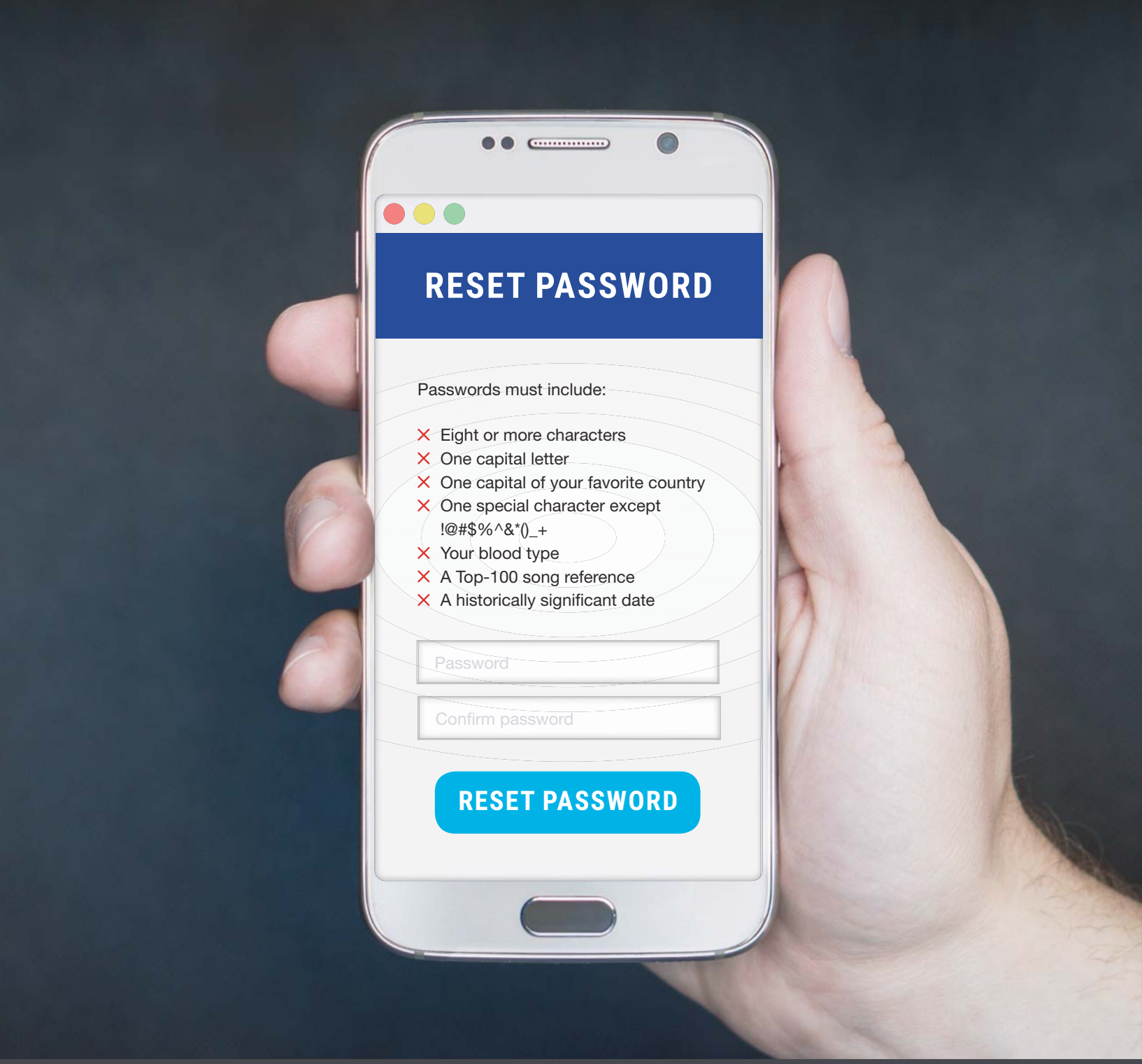
PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

Spring 2019 | VOL 29 | NO. 2

Physician, Heal Thyself

Photography by Chip Coscia



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On The Cover: Chip Coscia Photography

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Executive Director's Message

by Cindy Barnard, Executive Director

The Spring issue of *Panhandle Health* is entitled "Physician, Heal Thyself", an ancient proverb appearing in Luke 4:23. Jesus is quoted, saying, "Ye will surely say unto me this proverb, 'Physician, heal thyself'; whatsoever we have heard done in Capernaum, do also here in thy country." It has been pointed out that Jesus, while hanging on the cross, had cured and saved others, but he could not save himself.

Proverbs similar to this often appear in all kinds of literature. One of the most famous is an Aesop Fable, "The Frog and the Fox". "An old Frog once informed all his neighbors that he was a most learned doctor. In fact, he announced he could cure anything. The Fox heard the news and hurried to see Dr. Frog. He looked Frog over carefully, and finally said, 'Dr. Frog, I've been told that you cure anything! But just take a look at yourself, and then try some of your own medicine. If you can cure yourself of your blotchy, spotted skin and your lame, rheumatic gait, someone might believe you. Otherwise, I should advise you to try some other profession." Here, at PRCMS, we have several confidential committees existing solely for the purpose of assisting our physicians in healing themselves from specific problems such as alcohol and/or drug addiction, depression, suicidal ideation, etc. (i.e. the Caduceus Committee, a 12-step fellowship meeting specifically for medical professionals, and our Physician Health and Rehabilitation Committee.) These committees are not to take the place of NA/AA meetings, which include the general public, but exist in addition to NA/AA. Their members include licensed physicians, presenting a different collegial learning atmosphere. The physician no longer has to heal himself, at least in certain areas.

PRCMS is here to help!

The 116th Annual Meeting of Potter Randall County Medical Society was held January 11th. The gold-headed cane was passed from Dr. Ryan Rush, 2018 President, to Dr. Daniel Hendrick, 2019 President. Officers for 2019 were installed by the President of Texas Medical Association. New Officers include President, Dr. Hendrick, President-Elect, Dr. Neil Veggeberg, and Secretary-Treasurer, Dr. Gerad Troutman. I want to thank our Circle of Friends for their continuing and unfailing generosity and hospitality.

Presidential appointments to Boards and Committees of PRCMS are now ongoing. If you have an interest in serving on a committee, please call the Society office at 355-6854. The core of the Society is its volunteers—the physicians who volunteer for committees and board positions, working on behalf of their colleagues. We truly need you!

Get ready for "First Tuesday" at the Capitol. Pack your white coat and travel to Austin on March 5, April 2, or May 7 to participate in TMA's first Tuesdays. Please don't miss the chance to meet with legislators and their staffs to make sure the voice of medicine is heard. Remember, YOU, our physicians, are the best lobbyists for our patients. You will visit with your senator, representatives, and their aides about key issues facing your profession, attend committee hearing and house and senate sessions, and learn about the obstacles medicine faces: taxes, Medicaid, CHIPS, physician ownership, and scope of practice. Physicians are asked to wear white coats while at the Capitol. Legislative talking points and other materials will be provided. A course on lobbying will be conducted early on each First Tuesday. A $25 charge for each First Tuesday covers your breakfast, lunch, and all materials. For more information, visit www.texpac.org.

On March 29, we will celebrate Doctors Day which was first observed in Winder, Georgia in 1930. According to Wikipedia, Eudora Brown Almond, a physician's wife, decided to declare a day in honor of doctors. The red carnation was chosen as the symbolic flower for National Doctors Day. In 1958, a resolution commemorating Doctors Day was adopted by the U.S. House of Representatives, and legislation was introduced both in the House and Senate to establish a National Doctors Day in 1990.

President George Bush signed S.J. RES #336 (which became Public Law 101-473) in 1991, forever designating March 30 as National Doctors Day. President Bush wrote in the proclamation, "In addition to the doctors whose names we easily recognize, there are countless others who carry on the quiet work of healing each day in communities throughout the United States, indeed, throughout the world. Common to the experience of each of them, from the specialist in research to the general practitioner, are hard work, stress, and sacrifice. All those who serve as licensed physicians have engaged in years of study and training, often at great financial cost. Most endure long and unpredictable hours, and many must cope with the conflicting demands of work and family life." President Bush urged that all Americans "observe this day with appropriate programs and activities."

Our Next Issue Of
Panhandle Health
Features:
Preventative Medicine

Potter-Randall Alliance NEWS

by Ashley Troutman, President

MARCH 2019

The Potter-Randall County Medical Alliance recently had their first quarterly meeting @ The Indigo Room (inside the Metropolitan Speakeasy). We welcomed new members and introduced the new incoming board for 2019. The Alliance is looking forward to continuing the many successful community programs established over the last few years, such as the annual Back to School Event for Heal the City, meals for the Ronald McDonald House, donations for the ACTS Hygiene Closet, and the TMA's Hard Hats for Little Heads.

Thank you to everyone who has helped and continues to help make this organization successful in providing support to the health of Texas in the Panhandle. I look forward to seeing you throughout the year at one of the Alliance quarterly meetings or county medical society socials this year. Bring a friend, learn about our organization and serve in any capacity.

We are looking for volunteers to take a meal to the Ronald McDonald House or donate items to the ACTS Hygiene Closet. If you have interest, please email me at potterrandallalliance@yahoo.com.

Everyone can now join or renew your membership online! www.texmedalliance.org. Please check Facebook, email or the website for a list of events throughout the year.

SHOUTOUTS

Thank you Sofia Balderamos and Dr. Arsenault for providing a meal to the Ronald McDonald House in January and February, and to Michelle Agostini for stocking the Hygiene Closet. Thank you to Christine Cox and Michelle Agostini for planning our first quarterly meeting. We appreciate your service!

UPCOMING EVENTS

Thursday, March 28: Doctors' Day @ Prime Chophouse & Lounge 6:30pm-8:30pm

Sincerely,
Ashley Troutman-PRCMA President
www.potterrandallalliance.com

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LETTER TO THE EDITOR

Dear Editorial Board:

Imagine my surprise when I read the following in the President's Message of the Winter 2018 issue of *Panhandle Health,* the quarterly publication of the Potter-Randall County Medical Society, *"Disease and death are the consequences of sin, and only by tackling sin can we ever hope to be healthy. Sin, which is any deed, desire, or word contrary to our creator God's eternal law, has resulted in profound strife that resonates in all of our earthly relationships (family, neighbors, enemies, etc.), but most damaging to our relationships with God.*

But God, being rich in mercy and because of His great love for us, even though we are sick and dying from our numerous sins, can make us alive together with Jesus Christ, whose death in the cross atoned for every sin to every person who believes in him for salvation." The message continues discussing how "God gave us his greatest gift, Himself in the person of His unique and only son" to those "who have faith in Him."

Apparently, all those years I spent studying science in college, followed by four years in medical school, three years in residency, five years teaching students and residents in medical schools, and fifteen years attempting to diagnose and treat disease in pediatric practice, were wasted. What I should have been doing, according to Dr. Ryan Rush, was simply telling individuals to cease sinning, repent when they did sin, and to have faith in God's only son.

Doing such would have been impossible for me to do, as I am Jewish, and I do not have such faith myself; I am not a Christian. I might also emphasize that a significant number of other members of the Potter-Randall Medical Society would also not be able to follow Dr. Rush's *preaching,* as they are not Christians either.

Preaching, in fact, is what the president's message was all about, and I strongly question the appropriateness of such *preaching* in our medical society's publication.

Dr. Rush, and all other Medical Society members, too, absolutely have the right to believe whatever they believe, and I adamantly defend their right to do so. I do, however, feel such expression of religious belief has **NO** place in *Panhandle Health.* Such religious expression should **never** appear in *Panhandle Health* again, and it should not have appeared this time!

Sincerely,
Nathan (Nick) Goldstein III, MD, FAAP

Guest Editor's Message:
Physician, Heal Thyself

by Tracy Crnic, MD

One evening at an editorial board meeting, the idea for the focus of this issue was conceived. Its purpose is meant "To serve as a wakeup call" to each other regarding a national pandemic that has affected our community profoundly over the last few years. After recent losses of colleagues for several reasons, we decided as a group that this was too important and urgent a problem not to act on. While this is a sensitive subject and may be difficult for many of us to discuss, it is imperative that we as caregivers and colleagues recognize these issues for what they are. And by that I mean: one of the largest causes of morbidity and mortality of, well, **US**. I'm not referring to simple discontent with a situation or having a bad day at the office. These are real disease processes. Physician Suicide, Depression, Substance Abuse, Burnout... They are recognizable, preventable, and treatable!

If we address this problem the same way we would any other disease process, [here I thought of saying either – oral board style – as a lighter way of putting it, or – by applying scientific methodology – more stuffy but still descriptive] we begin by acknowledging that there is a diagnosable entity, then identifying signs, symptoms and risk factors. Once identified, preventative and interventional strategies can then be employed.

What is the Problem?

- Increased incidence of depression, anxiety, and other mental disorders among physicians
- Substance abuse
- Increasing incidence of burnout – this is different than depression.
- Low utilization among physicians of treatment options
- Poor understanding of and "stigmatization of" these issues among physicians as patients and peers
- Leading to increased morbidity and mortality – Suicide

What Signs or Symptoms might be recognized?

- Self-medication – prescription or other substance abuse
- Expression of negative feelings (hopelessness, feeling trapped, agitation, anger, revenge, suicidal plans)
- Frequent mood changes or actions "out of character" for the person
- Sleeplessness or sleeping too much
- Denial of feelings of depression
- Decreased interest in patients and diminishing self-satisfaction
- Withdrawal from peers and family
- Fear of the consequences of seeking help (further loss, retribution, becoming ostracized, or losing control)

Risk Factors: What other information would we want to support the diagnosis?

- Lack of treatment of mental disorders
- Previous personal or family history of mental disorders, especially previous suicide attempts
- Access to and familiarity with potential lethal substances
- Knowledge of ways to avoid detection of disorders
- Suicidal ideation
- Recent involvement in legal or regulatory board issues
- Competitive workplace – fear of loss of stature or job – increased caseload and time constraints
- Financial stressors
- Social or familial loss, lack of support structures (peers, caregivers, friends/family)
- Barriers to seeking care, especially lack of a primary health care provider
- Isolation and fear of seeking help
- Sleep problems
- Substance abuse
- Recent change in job, status, location, ability to practice
- Other physical illness

Intervention: How do we treat and prevent the problem?

- **EDUCATI**ON about these problems, causes, and options
- Acceptance and eradication of the stigma. These are diseases, not decisions.
- Be aware and in tune with your colleagues. Be kind, open minded, and supportive
- Discussion – be the one to break the ice. Eliminate the fear of being the starting point.
- CONFIDENTIALITY – become a safe zone.
- Copy programs that provide coping strategies, stress relief, support, health and wellness, and early intervention in communities or smaller groups…."A pound of prevention so to speak"(Examples of such are in the reference section in the back of this issue)
- Participation in programs to change discrimination in regulatory agencies, credentialing sources, and other institutions that serve to prevent taking action.
- Sharing your story. You may be surprised to find others who have had similar experiences. Hearing from you may break an unremitting cycle of frustration and might open opportunities for healing for you and others.
- Utilization of programs and available treatments – see reference page at end of this issue
- SAY SOMETHING – Get involved – Call someone – you can always change a situation, but you can't reverse death!

Discussion:

Burnout defined: a long-term stress reaction characterized by depersonalization, including cynical or negative attitudes toward patients, emotional exhaustion, a feeling of decreased personal achievement and a lack of empathy for patients. Burnout now affects more than half the physicians in this country. Burnout and distress have been linked to decreased empathy, reduced cognitive functioning and lower quality of care. Burnout is also associated with higher rates of alcohol use disorder and depression, increased risk for suicide, and lower quality of life.

