement through various postures. It is not uncommon for a practitioner to notice an improvement in posture within weeks of starting a yoga practice.

Noticing postural habits soon becomes second nature to a yoga practitioner. Standing taller, sitting up straighter, and walking with straight spine are all common benefits of a regular yoga practice. *Practicing yoga in an everyday setting can be as simple as noticing and observing one's posture when seated, standing, or even lying down.* For physicians, being mindful of how weighted down their white coats are can be a form of yoga. Lightening the lab coat to decrease the forward shoulder pull and the subsequent kyphosis is practicing yoga.

My growing yoga practice triggered a wonderful journey. From a comical introductory class where I thought I would receive a new celestial name, to networking with PhDs and joining the ACEP Well-Being Committee, the ever-apparent stresses of our profession levy a remarkable toll on our wellness unless an appropriate and rejuvenating response is initiated. While I do not live in constant Zen mode at work, yoga allows me to relax more, provide better care, and extend my longevity in medicine. Try a few brief introductory sessions to yoga, meditation, and carry your wellness tool to "unplug" with you... and take a deep breath.



THE SPIRITUAL WELL-BEING SPOKE

Quiet Spaces

By Jan Bull, MA

Life is a series of natural and spontaneous changes. Don't resist them—that only creates sorrow. Let reality be reality. Let things flow naturally forward in whatever way they like.
—Poem by Lao Tzu

Forget about your life situation and all the challenges with emergency medicine for a while and pay attention to your life.

Finding the Life Underneath your Life Situation

(from Eckhart Tolle, *The Power of Now*)

Your life is now.

Your life situation is mind-stuff.

Your Life is real.

Find the “narrow gate that leads to life.” It is called the Now. Narrow your life down to this moment. Your life situation may be full of problems—most life situations are—but find out if you have any problems at this moment. Not tomorrow or in ten minutes, but now....

So whenever you can, make some room, create some space, so that you find the life underneath your life situation.

Use your senses fully. Be where you are. Look around. Just look, don't interpret. See the light, shapes, colors, textures. Be aware of the silent presence of each thing.... Listen to the sounds; don't judge them. Listen to the silence underneath the sounds. Touch something—anything—and feel and acknowledge its Being. Observe the rhythm of your breathing; feel the air flowing in and out, feel the life energy inside your body. Allow everything to be, within and without. Allow the “is-ness” of all things. Move deeply into the Now.

Video

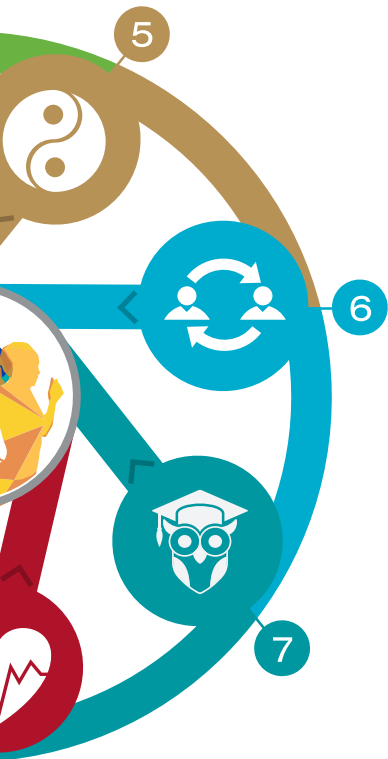
Take a look at this short video to get you started every morning or to end your day every evening. This is a great way to increase your energy and gain some relief from the stressors in emergency medicine. This 7-minute Qi Gong routine is from Lee Holden:

<https://www.youtube.com/watch?v=cXfKWm2QBAE>

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THE SOCIAL WELL-BEING SPOKE

“Yar!” Conquering Conflict at Work: Communication, Conflict Resolution, and Negotiation

By Summer Smith, MD, Peter Peloquin, MD, Arlene Chung, MD

Conflict. We Meet Again.

Although most of us do our best to avoid it, conflict is an unavoidable part of our day-to-day job in the emergency department. But while we don't have to love locking horns with others, there's no reason for us to be afraid of it either. Conflict is always around us. At work, *conflict is a golden opportunity*. If done well, conflict can be the vehicle that carries meaningful change. Conflict demands, “Listen to me!” This moment can start system improvements or inspire a teachable moment with a patient or colleague.

