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Wellness Book for Emergency Physicians

Editors

S. Shay Bintliff, MD, FACEP
Julius A. “Jay” Kaplan, MD, FACEP
J. Mark Meredith III, MD, FACEP

American College of Emergency Physicians®

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Foreword

The first foray into the subject of wellness for emergency medicine physicians was published in 1995. Emergency medicine was just beginning to experience the pain of adolescence. In response to a burgeoning need, ACEPs Personal and Professional Well-Being Task Force and Committee had the foresight to write the first edition of *Wellness for Emergency Physicians*. Described as "a labor of love," *Wellness for Emergency Physicians*, was written to serve as a resource for emergency physicians of all ages, in all stages of their career. We know many members have used the book as they met the challenge of balancing both personal and professional well being.

The Wellness Section is deeply committed to providing emergency physicians with the information and resources necessary to keep their personal and professional lives balanced and on target. In keeping with this mission we have taken a look at the original wellness book and revised it. We have looked at the changing demands of our specialty and have listened to the needs of the men and women on the front lines. New information is provided and the old has been updated.

Many predicted that the specialty of emergency medicine would never survive. Not only has it survived, it has thrived. We continue to grow and mature. The key to our success has been finding effective strategies to manage our unique personal and professional stressors. *Wellness for Emergency Physicians, 2nd Edition* is an excellent resource for all emergency medicine physicians. It is our sincere wish that you use it in good health.

Best wishes,

S. Shay Bintliff, MD, FACEP
Julius A. "Jay" Kaplan, MD FACEP
J. Mark Meredith, MD, FACEP

Introduction

Some years ago, when the American College of Emergency Physicians (ACEP) looked at what the practice of emergency medicine was doing to emergency physicians, it developed a Personal and Professional Well-Being Task Force and followed with a Committee. Under the leadership of Louise B. Andrew, MD, JD, FACEP, and others, ACEP published a booklet "Wellness for Emergency Physicians" in 1995. This wellness booklet explored the stressors in emergency medicine and provided guidance for coping mechanisms and wellness planning. The editors intended that we keep this reference readily available when issues come up in our lives, as they knew "almost certainly will."

Now the Wellness Section, thanks to S. Shay Bintliff, MD, FACEP and J. Mark Meredith III, MD, FACEP, and their dedicated subcommittee members, has revised the book. The issues are no less compelling now as when emergency medicine was young. They are important to each of us in all stages of our careers, whether we realize it or not.

Julius A. "Jay" Kaplan, MD, FACEP
Charles "Chuck" Henrichs, MD, FACEP
Co-chairs, Wellness Section

Career Planning and Longevity

Julius A. "Jay" Kaplan, MD, FACEP

To discuss career planning and longevity in emergency medicine, we should first start out by defining some key words:

- Career: a field for or pursuit of consecutive progressive achievement especially in public, professional, or business life; a profession for which one trains and which is undertaken as a permanent calling.
- Planning: the act or process of making or carrying out plans, specifically the establishment of goals, policies, and procedures for a social or economic unit. (Plan: a method for achieving an end, an often-detailed formulation of a program of action.)
- Longevity: a long duration of individual life; long continuance; durability.
  (Source: Merriam Webster's Collegiate Dictionary)

Thus, if we are looking at our desire to have a long and rewarding experience of work throughout our lives, we need to focus on specific approaches which will engender that fulfillment. In other words, we needs to plan our lives rather than just letting life happen to us.

When we began (or, if we are just starting out, begin) a career in emergency medicine we did so because we were attracted to the field for a variety of reasons: personal autonomy; the challenge of meeting and handling crises; the opportunity to establish relationships with people and influence their lives; the opportunity to make the world a better place to live in; lifestyle – the ability to create a work schedule that allows ample time for hobbies, play and leisure pursuits; finances – ability to make a reasonable income; security – as a physician our services would always be needed. You have your own reasons – take a moment and write down what you think were your reasons. As we all know, emergency medicine is fundamentally different from other medical specialties:

- People do not come to us for their regular check-ups nor are their appointments scheduled.
- There is not an established relationship between patient and physician and so that bond must be created instantaneously in an often difficult, impersonal environment.
- When people come to us they are commonly in crisis, whether that is physical or emotional in nature.
- Their expectations and needs vary tremendously and so we must constantly change the way we approach them, ie, "no one size fits all," and that adds challenge to our task.
- Our workday is also not "scheduled" in terms of the workload, which is never predictable and can change in a moment. We can go from caring for patients at a comfortable pace to crisis and chaos in a flash.
- Generally speaking we have no control over the day and many variables which affect us and our patients also over which we have little influence.
- We must work different shifts at different times of the day and night which affects our circadian rhythms and our ability to cope with the usual demands of daily living including our personal and family needs.

Now, add to those inherent stresses, the following which have also become part of our daily lives:

- Constant pressure for perfection
  - Re: the patient's diagnosis – the threat of malpractice litigation
  - Re: the patient's satisfaction – the threat of a patient complaint

- Loss of any assurance of professional security – there is no such thing as "security" as physician contracts may be lost with little warning and one bad outcome whether quality or service related may cost a physician his/her job.
- Risk of violence and/or infectious disease exposure
- Declining compensation as managed care ratchets down physician reimbursement.

Given these facts, it is clear that we cannot be passive with regard to our practice of emergency medicine and any hope for career satisfaction and longevity. We must take this on, just as we would accept the challenge of treating a patient who presents to us in pulmonary edema and needs our organized approach to doing the right things at the right time to help our patient return to health and live a long life.

The first step in our career planning should be to try to start in the right place. The poet William Blake wrote, "Follow your bliss," and the author Joseph Campbell in a similar way stated, "Follow your excitement." It is important to connect to what turns us on even amidst the necessities of fulfilling previous commitments with regard to home mortgages, school payments, car leases, etc. If just starting out, there are a number of key questions which you should answer for yourself as you choose where and how you want to work. These include the area of the country in which you want to live, the practice location (emergency department or urgent care or other, the patient mix in terms of acuity and/or illness, urban/suburban/rural), the kind of group which you join (democratic group, single hospital or multi-hospital, local/regional/national, employee or independent contractor, opportunity for ownership or not), and whether there are opportunities for you to develop special interests (administrative responsibilities, subspecialty expertise such as pediatric emergency medicine, toxicology, occupational health, etc). Even if you have been in practice for a while, doing a periodic re-assessment with regard to these issues is very worthwhile. In the same way that we think of having a yearly or regular physical check-up with our personal physician, we perhaps should adopt the concept of a yearly metaphysical examination where we take time to review where we are in our lives and where we wish to go from here (Silverman J. On the Meta-Physical Aspect of Health Care: Attitudes, Values and Other Thoughts We Use to Think. *Family and Community Health.* 1980;3(2):93-103). Such a periodic self-examination can often help re-direct course and focus on what fulfills us before "burnout" happens.

An important initial step in career planning at any stage of a career is to ask yourself what is important to you (your values) and how you want to operationalize those values in your life (your goals). Setting goals is vital to any career planning process and writing down your goals is essential. One exercise is to set aside one hour (at least) and sit down in a quiet place and write down everything that you want in your life:

- what you want to accomplish
- what you want to do
- what you want in terms of relationships
- what you want to have
- how much money do you want to make
- where you want to go
- what you want to give
- what you want to learn
- what are your dreams

You should write down at least 50 entries. Once you have completed that, the next step is to write down next to each goal your target date for accomplishing that goal, whether that is 1 year, 3 years, 5 years or 10 years. Thereafter, prioritize the goals within each category and create separate pages for each time period. You will want to keep these lists visible and available to you rather than just filing them away in a drawer where they will most certainly do you no good.

You may also separate your goals out in terms of professional and personal goals. Balancing your personal and professional life is crucial to being happy and fulfilled and to longevity in a career in emergency medicine. You simultaneously fill many roles in your life. In your work you are commonly physician, psychologist, colleague, manager, teacher, businessperson, and/or leader,

all at the same time. In your personal life you are an individual woman or man, partner – wife/husband/significant other, mother/father, daughter/son, and/or friend. You are not your job and emergency physicians sometimes must take special effort to avoid taking too narrow a view of their careers and overly identifying with their profession. When that occurs, a medical malpractice summons or poor patient outcome can be devastating.

It is important to remember that no one achieves success alone. Once you have begun planning your career, whether you are at the beginning or in the middle of it, it is important to share it with those closest to you. It may also be worthwhile to sit down with your professional colleagues and have a group discussion of individual and group goals. You may find that your aspirations are very consistent with those with whom you work. But you may also find that there are major differences, and if so, these will need to be addressed or will cause conflict in the future. Some physicians groups, on the basis of these discussions, have altered shift length and schedule, hired additional physicians to allow for more vacation time, decreased hours, provided for periodic sabbaticals, and encouraged and supported physicians to become entrepreneurs in related fields. Sharing of goals and hopes and dreams is crucial to the career planning process.

The concept of continuous quality improvement (CQI), or as it is now commonly referred to performance improvement (PI), may be adapted to the career planning process. It perhaps could be called continuous personal improvement (CPI). In CQI we learned that there are several phases of the change cycle – plan, develop, change, assess. Consequently, once we have set goals, we need to look at specific methods of implementing change so that we can attain our objectives. Then we need to periodically assess how we are doing to see if we need to alter our course or the path we are walking upon. This further builds upon the notion of the yearly "metaphysical examination" mentioned previously. One method of doing that is to take your own "Adult Apgar score." **(Please see *The Adult Apgar: an Instrument to Monitor Wellness*, last chapter of this book.)** Rather than allowing the state of "burnout" to "happen to you," monitoring your own personal and professional satisfaction and work life can proactively prevent that condition from developing. Jim Rohn, the noted author and business philosopher, has written, "You cannot change your destination overnight, but you can change your direction overnight." (Jim Rohn. The Treasury of Quotes. Jim Rohn International, Southlake, TX, 2001)

Emergency medicine as a profession is not easy. People do not come to us when they are happy, as when they have a wanted pregnancy come to fruition with the birth of a healthy child. They present to us with their pain, anxiety and/or grief. In the emergency department, we have a choice – we can ourselves keep them at an emotional distance in which case we will not be affected by their "negative" or "difficult" energy; the other option, which I suspect is the one most chosen, is to empathize and "connect" to the human being sitting or lying across from us. When we do that, invariably we will be affected by their stress and "pick up" or "take in" some of their pain or anxiety. Unless we develop methods to channel that stress and deal with it constructively, we may keep it in our bodies and become ill or anxious or depressed. As many of you are aware, the rate of substance abuse, suicide and divorce in physicians is 3 times that of the general population, and some say it is even higher in our specialty.

R.I.P. is thought to stand for "Rest in Peace." While at times we use that phrase prefaced by "May he . . ." or "May she . . ." referring to those who have passed on, Tom Peters, the gifted management consultant and inspiring speaker, suggests the abbreviation be used to represent "Renewal Investment Plan." (Tom Peters. Reinventing Work: The Brand You 50. Alfred A. Knopf, New York, 1999). To be active with regard to our health and wellness is fundamental to career longevity in emergency medicine. So what can we do? Create a formalized "renewal investment plan" for ourselves, to help us remain healthy and enhance our well-being. We may choose to keep it

private or share it with our significant others in order to obtain their support. Some areas to include in your RIP are the following:

1. Rest – how much sleep do you need on a nightly basis? Plan to get it – even if that means setting an alarm clock or watch to tell you not when it is time to wake up but rather when it is time to go to sleep. Make certain that when you are working other than day shifts you get enough rest and have the support of your family and environment to support your sleep time.
2. Exercise – what and how often – you should put this into your calendar. Most studies suggest that people who exercise early in the morning are more successful in maintaining an ongoing and regular exercise program. Give yourself enough time to warm up, cool down and stretch in general in order to remain flexible in both mind and body.
3. Family/Significant Other time – amidst our harrowing and busy work lives we must ensure that we take the time to connect with those we love and who love us. As Gandhi once said, "There is more to life than merely increasing its speed" (and he said that more than 50 years ago).
4. Build down-time into your schedule – time to "just be" rather than "do." I am not an expert in this field. I was recently at a poetry workshop and we were given the exercise to write the first line of a poem that we wouldn't have the courage to finish. I wrote: "pure terror at the mere thought of nothing to do and nowhere to go."
5. Spirit – time and energy to relate to our humanity and to a power greater than ourselves. How do you connect to spirit and from what do you derive your sense of meaning in your life? Write out a mission statement for yourself, in a similar manner to the way that the organizations for which we work do.
6. Nutrition – how do you physically nourish your body? What kind of diet makes you feel great? As a friend of mine once said, "My body is my temple, not just a vehicle to carry me from place to place."
7. Joy – how do you emotionally nourish yourself? Create a joy list – a list of things which you can do or how you can be that really brings you happiness and joyfulness. After you create the list, write down next to each entry the last time you did or experienced that particular event. It can be sobering to realize that it has been a very long time since you gave yourself a particular experience of joy or pleasure.

Finally, it may be helpful to start each day with the following exercise. Ask yourself to answer the following questions:

- What am I most grateful for in my life?
- What am I happiest about in my life?
- Who/what am I proudest of in my life?
- What am I most enthusiastic about in my life?
- Who/what am I most committed to in my life?
- Who do I love? Who loves me?

By asking yourself these questions when you first get up in the morning, in the shower or on the way to work, your whole day (and life) gets put into proper perspective.

To summarize, consideration of sustaining a long and successful career in emergency medicine begins with planning. Taking time to consider what is important to you and stetting goals to help you live your values are initial steps. Writing down those goals and prioritizing them are next, and then developing specific plans (objectives, guideposts along the way, implementation strategies). Periodic re-assessment is critical as is occasional re-direction based on changes which will invariably occur in our age, health and desires. Ferdinand Foche, the French Allied Supreme Commander who led the French in World War I wrote that "The greatest force on earth is the human soul on fire." If we can stay connected to that creative fire within us and keep it burning brightly, longevity in whatever we choose to do will be a natural outcome.

Resources

Albom M. *Tuesdays with Morrie*. New York, NY: Doubleday; 1997.

Bach R. *Illusions: Adventures of a reluctant messiah.* New York, NY: Delacorte; 1977.

Bintliff S. The adult APGAR: An instrument to monitor wellness. *Emerg Med News.* 1998:42-43.

Carius M. Avoiding 'training toxicity' – staying human during residency. *Ann Emerg Med.* 2001;38(5):596-597.

Chipman C. If the walls could speak. *Ann Emerg Med.* 2002;40(1):120-121.

Covey S. *The seven habits of highly effective people*. New York, NY: Simon & Schuster; 1989.

Goldberg R, Boss RW, Chan L, et al. Burnout and its correlates in emergency physicians: four years experience with a wellness booth. *Acad Emerg Med.* 1996;3:1156-1164.

Goldberg R, Kuhn G, Andrew L, et al. Coping with medical mistakes and errors in judgment. *Ann Emerg Med.* 2002; 39(3):287-292.

Heider J. *The tao of leadership: Leadership strategies for a new age*. New York, NY: Bantam Books; 1985.

Houry D, Shockley LW, Marcovchick V. Wellness issues and the emergency medicine resident. *Ann Emerg Med.* 2000;35:394-397.

Hunter ML. The five stages of dying in a malpractice suit. *Tex Med.* 1990;86:50-53.

Johnson S. *Who moved my cheese?* New York, NY: Putnam Publishing Group; 1998.

Klein A. *The courage to laugh: Humor, hope and healing in the face of death and dying*. New York, NY. Jeremy P. Tarcher, Putnam; 1998.

Kuhn G. Circadian rhythm, shift work, and emergency medicine. *Ann Emerg Med.* 2001;37(1):88-98.