Physicians have higher rates of depressive symptoms, anxiety, substance abuse,

and suicide risk than the general population. Physicians and trainees can experience high degrees of mental health distress and are less likely than other members of the public to seek mental health treatment. Physicians report several barriers to seeking mental health care, including time constraints, hesitancy to draw attention to self-perceived weakness, and concerns about reputation and confidentiality.

Physicians are very adept at dismissing feelings of despair and hopelessness. For example, do any of the following sound familiar?

- I should be able to "heal thyself." I'm a doctor; I'm supposed to know how.
- Call me if you need me. If you call me though, it is a sign of weakness
- I could handle the strain in school; I should be able to tough this out. I just need to toughen up.
- I'm not sick; I'm just unhappy with my life. I am not allowed to be weak. I have to be on top of things or the competition will swallow me.
- Everybody feels this way; this is not a big deal. It's not worth the time and risk to ask for help. I don't want people to think I'm weak or crazy.
- If anyone found out about this, I could lose my license, my privileges, even my practice; then I'd really have no way out.

If not, they should. Many physicians have told themselves these things to justify not seeking help and have heard other physicians express the same thoughts (So you aren't the only one).

Many references I reviewed discuss reasons that physicians in particular are hesitant to seek treatment for these problems. Fear of negative consequences in relation to licensing, regulatory intervention, limitation of privileges, and insurability prevents as many as 60% of surgeons from reporting suicidal ideations. Fear of being labeled "impaired" by peers prevents as many as 1 in 3 physicians from obtaining even regular medical care. Even physicians receiving treatment have reported problems with licensing boards and credentialing agencies, resulting in negative consequences (despite this being considered discrimination according to title 2 of the Americans with Disabilities Act).

Physicians worry that reporting their symptoms will negatively affect their finances, their personal relationships with peers and family, their freedom to practice medicine, and their ability to participate in other activities that promote well-being. The belief that treatment will add financial and time burdens to already overwhelming schedules and the absence of a primary care provider also act as barriers to seeking help. Physicians feel isolated and hopeless. Knowledge of the signs of these disorders enable physicians to "avoid detection." Understanding of and access to means of committing suicide increase the number of successful suicide attempts. In addition, physicians seem to have more fearlessness or desensitization to "blood, injury, and pain" – the ordeal of death. Experts note this as unique to physicians. "Having fear is a huge factor that prevents others from committing suicide."

Physicians are less likely to confront colleagues because of fear of retaliation or blame. Many also fail to recognize signs or choose to ignore them. We fear the stigmata associated with the "tattle tale" persona and the "accuser" role. Colleagues may fear that, if they get involved and a poor outcome ensues, they will be held to blame. One important thing to keep in mind – these are illnesses, not crimes.

Suicide claims the lives of more physicians than of any other profession – more than twice that of the general population. The statistics show rates 1.5 higher among male physicians (compared to the general population) and even higher than that among female physicians. According to Dr. L. Andrew MD in an article from the AMA, this figure approaches a physician per day. He also states that this number is probably underreported because of the stigmata associated with suicide. Among medical students, suicide is listed as second only to accidents as the most common cause of death.

From the American Suicide Prevention Association: Facts about depression and suicide

- Suicide generally is caused by the convergence of multiple risk factors — the most common factor being untreated or undertreated mental health conditions.
- The suicide rate among male physicians is 1.41 times higher than the general population. Among female physicians, the relative risk is even more pronounced – 2.27 times greater than the general population.
- More physicians die of suicide than the sum of all American military deaths in recent Middle Eastern wars.
- Suicide is the second-leading cause of death in the 24–34 age range (Accidents are the first).
- Twenty-eight percent of residents experience a major depressive episode during training (versus 7–8 percent of similarly aged individuals in the U.S. general population).
- Self-medication develops as a way to address anxiety, insomnia or other distressing symptoms. Although self-medicating, mainly with prescription medications, may reduce some symptoms, the underlying health problem is not effectively treated.
- In one study, 23 percent of interns had suicidal thoughts. However, among those interns who completed four sessions of web-based cognitive behavior therapy, suicidal ideation decreased by nearly 50 percent.
- Drivers of burnout include: workload, work inefficiency, lack of autonomy and meaning in work, and work-home conflict.
- Unaddressed mental health conditions are more likely to have a negative impact on a physician's professional reputation and practice than reaching out for help early.
- Physicians who proactively address their mental health are able to provide better quality of care for patients and to sustain their resilience in the face of stress. Mental health problems are best addressed by combining healthy self-care strategies (not include self-medicating) along with effective treatment for mental health conditions.

The most important factor in implementing change that I found in these sources is breaking the barrier by opening a dialog. Whether it is patients themselves or a concerned observer, speaking up is the best first way to make a difference. Openly discussing suicide as an illness helps to "bring it out of the shadows" and to shed the stigma shadowing this problem. Consider this example of one physician's story published in an AMA article.

| *continued on page 10*

After two interns in New York City jumped to their deaths within days of each other, he explained that a dozen years earlier, as a physician in his 40s, his life had all the trappings of success but he was depressed. "[Depression] is a malignancy of the mind," he observed. "It disables our ability to see it in ourselves." He had gone as far as planning how to make his death appear to be an accident rather than suicide. What pulled him back from the brink was a friend's expression of concern. In 2002, at the funeral of a college classmate, he describes a discussion between his friends about struggles in their lives. He quotes, "I sat mute, listening – Then one of my friends turned to me and asked, 'How about you, Jay? You're awfully quiet.' I knew I finally had a chance to be honest... I muttered something like 'Not too well, I think.'"

As soon as he got home from the funeral, he called a psychiatrist friend. "She asked me, 'What is it you're so afraid of?' I said, 'All I do is disappoint people.'... As false as that was objectively, that's the way everything felt."

Once he had acknowledged the problem and had broken his silence, his turnaround was swift. "My response to antidepressants was so dramatic, it's hard to articulate it," he said. "Within seven to 10 days, I felt like a new person." He goes on to explain, "It shouldn't be that this is such a taboo subject in an era when anybody who knows anything about physiology realizes that neurotransmitters and neural networks are how we think and feel."

Since revealing his own safety net, he has heard from more than 100 people moved by his story. One was the wife of the physician with depression so deep that she said the cat sensed it. About a month later, after seeking treatment, the physician's wife told him that her husband was "not perfect but he's better—and the cat sits in his lap now."

On a positive note, as this pandemic has drawn more attention, multiple projects to initiate programs to provide early intervention have taken wing, even in academic institutions. Collaborative committees in government are actively working toward eliminating bias among regulatory agencies. Educational and preventative resources have become more publicized and made more accessible. Means of breaking down barriers and rejecting the "labels and shame" are becoming more acceptable. However, the only way to affect a positive change is to ACT. TALK…ASK… SHARE…LEARN – the same way we would treat any disease or patient. You could SAVE A LIFE!

I have included in the reference section at the conclusion of this issue many avenues for obtaining more information about these problems and opportunities available for confidential professional help.

The most important take-home message both to those of us suffering and to those observing our peers is that **YOU ARE NOT ALONE**. Though things may seem hopeless, there are many of us who experience these problems and who are avenues to help. One of the most important of those opportunities is to talk to someone. If you are in need or you know someone who is, don't be afraid to **TALK TO SOMEONE** that you trust. There are CONFIDENTIAL peer supported groups available locally. We do care, and it can get better.

The Spiritual Practice of Medicine

by Joy Cox, MDiv, LMFT

A Pivotal Story:

I was just out of seminary, continuing training with a year at the school of pastoral care of (now named) Wake Forest Baptist Medical Center and Wake Forest School of Medicine. And I was about to learn some of what I did not know about the life of a physician.

One of the physicians told stories to our cohort about physician stress. With respect and compassion he described a cardiothoracic surgeon practicing hour upon hour to refine his technique; emergency medicine physicians fighting to stabilize trauma patients; a neurosurgeon opening a patient's skull and operating on the organ which is the locus of selfhood. He told stories that are normal for the physicians who do this work, and far from normal for people who don't.

This healer-teacher invited us to imagine what these experiences were like and how they might shape us. He helped me understand the trauma inherent in the work of physicians, and their experience when people who benefit from their sacrifice do not extend grace to them when they exhibit the effects of that sacrifice.

Meaning:

To commit one's life to help suffering people is a profoundly spiritual choice. This sacrificial life can feel even harder when the sacrifice and the inherent spiritual activity are not acknowledged or respected. Although studies support the mental health benefits of prayer and meditation, sacred texts, participation in religious communities, and the classic spiritual disciplines, these are not my focus here. Newberg and Waldman provide extensive references related to these topics (1). What I invite you to consider – or reclaim – is the built-in transcendent power and dignity in what physicians do: work to lessen human suffering.

We all make sense of our world through a meaning system. Our meaning system affects the emotional impact we experience from events in our lives. Confused or conflicted meaning systems correlate with increased psychological struggles. When people are unable to work events into their meaning system – or to enlarge and deepen their meaning system to better contain the events of their lives – they are more prone to rumination, intrusive thoughts, and depression. On the other hand, people whose time, effort, and choices closely align with their core meanings and goals tend to be psychologically healthier and to experience meaningful lives (2).

Periodically revisiting why one practices medicine, resolving conflicts among core beliefs and life choices, and reclaiming the transcendent significance of one's calling may help avert the slide into meaninglessness that is one element of a depressive crisis. A life lived in the midst of human suffering, on the boundary of life and death, calls for a powerful sense of meaning to contain the trauma and sustain vitality and hope.

Relationship:

We know that suicide attempts can be triggered by loss of a person through death or alienation, or loss of face – shame – which resonates with primitive fears of abandonment. Cozolino suggests that apoptosis and failure to thrive can serve as models to understand self-destructive urges as signs of deep loneliness and not feeling connected and valued within one's relationship system (3). Clearly, tending to the health of relationships and resolving inner struggles that hinder one's ability to experience love and support are important for physicians' well-being.

But the challenge does not stop there. The calling of physicians sets them apart. What physicians do, the strain it places on them, the idealizing and de-idealizing transferences people project onto them, and the way these projections cloud people's empathy for them all complicate relationships and can contribute to a sense of isolation. In Wendell Berry's novel, *Andy Catlett*, the title character describes someone as "a knot in the net that has gathered me up and kept me alive until now" (4). The peculiar pressures of a physicians life warrant adding some knots to enlarge that net.

Many spiritual traditions – whether of the East, the West, or of native and indigenous peoples – honor the healer-teacher who chooses to minister where suffering is inevitable. These powerful figures, who grapple with suffering and death and expend themselves in remarkable ways for the good of others (and are often misunderstood), can become a kind of extended community across time and space for experiences that find no home in other relationships. Recalling that, as a physician, one is gathered in the net of generations of spiritual healer-teachers can provide a meaningful sense of belonging.

Nurture:

The community of spiritual healer-teachers also lends support to physicians struggling to nurture themselves and their relationships. Sacred texts and traditions relate stories of people making demands on their healer-teachers even when they are exhausted, and criticizing them for taking time to tend to their health, their inner life, and their relationships. And yet they still make these choices.

Because of the difficulty of what physicians do, they need compassion for themselves. Practicing grace, acceptance, and mercy is a central spiritual discipline

| *continued on page 12*

in many traditions. Not only does self-care find support among the community of healer-teachers, it also aligns with a meaning system that acknowledges the transcendent power and dignity of working to lessen human suffering. Having grace for oneself, accepting one's very real human limitations and needs, and caring well for oneself can help physicians endure in a calling that is both draining and powerfully significant.

Story:

We all have a story, and we tend to live into the stories that other people and we ourselves tell about us. Positive self narratives aid in the maintenance of a vital and secure self, while negative stories perpetuate anxiety and depression. Since stories involve events taking place over time and some kind of emotional punch, they integrate the linear linguistic processing of the left hemisphere with the areas in the right hemisphere that deal with emotions. The cognitive processes that are involved in narration activate the kinds of frontal lobe functioning that help calm amygdala activation. Positive self stories nurture a state of mind that supports thinking and modulates painful affects (3). Stories have power.

A Sacred Story:

In a sense, what I have offered here is the kernel of a story. It is a story of power and dignity, a story that honors the transcendent meaning of a life committed to ministering to human suffering. It's a story that acknowledges the spiritual practice woven throughout the practice of medicine. And it includes some kindred characters as knots in the net to gather up and sustain hurting healers.

How you tell your own unique story can make a difference in facing the challenge to "heal thyself." I hope you tell your story with respect and compassion, with truth and grace.

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Rev. Joy Cox is a Licensed Marriage and Family Therapist in the state of Texas and is certified as a Fellow of the American Association of Pastoral Counselors. She received her Master of Divinity from The Southern Baptist Theological Seminary in Louisville, Kentucky, and is a minister with standing in the Christian Church (Disciples of Christ). She practices pastoral psychotherapy, working with individuals and couples, in Amarillo, Texas.

PANHANDLE HEALTH

A Publication of the Potter-Randall County Medical Society

Editorial Policy and Information for Authors

Purpose *Panhandle Health* strives to promote the health and welfare of the residents of Amarillo and the Texas Panhandle through the publication of practical informative papers on topics of general interest to most physicians while maintaining editorial integrity and newsworthiness.

Spectrum *The Journal* seeks a wide range of review articles and original observations addressing clinical and non-clinical, social and public health, aspects as they relate to the advancement of the state of health in the Texas Panhandle. Pertinent letters to the editor, news submissions, and obituaries listings are accepted pending editorial review. The Editorial Board accepts or rejects submissions based on merit, appropriateness, and space availability.

Submission process Material should be e-mailed to the editor at prcms@suddenlinkmail.com or mail a hard copy to Cindy Barnard, PRCMS, 1721 Hagy, Amarillo, TX 79106. A recent photograph of the author (optional) and a curriculum vitae or a biographical summary are also to be submitted.

Conflict of Interest Authors must disclose any conflict of interest that may exist in relation to their submissions.

Journal Articles Manuscripts should be double-spaced with ample margins. Text should be narrative with complete sentences and logical subheadings. The word count accepted is generally 1200 to 1500 words. Review articles and original contributions should be accompanied by an abstract of no more than 150 words.

References References to scientific publications should be listed in numerical order at the end of the article with reference numbers placed in parentheses at appropriate points in text. The minimum acceptable data include:

Journals: Authors, article title, journal, year volume, issue number, inclusive pages.

Books: Author, title, place of publication, publisher, year.

Web sites: URL of the site and the date the information was accessed.

Other sources: Enough information must be included so that the source can be identified and retrieved. If not possible, the information for source should be included parenthetically in the text.

Illustrations Illustrations should be black and white only with complete-sentence legend.

Previously Published Material Short verbatim quotations in the text may be used without permission but should be quoted exactly with source credited. Otherwise, permission should be obtained in writing from the publishers and authors for publishing extensive textual material that was previously published.

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Long-Term Psychoanalytic Psychotherapy: One Form of Suicide Prevention

by Pamela M. Kirby, Psy.D.

Richard Cory
Whenever Richard Cory went down town,
We people on the pavement looked at him:
He was a gentleman from sole to crown,
Clean favored, and imperially slim.

And he was always quietly arrayed,
And he was always human when he talked;
But still he fluttered pulses when he said,
"Good-morning," and he glittered when he walked.

And he was rich—yes, richer than a king—
And admirably schooled in every grace:
In fine, we thought that he was everything
To make us wish that we were in his place.

So on we worked, and waited for the light,
And went without the meat, and cursed the bread;
And Richard Cory, one calm summer night,
Went home and put a bullet through his head.

BY EDWIN ARLINGTON ROBINSON

Why did they kill themselves?

When someone in our acquaintance commits suicide successfully, we are bothered with painful feelings and questions. People who were closest to the dead person will most often have intense grief, anger, guilt, and stress that lasts a long time. For parents, spouses, and children of the deceased, full "recovery" may be elusive, and most are permanently changed (1). Even those of us who were just an acquaintance, think back to the last time we saw this now-dead person — and scan our memories, searching for a sign missed, some hint or indication of the person's evolving plan to die at their own hand.