Here are some concrete steps that you can use the next time that you experience conflict in the ED.

First, acknowledge it.

As astronaut Jack Swigert famously said, “Houston, we've had a problem here.” Conflict has happened. Now you must acknowledge it. Feel it. For example, think about a time when you felt your body tighten and your heart sink when a young orthopedic consultant impatiently started reducing the broken limbs of a pediatric patient before proper sedation took effect. In this moment of conflict, when you feel your heart squeeze, your chest tighten, or your stomach knot up, be aware of the sensations your body is sending. Acknowledge it.

Then, breathe.

After acknowledging the presence of conflict, take a moment to breathe. Conscious breathing helps to dissipate some of those visceral reactions to stress and lets us focus on the problem at hand without distractions. It also gives us a little mental space to develop a plan of action.

Next, develop a plan of action.

In the well-known conflict resolution book, *Getting to Yes: Negotiating Agreement Without Giving In*, the authors describe a plan of action in four steps:

- Separate the people from the problem
- Focus on interests, not positions
- Invent multiple options looking for mutual gain before deciding what to do
- Insist that the result be based on an objective standard

1. Separate the people from the problem

We all have knee-jerk reactions when someone pushes our buttons—whether it’s a needy patient asking us repetitive questions or a consultant accusing us of incompetence. Our automatic response is to lash out at the person, but almost inevitably this leads to an unproductive spiral of finger-pointing. However, *if we can separate the person from the problem, then the focus of conflict turns to the situation instead of a personal attack*. Rather than thinking, “What is wrong with this resident!?” it is more helpful to think, “What factors are influencing this resident’s behavior?” Perhaps the young orthopedic consultant in the example above has never dealt with ketamine sedations in pediatric patients. Perhaps his role models have been overworked attending physicians who condoned such behavior in similar settings. Separating the people from the problem allows us to form nonjudgmental solutions to conflict.

2. Focus on interests, not positions

I once cared for an adolescent female with a 3-week history of worsening headaches who was unable to go to school because of the severity of the headaches. Her mother felt distraught and demanded answers. She insisted on a head CT, despite 2 normal scans in the past 2 weeks at other facilities. As I listened to the mother’s concerns, I shifted the conversation to focus on discussing ways to alleviate her daughter’s symptoms rather than taking a position on whether or not to perform yet another CT scan. I asked the mother about her primary interests. Did she want another round of ionizing irradiation for her daughter or would she rather talk about other causes of headaches and alternative management strategies? We were then able to come up with a sound therapeutic plan for the patient and averted another, likely unnecessary, CT scan. Everyone benefited.

3. Invent multiple options looking for mutual gain before deciding what to do

In the story above, I reframed the discussion and then developed other therapeutic options for the mother to consider and discuss with her daughter. This particular visit took a bit of

At work, conflict is a golden opportunity. If done well, conflict can be the vehicle that carries meaningful change. Conflict demands, “Listen to me!”

time, but the mother felt that I had appreciated her concerns and that she now had the best plan of care in place for her daughter. I also felt satisfied that we had provided the best care to this patient while she was in the ED. In this way, offering more than one solution to a problem creates greater autonomy and buy-in from both parties.

Conflict is inevitable. But when handled well, conflict can lead to a productive sharing of ideas, interests, and opinions around an unresolved issue.

4. Insist that the result be based on an objective standard

By using an objective standard, we accomplish two primary things: collaboration and teamwork to determine objective standard, and mutually agreed upon goals.

Basically this means that your rationale for a possible solution to the conflict has to be more substantial than “because I said so.” Each of the possible solutions must have objective reasoning and a mutually agreed upon form of measurement behind it. So, for example, when talking with the young orthopedic consultant, a *non-objective* standard would be to state, “I am the attending of record and you can either perform the reduction when I think it’s appropriate or you can leave.” Here, although you are providing more than one option (in the spirit of #3 above), neither is based on any type of objective evidence aside from your opinion. Using an *objective* standard, you could instead argue, “If we wait a few more minutes for sedation to really kick in, then 1) it will be better for the patient’s comfort and 2) easier for you to perform the reduction.” In this case, even though you only provided one option—to wait a few minutes—you rationalized your decision in a nonjudgmental and objective fashion.

