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FROM SELF TO *SYSTEM*

Being Well in Emergency Medicine

Edited by Rita Manfredi, MD and Diann Krywko, MD

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This Guidebook is dedicated to all Emergency Physicians, past, present, and future who have fought to be well and succeeded and to those who struggled for wellness and died in the process.

Our sincere thanks to members of the ACEP Wellbeing Committee, the ACEP Wellness Section, and all ACEP staff members for recognizing that wellness and resilience are the only path to longevity in Emergency Medicine.



Foreword

By Rita Manfredi, MD and Julia Huber, MD

ACEP recognized the importance of wellbeing for emergency physicians and established a Personal and Professional Wellbeing Task Force in the mid 1990's. The task force published the first professional wellness resource for emergency physicians, a printed booklet entitled "Wellness for Emergency Physicians". About 10 years later the Wellbeing Committee upgraded this booklet to printed book form and called it the "Wellness Book for Emergency Physicians." These early guides explored the stressors specific to our specialty and provided guidance for coping mechanisms and wellness planning.

In 2017, the Wellbeing Committee expanded the book to an electronic 20-chapter resource based on the 7 Spokes of the Wellness Wheel describing emotional, occupational, physical, financial, spiritual, intellectual, and social wellness.

Fast forward to the Covid pandemic which uncovered the extreme "un-wellness" and moral injury in emergency medicine. It became blatantly apparent to everyone that the bulk of an emergency physician's wellbeing is determined by the system. The individual emergency physician is only partly responsible for his or her wellness.

Emergency physicians are called upon to be flexible, resilient, and self-sacrificing. They are expected to solve any problem that comes through the doors of the Emergency Department. Years of moral injury topped off by the Covid pandemic took their toll and many emergency physicians left the specialty. One tiny antidote to this problem is this guidebook which explores solutions to many of the systemic issues that plague emergency physicians today.

The editors and contributors to this guidebook present ways to adapt and stay well throughout our careers to best serve our patients, communities, families, and most importantly, ourselves.

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The ART of Emergency Medicine

By Jonathan Warren, MD

Emergency physicians are more than just their clinical acumen. Emergency physicians are doctors who are fortunate to have a broad collection of talents and hobbies — all of which contribute to their own wellness. Often, we find ourselves caught in the subtle clutches of moral injury and burnout. We know that rates for emergency department visits have reached an all-time high, especially during this pandemic. Up against the stress of our jobs, financial concerns, constantly fluctuating work hours, and emotional fatigue, we feel like we are alone in our struggle.

Fortunately, we are not without control.

Hobbies and artistic endeavors are one of many outlets that promote wellness. By following our passion, we focus on enjoyable tasks that may help express complex emotions, feelings, and frustration beyond what words in a conversation may communicate. We develop a positive identity while also preventing compassion fatigue. Managing our burnout, stress, and anxiety not only improves our own outlook, but improves that of patient outcomes and safety measures as well. Studies show that oncologists and palliative care physicians use art therapy to decrease emotional exhaustion and feelings of depersonalization. It is not unreasonable to expect this same benefit in emergency physicians as well. Even short sessions reflecting on photos or art will reduce tension, anger, fatigue, and other symptoms of burnout.



Art provides an avenue for physicians to practice mindfulness, allowing time for meditation, reflection, and a chance to navigate the complex feelings experienced daily on every shift. Multiple studies show the benefits of mindfulness in promoting wellness, mitigating stress, and reducing moral injury. Everyone pays an emotional toll when providing care in stressful, emergent environments. Mindfulness is a skill the entire emergency medicine community can use — from physicians to residents, nurses, techs, EMTs, and administrative staff.

The Art of Emergency Medicine is an online art blog created with the understanding that art and the humanities are the balm to emotional injury found throughout emergency medicine. Over the last 3 years, the Art of Emergency Medicine project has created an online community where emergency medicine providers display their creativity as a means to further open up conversations about how art and the pursuit of passions outside of the workplace help mitigate burnout. Each month, curated collections of artwork and stories of inspiration are released on the site to provide a burst of wellness and calm. At the end of most chapters of this book, there is an artistic selection from www.artofemergencymedicine.com.

Beyond stories, photos, and artwork, the goal of Art of Emergency Medicine is to provide education. The site highlights evidence-based, digestible reviews focusing on wellness issues with a new feature each month. There is a topic for everyone, whether you just started your wellness journey or want to challenge yourself. If you're short on time, take a look at the infographics.

View the galleries of your colleagues' work on Art of Emergency Medicine (www.artofemergencymedicine.com) and consider it a reminder to pursue those hobbies and passions that bring you significant joy.

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Happiness and Resilience in the Life of an Emergency Physician

By Rosanna Sikora, MD, Laura McPeake, MD 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. In this chapter, we have provided some thoughts about happiness and resilience, followed by a 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.

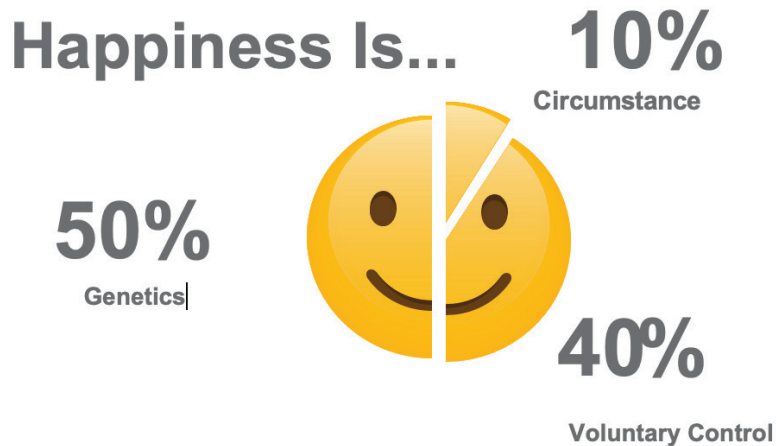
Defining happiness for an emergency physician is complex. The past several years have made it even more complex with COVID-19 inundating our lives and practice. Aside from the pandemic, is it cooperative patients? Interesting cases? Collegial consultants? Efficient supportive staff? Wonderful nurses? It is much more than a single entity. Happiness is sometimes thought of as “The Life.” It is more than the presence of joy and pleasure and not only the absence of suffering.



Happiness is not just the procurement of some object. Getting that new pair of jeans or a car may give you pleasure, but they ultimately won't give you meaning in life. Further, happiness is not solely the attainment of a great station in life. Take the emergency medicine residency match. Training is chock full of successful intubations and central lines and exciting resuscitations. It is also accompanied by mind- and body-numbing hours and hours of clinical work, on-call duties, and fatigue. There is meaning and engagement, but the pleasure may not be there. Wellbeing tends to wane and stress increases in that time.

Rather, happiness is a subjective state of wellbeing. 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 their own 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 daily. 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 despite 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 emergency department; 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 ECG, no other risk factors.

“Once his labs come back, discharge him with a 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.

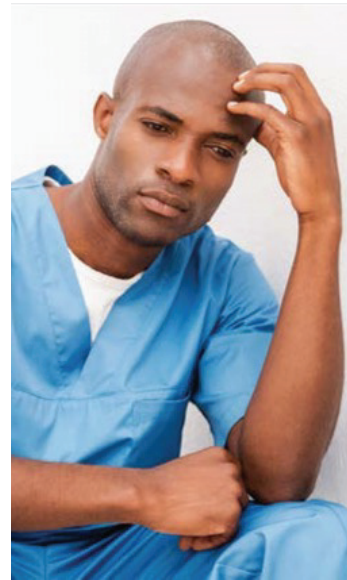
This case underlines the uncertainty with which we all live. It is a lesson in resilience, seeing something alarming and being able to be tougher on the other side of it because you were able to face it. Despite all the blows that time has thrown him, Dr. Silien has weathered every diagnostic dilemma, 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. 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. Alternatively, 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 talking 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.

Remember that 40% of happiness is voluntary. There are specific actions we can do to improve our happiness and resilience. We have developed specific strategies to help build resilience in the practice of emergency medicine. We encourage you to start using them today.





Writing in 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 wellbeing 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, among others.

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. Sometimes this fades as your career progresses. Multiple resources for building empathy exist, including books, workshops, and podcasts. Connect with your family, friends, and coworkers 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. On the most basic level, 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 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.

Back to our happiness and resilience. 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 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 and the more we are fulfilled in the emotional wellbeing spoke of our wellness wheel.

Resources

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Nature Makes Me Smile

Ryan Brown, MD

“Nature has been very therapeutic throughout my life. Now that I spend a majority of my time indoors, I really have to set time aside to go for a hike and take in the natural beauty of the world. Part of wellness is making sure that you take time to remove yourself from the pressures of living in society and especially with the stress of being an Emergency Medicine resident.”

Finding Your ~~Icky Guy~~... No, This Ikigai! A Japanese Way to Wellness

By Katerina Parmele, MD

“I had to reach burnout to find my Ikigai. I didn’t know what it was at that time. I found it after 20 years of practice in emergency medicine. I was dreading another night shift, where I was fully responsible for every patient in the department and running on fragmented sleep and low on empathy. It took hitting that wall to make the changes needed to find balance and wellness again. I had to find my ikigai.”

Ikigai is not a green monster. Ikigai is a Japanese concept that means “a reason for being.”

When we are growing up, we have hopes, dreams, and a laid-out path we follow. This path is prewritten for us, from elementary school to high school, through to college, medical school, residency, and finally to the workplace—the emergency department. Once I was in the workplace, I had reached my goal, and there was little to look forward to. During the first part of my life, I felt I was always striving to meet a challenge, and once I found myself in actual practice, I started to lose that sense of passion and purpose. I struggled going into work. I found myself jaded and ill-tempered with a very short fuse. I cried before my shifts.

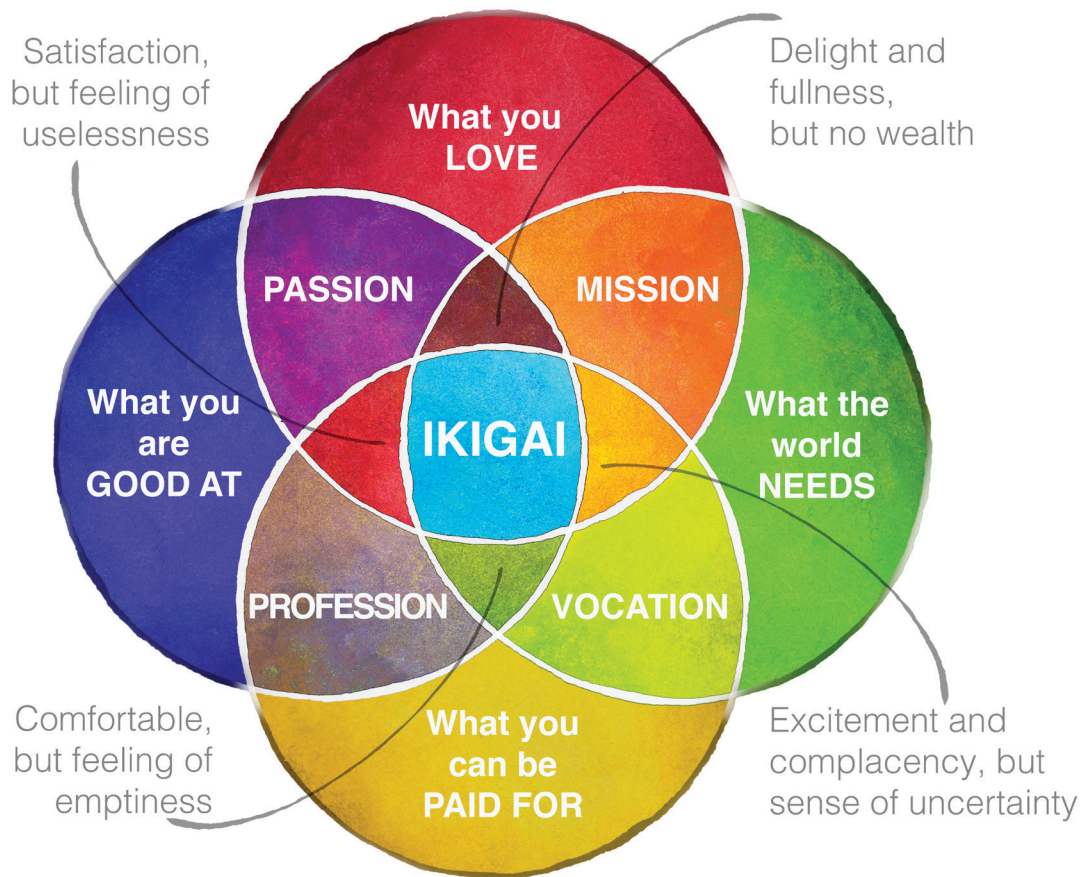


Staring my own burnout in the face, I tried looking into what wellness meant and how I would be able to get myself out of this deep, dark funk. Most of us are very familiar with the fundamentals of personal wellness, which include a healthy diet, exercise, sleep, social connection, stress management, and avoiding toxins like alcohol and drugs. What I didn’t realize was the huge importance of finding and nurturing your passion and purpose. That is when I stumbled upon the term “Ikigai.”

The Japanese term Ikigai translated to English roughly means “thing that you live for” or “the reason for which you wake up each day.” It is your passion, purpose, and niche in life. Ikigai is what you are meant to do at that moment. Ikigai is a reason to jump out of bed each morning. Your Ikigai is at the intersection of what you are good at and what you love doing.

The concept of Ikigai is the intersection in the Venn diagram of what you are good at, what you love to do, what the world needs, and what you can get paid to do. The very center of that Venn diagram is your Ikigai.

Take time to fill in your own choices in each of the Ikigai circles below. See how they all fit together and come up with your own passions for living—your own Ikigai. As an emergency physician, think about your own Ikigai and decide what will sustain you throughout your career.



During my younger years, I focused on excelling in school, finding a career, getting married, buying a house, and establishing myself in the community. Once I had my emergency medicine job, I never planned for the next step or goal. So, to extract myself from this pit of burnout, I decided to rekindle my passions and purpose.

During training, I could not wait to get into the emergency department and see more patients. Every time I picked up a chart (at that time, we wrote on paper charts on clipboards), I was excited to take care of the patient. Where had that excitement and energy gone? I wanted to bring that passion back.

So, I made an Ikigai list.

- What am I good at?
- What does the world need that I could provide?
- What can I get paid to do?
- What do I love to do?
- Is there anything I would do, even if I don't get paid, because I love it so much?

I wrote a list of all those things and sat with the list for a while, giving the seed time to germinate.

I discovered I loved so many different things, I wasn't sure I would be able to experience them all in one career. As it turns out, you don't have to experience everything! If your life has a sense of passion and purpose, all you need is one

special focus. For me, I started up a health and wellness coaching practice as well as a business running health retreats in my home country of Greece. I cut back on my clinical shifts in the emergency department. I wanted to share what I had learned so that others did not have to feel lost or isolated. Emergency physicians do not like to admit when they're struggling. We don't want to look or feel "weak." Sharing our stories lets us realize that we're human and not alone.

I started to feel better almost immediately and had a new direction to follow. All sorts of possibilities opened up for me, and I felt a positive change in energy when working in the emergency department. I was connecting better with my patients. My empathy improved. When the whole emergency department felt like it was crashing down around me, I was able to stay relatively calm.

I had found my Ikigai.

Resources

<https://positivepsychology.com/ikigai-test-questionnaires/>

<https://becomingbetter.org/ikigai/>

<https://www.sharedinspiration.co.uk/post/resources-about-ikigai>

Book:

Ikigai: The Japanese Secret to a Long and Happy Life by Hector Garcia and Francesc Miralles, 2017.



Together

By: Jonathan Warren, MD

“Working in the emergency department can often feel isolating, which always seemed odd to me for as many colleagues and patients you are around. The frequent swing and night shifts lead to difficulty seeing and spending time with the ones you love. Having the opportunity to get out and spend time one-on-one time together is frequently a dream come true and an antidote to burnout.”

The Adult APGAR: An Instrument to Monitor Personal Wellness

By Shay Bintliff, MD

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 simply measure it for ourselves?

What follows is a timeless tool devised by Dr. S. Shay Bintliff, an emergency physician from Hawaii. The Adult APGAR measures if we are well or working too much. Test drive it and see if you are well or if you need some support.

Please share with other physicians at work – it is portable, private, and most importantly, helpful!

<i>The Adult APGAR</i>	Almost Always Score = 2	Some of the time Score = 1	Hardly ever Score = 0
1. I am satisfied with the Access I have to my emotions – to laugh, to be sad, to feel pleasure or even anger.			
2. I am satisfied that my life's Priorities are mine and clearly reflect my values.			
3. I am satisfied with my commitment to personal Growth , to initiate and embrace change.			
4. I am satisfied with the way I ask for Assistance from others, professionally and personally, when in trouble.			
5. I am satisfied with the Responsibility I take for my wellbeing – physically, emotionally, and spiritually.			
Total Score = 0 – 10			

What is Measured?

Component	What is Measured:
1. 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.
2. 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.
3. 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.
4. 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.
5. 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 wellbeing.

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 indicated that the physician is in significant trouble or pain and needs to make significant changes to bring a wellness focus back to his or her life. Professional counseling, coaching, support groups or individual work or reading are recommended.



The Guardian of Santa Maddalena

Andrew Thorne, MD

“I had planned to capture this shot long before leaving for Europe. What I didn’t expect were the twists, turns, and obstacles that we’d face to get here. It’s only because of the patience, ingenuity, and stubbornness of my friends that my dream became a reality. Now I not only have an epic shot of this Italian landscape, but a reminder of a hilarious adventure with some of my best friends.”

Every Day You Focus: A Simple Meditation

By Jason Fleming, MD

“I take the deepest breath I can and then let out a slow exhalation. I do this as I walk to the next patient listed on the tracking board. That is my meditation in the emergency department before I see each patient. So simple.”

Practicing meditation is a skill that comes naturally to emergency physicians, even if you may not know it. We work in a chaotic environment and constantly need to refocus our attention. The act of continuously refocusing is similar to the process of meditation. Actively practicing meditation and honing those skills can enhance our abilities to focus in the emergency department, making us calmer and more effective.

Many people think that meditation is sitting quietly and concentrating. Visions of a Buddhist monk sitting peacefully under a tree may come to mind. While this might be the way a practicing mystic meditates, it is not the most common way to practice mindfulness.

Object and Mantra

The actual practice of meditation involves focusing the mind, often on an object or 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. Although the mantra can be in any language, more meaning is often found in a mantra that is in one’s native tongue.

How can we fit meditation into the chaotic realities of the emergency department? It really is possible.

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. If you choose, hold the object in your hand and focus on it as you sit quietly. The shape, curves, and edges can be intentionally felt with the fingers and appreciated. When the mind begins to interrupt this moment by naturally drifting to the myriad of distractions in our lives, we bring it back to focus on the object by intentionally noticing some new aspect—the weight, the texture, or 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, and more 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 that they are “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-focused 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.

Developing our ability to return our minds to a calm-focused state allows us to switch tasks rapidly and effectively during the practice of emergency medicine. Practicing meditation can enhance our abilities to focus in a chaotic emergency department, making us calmer and more effective, leading to decreased stress, a lower risk of mistakes, and an increased satisfaction at work.

Resources

Decker BW. Practical meditation for beginners: 10 days to a happier, calmer you. Althea Press; 2018. Multiple videos from Olivier Nguyen online.

Mindful Communications. How to Meditate. Accessed July 2022. <https://www.mindful.org/how-to-meditate/>.

the most beautiful people

lie in wait of resolution. they sink into
hospital beds and breathe out poems
across thick unlined paper sold in gift
shops. they hum curves around question
marks asking for the thing in their veins
next to icy water. each memory folded
into different sized cranes
invites perched on the windowsill
surely for the view. an audio diary is heard
pronouncing resolutions til sunrise
when the magic is still and the body wakes to go
the most beautiful people will touch an ear
to their smile and a whisper will come
close to any other ordinary quiet.

Elaine Hsiang, MD

“I started writing after going to my first spoken word show. It was a time of a lot of change in my life and I found I could be my most authentic self through poems.”

It's Always Time for Financial Planning: Seven Easy Steps to Financial Serenity

By Douglas Segan, MD, JD and Philip Shutler, MBA

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

Did you also try to convince your medical school interviewer that the acquisition of money was not all that important to you? Did you think 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 you believe that the desire to accumulate wealth is inherently evil and becoming financially secure is not really important to you, then it may be best to skip this chapter. But, if it is important for you not to worry about your monthly bills, provide for your family now and in the future, afford your children's education, and create a large enough nest egg so you and your partner can travel and retire with some degree of security, then you need a plan. 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 wellbeing.

This chapter provides a broad overview and encourages you to commit to follow a path to financial serenity. You need a roadmap and a plan to achieve your financial goals and the time to start planning is now.

Here are 7 easy steps for your financial planning pleasure:

- Step I:** Plan Now, Financial Bliss Later
- Step II:** Become Financially Savvy
- Step III:** Live Within Your Means
- Step IV:** Build Your Team
- Step V:** Protect Thyself (Insurance)
- Step VI:** Protect Thyself Even More (Asset Protection for Malpractice)
- Step VII:** Investing: Simple is Smart

Step I: Plan Now, Financial Bliss Later

Financial planning seems complicated and confusing, and that is why it is 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-sized steps that are painless—and start now—you can achieve your financial goals.

Unlike most folks who are eager to give financial advice, we are not looking for clients and do not have anything to sell. We are passionate about this subject because we care about the wellbeing of our emergency medicine colleagues. We believe that working in the emergency department is tough enough, and we should do what we can to reduce the stress of our colleagues. 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. We know that financial worries can be distracting and impair your focus.

We all have made plenty of costly financial errors and suspect that we will make plenty more. Hopefully, not the same ones! If we all learn from our collective errors, we will be better off.

Step II: Become Financially Savvy

Having advisors is a wonderful thing, but this is one area 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.

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 more digestible. His blogs are often entertaining and he provides a well thought out and careful analysis of numerous financial topics.

Step III: Live Within Your Means

Most emergency medicine 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, prepare for a secure retirement, and be able to weather the inevitable personal financial setbacks that occur in everyone's life.

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 Great Recession of 2008 and the COVID-19 pandemic were sober reminders to many of our colleagues who overextended themselves with elaborate houses, cars, credit card debt, and vacation homes. Even if the economy stays on course, it is prudent to prepare for a change of fortune. The risk 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. In the midst of good times is when you should save for a rainy day and for your retirement.

A great and achievable goal is to save 25% percent of your gross (pretax) income. It is good practice to save as much of this money in the retirement accounts that you and your partner qualify for. There are usually 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 IV: 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 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 with tax advantages are a gift from Washington that should be fully utilized. A CPA can help you with this.

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

An insurance agent who 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 always 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 a competent ethical professional take care of this, but beware of the possible costs and conflicts of interest.

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 you make. Alternatively, many low-fee brokerage firms, like Charles Schwab and Fidelity, offer a range of advisory services, from one-time financial plans for a set fee, to managed portfolios, to accounts with on-going advice from a personal broker (which typically charge an annual fee based on assets under management). You can choose the approach that works best for you. Remember—minimize fees to maximize your returns.

Step V: Protect Thyself (Insurance)

In addition to medical malpractice insurance, most physicians will need automobile and homeowners (or renters) insurance. An umbrella policy that supplements these policies provides a great deal of additional coverage at little cost. In the event you are sued for more than the maximum amount covered by these policies separately, umbrella insurance will provide additional protection.

Disability insurance is advisable for most physicians. This is a complicated product and due diligence is required 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 some homework and not signing up after the first sales pitch. Inexpensive term life insurance can provide financial security for your family during a set term such as 10-20 years when you are in your peak earning years and your family is most dependent on your income. Various forms of permanent insurance, such as whole life, include a retirement savings component, which may be unnecessary if you have other retirement savings such as a 401(k) account, an IRA, or a variable annuity.

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

Step VI: Protect Thyself Even More (Asset Protection for Malpractice)

The Good News

If you practice emergency medicine long enough, odds are that you will become a defendant in a medical malpractice case. That's not the good news. The good news is that the vast majority of medical malpractice claims are either dropped or settled or otherwise resolved before trial. Of the small percentage of claims that go to trial, approximately 80% draw defense verdicts. Huge verdicts in medical malpractice cases are not common, but they do get an inordinate amount of publicity and thus create fear in the medical community.

Two to five years may transpire from the time you learn of a suit to the time it is resolved. During this lengthy period, defendant physicians are understandably anxious about the risk of an unfavorable verdict that far exceeds their insurance

coverage. Your own insurer can increase your anxiety by asking you to acknowledge your understanding of the limits of your policy coverage.

Preparing for Bad News

The purpose of this section is to introduce the topic of asset protection. It is a powerful tool that you will probably never need but having it in place will reduce some of the significant stress of litigation before it occurs. The goal of asset protection is to arrange your assets so they are safe from malpractice judgment creditors.

Fortunately, federal and state governments have put in place a number of safeguards a physician can utilize immediately, so your financial survival with some assets is possible even if a worst case litigation scenario occurs.

Ten Steps to Consider

There is no “one size fits all” plan in asset protection. A plan has to be tailor-made to your individual situation in terms of which state you live in, your family situation, the nature and size of your assets, and how much control you are comfortable giving up in order to attain more asset protection. Here are ten suggestions to consider, which may motivate you to learn about your options and discuss them with your family and advisors.

1. Start Early

The ideal time to give asset protection some thought is before you are involved in a lawsuit. In fact, because of the fraudulent conveyance rules, many asset protection programs cannot be instituted if you are already aware of a pending case. Put your plan in action before you become a defendant.

2. Know Thy State

Understand the basics of malpractice law as it applies to your particular state. What works well in one state may be worthless in another state. Each state has specific laws that protect certain assets from creditors.

It makes for dry reading, but learn the rough outline of your state’s bankruptcy laws and what exemptions are allowed (ie, which assets a person may keep after bankruptcy, for example, a principal dwelling). Find out if your state allows an individual to choose between using the Federal or state exemptions or if your state only allows the use of the exemptions unique to your state. Knowing the specific rules of your state is the starting point for any asset protection plan. If you prefer reading from a book, Nolo publishes a helpful guide titled *How to File for Chapter 7 Bankruptcy*, which includes a clear chart explaining the exemptions for each state. If you prefer reading online, use your favorite search engine and enter the name of your state and the words “bankruptcy exemptions.” If you can scroll past all the ads, you will find some useful information for your state.

3. Seek Wise and Ethical Counsel

This area of the law is not for amateurs. The rules here are both complex and very state specific and also subject to change at any time by the state/ federal legislature or courts. Changes in the law could instantly render your plan obsolete, so this serves as a powerful argument to opt for simplicity and tradition when developing a plan with your counselor. There are plenty of unethical folks who will play on your fears of losing everything and sell you a pricey plan involving overseas trusts that is too complicated for your needs and merely substitutes one set of risks for another. In addition, your state-of-the-art cutting edge plan may be found to be illegal or ineffective in the next session of Congress. Seeking wise and experienced counsel who can devise and monitor your plan is a must.

Ask your senior colleagues for suggestions for an attorney who knows this area of the law and who will provide you with the pros and cons of your various options. The State Bar Association in your state may also provide some suggestions for attorneys in your area that claim a special interest in asset protection. Interviewing several may be worthwhile since this will be a long-term relationship between you and the firm.

4. Fully Fund your IRA and Retirement Plans

Determine which IRA and retirement plans you qualify for and fund them to the full extent allowed by law (and your pocket book). The benefits of compounding and dividend reinvestment are maximized when such plans are started as early as possible. This is true not just from an income tax and investment perspective, but because the asset protection benefits are also significant. While the specific rules, limits, and types of asset protection qualifying retirement plans may vary from state to state, as a general rule, assets in retirement plans provide a huge benefit in protecting your nest egg. Learn about the specific retirement plans and amounts that your state will allow you to keep safely protected from most creditors.

5. Buy a Home and Build Up Equity

Homeowners have always been a favored class in the eyes of the legislatures of our country, and this favored status frequently extends into the asset protection field. While the specifics, in terms of the monetary amount and the type of dwelling, will vary with each state; the majority of states provide some protection for homeowners from creditors. States such as Texas and Florida are well known for providing great protection for a primary residence. These rules make a compelling case for building up equity in your home.

In certain states, such as Michigan, married homeowners are given especially favorable treatment (tenancy by the entirety). Find out what special protections your state gives to homeowners who are in debt in an effort to keep them in their home. Be aware, though, that such protections from unsecured creditors will not protect your home if you are behind on your mortgage or a home equity loan.

6. Fund Your Child's Education Early

If you are able to take advantage of your state's program to fund your children's college, start saving the day they are born. The earlier the better! Learn about the 529 plans available in your state. Do it before you become a defendant. No one can take what you have already spent (in this case saved—for the worthy cause of college).

7. Learn About Trusts

After you take advantage of the simple steps that your state provides for asset protection, you may be in a position to look at more sophisticated options such as trusts. While they are a powerful asset protection tool, trusts do come with expenses and some complications. Trusts are especially useful if you have minor children. They provide some degree of financial security to your children if something unpleasant happens to you. Seek an attorney who will educate you about the risks and benefits and avoid anyone who pressures you to buy an elaborate plan that you do not need.

8. Look at Annuities

Annuities are not an ideal vehicle for most investors because of their fees and restrictions. However, many states do provide some asset protection for annuities. The specific level of protection will vary from state to state, and this option may be worth exploring depending upon the state in which you live. If you want this option, look for a very low cost annuity from a well respected provider.

9. Obtain an Umbrella Policy

While an umbrella insurance policy will generally not help you with a medical malpractice case, having umbrella insurance will provide substantial protection at a minimal cost in case of a bad outcome in many other types of civil suits (such as a motor vehicle accident or someone getting hurt on your property). Discuss this with your insurance agent. If you are worried that people hear the word “doctor” and assume you have deep pockets and a target on your back, this may help you sleep at night.

10. Don't Put All Your Eggs in One Basket

To reduce your risk from a civil lawsuit, do not increase other risks that make your investments vulnerable. For example, if you are married, do not put all your assets in one spouse's name. In our society, the likelihood of marital dissolution is at least as likely as a huge malpractice verdict exceeding policy limits. Each family member should have some assets. Do not put all your assets in some complicated expensive overseas trust that was promoted as making you “judgment proof.”

Prepare now to reduce litigation stress in the future. If you are lucky and wise enough to live below your means, and able to build up a nest egg, there are legal steps that each state provides to protect your assets from creditors. Learn about the specific options in your state and start by taking advantage of the low risk, simple, traditional, and inexpensive options first. If they match your overall financial goals and provide some asset protection, then you have an ideal plan. Discuss this topic with your family, your attorney, and your accountant, and it will greatly reduce your stress should you become a defendant.

Step VII: 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 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 low cost index funds in stocks and bonds.

The vast majority of investors will be well served by the following guidelines: keep it simple, stick with very low cost index funds or Exchange Traded Funds (ETFs) from large discount brokerage firms and 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 and the bond market and mix in a little international exposure. The exact mix will vary by age and your risk tolerance. Adjust your asset allocation yearly. Don't try to time the market. 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 this type of investment plan is the wisest course for most investors.

One way to think of asset allocation is to put your assets in appropriate “buckets,” depending on when you will need to use them. One bucket is for short-term requirements like mortgage and car payments or a college tuition payment due in three months; one bucket is for the medium term (5-10 years); and one bucket is for the long term (10-30 years) for things like retirement.

Your short-term bucket should contain no-risk assets like savings accounts, certificates of deposit, and money market funds, which guarantee the return of your principal. The medium term should contain low-risk assets like bonds and ETFs of dividend-paying stocks that offer some potential to earn income. The long term can include riskier assets like ETFs of small-capitalization stocks and growth stocks. It seems counter-intuitive, but longer time horizons allow those portfolios to tolerate more volatility and thus achieve more growth, which you will need to counter inflation.

The investment business has more than its share of 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.

Conclusion

Working in the emergency department is challenging enough without adding the stress of financial worries. If your financial house is in order and you are building your nest egg so you achieve your lifetime financial goals, you will more easily focus on your patients at work and be able to fully enjoy 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.

Resources

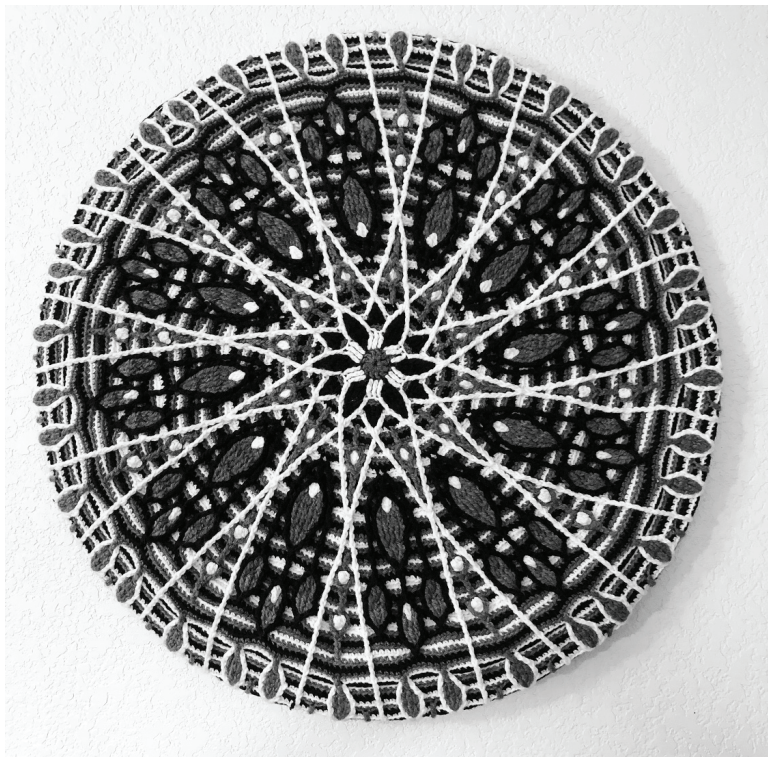
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Centered

Diana Trumble, MD

“I use crochet and fiber art as a therapeutic and artistic outlet. It helped me get through medical school, and though I don't have as much time nowadays in residency, a few minutes each day of my favorite hobby help to remind me that I'm a whole person outside of medicine.”

What to know about Food, Fitness, and Physical Health

By Christina Miller, MD, Marc L. Pollack, MD, PhD, Frani S. Pollack, MS, MSW, RD and Aaron Thomas, MD

Busy shift. Didn't exercise or eat before coming to work and didn't have time to pack a lunch. Even if there was time, there isn't anything in the kitchen to pack anyways. No time to go to the cafeteria now. YASS! Someone brought donuts and the vending machine has Mountain Dew®. That'll do the trick!

Optimizing physical and mental health is a key strategy to increasing emergency physician career satisfaction and longevity. As an added benefit, by doing so we serve as role models for our emergency medicine trainees, students, colleagues, and our patients.

Health and wellbeing 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 the self-care of physical health. The upside, getting and staying physically healthy, does not have to be boring, inconvenient, and time-consuming.

Taking time to optimize one's physical health is essential 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 career in emergency medicine.

You Are Definitely What You Eat.

Although we are concerned with longevity and aging well, 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 improved mood. As the performance of an athlete can be enhanced with proper nutrition, the energy, stamina, and mental clarity of an emergency physician, who works demanding shifts on a regular basis, can also be improved with good nutritional choices.

What To 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 may become.

In some market surveys there has been a trend toward increased consumption of long-life foods, junk foods, and frozen foods with a reduction in fresh fruits and vegetables during lockdown periods. Lockdown periods? While this wouldn't apply to most people in the past, Covid has changed the norm to include lockdown periods being a common occurrence.

The World Health Organization (WHO) announced updated dietary guidelines during the COVID-19 outbreak with emphasis on a balanced diet to maintain a strong immune system and to avoid or minimize chronic diseases and infections.

Current dietary guideline recommendations include consuming 4 servings of fruits/day and 5 servings of vegetables/day, making a total of 9 servings/day. Add this to a combination of whole grain cereals (180g) and a variety of meats and beans (160g) to optimize the nutritional requirements during any pandemic. A healthy balanced diet will also ensure adequate intake of micronutrients like vitamin A, C, and D, as well as Zinc and Selenium which are essential for immune function.

Healthy U.S.-Style Eating Pattern at the 2,000-Calorie Level, With Daily or Weekly Amounts From Food Groups, Subgroups, & Components

Food Group ^a	Amount ^b in the 2,000-Calorie-Level Pattern
Vegetables	2½ c-eq/day
Dark Green	1½ c-eq/wk
Red & Orange	5½ c-eq/wk
Legumes (Beans & Peas)	1½ c-eq/wk
Starchy	5 c-eq/wk
Other	4 c-eq/wk
Fruits	2 c-eq/day
Grains	6 oz-eq/day
Whole Grains	≥ 3 oz-eq/day
Refined Grains	≤ 3 oz-eq/day
Dairy	3 c-eq/day
Protein Foods	5½ oz-eq/day
Seafood	8 oz-eq/wk
Meats, Poultry, Eggs	26 oz-eq/wk
Nuts, Seeds, Soy Products	5 oz-eq/wk
Oils	27 g/day
Limit on Calories for Other Uses (% of Calories)^c	270 kcal/day (14%)

How Much to Eat and Drink

The most recent USDA recommendations for dietary intake and physical activity have transitioned toward a cup- and ounce-equivalent unit which takes into account that food forms are not created equal. Some foods are more airy or contain more water and thus have varying nutritional values. While still recommending a 2000 calorie diet for most Americans, the following recommendations and figures are good general rules to follow when constructing a balanced diet.

The USDA released 2020-2025 adult dietary guidelines that recommend the following:

- Consume less than 10 percent of calories per day from added sugars.
- Consume less than 10 percent of calories per day from saturated fats.
- Consume less than 2,300 milligrams (mg) per day of sodium.
- If alcohol is consumed, it should be consumed in moderation—up to one drink equivalent per day (not an average) for nonpregnant women and up to two drinks per day for men—and only by adults of legal drinking age.
- Though it varies by person and medical condition, the average adult should drink about 44 ounces/day.



Practical Tips for the Emergency Physician

Working in the emergency department is often busy and stressful, lending itself to quick meals (if at all), fast foods, and readily available sweets in the break room. Here are some practical tips for healthy eating.

- 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.
 - This does require shopping and food preparation time. But it's worth every minute.
 - Food prep can be done on days off with leftovers (frozen or refrigerated).
- Try 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.

- Try to avoid sugary foods on shift.
- Try not to order out, but if you must, eat sensibly.
- 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, kale, 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

ED shifts are physically and mentally demanding, and evidence suggests that emergency physicians become dehydrated by the end of their shift. Dehydration can definitely impact clinical performance and patient safety. Emergency physicians must have adequate fluid and food intake to ensure that patients at the end of their shift receive the same clinical judgment as patients at the beginning of their shift. ACEP has worked with The Joint Commission to clarify that emergency staff can eat at an ED workstation during their shifts.

The complicating factor during the corona virus pandemic has been the impact of COVID-19 on workplace precautions. In fact, some facilities have closed food bar serving systems. There must be strategies for the emergency physician to remain hydrated and fueled. Precautions should be taken to remain safe in the workplace. Below are suggestions that have been utilized:

- Wipe down table or surface before and after eating.
- Do not share food, beverages, or utensils.
- Maintain social distance >6 feet when eating or drinking.
- Monitor food service workers for symptoms.