Lum G, Goldberg RM, Mallon WK, et al. A survey of wellness issues in emergency medicine (part 1). *Ann Emerg Med.* 1995;25:81-85.

Lum G, Goldberg RM, Mallon WK, et al. A survey of wellness issues in emergency medicine (part 2). *Ann Emerg Med.*1995;25:242-248.

Lum G, Goldberg RM, Mallon WK,et al. A survey of wellness issues in emergency medicine (part 3). *Ann Emerg Med.* 1995;25:407-411.

Muller W. *Sabbath: Restoring the sacred rhythm of rest*. New York, NY: Bantam Books; 1999.

Needleman J. *Money and the meaning of life*. New York, NY: Doubleday and Company, Inc.; 1994.

O'Donohue J. *Eternal echoes: Exploring our hunger to belong*. London: Barton Press; 1998.

Oliver M. *New and selected poems*. Boston, MA: Beacon Press; 1992.

Peters T. *The circle of innovation.* New York, NY: Knopf; 1997.

Peters T. *The brand you 50: Reinventing work.* New York, NY: Knopf; 1999.

Pirsig RM. *Zen and the art of motorcycle maintenance*. Toronto, Canada: Bantam Books; 1974.

Reinhardt MA, Munger BS, Rund DA. American Board of Emergency Medicine longitudinal study of emergency physicians. *Ann Emerg Med.* 1999;33:22-32.

Rohn J. *Leading an inspired life*. Niles, Ill: Nightingale Conant; 1997.

Seligman M. *Learned optimism: How to change your mind and your life.* New York, NY: Pocket Books; 1990.

Smith-Coggins R, Rosekind M, Hurd S, et al. Relationship of day versus night sleep to

physician performance and mood. *Ann Emerg Med*. 2001;24(5):928-934

The Arbinger Institute. *Leadership and self-deception.* San Francisco, CA: Berrett-Koehler Publishers, Inc; 2000.

Wenokur B, Campbell L. Malpractice suit emotional trauma. *JAMA.* 1991;266:2834

Whyte D. *Crossing the unknown sea: Work as a pilgrimage of identity*. New York, NY: Riverhead Books; 2001.

Whyte D. *The heart aroused: Poetry and preservation of the soul in corporate America*. New York, NY: Currency Doubleday; 1994.

Whyte D. *The house of belonging/Songs for coming home/Fire in the earth/Where many rivers meet (books of poetry).* Langley, WA: Many Rivers Press; various years.

Wilbert JR, Charles SC, Warnecke RB, et al. Coping with the stress of malpractice litigation. *Ill Med J.* 1987;171:23-26.

Zun L, Kobernick M, Howes D. Emergency physician stress and morbidity. *Amer J Emerg Med.* 1988;6:370-374.

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Financial Planning

Jack Healy

Introduction

Ideally, physicians entered the field of emergency medicine with the intention of helping those who have been physically, or perhaps emotionally, traumatized. Patients who present to the ED bring not only their physical ills but also the difficulties of their social situations with them. The same is true for the emergency physicians who care for them. Emergency physicians are faced with the same social issues as the rest of the population, including the issue of financial security. In fact, it is in the best interests of both the emergency physician and his/her patients that financial affairs be as sound as possible so that the emergency physician can be mentally and emotionally focused on the emergent patient care issues and challenges that are faced on a daily basis.

The Issue

Just as the issues in medicine are complex and require constant study to maintain competency, so are the issues related to maintaining a sound financial position. Although incomes will vary for emergency physicians depending upon several factors such as location and population, there is no doubt that the monetary rewards of the profession are adequate to support a comfortable lifestyle. A physician can start a career as a board certified emergency physician in his late twenties and can command a starting salary between $125,000 and $175,000. If we assume that a physician begins his career at age 30 starting at $150,000 and works to the axiomatic age 65, or 35 years, he will have been compensated over $5,000,000 in his working career. This, of course, does not include any increases in salary or stipends to which the physician may be entitled.

Since there are no courses offered in medical school to provide the physician with in depth knowledge as to how to handle finances, it is not surprising that the physician generally does not have the financial savvy necessary to adequately manage this revenue stream and achieve the maximum benefit from it.

The Art & The Science

Building personal wealth and creating financial independence is both an art and a science. To be financially successful, one must use a variety of skills in planning the outcome, implementing the plan and, as in any scientific procedure, controlling the desired results. It is the coordination of these three steps that provides the art in an ongoing and ever-changing process. These changes are due to variations in the economic circumstances surrounding the physician's life, both personal and professional, as well as changes in tax law and other investment considerations (ie, fluctuating market rates, changing inflation rates etc.)

There are also daily decisions that are made which affect the physician's financial foundation. How much should I spend on a house? How large of a down payment should I put down? Should I send my children to private or public school? Should I buy a luxury automobile or a basic transport? The answers to these types of questions are not simple and will vary depending upon one's age and circumstances. For example, a physician earning $225,000 who is already a homeowner and has been successfully funding his basic financial plan for several years will look at the purchase of an automobile very differently than the young

physician just starting out with $150,000 of school loan debt.
It is this homogenization of art and science that makes it is very possible for a physician to engineer his finances in such a way as to enjoy the same, or higher, level of spendable income in his retirement years as in his peak earning years.

The Phases

There are basically three distinct phases to the physician's financial life: *Wealth Creation, Wealth Distribution* and *Wealth Conservation.*

The *Wealth Creation* phase focuses on saving and investing money for both current and future needs, wants and desires such as cars, homes, appliances, children's education or for the physician's own retirement. Most physicians will save and invest in the traditional ways, that is, compounding interest, dollar cost averaging into investments, reinvesting dividends and capital gains and using tax deferred retirement plans such as IRAs, and 401(k) plans. In this phase, the prudent physician will also sequester away funds for use in the event of unforeseen emergencies such as temporary loss of employment and other such emergencies. Traditional financial planning does not fully disclose the effects of these various investment tools and it is probable that no exit strategies have been discussed for these traditional tools. Such exit strategies could potentially save the physician and his family millions of dollars in unnecessary costs over his lifetime.

The *Wealth Distribution* process is the phase when people need or want their funds. This phase, if not properly strategized, can be very costly. Excessive or unnecessary income taxes, early withdrawal penalties (both governmental and institutional), sales charges, distribution restrictions (timing issues) and inflationary pressures can substantially reduce the spendable income one had planned to have in this phase.

The last phase of a financial life is called *Wealth Conservation*. Leaving wealth to family or to others of our choosing without considerable wealth erosion is no mean feat. It is possible for portions of an estate to lose up to 80% of their value because of the lack of wealth conservation planning. The estate laws are not friendly when the wealthy physician dies without planning. Estate taxes, income taxes, attorney fees, accounting fees, appraisals, penalties, sales charges and liquidation sales of assets can be confiscatory to your wealth and provide frustration and distress to your heirs.

The Macroeconomic Approach

During all three of these phases, one must be constantly aware of the total, or macroeconomic, picture surrounding one's investments. As in any business venture, the physician must pay attention to all of the obvious, as well as the subtle, costs associated with financial decisions. One example of the obvious costs in a plan is the annual taxes paid on interest, dividends and capital gains. The subtle costs would be the lost opportunity costs (LOCs) associated with these same taxes. To understand LOCs, simply think of what happens if you lose a dollar: not only do you lose the dollar, but you also lose the value to which the dollar may have grown at some interest rate. Even though LOCs are taught in Economics 101, most traditional planners rarely discuss them. A classic example of the impact of LOCs can easily be demonstrated using a common investment vehicle like a Certificate of Deposit (CD). If we project a 6% interest rate for 30 years on a $50,000 CD, the physician would have an account value of $287,175. Conventional planners would then subtract the original $50,000 and report a profit of $237,175. While this analysis is simple, it is not at all representative of what is going on macroeconomically. By contrast, a cost accountant would look a little deeper. If we assume a 36% Federal Income Tax bracket for this physician, there would have been a total of $85,383 of taxes paid over the 30-year period. If we then assign a highest and best use of money, or LOC, of 9% to these taxes paid each year, the LOC on the taxes totals $209,866. This brings the true cost of the taxes plus LOC to $295,249. Adding in the original $50,000 reveals a true cost of a staggering $345,249to acquire

$287,175! Simply put, if you were running a widget company and you sold the widgets for $1, but they cost you $1.25 to manufacture, you would not remain in business for very long.

It would take an extraordinary amount of time and effort for the physician to remain current with the issues at hand. Most physicians spend large amounts of time keeping current in their own specialty and just do not have the time to devote to financial analysis.

Traditional planners will discuss different types (risk level) of investing to do at different ages. Generally speaking, this is because most planners, as well as investors, are accustomed to the risk-reward premise of stock market investing. Simply put, the higher the risk, the greater the reward. Often times, the rate of return must be "chased" to make up for the inefficiencies introduced by market risk itself, taxes and their associated LOCs, inflation and built in obsolescence etc. In addition, most physicians will look at spending only the growth or interest in their investments so as to protect their assets from being depleted at retirement time. This is done in contrast to a paydown mentality that will allow more spending by the physician as well as having positive tax consequences. By using a paydown methodology, the physician does not have to worry about the rate of return, and its associated risk, being so high and can achieve the same, or perhaps a higher, standard of living throughout retirement while greatly reducing his concerns and anxiety levels concerning volatility in the market.

Since most physicians will enjoy a higher income level than the general populace, traditional investing needs to be analyzed before any money is put away and a cost/benefit analysis performed at the same time. For example, most traditional mutual fund and stock market investing will produce annual dividends and short-term capital gains that will then generate current income and capital gain taxes. If current income were not necessary from the portfolio, most physicians would be better served by being invested in funds or stocks which will show only capital appreciation and therefore no current taxes to affect the efficiency of the plan.

Asset Protection

It is important to keep in mind that once an accident or lawsuit liability claim is in excess of the physician's policy limits, personal assets are attacked. Very seldom will the physician's financial advisor discuss ways to protect assets once they are accumulated. One area that does not receive adequate discussion with most physicians is in this area of asset protection, otherwise called liability protection. Most physicians are familiar with medical professional liability or malpractice insurance. This product is extremely important in today's litigious society. Many times whether or not the physician is at fault is irrelevant to the settlement of a claim. For example, many insurance companies will evaluate a claim, determine what the cost is to defend the claim and based upon that determination, settle the claim with no regard for how the physician would like to proceed. Also, many companies will allow the physician to choose the legal representation that he would like to use and many will not. For many physicians, this choice of legal representation is as personal as a patient having the opportunity to choose their own medical practitioner. The physician should investigate the types of policies and options being offered by various companies with an insurance advisor in whom he has confidence.

Another aspect of liability protection has to do with the physician's automobile and homeowner's liability insurance. Since each state has its own regulations regarding these types of policies, an in depth dissertation cannot be given here. However, there are some generalities that can be made. As far as automobile and homeowner's liability coverage is concerned, liability coverage through the auto or homeowner's policy is generally more expensive than if the physician purchased a separate excess, or umbrella, liability policy. This umbrella policy would be used if the liability of the physician were deemed to exceed the limits provided by the auto or homeowner's

policy. If the physician has to make choices between low deductibles on his collision coverage or funding an umbrella liability policy, most often the better choice is to fund the umbrella policy. This analysis is really quite simple. In the event of a collision, could the physician better afford to pay a high deductible to fix his auto or to pay a liability claim in excess of $1,000,000? It is important to keep in mind that once an accident or lawsuit liability claim is in excess of the physician's policy limits, personal assets are attacked.

Income Replacement – Life Insurance and Disability Insurance

The topic of income replacement will take two forms: human life value replacement and disability income protection insurance. The first issue, human life value replacement, concerns the loss of income to the physician's family in the event of his death. This replacement would be provided by life insurance. By definition, life insurance is concerned with providing indemnification of the loss of values. This value may simply be defined as the capitalized monetary worth of the earning capacity of the physician in his chosen specialty. Simply stated, how much money would a family need to have in an account to generate the same level of income for the family as while the physician were still alive? In the past, well meaning advisors calculated the amount of life insurance required by subtracting the physician's current assets from the total amount of capital needed to provide the same level of income as if the physician were still alive. There are some fundamental flaws in this traditional approach. By subtracting current assets, you are severely limiting the normal capitalistic nature of the family. The ideal scenario would be to allow the family to have the same standard of living as if the physician were still alive. Ideally, the family should still be in a financial position to save and invest money at the same rate as if the physician were still alive. Ideally, you would want the family to spend money and consume assets as if the physician were still alive. Ideally, you would want the children to still have the opportunities for higher education as if the physician were still alive. By not providing the full replacement value for the physician's family, the fundamental definition of life insurance is being violated. An example of full replacement value is simple to compute. If we use a physician making $150,000 as our example and assume that the family can safely expect a 6% return on its investment, then the physician would need $2,500,000 of life insurance to fully indemnify his family against his economic loss.

With the discussion on how much insurance to provide completed, let us now discuss the two basic types of life insurance. These are term and whole life. First let's discuss term life insurance: Term insurance gives death benefit protection and no cash accumulation. Depending upon the product, premiums either increase annually or they can remain fixed for certain periods of time such as 5 years, 10 years or 20 years. Most people would say that term is the cheaper product to purchase, and if premium payments were the only consideration, this would be correct. As discussed earlier, making payments for something, such as taxes, and receiving no return, results in an LOC. The same is true of term insurance premiums. If premium payments are made and the physician does not die, not only are the premium payments lost but also the opportunity costs associated with them. Also, if the physician makes the wrong purchase regarding how long the plan will be in force and he lives past the expiration of the plan, he must now hope to still be physically insurable. Not only will he have lost the term premiums and LOCs but the death benefit will also be lost. Of course, the physician could still be alive and insurable, but now the premiums may be prohibitively expensive. If the physician had taken out the policy many years before and not purchased additional coverage through the years, he will probably be underinsured for his replacement value.

The second type of insurance, whole life insurance also comes in several forms. There is traditional whole life, variable whole life, universal life, and variable universal life. There are other forms of whole life and, as the consumer demands it, there will probably more

variations in the future. Traditional whole life is the most basic of the whole life policies and is the one we will discuss. A whole life policy has premiums that are initially higher than a like amount of term insurance. However, these premiums are guaranteed level for life. Whole life offers cash accumulation. This accumulation is on a tax-deferred basis. The cash accumulation can then be accessed tax-free. Whole life offers loan provisions at favorable rates and there is no fixed repayment period for the loans. Whole life generally pays dividends that can either be left to accumulate or taken as cash to supplement income or to reduce premium payments. The dividends are not reported to the IRS and so they generate no tax issues. Whole life has no LOCs. Whole life does not require the physician to reapply for coverage later in life so changes in health are not an issue.

The decision as to whether to purchase term or whole life should only be made after careful consideration of all the issues surrounding both products and in the context of the physician's financial situation.

The second issue mentioned above, disability income protection insurance, is invaluable protection to the physician and his family. Yet, many physicians treat this potential lifestyle saving product very lightly. Some of the reasons, while questionable, are understandable. Typically, most physicians will be approached about disability insurance while in residency. At this point in time, income is low, free time for analyzing the product is short and concentration is on the task at hand, namely, getting through residency. Also, due to the youthful age of most residents, many physicians consider themselves "invincible" and that disability happens to other people. Quite the opposite is true. Statistically, we know that between the ages of 20 and 45, the odds of either the physician or his spouse becoming disabled for more than 90 days are one out of three. Also, the average duration of a disability that lasts more than 90 days is more than two years. Lastly, it is an actuarial fact that between the ages of 20 and 65, the physician is more likely to become disabled for at least 90 days than to die.