How can a person be at work or school, functioning one day, then kill themselves the next? Did someone else ignore the signs or something important? What happened to push the person to this point? Is someone to blame for provoking, or even for failing to prevent, this devastating choice? Could I or should I have done something to avert this catastrophe?

We are forced to realize that we know less about others than we imagined. Frank Bruni writes an OpEd in the *New York Times* right after the summer 2018 suicides of Anthony Bourdain and Kate Spade:

> [This speaks powerfully] to the discrepancy between what we see of people on the outside and what they're experiencing on the inside; between their public faces and their private realities; between their visible swagger and invisible pain. Parts unknown. (2)

The complexity of human beings is such that we can see on the outside a relatively high-functioning, sane, competent person: a professional, a worker, a student. However, on the inside there can be a hidden, locked-away, sometimes shamefully-protected part-of-the-self that contemplated and executed a murder. The suffering of daily life can be invisible to others as the strong, competent-adult part of the personality keeps going with normal life and functioning. Did anyone even know of the person's wish to be free of the shackles that bound them to their current misery, a desire for permanent release, or was it a secret? Some of my most desperately suicidal patients deny having told anyone in their family of their wishes, their planning, and their active preparation.

When I hear of a "successful" suicide, I always wonder: did they ever have a good therapist? Did they ever have a properly long treatment? If they had been my patient, would I have been able to convince them to hang on for a brighter tomorrow? Would they even have trusted me enough to tell me about their suicidal thoughts, plans, and intentions? Could I have been a part of making the intolerable tolerable – not perfect, but not hopeless?

In my therapy office, I hear a great deal about suicide. Some people have thought about suicide on and off, or persistently without pause, since an early point in life. Self-hate and suicidal thinking are quite common in teens or adults who were abused and neglected in childhood, or who have had too much early trauma (illness, loss, disruption, exposure to the trauma of others). The younger we are when trauma, negligent or abusive care occurs, the deeper the wounds. Even more perplexing, some people feel something deep down is wrong, but they cannot identify any early stresses, abuse or neglect.

Suicidal thinking is generally NOT about a wish to die. Rather, it is about a wish to relieve intolerable suffering, intense and hopeless despair, and anguish. Janina Fisher, author of the 2017 book *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation* (3), has an article available at her website entitled, "Self-Harm and Suicidality" (4). She states:

> Suicidal ideation is rarely, if ever, about wanting to die. Its intent is to make life bearable by giving the patient an "out," a way of feeling some control over her pain and shame. (p. 7)

| *continued on page 14*

So often, those left behind wonder why the now-deceased didn't consider them, the pain inflicted on others, the hole their death would leave behind. It is hard to imagine and recover from the injury that we weren't enough to keep them here, that "they left me." The sad truth is that sometimes people's relationship patterns have been so problematic or their suffering so compromising that they don't have an awareness of being loved and important to anyone, anywhere.

Not everyone can always be saved and treated successfully, but an emotional attachment with a therapist can be the thing that makes a difference when suicide is pondered (5). While psychic injuries can exert a destructive impact on us for a lifetime, help really is available and a much better life is often possible. There are therapists trained in building relationships with people who have difficulty loving, trusting, and being close to people, including themselves. Long-term psychodynamic psychotherapy really is often effective (6).

Jonathan Shedler published a helpful review article in the *American Psychologist* in 2010 entitled "The Efficacy of Psychodynamic Psychotherapy" (7). To diminish confusion, he first describes the distinctive processes and techniques emphasized in psychodynamic treatment, including:

1. Focus on affect and expression of emotion.
2. Exploration of attempts to avoid distressing thoughts and feelings.
3. Identification of recurring themes and patterns.
4. Discussion of past experience (developmental focus) [in terms of how this past manifests in the present].
5. Focus on interpersonal relations.
6. Focus on the therapy relationship.
7. Exploration of fantasy life.(8)

Shedler debunks the notion that long-term therapy is not effective, speculating on the origins of this damaging idea. The bottom line is that this type of therapy is associated with "large effect sizes," and with psychodynamic psychotherapy, gains are continued after the treatment is over. Psychotropic medication for depression and anxiety, by contrast, has only a "mild effect size" (9). Shedler ends the article with the following conclusion:

"With the caveats noted above [more research needed], the available evidence indicates that effect sizes for psychodynamic therapies are as large as those reported for other treatments that have been actively promoted as "empirically supported" and "evidence based." It indicates that the (often unacknowledged) "active ingredients" of other therapies include techniques and processes that have long been core, centrally defining features of psychodynamic treatment. Finally, the evidence indicates that the benefits of psychodynamic treatment are lasting and not just transitory and appear to extend well beyond symptom remission. For many people, psychodynamic therapy may foster inner resources and capacities that allow richer, freer, and more fulfilling lives" (10).

There are shorter-term therapies (Cognitive-Behavioral Therapy, CBT) that will often have a similar positive impact in the short run. CBT is typically a treatment paradigm where the clinician and patient will partner in a study of thinking and behavior, with a rational analysis of those thoughts, testing of beliefs, and consciously changing thoughts to something more rational and healthy. While this form of treatment will resolve depression, anxiety, and problems in living in some patients, it will be insufficient for some, and gains made early may be lost after treatment ends. Also, trauma treatment with this shorter-term approach has a much higher dropout rate, approaching 40% (11). There is research supporting that recovery takes more sessions than typical CBT protocols allow.

Psychotherapy takes time. Psychotherapy follows a "dose-response" curve. It takes more than 20 sessions, or about six months of weekly therapy, before 50 percent of patients show meaningful improvement. It takes more than 40 sessions for 75% of patients to show meaningful improvement. These findings, based on the scientific study of more than 10,000 therapy cases, dovetail with what therapists report about successful treatment and what patients report about their therapy experiences (12).

For those of us who know in a deep and abiding way that we are loved, that support is available, that life will be good again, it is difficult to understand that not everyone inhabits this plane of existence/awareness. Sadly, many people live their lives in a state of not being sure who they are; why they hurt so much; who truly, deeply cares for them; why their relationships don't work; what is wrong with them; and/or what would help. This is a person who may benefit from a longer treatment that allows for the gradual development of trust, a titrated revela-

tion of shamed aspects of the self, vulnerable states of being, and terrified feelings. When we are able to work with someone long-term, these painful ways of being can be held, attended to, and, hopefully, slowly healed.

It is so common for people in our culture to eschew vulnerability, and maybe professionals even more than others try to "push through," "man up," "tough it out." For some, seeking therapy is perceived as a sign of weakness, rather than a sign of strength. How sad for all of us that we as a culture so often have to deny our own brokenness, our humanity. The truth is that it seems to take a relationship to handle certain kinds of suffering, and there are people who can help. If you are in some kind of psychic misery, please call a therapist and give it a try.

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Physician Self-Care

by Olga Tolscik, MD, MPH

Most of us are familiar with the flight attendant's statement, "Please place your oxygen mask on first, before assisting others." If one applies this recommendation to physicians, this would mean that we should be tending to our own needs before attending to the needs of our patients. These needs include the physical, emotional and spiritual, to name a few. For many of us in the medical profession, the long and exhausting years of education and training have made consistent self-care a distant memory. Unfortunately, neglecting this critical aspect of health and wellness comes at a price. Depression, substance abuse, relationship challenges, physical illness and even suicide can be the result of a medical career intensely lived. In the current climate of medicine, however, with more patients and outside interference, longer hours and less reimbursement, physician self-care is more critical than ever. For us, the goal is not just to survive as care providers, but to also be able to thrive while doing so.

As a psychiatrist working with postpartum women who tend to relegate self-care to the bottom of their to-do list, I encourage the use of the "N.U.R.S.E." program. This self-care regimen, developed by Jean Watson Driscoll, M.S., R.N., C.S. and Deborah Sichel, M.D., although intended to meet the needs of post-partum women, has many applications for self-care of the typical harried physician. Simple to follow and extremely helpful, implementing the the N.U.R.S.E program in daily life can help physicians better manage stress and encourage regular self-care.

Nutrition is the first aspect of self-care that Driscoll and Sichel explore. Most of us forget Hippocrates's words, "Let food be thy medicine." Long office or hospital hours, lack of healthy nutritious food readily available, and a tendency to eat quickly and mindlessly in between patient encounters can make it difficult to eat healthfully. From obesity, diabetes and heart disease to depression, impaired memory function and anxiety, poor nutrition can negatively impact our performance as healers. Although many would argue that there is not enough time to prepare healthy meals, this ultimately comes at a price. People can get overwhelmed by all of the conflicting information out there about diets and thus often do nothing to change their eating habits. The recommendation of holistic and integrative health practitioners is to simply start with eating whole foods. According to Kelly Brogan, M.D., holistic psychiatrist, the farther food gets from its natural state, the more likely it is to trigger an inflammatory response in the gut. By sticking to fruits and vegetables, lean sources of protein and healthy fats such as avocado and coconut oil, you can avoid introducing inflammatory triggers into your diet. Refined sugars, dairy, gluten, grains (including corn), soy, and alcohol can be pro-inflammatory and should be kept to a minimum. Symptoms of gut inflammation can include fatigue, "brain fog" and flat mood. Much has been written about the gut-brain axis, the enteric nervous system, or ENS – that is, the cellular lining covering the entire GI tract. The ENS sends signals to the brain via millions of nerve cells. Gut bacteria in the gastrointestinal tract can activate neural pathways and central nervous system signaling systems, leading to symptoms of anxiety and depression. In addition, Dr. Brogan speaks about the importance of guarding against micronutrient deficiencies that can affect mood and energy regulation; she advocates supplementing with vitamin B12, magnesium, zinc and essential fatty acids via dark, leafy greens, oily fish like wild-caught salmon, pastured eggs and sprouted nuts and seeds. As patient advocates for improved nutritional choices for our patients, we should also be paying close attention to our food choices as an important part of caring for ourselves.

Understanding is the second element of Driscoll and Sichel's N.U.R.S.E. program. This self-care step focuses on understanding the unique aspects of our careers and how not balancing our needs with the needs of our patients can leave us feeling frustrated, dissatisfied or overwhelmed. Everyone who has gone through the years of education and training necessary to become a physician knows what a toll this unique profession can have on our lives. We face the challenges of caring for patients who are chronically ill or dying and feel the strain that long hours can have on our personal

and familial relationships. Additionally, we often make sacrifices for patients at the expense of our health and well-being. As such, we need to arm ourselves with tools to keep life in better balance. Acknowledging and understanding the impact that job-related stress can have on our professional and personal lives is the first step in recognizing that we, like our patients, are only human. If, in the course of life as a physician, you are struggling with mood, anxiety or substance issues, relationship or financial challenges or are just in need of a helping hand, resources are available in-person and online. It is vital for us to understand when it is time to ask for help. Even when things feel impossible or overwhelming, it is important to realize that we have many different choices that can improve our personal well being. Taking the time, with the help of a trusted friend, family member or therapist, to understand the unique demands of what being a physician is for each one of us, can afford us the opportunity to support ourselves physically, emotionally and spiritually along our trajectory as healers. We cannot truly heal others if we are broken ourselves.

The "R" of the N.U.R.S.E. program stands for **rest and relaxation** and is a critical component of a comprehensive self-care plan. Insomnia is a huge issue for many clinicians, many of whom are engaged in shift work or are stressed to the point that anxiety and worry over patients are preventing them from getting an adequate amount of restorative sleep. While many turn to sedative-hypnotics, benzodiazepines or alcohol to get sleep, the helpfulness of many of these strategies is short-lived and fraught with a unique set of issues, including tolerance and dependence. If suspected, ruling out a primary sleep disorder like obstructive sleep apnea or restless leg syndrome is a good first step. Cognitive Behavioral Therapy for Insomnia (CBT-I) can also be employed to help discover and overcome the underlying causes of one's insomnia. Finally, it is helpful to try to incorporate sleep hygiene measures like shutting off electronic devices at least an hour before bed, keeping the bedroom dark and cool, taking a warm shower or bath with magnesium salts to relax the body and mind, adding melatonin to help with circadian dysregulation and trying to keep a regular sleep-wake schedule, even on weekends. Relaxation techniques are about as individual as you are and might include taking a walk, reading a novel, trying out a new recipe, playing basketball or watching a game with some friends. These types of activities should be penciled regularly into a self-care to-do list.

Spirituality is the fourth element of Driscoll and Sichel's self-care program. The concept of spirituality can be as varied as taking a moment to revel in the majesty of an Amarillo sunrise, to participating in a structured religious service. Attending to our soulful needs as physicians is an important element of self-care. Our daily work requires a mix of empathic compassion and resolute determination to provide the best possible outcome for our patients. This form of intimate connection with a suffering fellow human being can eventually come at a high cost if we do not take time to regularly tend to our own soul needs. Whether connecting with nature or taking time to meditate or pray daily, making spirituality a consistent part of our self-care regimen will restore our resiliency in the face of professional and personal challenges.

The final element of the N.U.R.S.E. program is **exercise**. Many of us feel that walking from exam room to exam room should count as our daily dose of motion. Although that is a start and will likely rack up steps on your pedometer, choosing to engage in a daily form of exercise will not only lower stress levels, and improve sleep and health in general, it can even be as effective as medication for mild to moderate depression and anxiety. Whether it is throwing around a baseball with your child or grandchild, walking the dog, turning on a yoga DVD, gardening on the weekend or actually going to a gym, committing to at least 30 minutes of exercise daily will pay off with increased energy and vitality, lower levels of tension and lower rates of depression and anxiety. We should not be recommending exercise to our patients if we are unwilling to follow our own advice. Start with 10 minutes a day and gradually build up to 30 minutes a day. Your body and mind will thank you.

Working in the field of mental health has challenged me to seek out a more well-rounded, holistic and integrative approach to health and wellness. I always tell patients that medication is just one tool that we have in our toolbox to feel better. The N.U.R.S.E. program is a useful technique that I have committed to employing in my own life as a practicing physician, but also a set of self-care principles that I encourage my patients to incorporate into their daily routine. In the frenzied, demanding and ever-complicated world of medicine, physicians are often being pushed to their physical and emotional limits, often with tragic consequences. We owe it to ourselves as healers never to lose sight of the importance of tending to our own needs, so that we are capable of giving to those that seek our care. Are you ready to put on your oxygen mask first?

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One Physician's Story

by Jesse Benitez, MD
Acting Chief of Medicine, Amarillo VAMC

Like most college students, I was very nervous during my medical school interviews, making it difficult to remember the discussion. However, I do recall one question to which I blurted out the answer instantaneously, similar to a brisk patellar reflex. The question was simple: "Why do you want to become a doctor?" The response was even simpler: "To help people, sir". That year was 1981.

After medical school and a residency program in Internal Medicine here with Texas Tech, I was blessed to deliver what I had stated to my medical school interviewer. Most of my thirty-plus year career has centered around practicing primary care. In order to maintain my urgent care clinical skills, I would occasionally work in the Amarillo VA Emergency Department and a couple of LTACs as well. I was lucky to meet the woman of my dreams during a rotation at High Plains Baptist Hospital. Judy was working as a Registered Nurse on the medical floor during my residency years. We got married in 1989 and together raised two wonderful young men. Life was good.