Physical Fitness Leads to Total Fitness

A busy shift can be both physically and emotionally exhausting, requiring a high degree of mental and physical fitness to be successful. These demands may be more noticeable as we age and during times of personal stress or illness. Careful attention to a nutrient-dense diet with plenty of nonalcoholic fluids is key. Maximal health and wellbeing require physical fitness, relaxation and relieving stress, quality sleep, and involvement with family and friends in the community. Addressing all these areas increases your potential to achieve “total” fitness and wellbeing.

Physical fitness, including planned and regular exercise, can be adapted to any lifestyle, and helps prepare you for a busy shift. We all want to look and feel better and maintain an appropriate weight. Physical fitness decreases fatigue, and has been shown to improve symptoms of depression, anxiety, and improve self-esteem.

Getting Started and Staying the Course

Remember that any and all physical activity is helpful, although more strenuous activity does have its benefits. The first step is to engage in exercise that feels right and is enjoyable. It can be any program that is compatible with your physical abilities, is easily accessible, gets you moving, and can be done regularly. Make a list of all physical activities you enjoy, such as walking the dog or throwing a Frisbee. If your form of exercise doesn't motivate you, then try something else.

Schedule exercise time as a required event, not an optional activity. Block your calendar like an ED shift or meeting. Commit yourself to at least 30 minutes per day. Exercising when you first wake up is often convenient and prevents daily events from interfering. 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. High Intensity Interval Training (HIIT) may also be an option that require a lot of time. Many emergency physicians find exercising after a shift an excellent way to wind down and rejuvenate. Keep in mind not to exercise within 1 to 2 hours of bedtime, which might cause unwanted alertness and prevent an easy transition to sleep.

Engage a buddy to work out. This will hold you accountable and increase your likelihood of success.

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/equipment, workout clothes etc.

Location, Location, Location

With the public health crisis associated with COVID-19, many gyms and group exercise programs have either closed or altered their operations. There has been a re-direction to virtual and home-based exercise systems. Numerous companies have offered free use of platforms to direct workout routines from the comfort of your home. Many can be accessed through YouTube or simply by doing an internet search. Even the World Health Organization (WHO) has issued guidance with several at home exercises and programs.

Aerobic Exercise

Regular aerobic exercise will enhance your cardiovascular and respiratory fitness. According to the USDA, adults need at least 150 minutes of moderate intensity physical activity per week. This amount 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 a day.

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.

Target Heart Rate

What is your target heart rate? 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.

*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 consult with your cardiology buddy). You know how exercise-induced chest pain or cardiac injuries can adversely affect you.

*Remember that aerobic exercise raises your metabolic rate for several hours after exercise, which can make falling asleep difficult.

Resistance Training

Resistance training is another aspect of a personal fitness plan. Lifting weights, pulling on bands, or using your own body 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. This will increase your overall metabolic rate and 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. 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 join a class near you or participate virtually.

Flexibility and Balance

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 in conjunction with yoga or other exercise programs. Stretching in a group setting or solo at home with a DVD or YouTube video are all options for busy emergency physicians. Proper technique is essential to prevent injuries. An excellent book on stretching by Robert Anderson is listed at the end of this chapter.

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 twenty years ago. Aging is inevitable and it certainly beats the alternative!

The emergency physician is required to suture, auscultate, reduce dislocations, and perform other procedures that may become more difficult as we age. Minor abnormalities, such as the ability to ambulate, sit, or stand can have a significant impact of the ability to practice emergency medicine. Alterations in vision and hearing, as well as cognitive changes, will have a profound effect on the ability to practice medicine and are the most difficult to cope with for the practicing emergency physician.

We can optimize, postpone, and avoid many of the negative aspects of aging by paying attention to our physical health now. 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, 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 limitations and retirement must be part of every emergency physician's long-term plan.

Lastly, rotating shifts become much more difficult after the age of 40 and are the leading cause of older emergency physicians leaving clinical practice. Adjusting routines may become necessary for physicians to continue to practice as they age. Most groups have provisions for this, e.g., trading off nights for weekend shifts, no nights for less salary, no

night shifts after a certain age, or other alternatives. Junior faculty may not believe this will be applicable to them, but assuredly aging will occur and all emergency physicians will eventually be in this category.

Summing It Up

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.

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

We owe it to our patients, our partners, and especially ourselves, to take the best care of ourselves. The choice is ours, and the decision starts with us.

Resources

Diet

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3. www.ChooseMyPlate.gov
4. Home | dietary guidelines for Americans. (n.d.). https://www.dietaryguidelines.gov/sites/default/files/2020-12/Dietary_Guidelines_for_Americans_2020-2025.pdf
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2. <https://www.acepnow.com/article/the-joint-commission-clarifies-that-physicians-can-eat-and-drink-in-ed-workspaces/>
3. <https://www.shrm.org/resourcesandtools/hr-topics/employee-relations/pages/coronavirus-taking-precautions-with-food-at-work.aspx>
4. <https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/publications-and-technical-guidance/noncommunicable-diseases/stay-physically-active-during-self-quarantine>

Trainer Tips

1. <http://ow.ly/WhsFR>. “Exercise is a lifestyle, strength=self-sufficiency.”
2. 10 things you communicate to your daughters by working out. <http://ow.ly/Whthe>.
3. Boost your immune system—work out! Regular exercise strengthens the immune system and helps fend off illness. <http://ow.ly/Whupm>.
4. Regular exercise keeps your brain as well as your body young and nimble. Aerobic fitness improves cognitive functioning. <http://ow.ly/WhuFJ>.
5. Will run for beer? Exercise and alcohol consumption appear to be linked. <http://ow.ly/Whv1T>
6. Being “mindful” and “present” during exercise helps increase satisfaction and compliance. <http://ow.ly/WhvKW>.
7. Pressed for time? Try the Scientific 7-Minute Workout and Advanced 7-Minute Workout. <http://ow.ly/WhwCW>, <http://ow.ly/WhwR4>
8. 9 Totally Free At-Home Workouts for When Coronavirus is Keeping You Inside. <https://www.health.com/fitness/coronavirus-at-home-workout>



Winter Hike

Shivam Shah, MD

“As a child, I watched Bob Ross on TV on the weekends with my father. After a 16 year painting hiatus, I began painting again and discussed art with my father. Now, we routinely send each other landscapes and discuss future paintings. During the COVID pandemic, I’ve found a great hobby and another connection with my family. This also contributes to my wellness as painting is a peaceful process.”

Emergency Medicine & Sleep: Are They Compatible?

By Thomas Benzoni, DO and Jennifer Robertson, MD

To start, let's look at your current situation. Answer the following three questions, choosing 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 p.m. 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 p.m. 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 a.m. 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 can always use more “night people.”

If you answered mostly Bs, Cs, and Ds, read on. Unfortunately, most of us must work night and rotating shifts, which can be difficult on both the mind and body. However, there may be some solutions, so read on!

Circadian Rhythms

To understand and mitigate sleep cycle problems, it's important to first have a basic knowledge of intrinsic rhythms. 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-chiasmatic nucleus of the hypothalamus) and an exogenous component. The exogenous component comprises various time or environmental cues called zeitgebers.

One of the most powerful zeitgebers is the light/dark cycle.

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 orientation (work during the day, sleep at night) have a peak temperature at about 4 p.m. and a trough at about 4 a.m. 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 we don'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. It is unknown why this occurs but 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 you adapt 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.

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.

It is also notable that the current stress induced by the COVID-19 pandemic has been shown to impact sleep patterns across most occupations, although health care workers seem to be relatively spared by this impact. One recent study noted that there has been a tendency toward later bedtime and wake time with an increase in daytime napping. While most health care workers have continued to work through the pandemic, there is perhaps a social and home-life balance that has the potential to impact sleep patterns. Some research is ongoing to develop strategies for improving poor sleep during lockdown.

Physiology

Sleep is divided into several stages based on 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 between individuals 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 the 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, 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 you, 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 wellbeing 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.

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 are attributable to falling asleep behind the wheel each year. 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.

Multiple studies have shown that night shifts are hard on the body in many ways. In fact, there is a known disorder called shift work sleep disorder (SWSD), which is common in people who work nontraditional work hours. It is defined as difficulty sleeping and excessive sleepiness due to a non-circadian-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.

Shift Work Disorder Criteria

1. Significant insomnia or excessive sleepiness that interferes with functioning and is associated with a work schedule that overlaps the usual sleep period.
2. Symptoms must be associated with a shift work schedule over the course of at least 1 month.
3. Misalignment between the body clock and environmental clock manifested by loss of a normal sleep-wake pattern has been documented by a sleep log or diary, and laboratory or sleep recordings.
4. Sleep disturbance is not explained by another sleep disorder; a medical, neurological or psychiatric disorder; medication use; or substance abuse disorder.

**Adapted from the ICSD-2 Diagnostic Criteria*

Even without SWSD, nights and rotating shifts can negatively affect both body and mind acutely and chronically. A 32-year-old female physician comments 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. This would be a negative acute effect of night shift work.

In the long term, studies suggest that people who work nights are at an increased risk of developing breast cancer, metabolic syndrome, and type 2 diabetes. The good news is there are ways to combat the evils of night shifts. Below are a few suggestions. It should also be mentioned that while there are no known actual treatments to prevent these diseases, it is thought that maintaining a healthy lifestyle that includes a proper diet and regular exercise may go a long way toward preventing chronic disease.

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

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 and sleeping in dark and silence (leave the smartphone outside!) will permit 6 hours of solid rest.

Our bodies want to sleep when it is dark. Create a dark, quiet place for daytime sleeping. Room design is a special area. Best is a below-ground bunker that's 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 nonstarter is a regular bedroom in the busy center of an active house.

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 blackout goggles on his way home from work to avoid seeing the bright sun and throwing off his sleep cycle. (To paint a picture, this is a 6'5" man riding the subway home during morning rush hour in a hooded sweatshirt and black, metal goggles.) You can wear sunglasses home instead of blackout goggles.

3. Split sleep sleeping

There are also individual sleeping strategies that can be used. A split sleep period is a technique involving sleeping for 3-4 hours immediately before and 3-4 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. You stay up until 3 or 4 a.m. and then sleep until 10 or 11 a.m. That way, you get some time to socialize but don't completely lose a nocturnal orientation. Naps are problematic. 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.

4. Exercise

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 you're working, is most effective. Exercising within 2 hours of intended sleep time delays the onset of sleep, likely through activation of adrenergic mechanisms.

5. Blue light

It has been shown that the short-wavelength blue component of the visible light spectrum can alter the circadian rhythm and suppress the level of melatonin. The short-wavelength light emitted by smartphones can affect the sleep quality of those who use these devices at night through the suppression of this hormone. Several studies have shown potential positive impact on sleep quality using lenses that block blue light, although more research is still ongoing.

6. Medications

Pharmacology may be considered. 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. 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. Bright light of greater than 3,000 lux can also hasten resetting of circadian rhythms. 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 a.m. to 7 a.m.) can hasten adaptation back to days by phase advancing 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.

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.

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 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. Ramelteon, a selective melatonin receptor agonist, has proved to be a useful long-term hypnotic agent, although its use for daytime sleep is untested.

7. Schedule

A schedule that bounces from day to night and then night to day without a second to breathe is going to be hard for anyone. Emergency medicine shifts run 24/7/365, across 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 when we work rotating shifts.

The adverse effect of constantly rotating shifts is the single most important reason given for premature attrition from the specialty. As previously mentioned, there are many biological and social problems associated with rotating shifts. Additional physical problems include:

- Increased stress-related peptic ulcer disease (8 times greater than the general population)
- Increased cardiovascular mortality
- 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 (eg, Exxon Valdez oil spill, Three Mile Island, Bhopal chemical plant explosion, Chernobyl) occurred on the night shift when alertness is at its lowest point.

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. Therefore, there should be other solutions to help, including incentives for working night shifts and help for those with medical conditions. It is possible that some people just can't do night shifts. One emergency medicine program just implemented a policy where employees do not have to do nights in the third trimester of their pregnancy. Many emergency departments 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 a.m. 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 a.m. to 5 p.m. 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.

Scheduling Strategies

What can be done?

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. You may also want to consider, if possible, finding ways to make your rotating shifts work as best you can for you. Some studies have found that a forward rotating schedule may be superior to a backward rotating schedule in terms of sleep duration and sleepiness. However, not every study has shown this to be the case. Slowly rotating shift changes (several weeks versus several days) and more time off before starting a new shift schedule, even with backward rotations, may be more compatible with maintaining sleep and wellness. Ultimately, however, it is what works best for you.

What about the department?

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 members 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 6 a.m. to 8 a.m. 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 when 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 three 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. 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: 4-6 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 10-11 months of the year when they will only work an occasional night, on the night person's shift off. It is important for those working long strings of nights to stay up even on their nights off so they don't lose their hard-won night orientation. Whether this reorientation 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 a.m. 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. 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 shorten 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 2-3 hours of 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.

Other scheduling strategies for groups to consider are to change shifts at different times. Some groups start at 4 a.m., 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 4 a.m. is tough, noon is busy, 8 p.m. 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.

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 (eg, Stanford) looking at other values.

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. The American College of Emergency Physicians 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.
- Schedules for night shift workers 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 emergency department 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 wellbeing 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.

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Christmas in Manhattan Beach

Andrew Thorne, MD

“Take a moment to step aside from the bustle, the traffic, the smog, and it’s easy to see why my home is known as the city of angels.”

How to Never have a Bad Shift: Focus on What You can Control

By Christina Shenvi, MD, PhD

I was walking into a night shift and found myself wondering if it would be a good shift or a bad shift. In emergency medicine myriad factors outside our control contribute to a “good shift.” It can’t be too busy, but also not too “q-word.” The staff and residents should be fun and friendly while getting work done efficiently and effectively. The shift should be filled with interesting, high acuity patients, but not so many that things become unmanageable. Patients should be appreciative and well wishing. And I should feel like I made a difference.

We all know what “bad” shifts are. I started thinking about the boarders, the intoxicated and violent patients, the consultant with chastising comments, and the few staff who always poisoned the night. My outlook and my mood started to change to a negative one.

At this point, I realized my thinking needed to change. I sought to figure out how I could make the shift a good one even before I clocked in. The philosopher William James famously said: “I don’t sing because I’m happy, I’m happy because I sing.” I needed to learn to sing.

To understand how to create good shifts irrespective of the external factors, turn to the ancient philosophy of Stoicism. One of the core tenets of Stoic philosophy is to obtain eudemonia, the state of human flourishing, -- focus on what is within our control. Epictetus, an important Stoic philosopher born two-thousand years ago, said: “Happiness and freedom begin with a clear understanding of one principle: Some things are within our control, and some things are not. It is only after you have faced up to this fundamental rule and learned to distinguish between what you can and can’t control that inner tranquility and outer effectiveness become possible.”

Inner tranquility and outer effectiveness are desirable traits for any busy emergency physician and will certainly bring us at least halfway to having a good shift every day.

Too often, we focus our efforts on trying to control things that are outside our control while paradoxically relinquishing control of things that are within our control---something we all may do during our shifts. Things that are in our control, per the Stoics, are our own thoughts, emotions, and actions. We relinquish control of them by allowing our emotions to be affected excessively by external things. “That person said something that made me upset,” or “I’m angry because I couldn’t get the imaging study I needed.” We allow external factors to control the very few things that are actually within our control.

On the other hand, we try to control things that are squarely outside our circle of control, such as other people’s actions or opinions, politics, coronavirus, or even the weather. We try to control them in our minds by resisting their presence, continuously trying to wish them away, or perseverating on the idea that they should be different.

To have the inner tranquility and outer effectiveness Epictetus encouraged, we must give up the fiction that we can control things outside ourselves and maintain better control of ourselves.

Here are three practical steps harvested from the core of Stoic philosophy:

1. Maintain agency or ownership over what you can control.

Agency means taking rather than relegating responsibility for your thoughts and emotions. You can also think of agency as power. In a fascinating series of studies on power, Galinsky and his colleagues found that if you prime individuals to feel powerful, they will show greater “executive functioning, optimism, creativity, authenticity, and ability to self-regulate and perform in various domains.” When you give up control of your own thoughts and feelings, you are giving up your own power and succumbing to learned helplessness. As the most famous Stoic, Seneca, said: “He is most powerful who has power over himself.” By claiming ownership over your own thoughts and feelings, you are accepting that whether you have a good shift or not might be up to you, not only external factors.

2. Aim to even out your standard deviation and raise your mean.

Imagine a graph of your personal shift quality vs time. There would be variations day to day, and they would average out around a horizontal mean. Some shifts are truly heartbreaking: when we take care of a dying child or break the news of cancer to a young mother. Others are fantastic when a life is saved, or we bring good news that the chest pain is not a heart attack. Most shifts, however, fall within three standard deviations of our mean. Half of our shifts will always be below our own average. By choosing to make each shift a ‘good’ one does not mean we are artificially trying to like the terrible shifts. Instead, it means smoothing out the variation, and raising the mean itself.

3. Change your own mind.

Shifts are difficult. They often consist of an eight, ten, or twelve-hour exercise in tolerating a continuous stream of small frustrations, insults, barriers, and setbacks. The Stoics have many provocative things to say about enduring hardships.

Seneca said: “To bear trials with a calm mind robs misfortune of its strength and burden.” This quote may have been some of the inspiration for Voltaire, who wrote: “Life is thickly sown with thorns, and I know no other remedy than to pass quickly through them. The longer we dwell on our misfortunes, the greater is their power to harm us.”

We all work within an imperfect healthcare system, which we feel powerless to change. Victor Frankl, the Austrian psychiatrist and holocaust survivor, wrote: “When we are no longer able to change a situation... we are challenged to change ourselves.” The only way to be able to decide to have a good shift is by changing our own minds.

We can strive to change our minds using the analytical process of Stoic meditation. This is very different from meditation that involves emptying the mind or focusing on the body. Instead, Stoic meditation consists of becoming actively aware of one’s thoughts, analyzing them, selecting the thoughts we wish to entertain, and rejecting futile thoughts.

At 2 am when we are unable to get a patient a ride back to her nursing facility, the thought “I should be able to get the patient home” is futile and leads only to frustration. The thought “this should have been fixed already” is useful only if it leads us to action to fix it. We have precious cognitive bandwidth, and we should not waste it on futility. Entertaining futile thoughts leads to a sense of learned helplessness that reduces our ability to think creatively and solve problems.

Perhaps the most shocking of Aurelius’ statements on enduring hardships is this: “If it’s endurable, then endure it. If it’s not endurable, then stop complaining.” The ED, the challenges of providing healthcare within a broken system, and patients in need of help will be here long after each of us. The Goal is to fix the system while we are enduring the challenges. But enduring the challenges must be finite.

Finally, Aurelius wrote that: “Our actions may be impeded... but there can be no impeding our intentions or dispositions, because we can accommodate and adapt. The impediment to action advances action.”

When we work to overcome a challenge, we gain the inner tranquility and outer effectiveness that were the things we needed most in the first place. By managing our minds, we can repurpose obstacles into opportunities to build strength.

Here is your challenge: Maintain ownership over the things you can control. Raise your mean and decide to have a good shift under most circumstances. Choose your thoughts intentionally. Then, rather than flailing in the thornbushes of frustration and futility, gain the mental power to not have a bad shift.

Now, when I walk through those sliding doors, I sing, and I am happy.

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Obtainable

Diana Halloran, MD

“I painted this while in quarantine before my medical school graduation and it acted as a way to process all of the conflicting emotions that were in my life at that moment. In addition, I felt this piece was a representation of all of the goals I had that for so long had seemed intangible and unobtainable but now were finally right in front of me.”

Being Stoic When it Counts

By Dan Dworkis, MD, PhD and Andrea Austin, MD

By the time the patient arrives in your ED, he is barely breathing and covered in blood. The paramedics tell you he was crossing a street when a car ran a stop sign, sending him flying off the road. His breathing is shallow and ragged, he's tachycardic and hypotensive. How you and your team perform in the next few minutes might well determine his fate.

For most of our medical education, we're taught that learning more medical facts from textbooks and journals will make us better, but at some point, we know the medicine and that's not enough. Applying medical knowledge under pressure is what we do as emergency physicians, but we are humans, not robots and some days the stability, fearlessness, and fortitude we need comes easier than others. What can we do to build this calm from the inside out, to become the type of emergency physician we want to be?

One unexpectedly powerful source of training we can leverage is Stoic philosophy. The Stoics — Greco-Roman philosophers like the Roman emperor Marcus Aurelius, the writer and statesman Seneca, and the former slave Epictetus — lived a way of life that centered on finding joy and strength by acting from within, accepting the transience of existence, and letting those things outside our control do what they will.

We don't usually teach stoic philosophy in medical school, but maybe we should. As emergency physicians, we need to learn it. The core tenets of Stoicism — understanding personal responsibility during hard circumstances, fearless action in the face of uncertainty, and finding joy from within — are indispensable during a crisis.

Here are four stoic ideas that can transform your approach to the most stressful situations.

"The closer a [person] is to calm, the closer [he or she] is to strength." — Marcus Aurelius

There's a French word *sangfroid* that translates literally to cold-blooded. What it really means is the ability to stay calm in the face of chaos; to hold fast and stay cool when everything around you is going off the rails.

At first glance, it might seem that *sangfroid* is some innate gift, that some people are simply born with the ability to keep their wits about them and some are not. The idea of trying to save this man who was hit by a car might seem difficult or even completely overwhelming when you are just starting out. It would be easy for someone to conclude that being calm in these types of situations is not in their skill set.

Sangfroid is not an innate gift. Instead, it is a skill that each of us can learn and, with time and practice, to master. Notice that Marcus Aurelius does not say that calm is strength. He says that there is a gradient; the closer we are to calm, the more benefit we find. So, start small and get moving. When you are confronted by something in your daily life that makes you uncomfortable or uncertain — perhaps a critically ill neonate arrives in your ED—pause and take a breath, reflecting on calmness as a deep source of your strength.

If you don't already have a calming technique that works for you, consider trying "tactical breathing," which is designed to slow your heart and help you calm your mind. The basic idea of tactical breathing — also called "box breathing" — is to visualize a square, where each side of the square is one part of the breath. The length of each side corresponds to the amount of time each breath or exhalation takes, and as you breathe, you mentally move yourself along the edges of the square. Try incorporating tactical breathing into your set-up for a critical procedure, such as intubation or a central line.

"Between the earth and the stars, there is no easy path." — Seneca

There is nothing easy about our jobs as emergency physicians. There is nothing stress-free about our patient struck by a car, nothing simple about the work we will do to try to stabilize him. It is, however, easy to be upset about this, to be angry at the driver, to wish our ED was better equipped for serious trauma, to want things to be different than they actually are.

If we want to respond more effectively during our shifts and elsewhere in our lives, we must expect and train for hardship. Rather than devote energy to looking for an easy path that rarely exists, this second Stoic quote reminds us to prepare ourselves for hard work and to steel ourselves for the difficult things that are going to come our way.

The Stoics might call this *premeditatio malorum*, the act of purposefully thinking through the absolute worst situation one might encounter to better prepare for the worst case scenario.

In the ED, we often perform a version of *premeditatio malorum* by mentally "walking through" a critical procedure before performing it. In doing so, we potentially visualize a complication and realize that the piece of backup equipment we need to manage that complication is not in the room. Having identified this issue ahead of time, we can pause before the procedure and ensure the equipment is available if needed.

Like all forms of visualization, *premeditatio malorum* takes practice, but no matter what you visualize, you will be identifying areas for improvement in your training and mindset and build better support systems for tough times.

"Do not trip over what is behind you." — Seneca

Things will go wrong during an emergency. Equipment will malfunction, IV lines will blow, the patient will have an allergy no one expected. We will make mistakes putting in a critical access line, misinterpret an X-ray, or call out the wrong drug dose. When the situation is suboptimal during a crisis, we face a fundamental choice: either we are swept away by whatever happened, or we hold fast to our mission and figure out a way to take the next step forward.

Unquestionably, our best response during an emergency comes when we stay focused on the reality at hand and avoid being diverted by anger or frustration at things outside our control. This is not easy, especially when the consequences of an event might end in the loss of life or limb. Staying focused forward is necessary: If we trip over something behind us, we will struggle to take care of the next patient — someone who absolutely needs us to be at our best.

It is important to emphasize that this quote is not suggesting we ignore bad outcomes or pretend everything is coming up roses all the time! The Stoics would be the first to say that bad things do happen and it is up to us how we respond to them. We absolutely need to process and learn from mistakes and terrible outcomes, but we do not need to trip over them by wasting energy being angry or hurt.

Reacting to a crisis going wrong has two parts to it: First, don't make it worse and, second, process it productively. Imagine you're about to intubate a patient with a very difficult airway. Fortunately, you get a great view with the video laryngoscope, and then the nurse trips over the video stand, and you lose your view. It is easy to be upset in this moment, but it's wasted energy-- energy you need to channel to get the patient safely intubated.

“As long as you live, keep learning how to live.” — Seneca

At the end of a long shift, I often ask myself if I made the world a better place today. I spend a moment or two thinking about it before I move on to the main question: How am I going to do better tomorrow? At home or work, difficult times and emergencies will continue to come our way, so our training and self-improvement must continue.

Bad shift? Keep training. Good shift? Keep training.

I love this final Stoic quote because it reminds us that we are never finished evolving. As long as we are alive, we are students of life, and our job is to keep learning and practicing how to live. There is a deep joy in the idea of consciously choosing to be a student of your own life. With this decision, training to bring the absolute best possible version of ourselves to bear during an emergency becomes more than a part of our jobs — it is part of who we are. We keep training because we believe that we need to be better--- that there will be people who need us to be top notch during a crisis.

We cannot save everyone who comes into the ED any more than we can catch every single wave at the beach. If we demand this unobtainable perfection, we divert energy from the people and situations who need us. We also risk burnout, a particularly serious and prevalent problem among emergency physicians

So, let it go.

Let go of the idea that you can achieve perfection during a crisis. Let go of the idea that your training will be complete, and just keep training.

There is no right or wrong way to do this. Some people keep journals where they write down lessons learned from every emergency. Others form groups where they talk through what happened in minute detail and try to identify areas for experimentation and improvement. However you choose to start, each day strive to do the best you possibly can with what you have, and work to make improvements for tomorrow.

There is no shortage of difficult situations in which we can practice applying these four Stoic principles. In or out of the ED, friction and crisis are part of all our lives.

Thankfully, as Seneca said, “A gem cannot be polished without friction, nor a [person] perfected without trials.”

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Books on Stoicism, as recommended by Maggismo Pigliucci, Professor of Philosophy at the City College of New York

1. The Discourse of Epictetus by Epictetus
2. A Guide to the Good Life by William B. Irvine
3. Meditations by Marcus Aurelius
4. Letters on Ethics: To Lucilius by Seneca
5. A New Stoicism by Laurence Becker



The Fire Within

Jonathan Dangers, MD

“The reference for this painting was a trip to the mountains in Utah a few years back with my now fiancé. The light from an outdoor firepit lit the surrounding scene beautifully and created a great memory that I wanted to share through painting. I’m currently working on 2 more paintings inspired by the same trip.”

Art and the Emergency Physician

By Jeanette Hammerstein, MD

It creeps up on us all, and it may present differently for everyone. Perhaps you see it the day you snap at that new nurse, something your former self would never have done. Or maybe it comes home with you, and you notice after two packages of Girl Scout cookies that you don't seem to have any choices. Or yet again, you find that you prefer tuning out your spouse rather than tuning in. It presents its ugly face, and you don't like when it channels through you.

This insidious menace is “burnout,” “moral distress,” “mental fatigue,” “despair.” There are many names, and you can choose accordingly, but beware of this clandestine influence on our lives.

After all, we are human. And, particularly, it is this humanity that we must recognize, celebrate, and give voice to within ourselves. In doing so, we often can halt the erosion we encounter from working in the high-stress, high-demand specialty of emergency medicine. We wear our protective emotional armor when we care for our patients. We may not process the misery going on around us until we have downtime, and that is where the danger is. Comparable to the feelings soldiers have when fighting a war, we know that as soon as we stop doing, we will start feeling. Too often we want to drown out the feelings because in some ways, this seems easier.

Fortunately, learning is natural for us. We tune in via teleconferences, read journals, listen to podcasts, and study the newest medical news and research. Investing in our wellbeing should be as natural and important as investing in our medical knowledge. Art, in all forms, is one tool that every emergency physician can access and find beneficial.



“There is an artist hidden within every single one of us.” – Bob Ross



“Art enables us to lose ourselves and find ourselves at the same time.” – Thomas Merton

Art therapy has been used for years to help patients. What about physicians? Research clearly shows that integrating art into inpatient clinical settings helps in many ways: shorter hospital stays, reduced need for pain medication, and overall greater patient satisfaction. But evidence is still lacking on how healthcare professionals may profit.

Funded by the National Endowment for the Arts, the Colorado Resiliency Arts Labs (CORAL) is researching the effect of various art forms on critical care workers. CORAL will gauge the effect of four different 12-week exposures: writing, art, music, and dance. The expectation is that this creative exposure will have a positive impact on burnout and resilience. The proof is already there for medical students. A 2018 study in the *Journal of General Internal Medicine* showed that medical students who engaged in arts throughout their training had reduced levels of burnout. From ballroom dancing to literature immersion, multiple medical schools now integrate arts and humanities into the curriculum given the demonstrated benefits.

Some may balk, proclaiming, “I am not creative!” At our very core, emergency physicians possess a certain creativity to survive in our highly unpredictable environment. We are experts at thinking outside the box, masters of connecting the dots, and the “MacGyvers of Medicine”.

In terms of developing an “artist’s eye,” one could argue that physicians are already excellent observers. We are trained to scan for a smorgasbord of nuances in our first beside glance. However, working as a physician and an artist means utilizing a slightly different lens. And this lens may mean noticing and appreciating things that never occurred to you before.

For example, a painter physician may begin to see beyond the pursed-lipped COPD patient with an exacerbation and notice the way the light falls on the sheets and turns blue-violet in the fold, the gesture of a hand on a bedrail, or the way a reflection bends along the edge of a bedside stand. An “artist’s lens” means looking at light, shape, and color critically and finding beauty in the mundane.

What Will Your Artist’s Lens Show You?

The side effect of training your brain to see differently gives you the opportunity to appreciate what you are seeing in a new way. These few seconds of noticing as you work have an additive effect of providing joy in the unexpected. Sometimes, these small moments are just the pause needed for a mental boost or provide a small positive thought during a task.

Emergency physicians witness the unedited ugliness of life. Finding ways to enhance our experiences and translate this ugliness into a small silver lining can be a means to improved wellness. Creative expression in whatever venue chosen is a safe place to unfold emotions and explore.

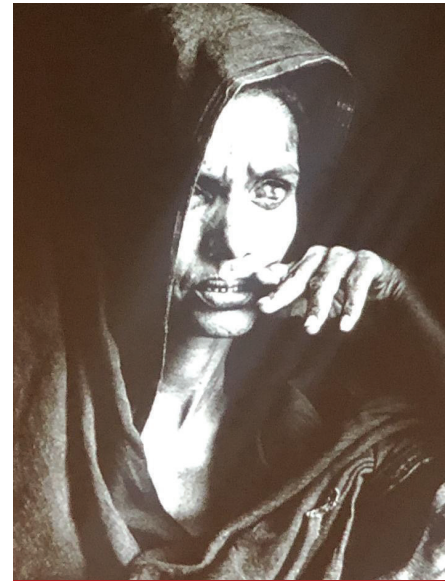
Having a space to do this is important. As physicians, we may feel silenced for a multitude of reasons: HIPAA, administrative oversight, or maintaining an idea of professionalism. Using the artist’s lens is a small tool to view the special in the mundane and experience a modicum of wellbeing.

Imagine if investing in yourself meant a happier you. What if an always available art-based creative outlet meant you could stave off burnout? Avoid bad habits? Connect better with your patients and family?

There are multiple ways to introduce the arts into your life more regularly:

- Wine and canvas event after the next department meeting
- Instituting a wellness officer to schedule protected-time opportunities (and not heap on additional activities that are a burden)
- Poetry night
- Storytelling for emergency physicians, similar to The Moth Hour on National Public Radio
- Open mic night
- Mini-narrative writing workshop where radical listening is introduced
- Provide a Buddha board for each emergency physician (relaxing painting on a surface with water)

At a minimum, you may have a good laugh trying something entirely new. But you may find that allowing yourself the time to explore is the secret to improved wellbeing.



“There is an artist hidden within every single one of us.” – Bob Ross

Resources

<https://medshcool.cuanschutz.edu/coral/research/critical-care>

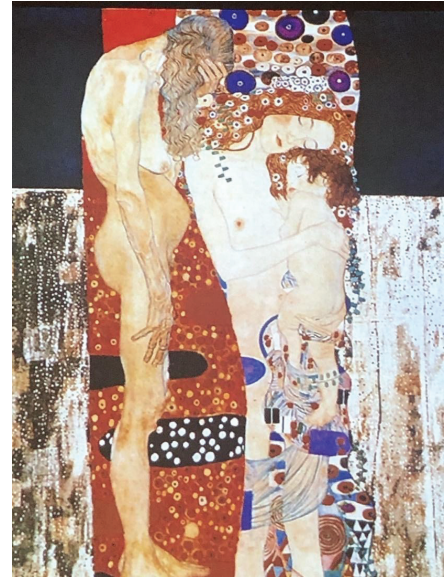
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Emergency Yoga for All Emergency Physicians

By Bryan Balentine, MD and Shawn Galin, PhD

The word yoga conjures up various mental images, from peaceful beach scenes with the setting sun to a game of twister—or anything in between. Whether you are a novice or a yogi, you can experience pleasure and be at peace with life through the ancient practice. Yoga is meant for all, emergency physicians included.

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. As emergency physicians, we are all keenly aware of the stresses of our profession, and I am not immune. What could be more relaxing than sitting around in a circle and chanting, “Ommmmm”? I needed a break from the 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 and then touch their toes without bumping into a neighbor. Alternating the stretches (Sun and Moon) next to your neighbor prevented “full contact” yoga. I chuckled. - Bryan Balentine

Two years later, I developed a deeper appreciation for yoga, better flexibility, and a greater ability to simply relax in most situations. Then, 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. At work, I am more aware of posture while sitting. 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 Wellbeing Committee. After discussing 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.

Developed thousands of years ago in ancient India, yoga is a mind and body practice, bringing those two entities in harmony, but today it is still as useful as ever. Yoga can be done on a mat to focus on building strength and increasing flexibility, but that wouldn't work in the emergency department. Instead, we will focus on the breath and maintaining mindful posture that you can use on every shift.

The Breath

Breathing is so portable and omnipresent. That said, this is where we can focus and find calmness, no matter the situation or the place.

As in life, proper breathing is very important in 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 helps the practitioner slow down their breath. An article in *The Wall Street Journal*, titled “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 explains 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, which slows down heart rate and digestion, suggesting the physiological response to stress can be altered simply by focusing on breathing. Taking long deep breaths with conscious observation of exhalation length promotes 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 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 beginner 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 a 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 your white coat weighs you down 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 Wellbeing Committee, the ever-apparent stresses of our profession take a toll on our wellness unless an appropriate and rejuvenating response is initiated. While I do not live in a constant zen state of mind at work, yoga allows me to relax more, provide better care to patients, and extend my longevity in medicine.

Yoga is meant for everyone. It's a journey for the mind and soul. Whether you learn from a friend, video, book, or podcast, just begin the journey. Try a few brief introductory sessions to yoga and meditation and carry this portable wellness tool with you to unplug.” And remember to take a deep breath.

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Garden City Sheen

Fardis Tavangary, MD

“My partner and I took a 3-week long post-residency (and fellowship for her) international trip through Singapore, Bali, and Thailand. For me, photography allows me to take a few extra seconds to appreciate the beauty of whatever it is I’m looking at. It’s been a creative outlet for me ever since I bought my first camera, a good ‘ole Canon Rebel T6, post 6 of the hardest weeks of my life studying for step 1. My art allows me to look back at fleeting moments in life and make them blissfully eternal.”

Maintaining Physician Health with Effective Leadership:

The Need for Chief Wellness Officers and Wellness Champions

By Jennifer Robertson, MD, Kristen Nordenholz, MD and Rita Manfredi, MD

Are you emotionally exhausted? Burned out? At your wit's end? Do you feel like never returning to a clinical shift? You are not alone. 3 in 10 healthcare workers have considered leaving medicine for good.

It is estimated that over 50% of physicians are burned out. Over 400 physicians die by suicide each year, a rate higher than that in the general population. Not only does poor physician wellness have a deleterious personal health impact but burned-out doctors commit more medical errors and have worse patient outcomes, which continues the downward spiral and contributes even more to burnout. This high rate of burnout in US physicians may be due to excessive physician fatigue and poor self-care. It is also a marker of dysfunction in the health care system itself: increased patient-care demands, compensation issues, growing bureaucracy and organization-patient conflicts are all threats to physician wellness.

So the question is: Do we need to help the individual, fix the system, or address both?

Individual wellness programs AND wellness officers are BOTH necessary. Our dysfunctional healthcare system has contributed to physician burn out and disengagement. This is not reparable with unlimited exercise, healthy nutrition, yoga programs or creative wellness initiatives. Rather, the only solution is to fix the ailing healthcare system itself and create sustainable careers in medicine.

Individual and System Solutions

Programs assisting all physicians with individual wellness strategies are a good idea. Individual solutions such as mindfulness-based stress reduction and programs that promote community, connectedness and meaning have been shown to be effective in reducing burnout. By promoting the wellness message and encouraging self-care, physicians will likely improve their own personal wellness.

But when you immerse a “well” physician into a broken healthcare system, those individual positive wellbeing effects dissipate very quickly.

So, systemic wellness solutions are the answer. The National Academy of Medicine’s conceptual model for wellbeing and resilience clearly shows that the healthcare system is the major determinant of an individual physician’s overall wellbeing. You will not be able to meditate or exercise your way into wellness if the system is defective.

Effective leadership is vital for improvement in organizations. Having a leader who can propose and encourage system wide changes and a champion who can advocate for physician health and wellness are critical to make the necessary system changes which ensures career longevity. Without a wellness champion, issues regarding physician wellbeing may never be addressed at stakeholder meetings where leaders who can impact change are present. A wellness officer or champion can be the catalyst to promote individual wellness and elevate the importance of system wide changes that support physician engagement and wellbeing.

What is a Chief Wellness Officer (CWO)? How does he/she affect changes?

As an executive leader, in the Corporate suite (C- suite), a “healthcare chief wellness officer focuses on protecting physicians from occupational distress to enable these clinicians to provide high-quality, patient-centered care” .The CWO and team start with incremental improvements in the system that are so desperately needed because those small changes make a large and possibly long-term difference to those working on the frontlines of medicine.

Ripp and Shanafelt make the case for a CWO on 4 levels: the moral case, the business case, the regulatory case, and the tragic case.