The physician cannot count on social programs such as Social Security to meet his disability needs. First of all, the maximum benefit paid is nowhere near even the starting salary of an emergency physician. Secondly, nearly two thirds of Social Security claims are denied. Some states offer their own social program, but their income limits are also very low and generally short lived, perhaps six months of benefits are available. Many physicians will try to save their own money to provide for a disability. Let's look at this approach. If the physician were to save 5% of his income to provide for a disability fund, just 90 days of total disability could wipe out nearly 5 years of the principle saved. One year of disability could destroy over 15 years of disciplined savings. Clearly, risk shifting to the insurance company is the best option for the physician.

The products available are varied and are changing constantly. As with most purchases, this is a product with which you will get what you pay for. The product that offers the highest level of benefits and the most flexibility is individual disability insurance. A huge benefit for this product, since the physician pays the premium with after tax dollars, is that the benefit is received income tax free.

When looking at an individual policy, the physician should make sure that he is covered by an "own occupation" definition of disability. That is, if the physician becomes disabled, and cannot work in his recognized specialty, he cannot be required to go back to work in another occupation. With this provision, the physician may be at work in some other occupation, but will still be eligible to collect his disability benefit. If available, a lifetime benefit period is preferred. As a minimum, the benefit period should extend to age 65. Also important is a cost of living increase benefit that will allow a benefit being paid to increase with the Consumer Price Index rate of inflation. Another important feature is the elimination period, or the amount of time that will pass before the physician is able to start collecting a disability benefit. A reasonable amount of time for an elimination period is ninety days. With less than a 90-day elimination period, the premium increases

dramatically, more than 90-day elimination has a very small relative decrease in the premium. The physician should also look for a policy that is non-cancelable and guaranteed renewable. This will insure that the insurance company can never cancel coverage for the occupation class that the physician is in and that the premium will never increase. Individual disability insurance is also completely transportable throughout the physician's career. Once the individual disability policy is in place, the physician can obtain group coverage, if offered by his employer, and truly maximize his disability protection.

Concerning individual disability insurance, this product should be the core of the physician's disability income protection portfolio.

The other type of disability insurance is group coverage. The best feature of this type of coverage is that it is relatively low cost. But remember, very often you get what you pay for. Most group policies will pay a benefit of up to 60% of earned income, but will generally have a cap on the benefit amount paid. A typical cap on a group plan would $5,000 per month of benefit paid. So, if the physician were earning $150,000 annually, the maximum benefit paid under the cap would be $5,000 per month or 40% of pre-disability earnings. Depending upon who pays the premium, the benefit could then be taxable. Many group policies will only cover "base salary." This could have a significant impact if the physician receives bonuses, elective deferred compensation or other forms of income not classified as "earned income." By contrast, many individual disability policies will cover these other forms of income, including pension contributions. Many physicians are also not aware that coverage provided by a group policy will offset the amount of coverage available through an individual policy. Unlike individual policies, the premiums for group can be changed at will by the insurer and the insurer can cancel coverage at any time. In most cases, group coverage is not transportable.

The ideal disability plan would be that the resident obtain the maximum individual disability coverage available and then apply for any group benefits that his employer may offer. By implementing the disability plan in this manner, it is possible for the physician to have 100% of his pre-disability earnings provided by the insurance program.

Retirement Planning

Many physicians consider retirement planning to be the use of tax-deferred vehicles to accumulate funds for later in life. The basic reason most physicians prefer tax deferral is that they assume that they will be in a lower marginal tax bracket at retirement so the tax burden will be less onerous. Also factoring into the analysis is that the taxes built into the retirement plan will make the account grow faster. While it is true that leaving the taxes in the plan will allow it to grow faster, there are other considerations to be given to conventional retirement planning. The physician must be sure to fully understand all of the implications of using tax deferral for retirement. No blanket statements can be made for all physicians as to the benefit of traditional retirement plans with perhaps one exception. That is, that retirement plans, be they 401(k), 403(b), IRA, SEP or Keogh plans are great wealth accumulation vehicles.

One issue surrounding tax deferral is that the taxpayer never knows what the tax brackets will be at retirement age. They could be higher than they are now or they could be lower. The IRS always maintains the right to change the tax laws. Let's consider the possibility of being in a lower marginal tax bracket at retirement. Assume that our new 30-year-old emergency physician is married, has children, owns a home and has a taxable income of $100,000. His current marginal tax bracket is 28%. Assume that he is able to put $10,500 per year into his retirement plan at 10% interest. By his age 65 he would have accumulated $3,130,331. If we assume that he just draws $310,000 per year at retirement, his marginal tax bracket would be 36% under current tax law. There is no doubt that the account grew faster than if the had been netted of taxes. If netted, the $10,500 would have been reduced by 28% or $2,940; leaving $7,560 to invest. This amount would have grown to $2,253,839.

Other tradeoffs are made when using tax-deferred vehicles. At retirement time, the physician would not have capital gains treatment for stock market investments in his qualified plan. Capital gains tax rates are generally more favorable than income tax rates for high net worth individuals. The physician would not be able to offset capital gains with capital losses for tax planning purposes. Access to the plan is generally limited to loans of not more than 50% of the account value up to $50,000 and must be paid back within a 5-year period. The physician is prohibited from taking distributions before age 59 ½ or he faces a 10% early withdrawal penalty in addition to paying current income taxes. On the other hand, distributions must start by age 70 ½ or he faces a severe penalty (currently 50%) on the distribution not taken.

The bottom line to retirement planning and tax deferral is that it must be done in concert with the rest of the physician's financial plan. The physician must seek the help of a competent personal financial engineer to determine a plan for retirement. Options and strategies must be available to the physician in to order to maximize the efficacy of a traditional, tax deferred retirement plan. There are exit strategies which could allow a much more favorable treatment of withdrawals from qualified plans.

Estate Planning

The topic of estate planning is very complex and should be done with an estate-planning attorney and a personal financial engineer. There are some basic steps that all physicians should take regarding estate planning regardless of the stage of their career. Writing a will is a must for all. Without a will, the state will determine who your beneficiaries are according to strict rules of intestacy. Most emergency physicians will have heard of a living will and again, all should have one. If you don't, it is your loved ones who are left the task of determining your ultimate fate at an already stressful time and your wishes may not be the same as theirs. Also in this must have category is a Durable Power of Attorney. This document will allow someone else to make decisions for you when you have become incompetent to do so for yourself. Having this document will avoid the need of a friend or relative going to court to be granted a power of attorney. Since named beneficiaries receive assets outside your will, one simple way to avoid probate costs, attorney fees and other legal issues is to have named beneficiaries for as many of your assets as you can. Simply properly arranging ownership of assets can also avoid many of the legal issues with the physician's estate.

The subject of estate taxes has come and gone 5 separate times in our history. Currently, the IRS is phasing out estate taxes over time. However, they will be completely gone for only one year and then, by law, must come back in again. Estate taxes can take 55% of the physician's estate, depending upon its value. This is in addition to any income taxes due from the estate. An example of confiscatory taxation would be our physician who died leaving $5,000,000 in his pension plan. His heirs would first have to pay 55% federal estate tax ($2,750,000) and then 36% federal income tax ($810,000) leaving $1,440,000.

Many planners will recommend the use of trusts to protect various assets. The pros and cons of these tools must be carefully evaluated before implementing them. Many of these decisions are irrevocable and will be out of the control of the physician once these decisions are made. Some of these decisions could completely "disinherit" the physician's loved ones if not carefully planned.

The Summary

Personal financial engineering is something that all physicians should make use of. Just as the prudent physician would not try to practice medicine that was current 50 years ago, so should he not try to plan his financial future based on tax laws and economic issues that are equally outdated. Also, just as the competent emergency physician refers his patients to specialists once the emergent situation is under control, he should also seek the help and

expertise of those specialized in the financial world. Just as the physician would advise his patient of any side effects of medications or therapies, be sure that your advisor gives you the same disclosure regarding taxes, LOCs and the long and short term effects of your financial plan.

Hopefully, some topics have been mentioned in this primer that will serve as a guide to a path of financial well being and prosperity for all physicians, young or old.

Health, Diet and Exercise

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

Maintenance of physical and mental health are key elements for emergency physician longevity. Health and well-being can be maintained throughout a career in emergency medicine by careful attention to signs and symptoms of fatigue, stress and "burnout." Of course, certain predictable changes will occur with aging. The decision to make certain health enhancing choices, such as to quit smoking or to start an exercise program, is the first step to enacting these life saving changes. There must then follow an emotional decision so that these changes will actually occur. Changing one's daily patterns at first seems impossible, but once success has occurred, the rewards of new good habits bring a sense of energy and physical freedom that few willingly relinquish.

You Are What You Eat

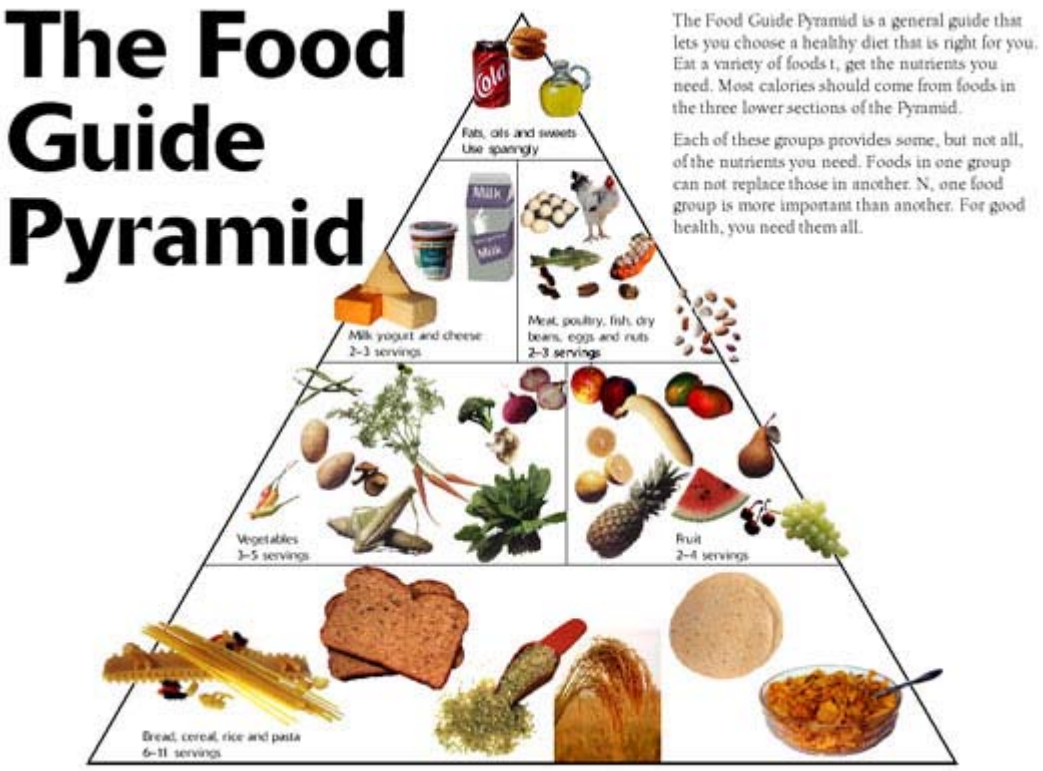
It has become clear, through laboratory and epidemiological research, that a low-fat, high-carbohydrate diet is the best way to improved health and increased longevity. Standard guidelines recommend a total fat intake of 30% or less of total calories consumed, saturated fat of less than 10% of calories, and total cholesterol less than 300mg per day. The guidelines also recommend an increased intake of complex carbohydrates, moderate protein intake, about 1 ounce of ethanol per day, less than 6 grams of salt per day, adequate calcium, magnesium and fluoride, and generally not more than the RDA of supplemental vitamins and minerals.

The four food groups we learned in school have been replaced by a classification system called the food pyramid, designed to help put these guidelines into daily food choices. The emphasis is shifted toward carbohydrates, fruits, and vegetables. For an adult, the pyramid recommends daily intake of 6-11 servings of bread, cereal, rice, pasta, or other complex carbohydrates; 3-5 servings of vegetables or beans; 2-4 servings of fruit; 2-3 dairy servings; and 2-3 servings of fish, poultry or meat. This pyramid represents a large reduction in the consumption of animal products and offers alternative protein sources. Adequate protein can be derived from non-animal sources such as beans or soy.

Other important considerations in planning a healthy diet are moderation and variety. Eating a variety of foods in each category provides a better balance of nutrients. A moderate diet provides limited salt and simple sugars without excess calories.

Despite the popularity and early success of "quick weight loss" programs, they almost never work for the long term. The vast majority of participants eventually gain the weight back. A program that works long term must include dietary changes you can live with for the rest of your life and that you actually enjoy. The high protein, low carbohydrate diet (such as the Atkins Diet) for weight loss is currently popular. The initial rapid weight loss that is observed is likely due to water loss, decreased caloric intake and possibly decreased insulin resistance. This diet is often high in cholesterol and fat and worsens the risk for progression of atherosclerosis. The long-term effect of this diet on overall health has not been established.

Over consumption of food is a major problem in Western society. Much pleasure and social activities are centered around food consumption. Many people do not recognize the sensation of satiety and therefore do not know when to stop



eating. They may have been told in childhood to "finish your plate" and never learned to recognize satiety signals. A useful method to learn to recognize satiety and to reduce over consumption is listening to your internal signals of hunger and fullness. Frequently, weight gain results from not listening to appropriate satiety signals during a meal. Rate your satiety on a scale from 1 to 5 where 1 = hungry, 2 = moderately hungry, 3 = satisfied, 4 = full, and 5 = stuffed (Figure 1). Ideally, you should only eat when you are moderately hungry to hungry, and you should always stop eating when you are satisfied to full. It takes at least 20 minutes for the body to send and have recognized its hormonal signals of satiety, so eating slowly is important so you can readily evaluate the satiety signals. Try rating your satiety on this scale and get in touch with these submerged signals.

Figure 1

Satiety Scale

1	2	3	4	5
hungry	mod hungry	satisfied	full	stuffed

For an emergency physician, work is often busy and stressful, lending itself to quick meals, fast foods and doughnuts at the nurses' station. You must learn 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, low fat, complex-carbohydrate meal before your shift. Make time for an adequate meal break during the shift. Bring in some low-fat muffins, fruit, and high-fiber snacks for the staff (Table 1). Although caffeine initially provides increased alertness and stamina, the long-term effects include fatigue and less restful sleep, especially at higher doses.

Table 1

Good ED Snacks

Grapes, cherries, fruits, dried fruit
Low-salt, whole grain pretzels
Almonds, peanuts
Non-fat popcorn

Excessive caffeine intake (>5 cups coffee/day) can produce nervousness, palpitations, and anxiety. There is a caffeine withdrawal syndrome that generally occurs 12-24 hours after cessation and is usually manifested by headache. It is best to restrict caffeine to 1-2 cups of coffee/day and use substitutes such as decaffeinated beverages.

Aerobic exercise and strength training are essential components of any weight loss and fitness program. Reduced caloric intake by itself will reduce both muscle mass and adipose tissue. The combination of caloric restriction and regular exercise of the major muscle groups will maintain muscle mass and tone and reduce adipose tissue.

Emergency Medicine Requires Total Fitness

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

The first step is physical fitness, which usually requires planned and regular exercise. You will not only be better prepared for the busy shift, but will look and feel better and maintain appropriate weight. Regular aerobic exercise will enhance your cardiovascular and respiratory fitness. In addition, an aerobically fit EP will not suffer the physical fatigue often associated with a busy ED shift. Aerobic exercise involves the repetitive use of large muscle groups over a period of time. In general, during aerobic exercise, you want to maintain your heart rate at 60% - 85% of your age-adjusted maximum heart rate. A rough estimate of maximum heart rate is 220 minus your age. The duration of each session should be greater than 20 minutes, and ideally 45 minutes, and should occur 3-5 times per week. If you cannot exercise 30 to 45 minutes in one session, you still get the same benefit if you exercise that time broken up into two or three session in a day. Most new exercisers do too much too soon. Start slowly and gradually increase your exercise time while maintaining your target heart rate.