Key Points

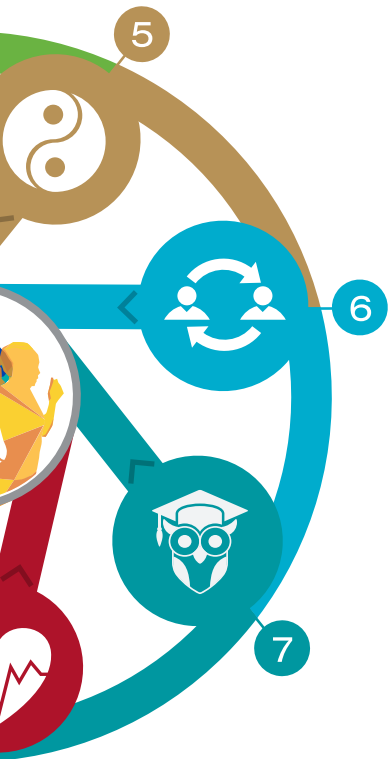
- Conflict is all around us.
- Conflict is an opportunity to learn. Now breathe!
- Separate the people from the problem.
- Focus on the interests.
- Provide multiple options for mutual gain.
- Have the result be judged by an objective standard.

Conflict is inevitable. But when handled well, conflict can lead to a productive sharing of ideas, interests, and opinions around an unresolved issue. It can inspire mutually beneficial change. All it takes is a little reframing. So take a moment to acknowledge your feelings, breathe deeply, and create a concrete action plan that will benefit you, your colleagues, and your patients alike.

RESOURCES

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THE SOCIAL WELL-BEING SPOKE

Well-Being for the Emergency Medicine Resident

By Rory Merritt, MD, Ryan Tansek, MD, Arlene Chung, MD, Elaine Josephson, MD, FACEP

Well-be-ing (noun): the state of being comfortable, healthy, or happy

Well-ness (noun): the state or condition of being in good physical and mental health

“While we cannot select the patients that we care for, we can control how we choose to react to those for whom we provide care. This is a powerful tool to protect against helplessness and permits the provider to exert an element of control over his or her workplace. It is important to acknowledge that certain patients will frustrate, frighten, offend, sadden, or anger us. We are distinguished as professionals by our ability to control how we modulate these normal human emotions. For when we deny our own humanism, we can no longer effectively serve our patients.”

—Carey Chisolm, MD, Reflections about Burn-out

Welcome to Emergency Medicine . . . Now Go Intubate This Patient!

So here you are, starting your emergency medicine residency, a program that is maybe in a different location away from your home, family, or where you attended medical school. Adjusting to the new environment can be difficult with having to make new friends, moving, finding a place to live, and learning how to survive as a resident in the ED and during off-service rotations.

Perhaps you are doing your residency in a place close to home and have to spend more time away from local friends and family and explain your work priorities. Or maybe you are a senior resident learning about graduated responsibility in the ED and wondering what to do with your career. What should the next step be: fellowship or an academic or community job? Where in the country should you begin your practice as an attending physician?

No matter what, every step of the way, emergency medicine residents face challenges in their training. It is very exciting and stimulating to be part of an emergency medicine residency. There are so many interesting patients and procedures to see. It is so satisfying to be a member of a team that successfully resuscitates a seriously ill patient. How useful we feel when we teach a new procedure or technique to someone else.

On the less positive side, uncertainty, for emergency medicine residents, remains a fundamental aspect of training. Patients flow in and out of emergency departments, attendings clock in and out with different expectations, consultants question resident decision-making, and work schedules constantly fluctuate. This uncertainty coupled with the many demands an emergency medicine resident faces can lead to stress. Over time, unmitigated stress can lead to burnout. For our families, friends, patients, careers, and ourselves, we must be diligent in learning how to cope. This brief guide describes some strategies and provides several resources for promoting wellness and avoiding burnout during an emergency medicine residency.

Can Emergency Medicine Residents Become Burned-out?

With relatively new work-hour restrictions and increased attention to reducing healthcare-related errors, burnout has gained increased attention. Burnout is defined as having *a high level of emotional exhaustion coupled with a sense of depersonalization and low accomplishment*.

Emergency physicians are particularly susceptible to burnout given Circadian disruptions inherent to shift work, stress associated with potential litigation, infectious disease exposure, and patient morbidity, just to name a few.

