

minnesota MEDICINE

Battling **BURNOUT**

Physicians recognize the importance of well-being

ALSO INSIDE:

Demystifying
Mindfulness

To Cry or Not
at the Bedside

Dealing with
Disruptive Docs



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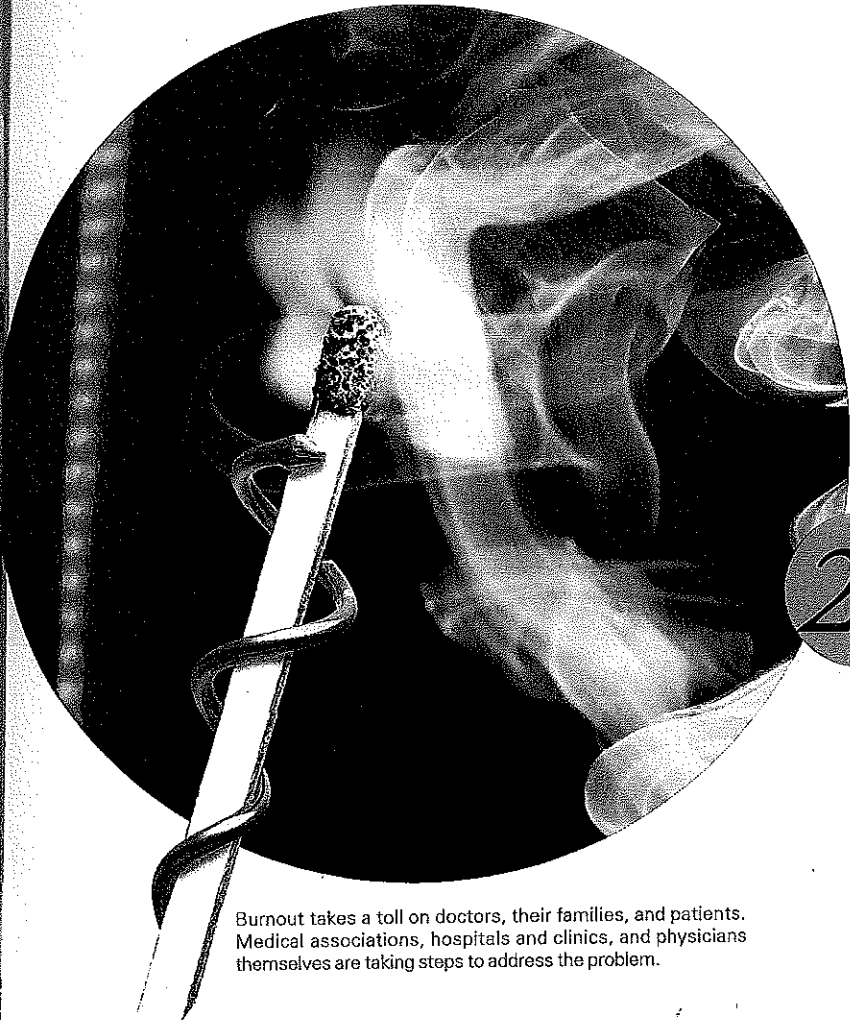
The MMA recognizes physician well-being as an important component of professionalism.

To read more on the topic, go to
www.mnmed.org/PhysicianWellBeing



JANUARY 2011

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Minnesota Medicine, 1300 Godward Street,
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 612/378-1875 or 800/DIAL MMA
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Photo by Scott Walker

Playing hurt may work in the NFL, but it is inappropriate in the clinic or operating room.

Working on Wellness

The doctor was clearly not getting the job done. Always meticulous, his notes were still exhaustive—when he got them done. But the charts piled up for weeks. Warnings from the billing office received well-intentioned reassurances from him. His partners first encouraged him, then chided him, then gave him deadlines. His normal late afternoons now stretched into later nights as he tried to get his work finished. He was irretrievably behind when he found out his hemoglobin was 5 gm.

Medicine is tough work. It takes mental and physical stamina to survive medical school and training. In most settings, practice requires mental agility and physical endurance to track and manage the deluge of data that is the coinage of medical practice. Illness undermines doctors' performance. Try listening to a patient's history while suffering the diffuse myalgias of influenza. Try tackling a stack of phone messages with the cloud of depression distracting your every thought. Try dictating office notes from last week with a hemoglobin of 5. Physicians need to be on top of their game to do the job.

As physicians, we learn about DNA structure and cranial nerves in medical school and diagnosis, treatment, and procedures in residency; and we emerge from two decades of schooling as superbly trained professionals, our heads crammed with knowledge and wisdom about keeping people well. Yet somehow, many of us haven't finished grade school when it comes to keeping ourselves well. In fact, some of our training was anti-wellness, with 48-hour workdays as the acceptable standard and generations of physicians indoctrinated with the macho ethic of "I'm the only one who can do it, so I have to be there." The message: Ignore your sleep deficit and battle your foggy mind, all for

the "good" of the patient.

When docs surfaced from training and entered practice, they carried their dysfunctional habits with them, driving body and mind in the name of dedication to patient and practice. Nobody had taught them to pay attention to their own bodies for signs of illness. Nobody had mentioned what burnout was or felt like. They listened to their patients but not to themselves.

Thankfully, that is changing. Realizing that fatigue is dangerous to patient and physician alike, the Accreditation Council for Graduate Medical Education placed caps on resident work hours a few years ago. Learning to mind their minds and their bodies, medical students are now pursuing approaches to their own wellness with the avidity they once marshaled for the MCATs. Listening to their bodies and hearing a chorus of groans, practicing physicians have restructured their lives in order to decompress. And hoping to yank physician burnout and depression out of the closet, the MMA and other physician organizations are highlighting it as one of the perils of practicing medicine. Playing hurt may work in the NFL, but it is inappropriate in the clinic or operating room.

When I was selecting an internal medicine residency, I visited a highly touted program notorious for the hours demanded of its residents. At the time I visited, the call rotation was five out of seven nights. When I asked one of the residents what he thought of the schedule, with a bit of a swagger, but through clenched teeth, he said, "We love it." Hopefully, the day of such macho self-flagellation and the day of pressing on with work despite a hemoglobin of 5 is past.

.....
Charles R. Meyer, M.D., editor in chief,
can be reached at cmeyer1@fairview.org

Editor's Note: Minnesota Medicine received the following letter regarding MN Community Measurement's quality-reporting requirements and their effect on groups that participate in federal comparative effectiveness research. We asked MN Community Measurement to respond. Here is the exchange between Barbara Yawn, M.D., from Olmsted Medical Center and officials from MN Community Measurement.

A Problem of Rigidity

Measuring and reporting quality metrics has become a goal for many payers, employers, and public-interest groups.^{1,2} The idea being that if we publicly report some type of quality indicator, all health care groups will strive for higher scores and, therefore, achieve better outcomes.³ MN Community Measurement was one of the first organizations to convince large and small health care groups to report outpatient quality metrics. Their work has been held up as an example to be emulated on a national level.⁴

The metrics MN Community Measurement uses are designed by a group of practitioners in the state who review and approve them with limited expert support on evidence-based reviews. MN Community Measurement puts the metrics in a standardized format. Clinics then collect data and send that information to MN Community Measurement for analysis and publication. Because of the connection between publicly reported metrics and pay-for-performance programs, the metrics drive the standard of care in our community for several chronic conditions.

Recently, the pressure to use these metrics and the unwillingness of MN Community Measurement to waver from them has led to a significant problem in carrying out fed-

erally funded comparative effectiveness research. Two examples illustrate this point.

One case is a study of decision aids for patients with diabetes funded by AHRQ under the R34 mechanism (R34 – 5R34DK084009). The decision aids provide patients with information regarding the risks and benefits of daily aspirin therapy. The risk-to-benefit ratio presented was based on the latest evidence from the medical literature and led several patients without diagnosed cardiac disease to refuse daily aspirin therapy. MN Community Measurement does not take patient preference into account. The publicly reported metric is simply the number of patients with diabetes who appear to have been prescribed daily aspirin according to medication records review.⁵

Before participating in this study, physicians had compliance levels of 60 percent to 80 percent. When using the patient decision aids, they had levels of less than 40 percent. For some who were participating in pay-for-performance programs, these scores resulted in a salary decrease. In addition, during the year of the study, evidence became available that aspirin indeed did provide more risk than benefit for people with diabetes who did not have known cardiovascular disease. However, the metric did not change and, thus, rewarded care that was

not evidence-based and did not meet the recommendations of several national groups including the American Heart Association.^{6,7}

In the second case, the Agency for Healthcare Quality and Research funded a five-year \$2.5 million study (1R01HS018431) on the comparative effectiveness of older asthma control tools listed in the 2007 NAEPP guidelines (eg, ACT) with newer tools shown to improve outcomes in primary care settings. Sites randomized to the newer tools would fail the asthma metric set by MN Community Measurement since they only approve of tools mentioned in the 2007 guidelines. Several practices in Minnesota and one in Wisconsin felt they could not participate in the federal study because of the poor scores they would receive on the publicly reported asthma metrics and the resulting decrease in reimbursement they would receive if they were randomized to the group using the new tools. A formal request was made to MN Community Measurement to provide a waiver to those participating in the study. The request was refused with the comment "We do not want to block research, but we will only accept the asthma control measures approved by the guidelines."

There are two unintended consequences of the rigid MN Community Measurement process. It is blocking research, and, in the case of the diabetes study, it is continuing to support inappropriate care. The asthma and diabetes studies will go forward, but the work will have to be done in other states. Is this what we want

for quality improvement in Minnesota?

The potential solutions seem clear. First, MN Community Measurement needs to provide a waiver to practices that participate in large federally funded comparative effectiveness studies, especially when they compare the tools used in older approved metrics with newer ones. And second, when evidence becomes available that a metric may be supporting harmful interventions, it needs to review the data and if they appear to warrant closer evaluation immediately state that the metric in question will not be assessed or reported that year. And it needs to allow Minnesota practices to do what this quality program professes to do: support the provision of evidence-based high-quality care and allow practices to help determine comparative effectiveness.

To encourage MN Community Measurement to move forward, I urge researchers, quality advocates, and payers to make this a public issue. Since the organization was founded on the belief that public reporting will move quality forward, they should also believe in publicly discussing their quality-assessment processes. Quality metric reporting and pay for performance should not block federally funded quality research or innovations in care.

Barbara P. Yawn, M.D., M.Sc.
Director of Research
Olmsted Medical Center

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MN Community Measurement Responds

Dr. Yawn is certainly correct that Minnesota has been a leader in using quality metrics to support improvement in care for people in our community. We have seen significant improvement in the results for many of our measures over the last several years. Medical groups across the state have worked to both standardize processes and redesign care to improve results. To support quality improvement, we believe that our measures should be based on the latest evidence, evaluate patient outcomes and not just processes of care, be as inclusive as possible of all patient populations, be standardized and aligned across the community in order to have

the greatest impact, and be developed and updated using a multi-stakeholder process supported by clinical experts.

Dr. Yawn's example of changes in the science of diabetes care actually shows how these principles can work to ensure that measures are up to date. In 2010, the Institute for Clinical Systems Improvement and the American Diabetes Association changed their recommendations for use of aspirin therapy in diabetes care based on new evidence. MN Community Measurement's technical advisory committee, which included experts in endocrinology, family medicine, and internal medicine, recommended that the measure be changed to require aspirin use only in those patients with ischemic vascular disease. This

change will go into effect for 2011. Since the measure is based on 2010 dates of service, we are able to keep the measure aligned with the timing of the change in the guideline.

The asthma care study referenced by Dr. Yawn presents another interesting issue: How should we address patients involved in clinical trials? In 2009, MN Community Measurement formed a technical advisory committee to develop a new asthma care measure that would go beyond our former HEDIS measure on appropriate use of medications. The new measure includes assessment of asthma control using standardized tools, assessment of asthma risk using patient-reported emergency room visits and hospitalizations, and use of a written asthma action/

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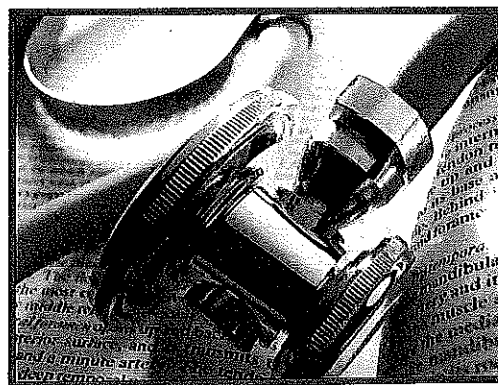
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management plan.

To assess asthma control, the committee approved the use of three standardized tools that have had extensive validation. One of the gaps in care that the committee identified was the lack of consistent use of these standardized assessment tools in our community. Dr. Yawn recommended to the committee that another assessment tool, the Asthma APGAR, which she proposes to use in the federally funded research project, should also be included. After much consideration, the committee felt the APGAR tool did not have enough validation to be included in a standardized measure for public reporting, but it could be reconsidered once additional evidence was obtained. This recommendation was also reviewed and accepted by MN Community Measurement's Measurement and Reporting Committee and Board of Directors, submitted for public comment, and then accepted as part of the Minnesota Statewide Quality Reporting Rule submitted for 2011.

We believe our first priority is to encourage greater use of tools and processes such as those in the asthma measure that have already been documented to improve care. Clinicians participating in clinical trials should consider incorporating validated instruments for testing their experimental tools and processes. The stan-

dardized tools are easy to use and will not hinder new studies of clinical efficacy. One of the benefits of MN Community Measurement is that it allows health care sites to be compared using measures that can be applied to all eligible practices. That way, we can identify processes that can be widely adopted to improve patient care. Participation in clinical research, while commendable, should not constitute grounds for exemption from measuring performance using standardized and validated instruments. If this were to be a rule, all clinical sites that participate in clinical or academic research could claim exemption.

Jim Chase
President
MN Community Measurement

Beth Averbeck, M.D. and
Linda Walling, M.D.
Co-chairs
Measurement and Reporting
Committee

Kaiser Lim, M.D.
Asthma Technical Advisory
Committee
MN Community Measurement

CORRECTION

The author of the article "Therapeutic Musculoskeletal Injection: What Is Current Practice? What is the Evidence?" in the December 2010 issue is James E. (Jamie) Peters, M.D., not James E. Peters, as we incorrectly printed. We apologize for this error.



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Medical Students Study Break

Kathleen Pladson realized during her first year of medical school that she needed to take better care of herself. “I was feeling stressed out during anatomy,” she recalls, noting that she wasn’t taking time to exercise, eat right, or simply have fun. She decided she needed to do something to change that if she was going to get the most out of her medical school experience

and avoid becoming burned out. So when Pladson discovered a medical student well-being group at a student activities fair, she signed up.

Now a second-year student at the University of Minnesota Medical School, Pladson is president of the group. About a half-dozen students help plan events designed to promote a sense of community

and to bring balance to lives that otherwise might be consumed by academics. In recent years, they have written a cookbook and sponsored an evening with massage instructor Sister Rosalind Gefre.

Last year, the group sponsored a canoe trip on the Mississippi River and workshops on emotional shifting, a technique for substituting a negative emotional response for another more positive one, and identifying personal strengths. This month, medical students are collaborating with other students from the schools within the Academic Health Center on Mental Health and Medicine Week. During a workshop that week, they will portray people with depression to illustrate the different ways it can manifest. The group is also planning open-gym, bowling, and dance nights, and another evening of massage. More information is available at www.meded.umn.edu/wellbeing.

Pladson says the activities are designed to be fun and to encourage students to be mindful of wellness. “It’s important for them both professionally and personally,” she says, “to avoid burn-out.” —Carmen Peota



Photo courtesy of Kathleen Pladson

A canoe trip on the Mississippi River was one of the activities sponsored by a wellness group for University of Minnesota medical students last year.

Integrative Medicine

Mindfulness in the ER

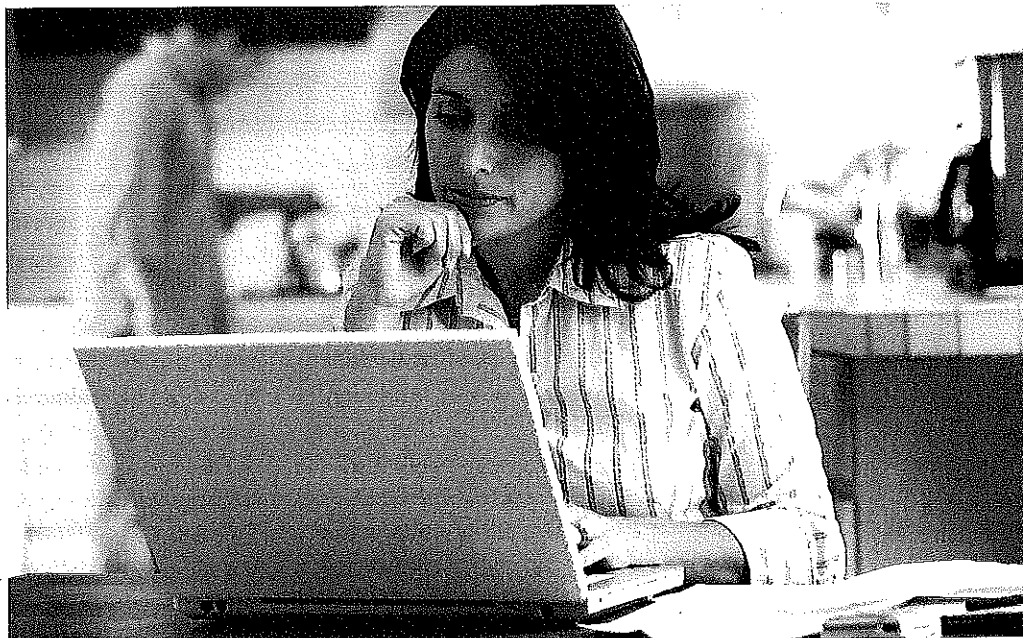
When emergency medicine physician Laurie Drill-Mellum, M.D., first decided to study integrative medicine at the University of Arizona two years ago as part of a Bush Foundation fellowship, it was because she wanted to find new ways to help her patients at Ridgeview Medical Center in Waconia. Drill-Mellum had noticed that an increasing number were coming to the ER complaining of depression and anxiety or with problems related to chronic conditions. “What we’ve traditionally offered, giving them a pill or

doing a procedure, wasn’t enough,” she says. She wanted some new tools to use with them.

Drill-Mellum was surprised to discover how relevant one of those tools—mindfulness—was to her professionally. She realized that the state of awareness and focus it brought was exactly what was called for in the Comprehensive Advanced Life Support (CALs) classes she taught. One of the basic tenets of CALs is to pause for a moment before responding, she says. “They’re not calling it mindfulness, but

what they’re doing is ... taking a calming approach instead of a frenzied approach,” she says. “In a frenzied environment, care becomes scattered and inefficient.”

Now Drill-Mellum says that when she feels the energy level in the ER mounting, she’ll stop and remind her colleagues to take a deep breath in order to settle before acting. “When you’re taking care of someone who’s critically ill, as a leader, you need to be able to focus and focus your team.” —Carmen Peota



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Whether in person or online, spouses of physicians need to support one another.

Medical Marriage

The Importance of a Happy Home

Last May, members of the West Metro Alliance, Hennepin County's organization for physician spouses, gathered at the Interlachen Country Club in Edina to celebrate the organization's 100th birthday. Shortly after the event, the leaders of the group began disbanding it. With an aging membership, "the leadership just wasn't there," says Dianne Fenyk, a longtime member and current co-president of the statewide MMA Alliance.

Fenyk says demographic changes (many more women going into medicine) and cultural shifts (many more two-career households) made the group less viable than it once was. But, she says, the organization was a vital part of its members' lives for many years not only because it provided an opportunity to work on public health issues but also because it functioned as a *de facto* support group. "We all had the same kinds of issues," she says. "Our spouses would be involved with their patients. Sometimes the family came second. We all learned to accept it. But it was nice to talk to someone about this."

Fenyk, who is married to John Fenyk, M.D., a dermatologist who had his own private practice for 25 years and is now a professor at the University of Minnesota,

became especially interested in the issue of the medical marriage. While attending an AMA Alliance meeting in Chicago a number of years ago, she was introduced to the work of Wayne and Mary Sotile, psychologists who'd identified stresses faced by couples when one is a physician. The ideas they shared resonated so deeply with Fenyk that she eventually developed a talk on medical marriage that she has given at various Alliance gatherings.