1. The **moral** case relates to caring for the medical staff and acknowledging that burnout leads to serious detrimental consequences as devastating as substance abuse or leaving the health care profession altogether.
2. The **business** case demonstrates that burnout erodes quality of care and increases unprofessional behavior and the risk of medical errors. “Physicians who experience burnout are at twice the risk for leaving their organization than those who do not experience burnout” and this is costly to healthcare institutions.
3. The **regulatory** case is driven by a “call to action to improve the learning environment in medical school and residency. Accrediting organizations, such as the Accreditation Council for Graduate Medical Education (ACGME), have prioritized the wellbeing of physicians in training by requiring that all institutions that train physicians cultivate learner wellbeing. Both the ACGME and the Association of American Medical Colleges have made mitigating trainee burnout a priority through their partnership with the National Academy of Medicine Action Collaborative on Clinician Wellbeing and Resilience.”
4. There are **tragic** consequences resulting from burnout. Physician suicide rate is much higher than in the general population. Early identification of burnout, and hopelessness, with proactive measures in place for providing help and healing may avert these horrors.

In a recent *Health Affairs* article, several physicians in leadership roles mention that the chief wellness officer should “have the authority to monitor conditions for clinicians, oversee evidence-based improvement efforts, and influence cultural shifts”. Shanafelt et al and the Institute for Healthcare Improvement reinforce this point and suggest several solutions for promoting physician wellbeing utilizing a simple 4 step approach to making change at the system level:

The first is to simply acknowledge and address the problem.

The second and third are harnessing the power of leadership and having targeted interventions. This includes focusing on departments in the hospital where there are higher levels of burnout and addressing the system issues that are causing disengagement and distress. System change will not occur unless a problem is identified and there is C-suite leadership and support to implement the solution. Executive leadership, in the form of a CWO, allows for the legitimacy, collaboration, and financial support for encouraging wellness solutions, both on the individual and systems level. The CWO may also help centralize all activities since wellness programs in hospitals are often scattered.

Finally, and probably most importantly, CWO’s should serve as leaders for change in driving health systems toward cultures of wellbeing . Measuring the changes made will inform the CWO whether the intervention is successful or not.

Unfortunately, many institutions are under the impression that burnout is simply an individual responsibility on the part of the physician. Evidence clearly shows the causes of burnout are both individual and system related. Individual changes, including personal self-care, can still be promoted by institutions, but system issues must be recognized and addressed by leaders in the organization. In addition, changes in the system must focus on positive innovations that encourage physician engagement and must be brought to the forefront. These are unlikely to occur unless there is an effective leader in charge who is addressing and promoting physician wellness. Changes will likely take time but having a wellness champion/ CWO within hospital systems will be vital toward initiating and sustaining long term change, wellbeing, and career longevity.

The Institute for Healthcare Improvement 4-Step Plan

1. Ask Staff: “What matters to you?”
2. Identify unique impediments to joy in work
3. Commit to a systems approach
4. Test approaches to improving joy in the system

Resources

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Tetons in Summer

Joshua Goldstein, MD

“Medicine, and particularly the match process, can be demoralizing and cause us to lose sight of what’s important in life. Sometimes wellness is eating healthy or working out. Other times it is putting physical, emotional, or psychological distance between medicine and the person you are outside of the hospital.”

Moral Distress and Moral Injury in Emergency Medicine: Part I

By Wendy Dean, MD, Simon G. Talbot, MD and Keith Corl, MD

Does it matter what label we use for physician distress? Roughly half of physicians report experiencing at least some level of distress. Words matter. Distress isn't a designer label that each physician should create in isolation. Words have meaning when they hold a shared definition within a community. Language frames how people think about concepts and how they conceive solutions. If the terminology is non-specific, or incorrectly defines the problem, the solutions are destined for mediocrity or failure.

For more than a decade, research and interventions around physician distress have focused on burnout, which is defined by the ICD-10 as a constellation of symptoms including emotional exhaustion, a perceived lack of effectiveness, and depersonalization caused by the workplace environment. Yet in the US, we do not recognize burnout as a medical condition. We have tried to treat it with yoga classes, mindfulness, wellness retreats, and coaches. Despite more than a decade of these programs, a study completed in 2018 found that 43% of surveyed physicians still reported at least one symptom of burnout. It's time to reconsider both the diagnosis and the approach to this epidemic.

On any given day, the emergency physician must navigate a system where a patient's needs are in competition with the interests of the hospital, the health care system, or even the physician themselves. This sets up a challenging dynamic in which the physician is forced to choose between upholding the oath she or he took to always put the patient first, and the reality of a work environment where not putting the corporate interests first can result in diminished income, reprimands, probation, or unemployment. This dynamic, in which the physician is forced to make a mutually exclusive choice—a “damned if you do and damned if you don't” scenario—is a double bind.

The double bind is the defining element of moral injury. Brett T. Litz described moral injury in an article in *The Clinical Psychology Review* as “...perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.” The deeply held moral beliefs and expectations of physicians are the oaths we took when we first became doctors. No matter whether one swears the Oath of Hippocrates, the Declaration of Geneva, or the Oath of the Healer, each includes a promise to put the needs of the patient above all else. At their core, these oaths imply that patients can trust the physician to put only the patient's best interests first. This mindset is ingrained into physicians over the decade of medical school and residency training that each physician undertakes when they learn the art of medicine. The oath is a touchstone for physicians. It is in the background of every decision a clinician makes, whether they are aware of it in the moment or not.

“Continually being caught between the Hippocratic oath, a decade of training, and the realities of making a profit from people at their sickest and most vulnerable is an untenable and unreasonable demand.” The increasingly common expectation that the corporate interests of medicine supersede the patients' needs belies the doctor-patient covenant. Repeatedly breaking that covenant because our 21st century medical system demands it of us is the essence of moral injury, which extracts a toll on physician wellbeing.

Emergency physicians are deeply committed to patient care. When a patient's needs are frustrated by the constraints of some part of the health care system, we will go to heroic lengths to extract what the patient needs from our broken system. We improvise daily to navigate complex bureaucracies and build single-use workarounds to effectively game

the system into delivering the care our patients need. But daily struggles against massive, immovable machinery are exhausting. And they are too often unsuccessful. Our failures can get magnified and lead to a sense of ineffectiveness or lack of accomplishment. And when an emergency physician is forced to bear witness to a patient's anguish when their needs are denied, eventually it becomes necessary for the physician to depersonalize to escape the distress. This may sound an awful lot like the constellation of burnout. Perhaps then burnout, is the end stage of moral injury left unrecognized, unacknowledged, and unattended. If our efforts to combat physician distress have largely focused only on addressing the late-stage pathology of moral injury, no wonder they have had such dismal results.

The goal is to move interventions earlier during the distress illness. At the early stages of moral injury, the challenge is not entrenched, the damage not quite so diffuse, and the potential for cure (rather than palliation) is much greater. The solutions for addressing moral injury must concentrate on the dysfunction in the corporate framework of the healthcare system. The mismatched values and perverse incentives must be aggressively addressed. Our clinical leaders should have sustained support so we can break down barriers to good care, not explain why the barriers exist. In summary, solutions focus in three main areas:

1. Value the care emergency physicians provide for patients. This encounter is the lynchpin of healthcare.
2. Value the physician-patient relationship.
3. Rebuild community — between various physician specialties and with other licensee groups — and build bridges with leadership and administrators to work together for change.

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Kupka

Greg Zivic, MD

“Kupka means “bath” in Croatian, my father’s homeland. This past year has been extraordinary and in a particular and important way we as EM Physicians have had guts in the face perspective of it all. This piece is about what we’ve all been through. We are constantly at odds with our empathy and our vulnerability. We’re important, even if we’re uncomfortably comfortable with that.”

Moral Distress and Moral Injury in Emergency Medicine: Part II

By Wendy Dean, MD, Simon G. Talbot, MD and Keith Corl, MD

“She was 45, non-English speaking, and had right upper quadrant pain and vomiting. The US report showed wall thickening, a bit of sludge, and gallstones. The consultant surgeon wanted to know if the patient had insurance. Once I answered he said, “Give her antibiotics and send her home. She can follow up in the clinic.” I was astounded. Only yesterday I had talked to the same consultant about a similar case, but that patient had private insurance, was 56 years old, and lived in the upscale part of town. He had taken her directly to the OR. I shook my head, felt sick to my stomach, and reluctantly signed the discharge papers. I felt so discouraged.”

Emergency Medicine is emblematic of the crisis in medicine: a loss of autonomy and latitude. Clinicians are tracked, micromanaged, threatened, and incentivized to forsake the oaths they took to put patients first. Directly or indirectly, clinicians are being asked to prioritize profit and compliance over patients, compassion, and the desire to practice high quality medicine.

The National Academy of Medicine report, released October 23, 2019, intended to provide guidance for addressing the crisis. Yet, the report openly acknowledges the committee could not recommend any specific solution for physician distress. In two decades of assessment and intervention, we are no closer to resolving this epidemic. If any of our patients suffered from a refractory condition, which did not relent despite various treatments, we would not accept their suffering as immutable. We would ask for a second opinion, reconsider the diagnosis, revise the treatment plan, and if necessary, move mountains to get our patients what they need. We are emergency physicians; we move mountains. But not for ourselves. As emergency clinicians in distress, we seem resigned to our own struggle.

So, what will we do about it? Shall we keep pouring antibiotics and bronchodilators on heart failure, or do we rethink the diagnosis and treatment of the patient’s distress? To date, the body of literature on physician distress has focused on burnout as being a problem of individual physicians who lack sufficient resilience, self-care, or coping skills. Most emergency physicians now identify the challenges inherent in the business or financial framework of healthcare as the primary driver of their distress.

Approaches that address the systemic problems inhibiting clinicians from providing the best care for their patients can eliminate the binds that cause moral injury. So, the question is, will emergency physicians advocate as powerfully for resources to address our own distress, as we would for our patients? Most clinicians struggle to speak up for themselves, yet this must become a priority.

Advocating for ourselves is tricky. Emergency physicians are a privileged class so we garner little sympathy. Television, movies, and our own machismo have led non-clinicians to believe that our training hardened us to any abuse, that we will always perform at superhuman standards, and therefore, we need no sympathy. Compared to an elementary school teacher making \$40,000 a year, who are we to complain?

Given the current epidemic levels of distressed emergency physicians, not advocating for ourselves is no longer an option. Our previous inaction enabled the ascendance of the external forces that feed moral injury. Trusting others to manage the complex business of healthcare, we were absent at the table where decisions were made, or allowed one physician voice, such as the Chief Medical Officer, to speak for all. At a table full of business-minded decision-makers, one clinician's voice is easily drowned out. Instead, the critical need is to start speaking as one powerful collective voice advocating return to a system that values both the professional health of clinicians and good patient care.

The lesson in the history of moral injury is that no one is coming to the rescue. As emergency providers, we must resist the pull to victimhood and support iconoclastic leaders who will speak truth to power. We need to be relentlessly curious about our current professional satisfaction, learn to be effective advocates, and play the long game. We are cognizant that all clinicians are experiencing distress and understand that working together will result in a much larger impact than if we work in separate silos.

Clinician leadership is where change starts. Effective emergency department leaders live in both the administrative and clinical worlds. Those leaders have a visceral understanding of the challenges their clinicians face every day, and can speak directly to the myriad binds that compromise their physicians. Leaders who advance the cause of reducing moral injury believe the job of a leader is to break down barriers, not to explain why they exist. The future will bring countless unpredictable changes that will alter the face of healthcare and have the potential to impact clinicians negatively. An effective leader can manage both the day-to-day issues that diminish the clinician (i.e. that never-ending stream of best practice alerts in the electronic health record) while navigating the larger issues that shape our profession (i.e. nursing and clinician staffing, employee safety, profit-driven metrics, the entrance of private equity into the emergency medicine landscape).

Good leaders recognize that the entire healthcare system depends upon the clinician-patient relationship. It is the cornerstone of healthcare. Each physician supports 17 other jobs. Of those, 6 are clinical (i.e., nurses, radiology technicians, phlebotomists) and 11 are nonclinical (i.e., executives, administrators, clerks, coders). Each physician supports a total of \$3.4M in annual economic output. And half of all healthcare is delivered through the emergency department. But the current system needs to be turned on its head. Instead of physicians spending precious time doing data entry and clerical tasks, or answering to myriad departments (billing, compliance, safety, risk), these departments should be asking how can they better support the clinician revenue-generating machine that funds the entire system. Let's reframe the discussion by asking how can billing or risk management or patient safety make the physician's job smoother, faster, or smarter—invisibly? Why isn't executive compensation tied to physician satisfaction since clinicians are the revenue generators for the enterprise?

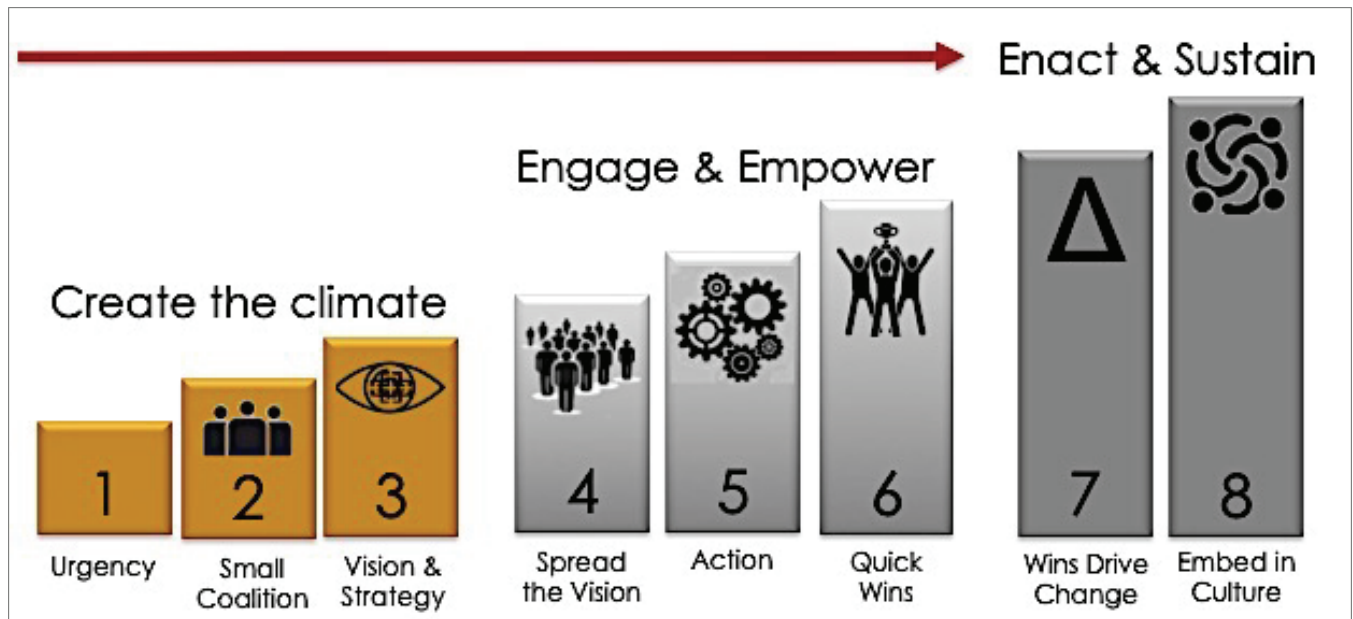
The National Academy of Medicine report opines, "Many different aspects of the health care environment have to work together in an integrated way to prevent, reduce, or mitigate burnout and improve professional wellbeing." Clinicians have been trying to single-handedly fix the broken system for decades. It is time we demand assistance and resources from the non-clinician leaders in our healthcare system.

Lasting change tends to happen slowly and incrementally. It involves organization and coalition building. But the collective accumulation of our small efforts can build to a critical mass that pushes the cause beyond an inflection point.

Start local, start small, and be persistent. Figure out the pebble in your shoe and learn everything you can about it. Dissect the problem and the players, and then start testing solutions. Make sure you know your organization's policies, your rights as an employee or a contractor, and the laws of your state. Use readily available public information to better understand the landscape of the problem and to build arguments and solutions. Along the way, take time to recognize every small win. Nibbling at the edges of a problem can have tremendous downstream effects that precipitate the collapse of barriers.

SYSTEM: Systemic Wellness Factors – Organizational Influences

Find organizations that resonate with you. Support them with your time, talent, and donations. They need you. Spend time getting to know how healthcare policy is made and how to go about changing it. Meet with your state legislator, if possible, a few times each year. Talk with him or her about the change you would like to see, and the vision you have of a better healthcare system. Kotter's 8 Stages in figure 1 suggest that change is neither simple nor quick, and you cannot do it alone. But there is a path, and there are others who will join you.



Resources

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Ice Cream Socials to Improve Wellbeing? Innovative Wellness Initiatives That Really Make a Difference

By Loice Swisher, MD and Gregory Guldner, MD

Dr. Green, the chair of the Emergency Medicine Wellness Committee, is struggling once again deciding what the next wellness event will entail. They've already had a bowling night, a karaoke night, and even an intramural dodgeball game. Efforts to have team members watch and discuss TED talks on mindfulness and resilience were popular, well, among the very few people who actually took the time to attend. Most were "too busy." With a small budget and even less available time, Dr. Green settles on another event. Maybe a casino night will lessen workplace burnout and fight what she perceives as the worsening overall wellness of the group. She truly wants to make a difference but just isn't sure what else to do.

Begin with the End in Mind, but Understand the Middle

The goal is to develop a working model for emergency clinician wellbeing and wellness interventions before instituting changes that might not make an impact. Doing this provides several advantages:

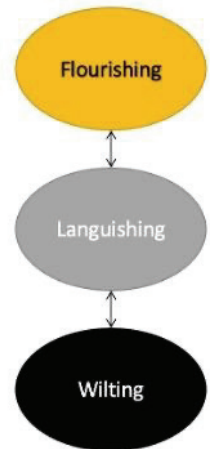
- **Avoids harm.** Some wellness interventions can cause harm, particularly in the development of cynicism, doubt, and distrust among those required to participate. Linking interventions to well understood principles limits the likelihood of well-intentioned efforts being perceived as a waste of time, money, or both.
- **Minimizes "mis-wanting."** Mis-wanting refers to misunderstandings about which interventions will result in future professional satisfaction. Understanding the realistic foundations of workplace wellbeing allows us to challenge and then test these mis-wanting assumptions, rather than continue with intuitive but erroneous approaches to wellness.
- **Targets applications to avoid thwarted expectations.** Many interventions (such as Mindfulness Based Stress Reduction) require a substantial investment of time and may moderately improve individual physician anxiety and depression but do little for workplace burnout.
- **Draws out intermediate goals in day-to-day efforts.** An intermediate goal defines the interest variable that the wellness initiative hopes to impact. For example, a wellness program may have an intermediate goal of "increasing perceived meaning of work." This intermediate goal then results in brainstorming efforts around "how to increase the perceived meaning of work" rather than the larger more diffuse question of "how to improve wellness."
- **Allows for synergistic efforts.** Understanding intermediate goals allows previously isolated approaches to synergize with one another.

- **Enhances feedback loops.** When participants understand why a program results in a general feeling of improved wellbeing, they commit more fully to the effort.
- **Predicts program impact more accurately.** Understanding intermediate variables allows the better prediction of outcomes and failures as well as develops successive innovations.

Tackle the Big Question: What is Wellness?

What is wellness? Without answering this question, wellness leaders may lack a vision of their outcome and risk becoming reactive — responding to the loudest or most persistent requests or the desire to “just do something.”

While physicians typically understand the disease model of wellness (fix burnout), they often struggle to understand the broader continuum. This continuum between *wilting* (a state dominated by negative emotions, cognitions, and behaviors) and *flourishing* (a state of optimum human engagement with the world) defines the broader landscape of wellbeing. In between is *languishing* (a state where there is no flourishing; it's filled with emptiness and stagnation). Frequently, the wellness initiatives that move us from wilting to languishing differ from those that move us from languishing to flourishing.



Target in EM: Flourishing

Flourishing is a dynamic process that results in an overall positive appraisal of your life. Flourishing consists of efforts to evolve along five constructs reflected in the acronym **PERMA**.

- **Positive Emotions**
- **Engagement** (for example, when you start a challenging project with sustained focused effort and become so engrossed that you lose track of time and surroundings)
- **Relationships**
- **Meaning** (understanding your own effort being connected to something greater than yourself)
- **Achievement**

A wellness program which incorporates both strategies — elimination of negative states and maximizing **PERMA** tactics — promotes flourishing.

Traditional Wellness Initiative Approaches

Many programs adopt one of four models with varying success.

- **The Ice Cream Social.** Enjoyable social events require relatively little planning and no long-term investment compared to other initiatives.
- **Wellness 101.** These are lectures. While developing shared beliefs around wellness is important, no one ever became resilient listening to a resiliency lecture!
- **Hedonism.** Pleasurable activities can temporarily improve wellness but often less than expected. Massage chairs, spa giveaways, and pet therapy all fall under this model. When introduced alongside the positive psychology constructs of savoring and gratitude, these activities can have important impacts as they develop habits that lead to flourishing.

- **The Drink Your Milk Strategy.** These are broad health concepts including sleep hygiene, nutrition, and exercise. While helpful for general wellbeing, they may not address the unique emergency medicine career related issues necessary for wellness.

The Multi-Dimensional Three Pillar Model

In this approach, wellness initiatives fall into one of three pillars:

- **The Work Environment Pillar.** This is the most important component for dealing with workplace burnout. Using the Job Demands-Resources (JD-R) Model to understand occupational stress, efforts focus on refining and lessening job demands while maximizing job resources and joy in work.

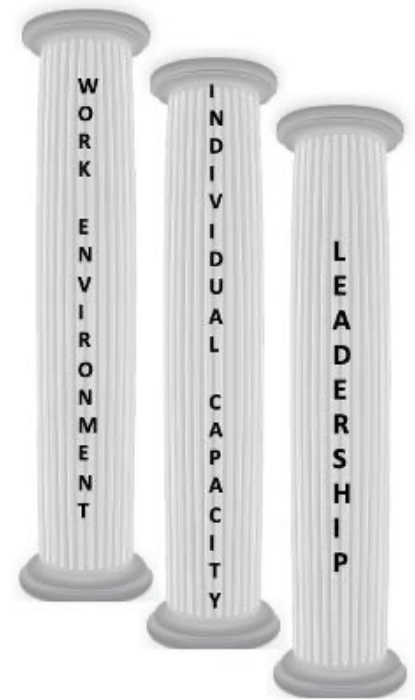
Example: Role ambiguity created a problem in the trauma bay. Clarifying roles can help reduce anxieties and confusion and improve the workplace environment.

- **The Individual Capacity Pillar.** Initially, physician wellbeing often focused on personal or individual factors to attempt to explain workplace burnout. This individual approach has given way to the “system is the problem.” Neither should occur to the exclusion of the other as wellness requires both efforts at improving the system and developing individual capacity.

Example: Efforts to reduce imposter syndrome via cognitive behavioral techniques are coupled with efforts to improve optimism via positive psychology techniques.

- **The Leadership Pillar.** This is the most commonly overlooked element of wellness. Think of a time in your career when you really flourished. It is likely that the underlying cause of that sense of growth and flourishing stemmed from a leader who made you feel seen, supported your goals, and provided you with an appropriate level of autonomy.

Example: Leaders that promote joy in work and physician engagement provide the most opportunity for flourishing. Toxic leaders are removed or educated in autonomy-supportive leadership (ASL) styles.



Culture over Curriculum

Whenever possible, work to develop a culture that supports long-term wellness rather than a didactic or lecture approach. Within the context of wellness, Shanafelt and colleagues defined culture as:

- Shared beliefs
- Shared values
- Shared social practices

All of these are so ingrained, they are no longer challenged.

1. Some didactics are required to establish the underlying adoption of beliefs related to wellbeing.
2. Shared values develop with a combination of didactics and experience. As wellness initiatives lead to positive emotional states, team members move from understanding a value to accepting its importance.

3. Shared values around wellness come through shared social practices. A habitual gratitude moment, in which team members spend less than 60 seconds identifying and verbalizing something for which they're grateful, is a shared social practice stemming from a shared belief in the power of gratitude that leads to a value that gratitude is important.
4. As this powerful trio of shared beliefs, shared values, and shared social practices reinforce one another over time, the team will spiral toward positive flourishing states, which leads to a culture of wellness.

Primary Drivers of Flourishing

The primary drivers of flourishing that can be targeted in wellness interventions include:

- **Autonomy.** The perception that we have control over what we do, and we do it voluntarily.
- **Belonging.** The perception that we are connected to and interact with a team; we care for others on the team, and they care about us.
- **Competence.** The perception that we are increasing our ability to perform difficult team tasks well, contributing to the overall goal.
- **Deep Meaning.** The idea that what we do voluntarily, as part of a team and with competence, results in prosocial effects. Simply, what we do makes a difference in the world.
- **Environmental Optimization.** A sharp eye on the overwhelming importance of job demands on workplace burnout and a leadership focus on the improvement of the workplace environment by maximizing autonomy, belongingness, competence, and deep meaning results in team flourishing.



Questions for wellness committees and champions using this model would include:

- What are we doing to lessen the demands in the workplace environment day to day?
- What are we doing to increase the resources available in the workplace environment day to day?
- How are we deliberately finding and enhancing meaning and joy in work on a day to day basis?
- How are we deliberately developing and showing growth in competency?
- How are we enhancing autonomy (and minimizing loss of autonomy)?
- How do we encourage a sense of belonging, teamwork and engagement?

Examples of Wellness Initiatives Stemming from Theories of Wellness

Scenario One

Knowing that job demands have the greatest impact on workplace burnout, the wellness champion initiates twice daily physician engagement rounds. They initiate a real time practice of asking emergency department physicians during their shift, “What is bothering you during this shift?” and “What would make your shift better right now?” Recognizing that workplace wellness often revolves around seemingly trivial frustrations, such as the location of a printer relative to a workstation, the committee carefully records and sets “next action” lists to help reduce these day-to-day frustrations.

Scenario Two

Interested in positive psychology approaches to wellness, a team decides to initiate a “What Went Well” practice at each shift huddle. Team members take a moment to discuss something that went well for them or the team during the last few shifts. This practice develops optimism (a focus on positive outcomes), self-efficacy (recognition that team members can have control over events), competence (growth in ability), and hope (understanding there are paths to a goal).

Scenario Three

Knowing the importance of meaning, a residency wellness champion begins teaching faculty how to link meaning to competence. They notice faculty routinely praise residents for competence (“nice job picking up that aortic dissection”) but fail to link that competence to deep meaning. Didactics and role playing are used to develop a habit of drawing out and amplifying meaning. “Nice job picking up that aortic dissection. Mr. Poole’s family will be able to spend the holidays with him rather than planning his funeral. Please take a moment to let it sink in. All of the hours studying emergency medicine and practicing led to this moment, and you saved his life.”

Scenario Four

*Wanting to continue monthly pizza parties, a wellness committee decides to integrate social support activities to help augment a sense of **belonging**. They review the four types of social support — emotional, instrumental, appraisal, and informational — and decide to focus on instrumental support. They brainstorm ways that the team could have been helpful in the past year — pet sitters, babysitters, drivers to the airport, fellow hikers, etc — and develop shared signup sheets, posted on Slack, for those willing to help.*

Scenario Five

*The medical director, recognizing that **autonomy** holds a key role in physician wellbeing, begins a practice of assessing the impact of all emergency department policies on team member autonomy. Multiple newly proposed projects, that would have limited autonomy, are shelved or modified. A comprehensive review of current policies results in multiple changes and deletions to help enhance autonomy.*

Scenario Six

An institutional chief wellness officer recognizes the importance of enhancing the perception of meaning on the hospital’s physicians. She initiates a program where she identifies patients and families who came through the emergency department and are willing to share their experience. Every other month, the emergency physicians interact remotely with these prior patients who describe their experience and the impact the care in the emergency department had on their lives. Always impactful and often tearful, these events become the most attended meetings in the hospital.

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Center for Self-Determination Theory
<https://selfdeterminationtheory.org/>

Foundations of Positive Psychology Specialization on Coursera (free)
<https://www.coursera.org/specializations/positivepsychology>

Motivation Works
<https://motivationworks.com/>

National Academy of Medicine Clinician Resilience and Well Being
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Positive Psychology
<https://positivepsychology.com/>

University of Pennsylvania — Authentic Happiness
<https://www.authentichappiness.sas.upenn.edu/newsletters/flourishnewsletters/newtheory>

University of Pennsylvania — Positive Psychology Center
<https://ppc.sas.upenn.edu/learn-more/perma-theory-well-being-and-perma-workshops>

Yale Science of Well-Being Course on Coursera (free)
<https://www.coursera.org/learn/the-science-of-well-being>

Podcasts

Chip Conley: Measuring What Makes Life Worthwhile

Dan Gilbert: The Surprising Science of Happiness

David Steindl-Rast: Want To Be Happy? Be Grateful

Martin Seligman: The New Era of Positive Psychology

Mihaly Csikszentmihalyi: Flow, the Secret to Happiness

Nic Marks: The Happy Planet Index

Philip Zimbardo: The Psychology of Time

Tali Sharot: The Optimism Bias

Physician Suicide: Tragic, Terrible & Needless

By Loice Swisher, MD, Megan Murphy McCreery, MD and Christopher Doty, MD

You receive sign-out from the overnight emergency physician, Dr. X. He is a 55-year-old male emergency physician who has been part of your group for years. He relays he had to come in earlier the day before for a Root Cause Analysis meeting which went “as well as you would think.”

When you tell him to go home and get some sleep, he says, “Well, there isn’t anyone home since she has the kids this weekend, so I’ll be able to do what I want.” Then he smiles and says, “Good Luck. Have a good shift.” The next day you hear that Dr. X has been pronounced dead of a gunshot wound. He was found in his car in the driveway, alone, at his home.

Statistics

There are a variety of statistics on suicide that are often repeated but have little data to back them up. Others are often misunderstood. Here are four:

1. Every year, 300-400 physicians die by suicide.

Limited Data — most likely many more.

The original source of this statement is unknown, and recent studies vary. It is highly possible that these numbers were expert estimates by extrapolation from limited studies. There is no current database for physician suicide to garner accurate numbers and estimates are difficult due to inaccurate cause of death reporting and coding. It is possible that the actual number is significantly higher.

2. Physicians die by suicide more than any other occupation.

False.

The job with the highest rate of suicide almost always goes to construction workers, whose numbers far exceed those of physicians. In the past, there have been years that physicians were the highest group of white-collar professionals who died by suicide. In other years, dentists and veterinarians have had higher rates than physicians.

3. Women physicians die by suicide at a greater rate than women of the general population.

True, but not more than men.

Although women in the general population attempt suicide more than men, women tend to use less lethal means. As a proportion, female physicians are more likely to die by suicide. Generally, it is thought that women doctors choose more lethal means, which is probably influenced by their medical training. A caveat: this actual number is far less than the actual number of male physicians even though the proportion goes up. The demographic with the largest risk is middle-aged white male physicians.

4. Residents are at high risk for suicide.

False.

Due to an in-depth review from 2000-2014 by the Accreditation Council for Graduate Medical Education (ACGME), this is an area in which we have good data. Resident suicide death is actually below the rate of the general population. The highest risk is within the first three months of internship. Similar to the general population, men make up the greater percentage. Despite this, suicide is the leading cause of death of male residents and the second-leading cause of death of female residents in this study.

Taking about Suicide

- **Werther and Papageno Effect**

Often people are concerned whether talking about suicide will increase the likelihood someone else will also attempt to take their own life. This fear has been driven by the media publicizing suicide clusters and “copycat suicides” after a celebrity death. Suicide prevention research has shown that the impact on subsequent suicide statistics is correlated with the messaging about the initial suicide.

The Werther Effect is the term given to suicide contagion after reading about suicide. These copycat suicides were given the name after an increase in suicides occurred when Johann Wolfgang Goethe published a book called *The Sorrows of Young Werther*. Suicide clusters have been classified as point clusters, which are grouped together in time and location by relatively direct contact. Mass clusters are grouped in time but not location and usually result from media portrayal including social networks.

The Papageno Effect is the opposite — suicide rates go down after a publicized suicide. This effect is named for a character in Mozart’s *“Magic Flute”* who is visited by three ladies during his suicidal crisis, during which they listen to him and give him reasons to live. Suicide prevention research has shown that including stories of hope and recovery in the face of suicidal crisis actually decreases the rate of suicide.

- **“Commit Suicide” Versus “Died by Suicide”**

The way we traditionally talk about suicide separates it from all other types of death. There is no other “committed death.” The word commit unconsciously brings up the sense of unchangeable sin or crime. Those in the suicide prevention community believe suicide is one of the most preventable causes of death. Suicide stems from a person’s pain exceeding their coping skills. One of the best ways to reduce psychological pain is to express it and for someone to just listen. A way to decrease stigma and show one is open to a conversation on suicidal ideation is to use the wording “died by suicide.”

- **Other Media Guidelines**

There are a variety of other media guidelines that can help reduce the risk of negatively impacting others, such as:

- Include trigger warnings before talking about suicide.
- Reframe from using the terms successful or unsuccessful when discussing suicide attempts.
- Do not include details of the suicide. People with suicidal minds may incorporate these details into a plan of their own.
- Include resources.

When To Be Concerned

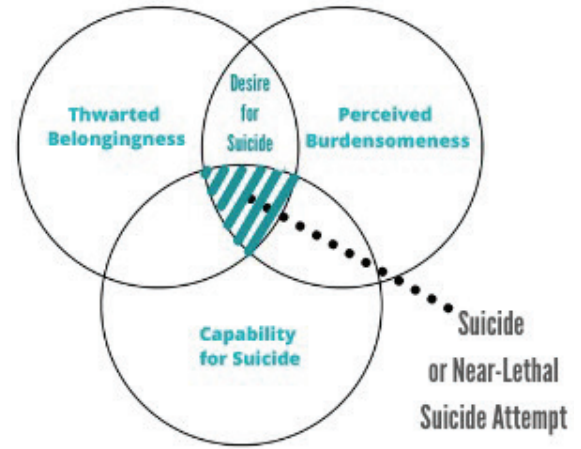
- **Who is at risk?**

All physicians are at increased risk.

The Reason: The Joiner Theory of Suicide describes three overlapping factors which must come together to produce a lethal suicide attempt. These are:

- Thwarted Belongingness: a sense of isolation and loneliness.
- Perceived Burdensomeness: a sense of failure, loss of direction and purpose.
- Capacity: the knowledge and access to lethal means to kill oneself as well as overcoming the fear of death.

By the nature of their medical training, physicians will always have one of these criteria against them. This means to prevent physician suicide, connections and meaning in one's life must be boosted.



- **How will you know?**

Sometimes people will directly talk about killing themselves. Take all of these seriously and explore the intent. Don't assume this is merely black humor, as it might be a cry for help. Indirect signs that a person may be at risk for suicidal ideation or intent are more common. These can be verbal, behavioral, or affective cues.

- Verbal: people may talk about feeling hopeless, helpless, worthless, pointless, meaningless, trapped, a burden, or without reasons to live.
- Affective: depression, anxiety, shame, loss of interest, anger, and sudden improvement in mood.
- Behavioral: withdraw and isolation, substance use, aggression, fatigue, visiting or call people.

You may have experienced yourself or heard from a physician who recalls a colleague calling to go out or get together, but it never happened and was followed by a suicide. It is worth being concerned if a fellow physician reaches out unexpectedly or for seemingly no reason.

- **What can you do if there are no signs?**

Unfortunately, physicians often avoid seeking help. Physicians know what to say and not to say to avoid detection. It may seem practically impossible to reach these individuals. However, there are three potential strategies that can help.

- Prophylactic Conversation

Assume that every physician is at increased suicide risk with the potential for circumstances that could lead to suicidal crisis in the future. Specifically, state that if one ever reaches that point, you are willing to listen, that if one ever gets to that moment of crisis, the conversation will go through their mind that you care.

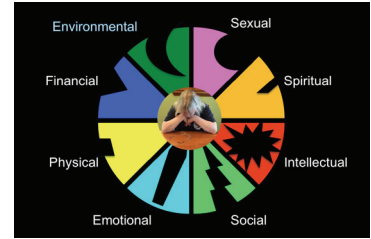
- Double Tap

Directly ask a person if they are OK? Often the rote response is, "I'm fine." Ask a second time, "No, really, are you OK?" It is surprising how often the second time yields a more honest answer.

SYSTEM: Systemic Wellness Factors – Organizational Influences

- Anaphylaxis Equivalent

As emergency medicine physicians, we are all aware that the trigger to pull out epinephrine for anaphylaxis is when two organ systems are involved. With potential suicidal crisis, one can pull out the questions whenever two parts of a wellness wheel are involved.



What to Do

Although many of us are quite comfortable talking with a patient about their suicidal ideation and plan, it is a different situation with a friend or colleague. Reasons for that range from not wanting to be wrong or offend someone for asking to not knowing what to do if they say that they are suicidal. Some feel unqualified to start a conversation feeling that it is better left to a therapist or psychiatrist. It's important to remember that the one who is most likely to make a difference is an arm's length away. It will be a friend or family member who most likely recognizes the signs and is in the best position to help one at risk find help.

You can use the LEAD structure as a way to approach a conversation:



Look and Listen for the Signs

Uninterrupted, non-judgmental listening often is one of the most relieving factors for suicidal ideation.

Engage in the Dialog

When one has concerns about signs of suicidal ideation, the next step is to ask. This can be done directly by asking someone if they have thoughts of suicide or hurting themselves.

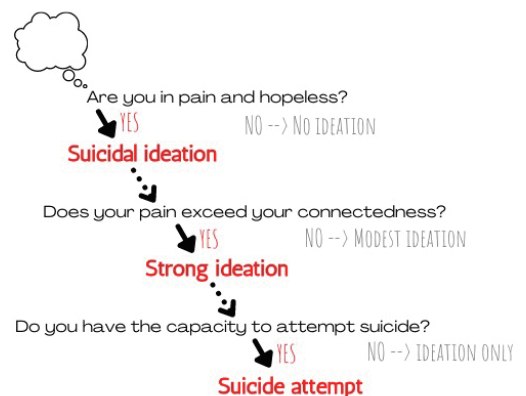
Ask Follow-Up Questions

Often the concern is what to do next if the person says yes. Usually the best next step is to listen. Allowing a person to verbally release their pain substantially decreases suicidal thoughts. When the listener is at a loss of what to say, use interventional empathy. Dr. Mark Goulston suggests saying, "Seven words: Hurt, afraid, angry, ashamed, alone, lonely, tired. Pick one and start telling me about it." This often expands the conversation.

Consider these three additional questions in assessing a person's risk:

- Are you in pain and hopeless?
- Does your pain exceed your connectedness?
- Do you want to kill yourself now?

These questions come from the three-step theory of suicide. The last one is modified, as physicians always have the knowledge and access so that one may get more by assessing desire.



Develop a Plan for Living Together

There is no set way to develop a new plan. The idea is to offer an alternative option to a suicidal mindset. Here are some things to consider:

- Rules to Live By
 - Sleep at least 8 hours in a consecutive block before making any permanent decisions.
 - There is no safety without sobriety.
 - You don't have to catch every train of thought.
 - Wait 3 days before acting on suicidal ideation.
 - Call someone and talk with them about this before acting on your thoughts.
- Resources
 - Self Help: Physicians, like police and airline pilots, are unwilling to seek treatment. There are self-help resources available on the internet, which can help one develop alternative lines of thinking.
 - Employee Assistance Programs (EAP): Many physicians have an employee benefit of several free confidential therapy sessions through this resource.
 - ACEP provides free counseling resources for ACEP members.
 - Peer Support/Crisis Incident Support: Hospitals are increasingly developing peer support resources as physicians often want to talk with other physicians.
 - Hotlines
 - National Suicide Prevention Lifeline: 988
 - Crisis Text Line: Text HOME to 741741
 - Physician Support Line: 888-409-0141
 - Individual Institutions: Some institutions have developed their own hotline system.
 - Counseling
- Crisis Management Plan: Individuals can develop their own crisis management plan on paper or in their cell phone to access when needed.