Burnout occurs in a milieu of stress. In a medical environment with high acuity, high expectations, and few opportunities for decompression, it is no surprise that approximately half of residents experience burnout.

Can You Recognize Burnout?

We have likely all seen burnout in our peers: the overly dismissive consultant or perhaps even an attending with horrible bedside manner. It is harder to recognize and acknowledge when burnout becomes your own issue. But we must try to recognize it.

Unchecked, burnout can lead to poor interpersonal communication affecting patient and colleague rapport. Others have noted that burned out physicians tend to make more cognitive errors leading to mistakes. As physicians, we have a responsibility to ourselves, our profession, and our patients to recognize when we are struggling and to do something about it.

...unmitigated stress can lead to burnout. For our families, friends, patients, careers, and ourselves, we must be diligent in learning how to cope.

Are You Burned-Out?

Consider using a “burnout score” as a jumping off point (see Burnout, Stress, and Wellness Resources at the end of the chapter).

Although we may address some of our concerns during informal conversation, specifically seeking feedback from a trusted co-resident or attending on certain issues can provide additional perspective.

Residents Can Promote Personal Wellness

There are many strategies and resources that residents can use to ensure their own well-being. Spending time with people you really enjoy can be rejuvenating. Seeing the world outside of the hospital and expanding your interests is a great way to refresh your outlook. Maintaining old hobbies or exploring new ones can be therapeutic. *Maximizing “work-life balance”* is essential, and every individual’s balance will be different.

Advice from other residents and attending physicians can be insightful. Although we may address some of our concerns during informal conversation, specifically seeking feedback from a trusted co-resident or attending on certain issues can provide additional perspective. Also, organized group gatherings of residents, particularly those of the same class or with similar interests, can be effective, especially if residents are brought together specifically for the purpose of exploring resident wellness.

Spend time with supportive family and friends; even though they may not completely understand the issues at hand, they can certainly contribute perspective and insight. Seeking assistance from professional counseling sources can also be very helpful. Many hospitals and residency programs offer resources for staff mental health. Taking advantage of these resources early may prevent disruption in training if the issue is serious. You would go to a physician for diagnosis and treatment of strep pharyngitis, so why not seek the services of a mental health provider if there are stressful issues that need to be discussed during residency? Just a thought, not a lecture.

Residency Programs Must Foster Wellness

Not only can residency programs be fundamental in assisting their residents with their well-being, but they also have a professional obligation to do so. Program leaders must strive to promote an atmosphere that addresses and promotes resident well-being. Programs may elect to *create wellness committees* to specifically focus on particular issues. Residency programs should provide medical and psychological resources for residents to utilize as needed.

Resident wellness can be significantly impacted by inconsistent daily routines in resident schedules. The great time commitment and heavy work load during residency can be challenging, and programs should strive for fairness of resident schedules. An equitable schedule can contribute positively to the morale in the residency program. Promoting a healthy circadian rhythm should be taken into account when the clinical schedule is prepared. Having a call-in back-up system for residents to utilize in case of medical or serious personal issues is essential.

Shiftwork Coping Strategies?

Ask a group of emergency medicine residents about the best strategy for dealing with shiftwork and you will get a different answer from every single one. *Fatigue is a consistent complaint* among residents, who work long hours with varying schedules. This weariness not only affects work performance but also impacts the personal and social lives of residents. As a result, increased emotional and psychological stress may occur.

Along with a residency program's effort to optimize resident schedules, there are several approaches that residents may use to decrease fatigue. Obtaining the appropriate amount of sleep will make all the difference in how you are able to function. Different people need different amounts of sleep, but it is key to obtain an adequate amount of sleep overall. Good sleep hygiene includes room-darkening shades, cool temperatures, ear plugs, eye masks, and anchor sleep. Utilizing call rooms, when the opportunity presents itself, can help curtail fatigue caused by on-call days. Some residents find the use of caffeine and melatonin and other sleep aids to be helpful with managing the nature of shift work. Self-awareness of fatigue is crucial. Refrain from driving and other potentially dangerous activities when you are really tired. (<https://www.acep.org/Clinical--Practice-Management/Emergency-Physician-Shift-Work/>)

Strategies for Creating Wellness during Emergency Medicine Residency Training

“While it is always important to be very professional, maintaining a sense of humor can be helpful in light of the challenging circumstances we encounter as emergency physicians during our training and throughout our practice.”