Fenyk emphasizes that the unique challenge in a medical marriage is that patients have to be the priority for the physician. "The only other profession that's somewhat similar is that of a minister or pastor, whose congregation members often come first," she says. "It really is important that everybody in the family is comfortable having the same priorities and understanding why."

She believes that physicians and their spouses need to pay attention to their marriage because it can affect the physician's performance. "It started to dawn on me that a healthy home life makes for a happier physician and that leads to better medical care because then the physician can focus on the patient," she says.

Fenyk says she'd tell young people

Support for Young Spouses

In her talks about the medical marriage, Dianne Fenyk advises spouses of physicians to support each other. Although this can still be done in person, it's now also possible to find support online. Here are a few websites:

Mrs. MD ([//mrsmd.wordpress.com/about/](http://mrsmd.wordpress.com/about/)), a blog for medical wives that claims to be "where women who happen to be married to doctors or docs-to-be gather to share the joys and challenges of living a medical marriage."

The AMA Alliance Young Member Connection (physiciansintraining.blogspot.com/2009/04/medical-marriage.html), a site for medical students, residents, and their spouses.

The AMA Alliance's "Personal Space" section of its website (www.amaalliance.org/site/epage/77832_625.htm), which is dedicated to the well-being of medical families.

simply to "accept your partner for who they are. The profession they've chosen," she adds, "is part of who they are." —Carmen Peota

Invisible Disabilities

Med School Tackles Hidden Problem

The University of Minnesota Medical School is in the midst of a three-year effort to raise awareness about and improve the climate for medical students and residents with invisible disabilities, in particular psychiatric conditions, attention deficit disorder, and learning disabilities. The project Taking It to the Next Level: Advancing Awareness and Equity of Medical Trainees with Invisible Disabilities was launched in September of 2009 with a \$75,000 grant from the Marcus Foundation.

As a first step, staff from the medical school and the university's Disability Services office held focus groups consisting of medical students, fellows, residents, and faculty to find out how invisible disabilities affect trainees and the medical school as a whole, and what changes might be made to improve the environment for all. The university plans to hold a faculty training session that will feature Michael Myers, M.D., vice chair of education and director of training in the department of psychiatry and behavioral sciences at State University New York–Downstate, on promoting mental health, resilience, and success in medical trainees.

Marilyn Becker, Ph.D., director of learner development for the medical school and the principal investigator for the grant, says she hopes these activities will reduce the stigma around mental illness, attention disorders, and learning disabilities and that the medical school community can come to see these conditions as differences that enrich the educational environment.—Carmen Peota



Studies have shown that residents are at high risk for automobile accidents because of sleep deprivation.

Drowsy Driving

Asleep at the Wheel

Driving while intoxicated, speeding, and not wearing seat belts are among the most dangerous things one can do behind the wheel. Almost as risky, but likely even more prevalent, is driving while drowsy.

In a telephone survey conducted last spring, AAA found that 41 percent of U.S. drivers admit to having fallen asleep while driving at some point in their lives. Eleven percent said they'd done so in the past year and 3.9 percent in the past month. AAA estimates that drowsiness is a factor in 16 percent of auto accidents that result in a fatality.

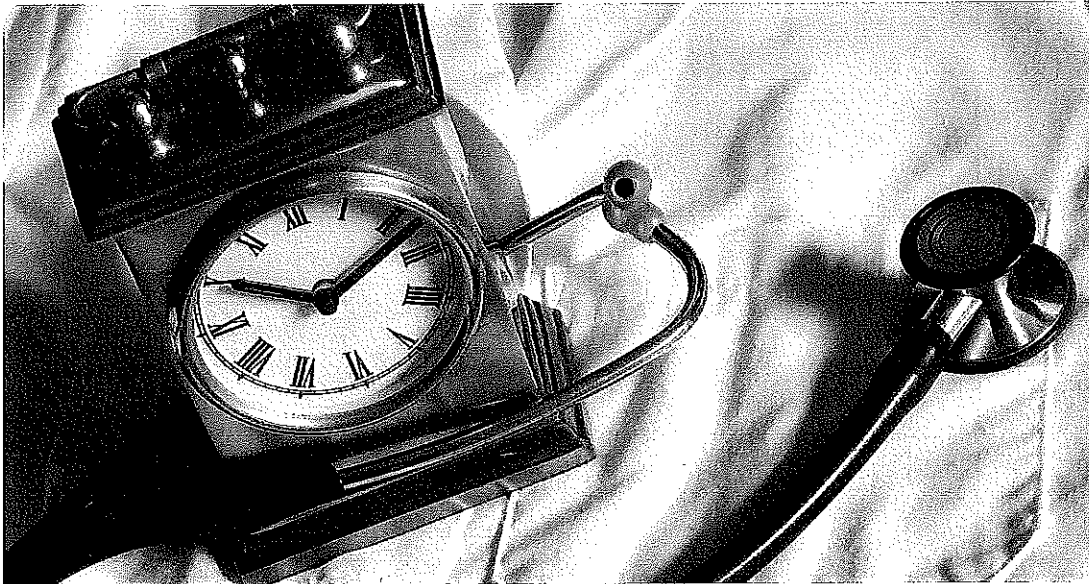
Physicians, particularly residents and interns, are among the groups the National Highway Traffic Safety Administration considers most at risk for drowsy driving because they routinely are sleep-deprived. In a 2005 study published in the *New England Journal of Medicine*, Harvard researchers found that the likelihood that interns would have a motor vehicle accident on their drive home after working an extended shift was more than double their odds of having one after a regular shift. And a 2005 study published in the *Journal of the American Medical Association* found that residents who had worked a heavy call schedule were more impaired than controls with a blood alcohol level of 0.05 percent when performing simulated driving tasks.

The National Sleep Foundation's advice: Nap before you navigate.

Part-Time Practice

Scaling Back

For some physicians, reducing the number of hours they work has been the secret to finding a new enthusiasm for medicine.



More and more physicians are choosing to reduce their hours to spend time with family, explore new interests, and have time for themselves.

New Ulm physician Ellen Vancura, M.D., was seeing a patient who was new to her—a developmentally disabled man who had been having repeated pneumonias—when she suddenly felt an uncontrollable sense of panic.

She finished the interview but walked out of the exam room knowing something was wrong. “I didn’t understand what was going on,” she says.

Vancura eventually recognized her problem as burn-out. After decades of working all day in the clinic, following patients in the hospital, then covering the emergency department or taking call at night, she realized she was exhausted. “After 31 years, it was getting to me.”

Vancura went to the medi-

cal center’s administrators and explained how she was feeling. She was granted a 12-week leave of absence in September of 2009, during which they worked out a way for her to lessen her load. “Retirement wasn’t an option for me,” she says, “so I had to negotiate my own slow-down.” Today, Vancura works three days a week and sees between 36 and 40 patients—the vast majority of whom are geriatric (“I have a lot of grandmas,” she says). She also makes rounds at the nursing home.

More physicians than ever are doing what Vancura did—cutting back hours or choosing to work part time. In its 2009 Physician Retention Survey, the American Medical Group Association and Cejka Search found that more physicians are

choosing to practice part time than in the past. The practices that responded, which represent nearly 12,500 physicians in the United States, noted that 21 percent of their practitioners worked part time in 2009—up from 13 percent in 2005. The top reason cited by male physicians for cutting their hours was to take on administrative/leadership duties. The top reason for females: family responsibilities.

In early November, *Minnesota Medicine* asked physicians in an online survey about whether they had reduced their hours and why. Respondents cited numerous factors including wanting to spend more time with family, pursue hobbies and interests, take better care of themselves, and explore new career possibilities.

Digging Deeper

Although their motives vary, the physicians’ responses reveal a common theme: Changes in medicine and the economics behind those changes are affecting their lives—and not for the better. For Vancura, spending less and less time with her patients was wearing on her. “Geriatric patients are very complicated. You cannot get through their issues in 20 minutes,” she says. And the clinic’s move to an electronic medical record system several years earlier made it all the more difficult to see the required number of patients in a day. “It takes us all longer to do our work,” she explains.

Teresa Gurin, M.D., a physical medicine and rehabilitation physician in Minneapolis, wanted more time with her four children—ages 12, 10, and 7 (her youngest are twins). “I’ve always been very family-oriented,” she says. “I’ve had a lot of help over the years, but I decided I really needed to be there to make sure the kids felt loved, did their homework, and that things got done.” But she felt she couldn’t. Financial realities were already making it hard for her to maintain even a three-day-a-week schedule at a Twin Cities clinic, much less scale it back even more. In 2010, Medicare eliminated its codes for consultations. As a result, physicians were required to code such visits as

office visits for new or existing patients—both of which paid less than consultations. “This was approximately a 50 percent reduction in my main source of reimbursement,” says Gurin. “When you work part time, your overhead is high compared with your income, and the overhead was going to be impossible to overcome. I would have had to increase my days at work to cover that overhead and still make a living.”

After working in a rural clinic for four years, family physician Troy Hanson saw a need to educate patients about how to prevent health problems. But he found it impossible to do so. The Belle Plaine, Minnesota, clinic, where he had worked since residency, was chronically understaffed. “I felt like I was putting out fires and running from one crisis to the next,” he says. “I felt depleted and unable to practice medicine the way I wanted to practice it.” Hanson decided to go back to school to earn a master’s degree in public health.

Redesigning Practice

For these physicians, getting what they wanted—whether it was time with family, time for school, or time for themselves—has meant charting a different path. For Hanson, it meant leaving his practice to do locum tenens work in rural clinics and emergency departments—an option that reduced his work hours by 25 percent.

The move allowed him to not only work on a master’s degree in public health at the University of Minnesota but also complete a certificate program in infant and early childhood mental health. Today, he

serves on the state’s advisory council on mental health, is a member of the Great Start Minnesota early childhood development steering committee, is co-chair of the Minnesota Association for Infant and Early Childhood Mental Health, and works at Scott County’s mobile health clinic once or twice a month. “This is allowing me to take a more global perspective on health for my patients and focus more on issues like health promotion and prevention and integrating care from many different disciplines based on a person’s overall need,” he says.

Earlier this month, he began a part-time practice at Sibley Medical Center and Clinic in Arlington—one of the facilities at which he did locum tenens work. He’ll be working in the clinic and doing some emergency department call duty. The schedule will allow him to continue with his other commitments. In addition, the clinic’s administration agreed to let him work on setting up a system to screen kids for developmental concerns and help parents find resources for kids who are identified as having delays or other issues. “They had some interest in at least letting me pursue some of my public health ambitions,” he says.

Gurin also left her practice in order to find a better balance. With a mini MBA from the University of St. Thomas and an entrepreneurial streak (she started her own house cleaning business while in college), she decided to go into practice for herself after she learned about the pending Medicare changes, and in October of 2009 opened the

How Clinics Can Help

Physicians who’ve figured out for themselves that they needed to slow down say clinics could do a number of things to help prevent physicians from becoming burned out. One way they can help is by coming up with strategies to help long-time physicians ease into retirement, says Ellen Vancura, M.D., of New Ulm Medical Center.

Another is to hire more part-time physicians, especially in rural areas, where it’s often hard to find full-time providers. “There are a lot of medical groups where you work full time or you don’t work,” she says.

Another way clinics can help doctors maintain their enthusiasm for medicine is to tap into their strengths and interests. “By looking for ways to benefit from someone’s passions or interests or strengths, your facility can improve the environment for everyone,” says Troy Hanson, M.D., a family physician in Arlington, Minnesota.

Hanson also says clinics should allow physicians time for reflection. “You’re used to giving 110 percent effort 24 hours a day for a long time,” he says, adding that it’s important for physicians to step back and look at the big picture to see whether what they’re doing fits with what they value.—K.K.

Sports Orthopedic Advanced Rehabilitation (SOAR) Clinic in Minneapolis.

Today, she spends two days a week on patient care and also does independent medical exams for insurance companies. To keep expenses under control, she sublet space from a physical therapist, bought an electronic medical record system to automate as many administrative tasks as possible, and hired part-time employees to enter data for billing, do the filing and faxing, and run errands. “I took my costs down to as rock bottom as I could,” she says.

The move has allowed her to practice the way she wants. She treats a contingent of patients with complex musculoskeletal problems and chronic pain, whom she describes as “very loyal,” and she’s able to be home when her kids get out of school. “My youngest got

home the other day and was upset because a kid threw a snowball at him. I was able to be there to comfort him,” she says. “That’s a great success.”

In Vancura’s case, the medical center started a hospitalist program about the time she took her leave of absence, so she is no longer expected to take call. She’s become the clinic’s *de facto* geriatrician and is allowed to spend more time (30 minutes) with her aging patients. “I’m now the lowest producer, but I maintain a niche,” she says.

Since coming back part time nearly a year and a half ago, Vancura says she feels like she has more emotional and physical energy. “I feel like I can take a deep breath and have some private time,” she says. “I’m not rushing as much through life, and I’m enjoying practice again.”—Kim Kiser

Ill Will

No one would deny that working while sick, also known as presenteeism, is firmly entrenched in medicine. Doctors tell stories about seeing colleagues “pushing through”—coughing and sneezing in the lounge, and popping acetaminophen or ibuprofen to keep symptoms from intensifying.

There’s other evidence as well. A study published in the September 15, 2010, issue of the *Journal of the American Medical Association*, for example, found that nearly 60 percent of 537 residents from 12 hospitals reported they had worked while ill at least once (a third said that they had worked sick more than once) during the previous year. Ironically, those who tell patients to take it easy and rest when they’re ill rarely do so themselves.

Why do doctors tough out illness?

Why They Go to Work

There are multiple reasons for presenteeism in health care. One is that it’s taught. “Historically, doctors have been macho in their approach to things thinking, ‘We have to be there for our patients’ or ‘Who is going to be responsible for our patients when we are gone?’” says Louis Ling, M.D., associate dean for graduate medical education at the University of Minnesota and associate medical director for education at Hennepin County Medical Center. “Residents cannot be blamed for that mentality. They’re only following what we, as their role models, have all bought into.”

Guilt may be another factor that encourages doctors to work sick. “Both nurses and docs have a tremendous concern that if they stay home sick, they will be piling more work onto their already-overburdened colleagues,” says Greg Poland, M.D., director of the vaccine research group at Mayo Clinic.

Financial motivations also crop up when doctors contemplate whether to ride out an illness in bed or at the bedside. “Most of the physician groups I know of are paid for their productivity, which incentivizes them to come to work because they are compensated according to how many pa-

tients they see and how many procedures they do,” says Robert Moravec, M.D., medical director at St. Joseph’s Hospital in St. Paul. “When you’re sick and you’re working within that payment structure, it can become difficult to talk yourself into staying home.”

The Public Health Imperative

Currently, there are no national policies or state rules to help physicians gauge when they should call in sick. “We’re trying to recognize that physicians have the scientific background to make that decision,” says Kristen Ehresmann, R.N., M.P.H., director of the Minnesota Department of Health’s Infectious Disease Epidemiology, Prevention, and Control Division. “We know that if we came up with guidelines for doctors staying home, they would feel offended.”

Ehresmann would like physicians to think about one more thing when they start coming down with the sniffles—the public’s health. “When they come to work sick, they are putting their patients at risk. They are exposing patients to their illness, and in many cases, those individuals are more vulnerable than the general population. That makes presenteeism a public health problem.”

At the moment, though, the decision whether one should go to work or stay home is



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Even though they tell their patients to stay home and rest when ill, physicians rarely do so themselves.

predominantly a personal one that involves providers gauging their energy level and forming realistic perceptions about their ability to carry out their professional duties. That said, physicians don't always get it right, and a comment from a peer may nudge someone to exercise better judgment next time.

When Moravec comes face to face with a colleague who's coughing and sneezing in a hospital hallway, he doesn't hesitate to speak up. "If I see someone who is sick, I have zero trouble telling him or her ... to wear a mask," he says, adding that he thinks physicians understand that his motive is protecting patients. He admits it's not the best method because it relies on an accidental meeting, but he thinks it works. "Anecdotally, I have seen more physicians accepting those practices to prevent transmission of illnesses to their patients," he says.

A Shot in the Arm

A more effective strategy for protecting patients is vaccinating health care workers against influenza. Poland cites studies published in the *Journal of Infectious Diseases* in 1997 and *Lancet* in 2000 demonstrating that vaccination of health care workers reduced mortality rates among elderly patients in long-term care facilities by as much as 40 percent. "In contrast, when health care workers do not get vaccinated and come in sick, data show that the mortality rate of the ICU patients they care for increases 30 to 60 percent," he says.

Despite the demonstrated effectiveness of vaccinating health care workers, the Min-

nesota Department of Health notes that only about 70 percent of health care workers in the state get vaccinated (nationally, the rate hovers around 50 percent). Last winter, a Minnesota Medical Association (MMA) task force evaluated flu vaccination policies among health care workers statewide. Although the group opted not to seek legislation mandating that Minnesota health care workers get vaccinated, it did recommend that the MMA work with the Minnesota Department of Health, the Minnesota Hospital Association, and other organizations to promote awareness of the importance of getting vaccinated and encourage hospitals to adopt and implement policies on influenza vaccinations for medical staff.

From this recommendation came the Minnesota Department of Health's FluSafe program, which was implemented this fall. FluSafe recognizes hospitals and nursing homes that attain influenza vaccination rates of 70 percent, 80 percent, and 90 percent among their employees. More than 180 out of 519 eligible facilities have enrolled in the voluntary program thus far.

Poland believes that FluSafe is just a start, however. For a decade, he has been pushing for mandatory flu vaccination of all health care workers in Minnesota and nationally. In the past year, a number of national organizations—including the American Academy of Pediatrics, the American College of Physicians, the American Medical Association, the National Patient Safety Foundation, the Association of Professionals in Infection

Sick Leave

U.S. workers took an average of 14 sick days to care for themselves or a family member in 2007, according to the latest numbers from the Agency for Healthcare Research and Quality. The agency also found that

- Workers ages 55 to 64 years took an average of 18 days off a year compared with 10 days for those ages 16 to 24;
- More women than men miss work because of sickness (38 percent of female workers versus 30 percent of males); and
- Twenty-six percent of uninsured employees took sick leave as compared with 36.5 percent of privately insured workers and 32 percent of people with public insurance.

Control, and the Society of Hospital Epidemiologists of America, to name a few—have shown support for mandating that health care workers get flu vaccinations. (Conspicuously absent from the list is the American Nurses Association, which supports flu vaccination programs but is not advocating for a mandatory policy at this time.) "Momentum is building," Poland says. "Many of the best medical institutions already have mandatory policies, and I think we'll see the tide change dramatically in the next year or so."

With no law currently on the books to make flu vaccines mandatory for Minnesota health care workers, health care organizations are tackling the issue themselves. Children's Hospitals and Clinics of Minnesota has had a mandatory influenza vaccination policy for the last four years. Only clinical staff who have a medical contraindication may decline being vaccinated; those individuals are required to wear a mask in patient care areas.