I suffered a catastrophic illness on March 20th, 2011. I had just returned to Amarillo after traveling with my family to the Texas Hill Country for spring break. March 19th was a fun day of tossing baseballs with my youngest son Joey, who was in Little League at North Randall County Baseball Association. The next morning I woke up with body aches and a fever of 104 F. Judy took me to an urgent care center where I was diagnosed with cholecystitis, with treatment consisting of IM Ceftriaxone and Phenergan, along with a prescription for a gallbladder ultrasound. I was no longer febrile and vital signs were stable. A CBC and Chem panel were unremarkable except for mild thrombocytopenia. After getting home I was so sleepy from the Phenergan injection that I took a nap, only to wake up six hours later with severe chills and very cold, painful hands and feet. Judy was concerned when she looked at me, and for a good reason: my face and neck had developed scattered purpuric lesions. A feeling of doom swept across me as Judy rushed me to the emergency room. I didn't know at that time that I'd never toss another baseball with my hands again.

My presenting illness consisted of severe sepsis with acute kidney injury and diffuse intravascular coagulation, which quickly decompensated into septic shock; however, there was no obvious source of infection. I received IV fluids, pressor agents, and antibiotics, along with plasmapheresis and hemodialysis. On two occasions I required mechanical ventilation. Due to ongoing bleeding I received over forty-five units of packed red blood cell transfusions and other blood products. Despite the aggressive therapies, I began to develop markedly decreased perfusion to my extremities, refractory to leech therapy and a sympathectomy.

My clinical course continued to deteriorate, and my four extremities worsened from cyanosis to frank gangrene, and a decision was made to amputate my right hand, which was the extremity which had initially suffered the most ischemia. This was almost one month into my hospital course, and I had been in a delirious state most of that time. I clearly remember waking up to see my right distal arm in a clean dressing, along with a black, necrotic left hand and feet.

Luckily my condition began to improve. My physicians explained what had transpired and that inevitably I would need amputations of my left hand and both lower legs, but the level of amputation would depend on the final demarcation between viable and dead tissue. Now that I was coherent, panic began to set in. What was I to do as a quadruple amputee on dialysis? How would I support my family? How would I ever practice medicine again? Why did this happen to me? My future seemed hopeless.

My family visited me during Easter. My young sons had not seen me due to my confusion and poor physical status. In order to not worry my children, my necrotic hand and feet were covered best as possible, but at one point the sheets shifted and my right leg was exposed to my oldest son, Javier. I'll never forget the horrified look on his face and the uncontrollable crying that took place. It was that incident, along with the thought of living hopelessly on social security disability, that changed my attitude from a "victimized", helpless person to a more positive, constructive one.

Over the course of a few weeks, the gangrene finally halted, and I had my left hand and both distal legs amputated. Along the way I had a laparoscopic cholecystectomy secondary to acalculous cholecystitis. Hemodialysis continued, and a renal nuclear scan gave my nephrologist no hope of any kidney recovery. Plans were made for peritoneal dialysis, and I had a dialysis catheter inserted into my left lower abdomen prior to leaving the hospital. I was now a quadruple amputee with end stage renal disease. What a disaster! I focused on rehab; luckily, I had always been in decent physical shape, so I progressed rapidly. I had to maintain an anabolic state, but the chronic nausea and horrible renal diet made it difficult to eat. I met my future prosthetist, Chad Mason, of Amarillo Artificial Limb and Brace during my rehab stay. He used his amazing knowledge and skills to make my arms and legs functional again. Physical therapy for my legs was easy, but not the occupational therapy for my hands, as bilateral arm amputees were a rarity in this area at that time.

I was discharged after 103 days of hospitalization. I continued both physical and occupational therapy and eventually transitioned into peritoneal dialysis. My wife quickly learned how to use and to troubleshoot the dialysis exchanging machine, and my bedroom was converted into a dialysis ward. The parents and boys of Boy Scout Troop 1221 stepped up to the plate and constructed a concrete ramp

so I could drive my electronic scooter into my home. For some reason I had an aversion to meat products; a large part of my caloric intake included eggs and beans, prepared Mexican style. After about a month, I developed a consistent routine and made a decision to return to work.

It was heartwarming returning to my office, despite the multiple times that I sat frustrated, staring at an electronic medical record or a large pile of medical charts to review. Adjustments were made so I could use my scooter in place of a chair, and the IT service provided me with a joystick to replace the computer mouse and a keyboard so large it appeared comical. My work was purely administrative due to my handicap. My wife would visit every day around noon, were she would administer a dialysis exchange to keep me as healthy as possible. I was so happy to be productive once again, as I had never in my life been a sedentary person.

After about two years of peritoneal dialysis, I received a phone call from Baylor All Saints Medical Center in Fort Worth, Texas: they had a kidney for me. It took awhile to find the best kidney since I had so many antibodies in my serum from multiple blood products during my illness, making a match difficult. Judy drove me to Fort Worth, and the pre-op work-up revealed hyperkalemia, so I was treated with IV insulin and dextrose, only to suffer a hypoglycemic reaction…wow, that was weird! On May 14th I was taken to the OR to receive my cadaveric kidney: a precious gift from an unknown donor. The surgery went well, and I awoke to find a scar on my lower right groin area (transplanted kidney) and the peritoneal dialysis catheter was gone. It was awesome to urinate again! Unfortunately, I began to develop abdominal distension, and three days post-op I perforated my cecum and developed peritonitis requiring emergent surgery. After two exploratory laparotomies and three days in the ICU (yes, sepsis and mechanical ventilation once again), my condition improved. It was horrible looking at the scar running vertically across my abdomen, along with an ileostomy bag in my right lower abdominal quadrant. I was confused, but mostly I felt so sad for my wife. I had put her through two horrible ordeals, and this time in a foreign place without friends or family to give support. I had to get better soon.

After six weeks of PT and multiple visits to the transplant clinic, I was strong enough to go home and so happy to be off dialysis. The ileostomy bag had to be emptied multiple times daily, and the maintenance required a lot of work. Once again, my wife to the rescue. I went back to work and wore scrubs so as to accommodate my abdominal "accessories". Judy would visit me three times a day. Luckily, we didn't live far from the clinic. After three months I had the ileostomy reversed, and quickly abandoned the "hospital scrub" look.

It was now time for some "normalcy" in our lives. I had handicap equipment installed in my truck. I took the mandatory training to apply for a new driver's license and passed. I studied for the Maintenance of Certification in Internal Medicine and eventually passed. I joined a gym and began weightlifting and bicycling, which required a lot of re-training. I kept breaking prosthetic parts, but my prosthetist, Chad, would quickly fix them and keep me going. I needed to show the Texas Medical Board (TMB) that I was physically and mentally sound to practice medicine again, which required evaluations from a multidisciplinary team of healthcare professionals, and then received a "thumbs up" from the TMB, along with ongoing evaluations from a worksite monitor.

I was eager to practice medicine again, as administrative work decreased interactions with patients. It's heart-warming to receive a smile and sincere "thank you" from patients and their families. I applied for basic medicine privileges and after receiving them began to treat patients in an ambulatory care setting. After several months I transferred from an outpatient to inpatient hospital setting and began supervising residents from the Texas Tech Internal Medicine program. After two and one-half years of hospital medicine I have relearned practices from many years ago, along with the changes that have occurred. I recently took a course in bedside ultrasound (POCUS: point of care ultrasound) and have a new tool that I can use with my prosthetic hooks.

I'm very lucky I didn't die on March 20, 2011. There are good days and bad days. Phantom pains are real, but the meds to treat them make me too groggy so I put up with the pain. Every day I think of the brave physicians, nurses, and ancillary staff that spent much of their time keeping me alive. They are my heroes and I respect every one of them. I feel that God kept me here for a reason: to help other people, despite my limitations. I've been able to see my sons grow into young men and to appreciate my wife more with each passing day . I live my life as if I'm driving an automobile, not staring at the rearview mirror (i.e. dwelling in the past), but rather concentrating on the road ahead: my future. I realize just how physicians, with their knowledge and skills, can help many people. Yes, our profession is very stressful with all the responsibilities and expectations that occur daily. But don't forget one thing: we save lives. We bring comfort to patients and their families. The caring and compassion that come from our hearts to help people are wonderful assets: assets that should make every physician proud of what they do. I'll continue to practice medicine and help people, and if by chance I stumble and fall, please pick me up, and together we'll do our best during our journey in this wonderful world.

Understanding and Assessing Substance Use Disorders in Physicians

by Amy Stark, MD

Tony Montana (Al Pacino's infamous character from the film "Scarface") was warned, "Don't get high on your own supply," which unfortunately was sage advice that he didn't heed. Like Montana, many physicians find themselves in stressful situations with proximity and easy access to substances. This combination can easily lead to misuse use of alcohol, prescription medications or illicit drugs. For example, Dr. William Halstead (known as the father of modern surgery) developed an addiction from his own experimentation with cocaine when he was studying it's use as a surgical anesthetic. And Dr. Halsted wasn't the first physician to succumb to substance abuse; in his documentation of the medical profession, Sir James Paget, one of the founders of the study of medical pathology, mentions in 1869 physicians who are impaired by "habits of intemperance (3)."

Physicians and other health care professionals are not immune to developing psychiatric problems or issues with substance use (SU). In fact, the rates of substance use disorders (SUD) among physicians are similar to those in the general population, although assessing rates of SU in physicians has proven to be more difficult than in the general population, likely given a reticence to self-report (2). Recently identified evidence suggests that SUD in physicians may be increasing above the national average (3). Unfortunately, given their roles as healthcare providers, physicians who develop SUD not only place themselves in harm's way, but they are risking the wellbeing of their patients, too.

But what exactly is a substance use disorder? According to the DSM-5, "the essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems (1)." More specifically, there are criteria that are used for all classes of substances (except for caffeine) to assess and diagnose a SUD (table 1). The criteria are organized into groups, with criteria 1 -4 representing impaired control over use; criteria 5-7 representing social impairment; criteria 8 and 9 representing risky use; and criteria 10 and 11 indicating physiological dependence. Meeting two or three criteria represents a mild SUD, four or five represents a moderate SUD, and six or more a severe SUD (1).

Rates of SU (not meeting criteria for a disorder) in physicians have been reported as five times higher than that of the general population (2). One theory to explain this phenomenon is that physicians are self-medicating to address their medical or psychiatric problems with substances of abuse (alcohol, pain killers, and sedatives). All too often, physicians procrastinate in addressing their own health problems (medical and psychiatric), while continuing to work long hours in high stress environments that demand excellence and exact an emotional toll. This is unfortunately fairly common, and places physicians at an increased risk for developing SUD.

There are risk factors that increase the chance of developing a SUD which apply to the general population and physicians alike; for example, family history of SUD and comorbid psychiatric illness. There are some risk factors, though, that seem to be specific to doctors including: idealistic beliefs, perfectionistic behaviors, and having a high rank in the academic class while training. While these may seem like admirable traits to have, when they clash with restrictive systems of care, unending documentation requirements, and an unforgiving work-life balance, they can lead to disenchantment with the profession, compassion fatigue, and burnout. Certain specialties appear to be higher risk than others for developing a

Table 1:

1. The individual may take the substance in larger amounts or over a longer period than was originally intended
2. The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use
3. The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects
4. Craving, or a strong desire to use the substance
5. Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home
6. The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
7. Important social, occupational, or recreational activities may be given up or reduced because of substance use
8. Recurrent substance use in situations in which it is physically hazardous
9. The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
10. Tolerance, or requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed
11. Withdrawal, recognized as a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of the substance

Diagnostic criteria for substance use disorders (1).

SUD, with emergency medicine physicians, anesthesiologists and psychiatrists topping the list (2, 3). There are many hypotheses for why these specialties are at higher risk, but likely it's multifactorial. Some factors that are often cited, like demanding hours, easy access to abusable substances, and a high emotional toll to the work, are seen frequently in these three specialties, but certainly aren't limited to those areas of practice. It's also worth noting that physicians are more likely than the general population to consume alcohol or misuse prescription medications than to use illicit drugs (2).

Unfortunately, recognizing SUD in physicians isn't always as easy as counting criteria; they tend to be particularly adept at masking developing problems. By the time signs of a SUD are apparent in the workplace, SU is likely to have become an entrenched habit. Even if subtle signs start to show, they are often ignored if there is no obvious impact on the physician's work (3). There are several warning signs that can be observed, both in the work place (fig. 1) and on a personal level (fig. 2) (2). Any abrupt change in personality or habits is always a clue that something may be amiss. More obvious signs include signs or symptoms of withdrawal from a substance or smelling like a substance, but there are many subtle signs that can be missed. Recognizing these signs in yourself or in a coworker should signal a call to action to get help.

Figure 1: Personal signs that may be a warning of substance use (2).

- Disheveled appearance
- Worsening personal hygiene
- Slurred speech
- Somnolence
- Moodiness, irritability or depression
- Smelling of alcohol
- Unexplained tremors or ataxia
- Unexplained weight changes

Figure 2: Warning signs of substance use in the work place (2).

- Changes in personality or behaviors
- Inappropriate trembling or sweating
- Difficulty adhering to a schedule
- Increase in patient complaints
- Frequent, unexplained absences
- Decreased workload
- Excessive ordering of drug supplies
- Writing prescriptions for oneself
- Asking others to write prescriptions for self
- Inconsistent quality of work
- Spending time behind locked doors

There are many different avenues to explore for treatment options. Some programs are designed for physicians or other professionals who require a residential program or inpatient care. In general, these programs are intensive, and those who complete them experience excellent success rates. The success rates for physicians, as high as 75-80%, is astronomically higher than that of the general population (2). Some of this success may be attributable to the level of motivation in physician's seeking treatment; they have much to gain from getting sober, and a significant amount to lose if they don't. Primary care physicians, psychiatrists and addiction specialists can provide care at the outpatient level. Peer support groups, like alcoholics anonymous (AA), often are an important part of recovery. For physicians in some cities, there are AA groups (and other peer support groups) specifically designed to cater to their needs. However, seeking treatment locally can be intimidating for many physicians – especially for those in smaller communities. Unfortunately, many barriers remain to obtaining care, and significant stigma exists around SUD, even in the medical community. There is also a long-standing tradition in medicine of tolerance and denial of mental health issues or SUD among our own cohort.

There are also physician health programs at the state level that can offer help. The Texas Physician Health Program (TXPHP) accepts referrals from colleagues and family members, but also encourages self-referral for those in need of guidance or assistance. All referrals are kept confidential, and, though the TXPHP receives administrative assistance from the Texas Medical Board (TMB), a participant's file is not available to the TMB while the participant is following the treatment plan. This allows for state-level support for physicians seeking recovery from SUD or assistance with psychiatric problems without the fear of punitive measures.

It is said that an ounce of prevention is worth a pound of cure, and this is true for physicians and SU, too. Basic self-care measures, such as making wellness a priority and addressing health issues as soon as they arise with one's own established physician, can be protective against developing SUD and many other problems. Medical degrees do not confer immunity to mental illness or SU, and seeking help early is not only the right thing to do to protect one's own health, but it also models the importance of self-care for our patients.

Physician health is an issue that often gets pushed aside, but our community is striving to optimize access to care for physicians, while raising awareness of the issue and reducing stigma. The Department of Psychiatry at Texas Tech University Health Sciences Center in Amarillo is opening its first professional's clinic to address psychiatric issues and SUD. Late hours will be offered for those who can't leave their own clinics during regular business hours. If you need assessment and would like to be seen in this clinic, please contact us at 806-414-9970, and mention the professional's clinic.

Physicians deserve a place to feel safe in addressing their needs and to get excellent mental health care. We aspire to fulfill that need, and to strengthen and support the doctors who give so much to our community. Please reach out if you are struggling with substance use or mental illness. You are not alone, and we are here for you.

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The Wall

by Rouzbeh K. Kordestani, MD, MPH

I had the pleasure and the fortune/misfortune of attending a recent Doctors Company event in Houston. A small group discussion had been assembled of members of the Doctors Company insured groups who are actively involved in lawsuits. The Doctors Company had convened this meeting of the minds to discuss something far more important—how do physicians feel when involved in litigation? And how they should work while going through this trial and tribulation?