What is the best aerobic exercise? A program that you can stay with on a long-term basis. It is usually something you enjoy, is easily accessible and is compatible with any physical limitations. Prior to starting a regular aerobic program an evaluation for occult coronary artery disease is appropriate. Evaluate your cardiac risk factors and seek an objective medical evaluation (not a hallway conversation with your buddy). Do you want to end up as an ED patient with exercise-induced chest pain? You know where that pathway goes.

Resistance training is another aspect of a personal fitness plan. Weightlifting keeps muscle mass and tone high and has a positive effect on bone density and joint function, which is especially important for women. Increasing your muscle mass will increase your overall metabolic rate and will reduce body weight. Isotonic resistance exercise is an alternative if there are physical limitations that prevent weight training. Starting a weight lifting program should involve a fitness instructor or getting a book on weight lifting. Remember, doing too much too soon can result in injury and will result in early termination of your program.

Flexibility is the third aspect 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. No extreme painful stretching or "bouncing." An excellent book on stretching by Bob Anderson is listed at the end of this chapter.

How do you get started on a fitness program? How do you exercise regularly with rotating shifts and all the other life commitments? It is

difficult to transform a commitment to exercise and get fit from an intellectual level to reality. Getting and staying motivated is difficult, even for regular exercisers. One strategy is to insert exercise time into your schedule as a required event, like an ED shift, not an optional activity.

Make Time to Preserve the Only Body You Have

Exercise does not have to be boring, inconvenient, and time-consuming. All physical activity counts. Make a list of all physical activities you enjoy, such as walking the dog or throwing a Frisbee. Commit yourself to these enjoyable activities for at least 30 minutes per day. Take a look at your weekly schedule and block out times you plan to exercise. Exercising when you first wake up is often convenient and prevents daily events from interfering. Also, studies have shown that those who exercise at the beginning of their day exercise more consistently and more persistently than those who wait until later in their day. In addition, exercise raises body temperature, so it can help you "wake-up" and feel more alert. Be sure to warm-up properly as your muscles will have been at rest while sleeping. Do not exercise within 1-2 hours of bedtime. Aerobic exercise raises your metabolic rate for several hours after exercise. This condition can make falling asleep difficult.

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

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

Aging is Not a Disease

As EM matures into an established specialty, the range of ages of EM practitioners reaches parity with other specialties. There are many more "older" EPs in full time practice than 20 years ago. Even though we do not necessarily look forward to getting older, it is inevitable. After all, what is the alternative? You can postpone and even avoid many of the negative aspects of aging by taking care of your mind and body. The aging physician can expect alterations in vision and hearing that can affect the ability to practice medicine. Even seemingly minor abnormalities, such as the ability to ambulate, sit or stand can have a significant impact of the ability to practice emergency medicine. Cognitive changes will have a profound effect on the ability to practice medicine and are the most difficult to cope with for the practicing physician. The EP is required to suture, auscultate, reduce dislocations and perform other procedures that may become more difficult as we age. Rotating shifts become much more difficult after the age of 40 and is a leading cause of leaving EM practice for the older EP. An alteration in practice may become necessary as these changes occur. A loss of muscle mass commonly occurs with aging and is primarily due to an increasingly inactive lifestyle. An active lifestyle and regular fitness program will maintain muscle mass and tone and physical strength and avoid an increase in adipose tissue. Regular visual and audiometric screening will permit continued high-level sensory function. Physical and cognitive limitations are inevitable and planning for practice limitation and retirement are advisable.

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

Additional Reading

Anderson RA, Anderson JE. *Stretching*. Shelter Publications Inc. Bolinas, CA; 1980.

John Robbins. *Diet for a New America: How Your Choices Affect Your Health, Happiness & the Future of Life on Earth.* HJ Kramer; 1998.

Julie Waltz Kemble. *The Weight and Wellness Game*. Northwest Learning Associates Inc., Tuscon, Arizona; 1993.

Hope S. Warshaw. *Restaurant Companion: A Guide to Healthier Eating Out*. Surrey Books Incorporated, Chicago, Illinois; 1990.

Burnout

Larry Vickman, MD, MHA, FACEP

Introduction

Burnout is a risk faced by physicians as well as other professionals. Emergency physicians may be at increased risk of burnout for two groups of reasons:

- Unique characteristics of both our work and of our workplace;
- Personal characteristics that make us quite effective as physicians predispose us to burnout.

Unfortunately there is a great deal of denial among physicians. We tend to deny that we have a problem even when others can see it clearly. When faced with hard evidence or by a true friend, our denial frequently becomes even more resolute.

Definition of Burnout

There are many similar definitions of burnout, and the most useful of these is offered by Maslach & Leiter. These researchers see burnout as erosion within three critical areas:

- Erosion of engagement. The initial energy, involvement, and engagement we felt when beginning our work are replaced by exhaustion, cynicism and ineffectiveness.
- Emotional erosion. The initial enthusiasm, patience, and compassion we had at the outset lead to anger, cynicism, bitterness and frustration.
- Erosion of fit. The initial feeling of fit, the excitement in being a part of a greater group, and engagement in our work fall to lack of fit, discomfort, a lack of belonging, and isolation.

The term erosion implies that burnout is a gradual process. It does not happen overnight, but occurs with repeated insults to our personal being as a result of difficulties in the interface of our personal selves with our work world. It is an ongoing and evolving process. Burnout can be avoided completely if each of us understands the forces that tend to create it and learns to take action in terms of life behaviors that create proper balance.

Burnout can vary in severity – it can be experienced at a low level and can be fully healed with proper treatment, or it can be full-blown and irreversible. At this more serious level, significant changes are needed in the work setting and perhaps the work itself combined with professional assistance to both assess and treat the manifestations.

Signs & Symptoms

Burnout is a syndrome that can arise in any of us. Although the way it manifests can vary, there are some commonalties.

We experience a loss of interest in our work. The attraction we once felt for our work is replaced by fear, avoidance, isolation, and ultimately loathing. We may find ourselves angry much of the time, and triggers that might ordinarily be deflected by properly functioning internal psychological mechanisms are put awry. We may find that we are less able or unable to find joy in life; activities that once were fun are no longer enjoyable and do not provide us refreshment. Vacations become a chore and we return from them no more refreshed than when we left. The financial abilities of many physicians allow them to indulge in more “toys” and many who “spend to find peace” only find that they do not enjoy what they have purchased

and are now in a hopeless spiral of debt, only adding to the problem at hand.
We may develop any number of physical or emotional symptoms when we think of going to work. These include anxiety, fear, or anger and loathing about having to attend the workplace. We may develop headache, back or neck pain, abdominal distress, nausea, or a general sense of malaise. Our appetite may suffer. Sexual interest may wane.

We may become isolated. Our interactions with peers, patients, and the most beloved of our families then invariably suffer. Most seriously, we can become depressed or dependent upon a number of substances to help us get through the days. Abuse of alcohol by itself or in conjunction with any of a large number of prescription drugs is common.

Since having a good relationship with the patient is vital to making the correct diagnosis, deciding upon correct treatment, patient compliance, and perhaps malpractice risk reduction, burnout that is manifest by poorer physician-patient communication poses a great risk to the physician's practice activities as well.

It is important to remember that often others can see the effects of burnout in us even when we are blind to them. We cannot usually hide it even though many of us develop elaborate mechanisms to conceal our pain. Additionally we are so good at denial that even when signs and symptoms are florid, we tend to hide behind the myth that we are still okay. This is the greatest tragedy and is no different from the denial we observe in a patient who is having chest pain and rejects the possibility that it is his heart, only to delay the benefits of early treatment and then to suffer untoward consequences. The metaphor is clear: we deny, we delay, and we suffer the consequences. The same is true when we see symptoms in our colleagues. We tend to think that "He/she will be okay and will be able to take care of him/herself." So we keep our mouths shut as our associates slip into the mire of worsening depression or substance abuse. Part of the reason for this is that in recognizing the symptoms in another, it puts us more in touch with our own state of being. So it is our own denial mechanism that comes into play as we begin to defend our partners who also seem stricken.

Why are we at risk?

Physicians undergo serious socialization in their private lives and most importantly in their training. We are taught to think in certain ways that may interfere with the establishment and maintenance of balance in our lives and this puts us at risk for burnout. These thought processes are exemplified by the following:

- Medicine monopolizes my being (enantiadromia) and leads to a lack of balance.
- My success as a physician counts as my personal success and I do not have to do anything else in my life to be successful.
- The final responsibility for patient care is mine and I will be held to task (leading to an over-developed sense of responsibility).
- Can I really trust anyone else to do it right? (I am irreplaceable, so I cannot leave work.)
- I delayed my gratification through years of training, so now what am I entitled to? (Do I deserve to have the time to let down and relax?)
- I deserve respect for my role and I do not have to earn it.
- Patients always expect me to know the answers and to do the correct thing . . . always (I have to know it all, and I must be perfect.)
- The system needs to revolve around my decision-making. The world of work pivots around me. (I am the quarterback of the team and hence the most important player on the team.)
- I am expected not to display vulnerability or emotions, especially sadness with death. (I have to keep it all together all the time.)

This latter feeling is one of the most tragic things many of us learn. Unexpressed grief is a huge contributor to burnout.

There are many more thoughts that we have learned which put us at risk, but I think you get the point. We are taught to think in ways that

lead us to a state of being emotionally and psychologically at risk for the erosions noted above.

What is it about emergency medicine that might add even more to our risk?

We exist in a fishbowl type of practice that is unlike that of any other practitioner in the community. Most of our work is eventually examined by another physician - either one of our colleagues or another practitioner in the community - and the judgment exacted upon us, especially by those who do not set foot in our busy departments, can be brutal.

We practice to a greater or lesser degree in isolation - physically within our departments and often professionally within the often-narrow scope of our involvement within the larger social and political framework of the hospital. The outcome of this is that we may experience a poor sense of community, and the support we all need to flourish is sadly lacking. Furthermore, some residency programs in EM teach that only the physician who has completed a residency in EM is qualified to treat patients in the emergency department (ED). This sets up non-EM-trained physicians for additional isolation in our profession.

Emergency physicians differ from many other members of the medical staff in that we are hospital-based physicians and depend upon a contract with the hospital in order to have a place to practice. In addition, we are not solo practitioners, but must be part of a group, whether we are employed by the hospital, part of a single hospital group, or part of a larger group staffing multiple hospitals. Our ability to control many of the aspects of our own practices is often lacking due to the contractual relationships many of us have with our hospitals or with the physician groups of which we are a part. Inequities and perceived injustices can occur in any EM practice setting, increasing our sense of lack of control. With regard to the ED environment, we often have little influence as to the quality or quantity of the support staffing we need to perform our work with excellence. Additional factors that are common in EM that predispose us to stress and burnout include (after Pfifferling):

- The intensity of the work by case types, by volume, and the unpredictability of both above factors.
- Rapid critical decision making is needed with often a paucity of data.
- Our successes in the ED may lead us into the delusion that since we can do all we do in the ED, we can have the same successes in the rest of our lives
- Shift work and circadian rhythm issues. Performance declines with night shift work and mistakes are more common then. With sleep deprivation, days to nights, and the time it takes to catch up, we may never catch up.
- There is rare appreciation shown for our work, both by patients and by our professional colleagues.
- Unrealistic expectations are set for us by others (patients, families, staff, hospital administration, regulatory agencies) or we set them unrealistically for ourselves.
- We leave little margin for ourselves personally with all we do. Any additional stress or illness or other personal unplanned event can throw us over the edge.
- Difficulty in establishing healthy boundaries. We are often asked to serve on committees or to take extra shifts. Many of us have extreme difficulty saying “no” when we need to do that. We end up spending more and more time professionally to the exclusion of supporting our personal lives.

What about the workplace itself?

Maslach & Leiter have identified six critical areas that must be examined when assessing the organizational contribution to burnout. These six areas include:

- Workload, especially in excess.
- Control, or more specifically, lack of adequate control over one’s work setting.

- Community, or more specifically, breakdown of the workplace as a supportive community.
- Reward systems, or more specifically, inappropriate reward systems.
- Fairness, or more specifically, lack of fairness in organizational decision-making. Values, or more specifically, conflicting values expressed by the workplace as compared with our own values.

Excess workload. Demanding too much of an individual in terms of workload, from the overlapping perspectives of volume, intensity, complexity, and time constraints of work. We as human beings can only do so much at once. We have the audacity to expect that we can perform large volumes of complex work for long periods of time without adequate respite. Eventually a toll is exacted on the person. The toll for us is burnout. Some of us have a bit of a cavalier attitude about what we feel we can do and this can be disastrous for us.

The perception of a lack of control. We all need a certain amount of influence over our environments. We may not be able to have much control, but we certainly must be able to have enough to create a feeling of self-protection for ourselves. Emergency medicine (EM) exists in a milieu of variable and often minimal control for the EP. The perception of inability to control or influence is the key issue. The reality of our practice is that we have minimal control or influence over ancillary staffing in our EDs, minimal control over the critical support offered by our on-call consultants, and absolutely no control over patient volumes or illness acuity. The moderate amount of control we all would like for personal comfort exists variably if not at all for us in EM.

The breakdown of community. Community is the concept that we have a group identity of which we are proud, a group that supports one another and that cares for one another. We need group support to thrive in our work. Supporting community takes awareness and the commitment of resources. Without adequate community, we lack the support we need to avoid burnout.

Inappropriate reward systems. If our reward systems, both monetary and non-monetary, are not in balance and effective, we will suffer. We need to be paid adequately for our work, and we all need adequate time off as well as appropriate non-monetary benefits. As important as the money are the words of encouragement that we all need to give and receive. As physicians, we are taught that the rewards are in seeing a good result and that this should be enough. Additionally, since we are taught not to expect a "pat-on-the-back" ourselves, we do not often give out those types of rewards to others. This is another reason medical organizations are difficult places to work. Our compensation and reward systems need to be structured to reward the behaviors that are important in EM.

Fairness, or more accurately, the appearance of the lack of fairness. Decisions and policies should represent the right thing at the right time for the right reason. Granted, this is all subject to interpretation, but most of us know when something is fair or not. Scheduling of shifts and having financial remuneration based on hours worked and the desirability of the shift rather than just on seniority are important factors in insuring fairness.

Conflicting values. Values are the underlying reasons why we do what we do and how we interface with our world. Examples of values are balance, fairness, truth, honesty, and value to the customer. These values are firmly anchored in the culture of the organization and influence how it operates. Emergency physician values might include providing the best service to the patient, excellence in care and communication, choosing only the indicated diagnostics and therapeutics, and keeping unnecessary admissions out of the hospital. Hospital values might include some of the same - providing services, etc. However, they will want to fill beds, increase the utilization of services, minimize the cost of doing business, and exert control over the physician practice to the degree they can. These differences can serve to create conflict for the physician and add to the burden of stress, therefore adding to the risk of burnout.