HealthEast encourages its

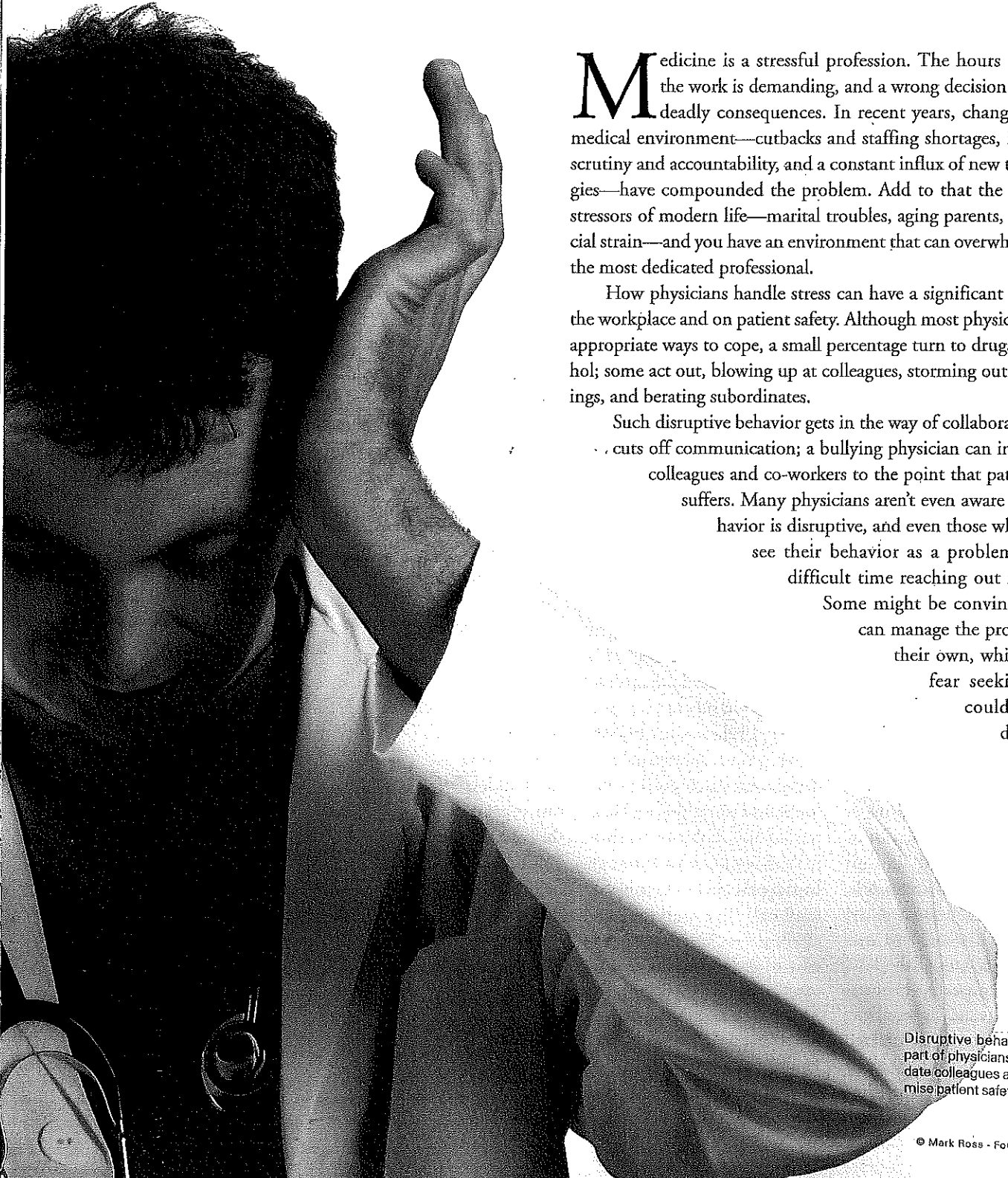
medical staff to receive a flu vaccine unless they have a medical contraindication and asks physicians to fill out a declaration form stating that they have been vaccinated. Those who have not are asked to wear a mask at all times while caring for patients.

Since HealthEast implemented the policy last year, Moravec has witnessed vaccination rates jump from 45 percent to more than 60 percent. Although HealthEast is still developing its program—it's still exploring what consequences to issue to those who do not comply—Moravec feels confident that they are heading in the right direction. "We may not have the perfect process, or the perfect identification method, or the perfect consequences for noncompliance, or even the perfect vaccine, but we are still working toward improvement," he says. "That's the key—not letting perfect get in the way of progress."—Jeanne Mettner

Workplace Behavior

Disruptive Docs

When a physician exhibits behavior that is out of line, it may be a sign of a larger problem.



Medicine is a stressful profession. The hours are long, the work is demanding, and a wrong decision can have deadly consequences. In recent years, changes in the medical environment—cutbacks and staffing shortages, increased scrutiny and accountability, and a constant influx of new technologies—have compounded the problem. Add to that the everyday stressors of modern life—marital troubles, aging parents, or financial strain—and you have an environment that can overwhelm even the most dedicated professional.

How physicians handle stress can have a significant effect on the workplace and on patient safety. Although most physicians find appropriate ways to cope, a small percentage turn to drugs or alcohol; some act out, blowing up at colleagues, storming out of meetings, and berating subordinates.

Such disruptive behavior gets in the way of collaboration and cuts off communication; a bullying physician can intimidate colleagues and co-workers to the point that patient care suffers. Many physicians aren't even aware their behavior is disruptive, and even those who might see their behavior as a problem have a difficult time reaching out for help.

Some might be convinced they can manage the problem on their own, while others fear seeking help could jeopardize their

Disruptive behavior on the part of physicians can intimidate colleagues and compromise patient safety.

medical license and professional relationships.

"It's the old thing of 'doctor heal thyself,'" says Doug Adamek, founder and CEO of Physician Wellness Services, one of several organizations in Minnesota that specialize in helping physicians cope with personal problems, stress, mental illness, and addiction. "You get in that mindset, and it can be really self-destructive."

Recognizing the Problem

Just as there is no single cause, there is no single definition of disruptive behavior, says Alan Rosenstein, M.D., a San Francisco internist and medical director for Physician Wellness Services, who has studied disruptive behavior in physicians for more than a decade. A general description, he says, is any interaction in which a physician intimidates another individual to the point where it compromises the quality of care and patient safety.

Disruptive behavior can be subtle: a physician who doesn't return calls, ignores charts, or refuses to follow best practices because the guidelines "don't apply to them," for example. It also can be overt: a physician screaming at a nurse who is trying to draw attention to a potential mistake, such as cutting on the wrong side, or responding belligerently when someone calls with a question. The cumulative effect of disruptive behavior, Rosenstein says, is that co-workers become so intimidated they begin to avoid the physician.

Although organizations once might have turned a blind eye to bad behavior from high-performing physicians, Rosen-

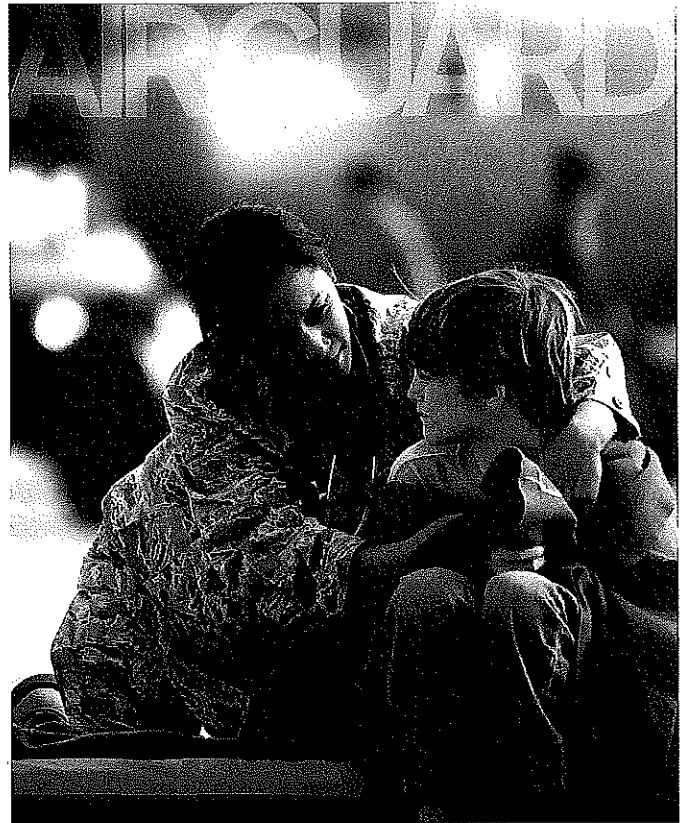
stein says, increasingly they're calling physicians on it. Research shows that bad behavior translates into bad patient care. In 2009, a Joint Commission review of sentinel events found the safety and quality of patient care depends on teamwork, communication, and a collaborative work environment. Further, the commission found that intimidating and disruptive physician behavior can foster medical errors and contribute to preventable adverse outcomes. Disruptive behavior also reduces patient satisfaction and increases costs and staff turnover.

The Joint Commission now mandates that all accredited hospitals and health care organizations have a code of conduct that defines unacceptable, disruptive, and inappropriate behaviors and a process for managing such behaviors.

Often, the first step for hospital and health care administrators who encounter a disruptive doctor is letting that person know his or her behavior is unacceptable, says Rosenstein. The next is to determine the cause of the problem. "The issue we see on the surface probably isn't the issue," Adamek says. Although the presenting symptom might be an angry outburst at a nurse, the underlying issue might be concern about an adolescent child, depression, or stress about the financial health of the practice. "The core is what we're looking for," he says.

Getting Help

The next challenge is to convince the physician to seek help. The type of help depends on the extent of the problem. Some physicians just need as-



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sistance managing the details of life and work. In those cases, Physician Wellness Services offers concierge-style services that help mitigate day-to-day stress such as finding appropriate child or elder care, making travel reservations, or contracting a lawn service. Others need to talk with someone. The organization can connect physicians to a physician peer coach or mental health professional for individual counseling and support for issues such as stress, depression, dealing with grief or loss, or conflicts with colleagues or family members. The services are designed specifically for physicians and the organizations that employ them.

Another organization, Physicians Serving Physicians, provides confidential intervention and counseling services to doctors struggling with drug and alcohol addiction. It tries to pair clients with recovering physicians in the same medical specialty. "It's been effective to have somebody present who has been there, done that, and is in recovery and who can say that life doesn't end, the medical practice isn't affected," says Diane Naas, executive director of the Edina-based organization.

In June, Hazelden opened a new treatment program specifically for addicted health care professionals at its Center City campus in Minnesota. "Although addiction affects the brain in the same way whether you're a neurosurgeon or a longshoreman, physicians face some unique issues," says Omar Manejwala, M.D., medical director at Center City.

"First and foremost, it's really, really hard for people

"Addiction affects the brain the same way whether you're a neurosurgeon or a longshoreman."

—Omar Manejwala, M.D.

who spend their lives treating patients to themselves be patients," he says. "When you remove alcohol or the drug, the individual can often feel a tremendous sense of shame," he says. Because health care professionals' self-esteem often comes from helping others, he explains, they can end up trying to help everybody else in treatment rather than focusing on their own issues. To break that pattern, Hazelden houses health professionals together during treatment so that they interact with each other as part of their recovery process.

"So a doctor who has been sober two or three months can talk to the new guy, the new neurosurgeon who walks in the door," Manejwala says. "Being able to share their experience with each other is very powerful and can make a physician who comes into treatment feel a real sense of connectedness."

It can also help physicians deal with some of the unique issues they face upon re-entering the workforce, such as what to tell patients and colleagues, how to manage stress, how to handle the availability of intoxicants, how monitoring works, and what they can do to protect their license.

The state licensing form

physicians are required to fill out every year asks applicants to disclose whether they have a mental, emotional, or substance abuse problem that impairs or limits their ability to practice medicine with reasonable skill and safety. Answering yes could result in disciplinary action or jeopardize a physician's license. The state-run Health Professionals Services Program (HPSP) offers physicians and other medical professionals with addiction and mental health issues a non-disciplinary alternative to reporting such problems to the Board of Medical Practice.

Physicians can come to the HPSP either through self-referral, referral from a colleague, an employee health program, or some other third party. Or the Minnesota Board of Medical Practice can refer physicians to the program with or without discipline. The HPSP evaluates the physician, and, when warranted, sets up a monitoring program to track how he or she manages the illness over time, says Monica Feider, HPSP program manager.

Participants are required to seek treatment from an approved provider such as Hazelden, and both the physician

and the provider must provide the HPSP with regular progress updates. The physician must also be accountable to a worksite manager or supervisor. If the problem is addiction, they may be asked to attend a support group and undergo toxicology screening. Monitoring lasts an average of three years but could continue for as long as five years.

Feider says physicians are highly motivated to complete the program, and most do. Last year, 83 percent successfully met the conditions of their monitoring plan. "When physicians complete monitoring, their file is closed. If they were self-reported or reported by a third party, and if they have been compliant with monitoring, the board never knows of their involvement in the program," she says.

A Pound of Prevention

Increasingly, health care organizations are realizing that the easiest way to deal with disruptive behavior may be to prevent it. That means talking about the effects that stress can have on a work and personal life as early as medical school and providing targeted employee assistance programs or other services to help physicians cope with the issues that can affect not just their lives but the lives of their patients.

"Our goal is to make physicians happier and more satisfied," Rosenstein says. "If you're more satisfied, you are more well-adjusted, more productive, and there's less likelihood of a disruptive event later on, either at home or at the workplace." —J. Trout Lowen



Patricia J. Lindholm, M.D.
MMA President

Physicians are not
immune to the
maladies common
to humankind.

Photo by Steve Wewerka

Hope for Healers

You are holding in your hands an issue of *Minnesota Medicine* dedicated to the subject of physician well-being. As I wrote in my last column, physician well-being is the theme of my MMA presidency. I am thrilled that so many other MMA members are concerned about this issue as well.

Since March 2010, I have been convening the MMA's task force on physician well-being, a group of physicians and others who are devoted to work and study that is directed at healing the healers. We have reviewed literature on the morale of physicians, medical students, and residents. We have explored how others are already addressing the spiritual and mental health needs of physicians. And many members were privileged to participate in a Courage and Renewal retreat facilitated by Laura Kinkaid and Jud Reaney, M.D.

From my experience, I can say that there are many of us wounded healers out there. Physicians are not immune to the maladies common to humankind. I suspect that many of our troubles are related to our denial of our own humanness when we subjugate our own needs to those of others. But for many of us, the cause of our suffering is related to the rapid technological developments and changes in health care delivery that have taken place in recent years. The unintended consequences include the erosion of the physician-patient relationship and the commoditization of health care. As a result, many of us have lost our sense of calling.

Fortunately, sources of healing are all around us. Our colleagues can be one source if we can find ways to safely and

confidentially share our pain, doubts, and joys with them. In Fergus Falls, we have a group of physicians who meet every other week to share their struggles and triumphs. This is one example of how we can make our collegial relationships work for mutual healing. The Finding Meaning in Medicine groups founded by Rachel Naomi Remen, M.D., which bring physicians together to rediscover their passion for their work, are another example.

Recently, a number of MMA members responded to a survey on physician wellness developed by our task force. Many of you shared your personal strategies for maintaining health and a sense of well-being with us. Making family time a priority, scheduling vacations, reducing work hours, and practicing yoga, meditation, and prayer are among the more common ones you mentioned. Involvement in hobbies and activities outside of medicine are also valuable strategies for many of you.

I'm grateful for the work that this task force has already done. The physician members are Jud Reaney, William Spinelli, Bill Manahan, Karen Lawson, Cindy Firkins-Smith, Mac Baird, Kristin Haugan, James Jordan, Laurie Drill-Mellum, Tait Shanafelt, Dale Anderson, and Rebecca Hafner-Fogarty. The committee also includes two hospital chaplains, Paula Bidle and Bradley Skogen, MMIC attorney Libby Lincoln, and physician spouse and co-president of the MMA Alliance Dianne Fenyk. I extend heartfelt thanks to all of them.

May we all find healing and wholeness in this new year.



Medica to Rate Individual Physicians

In an unprecedented move, Medica has announced that it will publicly release cost and quality rankings of individual physicians this month.

The assessment program, called the Premium Designation Program, will rate individual physicians on cost and quality of care based solely on claims data. The program, which was designed by UnitedHealth Group, will grade physicians on a zero- to two-star scale, with two stars indicating that they met both the quality and efficiency criteria. One star means they met the quality criteria, and no star indicates they met neither.

Medica will add stars to its provider list. When a Medica enrollee searches for a physician online, the names of physicians who received one or two stars will come up before the

Board Takes Stand on Mandatory Staffing Levels

The MMA is calling for health care providers and organizations to create safe practice environments without resorting to legislatively mandated staffing levels.

The MMA Board of Trustees voted in November to approve a recommendation put forward by the MMA Medical Practice and Planning Committee that considered the issue of mandated nurse-to-patient staffing ratios in hospitals.

This issue dominated contentious labor negotiations between several Minnesota hospitals and the Minnesota Nurses Association in 2010, and it may come up during the 2011 legislative session.

The committee reviewed a number of studies regarding staffing levels and concluded that although adequate nurse staffing is critical to high-quality care, mandating staffing levels is an approach that is too inflexible and narrow in scope given the complex factors affecting patient safety and the delivery of health care.

The Board approved the following policy position:

The Minnesota Medical Association encourages physicians in hospital practice and hospital leadership positions to work with interested stakeholders to assure a safe practice environment. These efforts should include careful analysis of the application of technology and impact of workflows to develop the best structure and systems for patient care without resorting to legislatively mandated staffing levels.



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names of those who received no stars. Medica has not said how else the system will be used, but large employers in other states have used it to cre-

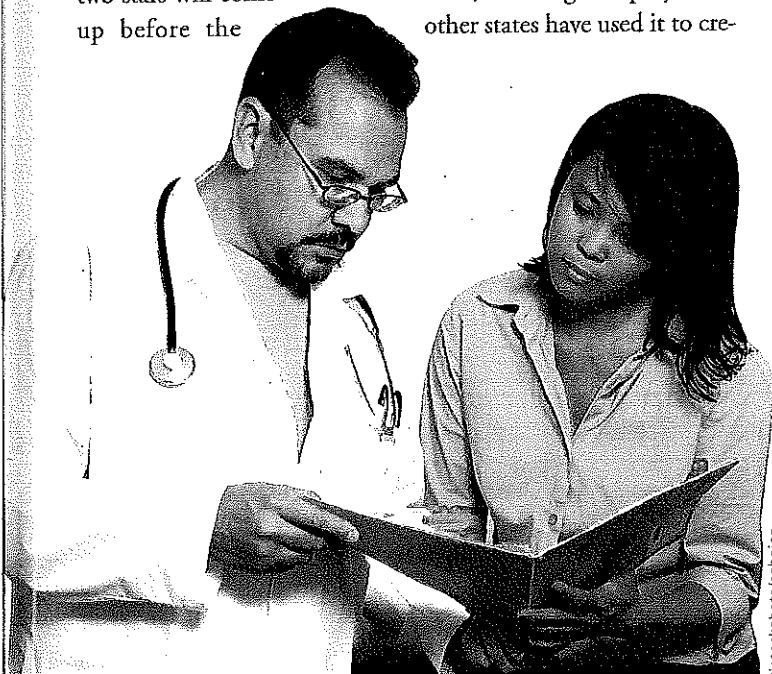
ate benefits that tier providers and encourage employees to choose two-star doctors. Although it supports valid and reliable performance measurement, the MMA is concerned that this program is flawed. Some physicians' results could be based on claims from as few as 10 patients.

"Measurement and public reporting at the individual physician level are plagued with very serious challenges," says MMA President Patricia J. Lindholm, M.D. "Ensuring the statistical soundness of measurement at the individual physician level is foremost among such challenges. In addition, physician-level

analysis fails to recognize the numerous other health care providers involved in delivering patient care and the complex systems in which such care is delivered."

On December 3, Medica sent letters detailing individual results to the approximately 9,400 physicians in the Premium Designation Program. Physicians were given until December 24, 2010, to request a formal reconsideration of any of data in their report.

The MMA sent an action alert to members about the new program in December and contacted Medica to voice concerns about the underlying design of the program.