As a member of this small group, I too am involved in a lawsuit. My suit is about something trivial, and I believe can truly be considered frivolous. However, that is not the point of this discussion. As about a dozen physicians discussed their feelings, it became obvious that we each had gone through a great deal. We noted feelings of helplessness, sadness, betrayal, disgust, annoyance, anger, confusion, fear and loss. These were common. Each physician had learned to temper their response to meet these feelings. Many had gone as far as becoming hardened towards their newer patients. As a lesson, it became obvious that, without introspection, these feelings could change the physician and not in a good way.

I for one offered something that has helped me over the last 12 years. I am a plastic and reconstructive surgeon and so have a diverse number of patients and cases. As I have completed these over the years, my patients have ingratiated me with accolades and thanks. Simple thanks is what has powered me through. First it was the hugs. Then it was cards. I have been fortunate to get dozens and dozens of cards. I have taped these to a wall in my office and just refer to it as "the Wall."

On the Wall, I find a note from a young girl whose arm was saved from necrotizing fasciitis as she fought ALL and had no white count. There was a note from a fellow physician whose ICP monitoring was poorly followed and was on the verge of brain death. There are notes from school kids thanking us for saving their friends. There are notes from parents thanking us for the life of their loved ones and their promised future. I even have notes from the parents as their kids have grown up and I now have a chance to see what they look like. I have softballs from kids' first home runs after they learned to wield a bat with fewer fingers. I have pictures from their proms.

The Wall has enabled me to see what I have been able to achieve over the years. As opposed to the athlete, my trophies are walking around in the community. Whenever the day gets heavy and the situations difficult, I do my best. When the staff leaves, I grab a cup of coffee and sit in front of the Wall. I look through these notes and regain my smile. I cry a bit for my specialty and for my field, because I know we are fading as the world is changing. The ability to heal and to care is now falling far behind keeping up with the numbers and the business of medicine. The staff knows this too, but they do me the honor and the favor of continuously adding cards and notes as they come in. The Wall continues to grow.

I am proud to be a physician and a surgeon. I do not believe I had any idea that the job would be this difficult when I started; maybe it wasn't back then. Listening to so many physicians in the conference from Doctors Company that day in Houston, I realized I was not alone in my feelings--but by the same token, I have my Wall.

I would ask each and every physician out there to make your own Wall and let it help you remember why you became what you became. Maybe, in that way, we can help medicine again become more of an art and less of a science.

Cover Artist - John Coscia, MD

I lived in Memphis, TN from birth through medical school. The Air Force then sent my to Lackland Air Force Base in San Antonio for residency. I had wanted to be a surgeon since a teenager until the third month of a surgical residency. While making 4:30 am rounds I realized I could not work for 48 hours straight and that I had to choose another specialty. Since I had never given a thought about being anything else I didn't know what to do. The department chairman recommended I take off 2 weeks and think about it. Two things determined my fate: I had an interest in photography and my med school radiology professor asked if I had ever heard of anyone getting out of radiology. I hadn't, so since radiology was somewhat like photography and with my professor's mention of the retention rate in radiology, I switched residencies and never regretted it. A few years after getting out of the Air Force and having worked with a general radiology group, I became interested in subspecializing in breast imaging. I left the group and started my own practice limited to breast imaging. I later started a breast imaging rotation for radiology residents at UT Southwestern Med School in Dallas and subsequently was asked to come to Amarillo to start a breast imaging section at the Harrington Cancer Center. My family moved here in 2002. I then became the medical director at Texas Breast Specialists at Texas Oncology in 2008. I retired in 2017 and am now looking for places to go and subjects to shoot photographically. The change in my medical direction reminds me of what I heard a long time ago: Life is what happens while you're making other plans.

Chip Coscia

Acceptance, Self-Compassion and Resilience

by Jim Rogers, LCSW

Life is hard. At least so says M. Scott Peck, M.D. in the beginning of his well-known book, The Road Less Traveled (Peck, 1978). And, I think, he is generally right. Life can be very hard. It can also be delightful. Life itself presents us with a wide variety of experiences, pleasant and unpleasant, some difficult, some free and easy. They happen whether we like them or not. Our responses over time to these experiences will strongly influence the quality of both our professional and personal lives. The purpose of this paper is to explore how the processes of psychological flexibility, acceptance and self-compassion can enhance our successful navigation of the bumps and detours that we will inevitably encounter in our daily lives.

Why the need for this? In our culture, we are obsessed with the idea that we should always be "happy" and abhor anything that results in pain, either physical or emotional. As a result, we go to great lengths to eliminate all forms of discomfort, as well as to avoid almost all situations that might give rise to unpleasantness. And, if we find ourselves in the uncomfortable position of actually hurting, we do everything we can to avoid, run from, or numb it, including isolating from other people. Our lives are the less for it.

Not only are our lives diminished by this compulsive avoidance of pain, but in the process we also lose our skills and abilities to overcome difficulties in the future. So, if we do experience trauma of some sort (and we all have, and will), we will have limited responses. When difficult times fall upon us, we wind up having no options but to withdraw more and more from life. To make matters worse, as we begin to run from unpleasant experiences, we also begin to have a damping of our pleasant experiences as well. Our lives become flatter, more constricted, and lonelier.

This becomes even harder if we buy into beliefs that justify our avoidance. Those of us who are used to operating in arenas where we are constantly seen as the expert, or the guy or gal who has it all together, often begin to believe our own press. We forget that we are ultimately just another member of the human race who may have specialized knowledge and skill, but at the end of the day we are just another Bozo on the bus. We come to believe that we are immune from normal human experience, and, therefore, should be "above" doubts and struggles. Should one of those experiences blindside us, we quickly fall into self-criticism and self-recrimination. And because of the potential shame, we won't let anyone else share our struggles; we have to do all of this alone.

Frankly, doing this alone doesn't work too well. Not only do we turn away from others, but we turn away from ourselves as well. We begin to lose perspective, and lose any ability to see our thoughts and emotions with any sense of balance. Instead of transient experiences, our thoughts and feelings become things that must be conquered and mastered. We find that we are at war with ourselves, with no clear path to either victory or defeat.

It doesn't have to be this way. We can learn to view thoughts and feelings differently. We can learn to move toward thoughts and feelings and hold them lightly. We can then see them in a more positive light, not as things to be coped with, but as experiences that can truly add to our lives. In his last book, *The Wisdom of Wilderness,* which was written while dying from cancer, psychiatrist Gerald May, M.D. writes about his experience during his years of practice, and how growing in his ability to be open and accepting of life on life's terms allowed him to embrace and savor his experiences, rather than attempt to control everything around him. He talks about his years in practice, during which he worked with patients to help them cope with their feelings, and ignored the deep meaning and power that those experiences could have provided. "Even when I assisted people in uncovering long-buried emotions, I seldom encouraged them to savor the life-juice of the feelings themselves: the rich dark love-nature of grief, the warming fire of anger, the subtle luminosity of loneliness, the pure gut-driving power of sexual desire, or the exquisite clarity of fear." He goes on to rue that he simply helped them cope. "I have come to hate that word," he writes, "because to cope with something you have to separate yourself from it. You make it your antagonist, your enemy." (2) He finishes by acknowledging that these emotions neither need to be acted out, nor do they need to be tamed. Amen. Our innards are not enemies that have to be locked up. Ultimately everything belongs.

This ability to allow everything to belong is really what acceptance is about. Some people cringe at that word, equating it with passive resignation. It is not. Acceptance is an active process that requires conscious willingness to allow whatever is to be as it is. When we can let whatever is just be as it is, we can see the situation with clarity, and then can flexibly choose responses that are effective and aligned with our values (including responses that require us to act quickly and decisively even if that means not attending to any emotional response that may be lurking in the background).

This is not always easy to do, especially if we are caught up in thoughts and belief systems that label any difficult or painful emotion as unnecessary, irrational, unproductive, or weak. Under the sway of these belief systems we try to prevent, banish, or ignore any semblance of

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emotional activity. And should a pesky emotion break through our defenses we may retaliate by suppression, self-recrimination, shame, and withdrawal.

As with feelings, these thoughts and beliefs are really not our enemies. They can exist, but they do not have to dominate our minds and behaviors. We can learn to appreciate them too without being hijacked by them. Learning to view them from a distance, and with a willingness to understand their function, may allow us to begin to have some compassion for the battle that seems to rage within.

For many of us, the thought of having compassion for ourselves can seem a bit odd, maybe even a bit selfish, or a form of self-pity. But acceptance is not passive resignation; self-compassion is not self-pity. Self-compassion is a positive process that acknowledges the importance of, and the normal desire for, health and well-being for oneself. It also includes engaging in proactive behavior to better one's situation.

Self-compassion is a way of viewing oneself with acceptance, kindness, and a gentle recognition that we all share a common humanity (Neff, 2011). Doing so allows us to drop our pretensions and protective personas, gradually enabling us to see ourselves as individuals who deserve care, kindness, and understanding. And when we can do that, perhaps we can begin to turn toward ourselves with curiosity and kindness.

When we can turn toward ourselves in this way, we can begin to just let ourselves be, without needing to explain or defend. This is hard because it allows the discomfort to be present. Most of us would fear approaching that pain for fear that it would lead to more and more pain, leaving many people to say "If I go there, I will never stop crying". The truth is, that never happens. The greater truth is that, if the deeper pain is touched, it can then begin to be set free. Emotion that is blocked or suppressed doesn't really go anywhere. It just hangs around quietly tormenting us. When it begins to be set free, vitality begins to return. We actually feel something, and that feeling flows through us. And this doesn't apply only to painful emotions. When we begin to free any stunted feeling, all are revitalized.

This works better if we don't do it alone. Since we are all members of the same humanity, we all experience pain, sorrow, rejection, and grief, as well as joy, happiness, excitement, and the myriad other emotions with which we have been gifted. So, again with a sense of kindness and a desire for real healing, we can hold ourselves lightly, staying open, and then allow someone we trust to be with us and our experience. When we do that, we can really allow life to flow within us, perhaps even experiencing the vitality of those experiences that Dr. May described. We can truly leave the prison of our thoughts and feelings and begin to have real freedom.

After all of that, we can very simply spell out what to do when life is hard. Accept what is (including thoughts and feelings), acknowledge that we are all just people, share your pain (and joys) with yourself and another person, and take what you learn from those experiences to live in ways that give you meaning and purpose.

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Biographical Statement

James S. Rogers, Jr. received his MSW from the George Warren Brown School of Social Work, Washington University, St. Louis in 1979. He provided clinical services with the Missouri Department of Mental Health and Deaconess Hospital in St. Louis, MO from 1979-1984. He returned to Amarillo in 1984 and served as Executive Director for Family Guidance Center of Amarillo (now Family Support Services) and Catholic Family Services (now Catholic Charities) until 1988, when he joined the Department of Psychiatry, Amarillo Campus of the Texas Tech School of Medicine as an instructor. He also began a private psychotherapy practice in 1988, and has continued to practice psychotherapy in Amarillo since then. He has served as instructor for the Social Work Program at West Texas A&M University, and field instructor for the University of Missouri School of Social Work and the George Warren Brown School of Social Work in St. Louis. He has received advanced training in Cognitive Behavioral Therapy, Mindfulness-Based Cognitive Therapy, and Acceptance and Commitment Therapy.

POTTER RANDALL COUNTY MEDICAL SOCIETY (PRCMS) OFFERS HELP TO TROUBLED PHYSICIANS

If you, or a physician you know, are struggling with addiction, depression or burnout and are unsure what to do or whom to contact, the Potter-Randall County Medical Society is here to help. We offer face-to-face confidential sessions with the PRCMS Physician Health and Wellness Committee, made up of your physician peers who know and understand recovery. Please don't struggle alone when help is a phone call or an email away. Whether you are calling for yourself, your practice partner, or as a family member of a physician, contact Cindy Barnard, PRCMS Executive Director, at 806-355-6854 or prcms@suddenlinkmail.com. Membership in PRCMS is not required.

Understanding Suicide in Physicians: Risk Factors and Interventions

by Mun Yee Kwan, PhD

Suicide rate is alarmingly high among physicians – 1.41 times higher for male and 2.27 times higher for female physicians in comparison to the general population (1). Some risk factors of suicide identified as particularly relevant to physicians include burnout, working environment, substance-related problems, and psychiatric disorders, specifically depression (1, 2). Several other risk factors of suicide that are important to consider include acute stressors (e.g., agitation, sleep disturbances) and hopelessness (3).

According to the Interpersonal Theory of Suicide (4, 5), the perception that one is a burden to others (perceived burdensomeness) and the lack of social connectedness (thwarted belongingness) contribute to suicide desire. A third component that moves suicide desire towards suicide attempt is capability for suicide, which is composed of decreased fear of death and increased pain tolerance. Capability for suicide is particularly relevant to certain populations, including medical physicians. The nature of this profession involves exposures to provocative events that are fear-inducing, such as treating severely wounded patients in the emergency room or performing life threatening surgical operations. Over time, physicians become habituated to these provocative events, thus increasing their capability for suicide. Other painful and provocative events that may contribute to an increased capability for suicide are previous suicide attempts, non-suicidal self-injurious behaviors, childhood maltreatment, and combat exposures. Research shows that suicide risk is greatest when a previous attempt has occurred within the past two years (3). These risk factors are important to consider when understanding and assessing the risk of suicide.

According to **cognitive-behavioral theory**, dysfunctional thinking and impairment in problem-solving contribute to suicidal thinking and behaviors (6). Common dysfunctional thinking associated with suicide includes hopelessness, helplessness, and unlovability (7). The goals of cognitive-behavioral therapy (CBT) include the modification of dysfunctional thinking and the improvement of problem-solving skills (e.g., conflict resolution, social support). For example, clinicians may facilitate the construction of a hope box and coping cards with their patients (8). A hope box helps challenge dysfunctional thinking (e.g., I am a failure, I am unlovable) with personalized items such as pictures, poems, or stories that remind patients of their previous successes, reasons for living, and pleasant experiences. Coping cards aim to promote the utilization of effective problem-solving skills. For instance, a list of 8 to 10 coping skills are prepared in response to a potentially distressing situation or thought, such as "when I feel worthless, I…" Problem-solving skills are personalized but may include "play with or walk my dog," "practice progressive muscle relaxation," or "pay a visit to the local homeless shelter."

Cognitive-behavioral therapy is available in multiple modalities. Cognitive Behavioral Therapy for Suicide Prevention [CBT-SP; 7)] is a manualized, short-term (approximately 10 sessions), face-to-face CBT for patients with a recent suicide attempt or an acute suicidal ideation. In addition to some of the intervention strategies discussed above, developing a safety plan and relapse prevention are critical. During relapse prevention, patients visualize events that could potentially lead to suicide attempt and describe skills they might use to mitigate suicide risk. CBT-SP is an empirically-supported treatment that reduces suicide risk in various populations and settings.

Web-based (e-health) intervention, a treatment modality with certain advantages over face-to-face intervention, has been shown to be effective for various psychiatric disorders, including depression and anxiety. One major advantage of web-based intervention is accessibility as it relates to cost, transportation, distance, and stigma. Web-based intervention may be a viable option for physicians, especially when considering erratic schedules and, in smaller towns, dual-relationships (e.g. the physician may be both a friend of and health care provider to the potential therapist). Is web-based intervention effective in preventing suicide? A recent meta-analysis examined the efficacy of CBT delivered face-to-face and via e-health. Findings supported the efficacy of the former in reducing suicidal ideation and behaviors (9). The findings, however, were inconclusive due to the very limited number of studies that had examined web-based CBT on suicide.