Approaches to dealing with burnout in the practice of EM

There are as many approaches to dealing with the risk of burnout as there are causes. Here are some that make sense in the context of the greater picture as we know it:

1. Understand and admit that you are at risk. Our denial in this arena is astounding. I have heard the physician title, MD, as representing "malignant denial." We are all at risk.
2. Understand that you cannot see the forest for the trees. You cannot see the early signs or symptoms of burnout in yourself. You might not even be able to comprehend how your approach to balance (or lack of it) and other behaviors currently add to your risk. Realize that others can see the symptoms in you; however, they might not be willing to take the risk of saying anything because of their own fear and because of the long-lasting wall of silence that exists in this area. How then, do you know? Ask others. Ask your significant other or best friend. Then be willing to listen. You could take the Maslach Burnout Inventory, a 22 question assessment test with proved statistical reliability (usually available at the Wellness Booth at the ACEP *Scientific Assembly*). You could ask for professional help from a counselor or some other professional who is qualified to assess you and your situation.
3. Read articles and books on the subject. Some very good references follow this article.
4. Learn to develop emotional honesty. This can be very challenging for physicians who are often taught not to show emotion, particularly grief and sadness, at some of the untoward or grievous outcomes we witness every day. We often consider it inappropriate to share sadness with tears over the tragic loss of a patient. And yet, unexpressed grief can be a major cause of burnout. We are expected to perform at standards nearing perfection and to handle very difficult or sad situations. "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet. This sort of denial is no small matter. The way we deal with loss shapes our capacity to be present to life more than anything else. The way we protect ourselves from loss may be the way in which we distance ourselves from life." (from Kitchen Table Wisdom by Remen) Critical Incident Stress Debriefing (CISD) counseling and group sessions to manage the emotional scourge of a tragic loss can be very helpful for us.
5. Develop a sense of balance. It is in being in balance with several important areas of your life that you will be able to develop the greatest immunity to burnout. Significant areas in which we should search to attain balance include (after Moskowitz):
   - physical balance (staying in shape)
   - emotional balance (our underlying state of calmness and resilience)
   - spiritual balance (our internal connectedness to a higher essence)
   - relationship balance (in all of our levels of relationships)
   - community balance (developing community relationships to keep us healthy)
   - work and career balance (with flexible boundaries that preserve health and happiness)
6. Remember why you went into emergency medicine, provided you did it for the service you can provide to humanity. It is in the reconnection to the humanity that many find renewed energy and vigor in medical practice (see the article noted in Hippocrates, 1993, below).
7. Face the issues causing conflict in your professional groups and in the hospital. Open honest dialogue can be terrifying, but it is truly the key to dealing with issues in an enduring manner. If you cannot do it yourself, search for help from a professional who can assist you.
8. If you are having issues with emotional distress, issues that are affecting your professional abilities, or a drug- or alcohol-related problem, by all means, take time out

of work and seek professional help. Every day you delay is another lost opportunity.

Additional Material & Resources

Christina Maslach, PhD, Michael P. Leiter, PhD. *The Truth About Burnout*: *How Organizations Cause Personal Stress and What To Do About It.* Jossey-Bass Publishers; 1997.

Richard A. Swenson, MD. The Overload Syndrome: Learning to Live within Your Limits. Navpress Publishing Group; 1999.

Rachel Naomi Remen, MD. Kitchen Table Wisdom: Stories that Heal. Riverhead Books; 1997.

Hippocrates. One Internist's Pilgrimage to Reclaim the Joy of Medicine. February 1993. Peter Moskowitz, MD, Physician Renewal: The Importance of Life Balance. Sonoma County Medical Association. 1999. Available at: www.scma.org

Entire issue relates to recapturing the spirit of medicine. West J Med, 2001;174(1).

Jacob Needleman, PhD. Money and the Meaning of Life. Doubleday & Company Inc.; 1994.

Wayne Muller. Sabbath: Restoring the Sacred Rhythm of Rest. Bantam Doubleday Dell Pub; 1999.

Organizations

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The Scheduling Process

Louise B. Andrew, MD, JD, FACEP

When emergency physicians are asked what drew them into the specialty, one of the most common responses is the defined hours and absence of on-call responsibility. Yet surveys of emergency physicians relating to job satisfaction nearly always find schedules and the scheduling process highly ranked among stress-producing factors. There is an entire chapter devoted to circadian rhythm considerations. This section covers the process of schedule ***making*** and its effect as a stressor to emergency physicians.

Your schedule grows in importance as you grow older

During residency, young physicians usually work long hours and often have little or no control over when and where they must work. Some residents enthusiastically volunteer for the schedule-making duty, or excel in ultra-long range planning so as to get first consideration for requests for time off for themselves. After residency, for at least several years, it is usually possible to continue to plan your life around your work schedule. However, as the family grows to include children with their scheduled and unscheduled demands for parental time, or when personal, relationship or community interests and avocations become more important around midlife, the prospect of working according to a schedule designed by someone else becomes less attractive. Yet somehow, the ED must be covered 24 hours every day of the year. And someone has to figure out how.

Schedule making is never an easy task!

Groups have devised many methods for developing a schedule, and there are several computer programs designed to mechanize this thankless task. Several methods are summarized in the chapter on Scheduling Methods in *Managing the Emergency Department: A Team Approach***.** At a minimum, schedules should take into account the needs and desires of the individual practitioners, and should be designed wherever possible to minimize circadian rhythm disruption. It is easy to argue that "fairness" is the controlling principle in scheduling procedures; but in practice, the individualized needs of group members (such as non delegatable family care responsibilities, administrative obligations, physical needs diversity) may preclude absolutely "fair" distribution of allotted shifts. Such special needs should be acknowledged, and should serve as reassurance to all members that their special needs, if they occur, will be respected. There should also be some agreed-upon technique of prioritization of individual requests for time off, and maximum flexibility to allow exchange of shift obligations between members. Some groups meet regularly to share information and perform peer review; this setting can allow for a collaborative schedule making session, provided all affected individuals agree to participate and have equal voice in the process.

Pay incentives may ease the sting of unpopular shifts and schedule-making

The use of pay incentives for unpopular shifts has been successfully used in many industries as well as health care. Substantial differentials should be strongly considered in ED group practice settings as an inducement as well as a tangible acknowledgment of the value placed by the group on individuals willing to work unpopular shifts (eg, night or weekend shifts). Younger emergency physicians who are less impacted by the health effects of night shifts may welcome the additional income while paying off student loans or planning for a family early in their career. If there is a schedule maker among the physicians, this individual should also be thanked and compensated for the time and emotional distress inherent in this job.

Work Relationships

Louise B. Andrew, MD, JD, FACEP

Work relationships in emergency medicine can make or break a position. Relationships with nurses and other ED staff, with coworkers, hospital staff and administrators, and with community physicians can either become critical stressors, or function as essential relief mechanisms in the practice of emergency medicine.

What is a healthy work relationship?

A healthy work relationship is characterized by mutual respect, the recognition and validation of reciprocal roles, and a willingness to cooperate in facilitation of mutual goals. Communication in a healthy relationship can be quite direct, will usually be heard out, and when ambiguous, will be interpreted in the best possible light. What is a toxic work relationship? It is often characterized by an assumption of inequality, with little or no recognition or validation of differing roles, and/or an unwillingness to cooperate in shared goals. Communication in a toxic relationship may be completely lacking, may be indirect or passive, or may even be intentionally misleading. Toxic work relationships, like toxic marital relationships, can be hazardous to health and wellbeing.

Relationships are essential in emergency medicine.

Maintenance of healthy relationships and avoidance or repair of toxic relationships in the workplace are essential to survival in emergency medicine. How can healthy relationships be maintained?

- Frequent validation and feedback are invaluable gifts to coworkers, and they are noticed and remembered.
- Saying hello to a coworker, or asking, "How are you?" however automatic, conveys your personal concern for their wellbeing.
- Thanking coworkers for assistance on a busy shift, or at the end of a harrowing resuscitation, is an often overlooked kindness which can go a long way.
- Thanking staff physicians for responding promptly to pages, or apologizing for calling at an inconvenient time also "turns away wrath," and may enlist their cooperation.
- Writing brief thank you notes to administrators who have helped out in a crisis, naming department or consulting staff who have exceeded expectations in such communications, and sending cards to the department on holidays or when you are away to someplace interesting, all convey caring for the individuals and validation for the work of the group.
- Contributions to staff parties or "sunshine funds" are also particularly appreciated.

Some relationships are not salvageable.

How can toxic relationships be managed? Toxic relationships may not be salvageable. An example is the head nurse, hospital staff physician or hospital administrator who will not communicate with you at all, but goes through a third party, such as your director or a higher administrator to avoid confrontation or to discredit or embarrass you. Another example is the nurse or secretary who appears to comprehend your needs, but attempts to frustrate or subvert them by acting passive aggressively, for example by complaining to patients or colleagues while following your orders. Toxic relationships are habitual with certain "difficult"

individuals, while normal people may find themselves relating toxically in certain circumstances. Difficult individuals are not readily changeable. But anyone can relate toxically in difficult circumstances. So some seemingly toxic relationships may be repaired.

Many relationships, behaviors or interactions can be modified.

All hospital personnel have an obligation to care for patients in a professional manner. Therefore, naming a behavior which is unprofessional to a patient, will often terminate such behavior in a provider. Unfortunately, there is less of an obligation for professional behavior between individuals working in a hospital, so an appeal based on patient care may not be successful. However, no professional really wants to appear unprofessional in the workplace. If you are being treated unprofessionally, ask yourself, "Is this person relating to others better than s/he is to me?" If so, "Is there something I am doing which is prompting him/her to act this way with me? Or is there something else going on here which could explain this person's difficult behavior with me?" An honest look at self and situation will often supply the clue to a toxic interaction. If the person seems normal with others and toxic only with you, and you cannot find a reason within the environment (such as an extremely busy day/night, a type of patient which grates on the nerves, tiredness relating to an extended shift length), it may be worth asking the person directly, "Is there something I am doing which is irritating to you?" Of course, the question must be asked in a way that allows for an honest answer. And you must be willing to try to change that irritating behavior if it is revealed to you! Just acknowledging concern with the state of the relationship will often open the door to more effective communication and conflict resolution.

If there is no apparent clue from the environment, and no feedback forthcoming from the other party, there is little else you can do except to redouble your efforts not to aggravate the situation. If such situations recur regularly with the same individual, you may be dealing with a difficult or toxic person, whose relationship with you is probably not changeable. Then you must decide if you can live with it (see below). If, however, the person is honest in telling you something which you can acknowledge and attempt to change about your approach or the relationship, then there is hope that this is a developing and changeable relationship. Surprisingly often, the closest working relationships develop between individuals who have overcome initial animosity or misunderstanding with such honesty.

Some relationships cannot be changed.

If you find yourself in a non changeable, toxic relationship with someone who is subordinate to you in the work environment, you can probably maneuver around the individual without loss of effectiveness. If it is a peer, you may be able to avoid the person through scheduling (the one advantage of round-the-clock staffing!) or, in the case of another hospital staff physician, through selective consultation (through the chief of the department if necessary). If, on the other hand, you are in a nonchangeable, toxic relationship with someone who is your supervisor (or, in a well-entrenched hospital bureaucracy, is realistically the department supervisor: eg, the Head "Nurse Ratchet" or Queen Bee administrator), or on whom you depend, (such as the department chair or chief of staff who refuses to uphold hospital ED policies or coverage obligations) it may be wiser in the long run to change workplaces rather than to attempt to move mountains or wait for the individual to die or retire. Although a last resort, this is an avenue which EPs have been forced to take due to our contractual vulnerabilities and lack of bargaining power in the hospital setting.

Additional Reading

Hellstern RA. *Managing the Emergency Department: A Team Approach.* Dallas, Tex: American College of Emergency Physicians; 1992.

Covey SR. *The Seven Daily Habits of Highly Effective People*. 1st Ed. Simon & Schuster; 1990.

Ury W. *Getting Past No Negotiating Your Way from Confrontation to Cooperation*. Bantam; 1993.

Litigation Stress

Louise B. Andrew, MD, JD, FACEP

Threat of Litigation

The threat of litigation is a fact of life for physicians, and the average emergency physician can expect to be sued about once in every ten years. Litigation is often the result of ineffective communication or poor interpersonal interaction with patients, or of an adverse medical outcome in a patient who is the sole support for a family. Staying abreast of the current practice of emergency medicine, practicing with full attention and as wisely as you can, and seeking consultation when needed is the best insurance against an adverse outcome. But even the best medical care may result in an adverse outcome; so interpersonal skills must be honed and refined constantly in order to avoid litigation wherever possible. (see chapter titled Communication, Conflict Resolution and Negotiation)

Harmful Effects of Litigation

The harmful effects of litigation on physicians occur regardless of the outcome of a suit. Physicians who have been sued report feelings of demoralization, anger, depression, physical illness, and disruption of practice and family life, which may persist over many months or years, whether the case is won or lost, settled or even dropped. Mandatory reporting of settlements and judgments over a certain dollar amount to the National Practitioner Data Bank (NPDB) means that a case can follow the physician for life, particularly when applying for hospital credentials, malpractice insurance, or state licensure. The only way to avoid the stress of litigation entirely is to avoid litigation!

Stress reduction techniques are available.

Since prevention of litigation is not always possible, techniques for handling the stress have been developed.

- First, the legal strategies: do not speak to anyone but your insurer or your attorney about details of your case, know all of the medical details and assist your attorney in your defense by supplying articles, suggesting experts and heeding advice about deposition and trial tactics.
- Second, build a support network: enlist your family, your coworkers, other physicians, and/or a professional counselor in dealing with the powerful feelings involved in litigation. Some state medical societies have developed support groups for defending physicians. The Center for Professional Well-Being (www.cpwb.org) has published guidelines on starting your own group (919.489.9167).
- Third, reduce your future risk: take a critical look at your practice situation, and take steps to improve any practices or policies which contributed to your being sued.
- Fourth, take care of yourself, do what you can to keep your life balanced and to eat, exercise, and rest adequately: before litigation occurs, so that you will be less likely to inadvertently bring it on because of poor communication or interpersonal relations; during litigation, so that you can "weather the storm," and come out a stronger person; and after litigation, so that you can get on with your life and your life's work.
- Fifth, work to reduce malpractice litigation and its harmful effects: educate your patients and the public about limitations in the medical system, and the essential "humanity" of physicians; lobby for

malpractice reform; and teach other physicians about malpractice stress and its management.

Additional Reading

Henry GL, Sullivan DJ, eds. *Emergency Medicine Risk Management: A Comprehensive Review*. 2nd ed. Dallas, Tex: American College of Emergency Physicians; 1997.
www.acep.org/bookstore/

Charles S. *Defendant*. New York, NY: Vintage/Random House; 1985.

Foresight is ACEPs periodical on risk management presented in an easy-to-read newsletter format. Issues present strategies and suggestions for reviewing and modifying emergency medicine practice to reduce exposure to liability risk. You can earn CME credit by successfully completing the quiz that accompanies each issue.
Issue 25 (Malpractice Primer)
Issue 10 (Physician-Patient Communication)
ACEP, Dallas, TX
www.acep.org/bookstore/

Scott CD, Hawk J. *Heal Thyself: The Health of Health Care Professionals.* New York, NY: Brunner/Mazel; 1986.

Infectious Disease Exposure

Charles W. Henrichs, MD, FACEP

Human beings have a profound fear of contagious diseases.[1] As emergency physicians, this thought is not with us always but there are frequent reminders.

- Why didn't I wear a mask when I examined that febrile patient with respiratory complaints or when I intubated the one with meningitis that coughed on me?
- Why did I stick myself recapping that needle?
- Did I wash my hands before I ate my sandwich?

Our profession requires that we take precautions to protect ourselves, and that must be based on information, planning and consistent application.