Decreasing Stigma

- Sharing personal stories: One of the best ways to decrease stigma is to create a common bond by sharing stories. This often gives a sense of connection that one is not alone. It is particularly powerful when those in position of authority share such narratives.
- National Physician Suicide Awareness Day — September 17
This day was created to encourage conversation and include the topic in didactic sessions.



Resources

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Pregnancy Can be Accommodated in the Emergency Medicine Workforce

By Kimberly Chernoby, MD, JD, MA and Jaclyn Jansen, MD, MS

Alena stood up and washed her hands. The ED was overflowing with patients and she was able to get away for 10 minutes to pump as she was still nursing her infant son. She looked around and noted the paper towel dispenser, the sink, and the ever-present toilet. She mused to herself, “Wouldn’t it be wonderful if someone cared enough for mothers returning from maternity leave to have a clean place to pump that is not a bathroom!!!”

Emergency medicine is seeing an increased number of women enter the workforce. While 28% of active emergency physicians are women, 36 % of EM residents are female. We know that working in the emergency department is physically demanding, and comes with risks, particularly during pregnancy. Dr. Ayesha Khan and Dr. John Purakal highlighted this risk when they reported that 50% of previously pregnant women in health care had experienced a prior miscarriage, which is double the rate of miscarriage in the general public. Given the increased number of women in the workforce, it is critical that emergency medicine consider the effects of our work on pregnancy outcomes and adopt best practices to minimize occupational risks to pregnant physicians.

Work Hazards during Pregnancy

Emergency medicine is particularly rigorous with long periods of standing, shifting schedules, night shifts, and in the case of residents, 28-hour call on off service rotations. Studies have shown that in residency these aspects of training have led to increased fatigue, poor sleep hygiene, and other negative health effects for trainees. These negative health effects are compounded for pregnant residents, especially in the first and third trimesters, and have been associated with increased risk of miscarriage, preeclampsia, and preterm labor. The American College of Obstetrics and Gynecology (ACOG), has reported that working fixed night shifts has an increased risk of preterm delivery and adverse pregnancy outcomes. Studies also show that stress during early pregnancy can cause changes to the placenta and result in infants that are small for gestational age.

Supportive policies promote health and wellness during and after pregnancy.

The literature suggests there are health and wellness benefits from supportive policies. A survey examining a physician’s decision to defer marriage and/or have children compared to those who decided to marry and/or have children showed those who chose marriage and/or having children were significantly more satisfied with their career choice. Adopting accommodations to make emergency medicine work safer for pregnant physicians can improve pregnancy outcomes as well as improve career satisfaction. Both of these results are critical to attracting and retaining a diverse workforce.

Pregnancy Accommodations

In 1978, Congress passed the Pregnancy Discrimination Act. This law prevents discrimination on the basis of pregnancy and requires, in accordance with the Americans with Disability Act, that employers make accommodations for temporary disability related to pregnancy which are the same as accommodations for other temporarily disabled employees who are not pregnant. The U.S. Department of Labor provides suggestions to employers for how to accommodate disabilities, some of which apply to pregnant employees. These include lift aids, chairs, changes in scheduling, scheduled rest, food and water breaks, limiting overtime, and workplace policy changes. Additionally, several states have laws that require reasonable accommodations for pregnant employees regardless of disability status including bathroom breaks, sitting, and limits on lifting.

Best Practices in Emergency Medicine

A working group convened by ACEP published best practices for clinical scheduling during pregnancy. Recommendations were:

- The choice to opt-out of nights during the first and third trimester (automatic non-scheduling of nights, must opt-in to work)
- Exemption from mandatory overtime during the third trimester
- Scheduling easily cancellable/coverable shifts during the third trimester

How to Implement at the Residency Level

Recently, the Indiana University School of Medicine Department of Emergency Medicine (IUEM) adopted a pregnancy scheduling policy for resident physicians with the goals of reducing miscarriage and other pregnancy risks.

IUEM's policy is an opt-out no nights or call policy during the first and third trimesters. This means residents will automatically not be scheduled for nights shifts or rotations that include 28-hour call shifts during these trimesters due to the adverse health effects previously reported. Because some residents prefer to work nights or specific shifts, they are given the choice to opt-out of this scheduling change if they so desire. Given that a schedule will have been previously made with regards to first trimester shifts, the policy is explicitly clear that disclosure of pregnancy is confidential and that the Chief Resident would make necessary adjustments to the schedule without disclosing a resident's pregnancy status. This scheduling policy was also extended to off-service residents rotating within the emergency department. Residency Chiefs from other departments were made aware of this policy with hopes of encouraging other training programs at IU to adopt similar policies.

The IUEM residency leadership felt it was important that pregnant residents were encouraged to take advantage of this policy. One feature designed to increase usage was the opt-out alternative. The goal was to prevent pregnant residents from feeling obligated to work the night shifts, so establishing a policy of opting out decreased the barrier to usage. Additionally, night shifts would be covered by other emergency medicine residents and would not be made up at a later time. The program did not want to threaten residents with having to work twice the number of night shifts in a future block thus preventing them from taking advantage of the opt-out policy. Conditions other than pregnancy that made it difficult for residents to work solo-covered night shifts, such as orthopedic injuries, were also included in the policy with similar scheduling. After the policy was instituted, an anonymous survey was conducted to assess approval, with over 85 percent of residents supporting the policy.

In addition, the IUEM sick call policy was amended to explicitly include miscarriage and sick childcare as appropriate activations of sick call, and clarified that residents were not required to disclose the reason for activating sick call.

Recommendations for Emergency Departments

Emergency departments should adopt standard policies for pregnant physicians. With regard to scheduling this includes:

- An opt-out policy to eliminate night shifts and 28-hour call during the first and third trimester
- Back up call that includes coverage for pregnancy related conditions including miscarriage
- Scheduling which accounts for breaks to eat, drink, and use the restroom
- Double coverage as feasible to allow pregnant physicians to sit when needed
- Double coverage, or scheduling more desirable shifts that are easier to arrange back up coverage for, during the third trimester in anticipation of the need for a pregnant physician to be removed from the schedule

Emergency medicine is facing a workforce crisis. In order to attract and retain physicians, we must acknowledge the difficulties of our profession, including the disruptive nature of emergency medicine scheduling. The field must be responsive to the demands of life outside of the emergency department so that physicians may continue clinical work while optimizing their health, wellness, and fulfillment in their personal lives. As women become an increasingly larger part of the physician workforce in emergency medicine, this responsiveness includes accommodating pregnancy. The above recommendations, which have been successfully implemented in an EM residency, are feasible accommodations that can reduce the occupational risks during pregnancy. These recommendations are complimentary to those for parental and family leave, which are just as critical to physician wellbeing, and are covered in a separate chapter.

Resources

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<https://www.acepnow.com/article/best-practice-recommendations-for-clinical-scheduling-during-pregnancy/>

Family Leave and Pregnancy

By Breanne Jacobs, MD, Jane van Dis, MD and Sarah R. Williams MD

One month after graduating from residency, I am traveling with my husband, enjoying the adventure, and moving to a new city for my dream job working as a community emergency medicine physician. We've put off having kids for so long because of medical school and residency and have decided now is the time to see what happens. Surprisingly, it doesn't take too long, and I find out I'm seven weeks pregnant the day I start my first shift at my new job! Wow! This is so great, but I have so many questions. How am I going to manage my pregnancy while trying to make a good impression on my new boss and coworkers? Do night shifts increase the risk of miscarriage? How will I be able to take maternity leave without pay? How will I pump when I'm the only provider on shift?

Taking time off after the birth of a child is an important life priority as well as an occasion of significant anxiety for physicians entering the workforce. It may be difficult to uncover information about maternity/paternity leave policies in organizations or universities when you are searching for a job. There also may be difficulty finding this information when applying for an Accreditation Council for Graduate Medical Education residency through the Match.

Antepartum Considerations

The day-to-day duties of an emergency physician are physically and emotionally demanding, and some of the shift-work constraints may have adverse effects on pregnant physicians. For example, some studies show that women who work two or more night shifts per week may be at increased risk of miscarriage the following week. Furthermore, both the cumulative number of night shifts and consecutive number of night shifts increased the risk of miscarriage in a dose-dependent pattern.¹

Slowly, the culture in emergency medicine is evolving, and more employers are enacting policies to support pregnant physicians with the physical demands of pregnancy and work. Stanford University implemented a return-to-work policy for residents that addressed scheduling of pregnant residents (see Table 1).

Table 1: Example of Emergency Department Shift Scheduling Used By An Academic Emergency Department for Residents*

ED Clinical Shift Scheduling: The following accommodations will be dependent on availability of staff and scheduling feasibility. We may not be able to honor this policy if several residents are on leave at once. When able, new parents will be scheduled as follows:

- No jeopardy (sick call)
 - Antepartum (expectant birth mothers): 4 weeks before due date
 - Postpartum: 6 weeks for all parents from their return-to-work date
- No overnight shifts (unless requested by the resident):
 - Antepartum (expectant birth mothers): 4 weeks before due date
 - Postpartum: 6 weeks for all parents from their return-to-work date
- No more than three scheduled shifts in a row (unless requested by the resident):
 - Antepartum (expectant birth mothers): 4 weeks
 - Postpartum: 6 weeks for all parents from their return-to-work date

*Gordon AJ, Sebok-Syer SS, Dohn AM, Smith-Coggins R, Ewen Wang N, Williams SR, Gisondi MA. The Birth of a Return to work Policy for New Resident Parents in Emergency Medicine. *Acad Emerg Med.* 2019 Mar;26(3):317-326.

While not all employers are as progressive as Stanford, employment law, specifically Title I of the Americans with Disabilities Act (ADA), dictates that pregnant physicians, in collaboration with their obstetricians, may request reasonable accommodations for shift work to navigate difficult schedules. Reasonable accommodations might include:

- No shifts longer than eight hours
- No shifts without backup relief scheduled in case the pregnant physician has an emergency
- No night shifts in the third trimester
- No more than 30 clinical hours scheduled in a consecutive seven-day period

There are no set rules; some accommodations needed by one physician may not be necessary for another. The best advice is to discuss a mutually agreeable plan with your employer in collaboration with your obstetrician as early as possible in pregnancy.

Postpartum Considerations

While the physical toll of pregnancy is one concern, there are other stressful postpartum issues for new physician parents. One of the biggest stressors is financial and figuring out how to pay for maternity/paternity leave in a model where paid leave may not be part of the contract.

Early planning may greatly reduce the stress of this situation. Any employee who has worked for an organization for 12 consecutive months is entitled to take advantage of the Family and Medical Leave Act (FMLA). This entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health

SYSTEM: Systemic Wellness Factors – Organizational Influences

insurance coverage under the same terms and conditions as if the employee was still working. Many emergency physicians choose to work extra shifts before pregnancy and/or delivery, creating a savings account to preserve income during the months of maternity/paternity leave.

Short-term disability insurance is another important tool for emergency physicians. While some employers offer this assistance, every employer differs in benefits offered, so it is wise to personally invest in a short-term disability policy independent of your employer. Most policies cannot be utilized within the first 12 months of employment to avoid pre-existing conditions, which includes pregnancy. Thoughtfully consider these resources well before you plan to start a family. Several corporate medical groups (CMGs), which staff many emergency departments across the county, offer varied benefits to new parents. These can be researched by direct calls to human resource departments or through social media.

Pumping at work for successful breastfeeding often creates a significant amount of anxiety for new parents because many emergency departments have single coverage staffing with minimal opportunities for breaks. The American College of Pediatrics and the World Health Organization recommend exclusively breastfeeding children for the first 6 months of life.

All US companies with 50 or more employees are required to have a dedicated space for pumping and allow time for mothers to pump. Unfortunately, many barriers in the emergency department setting (single coverage shifts, schedule irregularity, and lack of space) prevent this from happening. In Table 2, Moulton, et al, offer initial recommendations to support lactation practices in the emergency department.

Table 2: Recommendations to Support Lactating Physicians in the Emergency Department[†]

Allow breaks	Provide adequate staffing models that allow for and encourage regularly scheduled breaks for both lactating and non-lactating personnel
Assign a breast feeding "champion"	Champions empower coworkers and trainees who need to pump, by offering cross-coverage and other support
Encourage parent groups/community organizations	Build a breastfeeding parent group community within the organization so working parents can connect, share resources, and find community support among other physicians.
Social Media Support	FemInEM; Facebook groups: EM Physician Moms, Physician Moms' Group (PMG), Physician Moms of Multiples, Physician Moms For Premies

[†]Moulton KL, Battaglioli N, Sebok-Syer SS, Is lactating in the emergency department a letdown? Exploring barriers and supports to workplace lactation in emergency medicine. *Annals of Emergency Medicine*, May 2021. Epub ahead of print: <https://doi.org/10.1016/j.annemergmed.2021.03.007>

It is well known that the House of Medicine continues to fall short of the well-researched recommendations that women physicians should receive between 12 weeks to 6 months of paid childbearing leave to “support the child’s medical and developmental needs [and] address the physical effects of pregnancy and parturition.” Emergency physicians need to work together to apply laws that are already in place that support pregnant physicians. Adams commented advocating for “new policies which support maternity/paternity leave will boost productivity in our industry and encourage qualified women to stay in the workforce.”

Resources to inform physicians or organizations about family leave policies:

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Psychological First Aid for Emergency Physicians: Critical Incident Stress Debriefing

By Thomas Benzoni, DO, Julia Marie Huber, MD, FACEP and updated by Andrea Austin, MD

“The parents rushed in carrying a pink blanket with an infant wrapped in it. Everything looked perfect — all 10 fingers and toes, long beautiful eyelashes, flawless skin. Not a mark on her. Only one thing was wrong: she wasn’t breathing. We did our best, but the child had most likely been dead for several hours, possibly a Sudden Infant Death Syndrome (SIDS) case.

I’ll always remember that day. The mom walked out of the emergency department quietly weeping, and in her hands was the pink blanket. Only this time, there was nothing in it.”

“Critical incidents are powerful traumatic events that initiate the crisis response.” The Greenane Center.

The definition of a critical incident (also called an adverse event) is based on the individual’s perception of that event. There are some events that are widely accepted as critical incidents such as pediatric deaths, mass shootings, and the COVID-19 pandemic. Yet, it is important to acknowledge that many other situations may trigger a stress response in health care workers (HCWs). For instance, an elderly patient with multiple comorbidities who resembles the emergency physician’s grandparent may trigger a profound stress response. It is important to recognize the large variety of events that can trigger a stress response. All too often in emergency medicine, there is an expectation of emotional toughness and emphasis on stifling emotional responses. Whether it’s a large mass casualty event, or a single patient with an adverse event, it is important to acknowledge individual differences in the stress response.

Awareness of critical incidents and the consequences is important for the mental health of HCWs. The stress associated with these events can lead to a variety of physical and mental health problems. Mental health problems may include burnout, depression, anxiety, post-traumatic stress syndrome (PTSS), and post-traumatic stress disorder (PTSD).

As individuals and leaders, it is important to know the risk factors and protective factors for PTSS and PTSD. A 2020 Psychiatry Research journal article by Carmassi et al, explored these factors reported in prior outbreaks of MERS, SARS, and, most recently, the COVID-19 pandemic. See the chart below for risk factors and protective factors.

Post-Traumatic Stress Syndrome and Post-Traumatic Stress Disorder Risk and Protective Factors

Risk Factors	Protective Factors
<ul style="list-style-type: none">• Caring for severely traumatized people• Crowded work environment• Interruption in circadian rhythm• Quarantine/social isolation• Preceding mental illness• Working in high-risk areas• Perceived high risk of injury/illness• Early in career• Lack of communication with department leadership	<ul style="list-style-type: none">• Supportive peers and supervisors• Adequate training/feeling prepared• Clear communication from supervisors• Access to PPE, well-organized, safe units• Openness to learning new skills/adapting• Social support• Professional support

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 include: guilt for perceived failure in resuscitation, fear for your own children, fear for your personal safety, and/or a sense of personal failure. These thoughts comprise PTSS and can eventually lead to PTSD.

Symptoms of PTSD are (perhaps not) surprisingly prevalent in emergency medicine personnel:

1. Re-experiencing symptoms
 - Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
 - Nightmares/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 adverse/dangerous event
3. Hyperarousal symptoms
 - Being easily startled
 - Feeling tense or “on edge”
 - Having difficulty sleeping and/or having angry outbursts

The Why and How of Critical Incident Stress Debriefing (CISD)

The goal of these debriefs are to fortify resistance to stress reactions, encourage resiliency or the ability to “bounce back” from a traumatic experience, and assist with recovery from traumatic stress while promoting a return to normal, healthy functions.

There is considerable uncertainty as to one best method for debriefing. Preparation is critical, which is why training and drills are important. The first time you have a real-life experience should not be your first exposure.

Crucial to PTSS/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 have a CISD team. This team can be activated by anyone within or outside the facility. For many years, CISD was 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 shown to be unhelpful and may actually worsen PTSD. As a result, prevention of PTSD on the job holds the utmost importance.

Emergency medicine clinicians need to feel supported, possess the tools to carry out their job effectively, and know that the organization is on their side. When unfortunate events inevitably occur, administrations must offer assistance rather than blame. Support from top leadership should flow from the executive level to the work unit level, directly impacting emergency physicians working on the front line.

New Evidence for Individualized Clinician Support

There is emerging evidence that individualized support versus debriefs may be more important for improved wellness in HCWs. At the core of the individualized support is a caring moment following a critical or adverse incident. Suggested models of implementation include “emotional first aid,” administered by peers and supervisors immediately following the event (Tier 1). The next level includes peer support, in which peers have undergone specialized training to provide added support (Tier 2). Peer support training specifically teaches when affected HCWs should be referred to professional mental health providers (Tier 3). Access to mental health care should be easy, confidential, and immediately accessible.

ACEP has developed a myriad of wellness resources, including peer support and access to counseling sessions, which can be found at <https://www.acep.org/corona/covid-19-physician-wellness/>.

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Resources

American College of Emergency Physicians

www.acep.org

888-817-2237 (call or text)

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

Cultivating a Culture of Teamwork in the Emergency Department

By Jessica Riley, MD

A critically ill patient is wheeled in, and you start the resuscitation. You are tired. This is your fifth shift in a row and there are 25 people in the waiting room with 50% of your beds filled with patients who are boarding. You order 10g of calcium chloride for possible hyperkalemia. The nurse mentally questions this request but is hesitant to speak up. He has had negative encounters with you in the past and does not want to risk another one now. Therefore, the nurse assumes that you are correct and administers the medication at ten times the appropriate dose.

Scenarios such as this are not far-fetched and play out in emergency departments, operating rooms, and physician offices every day.

As emergency physicians, we pride ourselves in our ability to work effectively as part of a team. However, effective teamwork is a skill, and, like any other, must be purposefully cultivated and practiced. Developing a culture of teamwork in our emergency departments is critical to our success. Ineffective teamwork and communication have been identified as a contributor in over 60% of sentinel events. Not only can poor teamwork lead to medical errors, but it can also inhibit the ability to identify errors that have occurred and recover from them.

What is Emergence?

The benefits of effective teamwork include not only prevention of errors but also improved patient care and decision making. Excellent cooperation in teamwork enhances diagnostic reasoning and patient care, as each team member brings different knowledge and experience to the patient care process. This concept is known as emergence and suggests that a highly functional team is truly more than the sum of its parts.

According to research, effective teamwork in health care includes developing a shared mental model for patient care, utilization of closed-loop communication, and an experience of mutual trust and respect. In order for this to occur, there must not only be effective leadership but also an ability for team members to monitor each other's performance and share tasks and adapt to changes in patient condition. Lastly, all team members must recognize that the goals of the team (excellent patient-centered care) are more important than the goals of the individual. Creating a culture of teamwork in the emergency department can be viewed from two different perspectives: the team dynamic of the individual patient encounter or resuscitation and the culture of the department as a whole.

Template Teamwork in the Patient Encounter

While interacting in the patient care setting, emergency physicians often find themselves in the role of team leader. Patient care teams in the emergency department are an example of a “template team,” meaning that the established roles on the team are filled by different individuals at different times. Research shows that these teams function best when the role of each individual is well-defined ahead of time. To this end, poor leadership and task distribution has been associated with delays in care and worse outcomes in resuscitations. Use of crew resource management (CRM) techniques before resuscitations and time-outs before procedures are critical to an emergency department team's success.

Leading an Emergency Medicine Team

There are two specific styles of leadership that can be used in a resuscitation setting: directive leadership and empowering leadership. Directive leadership occurs when specific tasks are delegated to each team member with a top-down approach and is most effective with less experienced teams or when patient acuity is highest. For the team to succeed, it is important that the delegated roles and responsibilities are appropriate for the training and knowledge level of each team member. It is the responsibility of the team leader to maximize the success of each team member by acknowledging their skill and level of training. Empowering leadership occurs when all team members work cooperatively to direct patient management. This type of leadership is most effective with highly experienced teams or when patient acuity is low.

Regardless of the type of leadership employed, the physician leading the team must make a conscious effort to encourage all team members to share their thoughts and question decisions. This creates an environment of psychological safety, which is a critical component of effective teamwork. Psychological safety is defined as the team's shared belief that it is safe to take interpersonal risks without fear of backlash. It is critical for leaders to admit their own mistakes to the team and express appreciation for the input of all team members. Team leaders can optimize psychological safety for the team after the patient encounter by leading a debrief that is focused on learning and identification of areas for improved team dynamics.

How to Cultivate Teamwork

Developing a culture that values the work of the team is not just the responsibility of the individual physician, but of departmental leadership. Emergency department leadership is instrumental in setting the culture of wellbeing, psychological safety, and teamwork. If this is done well, the emergency physician working clinically on the frontline will provide optimal care, enhance patient satisfaction, improve patient safety, and increase their own career longevity.

Emergency department leadership should strive to support the three main components of teamwork, despite the unstructured nature of the emergency department environment. These components are: preparation, execution, and reflection.

To support team preparation, emergency department leadership should sponsor team huddles that include all staff members and promote the practice of rounding on patients with staff. This allows team members to provide input and address any potential patient safety issues in a protected environment. Leaders may also share any critical announcements or information affecting the entire team.

The concept of execution in emergency department teamwork relates to the implementation of processes and protocols that support the work the team does. This can include care bundles for common complaints, evidence-based order sets, or standard handoff tools.

The final component of effective teamwork is reflection. Emergency department leadership should encourage staff debriefs after challenging patient encounters and support the process during team huddles.

Planting the Seed for Teamwork Cultivation

A culture of teamwork in an emergency department can be fostered by education and training offered to all staff members—physicians, nurses, advanced practice providers, technicians, and administrative staff. The development of multidisciplinary training sessions gives team members the opportunity to see each other's perspectives in a safe, low-stakes environment. This enables teams to successfully develop a shared mental model for clinical care during the individual patient encounter. Emergency departments can also offer training specifically focused on developing effective

teamwork. Modules such as the TeamSTEPPS program developed by the Agency for Healthcare Research and Quality (AHRQ) have been shown to improve communication with increased closed-loop communication such as checkbacks, call outs, and patient handoffs. As an added benefit, studies in the surgical environment have shown that team training programs improve staff perceptions of their work environment and decrease nurse turnover.

Successful Teams Practice Teamwork

As a subset of team-based education, simulation is an ideal way to build teamwork and communication skills in a safe, low-stakes environment. Studies have shown that two or more encounters are required to truly engage a team and build shared mental models, so organizers should consider involving participants in multiple encounters. Using simulation allows educators to insert specific triggers that will stimulate the team to practice a targeted skill. For example, if a team member intentionally arrives late to the scenario, this can stimulate other team members to practice use of the Situation, Background, Assessment, Recommendation technique (SBAR) for an organized handoff. As with any patient scenario, allowing time for the team to debrief after a simulation is critical for maximizing team benefit.

Building a team-based culture in the emergency department starts with emergency department leadership and becomes the responsibility of every member of the ED staff. In order to optimize patient safety and outcomes, the emergency department needs to be an environment where all feel safe to voice their concerns, ask questions, and advocate for the patient. This goal can be achieved through department-wide education and communication initiatives but also at the bedside during the individual patient encounters. As leaders in the department, the emergency physician has a special opportunity to lead this transformation.

Resources

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Team Communication Strategies and Training: Agency for Healthcare Research and Quality (AHRQ) TeamSTEPPS: <https://www.ahrq.gov/teamstepps/index.html>

SYSTEM: Systemic Wellness Factors – Organizational Influences

Healthcare Superteams podcast by USF Health: <https://podcasts.apple.com/us/podcast/healthcare-superteams/id1535658331>

Beyond Clinical Medicine podcast, Episode 4: Importance of Teamwork in Healthcare:
<https://www.beyondclinicalmedicine.org/e/beyond-clinical-medicine-episode-4-building-bonds-with-healthcare-team-dr-kissinger-goldman/>

Electronic Medical Records: Surviving and Thriving

By Thomas Benzoni, DO and Rita Manfredi, MD

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 stay calm amid all the chaos?

A Brief EMR History

Not many decades ago, a patient's medical record resided on a 5 x 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 EMR was born. The result was more useful data but also more extraneous information: more signal (data) and even more noise (non-patient data) caused a loss of the patient story.

Evolving EMR

The EMR currently is more of a billing record and less of a clinical record. Keeping this perspective in mind can be helpful in coping with any EMR-related stress. The EMR evolved from billing sheets, on which the physician circled the positive findings and X'ed off the negatives. The markings were tabulated and mapped on a 1 to 5 scale for level of service billing. So, 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 emergency physicians, and, in some cases, cause the physician to leave emergency medicine. This significant millstone wears us down every time we do a clinical shift, and it must 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 emergency medicine—the patient. We are reminded daily that we take care of patients; so, caring for the patient is the solution. Each patient has their own story, and all those stories must stay central to our work.

So how do we preserve this essential function of testimony and information transmission? The same way we have done it since the birth of emergency medicine: Listen to and document the patient's story. The story is the wonderful part of emergency medicine; it's the documentation in the EMR that is defeating us.

So how do we cope with the stresses of the EMR?

Start with the Patient

- Etiquette. Sit down in the patient's room. There's a reason the computer is called a laptop. Address the patient by name: Mr. Jones or Ms. Smith. Look at the chief complaint before you walk in and comment on it ("The chart says you are here for abdominal pain. It looks like you don't feel so good.") Let the patient know you are their advocate so you can find out their story and focus on the problem. Be sure to face the patient over the top of the computer screen so you can see the patient's face and eyes, and they can see yours. Do not type on the computer with your back facing the patient.
- Learn keystroke shortcuts. This will let you look at the patient while your fingers retrieve 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.
- Have a document/text/scratchpad 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 operating system), 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 emergency department
 - What you found
 - What you did
 - What you want the patient to do
- Utilize scribes. There is a huge literature base on this topic, clearly showing that a scribe will pay for him/herself. Hospital or department won't do it for you? Then, hire one yourself. You can afford it, but you can't afford to let this stuff stress you out! The productivity improvement will pay for the scribe. (<https://www.ama-assn.org/practice-management/sustainability/overlooked-benefits-medical-scribes>)
- 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 will push your most common tests to the top).
- Use a laptop or a Computer on Wheels (COW) and load the radiology picture archiving and communication system (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.

SYSTEM: Systemic Wellness Factors – Organizational Influences

- Show off your knowledge of past events by having prior visit dates, diagnoses, and inpatient discharge summaries pulled up on your screen.
- What if you still are frustrated with electronic medical records? 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 a way of life in emergency medicine, and we are the ones to transform them so both the patient and the clinician are benefited. As Jack Welch said, “*Control your own destiny or someone else will.*”

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Battling Harassment in the ED

By Yasmine Altrache, PA

Working with difficult patients is not foreign to me, especially in an urban hospital with a high prevalence of mental illness, poverty, and substance abuse. When I went into work that evening, I did not expect to be a victim of harassment by both a patient and provider. Nearing the end of my night shift, I requested an ophthalmology consult regarding an intoxicated patient with significant trauma to his left eye. The ophthalmology resident was unwilling to transport the patient to the evaluation room, which was standard practice. Transport services and nursing staff resisted my requests as well. Phrases such as “that is not my patient or my job” were spoken. Already exhausted with patience running thin, I reluctantly transported the patient myself. After transferring the patient from his wheelchair to the examination chair, he became agitated, flinching with every attempt at evaluation by the ophthalmologist. The ophthalmology resident berated me for requesting a “ridiculous” consult and demanded that I hold the patient still or he would leave, terminating the consultation. The patient grabbed me by the waist, with his other hand rubbing my arm. I was told to keep the patient still while the inappropriate touching continued. I said nothing. I didn’t speak up.

Later, as I wheeled the patient back to his room, I felt defeated, manipulated, and annoyed. I was mostly disappointed for allowing myself to be a voiceless victim of emotional, professional, and sexual harassment.

Identifying Workplace Harassment

Harassment can take on many forms, often leaving victims with feelings of confusion, anger, and guilt. It may lead to decreased work satisfaction, depression and anxiety, compromised patient care and loss of employees, among others. The #MeToo movement helped draw national attention to sexual harassment and numerous publications explore the prevalence and effects of harassment in the medical setting. High stress environments can amplify harassment, especially when there is a lack of constructive outlets and healthy coping mechanisms. Emergency medicine is not immune to the infection of harassment in the workplace and may even present with unique dilemmas that other fields of medicine may not encounter. And no one, from medical student to professor, is immune from the possibility of being a victim.

Workplace harassment creates a toxic environment, affecting victims’ productivity and safety. Workplace harassment is illegal. Let’s say that again. Workplace harassment is illegal.

Harassment can present differently from one situation to another. It can be verbal and/or nonverbal. It may manifest as unwanted sexual attention, inappropriate comments, macroaggressions, coercions, hostility, or exclusion. Harassment intimidates individuals through verbal, physical, psychological, and sexual threats.

Being able to identify harassment, whether you are the victim or an observer, is the first step in combating it.

Workplace Harrassment

Verbal: Excessive criticism, yelling, cursing, inappropriate jokes, demeaning remarks, name calling

Psychological: Exclusion, withholding information, bias scheduling

Cyberbullying: Derogatory online postings or reviews, unwarranted serial texting/emailing

Sexual: Unwanted touching, staring at certain body parts, sexual remarks, sexual assault

Physical: Damage to personal property, physical threats, unwanted physical contact, stalking, violence to your body

Harassment and Culture

Workplace harassment is often tied into workplace culture, feeding off an inadequate reporting system, fear of reprimand, lack of supportive colleagues, and the traditional model of hierarchy in medicine. Without a change in workplace culture there will continue to be harassment (Figure 1).

Figure 1: Contributors to Workplace Harassment



When harassment inflicts an individual(s), it is vital that not only the specific situation be examined, but the workplace culture be evaluated for deficiencies that may contribute to continued harassment.

Consider the following:

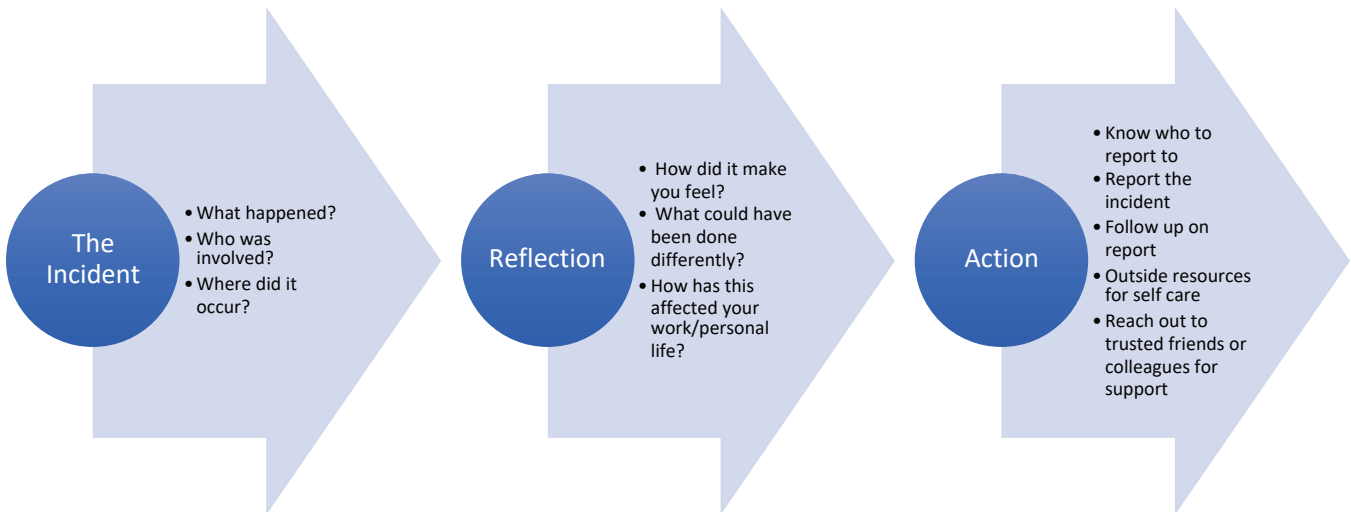
- Do employees and staff know what constitutes harassment?
- Is there adequate training in place regarding recognizing and reporting harassment?
- Do individuals know who to go to when they are victims of or have witnessed harassment?
- What safeguards are in place to avoid continued harassment?
- Is the overall workplace a safe, productive, and collegial work environment?

Working Through a Difficult Problem

In emergency medicine, aggressions can come from patients, colleagues, students, consulting services, management, etc. Each situation can present with its own particular set of challenges. An intoxicated patient using racial slurs brings up the question of capacity, judgement, and insight at that time. Contrast this situation to where a colleague touches another staff member inappropriately.

If you have been a victim of harassment, consider working through a self reflection chart to help identify the problem, how it made you feel, and what could be done about it (Figure 2). This chart can help you navigate the situation and point out potential solutions that promote workplace culture change, self-healing, and accountability.

Figure 2: Self Reflection Chart



Once you have had some time to reflect on the situation and your feelings surrounding the incident(s), you may decide among a few different paths to take next. No path is wrong and each is unique and situation-based.

The Case

Mona is a resident at a community Emergency Department. While caring for a patient, Mona was approached by a senior colleague to meet for dinner after work. Mona declined and went about her day. The following day, she noticed that the individual was abrupt and standoffish, often ignoring her questions and concerns regarding patients. That individual later began spreading rumors at work regarding Mona's sexuality, calling her "promiscuous" as well as propagating derogatory names. Mona began feeling uncomfortable at work and her self-esteem suffered, causing issues with her professional and personal relationships. What can Mona do and to whom can she go for help?

The Situation:

- Mona is a victim of verbal and sexual harassment by a senior colleague, putting her in an even more precarious situation as a subordinate learner. The harassment has affected her personally and professionally, negatively impacting her clinical work and self-esteem.

Next Steps:

- Mona might choose not to report the situation to management and rather approach the individual directly regarding the harassment. This is not wrong, however, it is important to do this in a professional manner and be aware that the harasser may not be willing to change/listen.
- Mona can speak to the directors of the residency program and report the incident. Or she can approach senior leadership/administration in the emergency department or hospital. There are human resources staff to assist and guide individuals through a formal process of reporting harassment.
- Mona may find emotional support through trusted colleagues, friends, and family members, as well as professional counselors. Individuals affected may reach out to their own therapists from whom they can gain insight and direction. If at any point Mona feels physically threatened, she should reach out to the police immediately. Multiple third party resources are listed at the end of this chapter for additional guidance.

Emergency medicine is demanding physically, emotionally, and spiritually. It is difficult enough without being a victim of harassment. Addressing and combating workplace harassment is important in fostering an environment that is safe and productive. When this environment of safety is present, it is only then we can flourish, addressing the needs of our patients, families, and ourselves.

Resources

9 to 5: National Association of Working Women
1-800-522-0925
helpline@9to5.org

Equal Employment Opportunity Commission
1-800-669-4000

Equal Rights Advocates
1-800-839-4372
24-hr line: 415-621-0505
info@equalrights.org

Websites

Empower work from <https://www.empowerwork.org/>

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What is Physician Impairment: Can It Happen to me?

By Douglas Char, MD and Preeti Jois, MD

Introduction

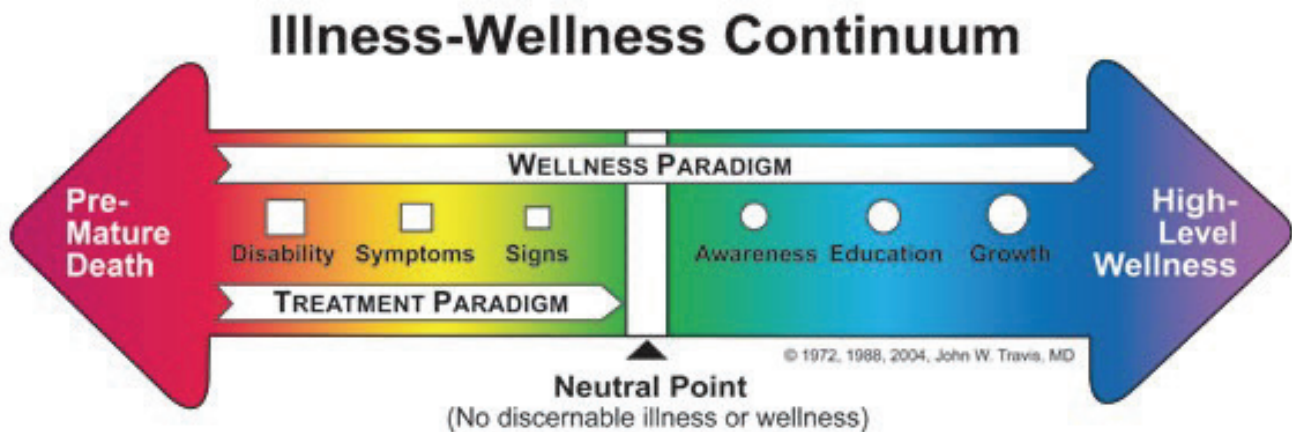
Physician Impairment sounds serious and scary. It's often thought of as something extreme or terminal. Maybe we should view it as the lack of physician wellbeing. Most of us are not 100% unwell, we just don't experience enough wellness in our daily lives. We are out of balance.

Like most chronic disease states (HTN, kidney disease, obesity), impairment and wellness are at two ends of a continuum. Each of us has a personal threshold and we move back and forth along the spectrum over time. It's only when we find ourselves stuck on the negative side of that continuum, we are at risk for severe impairment.

Harassment and Culture

Workplace harassment is often tied into workplace culture, feeding off an inadequate reporting system, fear of reprimand, lack of supportive colleagues, and the traditional model of hierarchy in medicine. Without a change in workplace culture there will continue to be harassment (Figure 1).

Figure 1: Contributors to Workplace Harassment



Illness-wellness continuum, Travis, 1970.

Not all stress is bad. Short periods of “situational stress” are part of a routine work environment for emergency physicians. Tension in certain settings, such as level 1 traumas and codes, allows us to step it up, focus, and become more efficient. However, all of us are guilty of allowing stress to build up to an unhealthy level from time to time. We are at risk of becoming impaired 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 Adult APGAR chapter).