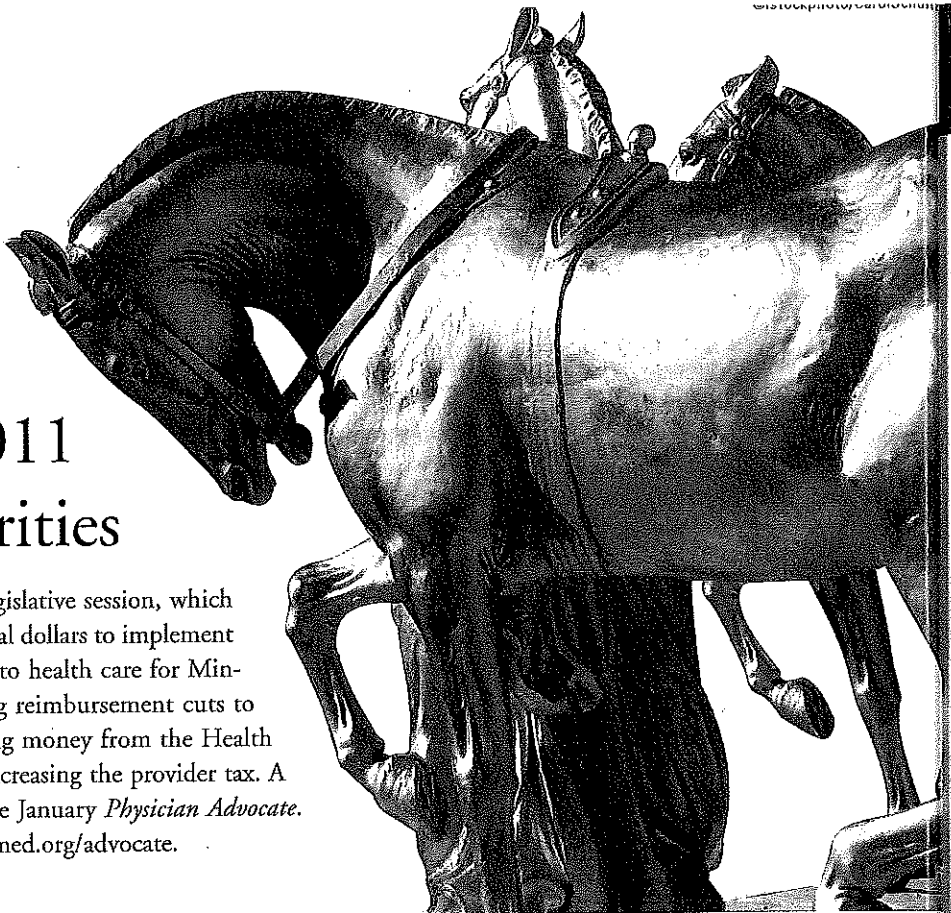


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MMA Sets 2011 Legislative Priorities

The MMA's top priorities for the 2011 legislative session, which started January 4, include accepting federal dollars to implement early Medicaid enrollment, protecting access to health care for Minnesota's most vulnerable residents, preventing reimbursement cuts to providers, and stopping lawmakers from using money from the Health Care Access Fund to balance the budget or increasing the provider tax. A complete legislative preview is included in the January *Physician Advocate*. Look for it in your mailbox or go to www.mnmed.org/advocate.



Law Stops Medicare Cuts for 2011

In December, President Barack Obama signed the Medicare and Medicaid Extenders Act of 2010. The law includes a 12-month reprieve from the 25 percent Medicare physician payment cut that was scheduled to take effect January 1. It also extends a number of other payment policies that were set to expire at the end of the year.

The goal now is to permanently fix the sustainable growth rate (SGR) formula in 2011. Each year, this formula generates a cut in Medicare payments to clinics and physicians, despite the fact that practice costs rise.

After the bill passed the House, President Obama issued a statement saying, "It's time for a permanent solution that seniors and their doctors can depend on, and I look forward to working with Congress to address this matter once and for all in the coming year."

The MMA urged members to contact their lawmakers to stop a 25 percent cut. Several hundred responded.

This year, the MMA and other state medical associations worked with the AARP to turn up the heat on Congress. In Minnesota, the MMA and the Minnesota chapter of the AARP conducted a media campaign to raise awareness about the issue.

Get the Latest Legislative Updates

For a week-by-week update on what's happening at the Capitol that might affect physicians, read *MMA News Now*, the MMA's weekly e-newsletter. To subscribe, go to www.mnmed.org and click on Publications and MMA News Now.

The screenshot shows an email interface with the following content:

- Subject:** "Congress Passes One Year Medicare Fix"
- From:** MMA News Now <mnmed@mnmed.org>
- Subject:** "Congress Passes One Year Medicare Fix"
- Body:**
 - MMA** Physicians working for a healthy Minnesota
 - Inside The MMA**
 - OUR NEWS**
 - FIND A PHYSICIAN**
 - GRASSROOTS ACTION**
 - PHYSICIAN CAREER CENTER**
 - PHYSICIAN RESOURCES**
 - CREDENTIALING Made Simple**
 - Top Stories | December 10, 2010**
 - Congress passes one year SGR fix**
The House of Representatives passed a one-year SGR fix Thursday on a bipartisan vote of 409-2. The "Medicare and Medicaid Extenders Act of 2010," which passed the Senate Wednesday by unanimous consent will stabilize Medicare physician payments at current rates for 12 months, through the end of 2011.
 - Medica to rate individual physicians**
In an unprecedented move, Medica has announced it will publicly release cost and quality rankings of individual physicians in January. The MHA believes the program is flawed and has shared its concerns that efforts to rate individual physicians have been found to be extremely unreliable and often inaccurate.
 - Dayton confirms plans to approve early Medicaid**
Governor-Elect Mark Dayton said Wednesday that he would approve Minnesota's participation in the Medicaid early expansion option as soon as he takes office in January.
 - Fit clinic scores improve blood pressure control**
Minnesota Community Healthcare released its 2010 annual report.

Tracking Reform



Quality Improvement

New Peer Grouping Timeline

The Minnesota Department of Health has updated its timeline for provider peer grouping in the state. Physicians are expected to get their first look at their peer grouping results for total care in late summer. Condition-specific results are expected to be available in the fall of 2011.

Peer grouping is an effort to compare the cost and quality of care provided by clinics and hospitals. The initiative is initially focusing on total cost of care as well as care for these six conditions: diabetes, coronary artery disease, pneumonia, asthma, congestive heart failure, and total knee replacement.

Providers originally were told they would receive their scores in June of 2010 and that those scores would be released to the public in September.

The MMA initiated legislation in 2010 to modify the peer grouping program to ensure the use of valid and reliable data and to adopt a more reasonable timeline. The 2010 legislation set October 15 as the target date to disseminate results, but the health department missed that deadline largely because of delays in claims data submission by payers and data clean up.

According to the current timeline, payers and the state are required to begin using the peer grouping results in the development of new networks or incentives within 12 months of publication. As such, it is unlikely that any use of the data by payers will occur before 2013.

Statewide Quality Reports Released, New Measures Added

The Minnesota Department of Health released its first statewide report on health care quality in November.

The report, which will be done annually, lays the foundation for provider peer grouping, which will compare providers on both risk-adjusted quality and cost.

The report, which was made available online at the Minnesota Department of Health website, includes data on the extent to which physician clinics provided optimal diabetes care and optimal vascular care in 2009. It also includes clinic data about asthma care, preventive screening rates, and the appropriate use of antibiotics based on 2008 HEDIS data collected by health plans.

Starting this year, Minnesota clinics will be evaluated on three new quality measures—depression care, asthma care, and colon cancer screening.

In addition, all clinics will be required to register with MN Community Measurement (www.mncm.org) and complete a health information technology survey. The MMA has created a brochure that clinics can use to educate their staff about the law's 2011 requirements. To learn more, go to www.mnmed.org/measure.

Federal Reform

Federal Judge Rules against Individual Mandate

U.S. District Court Judge Henry Hudson ruled in December that the federal government does not have the authority to require individuals to purchase health insurance, since doing so would be an unprecedented expansion of federal power that is not authorized under Congress's right to regulate interstate commerce. Hudson did note that the portions of the law that are not based on the requirement that individuals have insurance are legal and can proceed.

Other courts in Michigan and Virginia have ruled in favor of the constitutionality of this provision of the Patient Protection and Affordable Care Act.

Health Care Homes

Minnesota Chosen for Federal Health Care Home Demo

Minnesota is one of eight states that the Centers for Medicare and Medicaid Services has chosen to be part of the Multi-Payer Advanced Primary Care Practice Demonstration.

This initiative is intended to show whether having health professionals work in a more integrated fashion and receive coordinated care payments from Medicare, Medicaid, and private health plans leads to greater effectiveness and efficiency. The demonstration is expected to ultimately include as many as 1,200 medical homes and 1 million Medicare recipients nationwide.

Minnesota Medicine is updating readers monthly as Minnesota implements key components of the state's 2008 Health Care Reform Act and the federal Patient Protection and Affordable Care Act of 2010. Additional information is available online at www.mmaonline.net and at the Minnesota Department of Health's website, www.health.state.mn.us/healthreform/.

Battling

Medicine is recognizing that physician well-being affects both practitioners and their patients.

BURNOUT

By Kate Ledger

Macaran Baird, M.D., remembers a time early in his career when it seemed his professional life was getting the better of him. Only a few years into his first job as a family physician in the late 1970s, Baird was working as a clinician and chief of staff at a practice in Wabasha, Minnesota. With additional training as a family therapist, he also was writing a book on involving families in health care, and he occasionally took trips away from his own young family to teach. “I was tired, and, like most physicians, busy. But I thought I was doing OK,” he says.

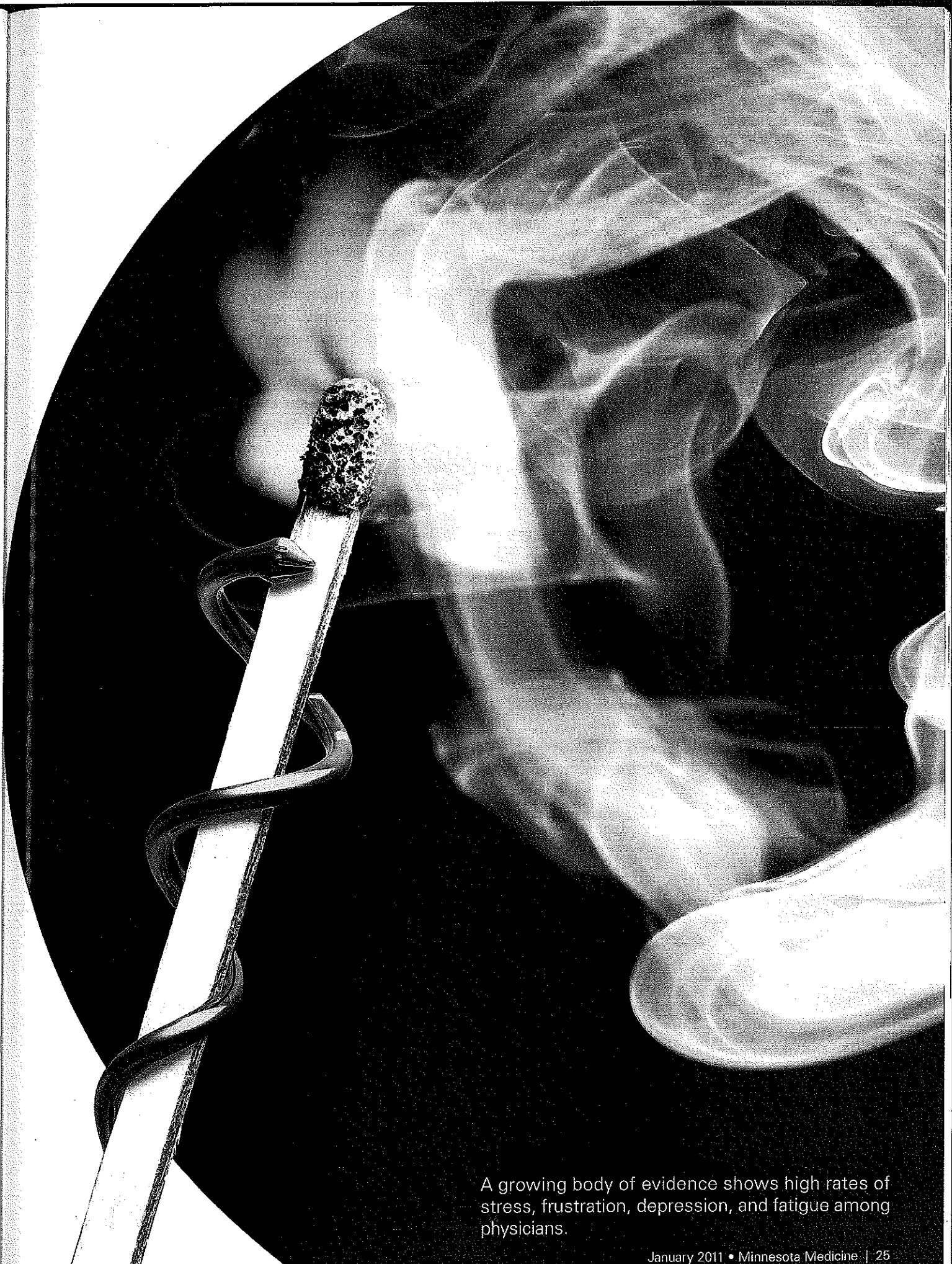
So it took him by surprise when one of the nurses he worked with asked whether he might be overextended. She’d noticed he’d grown “grumpy” at the hospital. In fact, she told him, nurses had begun trading shifts in order to avoid working the nights he was on call. The feedback hit home. Baird realized at once that what he knew intellectually about the importance of taking care of himself wasn’t playing out in his day-to-day routine. Having already seen some overworked colleagues grow depressed and others get in trouble with alcohol and other addictions, he knew he had to make some changes.

Ultimately, Baird took steps to fit more down time and family activities into each day. Today, as chair of family medicine and community health at the University of Minnesota, he pays attention to his daily stress level and takes breaks from work when he finds stress getting out of hand. As important, he continues to be concerned about the well-being of the physicians he’s working with and training.

Baird is not alone. A growing body of evidence is pointing out high levels of stress, frustration, depression, and fatigue among doctors in all disciplines and at all stages of their careers. In particular, physician burnout, long recognized as a potential landmine in a medical career, is now seen as a threat to the workforce and to the quality of patient care. The good news, however, is that physicians—and the institutions they work for—have begun talking about the problem more openly than ever before. Many are beginning to address the issue of physician well-being. “What we may be seeing now is the beginning of a cultural shift in medicine,” says Mayo Clinic internist Liselotte Dyrbye, M.D., who has studied the deleterious effects of stress on doctors. “There’s an enormous amount of interest in this issue. People are seeing that, yes, this matters.”

A High-Stakes Problem

The issue of physician burnout began cropping up in medical journals 20 years ago, with some studies reporting burnout in up to 60 percent of physicians. Recent investigations have shown that the number of those afflicted is still high (some say 37 percent to 47 percent among academic faculty and 55 percent to 67 percent among private practitioners). Research also now shows that burnout isn’t just a late-career phenomenon, which many had once presumed. Says Dyrbye, who serves as associate director of Mayo’s Program on Physician Well-Being, a recently created research entity to study the topic: “All the studies we’ve conducted across the continuum of [medical careers] have found



A growing body of evidence shows high rates of stress, frustration, depression, and fatigue among physicians.

a high prevalence of distress.”


The stakes are high, notes an article in the April 15, 2003, *American Journal of Medicine*. Burnout takes a toll on doctors and their families in the form of “depression, anxiety, substance abuse, divorce, broken relationships, and disillusionment.” Significantly, doctors have a higher suicide rate than other professions, according to a 2004 study in the *American Journal of Psychiatry*—that rate being as much as 3.8 times higher among male physicians and as much as 4.5 times higher among female physicians.

Although these and other studies have underscored the pervasiveness of physician distress, new work over the last decade has focused on another aspect of the issue: how physician distress may lead to lower-quality medical care. A study funded by the federal Agency for Healthcare Research and Quality (AHRQ) published in the *Annals of Internal Medicine* in 2009 found that today’s work environment makes physicians feel stressed more than it used to and postulated that physicians might become less effective at controlling patients’ blood pressure and diabetes, and more likely to omit preventive screenings and to commit medical errors. In another *Annals* study from 2002, residents who experienced burnout were asked whether they thought they’d provided “suboptimal care” at least once a month. Fifty-three percent acknowledged they had.

Lately, the topic of physician well-being has drawn new attention. The emphasis is just in time, many physicians note, as health care reform will add upwards of 40 million previously uninsured people to the patient population, increasing physicians’ workload and, undoubtedly, their stress. A number of organizations are starting to address the issue. For example, the meeting of the American Medical Association (AMA) last October included a gathering of the International Alliance for Physician Health, a group of practitioners and organizations working to promote the health and well-being of physicians. Researchers from the United States, Canada, and the United Kingdom presented talks and posters on modes of assessing physician stress and understanding its consequences. Other presentations focused on ways to increase positive communication within busy medical practices, how to enhance the personal health habits of physicians, as well as reviews of physician wellness and counseling programs at medical institutions. In addition, the AMA has created “AMA Healthier Life Steps—A Physician’s Guide to Personal Health,” a toolkit to help physicians support their own efforts to lead healthier lives.

In Minnesota, several physicians have been pushing to make physician health a better-studied, more talked-about topic. Fergus Falls family physician Patricia Lindholm, M.D., who became president of the Minnesota Medical Association (MMA) last September, has spoken about the issue to physician groups and

Healing Each Other



Family physician Patricia Lindholm, M.D., was well-read on the topic of physician stress, but she became aware of the loneliness and isolation that existed among her colleagues in a way she hadn’t anticipated. Giving a presentation about preventing burnout for the Minnesota Academy of Family Physicians two years ago, Lindholm took a chance and divulged her personal ex-

perience with depression and her struggle to “get more balance back in my life.” The response to her candor was overwhelming. “People came up to me during and after the conference, they called me and emailed me, sharing their own experiences. It was clear that there was a huge need for physicians to reach out to each other,” she says.

She talked with Rev. Bradley

Skogen, a chaplain at Lake Region Healthcare Clinic Services in Fergus Falls where she practices, and the two began to formulate a plan to address physician isolation. They developed a format for a discussion group, a hospital-based gathering in which physicians could talk freely with each other about the stresses, expectations, frustrations, and hardships of their lives. The group, they decided,

shared her own experience with needing to bring more balance to her own life. She also blogs about physician health for the MMA (<http://mmapresident.blogspot.com>) and continues to provide resources to anyone interested in health (one she recommends is ephysicianhealth.com from the Canadian Medical Association). One of her hopes is that physician well-being will become a priority issue for the MMA. "The time is right," she says. "If there's something we can do that will support people in their day-to-day practice and enrich their life as a physician, that's the goal."

At Mayo Clinic, Greg Poland, M.D., decided the topic of wellness was one for the entire community. Five years ago, he became acutely aware of the stress and lack of balance in his own life. He was working long hours, coming home so tired he wanted only to fall asleep on the couch. His children were growing up, and he felt he was missing out. "It's a dangerous temptress," he says of his work. "I love what I do. It's easy to get drawn in further and further and neglect important parts of life." But it was the suicide of a colleague, and the suggestion that burnout and work pressure had played a destructive role in that colleague's life, that was Poland's wake-up call. He began reading up on the topic of wellness, particularly the idea of work-life balance, and found inspiration in the book *Just Enough*. The authors, Harvard business professors Howard Stevenson and Laura Nash, espoused greater intentionality: determining goals in an array of spheres—work,

*"I love what I do.
It's easy to get
drawn in further
and further and
neglect important
parts of life."*

—Greg Poland, M.D.

would have a limited number of members. They would meet periodically in a hospital conference room, at an hour that wouldn't interfere with work. No one in the administration would know who belonged to the group. Any information discussed would remain strictly confidential.

The Lake Region administration offered instant and unquestioning support, providing space and the breakfast for each gathering. The initial "scary moment," Lindholm acknowledges, was inviting physicians to join. "Even though we may work together in the same building, we're really all quite isolated and live in our own silos," she says. "We can tell that others around us may be having some distress, but it doesn't feel comfortable to broach the subject in a day-to-

day conversation." She scheduled individual meetings with physicians from a variety of disciplines whom she thought might benefit and sat down with each one in private to describe the group that she and Skogen wanted to start. As she extended an invitation to join, she remembers, "every one of them said yes."

The group, which has been meeting twice a month for the last 18 months, consists of six male and two female physicians from different specialties who are at various stages of their careers. "It's not just crisis management and talking about problems, but also a chance to be proactive about well-being," says Skogen, who leads the meetings. Sometimes we watch a media presentation or discuss a book, and we talk about whatever people want to

talk about." (One book they discussed was national best-seller *Kitchen Table Wisdom*, by pediatrician Rachel Naomi Remen, M.D.) Skogen's training in clinical pastoral education helps him set the tone: "The idea is to provide a non-judgmental place where it's safe to talk. None of us are trying to solve or fix what's going on. The idea is to ask a question or respond in a way that may help another person express themselves or reflect on what they're going through."

What Lindholm found in the group was that the sense of isolation melted away at once. "There was all this pent-up hurt, and people shared it very frankly. And immediately people thought they could meet every couple of weeks. Over time, we've seen some [people's personal issues] resolve and get

better, and we're still meeting, still talking. Just sharing with each other," she says, "has diffused a lot of stress and tension, and we've forged a bond we didn't have before."

In fact, interest in the group is spreading. Lindholm and Skogen described the meeting format they developed at the American Medical Association's meeting in Chicago last year. And enough physicians at Lake Region Healthcare are asking about it that they plan to start a second group in the near future. "It's apparent if we can break down the isolation and be a little closer in terms of camaraderie and collegiality, and not be so stuck on appearing perfect to each other, we can do a lot of good," Lindholm says. "We can actually be healing to each other."—K.L.