Standard Precautions

The classification of universal precautions has evolved into the categorizations of standard, contact, droplet and airborne precautions with guidelines for their employment.[2] No patient should be regarded as without the need to consider these precautions and no time urgency is so great as to preclude their use. Clearly delineated protocols and readily available appropriate personal protective equipment (PPE) are a must in every ED. We should be so ingrained in the need for these precautions and PPE and so practiced in their use that it becomes our habit to do so.

Barrier Protection

Latex disposable examination gloves are and should be ubiquitous in the ED (even carried in the provider's pocket if the potential need for such a rapid response exists). Nitrile or other substitute material gloves must be available for providers (and for use with patients) with latex allergies. Suitable protective overgarments, shoe covers, masks, face shields and eye protection should be readily available. Disposable particulate respirators (commonly known as face masks) are regulated by the National Institute for Occupational Safety and Health (NIOSH) and the Occupational Safety and Health Administration (OSHA). NIOSH certifies the respirators[3] and OSHA sets the standards and requires each employer to develop and implement a written respiratory protection program.[4] Common surgical masks are not approved for and offer little protection against airborne pathogens. Currently, the minimum protection against airborne pathogens is the N (for Not oil proof) 95 (for 95% efficiency at a defined particulate diameter) mask. Use of N95 masks has its strongest scientific support (and is very effective) in protection against Mycobacterium tuberculosis (TB) transmission.[5] The N95 mask is not by definition, however, a High Efficiency Particulate Air (HEPA) filter. HEPA efficiency (99.97% filtration of a defined particulate diameter) is accomplished by the N100 mask. Some experts advocate for N100 masks in certain settings.[6] For attendance during procedures that carry high risk of aerosolizing particles (eg, nebulizer treatments) a loose fitting Powered Air Purifying Respirator (PAPR) may be considered.

Respirator protection begins at first contact with the patient identified with a condition having potential for health care worker risk. When medically feasible, a surgical mask should be placed on the coughing patient to minimize droplet aerosolization. The triage nurse should wear a suitable NIOSH certified disposable particulate respirator (N95 or better). The patient should be placed into a negative air pressure room which should be readily identifiable by staff. All patient contact staff should utilize airborne precautions. All staff using particulate

respirators should have been fit tested prior to their use and perform a fit check prior to each instance of use. A poorly fitting N95 mask offers much less protection.

Hand Washing and Hand Disinfection

It is easier to keep hands clean than to make them clean. Gloves can help accomplish this but good hand washing and hand disinfection are important and should be performed after gloves are removed. Techniques for hand washing with antiseptic soaps and running water are described in the literature.[7] Hygienic hand rubs conveniently located can help to reduce the release of transient pathogens.[8]

Sharps

Few experiences provide the immediate sense of alarm as that of a poke from a sharp. Bloodborne pathogens and the potential for incurable disease are dreaded by health care workers. Appropriate protocols, techniques and technologies can decrease the risk. Immunization and post-exposure prophylaxis (PEP) are available for some (eg, hepatitis B virus) but not all (eg, hepatitis C virus) pathogens. Human immunodeficiency virus currently has no effective immunization but PEP protocols exist from the Centers for Disease Control and Prevention (CDC) and should be implemented as rapidly as possible.[9] Occupational exposure management resources are available by telephone hotline and Internet website.[10-12]

Special Precautions for Women Emergency Physicians

The female EP in the reproductive years should know her immune status with respect to measles, rubella, varicella and other diseases before she contemplates becoming pregnant. This consideration should become a routine health practice for women emergency physicians.

Emerging Infectious Diseases and Bioterrorism

New threats to emergency physician wellness not considered in past reviews[13,14,15] may present at any time. Severe Acute Respiratory Syndrome (SARS) has shown significant contagion potential for health care workers. The potential for deliberately released pathogens (eg, smallpox) has prompted renewed interest in vaccination and exposure prevention. Updates, advisories and warnings are available from local and state health departments and the CDC.[16]

Policies

Written policies concerning infectious diseases exposure and prevention should be in place and regularly updated. Policies should consider immunization of health care workers, TB skin testing, exposure mitigation and management, isolation procedures and precautions, PPE, PEP, reporting and regulatory requirements, confidentiality and other important considerations.

References

1. Holloway HC, Norwood AE, Fullerton CS, et al. The threat of biological weapons. Prophylaxis and mitigation of psychological and social consequences. *JAMA.* 1997; 278(5):425-427.
2. Garner JS. Guideline for isolation precautions in hospitals. Part I. *Am J Infect Control.* 1996;24(1):24-31.
3. 84 CFR Part 42
4. 29 CFR Part 1910.134
5. NIOSH TB Respiratory Protection Program in Health Care Facilities. Administrator's Guide 1999
6. Schultz CH, Mothershead JL, Field M. Bioterrorism Preparedness I. The emergency department and hospital. *Emerg Med Clin North Am.* 2002; 20(2):437-455.
7. Larson EL. APIC guideline for handwashing and hand antisepsis in health care settings. *Am J Infect Control*. 1995; 23(4):251-269.
8. Hospital Epidemiology and Infection Control. CG Mayhall, ed. 1999;1339-1355.

9. CDC MMWR, June 29, 2001, No. RR-11
10. National Clinicians PEP Hotline 888.448.4911 http://www.ucsf.edu/hivcntr
11. Needlestick http://www.needlestick.mednet.ucla.edu
12. Hepatitis Hotline 888.443.7232 http://www.cdc.gov/hepatitis
13. Dorevitch S, Forst L. The occupational hazards of emergency physicians. *Am J Emerg Med.* 2000; 18(3): 300-311.
14. Sepkowitz K. Occupationally acquired infections in health care workers. Part I. *Ann Intern Med.* 1996; 125(10):826-834.
15. Sepkowitz K. Occupationally acquired infections in health care workers. Part II. *Ann Intern Med.* 1996; 125(11):917-928.
16. Centers for Disease Control and Prevention http://www.cdc.gov

Physician Impairment

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There is a growing awareness of the problem of physician impairment among health care professionals and society in general. Physician impairment exists when a physician's professional performance is adversely affected because of illness, including mental or physical illness, aging, or alcoholism or other chemical dependence. This chapter will focus on impairment due to chemical dependency and addiction.

The medical profession has recognized for over 40 years that chemical dependence (CD) is a primary disease. Like any other disease process, CD has a characteristic symptom complex, clinical course, morbidity, mortality, and treatment. It is a complex psychosocial disease with a defined genetic predisposition. Susceptible individuals become addicted through a combination of chemical (including alcohol) use and a biogenetic tendency. Addicts and alcoholics are born, not made. The course of the disease however cannot be predicted on an individual basis, but certain factors have been shown to contribute to successful recovery. The likelihood for successful recovery in physicians with CD is very high.

Definition, Pathophysiology, and Prevalence

The hallmark of addiction is the compulsion to continue to use a substance even after having adverse consequences. A common misconception is that addicts and alcoholics are somehow morally weak or lacking in ethical character or willpower. This myth has been dispelled in large part by the disease concept of addiction. Guilt and shame are key features of the disease as the addict's behavior violates their own value system. The compulsivity of the disease is due to altered brain chemistry in the hypothalamic and other limbic center areas. It is defined as the illogical, irrational, irresponsible, continued, repeated use of the drug even as it becomes destructive to the individual's life. Certain specific areas of the hypothalamic instinctual primitive brain lead to compulsive drug or alcohol use[1,2] and results in depletion of numerous dopaminergic and endorphin systems. Compulsion to use the chemical then becomes an instinctual survival mechanism like the fight or fight response. This deficiency is met with more substance use, which further depletes the endorphin-enkephalin system, and the cycle of craving, abuse, use, and addiction continues.

Alcoholism and drug dependence are not related to the volume, dose, duration, or degree of intoxication. It is estimated that 70% of the population will use mood-altering chemicals at some point in their life, 50% may progress to substance abuse, but only 10% will cross the biogenetic wall and show full-blown addictive disease symptoms. Thus it is estimated that one in ten people will develop the disease of CD. So addiction requires 1) exposure to a mind altering substance and 2) a genetic predisposition.

In physicians, the prevalence of CD is no different, however the disease is almost always in an advanced state before signs and symptoms become obvious in the workplace. Although the actual prevalence remains unknown, 8 – 12% of health professionals are estimated to develop a substance-related disorder at some point in their life.[3] Certain factors serve as particular risk factors for CD among physicians.

- Occupational stress, sleeplessness, and time stressors
- Tendency to self-medicate or self-prescribe

- Ready access and availability of drugs
- Lack of understanding of addiction, with physician experience with the disease of CD with the most extreme cases
- The "Titanic syndrome" – the physician is unsinkable, familiar with drugs and can handle it where others cannot
- Arrogance – the physician is "special," immune to stresses, can swallow painful feelings, and will not get sick

Similarly, the prevalence of CD among emergency physicians is unknown, but several studies have pointed to emergency medicine as being a high-risk specialty. In Talbott's study of 1000 impaired physicians, family practice, anesthesiology, and emergency medicine were over-represented compared to the general distribution of physicians by specialty. Emergency physicians represented 4.8% of the chemically dependent group compared to a 2.0% prevalence of emergency physicians among all practioners identified by the AMA.[4] Among physicians currently enrolled in the Pennsylvania Medical Society's Physicians Health Program, emergency physicians represent 5.4% of the population again compared to about a 2% prevalence of emergency physicians among all specialties. Among residents, emergency and psychiatry residents represented the group with the highest rates of substance abuse in a survey of 3000 residents[5]. Finally, in a study highlighting the difficulty of identifying the addicted physician, only 1% of program directors in emergency medicine had ever suspected an emergency medicine resident of having a substance abuse problem, while 13% of the emergency medicine residents had self-reported CAGE scores consistent with alcoholism.[6] It is unclear why emergency physicians may have a higher prevalence of CD, but certain postulates have been suggested such as the sleep stress of night duty; the risk-taking, high excitement personality of the emergency physician; emotional stress of dealing with acutely sick and dying patients; and easy access to drugs in the ED. In its policy on physician impairment, ACEP endorses the need to develop more research to determine the prevalence of impairment in emergency medicine practice in order to develop strategies for prevention and management.

Core Symptoms of Chemical Dependence

The key symptoms of CD include:

- Denial – There is always strong denial that a problem exists or that the problem is anything but chemical abuse. It is an unconscious psychological defense mechanism that develops over time through repeated rationalization. It allows the addict to justify their behavior and to avoid painful knowledge about their maladaptive actions, and often results from avoidance of the underlying guilt and shame. It is said that "the disease tells you that you don't have the disease."
- Compulsion – As previously described, there is an obsession to use despite obvious negative consequences. The disease results in deterioration of all aspects of life, but job performance is usually the last to be affected.
- Progression – Chemical dependence has a clear pattern of progression, but predicting a clinical course in an individual is difficult. A common pattern includes social use, abuse, addiction, and death.
- Relapse – Relapse is always a major risk and generally is brought on by resurfacing denial or not accepting the disease concept. "I don't really have a problem, I can begin to drink socially again."

Diagnosis of Chemical Dependence

The most difficult aspect of helping an impaired physician is making the diagnosis. Denial, guilt, and shame of the CD physician cause him/her to attempt to hide or mask the drug or alcohol use and resist treatment. But denial is often present in associates, colleagues, and family as well. The deteriorating behavior, poor performance, absenteeism, and isolation of the addicted professional are frequently attributed to stress

from relationships, financial or business difficulties that the person encounters, rather than the addiction that underlies them all. Fear of damaging the professional standing of a colleague causes associates to rationalize behavior, minimize difficulties, and avoid confronting the affected individual. Likewise, uncertainty about who to contact or about the success of treatment lead to fears about doing anything. Colleagues and friends often have the mistaken belief that by suffering adverse consequences the addicted professional will "get their life in order." This is almost never the case.

Chemical dependence is notoriously difficult for professional colleagues to detect in the early stages because troubles at home or in the community may not be generally known. The typical sequence areas of life affected by CD are:

1) community involvement (isolation, withdrawal, embarrassing behaviors)
2) family life (difficulties with marriage, children)
3) employment patterns (see next paragraph)
4) physical status (poor personal hygiene, frequent visits to fellow physicians, injuries on vacation, medication requests from colleagues), and finally
5) Office and hospital conduct.

A pattern of events, rather than a simple precipitating incident, usually must be recognized to make the diagnosis of impairment. Numerous clues to the diagnosis of CD have been suggested.

Prospectively, suspicion may be raised when a professional presents for credentialing in a new job. Ambiguous letters of reference, a history of frequent job changes (the geographic cure attempted by many addicts) or prolonged unexplained periods between jobs, and over qualification for the position may all be clues to CD. The chemically dependent physician may refuse or attempt to delay a pre-employment physical or drug screen. Most prospective employees do not object to employment testing, and those successfully recovering from CD will welcome it.

In the workplace CD may be suspected by any number of behaviors. Given that the workplace is normally the last arena for symptoms of addiction to emerge, a greater than 90% probability exists that when suspicions arise, they prove to be true. The following are some clues to CD.

- Unexplained absences or tardiness
- Behavior change – angry or hostile and inconsistent with previous behavior
- Frequent visits to the bathroom or closing and locking office door usually to ingest or inject drug of choice (locked-door syndrome)
- Over-prescribing or under-prescribing for patients
- Deterioration of handwriting
- Writing inappropriate orders
- Ordering "sample" medications – usually narcotic or benzodiazepine class
- Medical errors
- Disheveled or sleepy appearance

Physicians commonly are reluctant to pass judgment on a colleague's behavior. But co-workers and colleagues have an ethical and legal responsibility to protect patients from inadequate medical care. Most states have legal requirements that mandate reporting of impaired physicians. Failure to provide such a report is subject to a fine. The requirement does not include proving impairment because that is the purview of the licensing authority and civil immunity is provided to such reporters. The threat of disciplinary action, however, can serve as a powerful deterrent to physicians seeking treatment and to colleagues reporting suspected impairment.

In order to meet the need for public protection and to provide an avenue for confidential reporting which leads to the rehabilitation of the physician rather than punitive steps, most states have developed organized physician health programs (PHPs). Reporting to these entities may satisfy the requirements to report while avoiding formal investigation and disciplinary action[7]. It has been shown that disciplinary action or the threat of such action does little to

intervene in chemical dependency alone and is often counter-productive to recovery and professional reintegration. PHPs offer confidential consultation and assistance with interventions. They will assist in data collection from friends, family, colleagues, and medical staff. If sufficient information exists about a possible impairment, the PHP will usually contact the physician and encourage appropriate assessment and treatment. They facilitate the selection of a treatment plan and selection of a treatment center. After treatment, they assist with workplace reintegration, and provide a comprehensive program of aftercare and monitoring often for at least 3-5 years. All PHPs will report a practitioner for disciplinary action if treatment is refused or the practitioner insists on continuing to practice against the recommendations. In this way, PHPs work closely with state medical boards, but are separate and do not report the physician who agrees to treatment and follow-up. They also provide advocacy for the recovering impaired physician with state medical boards, Federal Drug Enforcement Administration (DEA), and hospital medical staffs. It is important to note that for health professionals entering treatment followed by comprehensive long-term aftercare and monitoring, success rates for long-term sobriety are 70-92%.[8-10]

Intervention

When addiction is first suspected, it is prudent to discreetly discuss concerns with others who may have additional information or observations. Never try to intervene alone. Get professional advice. All hospitals are now mandated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to have a plan or procedure in place (as part of their bylaws) designed to deal with physician impairment, such as physician wellness committees or employee assistance programs. PHPs are also extremely valuable sources of advice. It is important not to ignore a sentinel event. Document the incident, your observations, and your concerns for future reference. If current intoxication is suspected, getting a urine or blood specimen provides the most definitive answer. When patient care is in jeopardy, one should take immediate action to protect the patient from harm.