Good Stress Has Its Place

- Allows us to step up and focus
- Become more efficient
- Energizes us temporarily

Stressors

The cause of our distress may be acute and sudden, such as a medical error, or unexpected outcome (second victim), a threatened lawsuit or impending litigation (medical malpractice stress syndrome) or a traumatic event (mass casualty, shooting, disaster) that in its most severe form leads to the development of PTSD (post-traumatic stress disorder). Alternatively, 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 (moral injury and compassion fatigue).

In all these situations, caregivers often experience a predictable constellation of physical and emotional symptoms. We feel exhausted, restless, sad and angry all 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.

Dealing with Stressors

Once we recognize that stress is present, how we deal with it matters. What coping mechanisms do you rely upon to get through the shift, the day, and the week? 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).

When Physician Impairment Occurs

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 must be open to the idea that emergency physicians are not only at high risk, but deserve support and caring when we become or are at risk of becoming impaired.

Physician impairment can have potential negative impacts on the physician, their family, other physicians and staff, and their patients. If impaired physicians undergo appropriate treatment and aftercare, most can successfully return to work.

Definition

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 or assignments or requirements expected of an emergency physician.

Impairment runs the gamut from ignoring self-care to being unable to function at a professional and personal level. A physician can be impaired for many reasons: too many hours, improper work-life balance, chemical dependency, poor interactions with other physicians/consultants/staff, depression, mental health issues, obesity, physical health issues, as well as loss of previously employed coping skills, just to name a few.

Types of Physician Impairment

- Physical Illness – Cognitive Changes, Cancer, Obesity, Poor Health, Chronic Illness and Aging
- Mental Illness – Depression, Addictions, Personality Disorders, The “Disruptive Physician”
- Boundary Violations and Unprofessional Behavior

Warning Signs

Note: 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 single or in combination, and they may very well signify problems other than substance abuse. Rarely does someone demonstrate all these signs.

- Performance Deterioration
 - 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
 - Increased complaints of flu, stomach distress, sore throat, headache, or vaguely defined illness
- Attitude and Physical Appearance Changes
 - Details are often neglected, assignments handled sloppily
 - Others are blamed for the individual’s own shortcomings
 - Colleagues and the 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
- Increased Health and Safety Hazards
 - A higher-than-average accident rate emerges
 - Careless handling and maintenance of machinery and equipment
 - Taking of needless risks to raise productivity following periods of low achievement

- Disregard for safety of colleagues
- Emerging Domestic Problems
 - 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

What should be done if you suspect you or a colleague is becoming impaired?

If you sense that you are stuck in an unhealthy situation, seek out help immediately. If you are reading this, you already realize you are not alone – welcome to the epidemic of self-doubt and unhappiness. Talk to a trusted colleague, your personal physician or religious/spiritual counselor. ACEP offers free counseling sessions through a trusted partner which are strictly confidential. 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, hardest thing you can do.

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

Your expression of interest, support, and caring may be the extra nudge that your colleague 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 colleague will reactive negatively or deny that they need help? Sure, just like our patients. These reactions don't stop us from doing the right thing for our patients. Nor should they 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.

Aside from the personal need to help, it is a duty and obligation to report any good faith suspicion or concern about an impaired physician. This can be done with immunity. Check with your residency director, chief, chair, HR department, or state medical board on reporting avenues and resources. Many institutions and states have special programs to assist physicians in trouble. Many of these services are confidential and can be implemented without risk of licensure loss.

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 attitude is conducive to the objective tone of the intervention.

Help is out there. Don't be afraid to reach out for it.

Resources

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ACEP // ACEP Wellness & Assistance Program

INBOX ZERO: To Do or Not to Do

By Diann Krywko, MD

A few months ago, I asked my 16-year-old son to pull up a particular email about an upcoming very important event. Looking over his shoulder, I noted over 1,200 unopened emails, as well as the quizzical look on his face (meaning he had not read it). Palpitations and queasiness came over me. How could he have that many unopened emails? More importantly, how could he be mentally unaffected by that glaring red oval with that blinding white number within? As I turned to my husband to relay my shock and concern, he showed me his phone. A whopping 15,660 unread emails showed in that same bright red oval. “They’re probably all ads and useless anyways.” Like father, like son. My cardiac arrest ensued.

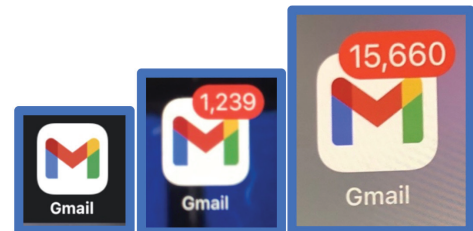
When New York native Ray Tomlinson (1941-2016) invented electronic mail, later coined ‘email’ or ‘e-mail,’ in the 1970’s, he never would have dreamed that over 300 billion emails would be sent daily worldwide by 4 billion email users. Until that invention, the only way to connect to another human being was in person (gasp!), with a phone call, a handwritten letter or note, or with another computer user on the same computer. What he also wouldn’t have dreamed of, is the amount of stress that incessant stream of email causes some people.

If you are like me, an ordinary emergency physician, seeing unread emails creates angst. Even knowing that there may be unanswered, lingering emails evokes the same feeling. My thumb gets twitchy, ready to tap that email icon on my phone, read it and respond. Anything but “zero” causes me to stop what I am doing and address it immediately, no matter where I am, what I am doing or how important the professional or personal task. On the other hand, you can also be an ordinary emergency physician and not be seismically affected with undo angst if your inbox is overflowing and stays that way indefinitely.

The problem is that we cannot control the incoming email. The senders keep sending, making their urgencies our urgencies. It is never-ending unless you don’t have an email account or block 100% of incoming messages.

Email Fast Facts

- Almost 3 billion emails are sent daily, totaling 74 trillion emails yearly.
- Approximately 60 billion of these are spam.
- The average office worker receives 122 business related emails and sends 40 each day, spending 16% (15.5 hours) of their workweek on email.
- 85% of people check emails on mobile device.
- Almost half of all people check email every couple of hours.
- 17% of Americans check emails during a conversation.
- 60% check email while in the bathroom, 40% while watching TV or a movie, 25% on a date, 79% on vacation and 15% in church.
- Nearly 20% check email or texts while driving.



Merlin Mann, a productivity expert and creator of 43 Folders, a personal productivity system, gave a Google Tech Talk in 2006. In that talk, he coined the term “Inbox Zero”. When I heard the term “Inbox Zero”, instant fascination overwhelmed me. What is Inbox Zero and how does one ever achieve such a thing? Contrary to what I had thought, an inbox of zero is not about the number of messages lingering for you in your inbox. Rather, it refers to zero stress surrounding email, which saves time and money in the long run.

Let's repeat that:

“Inbox Zero is about having zero email stress.”

That quote is directly from Merlin Mann himself! The secret is to put email aside with not one ounce of your brain power or attention dedicated to that inbox. Your inbox doesn't necessarily have to be at a numerical zero, however, utilizing his approach may very well get you there- a great potential side effect of his system.

Emergency Physician Strategy to get to “INBOX ZERO”

Is it even possible? The answer to that question is yes. More importantly, it is worth the time and energy to all emergency physicians. Some subscribe to the Inbox Infinity way of thinking, but more about that later. Having thousands of unread emails does not equate to increased stress levels for this group of people. But, for most emergency physicians, unread and unaddressed emails generate unwanted and negative stress. So, let's decrease that tension and get to work on the concept of Inbox Zero.

Pre-Inbox Zero Steps

Inbox Zero is a tool to address emails that arrive in your inbox. Before tackling the emails, the first step is to decrease the bulk of those emails, allowing you to address less volume right from the start.

Unsubscribe to all unwanted or spam email. You may have been placed on a mailing list either by choice or by no intention of your own. Completely get rid of these inbox nightmares. Here are three ways to do so.

1. Unsubscribe to all. This option is usually found at the bottom of the email in small print. Unfortunately, not all email lists include this unsubscribe link at the bottom, even though it is required by law.
2. If there is no opt out link, you may list these email addresses as spam. While this may take more than one mark before your email client and services learn to recognize the sender as such, it will eventually clear them from your inbox.
3. You can put a filter on unwanted email addresses, which will work instantly.

Decrease frequency of emails and notifications. Perhaps there is an organization or other entity from which you would like to receive emails and information and remain on their mailing list, but not receive emails quite so often. If so, you may change the frequency of emails. This can be done in 3 ways.

1. Contact the organization or entity directly requesting a change.
2. Log in to your account and change the email notification preferences.
3. Scroll down to the bottom of the received email. Buried in small print, click on the ‘manage account’, ‘unsubscribe’, ‘contact us’ or similar link.

Inbox Zero System: The Almost Five D's

Merlin Mann suggests that when processing email, you don't need to read every email thoroughly. This wastes precious time and energy and creates additional stress, which is opposite to Inbox Zero goal. Rather, each email should be scanned for importance and sorted into five potential actions upon the first processing: Delete, Delegate, Respond, Defer, and Do.

Delete

Once you have scanned the information contained in the email, you either delete every single email permanently or archive it for later use. And this means everything! This is the easiest action to do and efficiently eliminates as many new emails as possible. If the email has no relevance or you may never read it again (including junk, spam, unidentified senders), delete it. This stops the meaningless emails from clogging up your inbox and your mind. We've got too much in there already.

By archiving the remainder of your processed emails, your inbox will stay at zero. A word on archiving: remember to keep your archiving system simple. You want to be able to find it quickly and easily. This may be done with your own system or a professional Inbox Zero app.

Personal system: Give your folders labels and names you can easily relate to. For emergency physicians, some examples might be "promotion folder", "medical directors meeting", "wellness project", "residency folder" and so on. Don't label something "miscellaneous". That's a black box where emails go to die. The emails you put there should have been deleted in the first place!

Professional system: There are professional apps for organizing email. Who knew? Some examples include: "Clean Email", "Inbox" by Google from Gmail, "Boomerang" for Gmail, "Sortd", "Organizer", and "CloudMagic" to name a few. A more fun approach might be "The Email Game" app, which quantifies your effort and provides positive feedback.

Delegate

If there is a task that must be dealt with, but not necessarily by you, delegate it to someone else more appropriate. In this case, you may send an email or forward the one you received. Make sure to set a reminder to follow up with the delegated request. It is now out of your email inbox and you should go on to the next task.

Respond

If responding will take minimal time, less than 2 minutes, then do it on the spot. Do not scan and come back at a later time. Keep in mind that when responding, it doesn't need to be a lengthy novel. The headline should be brief and engaging, and the body of the message limited to a few lines. Short and sweet or you will lose your readers and waste your time. Once you respond, either delete it or archive the email. Now it's out of the inbox.

Defer

There are emails that need more attention, either in reading or responding more thoughtfully. If time permits while processing, take care of those responses right away. However, if processing or responding will require more time then defer the email until later. You can do so by filing the email in a 'to respond soon', 'require response', or 'to-do' file. This takes that email out of the inbox and out of the stress zone.

Make sure to set aside specific times every day or week, depending on the urgency and your shift schedule, to address deferred emails such as these. Answer these emails until that folder is as empty as possible for the day. Only emails that require additional information gathering for response or time should be left.

Do

If you can take care of the ask in the email in less than 2 minutes, then do it immediately. This is similar to responding, but here there is a task at hand. This might involve, putting an invite on your calendar, arranging a zoom meeting, responding with a phone call, printing something out, etc.

Be Mindful About Your Inbox

Adopt a strategy to unplug from email that meets your needs yet helps maintain wellbeing. Referring to the email facts above, are you among the 50% of all people who check email every couple of hours, or check email while watching TV or a movie? This does not create an environment of wellness. The Inbox Zero goal is to keep your email closed for most of the day and be ultra-productive when you open it. Think about it this way. You're off the clock. Enjoy yourself and your friends and family for a change, without the stress of work.

Do not enable email notifications on your device. One way to achieve this is to require a manual inbox refresh when you log in to the account. Further, do not install any web browser email plugin that instantly notifies you of emails as soon as they arrive. If you have one, un-install it.

Silence your notifications. If you cannot hear that beep or sense that buzz, you won't feel the obligation to react immediately.

Dedicate a specific time of day and length of time to open and address emails initially. As Merlin Mann recommends, this goes for the deferred emails as well. Depending on when you are most productive and when your schedule allows, this may be different for each emergency physician. The bigger the inbox, the longer time allotment. Remember this strategy is not a one-time event. Your goal is a change in behavior that results in a consistent habit.

To ensure you don't go over your allotted time, a timeboxing app such as "Clockify", "Hourstack", or "TickTick Premium" might come in handy. These apps will also calculate details of your productivity statistics.

If you still can't address all the emails consistency and effectively, then it might be time to enlist help. How about a personal assistant? Can't afford or justify this route? Consider installing apps like "Clean Email", mentioned previously, which can identify important emails and move junk messages to trash.

Close your email program when you are not on it. Every other minute of the day that is not dedicated to email response should be filled with things that are important to emergency physicians. This is a surefire backup to silencing the notifications.

Returning from vacation can result in a mountain of emails numbering in the hundreds to thousands. Here is an example of one strategy used by a Chief Wellness Officer in an "out of office email notice":

I'll be away from my computer until ____.

Your email will be auto-archived so I will not be overwhelmed with a deluge of emails when I return.

If your email requires a response, please set a reminder for yourself on ____ to follow-up.

By doing this, you're allowing me to return headache-free. I'll open my email and not feel immediately stressed about all that I missed.

That's good for my own wellness, as well as the wellness of my family.

Disconnecting is important.

Thank you in advance.

Are you addicted to your mobile device and unite with the other 85% of the population who checks emails on their mobile phones? The upside is that your phone is likely with you everywhere so there is no stress of restricted access. The downside is that you are never truly unplugged. Put the phone elsewhere so you cannot see, hear, or feel the notifications. Emergency physicians should know that this is especially important when driving--we take care of the MVC's in those patients who were texting and crashed.

Cons to Inbox Zero: *Inbox Infinity*

The pros to the Inbox Zero approach seem obvious and nirvana-like to a person like me. Many executives agree. However, there are also those who believe there is a case for not removing unopened emails in your inbox and allowing them to exist there. Steven Covey, who wrote *The Seven Habits of Highly Successful People*, believes prioritization is better than attempting immediate response to every email. Inbox Infinity is an approach coined in opposition to Inbox Zero, wherein the mantra of let go and let live takes over. Since inboxes are impossible to clear to zero, this approach encourages not responding to every email. It is accepting the fact that there will be a forever stream of emails, most of which might be useless, and deciding that ignoring most is perfectly acceptable.

Regardless of which approach and email mindset you subscribe to, if it works for you, your stress level, and your career, then continue with that system. There is no one absolute for everyone.

Just like Ray Tomlinson, no one knows the exact first email message he sent across the room. It was likely gibberish, a simple string of characters sent to a neighboring computer to determine if the message had been received. After 50 years, many emails we receive are still gibberish, taking up our time and energy.

It is time to lose them, both on our computer and in our mind space.

Resources

Blogs

<https://blog.doist.com/inbox-zero/> To Inbox Zero or Not to Inbox Zero? We ask 7 tech leaders whether they think inbox zero is worth it. Ambition & Balance

<https://flow-e.com/inbox-zero/outlook/> Achieve Inbox Zero With Outlook. Apply Fundamental Principle To Reach Inbox Zero In Outlook. FLOW-E

<https://review42.com/resources/how-many-emails-are-sent-per-day/> How many emails are sent per day in 2021? [And More Thrilling Stats]. Nick O. Review42

<https://flow-e.com/inbox-zero/> What Is Inbox Zero. The 2019 Guide To Achieving Zero Inbox. FLOW-E

<https://www.themuse.com/advice/your-stepbystep-guide-to-reaching-inbox-zero-even-if-you-currently-have-1000-unread-emails> Your Step-by-Step Guide to Reaching Inbox Zero (Even is Your Currently Have 1000+ Unread Emails) Alyse Kalish, themuse.

<https://clean.email/blog/productivity/what-is-zero-inbox> What is Inbox Zero and How to Achieve It? Clean Email

Videos

<https://web.archive.org/web/20140320004651/http://inboxzero.com/video> Merlin Mann's email video

Healthy Aging and Retirement: Transitioning, Financial Planning, and Resources for Retiring Emergency Physicians

By Shay Bintliff, MD, Richard Goldberg, MD and Gloria Kuhn, MD

Section One: The Transition

Any transition must be seen in the context of your life's journey. So ask yourself, "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 any transition, an understanding of which can benefit the prospective retiree:

1. Letting go of the status quo (an ending)
2. Suffering the uncertainty of limbo (a period of confusion and distress)
3. Beginning something new again

It is a natural process of disorientation and reorientation that marks the turning point in the path of growth and self-renewal that we all will face.

Stage 1

Every transition begins with an ending. We must let go of the old 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. Even though people may congratulate you on your new life, you may go through a period of mourning for the loss of the old life. That is normal.

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 to how you coped with other endings. Perhaps you have experienced the loss of a pet, a friend, a parent, or a loved one. Recall those feelings and thoughts — they can sometimes be reactivated in this phase.

Stage 2

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 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 go.
- Most importantly, think of what would be unlived if your life ended today.

Stage 3

You make it to the final stage — a new beginning! As stated earlier, we come to beginnings only after endings. It may help to navigate this final completion stage by recalling the important beginnings in your own past (e.g., the decision to become an emergency physician, meeting your significant other, or moving to a new home). 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.

Enjoy the ride!

Resources

Bolles, Richard Nelson, John E. *What Color Is Your Parachute? for Retirement: Practical Planning for Money, Health, and Happiness* Ten Speed Press 2015.

Fraunfelder, Frederic MD and Gilbaugh, Jim JR, MD *Retirement Rx :The Retirement Docs' Proven Prescription for Living a Happy, Fulfilling Rest of Your Life*, Thorndike Press 2008.

Section Two: Financial Planning Basics

A comprehensive discussion of financial planning is beyond the scope of this chapter. A broad outline of the subject will be presented here to get you started. Most emergency physicians will benefit from the services of a certified financial planner to deal with the complexities of retirement financial and estate planning.

I. Financial Planning – A Timeline

- Age 20s to early 30s
 - Save 10% of your income
 - Join your employer's retirement plan
 - Use an IRA or other retirement savings accounts if your employer has no plan
 - If self-employed, use an individual 401(k), Simplified Employee Pension Plan (SEP), or similar plans
- Age 30s through 40s
 - Save at least 10% of your income
 - Have adequate health and life insurance and emergency fund
- Age 50s and 60s
 - Boost savings to 20% of your income or more
 - Maximize tax-deferred contributions

- Begin shifting to lower risk investments
- Begin focusing on retirement lifestyle
- Calculate realistic retirement resources
- Retirement
 - Determine yearly withdrawal amount
 - Determine from which accounts to withdraw
 - Invest more conservatively but don't abandon stocks
 - Hold 2 to 3 years of living expenses and cash equivalents
 - Develop estate plan

Please refer to the Financial Planning Association (www.fpanet.org) for financial planning resources as well as a search for introductory publications. Also provided are listings of local certified financial providers. (www.plannersearch.org)

II. Estate Planning: The Four Fundamental Tools

Select a team of professionals, including a certified financial planner (CFP), 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 a minimum of four estate planning tools: a will, a durable power of attorney, a living will, and a medical power of attorney.

1. **A will.** This is a legal document that details who will oversee the execution of the will and where you want your estate's assets to go. 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.
2. **A living will.** This is an individual's written declaration of what life-sustaining medical treatments he or she will allow or not allow in the event they become incapacitated. Also look at Five Wishes at the End of life: www.fivewishes.org.
3. **Durable power of attorney.** This 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 court approval to carry out needed financial transactions.
4. **Medical durable power of attorney (or health care proxy).** This authorizes a person to make medical decisions on your behalf, ideally carrying out what you've specified in your living will.

III. Medicare Basics

Medicare is a national social insurance program, administered by the US federal government, that currently uses about 30 private insurance companies across the country. Medicare guarantees access to health insurance for Americans aged 65 and older who have worked and paid into the system, younger people with disabilities, anyone with end stage liver disease, and persons with amyotrophic lateral sclerosis. Medicare has four parts:

1. Medicare Part A.
 - a. This covers inpatient hospital stays, including a semi-private room, food, and medical tests. Also covered are brief stays for convalescence in a skilled nursing facility as well as hospice care, if certain criteria are met.
2. Medicare Part B (two types of services).
 - a. Medically necessary services. Services or supplies that are needed to diagnose or treat your medical condition and meet accepted standards of medical practice.

- b. Preventive services. Health care to prevent illness (like the flu) or detect disease (like hypertension or diabetes) 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 assignments. Examples include clinical research, ambulance services, durable medical equipment, mental health (in/outpatient), surgical second opinions, and limited outpatient prescription drugs.
3. Medicare Part C (Medicare Advantage Plans).
- a. 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.
4. Medicare Part D.
- a. A prescription drug option run by Medicare-approved private insurance companies.

There are services not covered by Medicare. If you need these certain services, you'll have to pay for them yourself (out of pocket) unless you have other insurance or you're in a Medicare Health Plan that covers these services. Examples include dental care, eye examinations related to prescribing glasses, dentures, cosmetic surgery, acupuncture, hearing aids and exams for fitting them, and long-term care.

Applying for Medicare can be a confusing issue. The Initial Enrollment Period is a 7-month period that includes the month you turn 65 and the 3 months before and 3 months after that month.

There are 3 steps.

1. Decide if you want Original Medicare [Part A and Part B (B is optional)] or a Medicare Advantage Plan (Part C).
2. Decide if you need drug coverage (Part D). This is sometimes included in Part C plans.
3. Decide if you need to add a Medicare supplemental insurance plan.

Resources

Medicare Basics – <https://medicare.gov>

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 payout. For example, by waiting until age 65 to start taking benefits, your annual benefits increase by 6% over the sum you would receive at age 62. Benefit payments begin about 4 months after your application is submitted. In applying for benefits, you can either schedule an appointment at the local Social Security office or online at www.ssa.gov.

Resources

Financial Planning Association (www.fpanet.org)

Planning for the Stages of Retirement. <http://www.fpanet.org/docs/assets/4-13-06retirementplanning.pdf>

<http://medicare.gov/pubs/pdf/11034.pdf>

Social Security Site: www.ssa.gov

Social Security Benefits: Do Your Homework. Scott M. Kahan, CFP—strategies for obtaining benefits.

Section Three: Important Resources in Pre-Retirement and Retirement Years

Sports, Fitness, and Exercise

1. **National Senior Games Association.** The association sponsor 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. www.nsga.com
2. **2011 Physical Activity Guidelines for Americans.** Developed with health professionals and policymakers 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. <http://www.cdc.gov/physicalactivity/everyone/guidelines/olderadults.html>
3. **The American Volkssport Association.** A nonprofit organization with a goal to promote physical fitness and good health by encouraging all people, regardless of age, to exercise in non-competitive, stress-free programs. Included are non-competitive 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. www.ava.org
4. **National Institute on Aging.** Find articles and other general information on how exercise can help you live a longer, healthier life. <http://www.nia.nih.gov/HealthInformation/Publications/>
5. **National Park Service.** Information is available on national parks, historic sites, and monuments across the country. Address: National Park Service, 1849 C Street, NW Washington, DC 20240 202-208-3818. www.nps.gov

Diet and Food

1. **Older Adults** — Healthy People 2030. By 2060, almost a quarter of the U.S. population will be age 65 or older. Healthy People 2030 focuses on reducing health problems and improving quality of life for older adults. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/older-adults>
2. **Protein Requirements for Older Adults** — The Geriatric Dietitian. Protein requirements for older adults may be different than for younger adults. This article explains what those requirements are and why it's important. <https://thegeriatricdietitian.com/protein-requirements-for-older-adults/>

Healthy lower-fat sources of protein include poultry, fish, dairy, and eggs. A 3.5 ounce (100 g) chicken breast contains about 30 grams of protein; 1/2 cup of cottage cheese, about 15 grams.

Greek yogurt is a great addition to toast and jam in the morning and offers about 15 grams of protein in half a cup. A large egg delivers about 6 grams of protein.

Retirement Planning

1. **U.S. Department of Health and Human Services, Administration on Aging.** This agency provides a variety of booklets with pre-retirement counseling services. <https://acl.gov/about-acl/administration-aging> or www.hhs.gov 202-619-0724

2. **U.S. Department of Labor:** Taking the Mystery Out of Retirement Planning. The online version includes interactive worksheets for each chapter. www.dol.gov/ebsa/publications/nearretirement.html
3. **CNNMoney:** Retirement Planning and Savings Plans. Find strategies and advice, including retirement calculators. www.money.cnn.com/retirement/
4. **Senior Health Insurance Information Program (SHIIP).** For assistance evaluating your health care needs and options, contact your state's SHIIP. <https://www.cms.gov/contacts/seniors-health-insurance-information-program-shiip/general-beneficiary-contact/1562161> This is a free service provided by the National Association of Life Underwriters 703-276-0220. www.nahu.org
5. **Consumer's Guide to Insurance.** This non-profit organization provides guidance on a variety of insurance options. www.life-line.org
6. **The Financial Planning Association.** Find articles on understanding the importance of financial planning as well as a search for local certified financial providers. www.fpanet.org or www.plannersearch.org
7. **Voya Financial.** Find resources and advice or connect with a professional for retirement financial planning. www.voya.com

Educational and Travel Opportunities

1. **Auditing Seniors.** A large number of local institutions and state and city universities allow seniors to audit their courses free of charge or for a nominal sum.
2. **The Earthwatch Institute.** Participants volunteer to go on scientific research projects. Worldwide in scope. www.earthwatch.org 800-776-0188
3. **Elderhostel.** A nonprofit 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. www.elderhostel.org 800-454-5768
4. **The Smithsonian Institution.** This program presents a wide variety of educational opportunities including cultural activities and public outreach programs, including performing arts, lectures, films, and courses. www.SI.edu 800-633-1000
5. **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. (800) 836-arts. www.chautauqua-inst.org<https://www.chq.org>
6. **Consumer's Guide to Insurance.** This non-profit organization provides guidance on a variety of insurance options. www.life-line.org
7. **Senior Summer School.** This organization offers seniors an opportunity to enhance their summer through leisure, education, and discovery at campus locations across the United States and Canada. (800) 847-2466. www.seniorssummerschool.com**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. <https://www.osherfoundation.org/programs.html> 415-861-5587

8. **Association of Graduate Liberal Studies Programs.** This organization offers graduate degree programs in a variety of liberal studies. <http://www.aglsp.org/> 919-684-1987

Health

1. **American Heart Association.** Find a variety of reports and brochures covering all types of heart disease, as well as guidelines for preventative care. 800-AHA-USA1 www.americanheart.org
2. **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. There is a minimal cost per year. www.consumerreports.org/health
3. **National Institute on Aging.** This is a government agency providing free publications on many areas of health and aging. <http://www.nia.nih.gov/HealthInformation/Publications/>
4. **National Heart, Lung, and Blood Institute.** Provides a variety of materials relating to cholesterol, blood pressure, obesity, asthma, and sleep disorders. www.nhlbi.nih.gov/
5. **CDC Healthy Aging Podcast Series.** An established program offering podcasts on a variety of health-related topics. <http://www.cdc.gov/aging/publications/podcasts.htm>
6. **MyPlate.** This website analyzes diet and level of exercise and makes recommendations on dietary change based on the most current guidelines. <http://myplate.gov/>
7. **Dietary Guidelines for Americans, 2020-2025.** A publication of the U.S. Department of Agriculture. <https://www.dietaryguidelines.gov>
8. **Five Wishes.** Find resources on advanced care planning. www.fivewishes.org

Organizations Providing Services for Seniors

1. **Social Security Administration.** Provides information on Social Security programs, Medicare and Medicaid benefits, and local senior programs and activities. 800-772-1213 www.socialsecurity.gov
2. **National Institute on Aging.** Provides many free publications on a variety of health and aging-related issues. www.nia.nih.gov
3. **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.
4. **National Senior Service Corps.** A national network of projects that place older volunteers in assignments in their communities. www.seniorcorps.org
5. **The Healthcare Finance Administration.** This agency is responsible for administering the Medicare Program and assists with all matters and questions relating to the program. 800-696-6775 <https://www.federalregister.gov/agencies/health-care-finance-administration> or www.hhs.gov
6. **American Association of Retired Persons (AARP).** A nonprofit organization providing a variety of services to seniors including insurance, travel, pharmacy, and educational resources. www.aarp.com 888-687-2277

Volunteer Opportunities

1. **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. www.projecthope.org 800-544-HOPE
2. **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. 212-679-6800 www.doctorswithoutborders.org
3. **AmeriCorps Seniors.** This organization links people over the age of 55 with organizations that need their services. Service opportunities available include helping a struggling child to learn to read, deliver groceries to an elderly neighbor, or support a family impacted by natural disaster. Other opportunities available are 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. <https://americorps.gov/serve/amicorps-seniors>
4. **American Medical Association, Senior Physicians Section.** Provides resources for physicians to remain active in medicine during late-career transitions. They have an extensive database of opportunities for volunteers, both in the United States and overseas. They also provide links 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 materials on financial planning, emotional aspects of retirement, and healthy lifestyles. <https://www.ama-assn.org/member-groups-sections/senior-physicians>
5. **Volunteers in Medicine.** Started in 1994, this organization uses retired physicians to provide clinical care to serve the needs of uninsured patients. There are now multiple clinics across the country. www.volunteersinmedicine.org
6. **Reach Out.** A national program to support physician's wishing to provide care for the underserved. (877) 843-7953

General

1. **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. www.info4seniors.net 770-934-8320
2. **Kiplinger's Retirement Report.** A monthly publication with wide-ranging reviews on topics such as finance, travel, and health. Free articles available or access more with a monthly subscription. www.kiplinger.com 202-887-6491
3. **Voya Financial ING Retirement Services.** Find resources and advice or connect with a professional. One example of a financial institution offering retirement financial planning. (855) 873-5288. www.voya.coming.us/retirement
4. **Retirement Living.** A directory of retirement communities and active adult communities. www.retirementliving.com

Storytelling in Emergency Medicine – A Balm for the Soul

By Rachel Kowalsky, MD, Rosanna Sikora, MD, S. Luckett-Gatapoulos, MD and Frederick Blum, MD

The Troublesome Case of Room 8

Imagine that you listen to the following presentation:

In Room 8 is a 55-year-old type 2 diabetic alcoholic male who is noncompliant with his medications and complains of foot pain after tripping over something on the sidewalk.

Now imagine that the presentation is told this way:

Mr. Jones is a 55-year-old male with type 2 diabetes and alcoholism, who recently lost his insurance and has had difficulty obtaining his medications and is here for foot pain after tripping over his granddaughter's bicycle.

What's the difference? By word count, the difference is just seven words, but in terms of meaning, the difference is immeasurable. In the second presentation, the “diabetic alcoholic” becomes “Mr. Jones,” a “*man with*” certain illnesses that we are trained to evaluate and treat. Moreover, Mr. Jones has a family—a granddaughter—with whom he spends enough time to trip over her bicycle, and presumably this granddaughter cares about him and his health. The type of story we tell about Mr. Jones allows us to identify with him, better care for him, and possibly change our sense that we can make a difference.

The impact of word choice in story-building is well known in the writing world. Author Nancy Kress wrote in an article in the *Writer's Digest* that “good writers are constantly aware of the impression each word carries.”

What is This Storytelling Venture Called Narrative Medicine?

It is difficult to succinctly define narrative medicine. There are threads throughout medicine and the humanities that presage this evolving area of medicine. We all carry our stories within us. Our stories connect us to each other and help us to understand each other's lives. They help us to have empathy for ourselves and for our patients.

We are all driven to find meaning in our lives. Viktor Frankl managed to survive the German concentration camps by learning that our lives can be stripped down to an essential search for that meaning. Rachel Remen pointed out that we all have mysteries in our lives. Our attempts to observe and interpret these mysteries can have a profound effect on our own health as well as the health of our patients. Rita Charon described the intersection of medicine and these stories at the bedside as narrative medicine.

Welcome to the world of narrative medicine. All that is needed is your eyes, your ears, and a good writing instrument! We each have already honed the ability to approach patients, collect their histories, and perform a physical examination. Now we will refine that approach by listening more keenly and using a new lens to help us find the meaning in our patients' lives — and in our own.

Dr. Lockett-Gatapoulos has described narrative medicine as follows:

“When we closely read a text, we focus sustained attention on it. We think about the formal elements of the text, like the voice, structure, and tone, even as we think about our reactions to it, like what we see, hear, smell, and taste.

In a typical narrative medicine session, we closely and intensely read a text. Sometimes, it might be a poem or piece of ‘literature’, but it might also be a music video, an advertisement, or an account of an interaction between a patient and physician. After we’ve done this, we move on to the process of reflexive writing.

When we write reflexively, we set a timer, read a short prompt, and then write whatever comes to mind. The only real rules are that we don’t self-edit, but instead write freely. Then we share our writing without prefacing it, ignoring the urge to say ‘well, this isn’t really very good,’ or ‘I’m not much of a writer,’ or ‘I could have done better if I had 8 minutes to write instead of 7.’

In sharing our written work, we again apply the principles of close reading, observing for ourselves and for one another what our choice of words, our syntax, and our tone can tell us about our inner experiences. Often, this process can lead us to an understanding of ourselves and our relationships to our colleagues and patients that we would not otherwise have access to.”

Forging Meaningful Connections

French novelist Marcel Proust once wrote, “The real voyage of discovery consists not in seeking new landscapes, but in having new eyes.” This is a fitting way to suggest how we might approach this field of narrative medicine. How do we receive the important and intimate stories that our patient’s share with us? This approach helps us to provide patient care from a more human perspective.

Every day we interact with patients to determine the history of what brought them to us for care. We listen, try to piece together a likelihood of certain conditions based on these histories, develop a plan of care, and then we suggest ways to improve health. Narrative medicine gives us a more complete tool to do this. It helps us improve communications with colleagues, patients, families, social workers, and nursing staff, as well as many others involved in the healing arts. It allows us to do a deep dive or close read of the situation as seen through the eyes of our patients. It enables us to view a much richer tapestry of our patients’ lives by adopting just a slight change in perspective from what we already have been doing daily.

Rest for the Weary – Drawing from the Well of Resilience

We know that physicians have higher rates of burnout than the general population, causing emotional exhaustion, depersonalization, and a sense of decreased personal efficacy. But we also know that engaging with creative pursuits such as poetry and the arts can foster a sense of wellbeing and bolster resilience. Healthcare workers engaged in narrative medicine programs have shown similar effects with decreased burnout and compassion fatigue. Team cohesion is also improved. Why is that?

Words convey shared experience

Have you ever wrestled with a medical error? Consider the scene from Jojo Moyes' *Me Before You*, in which the main character misses the significance of a fever in her compromised patient. Or, consider Ann Patchett's novel *State of Wonder*, in which an obstetrician-gynecologist resident makes a disfiguring mistake during a Cesarean section. These passages, and so many more, help put words to feelings of guilt and normalize our tough experiences as being universal.

Words slow us down and lift our spirits

Consider this line in Wendell Berry's poem "The Peace of Wild Things": *I go and lie down where the wood drake rests in his beauty on the water, and the great heron feeds.* The rhythms in this passage naturally slow our breathing and re-focus our minds.

Another example comes from Ross Gay's poem "Sorrow is Not My Name": *But look; my niece is running through a field calling my name. My neighbor sings like an angel and at the end of my block is a basketball court. I remember. My color's green. I'm spring.* This poem acknowledges sorrow but also reminds us to notice all the small gifts of daily life.

Words help us make meaning of our experiences

Writing about personal experiences has been shown to improve mental and physical health. Why? When we choose words to describe our experiences, we process the emotion those experiences bring up, make meaning from the experiences, and consider how to grow from them. Rita Charon, who defined and developed the field of narrative medicine, has written that, "Stories are the avenue toward telling and, therefore, knowing of the self... Narratives trigger changes of many kinds in both the teller and the listener."

Bread For the Pocket – Being Inspired by Our Work

"Poetry is a life-cherishing force. For poems are not words, after all, but fires for the cold, ropes let down to the lost, something as necessary as bread in the pockets of the hungry." –Mary Oliver, *A Poetry Handbook*

Reading, writing, and the arts can keep us inspired by our work. How?

Poetry and the arts repeatedly demonstrate to us how interesting and complex the world can be when one looks closely. And this is what we do as we care for patients: we look closely and listen carefully. The more closely we "see" the lives of our patients, the more effective our care will be and the more rewarding our connection will be. We can use the arts to hone and reinforce these skills. The Japanese filmmaker Akira Kurosawa said, "The role of the artist is not to look away." We could easily say the same of the physician.

Reading and writing also increase our sense of agency. Our work is important. How do we know? Because so many stories, poems, and other works of art tell us so. The intensity of the parents' fear as they regard their sick child in Luke Fildes' painting, "The Doctor," reminds us that our work is critically important. So do many scenes from Abraham Verghese's novel *Cutting for Stone*. There is raw pain in the parent who has lost a child in Don Paterson's poem "A Threshold." In emergency medicine we work hard to save that child, and if we are unable, then to comfort the grieving parent. Our job is no ordinary job. Poet Mary Oliver reminds us to rise to the task with the words, "Tell me, what is it you plan to do with your one wild and precious life?"

What Is It You Plan To Do?

Rachel Remen states, “The way we deal with loss shapes our capacity to be present to life more than anything else ... Each of us, with our wounds and our flaws, has exactly what’s needed to help repair the part of the world that we can see and touch.” Our keen observation gives way to words, and words give way to feelings, emotions, and context. The stories come to life and apply healing balms to both the provider and patient. We observe and intently study a life and discover its meaning and purpose. We give honor to these stories. We find ourselves alive, with a rich childhood focus and imagination. We have much to do with our wild and precious lives!

“The most basic and powerful way to connect to another person is to listen. Just listen. Perhaps the most important thing we ever give each other is our attention... A loving silence has far more power to heal than the most well-intentioned words.” – Rachel Remen

Resources

Websites

Our Break Room. Essays, poetry, and artwork by health care workers. www.ourbreakroom.org.

The Nocturnists. A community for health care workers to collect and share stories about their experiences to compel, provoke, and demystify the practice of medicine. <https://thenocturnists.com>.

LitMed. Literature Arts Medicine Database. <http://medhum.med.nyu.edu/>.

The Poetry Foundation. Poems, readings, poetry news and the entire 100-year archive of Poetry magazine. <https://www.poetryfoundation.org/>.

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Shame and the Importance of Empathy and Connection: Camaraderie in Emergency Medicine

By Jennifer Robertson, MD

A 44-year-old man presents to your emergency department with a large spontaneous pneumothorax after undergoing a bronchoscopy earlier in the day. You prepare for the urgent chest tube but decide he needs some sedation. Unfortunately, you are a solo provider in an ED where there is not another doctor to assist with the sedation while you perform the procedure. The patient keeps squirming, and because he is overweight, you have a difficult time passing the tube. You give some additional sedation. As you are unable to watch the monitor while placing the tube, he desaturates and briefly codes. He survives, but you are now the object of judgment. The case goes to peer review, and you are mocked and scolded for the error. You feel horrible and, worse, you are treated like a criminal. You survive the review, but due to the chastisement, you resign with your head held low, alone without support.