- Elaine B. Josephson, MD, FACEP



1. Orientation Block

- Take time to learn about what is expected of you in the program and bond with your fellow residents, as you are all in this together and will need each other's support.
- Find out about off-service rotations and ED shifts from junior and senior residents.
- Don't be afraid to ask questions while working with the emergency medicine faculty attending as you start to learn the practice of emergency medicine. This shows you are interested and motivated.
- You may be assigned to your faculty mentor at this time or shortly thereafter if your residency has a mentor program. Speak with your assigned faculty member about your academic goals and interests.

2. Family and Outside Friends

- Take advantage of your support systems outside the program. If you are away from home and close friends, make an effort to keep in close contact (phone, internet, facetime, skype)

and consider using your vacation time to visit them. If you are in the same locale as your family, take time to see them when you are not working. It is always so nice when someone cooks you a meal or helps you with your laundry. If you live with your significant other and/or have children, be mindful of them and enjoy their company when you are not in the ED.

3. Outside Interests

- Maintain previous outside interests or perhaps take up a new hobby to help relieve stress. Find fellow residents in the program with interests similar to yours and get together.

4. Health

- Get plenty of sleep in between shifts and on days/nights off. When transitioning between working days to nights make sure to nap in between to reset your body clock. If you or a colleague or attending recognize you are too fatigued to drive home after a shift, take a nap in the on-call room before traveling.
- Take time for yourself and set up an exercise routine that fits your shift schedule. Make healthy choices for meals and snacks as much as possible. Find a release for stress; examples are yoga, meditation, and working out at home or in the gym.
- If you become ill, take care of yourself and obtain a medical examination and treatment. Most residency programs have a sick call system in place.

5. Emergency Medicine Residency Program Wellness

- Take advantage of all the wellness offerings in your program. Most emergency medicine residency programs have at least one day (if not more) where faculty and residents get together for a team-bonding event. Be sure to attend. Go to other residency-sponsored events (holiday parties, graduation parties) and informal get-togethers (meet and greets for new applicants, resident informal gatherings, etc.) to talk to your classmates and faculty outside the hospital.
- If you encounter any workplace violence, health care exposures, or personal issues during residency training and need help, seek the support and advice of your program director and/or chief residents, mentors, colleagues, or the graduate medical education office if indicated. Remember, in addition to vacation and sick time, there is also time allowed by the Family and Medical Leave Act should you need extra time off.

6. Senior Year

- Being a senior is stressful but exciting as the end is near. Consult your program director, faculty members, and residents who have graduated before you regarding job or fellowship opportunities and speak with significant family regarding future location.
- Enjoy your emergency medicine residency training! This is your time to practice under supervision, learn from any mistakes, approach new challenges, and prepare for one of the most exciting careers in medicine.



RESOURCES

Organizations

American College of Emergency Physicians (ACEP)

www.acep.org

ACEP Wellness Booth at Scientific Assembly

ACEP's Wellness Section

ACEP's Well-Being Committee

Core Readings on Wellness for Emergency Physicians:

<http://www.acep.org/Clinical---Practice-Management/Core-Readings-on-Wellness-for-Emergency-Physicians/>

Emergency Medicine Residents' Association (EMRA)

www.emra.org

Recommended reading: <http://www.emra.org/students/education/reading-recommendations/>

Society for Academic Emergency Medicine (SAEM)

www.saem.org, various modules and sessions at meetings and online

Websites/Twitter Feeds/Blogs/Podcasts/Videos (search "wellness" at each site):

Free Open Access Meducation (FOAMed)

#FOAMed

Academic Life in Emergency Medicine (ALiEM)

www.aliem.com/

@aliemteam

Free Emergency Medicine Talks

<http://freeemergencytalks.net/>

Life in the Fastlane

<http://lifeinthefastlane.com/>

The New England Journal of Medicine, www.nejm.org

Healthcare Exposures: Video on Personal Protective Equipment

<http://www.nejm.org/doi/full/10.1056/NEJMvcm1412105?rss=searchAndBrowse&>

YouTube Videos

www.youtube.com

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THE INTELLECTUAL WELL-BEING SPOKE

The Adult APGAR: An Instrument to Monitor Wellness

By Shay Bintliff, MD, FACEP

How do we know if we are well?