Intervention consists of a carefully planned confrontation of the impaired physician. The ultimate goal of an intervention is for the practitioner to go forward with an immediate comprehensive evaluation and/or treatment. The impaired physician's acceptance of the problem at this juncture, while helpful, is not critical. A good intervention is supportive and respectful and may lay the groundwork for a positive treatment experience. Intervention must be tailored for the particular situation, whether it is peer-, administrative-, or family-generated. Each intervention however should include several participants. It needs to be as close to the precipitating event as possible and at a time when the participant is sober. The location should be quiet, non-threatening, and private. Specific events or reports of behaviors should be reviewed. The leaders should be well prepared and professional clout should be used when needed. Reinforce the personal and professional value, dignity, and worth of the physician. Remember that the person is likely to feel intense guilt, shame, and hopelessness and be prepared to address these feelings. It is advisable to evaluate suicide risk and be prepared to intervene with immediate hospitalization if required. The bottom line should be identified in advance, such as going immediately for treatment or evaluation to determine if CD exists. Because most interventions are successful, a treatment bed should be immediately available. If there is any delay, denial will quickly resurface and the window of opportunity may be lost. Offer hope, support, and respect.

Treatment and Recovery

Treatment of CD must be tailored to the individual physician and depend on the substance involved, the circumstances of addiction, and the work and home situation. Professional addictionologists such as those available through PHPs, are best able to recommend such treatment. Intensive primary

residential treatment of one to four months followed by comprehensive long-term monitoring and aftercare is thought to be largely responsible for the high rates of long-term recovery seen in physicians. Primary treatment is designed to remove the dependant physician from the practice environment and stresses of daily life, and enables them to focus on recovery. Receiving eight to ten hours of structured treatment per day over a period of weeks/months addresses professional arrogance and controlling behaviors, thus helping them focus on personal change. Outpatient treatment programs for physicians have largely failed. Impaired physicians have excellent outcomes when treated by programs geared specifically for health professionals.

Intensive treatment most commonly results in remission of active symptoms, but the disease of CD is always at risk of relapse, hence the need for long-term monitoring. The prognosis improves and relapse risk greatly decreases in proportion to the intensity, structure and length of follow-up monitoring. It has been shown that the majority of relapses occur in the first two years of sobriety. Thus most PHP contracts involve 5 years of required follow-up. A typical PHP agreement requires that the participant adhere to the terms of the initial treatment plan; attend 12-step meetings weekly; maintain weekly contact with a professional monitor and monthly contact with the PHP; undergo random, observed urine drug screens; and maintain contact with a personal physician. The PHP can then advocate for the physician for workplace reintegration, obtaining or retaining professional credentials, malpractice coverage, and other professional privileges. With proper treatment and follow-up, chemically dependent physicians can continue their practice, often with minimal interruption. Physicians typically recoup their professional and financial losses within 2 years. Life gets better. Many are eventually able to acknowledge that the intervention saved their life.

Conclusions

Chemical dependency does not have to be a condition that destroys an emergency physician's life and career. The recovery rate for physicians is high, and relapse is relatively low compared with other populations. Remember that identification, diagnosis, and intervention, with coercion when needed, may be life saving. The opportunity for recovery is a gift. Recovery is an intense process of personal growth and frequently includes a life long spiritual awakening. It enhances the life experience. Physicians return to work with a new outlook on life, their careers, and the caring that they show for their patients. The worst thing you can do for an addicted person, or yourself, is to ignore the problem. Waiting for spontaneous insight from an addicted person is futile.

Additional Resources

- American College of Emergency Physicians. Physician Impairment, policy statement. www.acep.org/1,636,0.html
- Your local PHP – usually associated with the state medical society
- Samkoff JO, McDermott ROW. Recognizing physician impairment. *Penn Med*. 1998; 91:36-38.
- International Doctors in Alcoholics Anonymous (IDAA). 859.277.9379. www.idaa.org
- American Society of Addiction Medicine (ASAM) 301-656-3920; www.asam.org
- Alcoholics Anonymous (AA); 212-870-3400; www.alcoholics-anonymous.org
- Narcotics Anonymous (NA). 818-773-9999 www.na.org

Booklets

- The Impaired Surgeon. American College of Surgeons, 63 N. St. Clair St., Chicago, IL 60611-3211, 312-202-5000 www.facs.org

- Chemical Dependence in Anesthesiologists. American Society of Anesthesiologists. 847.825.5586. http://www.asahq.org/publicationsAndServices/chemical.html

Videos

- The Wounded Healer. Talbott Recovery Campus, 5448 Yorktowne Dr., Atlanta, GA 30349, 800.445.4232 http://www.talbottcampus.com/

References

1. McBloom F, Bayon A, Battenberg E, et al. Endorphins: Developmental, cellular, and behavioral aspects, in Costa E, Trabucchi M (eds): Neural Peptides and Neuronal Communication. New York, Raven Press, 1980, 619-632.
2. Hertz A. Role of endorphins in addiction. *Mod Prob Pharmocopsychiatry* 1981; 17: 175-180.
3. Brewster JM. Prevalence of alcohol and other drug problems among physicians. *JAMA.* 1986; 225:1913-1920.
4. Talbott GD, Gallegos KV, Wilson PO, et al. The Medical Association of Georgia's Impaired Physician Program. Review of the first 1,000 physicians: Analysis of specialty. *JAMA.* 1987; 257:2927-2930.
5. Hughes PH, Baldwin DC Jr, Sheehan V. Resident-physician substance abuser, by specialty. *Am J Psychiatry.* 1992; 149:1348-1354.
6. McNamara RM, Marguiles JL. Chemical dependency in emergency medicine residency programs: perspective of the program directors. *Ann Emerg Med*. 1994; 23:1072-1076.
7. McCall SV. Chemically dependent health professionals. *West J Med*. 2001; 174:50-54.
8. Shore JH. The Oregon experience with impaired physicians on probation: an eight-year follow-up. *JAMA.* 1987; 257:2931-2934.
9. Gallegos KV, Lubin BH, Bowers CD, et al. Relapse and recovery: Five to ten year follow-up study of chemically dependent physicians – The Georgia experience. *MMJ.* 1992; 41:315-319.
10. Hobbs T. Addressing perceptions of the impaired physician. *Pa Med*. Feb. 1998:11.

Gender and Related Forms of Discrimination and Harassment

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Gender discrimination may take many forms.

In its simplest form, gender discrimination is a kind of bias in which some coworkers are treated differently, to their detriment on the job. The bias may be manifest in behaviors, policies, or procedures which adversely affect the work of one group. This effect may be due to:

- the disparate or differing treatment of one group, such as a dress code for men, but not for women;
- the disparate effect of a uniform treatment on one group, for example, lack of a maternity leave policy; or
- the creation of a hostile or intimidating work environment, as for example, display of calendars or caricatures portraying one type of person as a sexual object.

Employment discrimination based on sex is prohibited under Title VII of the Civil Rights Act of 1964, and under many state laws.

Sexual harassment is one form of gender discrimination

Sexual harassment is characterized by unwelcome sexual advances or other conduct of a sexual nature:

- where submission to such conduct is a term or condition of an individual's professional position; or
- is used as a basis for professional decisions affecting that individual; and
- the conduct interferes with the individual's work or creates an intimidating, hostile or offensive work environment.

Sexual harassment is prohibited under Title VII, and under Title IX in academic environments.

In the medical professional environment, many pervasive forms of gender discrimination are not actionable legally.

Called “micro inequities,” continuing small instances of gender discrimination exact a heavy toll from those whom they affect. These inequities may include:

- unconscious slights, such as being left out of informal networks of communication or information about opportunities or pathways, or being eliminated from consideration for professional opportunities for advancement because of negative presumptions about interest or dedication;
- invisibility, as when a woman’s suggestion at a meeting is initially ignored, and only validated when spoken by a man;
- conscious slights, such as stating that a pregnancy or illness is a disservice or a sign of disloyalty; or
- exploitation, as in assigning women a disproportionate clinical and teaching load, leaving no time for academic pursuits.

These continuing “slights” over time, exert a cumulative effect which can be quite damaging to self assessment and self esteem, and thus greatly reduce a woman's chances for professional advancement, and are not ethically or morally supportable. However, they are not, in and of themselves, illegal. Significant depressive, psychosomatic, and even post-traumatic stress reactions in women have been

associated with continuing gender discrimination of this "sub-actionable" form in the workplace. There is no clear way for one individual to combat micro inequities in the professional environment; but being aware that this type of discrimination is commonplace in the medical professional environment can at least sensitize the individual and the community to its existence. Ignoring or denying the effects of subtle gender discrimination can foster its continuation or escalation into full fledged discrimination or harassment.

Legal recourse is available for some forms of gender discrimination

The more publicized and obvious forms of gender discrimination include:

- passing over a qualified minority applicant for a promotion or position in favor of a less qualified majority applicant;
- paying a lesser salary to a minority for identical work, or the same salary to a more qualified minority individual; or
- laying off a more senior employee in favor of a more junior employee on the basis of subjective assessments which are based on consideration of impermissible factors such as work style "compatibility" rather than job performance.

Such discrimination is easily disguised in the medical professional hierarchy, where decisions have traditionally been made on the basis of subjective recommendations and by way of an "old boy network" of information. Yet, such discrimination on the basis of gender is prohibited under Title VII, and under Title IX in educational institutions. If you are experiencing this type of gender discrimination, gather all the data you can obtain about the situation. Ask your employer if it is a true perception (eg, that your salary is less than that of comparably situated others), and if so, ask for any justification(s). Record carefully any response. Make it clear that you will be looking at other opportunities where you will be given equal opportunity; and that you will also seek advice outside the corporation if some adjustment is not made to correct the inequity. Then follow through.

Sexual harassment is unwelcome sexual attention or behavior in the workplace which interferes with an employee's ability to do the job.

Sexual harassment may be physical, verbal or visual. Whether a particular conduct is considered to be unwelcome to some extent depends on the response of the victim. If you believe you are being harassed, there are a number of actions which you can take:

- First, put the perpetrator on notice that the activity is unwelcome, by direct communication, either verbally (preferably with a witness), or in writing.
- If this is not possible for whatever reason, a second approach is to ask a third party, preferably a supervisor, to mediate the situation.
- A third is to file a formal complaint or formal grievance proceeding, if your employer has established such a procedure. (and most have; many state laws require this.) However, experience has shown that this step should only be taken if lesser steps have failed, and if you are prepared for all possible ramifications, which may unfortunately include blacklisting or other forms of overt or covert retaliation (especially if the perpetrator is the supervisor).
- A fourth resort is to seek legal redress through federal or state laws. The advice of a competent attorney who has experience in employment discrimination, preferably involving physicians, should be sought as soon as this route is considered. Get several opinions if the first is not knowledgeable or does not seem invested in your issue.

How do I know if I am experiencing harassment or discrimination?

The American Medical Women's Association (AMWA) has an information packet on gender equity. They also have a position statement: Gender Discrimination and Sexual Harassment www.amwa-doc.org

The American Medical Association (AMA) has published *Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures.* www.ama-assn.org

Martha Langelan. *Back Off! How to Confront and Stop Sexual Harassers.* Simon & Schuster, Fireside, 1993. Contains excellent and practical suggestions for recognizing and dealing assertively with sexual harassment and harassers.

If you are experiencing any workplace difficulties and are isolated from other members of your gender, race, national origin, religion, or sexual orientation, look for a support group to discuss the difficulties and see what solutions have been successfully employed by others.

American Association of Women Emergency Physicians (AAWEP) section of ACEP www.acep.org/1,4249,0.html

National Medical Association (NMA) www.nmanet.org 202.347.1895

The Gay and Lesbian Medical Association (GLMA), www.glma.org 415.255.4547

These as well as local medical societies related to national origins, or religiously oriented medical societies, are good places to begin your search.

Critical Incident Stress Debriefing

Richard M. Goldberg, MD, FACEP

What are Critical Incidents?

Critical incidents are any traumatic events that have sufficient emotional power to overcome the usual coping abilities of people exposed to them. Typical critical incidents that involve emergency personnel include serious multiple-casualty incidents, injuries to or deaths of children, line-of-duty deaths, injuries to emergency personnel, events with excessive media interest, and events involving victims known to emergency personnel.

Most emergency personnel will experience some degree of acute or delayed stress reaction, which is manifested by cognitive, emotional, physical, or behavioral side-effects. In most instances and for most individuals, these effects resolve with time. However, when an incident is extremely powerful or well outside the range of human experience, post traumatic stress disorder may develop.

What is Post-Traumatic Stress Disorder

Post traumatic stress disorder (PTSD) refers to a prolonged, sometimes permanent abnormal emotional reaction to a critical incident. Primary characteristics of PTSD include the following:

- Exposure to a sufficiently disturbing event
- A continual reexperiencing of the event in thoughts, dreams, or daily life
- An avoidance of any stimuli associated with the event
- A sense of numbness of one's own emotions
- Cognitive, emotional, physical, or behavioral signs and symptoms that were not present before the event and that have lasted longer than one month.

Associated symptoms often include loss of memory of important aspects of the event, loss of interest in activities previously enjoyed, feelings of detachment and estrangement from others, loss of loving feelings toward others, sleep disturbances, difficulty concentrating, intense irritability, and loss of emotional control.

Critical Incident Stress Debriefing

The concept of critical incident stress debriefing (CISD) has evolved over the past 20 years based on the combined experiences and influences of a variety of military police and emergency medical services and disaster personnel. The two main goals of CISD are to lessen the impact of distressing critical incidents on personnel exposed to them and to accelerate recovery from such events before stress reactions occur.

The debriefings are structured group meetings that emphasize ventilation of emotion and discussion of other reactions to a critical event. The meetings typically progress through the following seven phases:

- Introduction phase – Team leaders stress that the process is confidential, voluntary, and safe.
- Fact phase – Objective details of the incident are discussed.
- Thought phase – Members of the group discuss their first thoughts during the incident.

- Reaction phase – Participants are asked to discuss their emotional reactions.

- Symptom phase – Participants describe any cognitive, physical, emotional, or behavioral symptoms.

- Teaching phase – Participants are given information on resources available for dealing further with their stress.

- Reentry phase – Plans now have a variety of resources capable of providing CISD. Community hospitals often have employee assistance programs that can be used for debriefing purposes. Formal CISD teams also may be available through local EMS agencies, fire and police agencies, and local Red Cross chapters.

Additional Resources

American College of Emergency Physicians
Emergency Medicine Practice Department
PO Box 619911
Dallas, TX 75261-9911
800.798.1822

International Critical Incident Stress Foundation
5018 Dorsey Hall Drive, Suite 104
Ellicott City, MD 21042
ICISFs hotline to request a debriefing team in an emergency situation: 401.313.2473.
www.icisf.org

Center for Professional Well-Being
21 West Colony Place, Suite 150
Durham, NC 27705
919.489.9167
www.cpwb.org

Communication, Conflict Resolution, and Negotiation

Louise B. Andrew, MD, JD, FACEP

Effective communication is probably the most essential skill for any physician to master, yet it is not taught in most medical schools and certainly not in residency programs!

What are the essential elements of effective communication?

- First, any communication must actively engage two or more individuals. There must be a give-and-take of information or ideas, which each party can recognize as such.
- Second, effective communication must be clear and unambiguous, so that both parties could articulate the basic points communicated.
- Third, effective communication must result in some change on the part of one or both parties: usually either acknowledgement or action.