One study included in this meta-analysis focused on medical interns. Specifically, this study investigated the effectiveness of a web-based CBT program as an intervention for suicidal ideation among medical interns (10). This web-based program consisted of four 30-minute weekly web-based sessions (total of approximately two hours) with modules focusing on the interplay between thoughts, emotions, and behaviors, identification and modification of dysfunctional thinking, and the development of problem-solving skills. Medical interns completing the web-based CBT program were less likely to endorse suicidal ideation in comparison to those in the control group.

Coping Long Term with Active Suicide Program (CLASP; 11) is a newer intervention that adapts some behavioral strategies, such as problem-solving and social support. It is delivered via two delivery methods, in-person meeting and phone contact, with both the patient and their significant other. A unique characteristic of CLASP is the involvement of a significant other, which improves

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family communication and increases support to both the patients and their family. Additionally, it utilizes the patients' values and goals to facilitate behavioral changes and to help patients move away from a sense of hopelessness. Preliminary evidence supports the effectiveness of CLASP in reducing suicide risk (e.g., suicide attempts, psychiatric hospitalization due to suicide ideation or intent). CLASP may be another feasible option for medical physicians, as most of the sessions are conducted via phone.

Dialectical behavior therapy (DBT) was first developed for patients with elevated suicide risk. It is based on three major theoretical frameworks: behavioral science, dialectical philosophy, and Zen practice (12). Two of the four skill-training modules within DBT may be particularly effective in reducing suicide risk: distress tolerance and emotion regulation. These distress tolerance and emotion regulation skills are to be practiced regularly, and not just during times of active distress, for them to be effective.

Distress tolerance skills aim to help patients survive crisis situations without making these situations worse. Some distress tolerance skills that are helpful in reducing suicide risk include self-soothing, distractions, and improving the moment. Patients experiencing distress are encouraged to engage in self-soothing with their five senses – for example, listening to comforting and pleasant music and smelling relaxing or invigorating scents. While distraction may not be an effective long-term strategy, it is effective in the short-term to cope with distress and suicide risk. Patients may choose to distract themselves with activities (e.g., watching a comedy, cleaning the house), contribution (e.g., helping others), or sensations (e.g., taking a cold shower, tasting a slice of lime). Patients may also improve the moment by engaging in relaxing imagery and actions (e.g., taking a hot bath), finding meaning, or praying.

The goals of the emotion regulation module are to help patients understand and accept their emotions, to lower vulnerability to unwanted emotions and suffering (increasing emotional resiliency), and to increase emotional balance. Some emotional regulation skills include: accumulating positive experiences and emotions, building mastery or competence, and maintaining emotional well-being. It is recommended that patients actively create and experience positive events and pay attention to pleasant moments in their lives to accumulate positive emotions. They should focus on positive events and emotions in both short- and long-terms – for example, taking a walk, listening to a joke, spending time with a friend, taking steps to go back to school, or learning a new instrument. Building mastery or competence helps patients feel a sense of accomplishment, which may be achieved from completing daily living tasks (e.g., taking care of personal hygiene, doing laundry, attending to children, friends, or pets) or challenging and yet realistic goals (e.g., resolving a conflict, developing a new hobby or skill). Basic self-care skills help reduce emotional vulnerability and suffering. Imagine a morning with sleep and food deprivation: what are the chances that you would be annoyed, angered, or saddened by a supervisor's critique of your work? Therefore, it is important to practice basic and daily self-care skills, including attending to your physical health, consuming balanced meals, avoiding drugs and excessive alcohol, getting adequate good-quality sleep, and engaging in physical exercises.

Suicide is a major public health concern, especially among high risk populations such as medical physicians. Cognitive-behavioral therapy and dialectical behavioral therapy are two interventions shown to be effective at reducing suicide risk. While various delivery methods (e.g., web-based, phone) are available, research is needed to examine the effectiveness of these deliveries in reducing suicide risk among physicians.

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Being a Doctor: Suggestions for Career Satisfaction in Medicine

by Steve Urban, MD

This issue of *Panhandle Health* looks at the problems that can beset a medical practitioner: lawsuits, burnout, substance misuse, depression, burdensome computer work, marital conflicts, and many more. Many physicians counsel their children against entering a medical field, and rates of physician dissatisfaction are higher than ever before. I'm writing to offer a counterbalance to such gloominess. Despite my obvious shortcoming of having failed to strike it rich as a general internist (no surprise there!), I look back on my 40 years with satisfaction and pride, and I'd like others to focus on the positive. Being a physician is a rewarding profession, and I'd encourage anyone with the grades, the humanistic skills, and the work ethic to consider medicine as a career.

I am fortunate that, for the most part, I have loved my work as a doctor, but I acknowledge that much of my optimism is due to good luck. I have been lucky to have a wonderful family; I did not have to spend time in divorce court or bailing my kids out of jail. I graduated from medical school debt-free (thanks, dearest Joan and parents). I have been blessed with supportive colleagues, both in private practice and at Texas Tech, who have shared my values and who lived (and continue to live) a deep commitment to patient care. I was lucky not to have suffered through a lawsuit – I use the word "lucky" because I certainly have committed my share of errors, many of which grieve my inmost soul to this day. But part of my satisfaction with my life in medicine relates to habits of mind and practice that I have tried to nurture over the years. I want to reflect on a few of these, in the hope that the lessons I have learned will have some general applicability to physician practice and career satisfaction.

Principle #1: Take time

He was young, and came to my first visit in a motorized wheelchair with PEG tube in place. He had been diagnosed with amyotrophic lateral sclerosis and needed a primary care physician. In those days, the standard practice at Nichols, Nicklaus, Grooms, Urban, and Pierce was to allow a full hour for the initial visit. So, I had plenty of time to do a good neurological exam. Surprisingly, the exam was nearly normal – no hyperreflexia, no atrophy, just a few scattered fasciculations below the knees. The patient has seen several neurologists, none of whom felt comfortable in excluding his feared diagnosis of ALS. I was probably dealing with a psychogenic illness!

My first thought was: do I really have time to take this on? This patient will consume hours of office time for explanations, evaluations, re-examinations, and more explanations. I will have to endure disbelief and recrimination; I will probably fail. The patient will angrily find himself another PCP. Plus, I had a wife and three kids that I really enjoyed spending time with--spelling bees and track meets and choir concerts to attend. Did I really have the time this patient would need?

I decided to take the time. Another neurologist's opinion and an EMG/NCV showed no evidence of motor neuron disease. So, I brought him back to the office and told him that this was a conversion reaction. "You mean, it's all in my head?" (a loaded question, to which I usually respond with another question), but this time I took the straight-ahead approach: "Yes, it is." Fast forward several months--PEG tube out, using a walker, getting stronger. I took care of him for many years until I retired from practice. The last time I saw him, he was having dinner with his wife and two kids at Outback.

Your best moments as a physician occur when you take more time than you thought you could spare. Now, obviously, you can't take an hour – or even 20 minutes – with every patient. Five or ten minutes with a patient with an upper respiratory infection is all it takes. But there are occasions – and you recognize them even when you want to deny it – when you just have to take that extra time. These borrowed minutes have been some of my best moments as a physician. When I see former patients who thank me for being their doctor, rarely do they say "You were so smart!" or "How cleverly you diagnosed my problem!" They say: "You helped my dad go to the bathroom when nobody else was around" or "Remember when you sat with Mom after my sister had passed?" or "Thank you for bringing me that cup of coffee when the nurses were busy." Sometimes these events take five minutes and sometimes they take hours – and you may have to make your remaining patients wait – but your self-respect and satisfaction as a healer depends on them. You cannot be kindhearted on a tight schedule.

Corollary of principle #1: be attentive. Listen to what your patient has to say, and notice too what he or she doesn't say. At the beginning of the interview, interrupt only for clarification (if the patient turns out to be one of those talkers who can never get to the point, proceed to plan B!). Remember Willy Loman's cry of the soul in *Death of a Salesman*--"Attention must be paid." To pay attention is the first sign of your respect. Banish from your mind, for a minute, thoughts of time, money, family, colleagues, appearance, and status. Give your patient the gift of your undivided attention.

Principle #2. Tell the truth

He was a 48 year-old school teacher, and his bones hurt. He was pale, and he had lost weight. An in-office lateral skull x-ray revealed what I most feared: the punched-out lesions of multiple myeloma. Within a few days a CBC, serum protein electrophoresis and urine studies had confirmed the diagnosis.

I called a hematologist, got him in the next day, and felt that I had done everything a good internist should do.

A few months later, though, I received a letter. The patient had accepted one course of chemotherapy, had fortunately gone into remission, but now at his family's request was pursuing "Complementary and Alternative Therapy" at a clinic in Mexico. Would I please write a letter to his insurance company, attesting that the alternative treatment was "medically necessary"? Late that night, I penned a long note to the patient, saying that I couldn't provide the letter because I just did not believe that such treatment was medically justified. I received a response, castigating me for being a terrible doctor, an uncaring dupe of big pharma, and (I remember the words exactly) a "robot of the AMA," (an organization to which I have never belonged). These last, taunting words: "By the way, we got another doctor to certify medical necessity, and the insurance company has agreed to pay." Oh, well, I sighed, another dissatisfied customer.

The real surprise came 8 months later when the patient showed up in my office. He looked terrible, groaned in pain with every movement, and begged for help. His bone pain had recurred after the effect of the chemotherapy had worn off. He went back to Mexico, where he was told "We're not sure what the problem is, but it can't be cancer. We cured that. Go home." The patient presented for help, and I was not going to turn him away just because of his previous hostility. We resumed the necessary chemotherapy.

Telling the truth – the whole truth – can be hard and time-consuming. I was pretty good at not lying as a resident, but I learned how to tell the truth with practice and by example of my private practice partners. Breaking bad news is never easy – you can't sugar-coat it, and yet you must be compassionate and try to preserve hope. I never enjoyed it, but I came to believe that I could do it well and no longer shied away from the responsibility.

Another situation that calls for honesty is managing conflicts of interest. The very practice of fee-for-service medicine involves conflict – you are paid for what you do, not what you don't do – and it can be hard to be honest with yourself and with your patients in ordering tests, making referrals, etc. Sometimes we order extra tests because of patient demand, or fear of lawsuits (less of a worry in Texas after tort reform), but sometimes it's because we make money that way. Unless you are a sociopath – in which case you will laugh your way through this whole essay --I believe that you will sleep better if you to try to honestly acknowledge and then to manage your conflicts of interest.

Principle #3: Be humble

Her family brought her to me because of intellectual decline. She was 81 years of age, and her previously impeccable sense of style was descending toward the disheveled. She forgot daily tasks and became confused in common situations. The neurological exam revealed a MMSE score of 22 but no focal findings.

| *continued on page 30*

My heart sank: dementia. But I knew what I was supposed to do: work her up for "treatable causes of dementia." I was elated (and not a little proud of myself) when her CT scan showed a benign 4 centimeter tumor in the left frontal lobe. I told the family that we could help her, and referred her to a neurosurgeon.

Two months later, after "successful" neurosurgery had removed the tumor, however, I was left to care and to grieve for a woman who was a shell of her former self – bedfast, mute, uncomprehending. Post-operative hemorrhage, followed by one complication after another, had left my patient severely impaired. I thought to myself on rounds one night: "She would have been better off if she'd never seen my face." Through her, I came to recognize two principles that I hadn't learned in medical school: (1) most "treatable" dementia really isn't – the patient usually has Alzheimer disease AND hypothyroidism, not dementia DUE TO hypothyroidism – and (2) old people tolerate brain surgery poorly. Unfortunately, my patient had to teach me this lesson at her own great cost, and I had to come to terms with my own unjustified pride. Despite my training and best intentions, this patient would have ended her life more happily without me.

I know what you're going to say: "It's easy to be humble when you're Steve Urban! What about me? I never make mistakes." I understand the point. Despite my attempts to be attentive and meticulous, I have overlooked important details, or lost the big picture in pursuit of minor symptoms, or let fatigue becloud my judgment. It is important to acknowledge and learn from your mistakes, and yet you have to be able to forgive yourself for your human failings. As the magisterial W.B. Yeats put it: "Measure the lot; forgive [your]self the lot!" Medicine is a complicated business, and as long as you don't err from neglect or carelessness (by which I mean: not taking time to care), you can acknowledge your failings and learn from them. Every time I felt that I was getting pretty good at this diagnosis business, I discovered that I was just setting myself up for the fall.

As an antidote to pride, I recommend that you attend the funerals of your patients. Sit there, listen to accounts of this person's real life – i.e. their life away from the doctor's office and the hospital--reflect on your weaknesses and strive to improve. "If I had been a better doctor, could I have prevented this from happening?" Patient CARE encourages humility.

Principle #4: As I said in the previous sentence: CARE

My friend, colleague, and patient Dr. Barton Grooms was dying of metastatic prostate cancer. He was in hospice and on a morphine drip because of bone pain; his alertness waxed and waned. As I was visiting, on the last day of his life, he asked his family members to step out and beckoned me to lean closer. "Check on

Rex Vermillion," he whispered – the last lucid words I heard him say. On the way home, I stopped by the clinic and went to Barton's office. On his desk was Rex's chart with a note about his laboratory results. On the last day of his life, almost to his last breath, Barton Grooms cared for his patients.

Much has been written on this topic of caring, from Francis Peabody to Abraham Nussbaum, and I cannot match their eloquence. But the ability to empathize with – in a way, to love – your patients undergirds a satisfying professional life for a physician. We often say, "I took CARE of her when she was in the hospital" or "I provide primary CARE" – dammit then, MEAN IT. Care about your patients enough to get to know them, to ponder over your best advice, to worry about them at night before you fall asleep. Imagine what it is like to be them: to grow up African-American in Amarillo in the 1950's, or to prefer alcohol to your family--to grapple with the implications of HIV, or to come face to face with the limits of mortality. Let them break your heart. Sure, you'll have to close the office door for a tearful minute after you have delivered (or heard) the bad news, but you – and they – will know that you are trying to live up to our best calling.

My favorite movie scene of all time occurs in "Field of Dreams", where Ray Kinsella (Kevin Costner) visits the office of Dr. Archibald "Moonlight" Graham (a real person, but in this case played by the incomparable Burt Lancaster). Ray laments the doctor's brief baseball career, to which Graham replies: "Son, if I'd only gotten to be a doctor for five minutes – now THAT would have been a tragedy."

Despite its pitfalls, medicine offers a wonderful career. You get to meet patients when they are sick and afraid, and to help them work toward wholeness – sometimes through judicious treatment and sometimes just by listening and counselling. You get to establish long-term caring relationships. Patients share deep fears and look to you for help – you are important in their lives! If you don't abuse their trust, you gain respect and affection. You are adequately remunerated for doing good – it doesn't get any better than this.

So, despite the time commitment and the stress of the busy clinic or the operating room, despite the rigorous training and the long hours of practice, despite the forms and the multi-layered bureaucracy – despite all these things--the rewards of a medical career are great. Seek help when you are stressed, talk to your colleagues when you are discouraged, admit your humanity when you have erred – but don't lose sight of the fact that what you do in your daily life is noble, that selflessness glows of its own warmth, that you are rewarded for caring. You are a healer, and the sum total of good in the world grows because of you and the work you do. Take the necessary time, reach toward the truth, walk humbly, care – and your rewards will be bountiful.

Addendum:

Some of my anecdotes have been altered to render the patients unidentifiable, but I use Rex Vermillion's real name with his permission. I use Barton Grooms' real name in this essay because he earned it.

Physician Burnout: Defining the Problems, Revealing the Solutions

Reprint from "The Doctor's Advocate" Second Quarter 2018

Physicians are perfectionistic, hard-working, and trained to put the patient first. The practice of medicine has always been stressful: physicians manage patients in a world of diagnostic uncertainty and frequently difficult decision making. These factors have always been a part of medical practice, but in the past few decades, and at an accelerating pace, increasingly burdensome nonclinical demands and requirements have been placed upon physicians, particularly in primary care, filling the day with barriers and frustrations, and making a challenging job even more difficult.