“Physicians who experience conflict are more likely to have distress, especially if a work-home conflict results in favor of work.”

—Liselotte Dyrbye, M.D.

exercise, family, spirituality, and connection to religion—and consciously attending to them.

Poland developed a lecture based on those ideas, which he advertised to Mayo staff. He knew his message about striving for work-life balance would resonate with some colleagues, but he was surprised when more than 800 people showed up for his presentation. He included in his talk a film segment showing a physician-father engrossed with his BlackBerry at his child's baseball game. As Poland looked out at the audience, he knew he had touched a nerve. He could see physicians weeping. Immediately after the lecture, he remembers, “We received hundreds of responses, some with comments from people who agreed that the problem existed and others offering suggestions, ‘Here's what I do,’ ‘Here's how I find balance.’”

In order to increase understanding of the issues that influence and promote physician well-being, the head of the department of medicine at Mayo, Nicholas LaRusso, M.D., formed the Program on Physician Well-Being. Directed by Tait Shanáfelt, M.D., who has studied wide-ranging manifestations of physician stress since 2001, the program serves as a research base and a resource for Mayo leaders as well as for those at other health care institutions seeking to implement programs to enhance the health of the workforce. Important studies of physician experience have already emerged from the program. One identified the negative effects of “work-home interference,” in which the demands of one realm of life impinge on another. “Physicians who experience conflict are more likely to have distress, especially if a work-home conflict results in favor of work,” Dyrbye says. Another showed that residents who had a greater sense of personal well-being were capable of being more empathetic to patients than others. Mayo researchers are pleased to note that some of their studies, in conjunction with others being done around the country, have already led to change. Recent investigations of medical student distress, for example, prompted the Liaison Committee for Medical Education, the accrediting authority for U.S. and Canadian medical schools, to require that every school have a well-being program in place for its trainees.

Workplace Culprits

One question that researchers continue to grapple with is what's at the root of burnout. Internist Mark Linzer, M.D., has long been interested in finding the answer. In the mid 1990s, when he was on the faculty at the University of Wisconsin, Madison,

Linzer led a Robert Wood Johnson Foundation-sponsored investigation of physician satisfaction. Surveying nearly 3,000 physicians, the researchers explored 10 domains of physicians' day-to-day experiences to pinpoint where satisfaction fell off. The team found that physicians who were under time pressure, and who had little control over their environments, were the most distressed. “A lot of [the problem] was the work environment itself, and this was across the board, primary care doctors and specialists,” says Linzer, who now directs the division of general internal medicine at Hennepin County Medical Center.

Linzer has looked closely at how the work environment contributes to physician stress and found some of the factors contributing to burnout may not be altogether different from the pressures that exist in other careers. He found that women physicians are 60 percent more likely to experience burnout than men and that the discrepancy may be the result of their lacking control over their time. He notes that although their work hours may not differ from those of men, they often have responsibilities outside the office such as caring for family members. However, there are also nuances in the exam room that may contribute to burnout among women physicians. “One of the factors [leading to greater stress] seems to be a gendered expectation for listening,” he explains. “Female patients often choose female providers, and many male patients choose a female provider because they expect women doctors will take great care of their medical problems, but then spend time listening and counseling and empathizing, and all those things are very hard to do in a 15-minute visit.”

The tenor of a medical practice—and the mechanics of it—can play a significant role not only in the well-being of physicians but also in the quality of care they provide. Linzer and his group defined four parameters that affect both physician well-being and patient outcomes: time pressure during visits, physicians' lack of control over their work environment and schedule, fast-paced or chaotic environments, and lack of alignment of values between leaders and practitioners. “The way a practice is organized can really affect us,” Linzer explains. To assess that, he and his research team developed the Office and Work Life (OWL) measure, which provides, in Linzer's words, “a snapshot of a practice.” After gathering data from doctors, patients, office managers, and staff, researchers then observe how the medical practice functions. In a new AHRQ-funded study, the Healthy Workplace Study, Linzer's group will use the OWL measure to evaluate a randomized array of medical practices. Clinics will use their OWL data to incorporate changes designed to smooth out operations and reduce stress among physicians. “We'll see if we can improve the quality of care by changing the work environment,” Linzer says.

Addressing the Issue

Researchers agree that there is no single strategy for relieving physician distress. What's hopeful is that many institutions are now offering new programs to address physician well-being. Accord-

BURNOUT continued on p. 50

Mid-Career Crisis

A family physician retreats and recharts her professional path.

By Kristin Haugan, M.D

I left my practice. It was my first practice, my only practice, the one I believed was going to take me to retirement, so deciding to leave was not easy. But it was something I had to do. I had worked in the same family medicine clinic in the Twin Cities since I completed my residency in 1994. For a number of years, I was content. The practice was stable, I worked three-quarter time, clinic only. The other doctors and physician assistants were supportive and collegial. I enjoyed seeing patients, their families, and their friends. As time passed, I grew more comfortable being me, being real, with these people. I realized that the practice of medicine is a sacred art.

So what happened?

The work environment changed. As all physicians are well-aware, in recent years, we have been asked to do more busywork: prescription refills, insurance-mandated prescription substitutions, other paperwork. Because of financial pressures, our clinic had to let office staff go. That meant having less support for getting that work done. Morale flagged. Doctors and physician assistants left. Then the electronic medical record came along. Time was required to document, order, code, and charge for visits. I found my attention divided between the patient in front of me and the computer between us. As I had less time to spend with my patients, I began to feel myself disintegrate.

I changed as well. Daily meditation practice was making me more aware of myself and the realities around me. I began to see my role in supporting the pharmaceutical industry and large health systems. It seemed I was a gear in an industrial machine designed for growth and profit.

It was time for a change, but it took a while before I was ready to jump.

A year went by as I soldiered on. As my partners left, I became more isolated. I didn't share my negative feelings at work. I thought I needed to be a good partner and a positive presence for my staff and patients: strong, reliable, getting the work done and not whining about how difficult it had become. If I couldn't be positive, I thought it best to be silent. But I was experiencing the emotional and physical pain that results from feeling "stuck." I was irritable and tearful at home with my family. My upper back and legs ached, and I developed a frozen shoulder. This was a telling analogy for the inertia I was experiencing.

One day, I realized I had labeled myself as the victim in my own life story. I knew I didn't want to continue in that role. So I decided to drag myself out of the hole I'd dug for myself. I began to search

for a new perspective, new friends, and a new way to think about healing others. I wanted to connect again with the sacredness of my work.

Finally, last February, I stepped away from my practice. I needed a break, and I knew that leaving would give me the space I needed for searching. Arriving at the decision to do so was very hard. I felt I was abandoning my partners, my patients, and the office staff. I was leaving behind that large piece of ego bound up with being my patients' doctor. I wasn't sure I would return to medicine.

I began my break at St. John's Abbey, where I stayed alone for three days, walking, journaling, and meditating in silence. I listened for my inner voice, wanting to follow my heart. I began to heal my achy body with regular exercise including outdoor walks. I began to eat a vegan diet. I attended conferences and retreats. One was Rachel Naomi Remen's Finding Meaning in Medicine, which was a wonderful way to connect with other doctors and nurses who were also hurting and looking to rediscover the heart of medicine. There, I learned that loneliness was a common theme; but none of us felt we were alone when we left. I participated in a Parker Palmer Circle of Trust retreat, which was two days devoted to listening to others, reflecting, and listening for my inner voice.

I discovered that the Minnesota Holistic Medical Association offered a great way to connect with local physicians and other providers who are interested in practicing the healing arts. We meet quarterly,



After leaving the group where she practiced since residency, Kristin Haugan is now working at an integrative holistic medicine clinic.

I needed both the space to step back and reflect on the big picture and enough silence to hear my inner voice.

always beginning by introducing ourselves and talking about what is currently exciting us in our work. I also met one on one with other physicians, healers, former teachers, and old friends who had previously inspired me or about whom I was curious. We'd meet for a couple of hours over coffee. Through them, I discovered fresh new ways of working and being. It truly was fun.

Since then, I've initiated a physician group that follows the model developed by Rachel Naomi Remen. We try to meet monthly in each others' homes for the purpose of listening and fellowship. We each bring a story to share about a chosen topic. Storytelling is a powerful way to listen and be inspired, to be heard, and to

touch each others' hearts.

I would not have been able to do this on my own. I'm grateful to my partners, who stepped in to care for my patients when I left. I'm grateful for my husband, who encouraged me to make this decision, trusted me to find my way to healing myself, and provided me an emotional refuge. I'm grateful to my physician supervisor, who was empathic and open-minded. She cared about me and supported my decision.

Reaching out to others to create a network of support has been crucial to my development and to getting unstuck. So has solitude. I needed both the space to step back and reflect on the big picture and enough

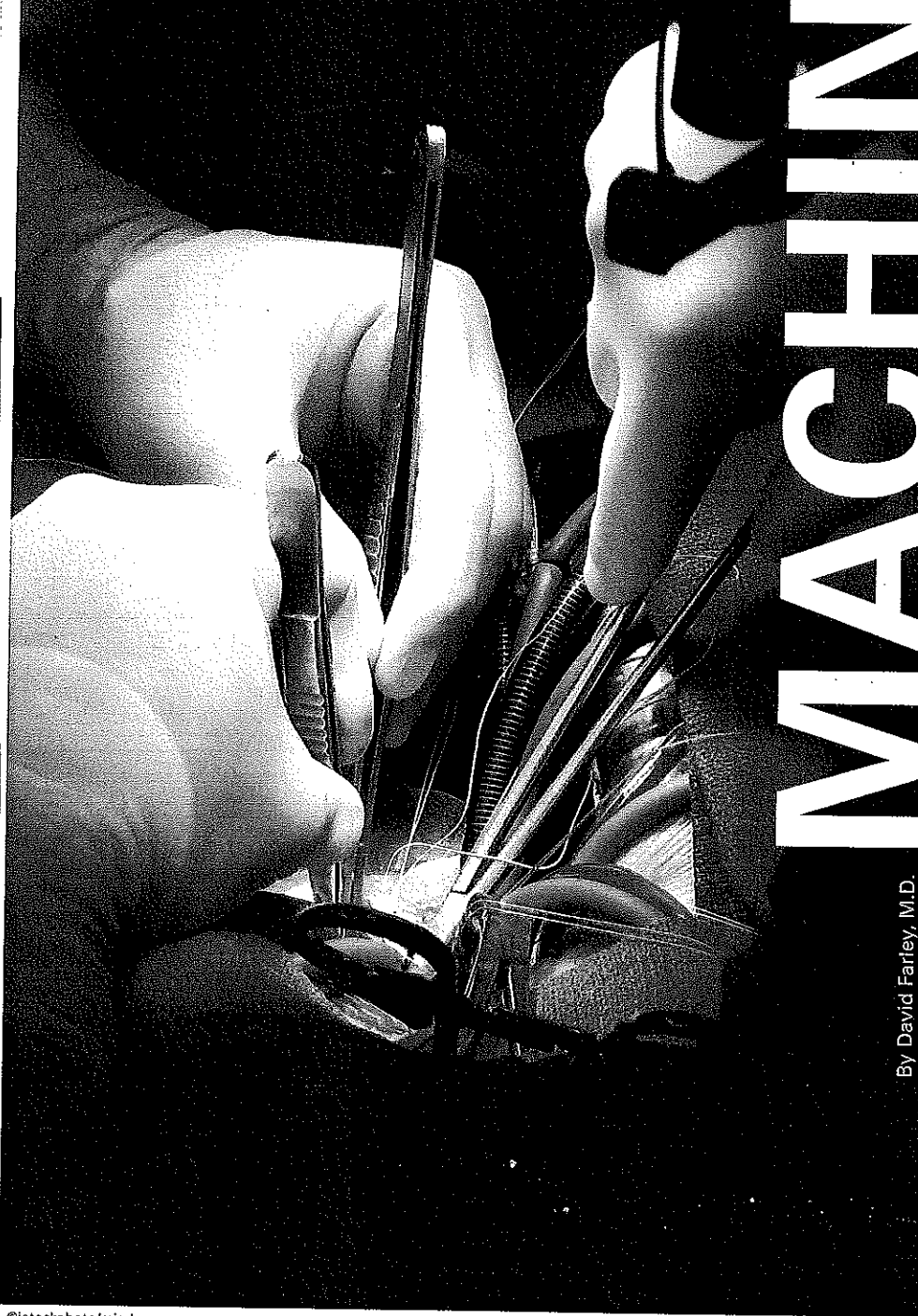
silence to hear my inner voice. We need a balance of community and alone time to be whole. I believe healing ourselves is important to helping others. My challenge now is to merge who I am with what I do while keeping my feet on the earth to support my family. Being aware of my inner voice will help me avoid getting stuck again.

I'm back in medicine now. I recently started working at an independent integrated holistic clinic. I work with a traditional Chinese medicine doctor and a physician who practices allopathic medicine and homeopathy. Here, I have longer appointments and a population of patients seeking a different approach to healing. I am board-certified in integrative holistic medicine and look forward to developing my own style of practice. I am inspired to help people heal themselves. **MIM**

Kristin Haugan is a family physician at Total Health Clinic in Fridley.

A WELL-OILED

W MACHINE



©istockphoto/miralex

By David Farley, M.D.

A surgeon marvels as a colleague calmly and expertly leads his team through a difficult case.

A while ago, a call came into OR 105 while our team was finishing up a laparoscopic procedure. The circulating nurse relayed that one of my cardiac surgery colleagues was asking me to come down to his operating room. "Is it urgent?" I asked. "No, but he clearly wants you down there," came the reply. "Tell him I will be there in five minutes."

As I helped a young surgical resident close up our patient's small wounds, my brain went into overdrive. What might a talented cardiac surgeon with a patient who was fully asleep on his OR table need from a general surgeon like me? To check for an incisional hernia? Comment on a melanoma? Palpate a thyroid mass? Review an X-ray with an abnormal feature? Maybe it was something even more ominous—an elderly gentleman with a big hernia.

Walking into the cardiac surgery room, I could see the procedure was temporarily on hold. The surgeon's back was to me, the atmosphere was subdued and the mood serious. A quick look at the monitors overhead showed adequate blood pressure, a steady heart rate, and nothing obviously wrong. Having asked for help in my own operating room many times, I was always appreciative of any surgeon who entered with an upbeat attitude and the words, "How can I help?" So I did the same. "How can I help?" I asked.

When the surgeon turned around, he was calm but visibly concerned—you can recognize when another surgical colleague is frustrated, struggling, or upset even when they're behind a mask. He wasn't upset. He just looked concerned. I feared the worst; but I was still unsure how I might be of service. He proceeded to tell me in a way that was orderly, insightful, and ... worrisome. The patient, a young man, was having his third cardiac operation. Among other problems, the man had previously had his aortic root replaced with a synthetic tube graft, and that graft was now eroding into the back of the sternum—a potentially lethal problem.

I wasn't smart enough to immedi-

ately figure out how I could help, but I nodded as though I knew what was coming next. "The real problem," my colleague explained, "is that I very well may get into this graft before the heart is fully exposed. If that is the case, then I will need to emergently go on bypass and won't have any access ... because ... look."

Peering over his shoulder, I could see a tiny innominate artery, and then looking to the exposed groin, I could see an exposed femoral artery that was miniscule. The vessels were unusually small. There would be no way to cannulate them. "If we get into this aortic graft, we are going to need you to get us rapid access to his abdominal aorta. That is the only vessel that will give us a chance of putting him effectively on bypass," the cardiac surgeon explained.

I got it. If the cardiovascular surgeon tore a hole in the artificial aorta, my job was to incise the abdomen and in rapid fashion, move the bowel out of the way and clear off the aorta so that a tube could be inserted. It was the first time I had been asked to scrub for a case where a colleague might make a lethal injury and would need immediate help addressing that very problem.

I scrubbed in. I took my place near the patient's neck, grabbed a retractor, and let the surgeon and his team proceed. They were a good team. A *very* good team. Little chatter. Skilled hands. I enjoyed the view of anatomy I don't often see as a general surgeon. It became obvious to me why the surgeon had called. The scar tissue was brutal. Tissue planes were nonexistent, and dissecting the heart, aortic graft, lung, and vessels away from the back side of the sternum was extremely difficult. It was slow going.

As I dutifully held my hook, and telepathically offered encouragement to my colleague, a sinking feeling came over me. Despite the surgeon's obvious expertise and meticulous care, it seemed likely to me that a tangential aortic conduit injury was forthcoming. In this obese male, it would take me 10 seconds to get to the

other side of the table, a few more to remove the sterile drapes covering the abdomen, and who knows how long to make an incision, enter the belly, pack the bowel away, and effectively expose the aorta for cannulation, presuming the vessel was big enough to cannulate. I felt antsy. Penetrating aortic arch injuries are usually fatal when caused by bullets or knives. In my mind, the cardiac surgeon's cautery tip counted as a knife.

Although not wanting to break his concentration, I had to speak up. "I think the likelihood is high of entering into the vessel." He agreed. "That's why you're here." I pushed on: "I think we should get control of the abdominal aorta now ... before we cause trouble." He agreed.

With the luxury of time and a stable patient, we took 10 minutes to make a small vertical laparotomy and expose the aorta. A large omentum and a thick, small bowel mesentery made getting to the aorta problematic. When reached, we both were pleased to find a soft vessel large enough to allow for effective cannulation.

"I feel better," I said. "So do I," my colleague replied.

Although my part was done, I stayed. What I witnessed over the next 30 minutes made me proud to be a surgeon, to be part of that team, and to be the cardiac surgeon's colleague. Everything was difficult, but nobody cursed. Everything was treacherous, but the dissection proceeded without injury to the heart or graft. The team was prepared.

Getting closer to the right atrium hidden within the scar tissue, the surgeon asked for the defibrillating paddles to be available should his electrocautery tip cause the heart to go into fibrillation. The paddles were ready. Is the unit charged? It was. He asked if the pump team was ready in case they had to go on emergent bypass. They were. Is blood ready? Yes, it was in the room. Do you have my special clamps handy? Ready. This was a well-oiled machine.

Suddenly, with a buzz of the cautery knife within the scar tissue, the patient's

blood pressure plummeted and his heart rate escalated. Looking at the heart monitor, I saw that it was ventricular fibrillation. The patient was effectively in the jaws of death.

With complete calm, the cardiac surgeon asked for the paddles and attempted cardioversion. Charge. Clear. Shock. Nothing. The sickening, disorganized gyrations of a fibrillating heart is a difficult thing to watch for somebody hell-bent on making people better. For the two seconds I watched this unfold, my mind raced, seeking a reason the cardioversion failed. Potassium too low? Potassium too high? Calcium too low? Hypothermia? Poor contact because of the scar tissue? I kept coming up with reasons as the milliseconds passed. Silence hung over the room until the scrub nurse calmly took the paddles away from the surgeon and tightened their connections and offered a "Sorry about that." Shock. The fibrillating heart instantly became a synchronized organ that generated 80 beats per minute and a blood pressure of 120 over 80. Success. The operation proceeded uneventfully.

This is the everyday world of the cardiac surgery team. Re-do operations in less-than-ideal candidates. Ventricular fibrillation, cardioversion, cardiopulmonary bypass, peripheral cannulation, cardioplegia. Terms and situations that imply patient demise unless corrected quickly and carefully. Although television portrays cardiac surgeons as arrogant, overbearing, foul-mouthed egomaniacs, and every patient's outcome the result of miracles or luck, I don't see it in my world. What I see daily, and what I saw on this particular day, was a poised leader of a well-trained team caring for a very ill human being with great compassion, knowledge, and skill. While politicians battle about the rights and wrongs of health care, well-prepared teams like this one show up to work every day and efficiently go about the business of helping needy patients. *MIM*

David Farley is a general surgeon at Mayo Clinic.

8 Suggestions for Promoting Physician Well-Being

Ways to make medicine more satisfying for doctors and better for their health.

By Bill Manahan, M.D.

Regular exercise, a healthy diet, not using addictive substances, and having less stress in our lives are essential components of wellness, whether for physicians or patients. But as I practiced medicine over the years, I realized that the system and culture in which we live and work also significantly affects our health and well-being. When I felt I was doing what I was called to do and was able to work in a way that felt congruent with who I am, I had energy and a sense of accomplishment. I felt good and, therefore, found it easier to take care of myself and stay healthy. When my practice felt out of control, my habits and health slid.