Effective communication is more likely to occur when there is some mutual regard between the parties. In the physician-patient interaction, the physician usually is vested with authority by virtue of position. Although patients may listen to any health care provider, for effective communication to take place, the physician must also show respect for the patient and concern for the patient's problem, something which is not always easy to do in a busy ED! Studies have shown that the average physician interrupts the patient less than 30 seconds after they begin speaking, often breaking the patient's train of thought. On the other hand, if the patient is allowed to finish speaking at that initial contact, the story will almost always end within 60 or 90 seconds. During that time, the true cause for the patient's problem is quite often revealed.

Unfortunately, even the language in which physicians are trained is not understandable to most lay persons. The inadvertent (but very widespread) use of "medicalese" may cause the patient to think that the doctor really doesn't care whether or not the patient understands. Therefore, patient communication must be in layman's language. It may be worth practicing some of your more common explanations of emergency conditions and treatments with your family to test your understandability. Written communications, such as discharge instructions, should be at the 5th to 6th grade reading level.

When communication is not effective, the likelihood of misunderstanding and conflict is compounded. Conflicts often result from the miscommunication. Conflict in the ED can also result from a mismatch in expectations of the ED encounter on the part of patient and provider. This may be fueled by ineffective communication, misperceptions by the patient or physician conduct affected by illness or overwork, or for a variety of other reasons. Conflict in the ED can be difficult to manage because so many hospital departments must interface efficiently to result in a satisfactory patient encounter. As a result, the emergency physician or nurse who is thrown into the conflict may feel helpless to change the situation which is causing the conflict. It takes a lot of maturity to accept the anger of a patient or family for a situation which you feel is wrong, but you feel powerless to change. Rarely, however, is there nothing which can be done to respond and create service recovery. As more control is denied to physicians by laws, regulations, and administrators, this is a skill which is becoming critical to survival in emergency medicine.

Successful conflict resolution requires the use of effective communication skills. The most important aspect of these skills as applied to conflict resolution, is the willingness to listen fully to the concern of the other party to the conflict, without interrupting or mentally preparing for a retort. Paraphrasing the communication back to the complainer, and expressing a willingness to find a common ground, in itself, can help to resolve conflict. This is often true, because the **conflict is often generated and always escalated by the fear of one party that their concern will not be heard or validated.** This may be captured by the concept of the "4 As."

- Acknowledge the conflict – "I understand your concern, I can tell that you are not pleased with what has taken place."
- Apologize – a blameless apology – "I'm sorry this situation occurred."
- Actively listen to the concern – "Please go on, I want to hear more about this."
- Act to amend – "I promise I will do my best to fix this situation and make certain it doesn't happen again to someone else."

If active listening, acknowledgement, and validation are not effective, bringing in a neutral third party such as a patient advocate or nursing supervisor may be. Finding a common ground within the conflict can also be effective, as can soliciting the support of the offended party in finding a solution. An example of the former would be empathizing with the patient that the lab results or consultant access are delaying their disposition. An example of the latter includes placing a complaining staff member in charge of a committee to address the problem. Avoidance of the conflict should be a last resort, since it does nothing to solve the problem and may allow it to fester and increase. Unfortunately, however, physicians have a tendency by disposition and training to avoid and compartmentalize conflict; therefore, jumping into the fray may require breaking a lifelong strategy which has previously seemed successful.

Negotiation skills differ from conflict resolution in that both parties enter into the negotiation with some hope or expectation of a positive outcome. Otherwise, the principles are very similar. Theoretically, therefore, negotiation should be easier than conflict resolution. However, negotiation is another skill which is not taught in medical schools, and spending prime early adulthood years in a regimented training program deprives physicians of the opportunity to learn and practice negotiation skills.

Resources

Several useful books on this subject include:

Fisher R, Ury W. *Getting to Yes. Negotiating Agreement Without Giving In.* 2nd ed. Penguin USA; 1991.

and its far more readable sequel:

Ury W. *Getting Past No: Negotiating Your Way from Confrontation to Cooperation*. Bantam; 1993.

Covey SR. *Seven Habits of Highly Effective People*. 1st Ed. Simon & Schuster; 1990. which provide a basic overview and suggested techniques for developing your negotiation skills.

Hellstern RA. *Managing the Emergency Department: A Team Approach*. Dallas, Tex: American College of Emergency Physicians; 1992. Has several useful chapters on conflict resolution, team building and team psychology.

Conflict Management, Prevention and Resolution in Medical Settings. *The Physician Executive.* 1999; 35:38-42. Contains examples on handling interprofessional conflicts in a group or hospital setting.

An excellent guide to patient communications can be found in:

King ME, Novik L. *Irresistible Communications: Creative Communication Skills for the Health Professional*. WB Saunders; 1997.
Unfortunately, this book is out of print, but you may be able to find it at online book sites or in a medical library.

ACEP offers educational courses on Negotiation and Conflict Resolution at many conferences and symposia.

Regardless of how you acquire your communication, negotiation, and conflict resolution skills, they will continue to serve you on a daily basis in all aspects of your life.

Wellness for the Emergency Medicine Resident

Dawn M. Ellison, MD

Residency is a time of tremendous personal and professional growth. As new physicians, residents must become intimate with the processes of birth, illness, and death. They must learn a phenomenal number of new skills and assume, for the first time, near total responsibility for the care of their patients. Because of the elements of responsibility, uncertainty, and change, this personal development is very stressful no matter what the field. Emergency medicine residents have special stressors unique to their specialty. For instance, they must learn to function within a system that is usually geared to the needs and desires of other residents who are primarily responsible for inpatient care. They must learn to practice with an incomplete database on an unknown patient population, the size of which can vary dramatically from day to day or even minute to minute. Decision-making requirements may shift instantaneously from the trivial to the immediately life-threatening, and supervisors and teachers may change from one patient or shift to the next.

Because of the steady flow of patients in most emergency departments and the limited numbers of residents in emergency medicine residencies, absences from duty even for very legitimate reasons are immediately obvious and threatening to fellow residents. In the "fishbowl" environment in which we practice, we are plagued by concerns about second-guessing from admitting physicians or referring physicians and we are aware of the threat of litigation that accompanies every patient decision we make. Residency is rarely considered a time to learn wellness skills. And yet we must begin to learn them now, if ever.

What is resident wellness? It is akin to physician wellness, with a very important caveat/difference (sometimes a bane, sometimes a blessing): residents are, in a very real sense, still students.

Emergency Medicine Residency is Stressful

Research clearly indicates that emergency medicine residency is stressful. Emergency medicine residents have been said to have the highest level of drug use among house officers.[1] Sleep deprivation, excessive patient loads, high patient mortality, dealing with uncompromising attending physicians, and peer competition are commonly perceived sources of stress.[2] Women resident report more stress than men and unmarried residents more stress than those who are married.[3] Married women, however, gain less support from spouses, are plagued by conflicting roles and obligations, and may be more stressed by the lack of personal time than men.[4] Pregnant residents are found to have higher rates of stillbirths and pre-term labor than the general population.

Emergency medicine residents are somewhat unique among residents in that their duty often requires them to make demands on the time of other residents. Simply communicating the fact of an admission to a receiving resident who perceives himself as overworked can precipitate a barrage of abuse. When working in an outside environment (and sometimes even in their own emergency department), emergency medicine residents must compete with other residents for procedures and other learning opportunities. Because most residents have had few outside work experiences, they usually do not have the negotiation skills necessary to accomplish learning objectives in a competitive environment. Because of the relative youth of the specialty, even emergency medicine faculty are often low in hospital hierarchies and

inexperienced in hospital politics, so residents may feel at a loss for advocates or mentors in the negotiation process.

Ironically, the shift work that is envied by residents of other disciplines has many drawbacks. In a busy ED (common to most residencies), the resident has no time to rest, socialize, or study, even at night. Disruption of circadian rhythms then limits participation in didactic sessions, which are nearly always held during the day. The camaraderie that develops between residents of other specialties because of teamwork may not be possible in emergency medicine residencies unless there is multiple coverage of clinical areas by residents. Isolation from other sources of social support caused by geographic distancing and scheduling also increases stress levels.

ED patients, however interesting, are generally not sources of resident physician satisfaction, because there is rarely time to establish a relationship with one. And ED staff, particularly nursing staff, can be perceived as threatening because of their clinical experience and impatience with the resident learning process.

How Can Residencies Promote Resident Wellness?

Think of residents as extremely motivated adult learners who are a valuable source of information on how to optimize the educational experience, including time for personal growth. Develop a parental leave policy, temporary disability policy (including paid replacements for sick residents), and a circadian scheduling policy.

Above all, the schedule must be perceived as fair. Publicize the equitable distribution of nights, weekends, and holidays. Whenever possible, consider personal preferences and circadian rhythms in designing schedules.

An efficient, supportive, and cooperative ED staff will effectively improve resident wellness. Allow residents to be involved in decisions regarding the functioning of the department, and at the very least, keep them informed of such decisions. Nurse and physician workshops discussing roles and expectation can be enlightening for all. Adequate staffing (physician, nurse and ancillary) and clear goals and defined responsibilities are of utmost importance.

Include wellness topics in the curriculum, such as communication skills, physician impairment, critical incident stress debriefing, and personal practice management. Encourage (and allow time for) patient-specific reading and discussions. Videotape lectures so that night workers can view them when not sleep deprived.

Support groups run by a facilitator can be a safe environment for expressing feelings during a residency.[5] An advisory program within or outside the department can provide mentoring and advocacy. A resident in crisis should be referred for professional counseling, but all resident should have someone to turn to for guidance during a minor upset. Department social events may provide social integration, especially for single individuals geographically displaced from friends and family. In addition, consider gender differences and individual coping styles when helping residents deal with stress.

How Can Residents Promote Their Own Wellness?

Make a personal schedule at least monthly, and try to stick to it. Include time for exercise, hobbies, eating well, visiting with friends and family, and study. Establish reasonable written goals and objectives for your personal and professional growth. Share these with an advisor or mentor. You may find that an advisor outside of emergency medicine, who is not evaluating you, can be most objective with wellness issues. Learn to say “no” to commitments that are not important to you. Get involved in some activity outside of the hospital; something in which you can feel useful and successful.

If you are feeling stressed about an incident, explore all the feelings you experience about it.

Write down these feelings. Reframe the incident, taking into account the perspectives of all the people involved. You will learn much about yourself by doing this. If you are in a crisis, seek out a support group, counselor, or professional advisor. It may be difficult to recognize that you are stressed. Listen to others who tell you that you are.

If there are things that can be changed about the residency, learn to make reasonable requests and negotiate diligently for the changes. Negotiating win-win solutions is a valuable skill of living.

Above all, don't let your MD stand for Master of Delay(ed gratification). Reward yourself appropriately for large and small things learned, both positive and negative. Appreciate the opportunity you have created for yourself in residency, and make all that you can out of it. Enjoy the process.

Conclusions

Emergency medicine residency can be a time of tremendous stress and gratification. It is the responsibility of the residency program to provide a healthy learning environment for the adult learner. It is also the responsibility of the residents to make the most of the opportunity to learn, to address problems that arise, and to care for themselves at least as well as they are learning to care for their patients.

References

1. Hughes PH, Baldwin DC Jr, Sheehan DV, et al. Resident physician substance abuse by specialty. *Am J Psychol.* 1992; 149:1348-1354.
2. Schwartz AJ, Black ER, Goldstein MG, et al. Levels and causes of stress among residents. *J Med Educ*. 1987; 62:744-753.
3. Kelner M, Rosethal C. Postgraduate medical training, stress and marriage. *Can J Psychol*. 1986; 31:22-24.
4. Whitley TW, Gallery ME, Allison ED, et al. Factors associated with stress among emergency medicine residents, *Ann Emerg Med.* 1989; 18: 1157-1161.
5. Brashear DB. Support groups and other supporting efforts in residency programs. *J Med Educ.* 1987; 62:418-424.
6. Pinhas-Hamiel O, Rotstein Z, et.al. Pregnancy During Residency-An Israeli Survey of Women Physicians. 1999.
7. Nahrwold DL. Toward a Better Residency. *J Laparoendosc Adv Surg Tech*. 1998; 8(6):355-359.

The Adult APGAR: An Instrument to Monitor Wellness

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Introduction

There is a growing awareness of the problem of physician impairment. Much has been written defining the problem,[1,2] quoting prevalence data[3,4] in practicing physicians, students and residents;[5,6] and describing intervention and recovery programs.[7,8] Articles describing strategies for prevention are not uncommon, and the Center for Professional Well-Being (CPWB) www.cpwb.org, founded in 1979, is dedicated to focusing on physicians' emotional health, burnout, stress control and impairment prevention. John-Henry Pfifferling, PhD, Director of the CPWB, in an excellent review of behaviors that can reduce physician distress and help promote an enhanced quality of life, stated that "We all lose if this epidemic of self care deficits persists."[9]

But how does the physician know when he or she is in trouble? Does one have to wait for burnout, be fired, to lose a license for drug or alcohol abuse, to be sued for malpractice, to be served divorce papers, or to develop an ulcer or angina? Unfortunately for most, the preceding events are what herald the impaired physician. "Overwork" is the most common excuse physicians use for everything from neglecting self and families, to rationalizing chemical coping behaviors, usually preventing them from reaching out for needed help. Thus, the image of a "busy" physician making time to evaluate wellness with a 17-page, 12-section Wellness Index,[10] or Minnesota Multiphasic Personality Inventory (MMPI),[11] is not only amusing but unrealistic. Burnout self-appraisals[12,13] and job stress indices and similar self-evaluations are available in various forms but do not cover global wellness.

The Adult APGAR is a brief, self-scoring instrument designed to assist physicians in assessing and monitoring their wellness status. The acronym APGAR was chosen, not only because physicians are familiar with a similarly structured evaluation of newborns, but also because it has predictive value of wellness impairment. The statements 1 through 5 are designed as much to educate as to score and monitor.

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

The Adult APGAR

	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 well-being – 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 well-being.

Scoring

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

References

1. Wasserberger J, Ordog GJ. Is emergency medicine built to self destruct by 1992? *Ann Emerg Med.* 1986; 15(5):603-604.
2. Keller KL, Koenig HJ. Sources of stress and satisfaction in emergency practice. *J Emerg Med*. 1989; 7(3):293-299.
3. Brewster JM. Prevalence of alcohol and other drug problems among physicians. *JAMA*. 1986; 255(14):1913-1920.
4. Zun L, Kobernick M, Howes DS. Emergency physician stress and morbidity. *Am J Emerg Med*. 1988; 6(4):370-374.
5. Gallery ME, Whitley TW, Klonis LK, et al. A study of occupational stress and depression among emergency physicians. *Ann Emerg Med*. 1992; 21(1):58-64.
6. Hughes PH, Conard SE, Baldwin DC Jr, et al. Resident physician substance use in the United States. *JAMA.* 1991; 265(16):2069-2073.
7. Vanderberry RC. North Carolina Physicians Health and Effectiveness Program. The first full year. *N C Med J*. 1990; 51(7):347-349.
8. Hall KN, Wakeman MA, Levy RC, et al. Factors associated with career longevity in residency-trained emergency physicians. *Ann Emerg Med*. 1992; 21(3):291-297.
9. Pfifferling JH. Things I wish they taught in medical school. *Resid Staff Physician.* 1990;36:85.
10. The WELLNESS Index. Alberta Center for Well-Being. 12245 131st ST, Edmonton Alberta, Canada T5 L1 M9.
11. Minnesota Multiphasic Personality Inventory (MMPI-2). University of Minnesota Press. http://www.upress.umn.edu/ 800.627.7271.
12. Pfifferling JH. Burnout Self-appraisal. Center for Professional Well-Being. Durham, NC. www.cpwb.org
13. Maslach C, Jackson SE, Leiter MP. *Maslach Burnout Inventory*, 3rd Ed. Consulting Psychologist Press. Palo Alto, CA. 1996.