Why Should We Share Our Stories?

“Recognizing the universality of our most private struggles often leads to a second important benefit of reaching out to others.”
— Dr. Brené Brown

That excruciating, all-consuming feeling you get when you feel you made a medical error...

That feeling of smallness when you flub up a lecture...

That rejected or silly feeling you get when you feel you said something wrong to your boss... What do these situations all have in common? Shame.

What is Shame?

Shame is a universal human emotion. Apart from psychopaths and sociopaths, we all feel shame when we evaluate our actions or feelings and conclude that we have done wrong. Shame is defined as an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging. Shame may occur when we compare our behavior against standards we were taught to believe as a result of our socialization. These could be collective standards from partners, family, friends, coworkers, children, membership groups, the media, and even yourself.

It is important to note that shame is person-specific, and there are no known “classic” shame-inducing situations. However, shame occurs more often in situations where we feel most vulnerable. Importantly, shame is different from guilt. In guilt, we judge our behavior to be wrong, while in shame, we feel that our whole self is inadequate or unworthy. Guilt can be adaptive as it helps one improve his or her future behaviors.



On the other hand, shame is maladaptive and has been found to be highly associated with depression and suicide, addiction, eating disorders, bullying, poor self-esteem, family violence, and sexual assault.

Shame is maladaptive and has been found to be highly associated with depression and suicide, addiction, eating disorders, bullying, poor self-esteem, family violence, and sexual assault.

There may be certain situations in emergency medicine as well as individual characteristics of emergency physicians that predispose us to shame. Doctors are not perfect, yet perfection is an implied social expectation. When we do not measure up to this perfection, we are at risk for shame. Other factors associated with shame in physicians may include medical errors, bullying and harassment, unhealthy competition with colleagues, power hierarchies, fear of failure, and failure itself.

The Power of Empathy and Connection

While we all may experience shame differently, we are not unique in that first, we are human beings and second, we are all physicians. Each of us have made medical errors sometime in our careers, no matter how big or small. We may have regrets about something we said previously. In the past, we may have failed tests or did not complete projects or accomplish specific goals. Failure can be an adaptive mechanism. The shame we may feel at the time, however, is not adaptive nor useful. However, talking about shame may be restorative.

According to Dr. Brené Brown, a well-known shame and vulnerability researcher, shame thrives in situations where there is secrecy, silence, and judgment. On the other hand, shame cannot survive when empathy is employed. Empathy is described as the ability to perceive a situation from the other person's perspective—to see, hear, and feel the unique world of the other. One author, T. Wiseman, identifies four defining attributes of empathy: (a) to be able to see the world as others see it; (b) to be nonjudgmental; (c) to understand another person's feelings; and (d) to communicate your understanding of that person's feelings. Shame is overcome if it is not held secretively. When emergency physicians realize that shame can be pervasive, with none of us immune, then no one person will ever be alone.



Empathy vs Sympathy

Empathy is very different from sympathy. Sympathy is feeling sorry for someone else, while empathy is actually putting yourself in the shoes of another person. Sympathy is a feeling of care or concern for someone, but unlike empathy, it does not involve a shared perspective or shared emotion. Empathy safeguards against shame, while sympathy can worsen shame.

The following short video by Dr. Brown provides useful information on the differences between the two: <https://www.youtube.com/watch?v=1Evwgu369Jw>

Empathy is most powerful when it comes from another person. However, self-empathy can improve shame resilience. Connection with others is critical when dealing with the universal stressors that we all encounter. Empathy provides mutual support, shared experiences, the ability to create options, and the freedom to enact change.

What Can We Do To Foster Empathy for Ourselves and Others?

There are solutions. Talk about our experiences in non-judgmental and supportive formats. Some options include:

1. Find a physician support group.
2. Have a trusted physician friend to confide in — chances are, he or she has experienced a similar situation.
3. Provide education and training for students and physicians in understanding and handling medical error in empathetic and supportive ways.
4. Reduce power hierarchies in medicine, knowing we are all human first with titles second.
5. Provide constructive feedback to learners, rather than destructive feedback that uses shame and fear as teaching techniques.
6. Simply remember you are not alone! Continue to feel empowered to reach out to individuals you trust who will be empathic and supportive.
7. Join a peer-to-peer support program, local and/or national.
8. Utilize formalized coaching services.
9. Offer Schwartz Rounds — grand rounds-style events that focus on a patient care case with great emotional impact on team members. Usually, a facilitated multidisciplinary panel share their experiences followed by open discussion from audience participants. Schwartz Rounds are a great way to reflect on subjects that may not typically be discussed in a group forum. Schwartz Rounds reduce isolation, normalize emotions, change culture, improve patient care, and develop cohesion among participants.
10. Implement buddy programs for new physician members, regardless of prior clinical experience and level of seniority. Programs such as these pair off physicians joining the practice with others who are already members of the group. Early career clinicians must adjust to a new professional role, whereas those with more experience have a different set of challenges and can also benefit from improved connectedness.

Simply knowing when you feel shame is critical. Understanding the shame response promotes the development of protective personal strategies, which helps avoid the negative consequences that can occur. So, go forth, know you are human, and resist shame.

Case resolution: You never share the story and feel shame for years. It is only after finding a more supportive job, hearing others' stories, and eventually discussing your story with others that you feel less alone and less shame. You realize others have gone through similar situations. After being around supportive individuals, you realize that maybe you aren't such a bad doctor after all and that we all struggle at times.

The Man in the Arena

“It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat.” — Theodore Roosevelt, 1910

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Diversity and Inclusion in Emergency Medicine

By Douglas Char, MD, Julia Marie Huber, MD and Michelle Caskey, MD

“Diversity is the mix, and inclusion is getting the mix to work well together.” – Global Diversity Practice

As the population of the United States grows more diverse, so do our patients in the emergency department and emergency medicine clinicians caring for them. Our ability to care for patients from all demographics safely and effectively is dependent on our understanding of cultural differences and adaptability in offering inclusive emergency care. Equally as fundamental is a welcoming workplace built on acceptance and respect for our colleagues and fellow health care team members.

The Benefits of Diversity

We inherently know diversity is important, and the benefits of a diverse medical workforce have been well described. Diversity can impact emergency medicine at the organizational and individual physician level, as well as impact patient care. An abundance of research and literature continues to proliferate, with some of the following findings:

- On the business side, innovation and creativity are essential for success, and diversity of leadership yields better financial performance.
- In medical school and residency, greater racial diversity translates into educational benefits, including enhanced critical thinking ability, openness to diversity of thought and challenge, racial and cultural awareness, satisfaction with the educational experience, and improved cognizant awareness of students’ own influences and bias.
- More diverse research author cohort was shown to yield more impactful publications.
- Overall, women physicians are less likely to be sued for malpractice.
- Patients who belong to racial/ethnic minority groups are more likely to choose a racial/ethnic minority physician and are more satisfied with their care when it is provided by a racial/ethnic minority physician.
- Female patients were shown to be two to- three times more likely to survive a heart attack (the leading cause of death in women) if their emergency physician was a woman.
- When health care providers have life experience that more closely matches the experiences of their patients, patients tend to be more satisfied with their care and more likely to adhere to medical advice.
- Lack of diverse 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.

The Current Landscape

There is a serious discrepancy between the population and the representation of racial or ethnic minorities in medicine. In the US population, 18% identifies as Hispanic/Latinx and 13% identifies as African American, yet only 6% of all physicians are Hispanic/Latinx and only 5% are African American.

In emergency medicine, 3.9% of our colleagues identify as Hispanic and 3.1% as African American. Regarding career advancement, 26% of white faculty members hold the rank of professor, yet only 19% and 17% of Hispanic and African American physicians, respectively, reached that same rank.

Another concerning discrepancy exists in gender leadership. Of all currently active physicians, 35% are women. Yet women physicians account for only 18% of hospital CEOs, 16% of deans/chairs, 10% of senior authorship, and 7% editors-in-chief.

The magnitude of opportunity for improvement in emergency medicine is enormous. Our specialty cannot attract, recruit, or retain the best and brightest (our colleagues, our protégés, our leaders) if our applicant pools are narrow and homogenous. Our profession's integrity is undermined when obvious inequities in advancement and leadership are allowed to persist.

Looking in the Mirror

Despite the growing literature and attention on diversity in medicine, the percentage of emergency medicine residents from underrepresented groups is small and has not significantly increased. Groups like ACEP's Emergency Medicine Workforce Section, DEI Committee, and Diversity, Inclusion & Health Equity Section all focus on increasing the number of individuals in our specialty who are underrepresented in medicine (URM). 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.

How to Enhance Cultural Competency

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.

There are several ways in which emergency clinicians working with multicultural patients and families can contribute to a positive and efficacious emergency department experience.

An important first step is to be sensitive to patients' cultural beliefs and practices and to convey our respect for their values through our actions and language as we care for them in the emergency department. 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, lifestyle, and value preferences.

It is critical that emergency physicians recognize individual preferences and differences and do not participate in cultural stereotyping. Because people of the same ethnicity or lifestyle can have very different beliefs and practices, it is important to understand the circumstances and views 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.

Delivering Culturally Aware Care

As emergency physicians, we have the privilege of treating patients from diverse social and global cultures who have varied and different health care values and practices. This includes others' concepts of time and immediacy. In the emergency department, empathy, and patience on the part of the clinician are invaluable.

Emergency physicians demonstrate respect by acknowledging:

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

Asking our patients how we can be sensitive to their unique needs applies not only to disabilities and pain but also to cultural respect. Sometimes the solution is as simple as a chaperone for the examination, explaining early on what will happen during evaluation, asking how our patients would like to be addressed, avoiding use of medical jargon, and being open to parallel alternative treatments.

Sometimes more in-depth group-specific training is required due to larger difficulties as barriers to care or understanding. Despite our best efforts, sometimes we get it wrong, and sometimes the situation becomes awkward. Our humility and ability to laugh at ourselves and with others can be the bridges that build a solid relationship with our patients. Conveying our commitment to safeguarding their wellbeing builds trust, and even small investments can reap huge rewards.

Being able to provide culturally appropriate care may take a lot of practice, but these changes can drastically enhance our physician-patient relationship as well as our patient outcomes. Seeking meaningful and more diverse patient interactions informs us of additional health disparities and actionable areas for improvement.

An Imperfect World: Discrimination and Prejudice

Emergency physicians and other health care providers may be victims as well as perpetrators of discrimination. Discrimination and bias may be based on differences due to age, ability, sex, race, ethnicity, religion, sexual orientation, or any other characteristic by which people differ. Discrimination may be subtle and not always easy to prove; however, its consequences are quite concrete and hurtful. Prejudice involves thoughts, attitudes, insensitivity, and ignorance, without discrete behaviors or demonstrable denials of opportunity. Prejudice frequently leads to discrimination.

Sexual Harassment

Sexual harassment in medicine remains a real issue. Surveys of faculty and academic physicians continue to show high levels of sexual harassment. A 2016 JAMA study showed 70% of female academic medical faculty perceived gender bias and 30% reported overt sexual harassment (compared with just 4% of men reporting sexual harassment).

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 African American physicians, 45% of Asian physicians, 63% of other race physicians, and 27% of Hispanic/Latinx physicians, compared with 7% of white physicians). A 2009 joint American Medical Association and National Medical Association 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, with 40% contemplating a career change.

Unsurprisingly, selective mistreatment undermines the work experiences of individuals who experience discriminatory behaviors. Professional outcomes include declines in professional satisfaction, increases in job stress, declines in productivity or performance, withdrawal from the organization, having thoughts/intentions of leaving the job, and quitting the job. Collectively, these inexcusable discriminatory incidents have a substantial influence on career trajectories and threaten retention of a diverse emergency physician workforce.

How Should Emergency Physicians Respond?

It is important that we dig deep, allow ourselves to be vulnerable, and identify and name our implicit biases. It is easy to tell ourselves we are not racist or prejudiced. Racism is an ugly habit, but when we let prejudice and discrimination go unchallenged, we give tacit assent to these malignant beliefs.

Ignorant attitudes need to be countered, and discriminatory behavior needs to be confronted. Only when we make a conscious effort to recognize and point out discriminatory behavior, even when unintended, will we be able to end it.

Inappropriate behavior needs to be recognized by all, and avenues for anonymous reporting should be instituted if not already available. We can actively help each other identify and address microaggressions by calling each other “in” instead of calling each other out. Most importantly, we should all reflect how our words and actions are interpreted within the context of a multicultural work and professional environment. A healthier, more equitable emergency department workplace encourages the professional growth of all and builds a culture where every person can bring their whole self to work.

Diversity is an issue we should be able to discuss openly. Diversity should not be an afterthought, a checkbox, or assigned to a single “diversity referee.” We should never assume a female, URM, or LGBTQ+ physician wants to be our department’s champion of diversity, nor should they be the default representative on the Diversity Committee. They have their own passions to pursue in research, teaching, mentorship, etc.

Diversity and Inclusion are Everyone's Responsibility

Our emergency medicine core leaders and managers should be at the heart of the inclusion and diversity effort. All of us are stakeholders in ensuring this occurs. Being an emergency physician can be both stressful and rewarding; learning to support one another in all facets will foster appreciation and celebration for all the ways we are individually unique.

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Doctors Getting their Groove Back: Aligning Expectations and Cultivating Respect

By Jennifer Robertson, MD

A patient walks into the emergency department. The complaint is epigastric pain and indigestion. You begin your history and physical examination but are only halfway through when the patient states he has consulted with “Dr. Google” before coming to the emergency department and is sure he needs a right upper quadrant ultrasound. You smile at the patient, listening respectfully to the suggestion as frustration starts to bubble up inside you. You think of all your years of training and sacrifice...

The Loss of Value and Respect:

Traditionally, medicine has been a highly regarded profession. Indeed, according to a recent Forbes article, the public still ranks physicians as some of the most trustworthy professionals. Despite this, there has been a recent decline of trust and respect for physicians. Some of the reasons include the rare cases of abuse of authority, misleading and/or negative media images, patients viewing healthcare as business transactions, unrealistic patient expectations, and the rise of the internet as a healthcare resource rather than physicians’ recommendations.

There have been some rare cases where the public lost respect because a physician abused their authority. Most physicians are honest and well-meaning, and if mistakes are made, they are rarely intentional or malicious. The climate of medicine has become one of medical consumerism in which the patient encounter is viewed as a business transaction. Patients may be more concerned about finances and less about what the medical expert thinks. Patients seem to be more demanding of physicians and no longer have complete faith in them.

Medicine has transformed itself from a healing profession into a business transaction. Patients view medicine as a commodity rather than a respectful relationship between healer and patient. By surfing the internet to answer medical questions, patients appear to undervalue the years of education physicians have completed. Big business also has devalued the patient-doctor interaction by transforming medicine into a for-profit entity.

Unrealistic Expectations

Patients may have unrealistic expectations of their physicians. The media may promote misleading information and denote negative portrayals of physicians, leading to decreased confidence in physicians, disappointment, frustration, and even malpractice suits. This declining respect has contributed to patient dependence on the internet as a source of medical information. This lack of acknowledgment of medical expertise has frustrated physicians and revealed that patients are less trusting of their doctors. According to one physician, “People think they can go on WebMD and understand what we understand. We have studied and seen so much, but people just don’t value or respect that anymore.”

In many ways, the culture of modern society has led to a lack of respect and confidence in physicians. Unfortunately, this contributes to burnout and a trend of emergency physicians leaving the profession. Emergency physicians are often faced with specific challenges that demonstrate this disrespect and lack of confidence in their abilities. Some examples include:

1. Expectation to carry out mandatory tasks that are below the top of your skill level (administrative tasks, some documentation, and order entry, etc.)
2. Lack of autonomy in patient care
3. Excessive regulations
4. Unrealistic expectations from patients
5. Patient perception that physicians have minimal training: “The internet will help me make my own medical decisions.”
6. Microaggressions from both patients and colleagues (especially toward females, other races or ethnicities, and transgender individuals)
7. Lack of recognition for accomplishments and maltreatment for mistakes
8. Utilizing generic terms when referring to physicians

Cultivating Respect in the Emergency Department

Respect for all human beings is an essential component of any high-performance organization, and emergency medicine is no exception. Respect cultivates an environment where health care workers are engaged and committed. A respectful culture encourages improved performance, innovation, and fosters greater resilience among clinicians. Alternatively, disrespect in the emergency medicine environment threatens provider morale, diminishes teamwork, leads to burnout, and contributes to patient safety issues.

Respect between colleagues can be established by supporting other members of the emergency care team. Simple strategies to cultivate respect between colleagues are as follows:

- Speak highly of other consultant services
- Actively listen to understand
- Keep your promise
- Express gratitude
- Try to walk in your colleague’s shoes
- Demonstrate you are a team player
- Continue to learn and grow

Leaders can promote respect by providing clinician autonomy, being open to input, affirming value to the organization, supporting emergency providers in critical situations, and taking an interest in clinicians’ personal interests and achievements.

The Issue of Expectations

Some physicians may interpret unrealistic patient expectations as a demonstration of lack of trust and respect. Unfortunately, handling patient expectations in a demanding emergency department environment can be difficult and frustrating for both patients and physicians. Stress and anxiety levels are high and split-second decisions are common, complicated by a chaotic environment and a universal lack of respect. However, there are ways to manage expectations and develop a respectful culture for both emergency patients and clinicians.

Patient expectations are defined as the anticipated conceptual pictures of projected events to be encountered in a medical consultation. Patients may or may not be aware of these expectations, but they do exist. Differentiating between appropriate versus inappropriate expectations affects the level of frustration in our emergency medicine patients. All patients have a right to quality health care delivered by physicians who are compassionate and competent. Some reasonable patient expectations include:

- The need to be listened to
- Treatment by staff who show care/concern/compassion
- Professional behavior by clinicians
- Receiving clear explanations and instructions about a medical condition

Patients also demonstrate inappropriate expectations, which frustrates both the physician and the patient. Patient reactions to unmet expectations can range from disappointment to anger. It is critical to understand our patients' expectations in a busy emergency department so we can avoid these reactions and minimize our exposure to liability.

Some examples of inappropriate patient expectations include:

- Desire to discuss several major problems, all in one brief emergency department visit
- Medications prescribed without a consultation
- Availability of telephone consultations with the emergency physician 24 hours a day for any problems
- Anticipation that the emergency physician will always know the exact diagnosis immediately

Handling Inappropriate Expectations

Emergency physicians should handle inappropriate patient expectations by first gathering an understanding of what matters most to the patient. Patients are grateful when a physician takes time to understand them. It is imperative that emergency physicians explain medical problems and solutions clearly without using medical jargon, so patients comprehend. Sometimes a firm stance helps to avoid manipulation by patients with unreasonable demands. Referral for a second opinion may be appropriate in those instances.

When emergency patients display inappropriate behaviors, we should remember that everyone deserves to be treated with dignity. It is important to acknowledge a patient's value as a fellow human and attend to their needs. Respect is exemplified by showing gratitude to patients when they entrust us with their care and a simple thank you to them can speak volumes. Although seen frequently in emergency medicine, inappropriate patient behavior does not have to be tolerated. Similar to disrespectful behavior between colleagues, disrespect from patients contributes to an unhealthy workplace. As emergency physicians and leaders, we serve as role models and can demonstrate how to react to disrespectful behaviors by cultivating a culture of acceptance and inclusion.

How to Cultivate Respect

1. Keep it simple. Acknowledge the bad behavior on the part of the patient and respond with, “Let’s take a step back and talk about this.” Debriefing with your team after the incident helps to identify best practices.
2. Be a role model who creates an environment of compassion in which people are kind to one another. This sets the stage for zero tolerance of disrespectful behavior.
3. Roleplay or rehearse prior to disrespectful behavior before it ever occurs. Know how you will respond when you are under pressure. You can then avoid freezing up or escalating when a disruptive situation arises.

Emergency Physician Expectations

Similar to the patients they treat, emergency physicians also have expectations of patients and society in general. Emergency physicians expect autonomy and reasonable financial return for their efforts. In addition, they appropriately expect to provide their services in a system that supports, and not subverts, the values of a professional healer.

The lack of respect for physicians and the doctor-patient relationship is a systemic issue that may not be easy to solve. However, as emergency physicians, we can urge one another to cultivate respect for all and discuss difficult issues immediately as they arise. As emergency medicine leaders, we can lead by example with the expectation that respect may become the rule rather than the exception.

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The Trials and Tribulations of Litigation

By Arlene S. Chung, MD, Douglas Char, MD and Tracy Sanson, MD

“Back in the day, as a newly-minted intern starting my residency in Emergency Medicine, I remember one of my venerated senior attendings say 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.”

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 where others 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, and it's not likely to change soon. To survive we need to learn 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.

Litigation Statistics

Although the statistics don't bear out a 100% risk of litigation, the threat of a malpractice claim is real for many 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 varied 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 eight percent 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 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 likely 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 for most physicians that he or she 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 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.

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 anticipate frequent interruptions to their schedules during this time and 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 the relevant information has been gathered, both sides will need to come to an agreement on whether 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 six percent 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 period, physicians should rely on the same coping strategies used in the months leading up to the trial. This can also be a time to examine any acknowledged mistakes and construct a plan of action carefully and objectively. 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 two 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.

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 features of Post-traumatic Stress Disorder (PTSD). 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 recreation 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 any negligence, real or imagined by the physician involved, actually occurred.

One word of advice; don't make any big life-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 several webinars and other resources on its website. See below under “Resources on Litigation Stress” for links.

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, but 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, and any of the symptoms consistent with Medical Malpractice Stress Syndrome. These professionals can provide a source of emotional support, 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 thing that will happen to us during our professional lives. Being equipped to handle the unexpected, 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.

Resources on Litigation Stress

Books

Adverse Events, Stress, and Litigation: A Physician's Guide Illustrated Edition
by Sara C. Charles, Paul R. Frisch, Oxford, 2005.

What is it like to be sued for medical malpractice? Bad medical outcomes traumatize patients, but they also traumatize physicians. The litigation that often follows is a profoundly human, rather than just a legal experience. Although every physician's case is different, this book shows how each case goes through the same judicial stages of complaint, discovery, depositions, motions, and delays that lead to trial, settlement, or being dropped. It also gives doctors an understanding of how lawyers think and work to help defendants. Written by a physician and a lawyer, the book provides unique insights - through real-life stories - into the personal experience of litigation as well as recommendations for dealing with each step of the legal process. It also includes up-to-date reviews of HIPAA legislation, the controversial subject of disclosure, and recent developments in the law affecting medical practitioners. Only about thirty percent of plaintiffs win their cases against doctors, but the journey from bedside to witness stand tests both the personal character and the professional skills of those accused. This well-documented book will help doctors understand and navigate the legal system while honoring their own ideals and emerging changed but stronger from the experience.

How to Survive a Medical Malpractice Lawsuit: The Physician's Roadmap for Success
By Ilene R. Brenner May 2010. ISBN: 978-1-444-33130-1

Everyone seeks to avoid getting into a lawsuit, but what do you do if this does happen?

Getting sued for medical malpractice is one of the most traumatic events of a physician's career.

This text will guide doctors and physicians through the process from the moment they receive a summons until the after-trial appeal process.

- Contains valuable information that physicians need to know to prevent making critical mistakes that can hurt their case
- Strategies explained to maximize chances of a defendant's verdict.
- Includes vital information on how to change your attorney, act at the deposition, and dress for court,

This book navigates through what is a mysterious and terrifying process in non-legalese language that is easy to understand including what makes patients angry, strategies for coping, sample questions and tips on answering them to what happens in court and how to continue if there is a bad outcome.

When Good Doctors Get Sued - 2nd edition, Angela M. Dodge PhD., Steven F. Fitzer JD, March 2015.

A practical guide for physicians (and other healthcare professionals) involved in malpractice lawsuits. Features understandable explanations of the legal process and necessary legal terms, how to give an effective deposition, improving listening skills, answering challenging questions, testifying in court, dressing for court, and managing the emotional strain of litigation. Provides basic must-know information, straight-forward guidance, and many Q&A examples designed to give the medical defendant a more confident sense of control.

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Malpractice in Emergency Medicine—A Review of Risk and Mitigation Practices for the Emergency Medicine Provider
Brian Ferguson DO, MPH, Justin Gerald MD, Jessica Petrey MSLS, Martin Huecker MD

The Journal of Emergency Medicine, Clinical Reviews in Emergency Medicine
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Anupam B. Jena, M.D., Ph.D., Seth Seabury, Ph.D., Darius Lakdawalla, Ph.D., and Amitabh Chandra, Ph.D.
N Engl J Med. 2011 Aug 18; 365(7): 629–636. PMID: 21848463

The Litigators Lions Pit: The Top 10 Medical Malpractice Issues Every Resident Should Know (EMRA).
Available online at: <https://is.gd/Lj5u9e>.

Webinar1

Adverse Medical Events, Second Victims and Litigation Stress
Louise B Andrews MD, JD, FIFEM, Stacia Dearmin, MD FAAP
Norcal Group, Free On-Demand Webcase
<http://bit.ly/NorcalWRC>

Podcast

Doctors and Litigation: The L Word podcast series by Gita Pensa, MD FAAEM
<https://thelword.podbean.com/>

Websites

<https://physicianlitigationstress.org/>

Medical Malpractice Support Resources

Louise B. Andrew, MD, JD, FIFEM – www.mdmentor.com

Stacia Dearmin, MD, FAAP – www.thrivephysician.com

“The Expert Witness Newsletter” – <https://expertwitness.substack.com/>

Video

Experience is Treacherous presentation at Case Western Reserve University Law School, April 2018

Stacia Dearmin, MD

Available online at: https://www.youtube.com/watch?v=_dhCxZlnKsc&t=301s

Physician Litigation Stress (Physician Litigation Stress Resource Center)

Available online at: <https://www.youtube.com/watch?v=OXZgh4-cKcE>.

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The Pearls and Perils of Social Media and the Internet in Emergency Medicine: Part I

By Jennifer Robertson, MD

Sophia looked twice at the Instagram post. Was that her EM attending who taught her how to put a chest tube into a critical patient? He wasn't in his white coat. He wasn't in scrubs. He wasn't in much of anything. He was dressed in tight fitting white jeans with no shirt. There was an admirable six-pack of abdominals, but Sophia felt very uncomfortable... almost embarrassed. She thought, "He must be 25 years older than me. How can he post a photo of himself like that when all the residents he teaches can see him?" Next time she saw that attending in the ED, she couldn't look him in the eye.

Pearls

The internet and social media have considerable impact (both positive and negative) on modern emergency medicine. Without divulging health protected information, social media provides positive reinforcement of stories that provide appreciation of the patient doctor relationship. It also allows for physician practice marketing and provides outlets to help patients interpret medical information accurately. The internet may also improve patient safety by providing information on certain medical practices such as surgical checklists, warning signs, and risk factors.

Perils

On the other hand, the internet also harms patients and the profession by potentially allowing for breach of confidentiality, violation of doctor-patient boundaries, and damaged integrity of doctors through problematic online relationships or exposure of personal information. Most emergency physicians have witnessed patient use of medical misinformation and "self-diagnosis" leading to patient harm and/or distress due to misinformation, physician frustration, and perhaps distrust in the physician-patient relationship.

Do's and Don'ts

Because of improper use of the internet, avoidable negative consequences have occurred. Understanding the "Do's" and "Don'ts" of online use keeps emergency physicians out of trouble and may bolster wellbeing. Avoiding misuse may help physicians circumvent potential and unintentional legal, personal, and/or professional consequences. The goal of this chapter is to highlight the impact of the internet in medicine, demonstrate how emergency physicians can monitor their activity appropriately, and provide strategies to deal with patients who use the internet in their medical care.

Maintaining Online Professionalism and Avoiding Unintended Consequences

We all have access to the internet for both professional and personal reasons, but physicians need to be particularly careful in using social media to ensure full professional standards. Physicians should be aware when posting anything online, that a “footprint” is left behind which will continue to follow them indefinitely. Postings of emergency physicians drinking alcohol, displaying disrespectful behaviors or speech, or publicizing confidential information could be professionally problematic. Viewers may interpret this online activity as a measure of how trustworthy and responsible the physician might be. By fully understanding the possible negative consequences of internet misuse, physicians can reap the benefits and avoid the pitfalls of social media.

At each institution, group practice, or workplace, emergency physicians should collaborate with colleagues and administrators to decide best practices and standards when using social media and the internet. On a more global level, emergency physicians should consider the recommendations provided by medical boards and physician organizations such as the American College of Physicians. For example, one recommendation is for physicians to manage patient-doctor boundaries online by separating their professional and personal identities. A position statement by the American College of Physicians and the Federation of State Medical Boards recommends maintaining high professional standards and avoiding the negative temptations of social media. There are five tenets physicians can employ to elude permanent negative personal and professional impacts when using the internet. The recommendations include:

1. **Utilize ethical principles.** Physicians should be diligent in upholding ethical principles to preserve the patient-physician relationship. This includes confidentiality, privacy, and respect for persons regarding online settings and communications.
2. **Separate spheres.** It is optimal for physicians to keep online professional and social spheres separate. The American Medical Association (AMA) is also a strong supporter of this recommendation.
3. **Use email professionally.** Email or any other electronic communication between physician and patient should only be utilized in an established clinical relationship and with patient consent. Documentation of any electronic communication should be noted in the patient medical record.
4. **Self-audit.** Physicians should consider periodically “self-auditing” to assess the accuracy of information being circulated about them online.
5. **Understand the permanency of online activity.** Physicians, residents, and students must realize that online activity can be permanent and may have implications for their future professional lives. For example, employers have rejected job applicants simply due to their problematic digital behaviors.

Dealing with “Dr. Google”™

The ever-expanding amount of health information online has led patients to the internet as their primary source of information. In a 2013 PEW Research study, 35% of U.S. adults admitted to searching the internet for symptom information. In one aspect, social media and the internet have strengthened the patient-physician relationship because patients feel more empowered with their improved knowledge about disease processes and medical terminology. As a result, communication has improved between patients and physicians.

Alternatively, there may be several negative effects of internet health information seeking. The quality of data ranges from high-grade peer-reviewed medical journals to informal unproven social media blogs that might lead to incorrect self-diagnosis. Online symptom checkers have been found to be correct about 34 % of the time, whereas physician diagnoses have accuracy rates up to 90 percent. When patients use only the internet as a primary health information source, harm

can potentially result. Internet diagnoses may lead to more questions during the medical encounter, conflict and/or distrust of the physician, patient dissatisfaction, and patients finding counsel elsewhere. These interactions may also trigger physician frustration and promote a sense that patients do not trust their doctor's medical training or knowledge.

There are strategies which emergency physicians can use in treating patients who are armed with information from the internet. Several sources show that if physicians learn to embrace a patient's choice to have an active role in their care, communication can actually be enhanced. Four suggestions for emergency physicians include:

1. **Understand the patient's motivation.** Patients who look up information online tend to want to hear the emergency physician's thought process. This also gives the physician the opportunity to state why or why not the information is accurate.
2. **Encourage patients to continue searching online.** While this may sound counter-intuitive, doctors who are receptive to a patient's own online research help improve the patient's sense of empowerment. On the other hand, doctors who are resistant to online research may cause patients more anxiety, distrust, confusion, and frustration. Open and honest conversations about the data fosters more trust from patients, allowing them to readily rely on physician expertise and advice.
3. **Join in and create your own online expert content.** Patients tend to trust information when content is easy-to-read, well-organized, and comes from authors with medical credentials and demonstrated integrity and reliability.
4. **Refer patients to reliable online resources.** If patients head to the internet to self-diagnose, clinicians can direct them to websites which provide credible and reliable medical information. Sites worth referring patients to include: *The Mayo Clinic, Centers for Disease Control and Prevention, National Institutes of Health, The New England Journal of Medicine and the American Academy of Family Physicians.*

The internet is here to stay. As individuals become involved in social media and other online activities, more and more patients will turn to the internet for health information. Emergency physicians must be aware of the data online and be ready and willing to speak with patients about it. Physicians should appraise their own online activity and refer to licensing boards, professional societies, and hospital policies regarding online and social media involvement. Emergency physicians who understand the pearls and pitfalls of social media can easily avoid the unintentional but negative ramifications of inappropriate online posts.

Resources

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The Pearls and Perils of Social Media and the Internet in EM: Part II

By Dennis Hughes, MD

You are at the monthly emergency department meeting. Everyone at the conference table has their cell phones in front of them. The item for discussion includes a topic that is crucial to the fiscal wellbeing of the EM group. As you are presenting the data necessary to facilitate the discussion, you observe that half of the physicians at the table are texting away. You wonder if anyone is listening to what you have to say.

FOMO is the “fear of missing out.” Are we truly missing something...anything? Perhaps emergency physicians are missing the opportunity to keep humanity (and balance) in their lives. In the age of “cancel culture”, we should not advocate “all or nothing” or strive to adopt an anti-tech, nihilistic view toward utilization of the vast information-sharing resources. However, it is important to remain grounded and aware of the power available to each of us via the electronic world in which we live. Facebook (Meta) announced membership of 1 billion people. We now connect to the entire world in a way never possible in times past. How do emergency physicians remained engaged in the present while attempting to engage everywhere?

We Are Prisoners of Our Own Devices. Are We Addicted?

DSM-5 lists 11 criteria for addiction (specifically substance abuse) many of which can be applied to social media use. Consider a few:

- Withdrawal (anxiety when not engaged)
- Tolerance (needing more for same gratification)
- Using more/longer duration of use
- Time spent (posting and checking for posts and being distracted from other life events)
- Craving (where is my phone? – wake up and immediately check my account)

It does not take much of a stretch to see some of the same addictive behaviors toward personal devices and social media that permeate current society. Perhaps dependence is a more appropriate term than addiction, but whichever term one chooses, it is clear there is a risk of becoming inexorably entwined. The phenomena of “social media creep” progresses like any addiction. For example: an emergency physician sets up a Facebook (Meta) account and checks it weekly, then every 5 days, then every 3 days; then the emergency physician downloads the mobile app and the notifications come several times an hour...you need the fix! It is a classic dopamine-reward positive feed-back loop.

Perhaps emergency physicians can borrow from Eastern philosophy. The solution may be to seek out the “Middle Way,” that sweet spot between overindulgence and abstinence. Integration of needs, desires, and avoidance of dogmatic extremes is not easy. Applying this approach to all aspects of life can be rewarding but, in the context of this discussion, it means taking control of our interactions with social media and the potential avoidance of the negative effects on our lives and health.

Negative Consequences of Social Media

There are potential negative consequences of social media:

- False reality (“what you see is not all there is”)
- Promotion of narcissistic behavior (“how many likes did I get”)
- Close mindedness (“only follow those who agree with me”)
- Privacy risk (this is real and can have financial implications-hacking, stalking, doxing, etc)
- It is a time sink (self-explanatory!)

Previously emphasized in Part I, an issue to seriously consider is the potential social media effect on an emergency physician’s professional standing. While posts may seem innocuous, they have a long shelf life. Checking one’s social media accounts is a customary part of screening potential candidates for hire these days. Those photos from spring break years ago or the political commentary posted (perhaps in jest) might be considered in an unfavorable light by potential employers. Perception is everything. Remember all that you post is in the public domain once you press “Enter”.

Positive Consequences of Social Media

Certain sites may enhance your professional status. LinkedIn is a networking site where many potential employers search for candidates. It is important to keep your profile accurate and up to date. But there are pitfalls lurking here as well. Be careful of those who ask to connect; they may be on a phishing expedition.

Consider Sarah. She is an emergency physician in her first job out of residency. She is active on a few social platforms and has a professional profile on LinkedIn. She receives a request from Sam. The message says: “Hello, I just read your profile and I represent an organization that is looking for an emergency physician for a position in a great location with a very attractive salary and benefits”. Included in the message is a link. Sarah clicks on the link and is directed to a page and then back to a home page. During this transition, malware is secretly downloaded to Sarah’s device which steals stored information such as her passwords. The next day Sarah discovers that her bank account is down \$10,000.

For the conspiracy buffs, social media is also constantly monitored by algorithm-based engines looking at key words, phrases, etc. These strategies are useful to commerce and marketing but can have more nefarious implications. Your connections and explorations online are exploited to determine your tendencies, likes, preferences etc.

What about the important stuff that one learns from the internet? There are several sites which are valuable sources of FOAMed (Free Open Access Medical Education). Many have potential for some of the same pitfalls as in the social media realm. Sticking with podcasts and other feeds where you control viewing is preferable to becoming over-engaged in a continuous dialog, particularly if you have a propensity to such addictive behavior. It is well known that sites such as Twitter, etc. can launch unending dialogue which may have unintended consequences.

JOMO and NEMO... Not What You Think!

What can an emergency physician do?

Adopt the JOMO (“joy of missing out”) mindset? Perhaps. Some have coined another colloquial term: NEMO (“nearly, but not totally missing out”). Detox may be necessary, similar to treating any other dependence! There are many different approaches to quenching addiction and one size does not fit all.

Several strategies for emergency physicians include:

- Deactivate your accounts
- Uninstall social media apps
- Use a web filter (examples include: Cold Turkey, Net Nanny, Self-Control, Stay Focused)
- Leave your phone in your bag at work or at meetings (leave a land-line number on your voicemail greeting for true emergencies)
- Fill your time void with other activities (have coffee with a friend, take a walk)
- Set times to check in and time limits on the check in
- Take charge of your device: turn off audio/vibration notifications

If you have no idea of the time you are spending on social media or just need to evaluate your productivity, consider an app like Flipd (available on android or iOS). It tracks your time, is customizable, and keeps you informed and honest about your time utilization.

If you cannot bring yourself to reduce your social media involvement, consider taking steps to protect yourself as much as possible:

- Hide your activity status so others can't identify your minute-to-minute site use (may reduce the cascading and time-consuming back and forth posts)
- Disable the read receipts which stops the notifications that others have read your messages and interrupts the feedback cycle
- Stay off the grid by turning off locator toggle to limit the apps' ability to track you and send ads or notifications about nearby events
- Be selective about your audience which limits who reads your posts by using direct messaging function or toggling the audience button to friends, etc.

If you are a person of moderation already you may be safe for the time being. However, if you find yourself constantly checking your smartphone between patients or at the next ACEP meeting rather than talking to the person next to you, perhaps a little search for that “Middle Way” may reward you and restore more control to your life.

Resources

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When Emergency Medicine Wears You Down: Burnout Persists

By Andrea Austin, MD, Dennis Hughes, MD and Amy Betz, MD

“Burnout is what happens when you’ve avoided being human for too long.” – Michael Gungor



Jane wanted to be a doctor for as long as she could remember. Now, she dreads going in for her shifts and finds herself being short with patients and staff. She feels disconnected from her colleagues and feels that if she didn't show up tomorrow, she'd be replaced without anyone even noticing. She wonders if she'll be able to keep doing this job for another year, let alone 10 more years.

It is no surprise that emergency medicine ranks among the highest of all specialties in burnout. While numbers vary, up to 60% of emergency physicians report being burned out. With the COVID-19 pandemic, numbers skyrocketed to catastrophically high levels. Up to one-third of all health care clinicians have left or thought about leaving medicine. Two-thirds of emergency medicine residents report symptoms compatible with burnout. The numbers are clear: our specialty continues to suffer from an ongoing epidemic of burnout. It is 100% guaranteed that you will experience or work closely with a colleague experiencing burnout. It is important to recognize the variety of symptoms associated with burnout.