Around year 10 of my career, I noticed that I had gained 12 pounds. I felt tired by mid-afternoon and was having heartburn and indigestion. Caring for patients had started to feel more like a business than a calling. I was irritable and felt that I, rather than my patients, was in charge of their health. I sometimes ordered tests out of fear rather than because of good sense and good science. Even though I was exercising regularly, eating well, and practicing meditation, I felt as if I were falling apart. It was then I began to realize that the culture of medicine was affecting my health.

I had once run my own primary care practice. I spent as much time with a patient as I needed, sometimes wrote off the bills of those who were having financial troubles, and felt a sense of unity with the people who worked in my office. It was like we were a family. Our patients felt recognized and honored for who they were, and I felt good at the end of the day. But things changed when I became part of a larger medical group. At first, I was delighted with not having to deal with the administrative concerns of running a clinic. However, after a year

or so, I missed not being in charge. My nurse and the person at the front desk were hired by the business manager, not me. I was told I could no longer write “no charge” on the bill of a long-time patient who was struggling because the clinic had a department to work with people who couldn’t pay. I had to attend meetings where decisions were made based on what was best for the business rather than what was best for the patients. My income rose nearly 25 percent during that period; but practicing medicine this way turned out not to be good for my body and soul.

Since then, I’ve realized that certain things in the culture of medicine harm physicians. And I’ve come to believe that unless we make some changes, neither physicians nor patients will thrive. Here are eight suggestions for improving medical practice.

I We need to view medicine as a calling as well as a business.

Prior to the 1960s, medicine, nursing, and other health care professions were primarily thought of as callings. Most practitioners felt it was an honor and a privilege to serve people in such an intimate way. Many would even go so far as to say that there was something sacred about being a doctor, nurse, or other health care provider.

During the 1970s and 1980s, larger clinics and hospitals began buying up practices and followed the lead of many other U.S. corporations and made the maximizing of profits a high priority. Managed care and HMOs came on the scene. And doctors became employees—“providers” who served “clients.” Medicine was becoming a business rather than a calling.

As a group, physicians blamed managed care for this shift. I

believe we could have said “no” to a lot of these changes, but we didn’t. Although we may never go back to the way things were, we again need to start viewing medical practice as a sacred calling. That must be balanced with a sensible approach to profit, so that physicians feel less pressure to “produce.” I hope and pray that the federal health care reform act starts us down this road.

2 We need to become more collaborative and less competitive in our approach to the delivery of health care.

Competitiveness is reflected in all realms of our society, including health care. We ask “What’s in it for me?” not “What’s good for all of us?” I believe that in health care we need to move away from this dominator approach and become more collaborative. A majority of the people who go into medicine are inclined to be heart-centered rather than head-centered; that is, they want to relate to, rather than rule over, others; but the existing culture of practice demands otherwise. Consequently, for some physicians, going into practice is like entering into a marriage and finding out that your partner and you think quite differently about most things. It is difficult to feel a sense of well-being in that kind of a relationship.

To change that, physicians, health care organizations, insurance and pharmaceutical companies, and patients need to sit down together and figure out a model for care delivery that works for everyone—one where health care is accessible to patients without driving up costs. We need to discuss what we can do to make careers in primary care—the lifeblood of medicine—more appealing to medical students who might be tempted by the high salaries of some subspecialties. I think Michael Moore said it best in the movie *Sicko* when he asked: “Are we a nation of *me*, or a nation of *we*?” We need to become better collaborators in order to make health care better for all of us.

3 We need to emphasize both the art and science of medicine.

Since Copernicus proved in the 16th century that the earth was not the center of the universe, the western world has recognized science as the major paradigm. Unfortunately, I believe we have shifted too far toward a material and mechanistic world view. Almost left out of the equation for our understanding of how things work, including the human body, are consciousness, mindfulness, and spirituality. Just as it is important for us to find a balance between viewing medicine as a calling and a business, we also need to find a balance between understanding medicine as an art and a science.

We need science, of course. We need to know that after a heart attack there are certain medications to take. If a patient has abdominal pain in the right lower quadrant, the evidence will say he needs surgery. But when it comes to treating chronic and recurrent conditions, there frequently is not a good evidence base, and we often need to rely on our instincts. We talk so much about evidence-based medicine that we sometimes forget that the majority of what we do is still an art.

4 We need to shift our focus from the health of the individual to the health of the community.

Public health initiatives related to clean water, sewage disposal, environmental safety, and food processing have accounted for the majority of improvements in Americans’ health and longevity over the years. But during the 1940s, when antibiotics were discovered and many other surgical and pharmaceutical developments occurred, we shifted our priorities. We put our resources and energy into preserving the health of the individual rather than the health of the community.

We need to change our way of thinking about what has the most impact on health. A number of studies show that 50 percent of what influences our health is our behavior and lifestyle, 20 percent our environment, and 20 percent our human biology (genetics). Only 10 percent is driven by medical care. What this means is that as a physician, my chance of making a significant difference in a single person’s life is about one in 10. It’s frustrating to see patient after patient who is overweight and at risk of one day developing high blood pressure, high cholesterol, and type 2 diabetes. If we put more resources into prevention and public health, it would lessen the pressure on physicians to constantly be encouraging individuals to make lifestyle changes that they may not be ready to make.

5 We need to set realistic expectations about what medicine can do for patients.

As new medications and surgical procedures were discovered, people began to have unrealistic expectations about what medicine could do for them. Medicine can indeed cure many illnesses that have a clear cause. It is not nearly as successful for long-term and chronic diseases, however. Yet since pharmaceutical companies began advertising directly to the public in 1995, patients’ expectations for medicine have increased dramatically. People see ads and think all they have to do is take a pill in order to solve their health problems.

But is this realistic? And is it really the best way to get a chronic condition under control? When a 45-year-old patient would come in with high blood pressure, I’d get excited. I knew there was a good chance the condition had been brought on by lifestyle. I’d tell him that if we worked together, we could likely get his blood pressure back to normal without medications. I’d tell him there was certainly a chance the strategy might not work, and then I would ask, “Wouldn’t you rather try changing your life than taking medication every day for the rest of your life?” Many people would say, “Yes, let’s give it a try.”

6 We need to stop doing the wrong things for patients.

In his 2008 book *Worried Sick*, Nortin Hadler, M.D., describes what he calls Type II medical malpractice. Type I malpractice is when we do the right thing the wrong way. Type II is when we do the wrong thing the right way. Hadler says physicians increasingly are performing inappropriate procedures and ordering tests and treatments that are not evidence-based. He lists

as examples some coronary artery bypass grafts, arthroscopy for arthritic knee pain, some back surgeries, long-term hormone replacement therapy, using drugs for decreased bone density as a first-line therapy, routine prostate-specific antigen screening, and some cancer treatments, all of which may do more harm than good no matter how skillfully they are handled. Hadler's conclusion is that more than half of medical care provided in the United States could be considered type II malpractice.

Type II malpractice has a number of causes. Practicing defensive medicine is one of them; but this accounts for only a small percentage of the tests that are ordered. The primary cause is the way we're trained. As medical students and residents, we are taught to look for zebras. We don't want to miss anything. When someone comes in complaining of headaches, rather than asking about stress, whether they're getting enough sleep, or whether they've had a neck injury or muscle tension, the doctor thinks about brain tumors. We are trained to not miss serious and significant disease, which is good. Unfortunately, that leads us down a path that sometimes makes it quite difficult to actually figure out what is causing the patient's problem. We are trained in and practice disease care, which is necessary, but that pushes us away from figuring out the actual causes of many of our patients' problems.

Type II malpractice happens when we look for zebras and there are deer all over the place. Our training encourages us to be perfectionistic. But by attempting to be perfect, we can miss simple causes of patients' problems. We need to change how we train primary care physicians so that they don't overlook the obvious.

7 We need to learn to accept illness and death as a normal part of life.

Until the early 20th century, it was not uncommon for a couple with eight children to see four of them die before reaching adulthood. Nor was it uncommon for adults to die before reaching their 50th birthday. As advances in public health and medicine allowed people in the United States to live longer, we changed from having a fatalistic acceptance of illness and death to having an almost hysterical fear of illness and death. Some people believe that this paradigm shift may be the single biggest problem with our health care system.

The stress and anxiety people feel about becoming ill can lead them to seek excessive testing and treatment, sometimes worsening the illness itself. Often physicians, being healers, continue to treat patients even though there may be no hope of recovery. The fatalism of our forefathers regarding illness and death is, of course, no longer appropriate; but neither is our current morbid fear of illness and death. As physicians, we're trained to always do as much as we can to save a patient. And if we can't save them, we sometimes feel as if we have failed. We need to learn how to have conversations about death and the end of life so patients can have a say in how they want to spend their final days and physicians can feel good about the care they're providing during that time. That is beginning to happen as society accepts palliative care.

8 We need to understand and accept that many diseases have multiple causes.

Approximately 70 percent to 80 percent of health care spending in the United States is related to chronic disease. Every chronic disease is caused by a long list of contributing factors; yet the medical system is designed for patients with single-factor illnesses (eg, trauma, broken bones, emergency medical problems, and many infections). Physicians are often unsure how to handle patients with chronic illnesses. Add to this the frustration of attempting to take care of those patients in 15-minute office visits and it is understandable why many physicians become discouraged and stressed.

We can do things to change this. Group Health in Seattle, for example, now has group sessions for patients with diabetes. Physicians meet with patients individually, then those patients get together as a group with a nurse or diabetes educator to go over information they've learned, share strategies for managing their condition, and provide support to each other. Studies have shown that patients who take part in group sessions are more likely to stick with their treatment plan and have fewer hospitalizations and emergency department visits than those who do not. And they love being part of the group. We need to set up our payment system so we can do more of this type of thing.

In dealing with my own frustration, I realized that I could not wait for all of these changes to occur, so I made some that enabled me to continue to work within a system that was not always conducive to my health and well-being. My wife and I took a sabbatical and did work in another country. I stopped doing obstetrics because of the stress of being on call at all times for deliveries. I began to schedule more time for patient visits, even though it meant my salary would decrease. I began to work a four-day week in the office. And I tried not to force patients to make changes they were not ready to make.

I gradually lost the weight I had gained, my mid-afternoon tiredness disappeared, and my heartburn and indigestion vanished. As my work life became more congruent with what I needed as a person, my physical and mental health gradually improved.

It is important that physicians embrace a plan for their own wellness that is more expansive and comprehensive than just exercising and eating right. We need to reshape how we see our profession and how we understand our role. And we need to help patients understand the role we play as well. I've identified eight suggestions for changes in how we practice medicine that could help us be healthier and happier physicians. I believe that physicians have the power to make these changes happen. The question we need to ask ourselves is, Do we have the will and the courage to do so?

MM

Bill Manahan is assistant professor emeritus of family medicine and community health at the University of Minnesota.

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Demystifying Mindfulness

By Karen Lawson, M.D.

ABSTRACT

Mindfulness-based stress reduction (MBSR) is an approach to health and wellness that an increasing number of health care providers are practicing and recommending to their patients. This article describes MBSR, its use in health care, and its benefits for patients with conditions such as anxiety, depression, chronic pain syndromes, and insomnia. It also offers advice about how physicians can incorporate elements of MBSR into their daily practices in order to reduce stress in their lives and prevent burnout.

If we keep our eyes open, we begin to discover that the healing relationship is itself a pathway, a Way of working with ourselves and others leading to the blurring of contrived boundaries, an awakening into our mutual shocking brilliance, the recovery of a deep and abiding joy ... To walk such a path requires a method: a disciplined way of learning to pay attention to all that is arising within. This is called "mindfulness."

—Saki Santorelli¹

The year was 1992. More than 280 health care professionals from all over the country had gathered at the Omega Institute in Rhinebeck, New York, for one of the first professional training programs in mindfulness-based stress reduction (MBSR) offered by Jon Kabat-Zinn, M.D., and Saki Santorelli, Ed.D., of the University of Massachusetts Center for Mindfulness in Medicine, Healthcare, and Society. I was one of them. During the first three days, we were to learn about and begin practicing mindful meditation. The next five days were devoted to learning about the science and research behind the practice, discussion of professional applications, and dialogue about future clinical and research collaborations. To some extent, that was accomplished; but that wasn't really what happened. As we began to practice mindfulness in the supportive environment at Omega, we found ourselves revealing to each other our hidden wounds, denied joys, and forgotten passions. Through laughter and tears, we talked late into the evening about our flaws and challenged humanness. It was painfully clear we were suffering as much as any of our patients, perhaps, in some ways, even more so. That event changed the life of every person there, myself included.

What we had discovered was that mindfulness was a direct means to access and monitor our thoughts, emotions, sensations, motivations, and behaviors. Kabat-Zinn describes it as "paying attention, in a particular way, on purpose, and in the present

moment."² Different from a relaxation technique, mindfulness enhances awareness and helps us disengage from maladaptive patterns of thinking such as generalizing, worrying, and perseverating, which create deleterious reactions to stress. It promotes the use of coping responses that are healthier and more effective.

Mindfulness-Based Stress Reduction

Mindfulness is a form of meditation originally derived from the Theravada tradition of Buddhism that is often translated as "to see with discernment."³ Over the last several decades, meditation has extended beyond the boundaries of religion or spirituality. For example, Daniel Goleman, author of *Emotional Intelligence*, speaks of it as an intentional self-regulation of attention.⁴

Mindfulness was introduced to the health care community as a technique for stress reduction by Kabat-Zinn in 1979. Since its inception, more than 18,000 people have completed his Stress Reduction Program; but thousands more have participated in spin-off programs around the world. Through these programs, individuals learn how to use their resources and abilities to respond more effectively to stress, pain, and illness. Participants not only include patients but also leaders within the business, education, and health care communities, along with health care providers. The central focus of the programs is intensive training in mindfulness meditation and how to integrate it into everyday life.

In its original format, MBSR training consists of 30 hours of class time (eight two-and-a-half-hour sessions once a week and one full-day retreat). The core program components are:

- Sitting meditation, which involves awareness of body sensations, thoughts, and emotions, and continuously returning the focus of attention to the breath;
- Body scan, a progressive movement of attention through the body from the toes to the head, observing any sensations in the different regions of the body;
- Hatha yoga, which consists of stretches and postures designed to enhance awareness and strengthen the musculoskeletal system; and
- A commitment to practice 45 minutes a day, six days a week.

The format has been modified in some settings. For example, some have added a three-minute mini-meditation that involves focusing on one's breath, body, and surroundings; others include Metta meditation, which is adapted from Buddhist practice.

What You Can Do Today

Simple ways to invite mindfulness into your day:

- Focus on doing one thing at a time and minimize multi-tasking;
- Take a walk outside without your pager or cell phone;
- Take a meal break without your computer, phone, or reading material; focus on all aspects of the food;
- Before each patient encounter, stop and take three deep belly breaths—one to release any thoughts about what has already happened in your day, one to release any expectations for the day, and one to invite yourself fully into the moment to be with the person you are about to see;
- Schedule time for relaxation, celebration, and fun—or just time that can't be scheduled;
- Spend time outside every day—even a few minutes;
- Begin meetings with 30 to 60 seconds of silence and breathing or share a brief, meaningful poem;
- Laugh often;
- Pay attention to your body, moving and stretching whenever you can even if you are at your desk, in the office, or in the hallway;
- Practice gratitude; end each day by acknowledging one thing you are grateful for (challenge yourself to never repeat things);
- Practice listening without interrupting or ruminating about what to say next;
- Ask for help;
- Create time everyday to leave behind your professional role and move into your personal roles with friends, family, or just yourself;
- Try a yoga, *Tai Chi*, or *qigong* class and take along a friend or colleague.

Research Findings

The existing body of research on the effect of MBSR on health is large and broad. It has been found to have measurable positive effects on chronic pain, psoriasis, insomnia, and other conditions.^{5,6} The positive effects of MBSR on anxiety, depression, and other mood disorders led to the development of a new approach to cognitive therapy, termed mindfulness-based cognitive therapy.⁷ In a healthy population, MBSR has been found to decrease perceptions of daily hassles, psychological stresses, and nonspecific symptoms.⁸ Additional psychological benefits include having increased empathy for one's self and others;⁹ an enhanced sense of well-being; and a greater sense of self-actualization, self-responsibility, and self-directedness.¹⁰

Mindfulness-based stress reduction programs are offered regularly in health care settings throughout Minnesota including the Woodwinds Health Campus in Woodbury and the Penny George Institute for Health and Healing at Abbott Northwestern Hospital in Minneapolis. In addition, a team of instructors teach MBSR at the Center for Spirituality in Healing at the University

of Minnesota several times each year. The center also offers customized programs for hospitals and other organizations and has even piloted a telephonic version of the program for corporations and school districts.

Additionally, the center has conducted multiple NIH-funded studies on MBSR including an examination of its effect on anxiety, depression, sleep, and quality of life in solid-organ transplant patients. Other studies have compared the effectiveness of MBSR with Lunesta in improving sleep for those with chronic insomnia; compared its impact on vascular function and exercise capacity with that of aerobic exercise in women; and looked at its effect on the general health and stress levels of caregivers of Alzheimer's patients.

The Importance of MBSR to Physicians

There is abundant evidence that workplace stress can significantly and negatively affect physicians and other health care providers, leading to depression, compassion fatigue, diminished job satisfaction, and professional burnout.¹⁰⁻¹² Logically, physicians should "pay attention" in clinical settings and during patient care; yet studies show individuals commonly demonstrate only brief and unpredictable attention. Thus, "mindlessness" has become a pervasive cognitive phenomenon in modern life, often occurring unintentionally for a substantial portion of the day and often leading to failures in task performance.¹³ Such failures can affect physicians' relationships with their patients and even lead to life-threatening errors in judgment.¹⁴ In the future, mindfulness may be the link between relationship-centered care and evidence-based clinical practice.¹⁵

Mindfulness-based stress reduction has the potential to improve physicians' health, well-being, and job satisfaction, as well as their effectiveness and safety on the job. Studies of medical, nursing, and dental students, medical residents, and practicing health care professionals, including doctors, have shown that MBSR can reduce depression and anxiety and increase empathy;¹⁶ decrease burnout by combating emotional exhaustion and depersonalization;¹⁷ and increase quality of life by reducing stress and increasing compassion for oneself.¹⁰

Although extensive efforts have been directed toward helping impaired or burned-out physicians, little emphasis has been placed on enhancing the well-being, health, and happiness of the professionals who should be modeling such a way of life for their patients.¹⁸ Mindfulness itself not only may be critical to personal and societal wellness, but it also may be an accessible route to developing and nurturing many other aspects of well-being. Mindfulness helps us be in touch with our physical and emotional states so that we can make conscious decisions that support our own health. It also can preserve our health and happiness, and keep us in medicine.

Most physicians go into medicine to be of service, to help individuals and families deal with the challenges of illness and trauma. Yet, after years of practice in a difficult and continually changing environment, many of us find ourselves struggling with

Physicians' Comments

Minnesota physicians describe how mindfulness has helped them in their personal life and practice.

I found the practice of mindfulness was far from simple. It was challenging to keep my attention on the present moment. The course offered helpful tools to counter my mind's tendency to focus on the problems of the past or possible challenges in the future.

The encouragement to focus on gratitude, compassion, and forgiveness was a helpful antidote to my tendency to think about the apparent shortcomings in my world. I continue to find mindfulness a helpful practice in my daily life. During my day, I will often notice how my mind is getting caught up in the frustration of the moment. When this happens, I can take a short pause, focus on my breath or other sensations for a moment, and let go of the negative thoughts.

—**Michael Mesick, M.D.**

Family Physician, Edina Sports Health and Wellness

If it weren't for mindfulness-based stress reduction, I wouldn't still be in medicine today. Metta meditation helped me start taking care of myself, listening to my body, cutting back. Since I learned to take care of myself, medicine has become fun again.

—**David Von Weiss, M.D.**

Family Physician, Park Nicollet Clinic, Eagan, and Methodist Hospital

Barely three years out of residency training, I was already frustrated in my role as a psychiatrist. I had assumed that psychiatry would offer a holistic way of working with patients, yet I spent my days managing crises and medications. It didn't feel as if it worked well for my patients or me, and I couldn't imagine doing this for an entire career. Then I saw Bill Moyers' "Healing and the Mind" and was struck by the work of Jon Kabat-Zinn, who developed mindfulness-based stress reduction. I signed up to train with him in the fall of 1992.