Is there a way to tell if we are impaired in the wellness category?

Professional and personal wellness – how do we measure it?

What follows is a timeless tool that we can use to evaluate whether we are well or working too much. The Adult APGAR, developed by Dr. S. Shay Bintliff, is a brief, self-scoring instrument designed to assist physicians in assessing and monitoring their wellness status. The acronym APGAR was chosen, not only because physicians are familiar with a similarly structured evaluation of newborns, but also because it has predictive value of wellness impairment. The statements, 1 through 5, are designed as much to educate as to score and monitor.

Each statement describes a wellness attribute. There are no trick questions to test honesty or consistency. It is straightforward—the greater you believe your wellness, the higher your score. The test is only as valid as the physician's willingness to answer each statement as honestly as possible. Although a change in score will monitor progress toward wellness or increasing difficulties, what the physician learns about himself or herself is what is most valuable about this instrument.

There has simply been no better or simpler measuring device ever proposed for physicians. Test-drive it and see if you are well or if you need some work. Please share with other physicians at work—it is portable and private, and most importantly, helpful!

The Adult APGAR

	Almost always Score = 2	Some of the time Score = 1	Hardly ever Score = 0
I am satisfied with the Access I have to my emotions – to laugh, to be sad, to feel pleasure or even anger.			
I am satisfied that my life’s Priorities are mine and clearly reflect my values.			
I am satisfied with my commitment to personal Growth , to initiate and embrace change.			
I am satisfied with the way I ask for Assistance from others, professionally and personally, when in trouble.			
I am satisfied with the Responsibility I take for my well-being – physically, emotionally, and spiritually.			
Total Score = 0 – 10			

What is Measured?

Component	What is measured.
Access	The physician’s satisfaction with his/her own openness and willingness to experience a variety of feelings. Mature people are willing to attempt to cope successfully with the stresses and turmoil of work, but also to respond to the joy of their successes.
Priorities	The physician’s satisfaction with knowing what really is important to him/her and acting on these values. Needing to respond to the demands of so many others leaves physicians unable to say “no” without feeling guilty or disappointed. In honoring your priorities, you maintain self-respect and reduce stress and resentment for yourself, your family, and patients.
Growth	The physician’s satisfaction with the freedom to take charge of his/her life and make significant changes if not satisfied or happy. Patients and personal relationships offer opportunities for us to clarify values and commitments of our time, money, and resources.
Assistance	The physician’s satisfaction with recognizing danger signals and asking for help when in trouble, professionally and personally. Stresses of juggling work and family can lead to abusive and dependency behaviors if you are unwilling to reach out for nurturance, empathy, and support.
Responsibility	The physician’s satisfaction with self-care, maintaining self-esteem, good health, financial security, and feeling good about doing it! Adequate diet, exercise, recreational time with family, and quiet time alone to live in our own spiritual sanctuary are essential to balanced well-being.

Scoring

Although the Adult APGAR was field-tested in various medical settings, the initial scoring outcome was empirically determined. If a physician’s total APGAR is 9 to 10, his or her wellness status is superior. If the score is 6 to 8, it is assumed that there are some imbalances and stresses that need attention, and the individual likely knows what he or she needs to change. A score of 5 or less indicates that the physician is in significant trouble or pain and needs to make significant changes to bring his or her life back to wellness focus. Professional counseling, a support group, or individual work or reading is recommended.

Final Thoughts on Being Well

When all is said and done, it's better to be vertical and not horizontal in the emergency department. We have given our time and our talents...

What a privilege to serve.

- Sheryl Heron, MD, MPH, FACEP

At the end of the day, know that you did well. You may not hear that from any patient but deep down you know it—we are the Marines of medicine... “the few, the proud.”

- Douglas Char, MD, FACEP

One evening when I was corresponding with one of our authors, I received an email response describing the best way for emergency physicians to cope in emergency medicine. The answer is short, thought-provoking, and wise:

“Going home is how I cope.”

Thomas Benzoni, MD, FACEP

Rita Manfredi, MD, FACEP





Being Well in Emergency Medicine: ACEP's Guide to Investing in Yourself