The following list represents some of these demands and requirements (1).

- Learn workarounds to maneuver through electronic medical record (EMR) user interfaces; perform data entry that could, and should, be done by others (e.g., scribes); demonstrate meaningful use (MU); answer questions coming in through the EMR patient portal; and manage EMR drug interaction warnings, which are often clinically irrelevant and/or incorrect.
- Hassle with payers over prior authorization issues.
- Pick the correct diagnostic code from the more than 69,000 choices in ICD-10.
- Conform to and report multiple quality measures (MACRA).
- Fulfill maintenance of certification (MOC) requirements and perform tasks and tests to demonstrate competency.
- Conform to HIPAA and state medical board regulations.
- Fulfill complex evaluation and management (E&M) coding requirements.

When physicians are unable to recover and rebound from the ever-increasing demands of their medical practices, the result is often burnout, a chronic condition that is a *normal response to an abnormal situation*, but that brings with it negative psychological, physical, and cognitive effects.

Recognized as a leading measure of burnout, the Maslach Burnout Inventory (MBI) lists three characteristics of burnout (2):

- Emotional exhaustion: the feeling of being overextended and exhausted by one's work.
- Depersonalization: the feeling of losing a compassionate approach to patient care, which may lead to cynicism.
- Loss of personal accomplishment: the feeling of loss of efficacy and competence.

A seminal paper, "Burnout and Satisfaction with Work-Life Balance Among US Physicians Relative to the General US Population," was published in the *Archives of Internal Medicine* in 2012 (3). This paper generated response by the lay press, including the *New York Times* and *The Atlantic*, thus demonstrating public interest and concern. The authors analyzed over 7,000 survey assessments using the MBI, and found that 45.8 percent of physicians reported at least one symptom of burnout, with the highest rates in family practice, general internal medicine, and emergency medicine. A further finding was that high levels of education and professional degrees seem to *reduce* the risk for burnout in fields outside of medicine, whereas a degree in medicine *increases* the risk of burnout. The authors concluded that "the fact that almost 1 in 2 US physicians has symptoms of burnout implies that the origins of this problem are rooted in the environment and care delivery system rather than the personal characteristics of a few susceptible individuals."

Given the expansion in practice reporting requirements and increasing EMR use and complexity, it should be no surprise that a 2015 survey published by *Mayo Clinic Proceedings* (4) found that nearly 55 percent of 6,880 physicians reported burnout, and a 2016 survey conducted by the physician recruiter firm Merritt Hawkins reported that 49 percent "often or always" experience feelings of burnout (5).

A 49 to 55 percent prevalence of burnout among physicians does not bode well for the delivery of healthcare—particularly primary care. Evidence also suggests the following:

- That medical students are learning to stay away from primary care (6), and only one in 10 doctors recommends medicine as a career (7).
- That physicians already in practice are reducing the number of patients they are willing to see per clinical session, or are transitioning to part-time (8).
- That physicians are converting to concierge practices (9).
- That 50 percent of physicians over 50 aim to retire within five years (10).
- That physicians leave clinical practice for administrative position (11).

What are the effects of burnout on patient care? They are not good for either patient or doctor. To quote Dr. Donald Berwick, former administrator of the Centers for Medicare and Medicaid Services (CMS) and former chief executive officer of the Institute for Healthcare Improvement: "As joy in the workforce erodes, quality goes down (12)." For each one-point increase on the depersonalization dimension of the MBI, the likelihood of reporting an error increased by 11 percent (13), with obvious liability and medical board implications. In addition, patient satisfaction surveys, increasingly important for both practice marketing as well as compensation, reflect negatively on physicians who are dissatisfied with their work.

The EMR and computerized physician order entry (CPOE) have been major

contributing factors to physician burnout. Shanafelt et al. report that over 80 percent of physicians now use EMR and CPOE (14). Physician satisfaction is generally low, with the amount of time spent on clerical tasks of particular concern. Valuable time is taken away from direct patient contact, including history taking and thorough physical examination.

Other concerns relating to EMR and CPOE are these (15):

- Physicians spend two hours on the computer for every hour with a patient.
- Fifty percent of time is spent on the EMR, while only 27 percent of time is spent in direct contact with the patient.
- Emergency room physicians average 4,000 total mouse clicks for charting functions and documenting patient encounters during a 10-hour shift.
- EMR documentation requires 6.5 hours per week more than time spent on paper record systems.
- EMR and CPOE compromise focus on the patient (not unlike operating a car while texting).
- EMR design is inefficient and nonintuitive.
- EMR use reduces productivity by 20 to 40 percent.
- EMR use decreases face-to-face communication with nurses, medical assistants, and other physicians.
- EMR alerts are too frequent, and too frequently make no sense.
- For every patient seen in the office, a physician receives a non-visit-related inbox message for another four patients.

Of course, EMR and CPOE are not the only burdens on clinical practice. ICD-10 has increased the number of diagnostic codes from 14,000 to 69,000. It has also added laterality and severity parameters, as well as combination codes to designate complexity. E&M coding and documentation are complex and time-consuming.

Physician burnout can result in decreased quality of care, reduced physician productivity, and diminished patient satisfaction. Burnout increases medical error and physician turnover. Personal repercussions of burnout include broken relationships and marriages, alcohol and substance abuse, depression and suicide. Burnout is expensive. The cost of replacing a physician is estimated to be two to three times the physician's annual salary. Each one-point increase in burnout on the MBI is associated with a 30 to 40 percent increase in the likelihood the physician will reduce work effort in the next two years. Burnout clearly needs to be addressed at the personal, institutional, and system-wide levels.

Progress requires an understanding of the multiple root causes of burnout and a willingness on the part of the individual physician, institutional clinic leadership, EMR software designers, and, importantly, those involved with healthcare regulation and documentation requirements to confront the issues leading to burnout. As Dr. Dike Drummond describes it, burnout represents a dilemma, the solution to which requires a commitment to foster a healthy balance between the energy put into work

| *continued on page 34*

and the effort spent on the restoration of energy: i.e., decrease work-related stress and/or increase the ability to recharge energy (16). Drummond describes many potential causes of burnout and provides a matrix of 235 ways to prevent burnout (17). From this matrix the physician should focus on the three to five measures most germane to him or her.

Examples include:

- Improving EMR skills through mentoring by a colleague who is skilled at making the EMR work efficiently for him/her.
- Shifting more data-entry burden back to clinical staff. This could include medication reconciliation, laboratory, and imaging CPOE.
- Using a scribe.

Of great importance is to make the case to the clinic administrator that changes will improve productivity and patient satisfaction.

Shanafelt and Noseworthy describe nine organizational strategies used at the Mayo Clinic to promote engagement and reduce burnout (18). The Mayo Clinic has been able to *reduce* physician burnout by seven percent despite an 11 percent *rise* in the absolute rate of burnout in physicians nationally. As a result, the physician burnout rate at Mayo Clinic is 33 percent compared to 49 percent nationally. The authors list nine organizational strategies to promote physician well-being. A few examples are these:

- Acknowledge the problem of burnout at the leadership level, and demonstrate that the organization cares about the well-being of its physicians.
- Consider ways to mitigate the potential negative effects of productivity-based pay.
- Promote flexibility and work-life integration.
- Provide resources to promote resilience and self-care.

In "Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians," published in the *Annals of Internal Medicine*, the authors acknowledge that the "growing number of administrative tasks imposed on physicians, their practices, and their patients adds unnecessary costs to the U.S. healthcare system, individual physician practices, and the patients themselves (19)." The American College of Physicians (ACP) "calls on stakeholders external to the physician practice or health care clinician environment who develop or implement administrative tasks (such as payers, governmental and other oversight organizations, vendors and suppliers, and others) to provide financial and time and quality-of-care impact statements for public review and comment." The authors

acknowledge that EMR vendors need to comply with MU and E&M documentation guidelines, but "not at the expense of being unable to offer tools that are tailored to a practice's workflow and the clinical needs of its patients."

Physician burnout is a big problem that has been a long time in coming. The root causes of burnout are interwoven into the American healthcare delivery system and will require solutions on the personal, institutional, and regulatory levels in order to bring joy back into the practice of medicine for many physicians and other healthcare providers.

Here are a few successful examples I've seen of successful adaptions to burnout, which demonstrate the importance of flexibility and innovation:

- A 60-year-old internist worked in a rural practice associated with the local hospital, which was acquired by a large hospital group, resulting in inflexible patient scheduling and rigid treatment protocols. After several years of frustration and burnout, the physician left his practice and joined a large physician-owned group in a nearby city, which has allowed for a greater degree of physician autonomy in medical decision making and scheduling. He is very happy with his practice.
- A 62-year-old internist adapting to the EMR and onerous regulatory documentation demands found that his productivity had declined by 25 percent while his work-related hours on data entry had substantially increased. This resulted in burnout. His medical group provided a scribe, which has increased his productivity above the pre-EMR levels and, most importantly, restored greater access for his patients while facilitating his return to a satisfying career.
- A 35-year-old pediatrician and single mother with school-age children was unable to meet both the practice schedule and parenting demands, resulting in fatigue and burnout. Her medical group provided a scheduling solution that has allowed her to meet full-time practice requirements and to fulfill her parenting responsibilities.

For Further Reading

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acpinternist.org/
Dike Drummond, MD
thehappymd.com/blog
Paul DeChant, MD, MBA
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The Prevalence of Addiction in Modern Medicine and the Rise of the American Society of Addiction Medicine (ASAM)

by Rouzbeh K. Kordestani, MD, MPH

"Addictio" is the Latin root word for addiction, to either a substance, behavior, or activity.

In the field of medicine, addiction is too often seen. Recent studies note that physicians have addictions to alcohol and to (pain) medications in similar proportions (8-15%) to the professional population at large. Physicians are more than 5 times more likely to abuse prescription drugs. It is believed that physicians' addiction to prescription drugs is in part due to their ease of access. In many cases, the opportunity is fed by the need for self-control. Physicians are often noted to have a "hard time relinquishing control." In this way, many use prescription drugs to keep control. Others use prescription drugs to relieve stress (emotional or physical pain/anxiety). Even when physicians are faced with the realization that the control they seek is an illusion, they concede that they continue their use/abuse in hopes of "holding on." Some physicians recall their early efforts, hardships and success in medical school and residency. They use these triumphs as hallmarks that they are capable of surviving any ordeal. Often they are noted as saying: "I worked hard and I succeeded. I thought that I had this (too) under control." Alas, too often, they do not.

Many articles note the lack of reception and response to the problem of addiction among core physicians. In general, physicians are more adept at hiding substance abuse from their friends and colleagues. More importantly, physicians are far less likely to self-report substance abuse because they fear a backlash within their core group(s)/profession. The stigma of being considered "impaired" forces many physicians to simply move along. Also, the lack of awareness of a mechanism for self-reporting or self-referral further silences the physician-addict. Because of all of these reasons, most physicians-addicts do not receive appropriate care or treatment for their problem. A recent study in the Journal of the American Medical Association revealed that 17% of almost 1,900 physician survey respondents personally knew of an impaired physician. Of this number, only 67% reported that individual to the proper authorities. Those who kept silent did so because they believed that someone else was taking care of the problem (19%), didn't think reporting the problem would make a difference (15%), feared retribution (12%), felt it wasn't their responsibility to report (10%), or worried that the physician would be excessively punished (9%).

Physicians concede that they are poorly equipped in responding to this (addiction) crisis within their own ranks. Unfortunately, this ignorance has dire consequences. When physicians do not report fellow impaired physicians, it can lead to life threatening issues. It can lead to patient injury. It can also lead to criminal offenses such as driving under (the) influence (DUI). In more extreme cases, deaths have been recorded. In its review of 2010 data, the Centers for Disease Control (CDC) attributed 60% of its drug overdose deaths to pharmaceutical drugs.

As physicians discuss this more openly, it is becoming apparent that there is truly a lack of acceptance and education. When retrospectively studied, few physicians have formal training in addiction medicine. As of this writing, fewer than ten medical schools have formalized systems in understanding and recognizing addiction.

Addiction Medicine

Addiction medicine is still in its infancy as a specialty compared to others. Only recently has "addictio" or addiction become recognized as a field of study. Although alcoholism has been a well-studied ailment and a recognized form of addiction for greater than 200 years, only in the 1930's was Alcoholics Anonymous (AA) formed as a support response for treatment. Curiously, even within AA, non-alcohol based addiction(s) were not welcome and not discussed. In fact, AA policy emphasized that "drug use other than alcohol was not be discussed at AA meetings." The stigma and poor understanding of addiction as a disease in itself continued for years. It was for this exact reason that the true pathology of addiction was initially poorly addressed.

In New York, a group of physicians under the guidance of Dr. Ruth Fox began to openly discuss their interests in alcoholism and its treatment. They soon took the name of the New York City Medical Society on Alcoholism. This group of physicians in New York chose to expand their scope of concern quickly, to encompass other maladies–including what they thought were issues of addiction. Because of the restrictions placed by AA, the New York City Medical Society was forced to change its name, to more appropriately reflect its concerns and its scope. They became known as the New York City Medical Society on Alcoholism and Other Drug Dependencies (NYCMSA-ODD). This association in New York was one of the original groups that eventually banded together to form the Society of Addiction Medicine.

Similar to New York, historical data shows that, in other cities such as San Francisco, (as recently as the 1960's), drug abuse and addiction also began to be openly discussed and studied. Because of the increased prevalence of drug experimentation of the late 1960's, cities such as San Francisco were exposed to greater numbers of patients/people with drug and alcohol addiction. These increasing population numbers and this new phenomenon forced these cities to respond and act.

One of the first local clinics to respond to this increase in (drug) addiction was the Haight Ashbury Free Medical Clinic (HAFMC). The focus of these smaller centers was on diagnosis, treatment, detoxification and support. As drug addiction became more recognized as a true problem, the efforts of these groups (HAFMC) became more mainstream. In the early 1970's, these centers became more accepted and became part of the effort of communities and cities to respond to the problems of addiction, with a focus on treatment and response. Through local cities and communities, on both coasts, these treatment centers received increased funding and recognition for their efforts. More importantly, their treatment response became more formalized. In part due to their efforts and to their successes, these treatment centers led to the recognition of addiction as a valid diagnostic category and a medical problem. Because of this cooperative response, addiction treatment became recognized as a formal focus in medicine. As bicoastal efforts continued and different medical societies banded together, addiction medicine came of age. In the mid-80's, the American Medical Association (AMA) began to recognize the field of addiction medicine. Finally, in 1988, the American Society of Addiction Medicine (ASAM) was formally accepted into the AMA house of specialty societies.

The Goals of ASAM

The first goal of the ASAM was to recognize the prevalence of addiction. Next among its goals was to destigmatize the misperception of addiction and to re-categorize it as a medical illness. With the recognition of addiction as a medical malady, the ASAM then attempted to re-focus society's efforts on treatment and recovery. Its core values are focused more on: the wellness of the people/patient (addict), and innovation and integrity in the treatment of these individuals. The ASAM places its highest value on compassion for the addicted.

The Efforts of the ASAM

Since its political inception (as a part of the AMA) in 1989, the ASAM has chosen to set policy for matters of addiction as part of mainstream medicine. More recently, it has redoubled its efforts in education with the resurgence of medical marijuana, and the more recent opioid epidemic.