I was profoundly affected by the training, and it helped shift my focus back to healing rather than just managing disease. I began offering classes immediately. We called them group psychotherapy and treated patients with anxiety and depression. I quickly realized that this had much of what I was looking for: It was cost-effective because it was done in large groups; it gave people tools they could use for themselves without relying on long-term therapy; and most importantly it worked. People recovered, and it prevented relapse.

—**Henry Emmons, M.D.**

Integrative Psychiatrist

*Developer of the Resilience Training Program, Penny George Institute for Health and Healing
Abbott Northwestern Hospital*

fatigue, a sense of futility, frustration with forms and computers, inability to keep up with the rapid flow of new information, and the demands of our own lives. There may be little we can do to quickly change the external factors in our lives and practices. But we can change our internal responses to these challenges. Mindful presence invites us back into each moment as it happens, helping us compassionately set priorities, recognize our limits, and rediscover the meaning in our work.

MM

Karen Lawson is an assistant professor in the department of family medicine and community health and director of health coaching at the Center for Spirituality and Healing at the University of Minnesota. She is a founding diplomat of the American Board of Integrative and Holistic Medicine.

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To Cry or Not to Cry

Physicians and Emotions at the Bedside

By Navneet S. Majhail, M.D., M.S., and Erica D. Warlick, M.D.

ABSTRACT

Whether it is appropriate for physicians to display their emotions in front of a patient is a question that has no easy answer. Some physicians may consider it an expression of empathy, while others caution against doing so. This article describes the findings of a survey of blood and marrow transplant physicians who were asked whether it is OK to cry in front of patients.

She appeared calm and peaceful, oblivious to the tubes and lines that violated her body. The silence in the room was disrupted by the sound of a ventilator pushing air down her endotracheal tube and the beeps from monitors tracking her cardiac and respiratory activity. We walked past her bed to the end of the room where her husband and mother waited anxiously. They watched us expectantly, waiting for a glimmer of hope, as we shook hands and settled down across from them to start the family conference.

She was just 36 years old and was two years out from an umbilical cord blood transplant for a highly aggressive acute myeloid leukemia. Her first few months after transplant had been complicated by acute graft-versus-host disease (GVHD) and multiple infections. She subsequently developed severe treatment-refractory chronic GVHD; after failing many drug therapies, her GVHD was finally controlled with a regimen of cyclosporine and high doses of corticosteroids. During the following year, however, she had been admitted to the hospital many times—for a subdural hematoma that needed surgical evacuation, renal failure, and numerous bacterial and fungal pulmonary and sinus infections. Each time, she would recover and go home.

But this time was different. She had recently recovered from *Pseudomonas aeruginosa* otitis externa and bacteremia. Two weeks later, she was readmitted with high-grade fevers and hypoxia. Over the next two days, she rapidly deteriorated and developed acute respiratory distress syndrome, septic shock, and multi-organ failure. Workup revealed a multi-drug-resistant *Pseudomonas* in her lungs and blood.

She had been hospitalized for almost six months during the two years following the transplant. She had been seen frequently

in the outpatient clinic as well, often several times a week. Although multiple providers were involved, the majority of her care had been coordinated by her primary blood and marrow transplant (BMT) physician. With her refractory chronic GVHD and penchant for frequent infectious complications, her BMT physician had had multiple conversations with her and her family about her advance directive for health care. She was determined to “make it” but was also very clear about not wanting to be a “vegetable.”

Her primary BMT physician and the BMT physician on inpatient service that day led the family conference. A medical student, hematology-oncology fellow, and nurse practitioner also participated. The BMT physicians summarized her clinical course since the transplant and since her most recent hospitalization. They noted that she was going to require dialysis soon and emphasized the almost negligible likelihood of her leaving the hospital alive. They recounted her resilience and the many times she had beaten the odds. Her mother and husband remembered her as a good daughter, wife, and mother and mentioned that she knew she would not beat the odds this time. All agreed that she would not want to continue with aggressive measures and allowing her to die peacefully would be in her best interest. At an emotionally intense moment, her primary BMT physician's eyes began to water, and she shed a few tears prior to regaining composure and continuing the conversation.

As the team left the room, the medical student asked, “Is it OK to cry in front of a patient?”

Emotions at the Bedside

The physician-patient relationship is the quintessence of clinical medicine. It is a complex construct that demands mutual respect, support, and participation, especially in the context of cancer and other life-threatening chronic diseases.^{1,2} According to Wade, “These relationships do not develop instantaneously; rather, they are cultivated over time and are usually strengthened by shared experiences.”²

The role and appropriateness of physician emotions has not been well-described. Some physicians may consider expressing emotion a sign of empathy while others caution against doing so

What Physicians Say

The following is a sampling of blood and marrow transplant physicians' responses to the question "Is it OK to cry in front of patients?"

"Not sure any of us attempt to show this type of emotion, but I personally don't feel it is something to be ashamed of, nor should one be looked down upon for doing this. ... The bigger question is how to maintain empathy with a family while keeping the appropriate distance."

"You are human and in partnership with another human being and her family. ... It is a fine balance of equanimity, confidence, resolve, and empathy in end-of-life discussions."

"We have to remember that the emotions are real for us and for the family. While it is their grief and not our own, showing or letting our feelings show is acceptable, professional, and, frankly, just human. It is OK as long as you can still do for the family what they need."

"Showing our honest concern and sadness in end-of-life conferences, demonstration of our empathy for the family's loss makes good sense, especially if we have cared for them for a long time. Oncologists can get very depressed if they grieve too much because they also have to move into the next room down the hall, where the new patient needs our optimism to face their own struggles. ... I don't think you help families by crying. ... I think it's our job to show we care, feel, and understand."

"I believe that members of the care team should not express more emotion than what is expressed by the family themselves. ... But we are human, and although we may try to distance ourselves from our patients/families ... occasions such as the one described in this case do occur and I believe are acceptable."

"A few tears are OK, but out-and-out crying won't help the family in the context of a family care conference. It is important ... to remain calm, composed, and be able to offer objective recommendations to the family and lead the discussion. There can be a fine line between being compassionate and empathetic versus allowing emotions to adversely cloud recommendations for patient care. As leaders of the health care team, we need to be attentive to that line."

"I think it is a problem if the emotional moment is primarily about the physician's feelings ... But if the context is about the patient or the family's feelings then I think it is good to show empathy. ... If the "primary gain" is to make the family or patient feel better ... then it is OK ... whereas if the primary gain is to make the physician feel better ... then that is not OK."

"I think that it is totally fine not to cry ... If that is not in your nature ... a physician should express some genuine sympathy/empathy for a grieving family, but it can be done with words or mannerisms. ... Not crying is just fine as long as the family feels that their emotions have been acknowledged and they are supported appropriately/adequately by the care team."

"I think it is acceptable to break down the austerity of the medical relationship at times ... when families and patients need someone they trust the most (eg, end-of-life crisis), the emotion we show only helps bridge the divide that we've built within medicine."

"I think it is important for members of the immediate care team to show some emotion ... in front of family and patients. ... It imparts that the medical provider is as frustrated as the patient/family, demonstrates a degree of empathy and closeness of the relationship that has developed with the patient/family, and I think it empowers the patient somewhat to take back control of the situation."

"Showing emotion is fine and, in some circumstances, may be good for the family as well as the clinician. ... The threshold between appropriate and inappropriate might be most easily defined by the family's response to the clinician's emotional display. If the family begins to feel uneasy by the display and are now in the role of supporting and consoling the clinician, then the emotional response by the clinician is both excessive and inappropriate. ... A death is very sad. Watching the family grieve is difficult. ... However, the clinician is not a friend or a family member. If it feels like the loss of a friend, then the relationship between the clinician and patient or family is inappropriate. Personally, I have never let myself cry in front of the family but have had difficulty speaking at times."

in front of patients.³ In a survey of 301 trainees, 69% of third-year medical students and 74% of interns reported crying for reasons related to medicine, with twice as many women as men reporting to have cried.⁴ Several factors may determine the nature of physicians' emotional responses including the personality of both the physician and the patient; the length of their acquaintance; the intimacy, frequency, duration, and intensity of their interactions; as well as the clinical setting in which a discussion that precipitates an emotional response takes place.

The relationship between patients undergoing BMT and the doctors who treat them is unique. Because of the high risk of associated morbidity and mortality, BMT is reserved for patients with a high probability of death without the intervention. Consequently, patients trust that their physicians will provide them with information and assist them with decision making. The initial transplant course itself can be quite intense. It is not uncommon for patients to develop long-term complications such as chronic GVHD. In addition, there is always the looming risk of relapse of underlying disease.

As patients move down the transplant path, they are frequently accompanied by their transplant physician and many other members of the transplant team, who may follow them closely for an extended period of time. Transplant physicians are often there for the joyful moments documenting remission or cure, for the hospitalizations for transplant-related complications, and to help the patient integrate their new reality into their life. If the patient has serious complications or disease relapse, they frequently have to lead end-of-life discussions. The initial patient-physician bond can grow stronger as patients deal with such challenges, and as physicians feel a sense of responsibility and sometimes guilt over the complications ensuing from a treatment they recommended. This dynamic can intensify conversations that are already emotional such as those dealing with end-of-life care.

A Minnesota Perspective

To explore what BMT physicians think about expressing emotions in front of patients, we presented the case of the 36-year-old woman to 15 BMT physicians at our institution and electronically surveyed them about whether it is appropriate to show emotions and cry in front of patients. Eleven respondents were male; five were pediatricians. The median year of medical school graduation was 1990 (range, 1975 to 2000). All generally agreed that it is acceptable to convey emotions; however, opinions varied about the extent and means of emotional expression in the presence of patients (see "What Physicians Say," p. 41). One respondent suggested that emotionally intense conversations with patients be held in the presence of a team so that providers could support one another and have an opportunity to debrief later on.

Although these comments were specific to physicians who care for BMT recipients, physicians who care for cancer patients and patients with other life-threatening chronic diseases likely have similar perspectives. However, considerable variation can be

expected based on the physician's personality, the patient population served (adults versus children), and cultural norms.

Conclusion

During end-of-life discussions with a long-time patient, it is not uncommon for a physician to shed tears. Doing so allows them to express their sadness for the patient's and family's current and future losses. Being able to express such emotion can provide relief for physicians and convey empathy to the patient and family. The challenge for physicians is being able to express how they feel while still being an objective advocate for the patient. **MM**

Navneet Majhail and Erica Warlick are assistant professors in the Blood and Marrow Transplant Program, Division of Hematology, Oncology, and Transplantation, at the University of Minnesota.

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The Physician's Role in Suicide Prevention

Lessons Learned from a Public Awareness Campaign

By Melissa Boeke, M.S., Tom Griffin, Ph.D., M.S.W., and Daniel J. Reidenberg, Psy.D., FAPA

ABSTRACT

The suicide rate in Minnesota has increased every year since 2000, making suicide a serious public health problem. In the spring and summer of 2009, the nonprofit organization Suicide Awareness Voices of Education (SAVE) launched a public awareness campaign targeting four populations at high risk of suicidal behavior and suicide: adult men, seniors, teens, and American Indians. The goals of the campaign were to increase awareness about suicide in general and to let people know how they could help someone who may be at risk. In their evaluation of the campaign, researchers found a need to provide physicians and other health care professionals with appropriate information about suicide and resources that are available for those who may need help. They also learned the importance of engaging physicians in planning future campaigns.

Suicide is a serious public health problem in the United States that results in approximately 33,000 deaths and 395,000 emergency room visits annually.¹ Minnesota's suicide rate rose from 8.9 per 100,000 population in 2000 to 11.0 per 100,000 in 2007. From 1998 to 2007, the state's overall age-adjusted suicide rate was 16.5 per 100,000 for males and 3.6 per 100,000 for females. In 2007, Minnesotans 50 to 64 years of age had the highest suicide rate of all age groups: 16.1 per 100,000.²

Depression, bipolar disorder, and other illnesses that underlie 90% of all suicides are medical disorders just like cancer, heart disease, and diabetes. People who suffer from these disorders not only have behavioral symptoms but also frequently complain of stomachaches, headaches, and back pain—physical manifestations of the shame they feel. We know from listening to survivors of suicide attempts that if their doctors had just asked about a

mental health problem when they saw them for other reasons, many would not have made their attempt.

More than 80% of patients who are depressed prefer to be treated by their primary care physician rather than referred to a mental health specialist.³ Although many patients are reluctant to seek mental health treatment, up to 75% of those who commit suicide have seen a primary care clinician for some reason within the month prior to their death.⁴ One out of every 10 persons who commits suicide has been seen in an emergency department within two months of his or her death.⁵ Physicians and other primary care providers need to be aware of the signs of suicide and feel comfortable addressing the issue with their patients.

The Campaign

In the spring and summer of 2009, Suicide Awareness Voices of Education (SAVE), a nonprofit organization working to prevent suicide in Minnesota, launched a public awareness campaign that targeted four populations at high risk of suicidal behavior and suicide: adult men, seniors, teens, and American Indians. The messages were directed at gatekeepers, that is, family, friends, colleagues, and peers who might intervene with and provide assistance to members of these high-risk populations. The goals of the campaign were to increase awareness about the problem of suicide and to let people know what they can do if someone is at risk. Messages were placed on signs in bus and transit shelters and skyways, in newspaper ads, in church bulletins, on billboards, and in radio public service announcements.

The Minnesota Institute of Public Health, a nonprofit organization that applies research findings and provides programming services to communities, evaluated the campaign to determine the extent to which it helped gatekeepers of adult men better

Table

Where Respondents Would Seek Help for a Suicidal Friend or Relative*

	Number of Mentions	Percent of Total Respondents
Physician	82	15%
Counselor	50	9%
Friends or family	18	3%
Therapist	17	3%
Psychologist	11	2%
Pastor/God/prayer	9	2%
Mental health expert	9	2%
Hotline/crisis line	9	2%
Psychiatrist	6	1%
Hospital/ER/clinic	6	1%
Organization/agency	5	1%
Support group	4	1%
Work/school program	4	4%

*Of the 626 people surveyed or interviewed, 565 responded to the question: "If you know someone who you think might be depressed, what would you do to be helpful?" Some respondents cited more than one source of outside help. Others simply said they would seek help without specifying who they would seek help from. Sixty-one respondents did not respond to the question.

understand that suicide is a serious problem and that there are things they can do to help prevent it from happening. The institute used a multi-method approach to do the evaluation, including records reviews, intercept interviews (a convenience sample of people approached for a brief interview in this case at farmers' markets and in skyways and shopping malls), focus groups, and web-based questionnaires.

A total of 626 Minnesota residents were either surveyed or interviewed about whether they were aware of the campaign and whether they were aware of how they could help the targeted group—adult men.

When asked what they would do if they knew someone who might be depressed or contemplating suicide, a majority of respondents noted that they would 1) talk to the person, spend time with him, and be supportive; 2) seek help or try to talk the person into seeking help; or 3) do both—talk to the person and then seek help. The respondents who indicated that they would seek outside help most often mentioned that they would turn to a physician for guidance (Table).

What Physicians Need to Know about Suicide

Physicians were frequently identified as the individual to whom gatekeepers would refer people at risk for suicide. But physicians do not necessarily understand the clinical rationale for suicide risk assessment and the role they play in preventing suicide attempts. The U.S. Preventive Services Task Force found that primary care

providers need to improve their ability to screen for depression and manage and assess suicide risk in patients with psychiatric disorders.^{6,7} Yet, medical students receive little training regarding suicide and continuing education offerings for practicing physicians are few and far between.^{8,11} There is also no requirement by licensing boards nationally or in Minnesota for training in suicide prevention.

The evidence for the effectiveness of specific intervention strategies is building.¹² For example, Kaplan et al. reported that physicians trained to directly question patients about suicide plans elicit more pertinent information than their peers who have not had such training.¹³ For those reasons, physicians and other health care providers clearly would benefit from training on how to ask patients about suicide, how to identify the warning signs of suicide, steps to take to reduce the risk of suicide among patients demonstrating warning signs, how and when to refer to a psychiatrist for further evaluation, and when to seek hospitalization for a patient. Training also should focus on medication prescribing and compliance issues for all anti-psychotics, including the frequency of prescriptions, the amount of medication supplied (eg, a 30-day supply versus a 90-day supply), and dosage. They also may find information about who is at greatest risk for suicide to be useful.

Asking the Right Questions

Assessing for suicide risk challenges physicians to go beyond typical patient-physician communications and probe deeply for often-unstated concerns. Vannoy et al. noted that physicians should frame their questions about depression and psychosocial functioning in a sensitive and straightforward fashion.¹⁴ Closed or polarizing questions such as "You're not feeling suicidal are you?" may stop patients from disclosing the truth. If the patient denies feeling suicidal, brief utterances by the physician such as "OK," "good," or "right" may convey lack of interest or discomfort with the topic and end the discussion.¹⁴ Instead, the physician might ask for more information or express supportive statements to convey concern.

Physicians should recognize the signs of depression, which include sleep disturbances; difficulty thinking, remembering, and concentrating; loss of interest or pleasure in doing things; and physical problems such as back pain, headaches, and digestive disorders.¹⁵ They also should know the signs of acute risk for suicide: talking about suicide, seeking lethal means, purposelessness, anxiety or agitation, insomnia, substance abuse, hopelessness, social withdrawal, anger, recklessness, and mood changes.⁵

When physicians inquire about suicidal ideation, they can do it in a way that feels comfortable as long as their questions include a fatality component. That is, they must use words that let the patient (or suicidal person) know that they understand what is going on. Examples of questions that include this component include the following:

- Are you going to kill yourself?
- Have you thought about killing yourself?

- Do you feel like you want to die or be dead?
- Are you thinking that it would be better if you were no longer around anymore?

If the patient answers "yes" or in any other way indicates that he is thinking about suicide, the physician should take appropriate action such as prescribing pharmacotherapy, referring the patient for psychotherapy or outpatient treatment, or hospitalizing the patient.^{16,17}

Conclusion

Physicians, in collaboration with other community leaders, can play an important role in reversing the suicide trend in Minnesota. They can learn to identify patients who are at high risk for suicide and take appropriate actions to reduce those risks and potentially prevent a patient's death. They need to be made aware of the prevalence of suicide and appropriate actions to take if they suspect a patient or even a colleague is suicidal.

As this research shows, there is a need to provide appropriate information and resources on suicide to physicians because they are the ones to whom concerned family and friends will turn if they suspect someone needs help. Efforts must be made to improve the training of physicians and require continuing education on suicide. At the same time, there must be a continued effort to destigmatize mental illness and suicide so that medical professionals and the public can discuss them without fear of humiliation or loss of their job or insurance. Patients must feel comfortable coming to their doctor and saying that they have been depressed lately. As important, primary care doctors should routinely inquire about a patient's mood, which can be symptomatic of mental illness. Showing care and concern, and understanding that mental pain can be just as severe as that caused by the worst migraine or kidney stone, is generally enough to start a conversation.

MM

Melissa Boeke is manager of epidemiology and assessment services at the Minnesota Institute of Public Health. Tom Griffin is associate executive director of the Minnesota Institute of Public Health. Daniel J. Reidenberg is the executive director of Suicide Awareness Voices of Education, managing director of the National Council for Suicide Prevention, and the U.S. representative to the International Association for Suicide Prevention.

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Resources

Suicide Prevention Resource Center

www.sprc.org

- Is Your Patient Suicidal? poster and guide
- Primary Care Toolkit
- Assessing and Managing Suicide Risk
- After an Attempt guides

Suicide Awareness Voices of Education

www.save.org

American Association of Suicidology

www.suicidology.org

- Recognizing and Responding to Suicide Risk
- Suicide Risk Formulation: A guide for psychiatrists

Florida Statewide Office of Suicide Prevention and Suicide Prevention Coordinating Council

www.helppromotehope.com/initiatives/MAR.php

- Medication compliance/adherence project

U.S. Department of Health and Human Services

<http://mentalhealth.samhsa.gov/suicideprevention/strategy.asp>

- National Strategy for Suicide Prevention

A Shoulder to Lean On

Physicians who are involved in a lawsuit need help maintaining their emotional health.

By Ronald L. Hofeldt, M.D.