Symptoms of Burnout:

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

The World Health Organization defines burnout as a syndrome that is characterized by chronic workplace stress that has not been successfully managed. This, in turn, leads to “feelings of energy depletion or exhaustion, increased mental distance from one’s job or feelings of negativism or cynicism related to one’s job; and reduced professional efficacy.”

We see a lot of suffering; often we see patients on their worst day. This can be a set up for emotional exhaustion and compassion fatigue. Compounding this problem, we are forced to compartmentalize and switch tasks very quickly (e.g., often going from consoling a distraught emotional family to a patient with a minor complaint who is irritated that the wait is so long). Emergency physicians develop a shorthand way of coping in which they create distance from their patients through depersonalization. Emergency medicine is a rough and tumble field; we are expected to be efficient, have a near zero miss rate while providing an excellent patient experience. These competing priorities, and an abundance of critiques, from administrators to consultants, can lead to feeling a lack of accomplishment.



System Contributors to Burnout

Burnout 1.0 was associated with a sole focus on the individual physician. We were often viewed as defective if we experienced burnout. We were often told to fix ourselves. Perhaps if we did more yoga, we would feel better.

You can’t “yoga” yourself to wellness, nor can you “meditate” your way to wellness.

This was a flawed approach, and we are moving to Burnout 2.0, in which there is widespread acknowledgment that the larger system and society level factors impact our wellbeing more than individual factors.

Burnout appears to be part of the continuum that begins with moral distress, which all of us are familiar with in our own lives. Constant moral distress leads to moral injury.

Moral Distress → Moral Injury → Burnout

Moral injury is described as “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.” This transpires in myriad ways. For example, many physicians feel increased pressure to discharge patients when the social, mental, or physical wellbeing of the patient is not guaranteed. This is a form of moral injury. When this occurs day-in and day-out during our careers, infinitely repeated, the birth of burnout results.

While much of the following discussion discusses personal strategies to mitigate burnout, we know this is not enough. We need health care systems to value physician wellness and realize that many of us start out well and end with burnout because of systemic stressors. The time for platitudes has passed. Burned-out physicians may provide substandard and unsafe care. It is in every emergency physician’s interest to address the root causes of burnout and create just and supportive workplace practices.

Burnout: Risk Factors and Protective Factors

As emergency physicians, it is critical that we acknowledge the risk factors and protective factors associated with burnout. The foundation of protective factors includes personal wellness and resiliency. While several other chapters discuss these topics, a few are particularly relevant to burnout.

Sleep is one of the most important cornerstones of wellness and integral to preventing burnout. The restorative properties of sleep are profound for our mental and physical health. Without proper sleep, no other strategies can mitigate the effects of sleep deprivation on our mental and physical wellbeing.

There is increasing research that nutrition is highly linked to mental and physical wellbeing. Emergency medicine work is mentally and physically draining, so adequate nutrition and hydration are fundamental to having the energy to tackle these challenges. Lack of sleep and poor nutrition is akin to starting a road trip with the low fuel light on. We might be able to go a short distance, but eventually we're going to run out of gas.

Dr. Dike Drummond suggests the analogy of the “energetic bank account.” Unlike a real bank account, in which we cannot run a negative balance (aside from bouncing a check), with an energetic bank account we can run a negative balance, albeit for a limited 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 in the emergency department.

In medical school and residency, we were conditioned to ignore our energetic bank account. We must often retrain ourselves to learn simple physiological cues that are necessary for wellness. For instance, the next time you're on shift and you begin to feel a little irritable, explore the cause. Are you hungry? Need to use the bathroom? Tired? Would grabbing a snack and taking a step out on the ambulance ramp for some fresh air renew you? Are you sad or frustrated about a case? Would walking over and commiserating with one of your colleagues for 5 minutes help emotionally and boost your productivity for the rest of the shift?

Appreciation and Positive Reappraisal

Appreciation, on the personal and system-wide level, is an important protective strategy to burnout. Appreciation increases a feeling of personal accomplishment. How often does your group recognize accomplishments? Often, people only hear about a case that ends in a Morbidity and Mortality conference. Finding ways to show gratitude towards colleagues can radically improve the culture of a workplace.

On a personal level, positive reappraisal is a useful strategy to thrive in emergency medicine. Our specialty has many phenomenal attributes, despite the challenges. Positive reappraisal is an authentic reframing of a moment that may appear (on the surface) to be negative but is actually positive. It does not equate with being a Pollyanna. It is not just blind, unrealistic optimism. Here is an example: After a difficult conversation with a consultant, rather than fixating on the annoying aspects of the conversation, reframe it as, “I advocated for my patient, and I communicated my concerns in a professional and collegial way.” This turns a negative interaction into a feeling of professional accomplishment (and may lessen the emotional exhaustion a bit).

Growth Mindset

Thriving in emergency medicine involves a growth mindset. The breadth of knowledge required in our specialty is daunting. Coupled with the interpersonal dynamics and system challenges, it is close to impossible to have a perfect shift. We encounter cases never seen in residency training, and even armed with all possible knowledge, a systems issue can arise that results in a suboptimal outcome. We are often our own worst critics and spiral into a downward cycle of shame and despair. Brené Brown, author and educator on shame, explains that shame involves feelings of “I'm a bad person,” while guilt is “I did something bad.” Shame can lead to self-loathing and is associated with addiction and other negative coping mechanisms. Guilt allows for appropriate levels of ownership and contemplation for improvement. For those prone to

perfectionism and shame, consider how you would respond to a friend or colleague who shared a similar suboptimal event. These events could be interactions with patients or consultants or a case that resulted in morbidity or mortality. Often, we are so much more understanding to our friends and colleagues than to ourselves. Thriving in emergency medicine involves a combination of humility and growth.



Time, Time, Time

Time is one of our most limited and important commodities. When time is wasted or feels taken from us, this is a recipe for emotional exhaustion. Leaving a shift on time is an important component to physician wellness. We respect each other when we provide prompt relief from a shift, arriving on time so our colleague is free to engage in life outside the emergency department—resting, sleeping, living. We honor and respect each other by being “on time.” In turn, leadership honors us with compensation for the hours actually worked. Consider ways that your group can improve how physicians leave their shift on time, which often includes 1-2 hours built in for documentation, disposition, and turnover of patients.

How much of your time on shift is spent looking for equipment? A well-stocked emergency department honors physician time, so we’re not frantically looking for those blasted tongue depressors ... or emesis bags. Systems do well by physicians when they make improvements in the electronic medical record to reduce clicks and increase ease of use with templates and other smart features. On the personal level, time spent increasing familiarity and forming custom templates can translate into huge time savings and reduce shift annoyances.

How much time do you need to rest and restore? According to *Burnout* by Emily and Amelia Nagoski, humans need 42% of their day devoted to sleep or restorative activities. Restorative activities include exercise, mindful eating (not inhaling a burger while driving and listening to a podcast), connection building activities such as talking to a friend or family member, cuddling with a pet, and other activities/hobbies. Humans need on average 8 hours of sleep per night; there are very few people that need less than 7 hours. With all of this in mind, we have about 14 hours per day to devote to work, commuting, and caring for others (such as kids, friends or family members). Start keeping track of what is gobbling up your time. Are there any activities that you could outsource, such as cleaning, administration, running errands, occasional childcare? Is it time for a renegotiation of the allocation of chores in your household? Not sure where your time is even going? Check out Dr. Christina Shenvi’s website on time management.

Reflection and Journaling

Sometimes a career in medicine can feel like running on a treadmill that is uncontrollable. Through reflection and journaling, patterns often emerge that help individuals better identify goals, values, and triggers for burnout. In addition to regular journaling, reviewing your career in detail every 1-2 years can lead to greater satisfaction.

In the book *Stop Physician Burnout*, Dr. Dike Drummond proposes finding ways to increase overlap between your current job and your ideal job. It is important to acknowledge that your definition of an ideal job may change, even drastically, over your career. It is critical to know what your non-negotiable items are. These are often items related to your values, and



workplaces that violate your values are often a recipe for severe burnout. Figure out a tempo to review your current vs. ideal job. Consider revisiting anytime there is a major professional or personal life event. Recognize that while many of us trained to work in an emergency department, our skillset is diverse and not tied to a place. We function extremely well as educators, administrators, researchers, writers, and advisors, to name a few.

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, which may include meditation or organized religion
- Cultivate connections with family, friends, coworkers
- 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)
- 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
- 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 during difficult times

In summary, burnout is a common phenomenon in medicine, which affects health care workers at all stages—from medical school to retirement. The personal- and systems-related risk factors have some commonalities, such as the inherent nature of emergency medicine work being high stakes and high stress, while other risk factors may be more personal, such as propensity towards perfectionism. Individual protective factors build upon a wellness strategy that ensures adequate sleep and nutrition, but it is the system-wide protective changes that will definitively protect against and mitigate burnout.

Resources

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

Videos

Milne E. SGEM (Skeptics Guide to Emergency Medicine, part of FOAM network) Burn Out. Published December 2, 2014. <https://www.youtube.com/watch?v=ERxBCxe-BdA>.

Physician Burnout — Four Main Causes. The Happy MD (www.thehappy.md.com). Published January 5, 2013. <https://www.youtube.com/watch?v=k1ouwQXcCtQ>.

Podcasts

Physician Thriving. This podcast explores the modern physician experience and tips for thriving in medicine. <https://www.physicianthriving.org/>.

The Emergency Mind. This podcast explores how to perform under pressure. <https://www.emergencymind.com/podcast>.

Authors and Speakers

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

Dr. Annahieta Kalantari. Speaks candidly about her own burnout experience, resilience and institutional changes that promote physician wellness. <https://annahietakalantari.com/>.

Dr. Christina Shenvi. Emergency physician, speaker and educator on time management. <https://timeforyourlife.org/2020/10/10/001/>.

Dr. Jennifer Mitzman. Wellness speaker with expertise in the second victim syndrome. <https://www.jennifermitzmanmd.com/>.

Dr. Kirsty Challen. Website and blog explores how medical errors impact physicians. <https://ededucate.co.uk/to-err-is-human-surviving-humanity>.

Dr. Leslie Koenig. Author of The Stress Relief Survival Guide, explores many strategies to combat burnout. <https://stressreliefsurvivalguide.com/>.

Dr. Stephanie Benjamin. Emergency physician and writer, educator on the benefits of writing to combat burnout. <https://stephbenjaminmd.com/>.

Dr. Tracy Sanson. Emergency physician, speaker and author on physician wellness. <https://tracysansonmd.com/>.

Dr. Yvette McQueen, <http://www.yvettemcqueenmd.com/speaker/>. Lectures on wellness and lifestyle modifications, along with strategies for success for women. <http://www.yvettemcqueenmd.com/speaker/>.

Shawn Achor (keynote speaker at ACEP 2014 Scientific Assembly). TED talk and materials that inspire achieving happiness. <https://goodthinkinc.com/>.

Journal

The Journal of Wellness

A peer-reviewed, open access, indexed journal that publishes original research articles as well as review articles in all areas of medical, physical, and psychological wellness.

<https://journalofwellness.com/>

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

Websites

ACEP Peer Support Project

Site dedicated to connecting emergency physicians for peer support.

<https://www.acep.org/peer-support-project>

Kevin MD: Social Media's Leading Physician Voice

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.

<https://www.kevinmd.com/blog/>

Our Break Room

Essays, poetry and art by healthcare workers.

<https://ourbreakroom.org/>

ZDogg: Healthcare's Unfiltered Voice

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Adverse Events in Emergency Medicine and the Risk for Post-Traumatic Stress Disorder

By Richard Goldberg, MD and Michelle Caskey, MD

“They kept coming in droves. Patient after patient arriving complaining they couldn’t breathe. There weren’t enough beds. We didn’t have enough nurses. We were running out of personal protective equipment, and this was the seventh day in a row for me in the ED. I wasn’t getting enough time to sleep or eat. My nerves were stretched tight. I wasn’t sure I could keep that pace any longer... that was my introduction to COVID-19.”

An **adverse critical incident** can be any traumatic event that has sufficient emotional power to overcome our usual coping abilities. Emergency physicians are potentially exposed to many such events, including line of duty deaths, multi-casualty/disaster/terrorism incidents, significant events involving children, pandemics, death of a colleague or loved one, divorce or major life incidents at home, to mention a few.

Post-traumatic stress disorder (PTSD) refers to a prolonged, sometimes permanent, disordered emotional reaction to a critical incident, also referred to as an adverse event. Some of the symptoms of PTSD may be part of the normal grieving, reactive, healing process, but PTSD is diagnosed when these symptoms persist for at least one month.

DSM-5 diagnostic criteria include:

- Exposure to actual or threatened death, serious injury, or sexual violence
- Via direct experience, such as witnessing the event, or repeated/indirect exposures to event details
- An intrusive re-experiencing of the event in thoughts, dreams, or daily life
- Avoidance of any stimuli associated with the event
- Distorted negative self-thoughts, event memory, emotions, or mood
- Symptoms such as insomnia, irritability, difficulty in concentration, hypervigilance, and increased startle reactions

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, loss of emotional control, inappropriate feelings of guilt, exaggerated negative expectations of self or the world, or social withdrawal. Studies of the biologic mechanisms of PTSD have found alterations in brain regions associated with fear and memory (amygdala, hippocampus), as well as changes in hormonal, neurochemical, and physiological systems involved in coordinating the body’s response to stress (HPA system, prefrontal cortex).

Treatment Options

- **Counseling.** Important components of treatment include education about PTSD and establishing a sense of support and safety. Trauma-focused psychotherapy is the most effective type of talk therapy for PTSD and is considered first-line treatment. More specifically, Cognitive Processing Therapy (CPT) is the most widely studied with over 20 randomized controlled trials showing large reductions in symptoms and loss of diagnosis. CPT teaches the patient how to process and change negative thoughts and feelings and its efficacy has been demonstrated even when delivered via interpreter or through telehealth. Other therapies include Prolonged Exposure (helping patients confront painful memories and feelings), and Eye Movement Desensitization and Reprocessing (EMDR, processing trauma while gazing at repetitive movements or sounds).

SYSTEM: Systemic Factors Determining Wellness – Practice Environment Influences

- **Medications.** Selective serotonin reuptake inhibitors (SSRIs) sertraline (Zoloft), paroxetine (Paxil), and fluoxetine (Prozac), and the serotonin norepinephrine reuptake inhibitor (SNRI) venlafaxine (Effexor) have the strongest evidence for PTSD pharmacology. Currently, only sertraline and paroxetine are FDA-approved specifically for treatment of PTSD (the others remain off-label use). Benzodiazepines have not been demonstrated to be useful in the treatment of core PTSD symptoms, are potentially addictive, and may lead to poorer outcomes.
- **Debriefing Traumatic Events.** Critical Incident Stress Debriefing (CISD) had for many years been recommended as a primary modality of treatment, and even possible prevention, for PTSD. However, findings from several rigorous meta-analyses provide no evidence that individual psychological debriefing is a useful treatment or prevention and can in some cases actually be harmful.

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Shift Your Shift Work in the Right Direction!

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

Mary: You look really tired. Are you Okay?

John: Not really. I just finished a string of nights.

Mary: When was that?

John: Two nights ago.

Mary: And you're back today at 7 a.m.?

John: Yes. I tried to stay awake yesterday to change my sleep schedule, but then I was up all night. I didn't get any sleep. I'm exhausted, and I haven't even logged on to the computer yet. Where's the coffee?

The necessity of emergency department coverage 24 hours a day, 7 days a week, 365 days a year requires shift work. Shift work takes a great toll on the physician, causing stress and physical problems. It has been cited as a dissatisfier and may be a key factor in attrition from emergency medicine. There is a constant disruption of circadian rhythm, especially the wake/sleep cycle. Shift work has been shown in many industries to lead to sleep disturbances and increased risk of obesity, gastric ulcers, depression (15 times normal), alcohol or drug dependence, hypertension, infertility in women, and divorce rates. Shift work may even be more detrimental to your health than smoking!



Younger emergency clinicians are better able to tolerate rotating shifts, working nocturnally with associated sleep deprivation. As we age, we are less tolerant of shift rotation and working nights. We take longer to recover and need more time to recharge. Personal demands for our time increase, and we typically find more difficulty in balancing work and family life. Often, it is burdensome to plan our personal time around our work schedule. As parental, personal, community, or avocational time becomes more important, working a schedule designed to cover a 24/7/365 job becomes more problematic. It behooves us all to work towards an optimal schedule. This will benefit ourselves, our partners, and our patients alike.

A schedule that bounces from day to night then night to day without a second to breathe is going to be hard for anyone. Emergency medicine shifts run 24/7/365; across birthdays, anniversaries, holidays, and weekends. 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 when we work rotating shifts.

The adverse effects of constantly rotating shifts is the single most important reason given for premature attrition from the specialty. As previously mentioned, there are many biological and social problems associated with rotating shifts. Additional physical problems include:

- Increased stress-related peptic ulcer disease (8 times greater than the general population)
- Increased cardiovascular mortality
- 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 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.

Equal Scheduling

Wouldn't it be fair for all members to work the exact same number of days, evenings, nights, weekends, and holidays? This might be feasible in a utopian world, without other issues and obligations. However, the reality is that administrative responsibilities within the group, age limitations, and outside personal responsibilities, among others, would make that impossible. Bottom line, emergency medicine physicians work varying shifts. The question becomes, "How do we optimize the schedule and shifts?"

Equitable Scheduling

There are as many creative ways to schedule equitably, as there are shifts in a month. Which solution or blend is used depends on local values, administrative support, and group dynamics. The only wrong solution is staying with one that grinds down providers.

Shift Change Times

"Casino Scheduling" shift changes that occur at 2 or 3 a.m. allows both the evening and the nighttime health care providers to get sleep during sleep anchor hours. This can work with 8-hour shifts but is not as helpful with 12-hour shifts.

Shift Rotations

Shift rotations can take either a counterclockwise or clockwise direction. Counterclockwise (or anti-clockwise) rotation means working in progression from night to evening to day. Clockwise rotations are where shifts progress from day to evening to night. **Clockwise rotation is the method of choice** and recommended by the Sleep Foundation. With this scheduling method, there is a better chance to adjust your circadian rhythm.

Shift start time and shift length depend on the group's sense of taking care of its members. Optimizing wellness of the emergency physician will enable the physician to provide exemplary care to patients. Creativity is useful here. A shift start time between 6 a.m. (0600) and 8 a.m. (0800) may not be the best for the group. A frank discussion among members and presentation of evidence-based information is a strategy that can be utilized to find a solution.

Shift Length

One of the age-old debates for emergency physician groups is the length of the shifts worked.

Many groups have worked two primary shifts of 12 hours each, with additional double coverage shifts of varying lengths as needed. The major advantage to longer, 12-hour shifts is having one-third more calendar days off completely free of hospital responsibilities while still meeting annual hour requirements. 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 of sleep on each night shift. The downside is that quality of care and service to patients tend to decline in the later hours of the 12-hour shift as mental and physical fatigue set in. If several of these shifts are consecutive, there is little time for recovery between shifts. Several consecutive shifts are also difficult as the emergency physician ages.

There is a trend to **shorten the primary shift to less than 12 hours**. Many believe that patient care improves with a better rested, more alert physician. Patient care is probably improved with shorter shifts, as there is a cognitive load to working; this cognitive fatigue is found around the 7th hour. A shorter shift allows the emergency physician to enjoy recreational pursuits even on workdays. Circadian principles are more easily adapted with 8-hour shifts. If a group adopts a system of many nights in a row, shorter shifts are an advantage. As physicians age or as patient census and acuity increase, most emergency physicians find shorter shifts more appealing.

ACEP strongly recommends that practitioners have regularly scheduled periods of at least 24 hours off work.

Night Shifts

If you are fortunate enough to be employed in a group where some physicians work only night shifts, then count your blessings! This allows the night doctor, often referred to as the nocturnist, to cover the majority of night shifts, leaving less night shifts for other group members to cover. Nocturnists reset their circadian rhythm over time, allowing for better alertness during the early morning hours.

If your group does not have a nocturnist (or two), then there are a few options to optimize the schedule for everyone sharing those night shifts.

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, when the nocturnist is off.

How to work those nights? The first option is to group nights into consecutive calendar days, so the physician has a run of night shifts. Those working long strings of nights should stay up even on their nights off so they don't lose their hard-won night orientation. Whether this reorientation-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 never to 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 implemented random night shifts 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.

Night Shift Caveats

Pregnancy

Some emergency departments have implemented policies where pregnant emergency physicians are exempt from working nights in the third trimester of their pregnancy. Others have instituted lactation policies (emergency physicians work double-covered shifts and no nights for 3 months after returning from childbirth) which ensure success for emergency physicians who are nursing their infants.

Shortened Night Shifts

One possible option is to have 10- hour day shifts, 8- hour evening shifts, and 6- hour overnight shifts. By doing so, no additional night shifts are created, and the nocturnist works less hours on shift.

One hospital in the Northeast has shortened the night shift from midnight to 6 a.m. so that the overall impact on sleep is less.

Age/Tenure Opt Out

Some groups have developed age or tenure opt-out policies that allow members to opt out of night shifts based on the physician’s age, years with the group, or some combination of the two. There are varying policies. An all or none approach would allow physicians to opt out of nights completely when they qualify. In a tiered approach, the policy may allow a reduction in the number of night shifts required as a physician has more years with the group. This solution requires that the group have members of various ages and tenure within the group or dedicated night-time physicians.

Nocturnist Differential - Worth their Weight in Gold!

Nocturnists are certainly valuable. Since working only nights puts these emergency physicians at risk for more long-term health problems, they should be fairly compensated for their endeavors, whether it be in less hours, more pay, or other fringe benefits. Nocturnal work can impact longevity and if the emergency physician is paid by a productivity model, can impact income as well.

Most industries pay a differential for their night shift workers, including the nursing industry in health care. A differential can be designed to cover all night shifts, whether they are worked infrequently or regularly (by the nocturnist). The night shift differential is meant to compensate for the rigors of overnight shifts, and the amount may vary from group to group.

If the pay model is fully or mainly productivity based, the night differential may need to compensate for lower volumes or reimbursement would suffer (e.g, lower compensation). Other options, such as a reduced clinical shift load, are considerations as well.

The Scheduler

Schedule-making is a thankless job. Should the scheduler be a member of the group or a non-clinician? Both have their pros and cons. Electronic scheduling programs ease the burden but often cannot provide a perfect final version. Hands-on review and editing is often required. Completed schedules may still need revision for illness or other unscheduled personal issues.

Assumptions that the scheduler receives the best schedule is often not the reality. If the scheduler is a clinician, then incentives (pay differential) should be included for their effort. Publishing schedules on a routine, timely basis will ensure a degree of professional satisfaction, allowing clinicians to plan their lives outside the emergency department.

Take Home Points

Shift work is a necessary evil when working as an emergency physician. Nocturnists are due special considerations. Taking steps to ensure optimal and equitable scheduling will be beneficial to patients and providers alike.

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Combating Compassion Fatigue

By Julia Huber, MD and Douglas Char, MD

Compassion fatigue is a state experienced by those helping people 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 know how to identify and combat its negative effects. However, most of us don't take action until we reach a tipping point.

At the beginning of this summer, I sat my family down at the dinner table and said, "Listen, you kids are off school for the summer. Mom's working. That means you all can now water the plants, do the laundry, and take out the garbage. Someone needs to help cook dinner. You girls need to put away your own toys and clean up after your activities." Everyone nodded in unison and volunteered for specific tasks. My social experiment had begun. Week 1 was ok: just a little mess, and some dry plants. By week 2, the living room was filled to the brim with cardboard box creations, some dead or dying plants, and the garbage stank. My nine 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 take it out," I responded, and finally, change began.

There is much published about compassion fatigue. However, the terminology is surprisingly negative. As emergency physicians, we hear about how as a cohort, we are "fatigued," "burned out," and work in a "toxic" environment, and we spend our lives aggressively compensating for it. It is also the social unit that needs to change, with a difficult but necessary transition phase somewhere in there, before one or all of us decide we are going to either unload some trash to create a healthy environment—or simply leave. It is with these thoughts in mind that this article was written. So, read along as we open the cabinet door and decide what to do next as individuals but also collectively without "sliming" one another in the process!

Definition/Terminologies

Burnout and compassion fatigue appear to be intertwined whenever we read about physician wellbeing when, in fact, they are distinct entities with similar symptomatology and parallel interventions. It is worth noting and exploring the distinctions.

Burnout, a term presented by Christina Maslach in 1982 and referenced by Francoise Mathieu, refers to the 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 (VT). In the *The Compassion Fatigue Workbook*, 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 our compassion—not only for others but also for ourselves." It is "the cost of caring for others in emotional pain," an "occupational hazard," and a "cumulative process." Some health care providers lose all empathy during this process and report feeling a fundamental shift in their world view.

What Do We Look For? What Are The Risks? How Do We Assess?

Signs and Symptoms

There are many lists of symptoms of compassion fatigue found on the internet and in other publications such as compassion fatigue workbooks. 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 Pfifferling, PhD, Director at the Center for Professional Well-Being, 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, please add, “gallows humor that clears a room within minutes, unless, of course, all the others work in a similar setting.” Some refer to this as “ER humor,” and we know it gets worse when we have had a really challenging shift in the emergency department. 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 at more risk than others. Consider the following risk factors for compassion fatigue, taken from Martha Teater and John Ludgate’s workbook *Overcoming Compassion Fatigue: A Practical Resilience Workbook*. Do any of these sound familiar?



- Secondary trauma that 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
- Personal trauma history
- Lack of social support
- Habitual self-negativity
- Working in isolation

Self-Assessment: The ProQOL Test

Several 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 has a very rich bibliography on this website. The ProQOL self-assessment 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. The test takes less than five minutes, is straightforward, and is quite easy to score. Future research that directly involves using this assessment tool to analyze emergency physicians and their assessment of their quality of life would be eye-opening.

Tools and Solutions

Personal Level

Raise your 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 are a series of exercises to try, rather than feeling like you have to drink kale smoothies.

- Write down how you feel. Which symptoms are the most prevalent? Do you have any of the 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 them. Base this list not on what you think everyone would recommend you do, but on what specifically works for you. For example, your list could include ample amounts of chocolate and reading great literature, even if it means sleeping less. 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 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. There are two kinds of debriefings, formal and informal. The formal type is scheduled, and is referred to as Critical Incident Stress Debriefing, and 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, the doctors' lounge, the holiday party, or even the kids' soccer field. Although this can be therapeutic for the person sharing, we can at times overwhelm the recipient by disclosing unwanted graphic information, which can then lead to suffering from vicarious trauma as well. Mathieu recommends the four-step process of "LID," or "Low-Impact Disclosure," which involves increased self-awareness of when and how you spontaneously debrief others, providing the recipient with fair warning of what you are doing, and obtaining the recipient's consent to engage at that level, and then limiting the amount of graphic information provided.

Organizational/Systemic Approach

- Managers and leaders must be educated to regularly check in with their staff rather than waiting for staff to approach them and avoid stigmatizing staff who are suffering from Compassion Fatigue or other stress-related issues. Organizations should encourage self-care programs with a focus to stay positive as well as instituting systemic changes that foster joy in work and professional satisfaction. (Adapted from Teater and Ludgate, *Overcoming Compassion Fatigue*.)
- Provide a lexicon of wellness early in residency, as well as identification of issues such as compassion fatigue and burnout; provide workshops that facilitate the creation of a self-care "toolbox" to turn to both during and after residency in order to support a continued commitment to well being.
- The ACEP Wellbeing Committee is committed to the well being of all emergency physicians. In collaboration with other sections and committees, the ACEP Wellbeing Committee is working hard on multiple endeavors for member physicians: Peer to Peer Support Project, Wellness Center of Excellence Awards, Wellness Week, Wellness Lounge and Storytelling at Scientific Assembly, Fitness Events, and informational exchanges such as ACEP's *From Self To System: Being Well in Emergency Medicine*, with updates on the ACEP website, enhancing visibility and access to information. The committee also writes policies for the ACEP Board including parental leave, retirement, interruption of practice, and determining what the priority of membership is in wellness, to name a few.

COVID-19 Pandemic

It took intense emotional and physical effort to care for an entire nation's population affected by COVID-19 — the cumbersome donning and doffing when personal protective equipment is available, the repetitive conversations regarding vaccination status and the importance, the long intense overtime hours, the conversations over an iPad with families, and the list goes on and on. For some of us, the era of COVID-19 accelerated and magnified our compassion fatigue. This is where self-awareness and action are critical.

Please look for the signs and symptoms, take the self-assessment test, and use the tools to work toward a solution. Not only do your future patients need you, so do your family, friends, and countless others of whom you may not be aware.

Conclusion

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

“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 and 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

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

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How Safe is Safe in the Emergency Department?

By Jason Chu, MD and Jenny Castillo, MD

We often take safety for granted in our everyday lives at home and in our workplace. While we may have the impression that our work is a safe space, the true level of danger varies depending on where you work. Office workers do not encounter as many threats to their safety as compared to workers in a factory or at a construction site, which can pose potential dangers. Federal government agencies like the Occupational Safety and Health Administration (OSHA) set and enforce workplace safety standards in many work sites including emergency departments.

Safety in the Emergency Department

Emergency departments are crowded with patients, staff, diseases, injuries, and equipment, creating a multitude of potential hazards. These hazards can range from a simple needlestick injury to a more serious physical injury, such as a slip and fall or an assault. Due to space constraints, equipment may block access to emergency exits generating further injuries. Slip hazards abound especially after a resuscitation or a traumatic arrest. Chemical and infectious exposures are other hazards which plague ED physicians. Additionally, psychological or emotional injury may be triggered after interactions with agitated patients or toxic consultants and colleagues.

Case 1

A 21-year-old man presents to the emergency department with a laceration on his forearm. The laceration was caused by a broken beer bottle and occurred after a fight at a bar. After determining there were no glass fragments remaining, Dr. Yubi starts suturing the intoxicated patient. The patient suddenly moves his arm, and Dr. Yubi gets stuck with the suture needle. What should Dr. Yubi do now?

Exposures

Employees in healthcare facilities, especially emergency departments, are at increased risk of exposure to infectious diseases from body fluids, airborne pathogens, and infectious materials. Though not foolproof, exposure risks can be decreased with the use of safety devices for “sharps” and standard precaution protocols with personal protective equipment. Currently, the major blood borne pathogens of concern are hepatitis B (HBV), hepatitis C (HCV), and HIV in order of decreasing infectivity.

Hepatitis B

HBV is highly infectious and can be transmitted by percutaneous, mucosal, or nonintact skin exposures. It remains infectious on surfaces for at least 7 days and can be transmitted even in the absence of visible blood. Seroconversion of non-vaccinated patients after needlestick exposures ranges from 27% for a HbsAg positive only source patient up to 62% for a source patient who is both HBsAg positive and HBeAg positive. However, most healthcare workers (HCWs) are

vaccinated for HBV, which offsets the high infectivity rate. For unvaccinated, non-responders or poor responders to the HBV vaccine, post exposure prophylaxis (PEP) with HBV immunoglobulin and HBV vaccine may be needed.

Hepatitis C

HCV is not nearly as infectious as HBV. After HCV percutaneous exposure, research has found a 0.2%-1.8% seroconversion rate and 0% for mucocutaneous exposure. The source patient should be tested for HCV, and the HCW should have baseline testing for HCV antibodies with reflex to nucleic acid test hepatitis C RNA within 48 hours and follow up testing in 4-6 weeks and 4-6 months. PEP is not currently recommended for possible HCV exposures. HCPs who develop HCV should be referred for further evaluation and treatment with direct-acting antiviral regimens.

HIV

Similar to HCV, the transmission rate of HIV is low after occupational exposure. The risk is about 0.3% for percutaneous exposure and 0.09% for mucocutaneous exposures. Human bites, semen, and vaginal fluid have not been reported to transmit HIV after occupational exposures. The risk of HIV transmission increases if the involved device was visibly contaminated with blood, the device was in a vein or artery, the patient sustained a deep injury, or the source patient had terminal illness from HIV. Although there is no vaccine for HIV, there are PEP options. Ideally the source patient should be tested to guide whether to start PEP. However, if that information is not available, then PEP should be started as soon as possible. Studies in animals and occupational studies show that 4 weeks duration of PEP is protective against HIV transmission.

Post-Exposure Key Concepts

Many occupational infectious exposures are treated in emergency departments, especially during off hours. Previously identified challenges in managing these occupational exposures include difficulty in evaluation of an unknown source patient or one who refused testing, a HCW inexperienced in managing occupational HIV exposures, and counseling of exposed workers in busy emergency departments. Having clear institutional protocols with access to expert consultation, testing of source and affected patient, PEP regimens, and follow up can overcome those challenges. Post-exposure testing should be available for HBV, HCV, and HIV, and PEP treatments should be available for HBV and HIV exposures.

Case 2

A 56-year-old female presents to the emergency department with a fever, cough, and shortness of breath. The triage nurse asks about travel history and discovers the patient just returned from a trip to the Middle East and thinks she has been exposed to someone with COVID-19. The patient was given a mask and placed in a negative pressure room.

Airborne Diseases

Over the years, multiple epidemics changed screening and operating procedures in health care facilities and emergency departments. Seasonal influenza brought patients to the ED during winter months leading to high volumes. In the spring of 2009, H1N1 changed this paradigm by arriving late in the season and causing a large upsurge of patients in healthcare facilities. Smaller epidemics of Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS) initiated a change in clinical protocols from merely screening patients to isolating all those suspected with the disease. For Ebola, facilities instituted rapid quarantine and increased PPE requirements and protocolized

specific donning and doffing techniques. Sporadic measles outbreak clusters due to decreased vaccination rates also forced institutions to make similar changes. The global pandemic of SARS-CoV-2 virus causing COVID-19 upended everyday life, work, and health care operations starting in early 2020. This new disease with high contagion and mortality caused fear and confusion due to its unknown nature, limited testing capabilities, PPE scarcity, and rapidly changing and fluctuating guidelines. These difficulties have lessened but other factors such as COVID-19 and vaccine deniers add to the stress and safety of HCWs. As we look to the future, new disease epidemics and pandemics are likely to occur again, and we must use the experiences from these prior epidemics to improve clinician safety and wellbeing in the future.

Mitigation of Departmental Hazards

Healthcare facilities must have standard operating procedures and policies to mitigate these hazards. The CDC outlines a hierarchy of controls in managing occupational infectious hazards. Most effective is (1 physically removing the hazard if feasible, followed by (2 substituting the hazard, (3 engineering controls to isolate people from the hazard, (4 administrative controls to change the way people work in relation to the hazard, and finally (5 personal protective equipment to protect the worker if the hazard cannot be avoided. Policies should ensure physical safety as well as psychological and emotional security.

Case 3

Dr. A. Bone was working the overnight shift on the nonacute side one Friday evening. At 0200, a patient's family member came to the area to visit. The family member was visibly intoxicated and getting into a heated argument with the patient. Dr. Bone walked over to investigate. The family member yelled, "This is none of your business," and pushed Dr. Bone to the ground. Dr. Bone fell onto her left hand, spraining her wrist. Since it was overnight, fewer HCWs were present, and no one came to her aid. Dr. Bone was terribly shaken by this but had to stay for the rest of the shift because she did not want to call someone in to cover her. The family member stormed out. Dr. Bone opted not to tell her chair or security about this event because she felt this was "part of the job." What does Dr. Bone do now?

Workplace Violence

Workplace violence (WPV) has been an increasingly prevalent issue within emergency departments. The Joint Commission found approximately 75% of 25,000 annual workplace violence incidents occurred in health care. This staggering number correlates with the ACEP study, which found almost 50% of physicians have been physically assaulted while in the ED. The current culture of emergency medicine encourages clinicians to deal with violence individually while continuing to be a productive worker. This strategy only perpetuates the violence and exacerbates the individual trauma.

The Workplace Violence Prevention for Health Care and Social Service Workers Act introduced in 2022 by Representative Joe Courtney (D-CT) and Senator Tammy Baldwin (D-WI) takes critical steps to address emergency department violence. This bill would require OSHA to issue an enforceable standard that would make sure hospitals and other health care facilities implement violence prevention, tracking, and response systems.

Emergency physicians and emergency nurses are united through the No Silence on ED Violence campaign, and ACEP has firmly urged Congress to pass this legislation.

Case 4

Dr. Wesson is an emergency physician in a Level 1 Trauma Center located within a large urban area. Without notification, EMS brings in a 21-year-old male with a gunshot wound to his chest. CPR was in progress upon arrival, and the patient had no breath sounds on the left side. Despite heroic efforts, the patient died in the trauma bay. Family is brought back to see the patient, and they begin screaming at Dr. Wesson to do something. A family member grabs the doctor by the collar of his white coat and threatens to kill him if the patient is not brought back to life. Dr. Wesson is clearly shaken.

Emergency medicine is an environment where stress and high emotion are the cultural norm. At times, this raw emotion can be translated into physical violence toward the clinician. As emergency physicians, we have the expectation that we will be safe at work and avoid injury. If violence does occur, then we expect easily accessible ways of mitigating this hostility.

What Can be Done to Decrease Workplace Violence?

We must strengthen protections for professionals on the frontlines. That effort can begin in earnest when everyone stops accepting violence in the emergency department as part of the job.

To create a safe working environment, emergency department personnel must operate as a team to develop effective strategies. Departmental leadership, security, nursing, advanced practice providers, and physicians should collaborate to create an algorithm addressing workplace violence. Departmental leadership must educate all emergency clinicians, so they are aware of the prevalence of WPV, know the reporting structure, and contribute to an environment where reporting incidents is destigmatized and normalized.

Institutions must create and promote an easily accessible reporting platform for WPV incidents for the purpose of determining the rate of violence and to identify those who are reporting and the locations where these incidents occur. This data can provide valuable information allowing for potential focused interventions in areas of higher occurrences.

From a security perspective, this requires a multi-pronged approach, including adequately staffed and trained personnel utilizing technologies such as video surveillance and staff alarms, de-escalation techniques, and policies that are reviewed and updated regularly.

Hospitals and institutions must prioritize solutions to violence in the health care setting. When the workplace is unsafe, the wellbeing of both patients and clinicians is compromised. An environment of zero tolerance must be created to reduce unreported incidents. Streamlined reporting encourages physicians to fill out an incident report. Situational awareness of potential violence is key. Routine and ongoing instruction of techniques to diffuse WPV helps clinicians recognize escalating situations and provides strategies to de-escalate potential violence.

From needlesticks to physical assaults and emotional suffering, the emergency medicine physician is at risk of injury. Heightened awareness and actively placing safety first is critical to the wellbeing of those in the emergency department.

Resources

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Combatting Second-Victim Syndrome: Pain Relief for an Emergency Physician after an Adverse Event

By Douglas Char, MD and Jennifer Robertson, MD

“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, by its very nature, is an imperfect science. All of us make mistakes; we are human. However, we have been indoctrinated to feel shame and guilt when mistakes or unexpected events occur. *Primum non nocere* (first, do no harm) is a mantra we have all dutifully engrained in our souls. Yet, adverse events are common and in fact, medical error is estimated to contribute to over 251,000 deaths per year in United States (US) hospitals. This statistic infers that medical error is the third leading cause of death in the US every year. This statistic also is an example that humans are human, and we are fallible. Despite our best efforts, errors will continue to happen. While patients are primarily the victims of error, the medical provider is often ignored as a victim, yet is someone who may suffer even more, both emotionally and physically.