According to the American Medical Association, 42 percent of physicians will face a medical liability claim at some point during their career.¹ Working through the litigation process is one of the most difficult things a physician will ever go through on both a legal and personal level. A study published in the *Western Journal of Medicine* in 1988 found that 70 percent to 86 percent of physicians surveyed reported feeling tension, depression, frustration, and anger while going through litigation. In addition, a portion of them were diagnosed with a new physical illness or experienced the exacerbation of an existing one such as hypertension or coronary artery disease during that period.²

A malpractice suit is often a shocking and unexpected event. Physicians who are sued often perceive themselves as having failed. That perception erodes their self-esteem and their confidence in their ability to practice medicine.

Because a typical malpractice claim takes an average of two years to resolve, it can have a dramatic effect on a physician's practice. Far too often physicians lose the feeling of joy they get from practicing medicine; some may even leave the profession during the prime of their careers. In an attempt to lessen the risk of further exposure, physicians who are going through litigation often limit their practice by refusing to treat high-risk patients or perform high-risk procedures. In addition, they are often at risk for a range of health concerns brought on by

exposure to chronic stress including myocardial infarction, cancer, hypertension, anxiety, depression, abuse of alcohol and other drugs, accident-related injuries, and even suicide. Because of the added strain, physicians' personal relationships can suffer, and anecdotal evidence of an increase in marital discord and divorce has been noted.

Physicians who've been sued worry about the five Rs: reputation, referrals, recredentialing, reinsurability, and remuneration.³ Yet, even though they have reason to be concerned about these issues, very rarely do they become problematic in the event of a single lawsuit. However, because their medical training fails to educate them about the likelihood of being sued and the emotional toll that it takes, physicians often feel shame and humiliation when they are sued. This often causes them to withdraw from social and professional activities: They avoid colleagues in the hospital, arrive late to meetings, and leave early. This creates a harmful cycle, as hiding in silence only further erodes their confidence and self-esteem.

More than Legal Aid

A number of groups have recognized that physicians need more than legal support when facing a lawsuit, and some have created resources that allow physicians to share their feelings, acknowledge their fears, and address the emotional impact of litigation. The Physician Litigation Stress Resource Center (www.physicianlitigationstress.org), for example, is a not-for-

profit organization that directs practitioners to articles, books, and websites that offer strategies for coping with the stress of litigation. In addition, a number of medical malpractice insurance carriers offer physicians help in dealing with the stress and emotions associated with litigation.

In Minnesota, MMIC Insurance Inc. created the Physician Litigation Support

Common Reactions to a Lawsuit

- Denial—the sense that it cannot be happening: "How can such a dedicated and caring physician be sued?"
- Avoidance—cutting back on the complexity of procedures performed to lessen the possibility of further litigation. In one case, an orthopedic surgeon refused to operate on left knees after being sued for a left-knee procedure.
- Assurance—ordering more tests and requesting more second opinions.
- Overwork—seeing more patients in an effort to prove that a physician has not lost his touch.
- Self-doubt—physicians thinking they should have provided different care, acted sooner, conducted more research, taken more CME, or spent more time with patients.

Program in 2008 after findings from a survey of physicians indicated that lawsuits deeply affect them and highlighted the lack of resources for those involved in a malpractice suit. It was also reported by defense attorneys that cases that were highly defensible were too often settled, sometimes for large sums of money, because physicians were unable to withstand the pressures of litigation and the rigors of trial. MMIC decided to take a proactive approach and developed a litigation-support program for its clients.

When a claim or lawsuit is brought, physicians automatically receive a letter introducing the litigation-support program. By taking advantage of these services, physicians have an opportunity to share their feelings with a colleague who is knowledgeable about the litigation process and has skills in litigation coaching. Most clinicians are greatly relieved to have an opportunity to openly discuss their feelings about the suit. They've often been carrying the load alone and are grateful to be able to confide in a fellow physician who understands their feelings and is non-judgmental. In addition to being able to discuss what they are feeling and how it is affecting them, physicians who take advantage of the program receive the following assistance, which can help them feel more empowered:

Education about the litigation process. Litigation is often an unfamiliar and intimidating process. Physicians need to know what to expect and how to prepare for the grueling ordeal that lies ahead. For that reason, it is essential that the physician is knowledgeable about every aspect of the litigation process. The more they understand, the better they perform in the courtroom.

Help with preparation. Before testifying at their deposition or trial, physicians are coached on how to be a credible and persuasive witness. Because the deposition and trial provide an opportunity for the plaintiff attorney to intimidate or discredit the physician, the physician must be well-prepared and skilled in maintaining control over his or her testimony. Physicians often are too helpful during the de-

position, which is a common mistake. The less information the physician volunteers, the better.

Because testifying is an emotionally charged experience, how the physician deals with the situation is central to how a suit eventually turns out. If the physician negatively reacts while in the witness chair, the outcome can be altered, and sometimes a case is settled that would otherwise be defensible. For that reason, the physician needs to learn about the attacks and tricks that often come from the plaintiff attorney. They need to also understand that comments should not be taken personally. With preparation and support, physicians will feel less fear and uncertainty and be more resilient when questioned by attorneys.

Referral to local resources. When the physician needs professional or psychiatric assistance, local resources are sought and appropriate referrals made. On occasion, physicians may be advised to promptly contact their primary care physician for assessment and treatment of underlying depression, anxiety, and other conditions. Appropriate follow-through ensures that necessary care is provided.

Education about the importance of self-care and self-awareness. Physicians who are going through litigation are encouraged to follow the advice they give their patients: to slow down, eat right, socialize, exercise, meditate, discover outside interests, play, laugh, and have fun. They are also encouraged to clarify their personal and professional values and goals. Are they practicing the way they want? Do they need a better balance between work and other priorities? Even though litigation is painful, it can help one refocus and define what in life is meaningful and fulfilling. Over the years, many physicians have shared that the malpractice suit helped them slow down and taught them to "take time to smell the roses."

Help with moving on. Once the case is over, physicians experience a huge sense of relief. But it takes time to put the experience in perspective. Physicians who have been through the process and received help through the Physician Liti-

gation Support Program understand that litigation is an inevitable part of practicing medicine. As a result, they can look at their work with new insight. For example, they might better appreciate the importance of documentation and informed consent—elements of medical practice that are sometimes forgotten. And they understand the importance of keeping an open channel of communication with patients and their family members as well as with co-workers in order to lessen the chance of misunderstandings. In addition, they may be more empathetic to colleagues who are going through the process.

They also learn to step back and remind themselves of their extraordinary talents and skills as healers who care deeply about their patients. Instead of focusing on the one patient who brought the lawsuit, they can learn to think instead about the good they do for all of their patients and the wonderful gifts they give them daily.

Conclusion

Litigation is a complex and demanding ordeal. Physicians who go through it often report that having someone who can help them gain in-depth knowledge and understanding of the process and offer them support along the way significantly lessens its toll on both their professional and personal lives. A physician who recently went through a prolonged trial that ended with a successful defense verdict stated, "I never want to go through this again; but if I do, take my hand and guide me through it. Reducing the uncertainty about the litigation process made a huge difference."

MM

Ronald Hofeldt is director of the Physician Litigation Support Program for MMIC Group.

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Rural Medicine Revisited

A collection of essays takes us into the lives of small-town physicians.

Review by Charles R. Meyer, M.D.

His tanned, cracked hands shook slightly as he held the emesis basin, vomiting bright red blood almost continuously. Stoically, he swallowed the large-bore oral gastric tube we used in those days to lavage the stomach with iced saline in patients with a GI bleed. Stoic was the cardinal word for this Iowa farmer who, for the past several weeks, would pause briefly while driving his tractor, vomit blood, and then continue his plowing. Only when he was too weak to walk did he come to the Mayo Clinic, where I was the admitting resident.

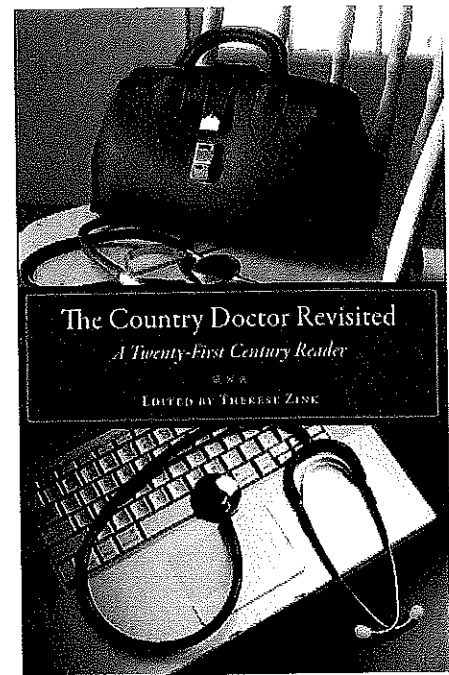
My Iowa farmer patient from long ago surfaced in my memory when I read about Elwin, a farmer described in Donald Kollisch's story "Good Will," one of the essays and poems about the practice of rural medicine contained in Therese Zink's collection *The Country Doctor Revisited*. A victim of valvular disease and congestive heart failure, Elwin insisted on baling hay, more than once triggering a bout of pulmonary edema. Reluctantly, he came to the hospital, telling the ER staff through his gasps that his stay would be short and that he would return to his John Deere. Patients from the farm seem to be made of different cloth. And, as all the pieces in this multi-authored collection show, medicine in the crooks and crevices of the U.S. countryside has a different weave than that of urban or suburban practice.

A family physician and associate director of the University of Minnesota's Rural Physician Associate Program, Zink explores this countryside drawing from widely scattered sources to highlight the heterogeneity that is rural medical practice

today and to portray the beauty, struggle, and pathos of the daily lives of rural practitioners. In her introduction, she says that she hopes to "inspire young men and women to learn more about being healers in rural communities ... and pursue the education to join the struggling labor force of rural health care practitioners."

Rural physicians have unique challenges. They see their patients at church, in the grocery store, and at the barber shop, seemingly never separated from their practice and always under the watchful eye of the community where "you have to be careful about a bad PR rep at church or in the beauty shops," according to North Carolina family physician Tom Bibey. Yet most of the authors in Zink's collection such as Maine family physician David Loxterkamp see the small-town connections as advantageous and pleasurable. "It is easier to be a family doctor and to feel a sense of connection and interdependence in a small community than it is in a large one," he writes, "just as it is easier to sustain one's religion in a monastery than in a mall."

But those connections can hide ethical land mines as physicians take care of fellow townspeople who are such good friends that the professional and the personal intersect. Pediatrician Megan Wills Kullnat explores those dilemmas in her essay "Boundaries," which is drawn from her experiences during a medical school rotation in rural Oregon. She discusses the pitfalls of the lack of privacy and the conundrum of what to say when. For example, she emerged from her rotation convinced that small-town patients



The Country Doctor Revisited: A Twenty-First Century Reader, edited by Therese Zink, M.D., Kent State University Press, 2010

liked encountering their doctor in "social situations [that] reinforce trust and confidence." She writes: "If you don't know your physician, how do you know you can trust him?" Physicians "have to follow the standard of care as you would with any patient. If it's a friend, you have to be extra conscious. Keep asking yourself, am I doing enough here? Am I doing more than I would for anyone else?" Kullnat concludes that this is controllable.

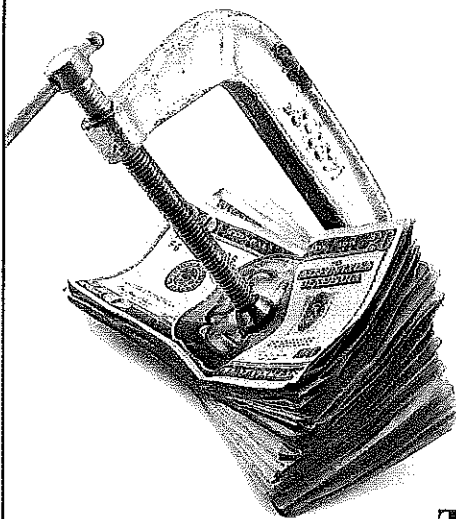
Whether on a house call or in a small clinic, rural physicians need to work with less, Zink and family physician Tara Frerks note in their introduction to the section "Whom We Serve." They write: "The geography isolates you, you confront the limits of your knowledge and your resources, even with today's technology. You learn to work with what you have and discover the confidence and creativity it takes to 'go it alone.'" Go it alone is what Joseph Gibes did in "If You Don't Have What You Want," performing a home circumcision on an Amish infant with an eight-inch steak knife, the only sharp instrument around, or what Emily Kroening did in delivering an Amish baby by oil-lamp light and wood-stove heat.

To a city doc like me, some of the scenes in these pieces sound like cuts from

a foreign film: "Kent raised the manure-splattered tailgate of the livestock trailer to let his cows enter the chute into the Farmers Livestock Auction stockyards. This was the last truckload of his 130 cows that were scheduled to be sold at today's auction." Yet any physician will find familiar strains in these rural docs' stories about their professional lives; for whether we take care of Iowa farmers or Minneapolis executives, we need to be connected to our patients. As David Loxterkamp said so eloquently in his piece "A Vow of Connectedness": "Most of what the doctor accomplishes is infinitesimally small, barely a quiver, broad and trickling like the St. John's River for those who are succored in the watershed of our care. We are stewards of a human ecology. Our practices are strengthened by diversity, interdependence, and the desire for our mutual long-term survival." **MM**

Charles Meyer is editor in chief of *Minnesota Medicine* and practices internal medicine in Edina.

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BURNOUT continued from p. 28

ing to the Joint Commission, hospitals must have a process in place to promote physician wellness. At Mayo, for example, a workout center makes it easier for physicians to take an exercise break, and nutrition counseling helps them plan a balanced diet. University of Minnesota medical students now learn about the concept of work-life balance and attend small-group meetings where they can reflect on their experiences with patients. For residents, the university established new support programs based on requirements of accrediting programs to address stress proactively. With the support of chaplain Bradley Skogen, Lindholm helped bring a physician support group to Lake Region Healthcare in Fergus Falls, where she practices (See "Healing Each Other, p. 26").

Health care leaders are also beginning to address the importance of "career fit" among physicians. Dyrbye describes "fit" as an alignment of the tasks a physician enjoys doing—teaching, for instance—

with what he or she does during a day. In academic settings, for instance, department heads leading annual faculty evaluations can ask physicians about career fit in order to incorporate roles and tasks a physician finds fulfilling into their work.

Some workplace pressures may be harder to address, researchers acknowledge. One frequently cited frustration is implementing an electronic medical record, which can involve a learning curve for doctors that can be burdensome. Moreover, some systemwide changes aiming to address one source of distress may lead to new ones. The national restriction on residents' weekly work hours is one example. The change has reduced fatigue among residents, which is important, according to Dyrbye. But studies have shown that the limits have not lessened residents' stress levels, as they find themselves having to do more work in a shorter amount of time.

Over time, institutions may be pressed to come up with new strategies for giving physicians more control over their

schedules, more autonomy, and more flexibility in their daily responsibilities. Linzer, for one, notes that such changes will slowly change the work environment for physicians. "I do hope people will begin to acknowledge that a more supportive environment for work-family balance, and more attention to time pressure and chaos and values can really change the landscape in how we practice medicine and the kind of care we deliver," he says. He's encouraged to hear that topics such as physician satisfaction and work control are now being discussed at department meetings and by clinic directors. Linzer says changing the work environment to make it less stressful for physicians may take time, but recognizing the magnitude of the problem of burnout is a critical first step. "It's not just an individual's responsibility to face up to the stress of the job," he says. "It's each organization's responsibility to take it on and make it better." **MM**

Kate Ledger is a St. Paul freelance writer and a frequent contributor to *Minnesota Medicine*.

On Seeing Beauty

Medical practice presents us with beauty every day, if only we look for it.

By Burgess E. Norrgard

A man sat calmly on a bed in the ER. He had come looking for relief from a cough and runny nose. But an exam showed his heart beat noticeably fast, and the telemetry indicated “sinus tachycardia.” With medication, his heart’s pace slowed. But the next EKG would read “bundle branch block,” and a day later, sound waves would paint this portrait of his heart: “ejection fraction 30%.” A week later, an angiogram would read, “significant three-vessel disease.” He sat in the ER, innocent, unaware of what was happening inside his body. When our translation was delivered, he slumped as if he had been hit by a bullet.

A month later, the same man stood up when we entered the exam room, as if the Queen of England had suddenly walked through the door. The incisions on his legs had already scarred and his heart no longer raced. When the follow-up was finished, he stood again in awkward silence and expressed his gratitude with a piercing gaze and handshake that had enough gravity behind it to send shivers up my spine.

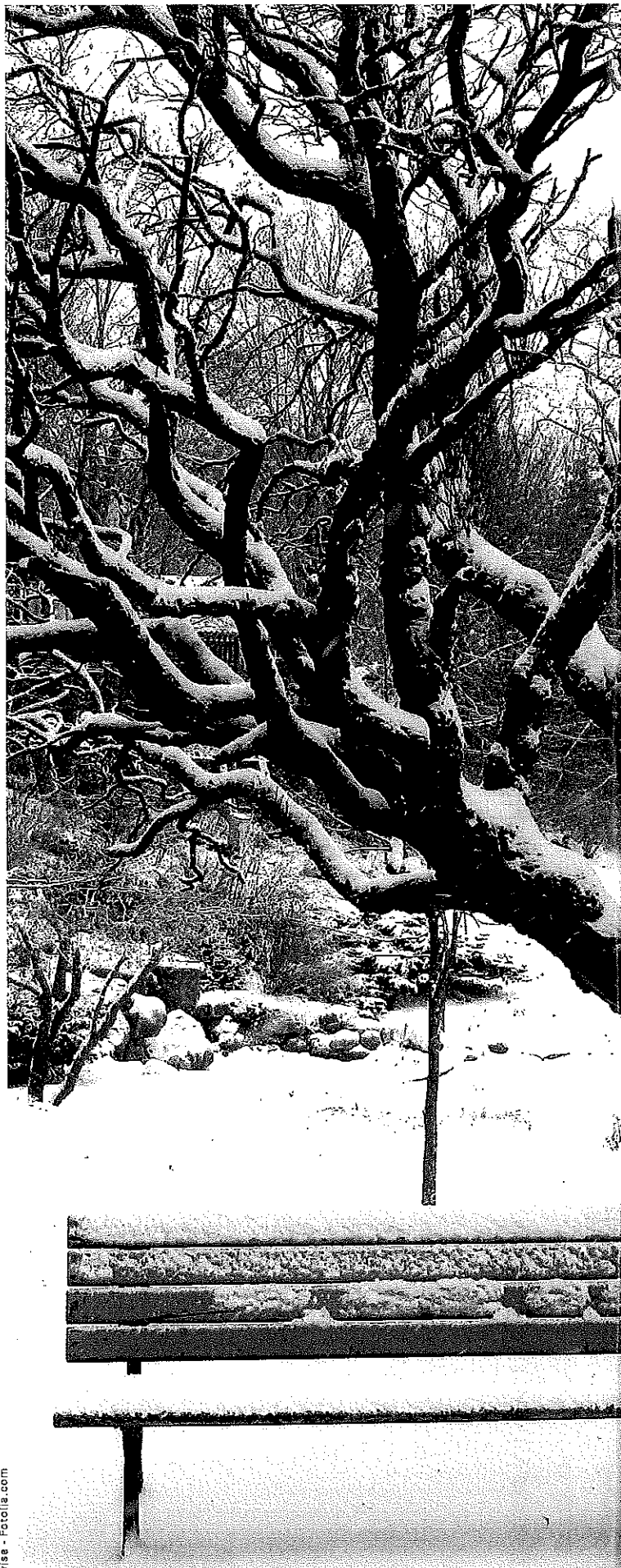
To him, we had saved his life. We knew we had gotten lucky.

The snow fell lightly outside the window of a hospital room. Inside, a patient struggled to breathe as fluid inexplicably filled his lungs. For a month, he had been bedridden as we exhausted possible explanations with tests that provided no answers. Yet when the fluid was drained, he slowly crept back to his former state. I arrived one morning and offered to help him into a chair, his first time to be seated upright in a month. He sat back as if on a throne of dignity and wept, his tears expressing joy in this simple act of living. The man left the hospital with few answers about the cause of his condition.

He and I both, however, had a greater understanding of the rapture of being alive.

As a medical student, I can observe the poignancy of the human condition every day. I have only to banish distractions to see it. Medicine endows physicians with such gifts. If only we stop to notice and admire what we are given. **MM**

Burgess Norrgard is a fourth-year medical student at the University of Minnesota.



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