Second Victim Syndrome Definition

Dr. Albert Wu defined “second victims” as health care providers who are involved in an adverse unanticipated patient event, a medical error, and/or patient-related injury and subsequently become victimized. The clinician is 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.”

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

- Anxiety
- Frustration
- Guilt
- Shame
- Depression
- 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 of us have not developed the skills necessary to navigate this emotional minefield. We certainly 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.

A related study found that those who reported an error scored lower on quality-of-life surveys 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 further 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.

After an Adverse Event, second victims have definite needs:

- 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

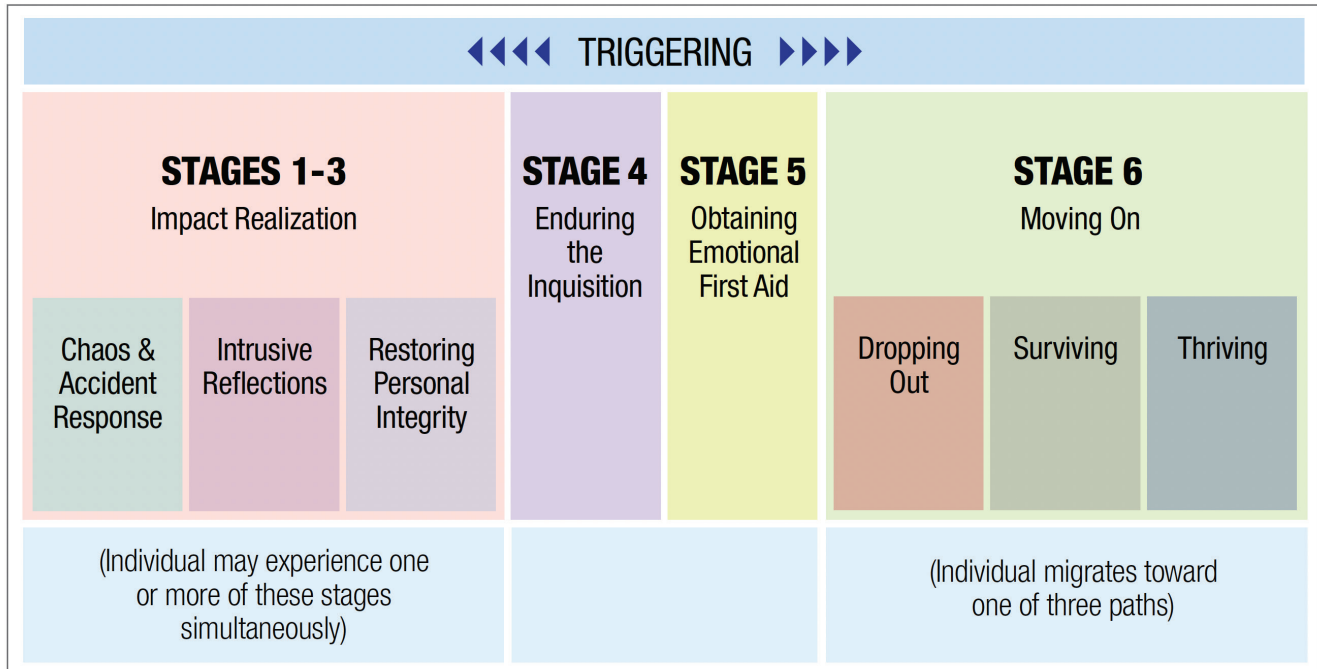
Stages of Second Victim Syndrome

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); and finally,
- stage 6, moving on (one of three trajectories; dropping out, surviving, or thriving)

Dr. Shelly Luu, a surgeon, describes three phases; the Kick, the Fall, and the Recovery (Luu) Immediately after the event, well-described psychological 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 post-traumatic stress disorder (PTSD) in the most extreme situations, and over the long term, if unaddressed, can lead to compassion fatigue.



While the term, second victim, was originally coined by Dr. Wu to define the emotional state after a medical error, it can be applied to the COVID-19 situation as well (Strametz). This includes anxiety over being infected, post-traumatic stress after caring for ill patients, concerns about infecting family members, social isolation, etc. (Wu 2020). Individuals may be a “second victim” from the stressors of the pandemic and extraordinary patient care situations (Strametz).

What Can Be Done?

The good news is that resiliency and support may help combat the negative responses that occur after medical error and other traumatic situations such as COVID-19. Support from medical institutions and peer support may fortify resilience in healthcare providers (Strametz; Wu 2020, Scott 2010; Lane et al).

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 wellbeing. However, it should not be assumed that resilience is necessarily the provider’s responsibility to develop.

The most desired outcome of resilience 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.”

Importance of Peer Support

Social support is of value in and of itself and directly influences biological processes and can be extremely effective for maintaining resiliency both after medical error and other stressful situations such as COVID-19 (Fisher; Wu 2020). This is the basis for the success of peer support teams (Fisher; Wu 2020).

Several years ago, John’s Hopkins established a confidential peer support program called RISE (Resilience in Stressful Events) (Wu 2020). RISE responds to calls 24/7 and provides in-person psychological first aid and emotional support

to healthcare workers (Wu 2020). The program has also coordinated with employee assistance and hospital wellness programs, chaplains, and psychiatrists in response to the COVID-19 pandemic (Wu 2020).

In collective cultures (such as medical teams, ICU staff, ED staff), the group is committed to supporting its members, however individuals may be discouraged from bringing forth personal problems that might impose on and burden the group. In such a setting, sharing personal problems (error reporting) may cause an individual to lose face or affect relationships negatively. What is needed is implicit support through presence and shared activity. It is what most of us crave when we are in this situation. In fact, research shows that to combat shame, secrecy should be avoided, and one should be encouraged to share his or her stories with safe and appropriate individuals (Brown).

According to well-known researcher Dr. Brene Brown, shame thrives in secrecy, silence, and judgement. Without these variables, shame cannot survive. Therefore, sharing with a non-judgmental peer who understands the situation is very important toward reducing shame and starting the healing process.

Peer support may assist second victims in multiple ways:

- Providing psychologic first aid
- Overcoming the culture of invulnerability
- Reducing shame and blame
- Limiting isolation by normalizing the situation
- Encouraging self-care

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 similar situations have 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.

Importance of Organizational Support

Organizational support is critical in promoting resilience for the second victim, both after medical error and other traumatic situations such as COVID-19 (Wu 2020; Scott 2010). For second victims of medical error, organized support programs now exist in several medical institutions. 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.

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 is employed (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 (Scott 2010).

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, but 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 with time, many of the negative attributes will resolve (Lane et al).

Institutional support has been key when handling second victim syndrome associated with the COVID-19 pandemic. Leaders should provide clear communication that is open, honest, and frequent. Extra effort should be taken to thank all healthcare workers and express gratitude for their effort. The most up-to-date information on COVID-19 and future pandemics should be readily available and outline what is being done to protect healthcare workers and delineate critical steps if healthcare workers are infected. (Wu et al 2020).

With increased support from healthcare leaders, clinicians involved in adverse events will hopefully be better able to handle the stress in a healthier and more productive manner than in previous generations. While regulations do require safety investigations, the hope is that healthcare workers will have the support they need. Unfortunately, there remain many barriers to implementing second victim support programs, including lack of formal structures, reluctance of individuals to use support services, fear of loss of professional respect, ineffective reporting systems, and stigma of seeking out assistance.

The culture of medicine has historically been one of blaming the individual for errors rather than the system. Despite the rarity of intentional negligence or harm owing to malice, many caregivers involved in human error and systems failures are “often treated with blame, shame, and abandonment” (Denham). We must encourage providers to seek out help, despite barriers and fear.

Our collective goal is to change the traditional medical culture of individual blame to one that embraces physician wellness and encourages improving the system and learning, rather than pointing out failure and blaming. Success will require a transformation in culture from seeking assistance as failure, to sharing your story as a sign of strength. (Brown et al Daring Greatly).

Additional Resources

<https://www.traumaresourceinstitute.com/>

<https://www.centerforpatientsafety.org/second-victims/>

<https://psnet.ahrq.gov/primer/second-victims-support-clinicians-involved-errors-and-adverse-events>

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Being Well as an Emergency Medicine Resident: Getting Started

By Rory Merritt, MD, Ryan Tansek, MD, Arlene Chung, MD and Elaine Josephson, MD
New additions and edits by Rykiel Levine, DO

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 [clinician] 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 Chisholm, 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 might be located far from your home, family, or where you attended medical school. Adjusting to a new environment is difficult. You must make new friends, move, find a place to live, and learn how to survive as a resident in the emergency department and on off-service rotations.

Perhaps you are doing your residency in a place close to home and now must spend more time away from local friends and family. It can be difficult to explain your work priorities.

Maybe you are a senior resident learning about graduated responsibility in the emergency department 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 (or world) should you begin your practice as an attending physician?

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 and do. It is so satisfying to be a member of a team that successfully resuscitates a seriously ill patient. We feel so useful when we teach a new procedure or technique to someone else.

Uncertainty in the life of emergency medicine residents, on the less positive side, 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 face leads to stress. Over time, unmitigated stress leads 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 emergency medicine residency.

Can Emergency Medicine Residents Become Burned Out?

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

You already know 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 chaotic emergency department 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 all seen burnout in our peers: the overly dismissive consultant or perhaps even an attending with an appalling bedside manner. It is harder to recognize and acknowledge burnout when it becomes our own issue. But we must try to recognize it.

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

Are You Burned Out?

Consider using a “burnout score” as a jumping off point (see Resources). Take a look at the Adult Apgar (see Adult APGAR chapter) or the ProQOL: Professional Quality of Life Assessment (see Compassion Fatigue chapter).

Promoting Wellness as a Resident

There are many strategies and resources residents can use to ensure their own wellbeing. Rejuvenate by spending time with people you really enjoy. To refresh your outlook, see the world outside of the hospital and expand your interests. Maintain old hobbies or explore new ones, which can be therapeutic. Maximizing work-life balance is essential. Every individual’s balance will be different.

Advice and input from senior residents and attending physicians is insightful. Although we may address some of our concerns during informal conversation, specifically seeking formal feedback from a trusted co-resident or attending on certain issues can provide additional perspective. Organized group gatherings of residents, particularly those of the same class or with similar interests, are effective, especially when meeting to explore resident wellness issues.

Spend time virtually or in person with supportive family and friends; even though they may not completely understand the issues at hand, they can certainly contribute perspective and insight. There is benefit in decompressing and discussing topics that don’t relate to medicine. Sometimes it is important to step away from the world of emergency medicine.

Assistance from professional counseling sources is all very helpful. Many hospitals and residency programs offer resources for staff mental health. Take advantage of these confidential resources as early as possible to prevent disruption in residency training, especially if the issue is serious. You would go to a primary care 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 require discussion during residency? Just a thought, not a lecture!

Residency Programs Must Foster Wellness

Residency programs are required by the Accreditation Council for Graduate Medical Education to foster wellbeing in their residents. Program leaders must promote an atmosphere of support and physician engagement that boosts resident wellbeing. Programs may elect to create wellness committees to specifically focus on issues that directly affect resident wellbeing. Residency programs are also required to provide medical and psychological resources for residents to utilize as needed.

Resident schedules impact resident wellness. Inconsistent daily routines have a negative impact. The significant time commitment and heavy workload during residency is challenging and programs must ensure fairness and equity when compiling schedules. An equitable schedule is a major positive contribution to resident morale. The schedule writer should consider healthy circadian rhythms when preparing the clinical schedule. A call-in back-up system for residents is necessary in case of medical or serious personal issues.

Shift Work Coping Strategies?

Ask a group of emergency medicine residents about the best strategy for dealing with shift work 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 negatively affects work performance but also impacts a resident's personal and social life, increasing emotional and psychological stress.

Optimizing resident schedules goes a long way in reducing fatigue. Obtaining the appropriate amount of sleep will make all the difference in how you function in the ED. Different people need different amounts of sleep, but it is crucial for YOU to obtain an adequate amount of sleep overall. Good sleep hygiene includes room-darkening shades, cool temperatures, ear plugs, eye masks, and anchor sleep. Avoid pre-sleep screen time on your phone or ipad. Utilizing designated call rooms helps curtail fatigue during on-call days. Some residents use caffeine, melatonin, and other sleep aids to manage alertness and sleepiness during shift work. Self-awareness of fatigue is vital. Refrain from driving and other potentially dangerous activities when you are exhausted.

Wellbeing During a Pandemic

The COVID-19 pandemic introduced an element of difficulty that changed emergency medicine for the foreseeable future. The pandemic affected residents across the country and across all fields of medicine. Both emergency medicine residents and attending emergency physicians realize that masks and personal protective equipment hide facial expressions so that human interactions with patients are much less personal. Masks make it difficult to hear what someone else is saying, so often we feel we are yelling when discussing medical treatment. It is important for us to be extra empathic during this time.

Our ability to socialize has been stressed with the limitation of organized events, conferences, interviews, and meetings outside of the hospital. Our world has become virtual, which has curbed face-to-face interactions. While virtual happy hours initially proved to be an outlet for those struggling with social distancing, there is a limit to the joy one gets through a computer screen. Emergency medicine residency applicants are unable to fully appreciate what a residency program has to offer during a virtual interview day. Despite virtual video tours and virtual resident meet and greets, medical students will largely have to base program selection from a website as this practice may continue indefinitely.

With these considerations in mind, plus canceled rotations, scheduling stressors, safety issues, and threat of illness, sustaining mental health has never been more crucial. Although the support for health care heroes during this time has minimized some of that burden, both systemic and individual innovations are necessary to improve and optimize resident wellness.

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 to Intern Year

Take time to learn about what is expected of you in the program and bond with your fellow residents. You are all in this together and will need each other’s support.

Find out about off-service rotations and emergency department shifts from junior and senior residents.

Don’t be afraid to ask questions while working with the emergency medicine faculty attending physician as you start to learn the practice of emergency medicine. Your initiative indicates you are interested and motivated.

You may be assigned to a faculty mentor if your residency has a mentor program. Discuss your academic goals and interests with your mentor. If you are assigned to a residency buddy or “big sister” or “big brother,” meet early and often to start off with a firm foundation.

2) Family and Outside Friends

Take advantage of support systems outside the residency program. If you are far from home and close friends, make an effort to keep in close contact (phone, internet, FaceTime, Zoom) and consider using your vacation to visit. If you are in the same locale as your family, schedule time to see them when you are not working. It is always so comforting when someone cooks you a meal or helps with your laundry. If you live with your significant other and/or have children, be present and mindful when you are together and enjoy their company when you are not in the emergency department.

3) Outside Interests

Maintain previous outside interests or perhaps explore a new hobby to help relieve stress. Find other fellow residents in the program with interests like yours and set aside time to socialize.

4) Health

Ensure plenty of sleep between shifts and on days and nights off. When transitioning between days to nights, be sure to nap when needed to reset your body clock. If you or a colleague recognize you are too fatigued to drive home after a shift, take a nap in the on-call room before traveling. After working a night shift, if you are stopped at a stoplight, shift your car into park. If you fall asleep for a second, the car behind you will honk its horn and wake you up. You may be embarrassed, but you’ll be safe!

Take time for yourself and schedule an exercise routine that fits your shift schedule. Make healthy choices for meals and snacks as much as possible. Avoid processed and fast foods. Find your individual release for stress: yoga, walking, meditation, biking, working out at home or in the gym, etc.

If you become ill, be responsible, and don't expose other health care providers and patients to your infectivity. Don't work when you are sick and obtain a medical examination and treatment. Most residency programs have instituted a sick call system.

5) **Emergency Medicine Residency Program Wellness**

Take full advantage of the wellness programs offered by your residency. Most emergency medicine residency programs sponsor team-bonding events or retreats where faculty and residents get together. Be sure to attend residency-sponsored events (holiday parties, graduation parties), informal get-togethers (meet and greets for new applicants, resident informal gatherings), and residency sponsored dinners to chat with your classmates and faculty outside the hospital.

If you encounter workplace violence, healthcare exposures, or personal issues during residency training and need support, seek the advice of your program director and/or chief residents, mentors, colleagues, or the graduate medical education office. In addition to vacation and sick leave, there is also time allowed off by the Family and Medical Leave Act, should it be necessary.

6) **Senior Year**

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

Resources

Organizations:

American College of Emergency Physicians (www.acep.org)

- Policy on Shift Work. <https://www.acep.org/patient-care/policy-statements/emergency-physician-shift-work/>.
- Wellness Section of ACEP
<https://www.acep.org/life-as-a-physician/wellness/>
- ACEP Wellbeing Committee
<https://www.acep.org/how-we-serve/committee/committees-list/well-being-committee/>
- Core Readings on Wellness for Emergency Physician
<https://www.acep.org/life-as-a-physician/wellness/core-readings-on-wellness-for-emergency-physicians/>

Emergency Medicine Residents' Association (www.emra.org)

Reading Recommendations – <http://www.emra.org/students/education/reading-recommendations/>

The Society for Academic Medicine (www.saem.org)

Twitter, Blogs, Podcasts, and Other FOAMed (Free Open Access Medication)

Free open-access medical education (FOAM) is a collection of interactive online medical education resources—free and accessible to students, physicians, nurses, paramedics and other learners.¹ FOAM uses multiple online platforms such as blogs, podcasts, tweets, videos and other web-based media to form a community that shares ideas and accelerates the translation of research into clinical practice. Search #FOAMed.

ALiEM (Academic Life in Emergency Medicine)
www.aliem.com/; @aliemteam

Free Emergency Medicine Talks
<http://freemergencytalks.net/>

LIFE IN THE FAST LANE
<http://lifeinthefastlane.com/>

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&>

Being Well as an Emergency Medicine Resident: Surviving Residency

By Kestrel Reopelle, MD

Louisa is a PGY2 emergency medicine resident at a busy urban ED along with 39 other residents. She prided herself as a happy, well-adjusted medical student at graduation, but over the next 2 years she has noticed her sense of satisfaction with medicine ebbing away and replaced with a low-level stress that she cannot conquer. She is confused as to why this is happening. It is unfathomable to her that her beloved Emergency Medicine has fallen from the pedestal, and she wonders if this is still the right path for her...

Resident physicians in emergency medicine are prone to many of the same stressors as their attending counterparts, including compassion fatigue, day-night shift switching, job disillusionment, and post-covid employment insecurity. Residents also have the added pressures of working longer, often more than 60 hours per week, with little control over their schedules, in environments of varied work cultures with lack of personal support.

These stressors faced exclusively by residents are unique in that they are regulated and implemented by varying levels of authority from the department level to national organizations. They arise from the institutionalization and regulation of post graduate medical education, as well as the staffing models and cultures of specific hospitals. In short, these stressors arise from systemic issues.

The exhaustion born from working 60 hours a week in addition to studying and attending conference cannot be combated by additional activities such as ice cream socials, yoga, and family/friend gatherings, whether virtual or in person. After such strenuous weeks, a resident might want to spend any remaining time (awake!) with their family or friends – but this activity alone cannot reduce the mental, emotional, and physical fatigue of such intensive work. These job factors, created and perpetuated by the system in which we work, can only be combated at the level where they are created – a systems level, not an individual level. So how can we help a residency program reduce these risk factors for burn-out? Here are a few strategies:

A Working Culture for Wellness

Whether through observed behavior, assumed professional expectations, overt instructions, or deeply engrained routine, many new emergency medicine trainees find themselves entering unhealthy work environments. These are departments where 12 hour shifts without lunch breaks are the norm, or perhaps where frequent restroom and other breaks are perceived as weakness, laziness, or hindering one from contributing to teamwork with his or her full potential. Oftentimes, this culture may go un-noticed because it has perpetuated itself for many years, and for younger trainees, it is the first and only professional environment they have encountered.

The detriment of these habits seems obvious and have been revealed through thoughtful research. A study of ICU nurses demonstrated fewer mistakes and faster completion of tasks such as IV insertion, after receiving a 40-minute break. If EM nurses, OR scrub technicians, and other health care professionals who are vital members of life-saving teams have found the means to ensure that each employee gets a break, then emergency physicians should be able to accomplish the same. Breaks are especially important for EM residents, who often stay late to sign out, perform procedures, or complete charts – working longer stretches and therefore more likely to benefit from mental breaks, proper nutrition, hydration, etc. during their shifts. One strategy a residency program may take is to mandate breaks during a shift which has recently been implemented in some EM programs. No literature, as of yet, has been published on the specific effect of this intervention on residents and their wellbeing. One emergency department in New York City has implemented breaks for their attending emergency physicians and found it to enhance productivity.

A strategic goal that all emergency departments should commit to is a scrutinizing assessment (by both internal and external/unbiased parties) to identify areas for improvement in on-shift wellness. It is essential that program leadership both describe the ideal and healthy “on-shift culture” to residents early and often in their training, as well as modeling exemplary behavior themselves, and encouraging the same of residents on clinical shifts.

Scheduling for Resident Wellness

Maximum hours worked by residents are regulated by the Accreditation Council for Graduate Medical Education (ACGME). Minimum hours are set by individual programs based on program duration, patient volume, and other factors affecting the amount of clinical exposure required to meet each of the ACGME milestones for competent independent emergency physicians. Working within these confines of absolute numbers are multiple opportunities to improve work-life integration, productivity, sleep hygiene, and circadian rhythm, if a scheduler is instructed to do so by program leadership.

One of the guiding principles of circadian rhythm scheduling is that the body’s innate rhythm is a little over 25 hours, making it easier to delay sleep than to advance it. However, adjusting a body’s circadian rhythm can take up to one week, so scheduling a shift progression from days, to swing, to nights, over a longer time period can be physically beneficial. Memory is sharpest after restorative sleep, and therefore most people are more productive in the morning. If longer shifts (e.g. 12 hours) must be scheduled, it may be wise to do so during the daylight hours and reduce evening and overnight shifts to shorter lengths of 8 to 10 hours to accommodate for decreased productivity. Another model is for trainees to work large blocks (e.g. one month) of only nights or days, with a designated cross-covering physician to work those shifts when the resident is not scheduled.

Chief Residents as Advocates for Wellness

In an emergency medicine training program, scheduling is most often performed by chief (senior) residents rather than the residency program directors and assistant directors. In addition to optimizing schedules, there are other opportunities for chief residents to utilize their position of power to improve the wellbeing of fellow residents.

Program leadership should train chief residents at the beginning of their term on the impact that their correspondence, decisions, and actions have on the residents with whom they will be interacting. For example, a chief resident is the first point of contact for any resident requesting time off or schedule manipulation for medical appointments, family events, or any emergency – all of which are significantly important to maintain resident wellness. Chief residents are also able to serve as mentors and offer professional support to junior residents, as well as to set an example and recruit their senior classmates to do the same.

Combating Dissillusionment

In an era of increasing EMR documentation, a continued covid pandemic, insurance regulations, and patient volume corresponding with decreased time for patient interaction, many residents feel disillusioned that medicine is not the job they had imagined it would be, at least not on a minute-to-minute or hour-to-hour basis. Residents today are not spending their time the way residents previously functioned five to ten years ago--in marked contrast with how their parents, mentors, and those that inspired them formerly worked.

User friendly EMRs with time-saving features designed specifically for emergency department workflow can alleviate the burden of increased electronic documentation. Use of scribes has also improved some facets of emergency provider experience⁴ in addition to the expected improvement in workflow and time-intensive charting, therefore increasing wellness in multiple ways. Resident participation in oral storytelling and experience-sharing events such as “Airway” Stories or “Tales from the Shift” allows residents to re-connect with and re-enforce the humanistic elements and experiences in EM which can fade in the daily grind of residency training.

Opt-out counseling programs in residency have shown to be effective in decreasing severe mental health problems and preventing suicide. Normalizing the option to work through stressful issues with a psychologist or psychiatrist ensures that our residents in training have a non-biased outlet for addressing depression, anxiety, anger, and fear.

Wellness in residency training is a priority that will guarantee a future workforce of well-adjusted resilient emergency physicians who have longevity in the specialty. Personal wellness in residency is vital, but system wellbeing initiatives instituted by residency and department leaders have greater overall impact.

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Resources

Videos

Michael Howell: “Physician, Sleep Thyself”

ALiEM: Wellness Think Tank Panel Discussion

Sites

<https://www.emra.org/books/emra-wellness-guide/cover/>

<https://www.bytebloc.com/Blog/optimal-scheduling-strategies-for-emergency-medicine.aspx>

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Articles You Don't Want to Miss

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You Made it Through Residency! What's Next?

By Rykiel Levine, MD and Elaine B. Josephson, MD

Joyanne is a fourth-year emergency medicine resident graduating in 3 months. She is busy with final projects and a mini-fellowship. She has been trying to find a job after graduation. Joyanne loves the community setting, but she so enjoys teaching and interacting with learners. She has some interests in geriatrics and palliative medicine and is also contemplating a fellowship. She thinks to herself: “So much to decide! How do I even begin to wade through this and make these life-changing decisions?”

Planning your post-residency life is exciting and filled with myriad possibilities. However, it can be intimidating, stressful, time-consuming, and overwhelming. The transition from resident to attending physician literally happens overnight but comes as no surprise. Planning for this instantaneous switch should start almost as soon as residency begins and certainly not less than one year before graduation. It is not uncommon for an intern to be making decisions about fellowship training and early sign-on bonuses. When deciding what you want as your first “grown-up” job, you should consider other various factors as well, including family, location, academic or community practice, and a strategic backup plan if the first job does not work out.

Ultimately, there are no right, wrong, or easy answers. So many factors go into your decision. The more you honestly and deeply reflect on what’s important to you—family, paying down debt and at what rate, work-life balance—the better choice you will make and the more likely you are to find the best fit for your first job as a board eligible emergency medicine physician.

The Search for a Job During the COVID-19 Pandemic

Historically, emergency medicine graduates were highly sought-after specialists, but recent pandemic events and other factors, such as a rapid and unchecked increase of residency programs, have drastically changed the emergency medicine job market. Due to low emergency department volumes during the COVID-19 pandemic, emergency physician hours were cut, salaries decreased, and layoffs occurred. Many teaching institutions faced a decreased ability to hire their own graduates, foiling a safety net that previously existed for residents wishing to stay at their training institution. Residents who graduated in 2020 and 2021 experienced loss of promised jobs, loss of contracts, and reduced job security not previously present.

Resultant cutbacks in the emergency medicine workforce have triggered the phenomenon of more and more residents applying to fellowships they would not ordinarily have considered. In a cascading effect, pursuit of these fellowships delays the attending job search for a year or two, creating a bottleneck for future graduating emergency medicine residents also looking for employment. More fellowship trained graduates in the ensuing year creates a more competitive applicant pool.

Factors to Consider When You Start Your Search

Family Influence

Immediate and extended family needs and desires should play an extremely important role in your decision-making process. If your significant other is planning to work, remember that he or she must be able to find meaningful employment as well in the desired location. If you have children, you will want to consider the quality of the schools in the area, access to childcare, and whether living close to other family members is important to you. It is vital to your wellbeing to set aside time to have fun, spend quality time with your family and friends, and take 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 one of the most important decisions you will make during the career planning process. Take time to think about geographic locations. Where in the country, or internationally, would you like to practice? Where do you see yourself living? Do you have flexibility in your choices? Keep in mind that your selection of location may affect your ability to do a specific fellowship or work in a particular practice. Be sure to investigate the attending physician salary ranges for that area, as they vary regionally in the United States.

Once you decide on a potential location, consider and research all options in the area. Do you want to be an independent contractor, try a locum tenens position, or join an already established group? Which practice settings (urban, suburban, rural, community hospital, trauma center, tertiary care center, transplant center, critical access, etc.) are available and which are hiring? For each potential place of employment, collect the following information: annual emergency department census, total shifts per month and hours per shift, 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. Make sure you can afford to comfortably live in that area on your salary and pay off your loans if you have them. Investigate for each location the state malpractice risk and liability.

Of course, you will need to weigh all the options and potentially trade one that is more important for another. Not every job is perfect, or we would all be working there! Decide what is most important to you and keep that at the front of your decision-making process.

Fellowship Decision

If you are considering fellowship training, first determine what type of fellowship as well as what your plans are post fellowship training. Emergency medicine fellowships include research, EMS, medical toxicology, ultrasound, academic/medical education, administrative, pediatric emergency medicine, critical care, hospice and palliative medicine, sports medicine, clinical informatics, and wilderness/disaster medicine. Not all fellowships are accredited by the Accreditation Council for Graduate Medical Education (ACGME). One of the main differences between ACGME and 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 deciding whether 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 intend to pursue a research-based career, fellowships are often recommended in the area you plan to study. Keep in mind that many federal research grants are given to physicians with formal training or those with extensive prior research in the subject.

If you decide to do a fellowship, realize that emergency medicine fellows may work clinically as part-time faculty and, therefore, are paid a part-time faculty or fellowship salary. After clinical duties, the remainder of time is spent in the subspecialty training. Expected clinical time will depend on the funding source.

Academic vs. Community

Take time to determine if you want to practice in an academic or community setting. Community positions will most likely pay more than academic settings and may be more conducive to lifestyle preferences. Further, there may be potential for leadership in a group. If the community position is part of a large national corporation, there may be an opportunity to relocate to a different part of the country with minimal disruption.

Academic positions may offer better benefits and job security than a community setting. Academic medicine affords the reward of teaching students, residents, paramedics, and 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

Many residents 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 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 401(k) vs a traditional pension). Does your salary seem high because you are asked to pay your own malpractice and health insurance premiums? Don't be afraid to 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.

Independent Contractor vs Academic Institution vs Hospital Employee vs Private Group Employee

Independent Contractor

- You are self-employed
- Maximum flexibility with scheduling shifts
- There are usually no benefits. These must be purchased for yourself and your family
- Contractor may or may not offer malpractice insurance
- 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.)
- Tax implications: Many common expenses are tax-deductible; however, you may be required to pay a self-employment tax

Academic Institution

- Most taxes and deductions are paid by institutions
- Benefits provided by the institution (e.g., health, basic life, and basic disability insurance)
- Typically more 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

Private Group

- 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 corporate group can lose a hospital contract
- Depending on the size of the group, some will provide health, basic life, 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

More than half of graduating residents switch jobs within 5 years, and the majority of those within 1-2. One reason is simply not knowing what job will fit you best and one in which you will thrive. You have trained in one setting and are inexperienced in the rest. Sometimes, trial and error are the only way to find the right place and practice for the long term. Beware of being enticed by sign-on bonuses offered by large corporate groups, sometimes with a 3-plus year commitment, even before you know where and how you want to practice emergency medicine.

Several other reasons cited for job turnover include the emergency department environment (workload pressures and consultant conflict), financial compensation, and work-life balance. These concerns ideally should be considered before accepting any job. If you find that you are not quite satisfied with your first job at the 2-year mark, you are not alone. 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

No matter what career path you ultimately choose, good mentors are invaluable. They can help you develop a solid plan, not only for the next year but also for 5 and 10 years in the future. If you know where you might want to be in 10 years, seek out individuals who have achieved the same goals. Ask your mentors 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. Ask for advice on financial planning, navigating the interview process, and everything from A to Z. Hopefully, their guidance will set you on a path of success and longevity in a career in emergency medicine.

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Naming It: A Glossary of Wellness Terms

By Kristin Nordenholz, MD, Diann Krywko, MD and Rita Manfredi, MD

ADULT APGAR

A brief, self-scoring instrument designed to assist physicians in assessing and monitoring their wellness. APGAR stands for Access, Priorities Growth Assistance, and Responsibility. (The Adult Apgar: A Guide to Physician Wellness, Shay Bintliff, MD, *Int'l Journal of Dermatology* 2012, 51,868-86)

BURNOUT

1. Coined by Maslach in 1982, it is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy. (ICD11)
2. A syndrome characterized by a high degree of emotional exhaustion and depersonalization (i.e., cynicism), and a low sense of personal accomplishment at work." (National Academy of Medicine [NAM])

CHIEF WELLNESS OFFICER

C-suite employee responsible for overall employee wellbeing. They oversee the creation and maintenance of a culture that promotes advocacy, openness, and support within their organizations, strategizing and collaborating with other leaders across the business to provide oversight and implement change for the betterment of the workforce. (The Future of Commerce)

COMPASSION FATIGUE (VICARIOUS TRAUMATIZATION)

1. The physical and mental exhaustion and emotional withdrawal experienced by those who care for sick or traumatized people over an extended period, apathy or indifference toward the suffering of others as the result of overexposure to tragic news stories and images, and the subsequent appeals for assistance. (Merriam-Webster)
2. The profound emotional and physical exhaustion that helping professionals and caregivers can develop over the course of their careers 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 our compassion – not only for others but also for ourselves... It is the cost of caring for others in emotional pain. (Francoise Mathieu "Compassion Fatigue Workbook")

COMPASSION SATISFACTION

Coined by Chris Figley in the 1980's, compassion satisfaction is the pleasure you derive from being able to do your work well.

GLOSSARY

CRITICAL INCIDENT (ADVERSE EVENT)

An event out of the range of normal experience – one which is sudden and unexpected, involves the perception of a threat to life and can include elements of physical and emotional loss. Often such events are sufficiently disturbing to overwhelm, or threaten to overwhelm, a person's coping capacity. (WHO)

CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

A facilitator-led group process conducted soon after a traumatic event with individuals considered to be under stress from trauma exposure. Seven step structure: Introduction; Fact Phase; Thought Phase; Reaction Phase; Symptom Phase; Teaching Phase; and Re-entry Phase. (OSHA, US Department of Labor)

DEPERSONALIZATION

Characterized by impaired and distorted perception of oneself, of others and one's environment and it manifests itself as an affective-symptomatic lack of empathy. (Maslach Burnout Inventory)

EMERGENCE

In philosophy of mind, the notion that conscious experience is the result of, but cannot be reduced to, brain processes. (APA Dictionary of Psychology)

EMOTIONAL EXHAUSTION

Feelings of being emotionally overextended and exhausted by one's work. (MBI)

EMPATHY

1. The concept was first described by the aestheticians in mid-19th century, used to describe the emotional "knowing" of a work of art from within, by feeling an emotional resonance with the work of art. Later, the psychologist Theodore Lipps expanded this concept to mean "feeling one's way into the experience of another." (Frankel, PMID: 28725865)
2. The action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner. (Merriam – Webster Dictionary)

HARASSMENT

A form of employment discrimination that violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, (ADEA), and the Americans with Disabilities Act of 1990, (ADA).

It is unwelcome conduct based on race, color, religion, sex (including sexual orientation, gender identity, or pregnancy), national origin, older age (beginning at age 40), disability, or genetic information (including family medical history). Harassment becomes unlawful where 1) enduring the offensive conduct becomes a condition of continued employment, or 2) the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive. (U.S. Equal Employment Opportunity Commission)

IKIGAI [ee-kee-gahy]

First recorded around 1970-75. It is a Japanese concept of one's reason for being, which in principle is the convergence of one's personal passions, beliefs, values, and vocation. (Dictionary.com)

GLOSSARY

MALPRACTICE STRESS SYNDROME (MMSS) (Litigation Stress Syndrome)

First described in the 1970's by Sarah Charles, a psychiatrist involved in a lawsuit. It is a recognized disorder characterized by symptoms of anxiety, depression and feelings of worthlessness and may be associated with physical illness as well as psychological dysfunction and is common among those facing malpractice litigation. MMSS shares many features of Post-Traumatic Stress Disorder (PTSD).

MASLACH BURNOUT INVENTORY (MBI)

Developed and published by Christina Maslach in 1981, it is the first scientifically developed measure of burnout, now widely used around the world. It is considered the gold standard for measurement of burnout, consisting of 22 items across three domains: emotional exhaustion, depersonalization, and personal accomplishment. (Mindgarden.com)

MICROAGGRESSIONS

A term first used around 1970 by Chester Pierce, MD, a Harvard psychiatrist describing a subtle but offensive comment or action directed at a member of a marginalized group, especially a racial minority, that is often unintentionally offensive or unconsciously reinforces a stereotype. (Dictionary.com)

MORAL INJURY

The distressing psychological, behavioral, social, and sometimes spiritual aftermath of exposure to such events. A moral injury can occur in response to acting or witnessing behaviors that go against an individual's values and moral beliefs. (National Center for PTSD)

PEER SUPPORT

Occurs when people provide knowledge, experience, emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters and can take a number of forms such as peer mentoring, reflective listening, or counseling. It also refers to initiatives where colleagues, members of self-help organizations and others meet, in person or online, as equals to give each other connection and support on a reciprocal basis.

Peer support is distinct from other forms of social support in that the source of support is a peer, a person who is similar in fundamental ways to the recipient of the support; their relationship is one of equality. A peer is in a position to offer support by virtue of relevant experience. (Wikipedia. Yes, Wikipedia had such a great definition that we kept it!)

PHYSICIAN IMPAIRMENT

Exists when a physician becomes unable to practice medicine with reasonable skill and safety because of personal health problems or other stressors. In most physicians, impairment is a self-limited state that is amenable to intervention, assistance, recovery, and/or resolution. (ACEP 2020)

POST-TRAUMATIC STRESS DISORDER (PTSD)

1. A prolonged, sometimes permanent, disordered emotional reaction to a critical incident, also referred to as an adverse event. PTSD is diagnosed when symptoms persist for at least one month. (DSM-5, 2013)
2. A condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world. (Oxford Dictionary)

GLOSSARY

PROFESSIONAL QUALITY OF LIFE TEST (ProQOL)

A commonly employed self-assessment test available online courtesy of researcher Beth Stamm, encompassing burnout and compassion fatigue, with assessment of “compassion satisfaction”, or the pleasure you derive from being able to do your work well. (www.ProQol.org)

RESILIENCE

An ability to recover from and adjust easily to misfortune or change. (Merriam-Webster Dictionary)

SECOND VICTIMS

Health care providers who are involved in an adverse, unanticipated patient event, a medical error, and/or patient-related injury and subsequently become victimized. (Dr. Albert Wu, 2000)

SHAME

1. A painful feeling of humiliation or distress caused by the consciousness of wrong or foolish behavior. (Oxford Dictionary)
2. An intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging. (Brene Brown)

STOICISM

A philosophy of the Greco-Roman philosophers like the Roman emperor Marcus Aurelius, the writer and statesman Seneca, and the former slave Epictetus. It is a way of life that centers on finding joy and strength by acting from within, accepting the transience of existence, and letting those things outside our control do what they will. It is a philosophy of life that maximizes positive emotions, reduces negative emotions, and helps individuals hone their virtues of character. Stoicism was designed to help people live their best lives. (hostee.com)

STRESS

A feeling of emotional or physical tension. It can come from any event or thought that makes you feel frustrated, angry, or nervous. Stress is your body’s reaction to a challenge or demand. (Medlineplus encyclopedia)

WELLBEING

The state of being comfortable, healthy, or happy. (Oxford Dictionary)

WELLNESS

1. The quality or state of being in good health especially as an actively sought goal. (Merriam-Webster)
2. The act of practicing healthy habits on a daily basis to attain better physical and mental health outcomes, so that instead of just surviving, you’re thriving. (Pfizer)

WORKPLACE VIOLENCE

Any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors. (US Department of labor)



City of Dreams II

Anisha Lashkari, MD

“As an emergency medicine resident, art has served as an outlet for me especially this past year. It allows me to express my vulnerability, my emotions through pieces of writing, photographs, and poems. It allows us - as people - to have a collective conversation of what brings us together in these volatile times.”