Medical marijuana has been a controversial topic for some time. As states continue to favor the legalization of marijuana, there appears to be a lack of knowledge of what exactly constitutes the components of "medical" marijuana. In this, the ASAM has held firm in its original policies/opinion. The ASAM holds that far too few physicians are knowledgeable about the benefits and risks of marijuana. Because of this lack of common/scientific knowledge, the ASAM advocates an education process and has established Practice Guidelines. The ASAM believes and advocates the support of the Food and Drug Administration (FDA) Guidelines. It "rejects a process whereby State and local ballot initiatives approve medicines because initiatives are being decided by individuals not qualified to make such decisions." It also "recommends that its members and other physicians/organizations and their members reject responsibility for providing access to cannabis and cannabis-based products until such time that these materials receive (appropriate and substantiated) marketing approval form the FDA."

Within the context of the opioid epidemic, the ASAM has made it clear that there is a clear lack of knowledge on the part of physicians in how best to treat this national addiction. Quite recently, the ASAM joined its efforts with the RAND Corporation and the University of California at Los Angeles (UCLA) to produce Practice Guidelines for the treatment of addiction (see ref 7). The recommendations include the initial evaluation of the addict-patient, the judicious selection of medications, the use of approved medications and combinations of medications, the treatment of special populations, and the use of naloxone in combination therapy (for withdrawal/ treatment).

Conclusion

Addiction continues to be a real issue and a problem within medicine. It afflicts patients and practitioners alike. However, as time has gone on, addiction has become recognized as a medical malady. With this new found understanding, it is now easier not only to view the problem as a valid medical diagnosis, but it is also easier to respond to this problem with established guidelines and treatments.

The American Society of Addiction Medicine (ASAM) was formed in response to this problem. It has grown in size and in breadth. It now works within the medical establishment not only to recognize physician addiction as a de-facto problem but also to treat these newly recognized (and no longer stigmatized) problems. As new challenges are being recognized, the ASAM is working hard to establish practice guidelines that make sense within the context(s) of diagnosis, treatment and recovery. In the new world (of medicine), with its new addictions (to opioid and marijuana), the ASAM is much needed.

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by Tarek Naguib, MD, MBA, FACP

New deep brain stimulation JAMA (02/19) - A study done at the University of California San Francisco on 25 patients with epilepsy revealed a new target for electrical stimulation that is successful in treatment of depression.

Young-onset type 2 diabetes burden Ann Intern Med (02/05) - A registry/population-based study of over 14 years of data in adults aged 20 to 75 years (over 600,000 patients) revealed that this population has an excess burden of mental illness and hospitalizations.

USPSTF recommendations JAMA (02/12) - The United States Preventive Services Task Force recommends that clinicians provide or refer pregnant and postpartum women who are at increased risk for perinatal depression to counseling interventions. The recommendations aim at improving perinatal depression.

Cannabis products not reliable JAMA (02/19) - In a sample of 84 cannabidiol extracts purchased online, 69% (58 extracts) had mislabeled cannabinoid content.

Wound botulism outbreak. JAMA (02/19) - A rare 9-person outbreak of wound botulism in California was traced by the CDC to the use of black tar heroin. 292 cases of the 350 cases of the disease in the US were reported in California between 2001 and 2016. The bacteria stay in the unsanitary black tar heroin and do not get killed when the drug is heated before injection.

Strict blood pressure control did not decrease dementia JAMA (02/12) - In a study of nearly 9000 randomized participants, strict control of systolic blood pressure to under 120 mmHg did not lessen progression to dementia when compared with a control group targeted to BP less than 140 mmHg.

ACE inhibitor before surgery ACP Hospitalist (02/01) - A study of 275 patients at a single academic center who were taking ACE inhibitors (lisinopril, enalapril, quinapril, etc.) for at least six weeks before non-cardiac non-vascular surgery showed that omitting ACE inhibitors before surgery decreased the incidence of perioperative hypotension.

Medications issues ACP Hospitalist (02/01) – Fluoroquinolones (ciprofloxacin and levofloxacin antibiotics) were found to increase the risk of rupture in the aorta in certain patients. The same drugs have previously been implicated in tendon rupture with physical activity. Also, an expanded recall of lots of the blood pressure medicines valsartan and losartan has been reported. The recall is due to detection of trace amounts of an impurity in the drugs.

Top insurance companies slow in payment in Texas Tex Med (03/01) - The worst 5 health insurance companies in terms of delayed payment (starting with the worst): Blue Cross Blue Shield of Texas, United Healthcare Insurance Company, Aetna Life Insurance Company, Humana Insurance Company, and Humana Health Plan of Texas. The total number of complaints of delayed payments for Blue Cross Blue Shield of Texas exceeded 1200 in the last four years, with 244 actual violations.

Most burnt out specialties in medicine ACP Hospitalist (02/01) - A survey among physicians has revealed that hospitalists have the highest burnout rate at 66%, followed by pathologists (63%), nephrologists (62%), radiologists (61%), and infectious disease specialists (60%). The specialties least likely to report burnout (tied at 51%) included endocrinology, internal medicine, and pediatrics.

Doctor Patient Relationship Tex Med (12/01) – In a survey of Texas physicians (800 doctors), 78% said that patient relationship is the most satisfying aspect of practicing medicine. 66%, however, said that electronic health records detracted from their interactions with patients.

Neonatal Abstinence Syndrome: A Review

by John Lung, BS; Umair Khan, BS; Ethan Chandler, MS, MBA; Jenda Arawiran, MD; Mubariz Naqvi, MD

Introduction

Neonatal abstinence syndrome (NAS), which was first described by Dr. Loretta Finnegan in 1970s, is a withdrawal syndrome seen in 55-94% of newborns exposed to drugs of dependence in utero. Between 2004 and 2014, the incidence of NAS among Medicaid patients has risen sharply due to increased illicit use of opioids such as heroin and oxycodone. NAS disproportionately affects Medicaid patients; the incidence of NAS was 7 times higher among infants covered by Medicaid in 2014 compared to private insurance patients. Among all patients, the incidence of NAS has increased from 1.2 per 1000 births in 2000 to 5.8 per 1000 births in 2012.

NAS-related admissions to neonatal intensive care units (NICUs) have quadrupled from 2004 to 2013. Additionally, inflation-adjusted cost of care for infants with NAS covered by Medicaid increased from $65.4 million in 2004 to $462 million in 2014. The increases in incidence of NAS have affected all races, diverse ethnic and socioeconomic groups, and geographical locations in United States. Infants with NAS are also at increased risk of need for pharmacological treatment, separation from mother, prolonged hospital stay, and admission to neonatal intensive care unit (NICU).

Special considerations for the Panhandle include a rural population spread out across three states and a urban population in Amarillo. The rural and urban divide for NAS is stark, with an incidence of 7.5 per 1000 hospital births among rural infants versus 4.8 per 1000 hospital births among urban infants in 2013. The frequency of deliveries complicated by opioid use is also much higher in rural areas: 8.1 vs 4.8 per 1000 hospital deliveries in 2013. In the Texas Panhandle, some of the most commonly abused drugs include methamphetamine and marijuana. When collecting a social history from the mother of a newborn with possible NAS symptoms, clinicians need to consider the unique needs of patients in the Panhandle.

Methods:

A PubMed search was completed using the MeSH function with the key phrase neonatal abstinence syndrome. The search included meta-analyses, clinical trials, and reviews.

Results:

The clinical symptoms of NAS typically develop within few days of life. The majority of NAS babies have maternal exposure to opioids, but other substances including SSRIs, marijuana, cocaine, nicotine, antidepressants, and antipsychotics can cause some withdrawal-like symptoms. Babies born to mothers who abuse opioids are at a higher risk for microcephaly, low birth weight, withdrawal symptoms, and long-term neurobehavioral impairments. Babies born to mother who abuse PCP, cannabis, amphetamines, and cocaine are a a higher risk of microcephaly, low birth weight, neurobehavioral issues, and long-term neurobehavioral impairments. Babies born to mother who use SSRIs have higher risk of persistent pulmonary hypertension. Neonates exposed to barbiturates and benzodiazepines in utero have a higher risk of a withdrawal-like symptom similar to NAS. Clinical manifestations may develop earlier in infants exposed to opioids with a shorter half-life than in infants exposed to long-acting opioids (e.g. methadone). Symptoms include tremor, irritability, poor feeding, inconsolable and high pitched crying, gastrointestinal distress, respiratory distress, seizures, and autonomic reactivity. A convenient method to learn the symptoms associated with NAS is to use the mnemonic: WITHDRAWALS (Figure 1).

Ideally, maternal substance use during pregnancy should be identified as early on as possible. During prenatal care, clinicians should use respectful questioning to maximize the chances of an honest discussion with the mother. This discussion will facilitate a good history from the mother who will report substance use if the information if obtained in an open, objective, and non-judgemental manner. Specimens can also be collected including urine samples, meconium stain, hair, and cord blood. Urine toxicology will only detect substances from the days before delivery, while meconium can detect drugs from weeks to months before delivery. Typical substances tested in drug screens include marijuana, cocaine, amphetamine, and sedatives (including barbiturates and benzodiazepines). All toxicology specimens require maternal consent to collect.

The course of management of NAS is guided by several objective assessment tools that measure the severity of NAS-associated symptoms displayed by a newborn. Quantifying the severity of NAS based on signs and symptoms requires the use of psychometrically validated samples using a large study sample size. The Finnegan Neonatal Abstinence Scoring Tool (1975) is the most widely used tool. Existing assessment tools can vary in terms of reliability, reproducibility, and accuracy of responses due to subjectivity of item responses. The FNAST measures 21 different items, with scores ranging from 0-62; scores of 8 or above in three consecutive

| *continued on page 40*

Wakefulness
Irritability
Tremors & Tachypnea
High-pitched cry, Hypertonia, Hiccups, Hyperacusis
Diarrhea, Disorganized suck, Diaphoresis
Respiratory distress, Rhinorrhea, Rub marks
Apnea
Weight loss
Alkalosis
Lacrimation
Sleep disturbances, Seizures

Figure 1. WITHDRAWALS mnemonic for symptoms associated with NAS.

evaluations qualify for pharmacological treatment. Its length and complexity limit its use. Also, it was originally designed in 1970s to assess otherwise healthy, term babies exposed to methadone in utero, but it does not account for different combinations of other drugs. The FNAST is also designed to consider only the first 28 days after birth, whereas hospital stays for some infants with NAS can be longer. Due to aforementioned limitations of original Finnegan tool, a modified version was developed which measures 7 items only and is easier to use. The modified Finnegan tool, however, has different adaptations, and no single version has been used universally. The American Academy of Pediatrics recommends using the Modified Finnegan Neonatal Abstinence Scoring Tool.

In recent years, emphasis has shifted towards non-pharmacological measures in additional to pharmacological measures as the sole management method in mild cases of NAS with a Finnegan score of less than 8. Non-pharmacological care focuses on maximizing infant-mother bonding and eliminating baby overstimulation. These methods include control of the environment, increasing breastfeeding rates, mother-baby bonding, and soothing techniques. Quiet and dim rooms that minimize environmental stimuli are important to prevent hyperarousal of the baby. All mothers should be urged to breastfeed their babies with NAS as long as the mother is in a substance abuse program, has a documented abstinence from the substance, and has a negative toxicology screen. Mothers can feed even if they are on methadone or buprenorphine therapy. A meta-analysis of several studies demonstrated that protocols integrating rooming-in when compared to a NAS NICU admission helped reduce the length of stay and the need for pharmacological NAS treatment. Skin-to-skin contact between mother or father and baby as part of a rooming-in model will also improve parent-infant bonding while reducing the need for pharmacological NAS treatment. Soothing techniques are also used, including pacifiers, non-nutritive sucking, and infant positioning in the supine position. A pilot project in Ohio called Substance Abuse, Treatment, Education and Prevention Program (STEPP) used prenatal counseling, pharmacological treatment of the mother's addiction, prenatal counseling, and a longer rooming-in period of up to 5 days. The pilot ended with only 10% of babies admitted to the NICU; the remaining babies were treated with nonpharmacological methods and were discharged in 3-5 days. With integration of nonpharmacological management of NAS, the average length of stay for babies with NAS has declined, from 58 days in 2009 to 17 days in 2018.

Pharmacological treatment is indicated when babies have concerning signs of NAS such as fever, seizures, and weight loss even after using non-pharmacological management. Currently, there is no widely accepted protocol of standard of care for pharmacological management. First-line therapy typically involves treatment with oral morphine or methadone. Morphine is the most common treatment for NAS, but can be associated with increased respiratory depression and sedation. Methadone has a longer half-life of 25 to 32 hours and also contains ethanol. Babies treated with sublingual buprenorphine have been shown to have a shorter treatment duration and hospital stay than comparable babies treated with oral morphine, with similar adverse event rates. However, sublingual buprenorphine contains ethanol. Phenobarbital has several issues that limit its use, including CNS depression and sucking reflex impairment. Data from clonidine clinical trials suggest that clonidine monotherapy as a first-line treatment is as effective as first-line opioids with a shorter treatment time and fewer adverse events.

Because of a dramatic increase in prevalence of NAS in the last decade, considerable research has been done on the subject, leading to many changes in its clinical management. A nationally accepted, evidence-based treatment protocol is still lacking to guide effective management of NAS. One of the most important implementations that a NICU can make to combat NAS is the development of a standardized pharmacological weaning protocol, though the specific protocol adopted does not affect outcomes. The Ohio Perinatal Quality Collaborative found that hospitals with weaning protocols have shorter lengths of stay and lower healthcare costs. The practice of developing a weaning protocol has now become common across the country. Northwest Texas Hospital in Amarillo has developed a protocol based on Modified Finnegan Scores. Two consecutive Modified Finnegan Scores of 8 or more lead to the initiation of pharmacologic therapy. Clonidine is the first line for infants withdrawing from opiates and SSRIs, which are the majority of NAS babies seen at Northwest. Methadone or morphine are used as adjuncts for NAS if clonidine does not control NAS withdrawal symptoms. While studies have demonstrated that the use of a weaning protocol can reduce hospital stays and lower costs, no set protocol has been widely adopted. Outpatient weaning is also an option, but clinicians must weigh the benefits of maternal-infant bonding and reduced costs with the risk of noncompliance and less-aggressive treatment in the outpatient setting.

Discussion

While attitudes about maternal substance abuse have changed over time, a stigma still attaches to some patients. A non-judgmental attitude that emphasizes collaboration with the mother will increase the chances for non-pharmacological management with a shorter NICU stay. A warm, embracing attitude from clinicians will improve the chances of full maternal cooperation, even though Child Protective Services (CPS) will get involved if there is a positive urine or meconium stain. Even if CPS investigates the mother, a positive attitude from clinicians and maternal collaboration and commitment to substance abuse treatment will result in a good outcome for the mother and baby.

Unfortunately, some NAS babies are not followed-up after discharge. Before discharging a patient, a full needs assessment of mother or legal guardians of the baby should be completed including feeding, financial means, home care, and scheduled follow-up. Follow-up for NAS babies should include well-child checks with a pediatrician as well as a specialty neonatal high risk clinic. NAS babies will frequently have CPS involvement that can include placement with foster parents or other relatives. CPS involvement can also involve custody battles that can increase guardian stress and result in poorer outcomes for the baby. Partially due to lower follow-up rates after hospital discharge, the neurodevelopmental effects over years are not well-studied and need further investigation.

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Post-Traumatic Stress Disorder (PTSD)

by Taru Bharadwaj and Tarek Naguib, M.D.

What is PTSD?
PTSD is a mental health disorder that stands for Post-Traumatic Stress Disorder (1). It is triggered by a traumatic event and can lead to stress and anxiety for a long period of time.

What are the causes of PTSD?
Many people think that PTSD is caused by only the most terrifying wars and disasters. Though those are valid causes, PTSD can be caused by any disturbing event. People can react to a bad experience in different ways; thus, some may develop PTSD and others may heal quickly. Some common triggers include: physical abuse, sexual abuse, car accidents, war, natural disasters, man-made disasters, witnessing death, having a loved-one pass away, and other extremely stressful events (1,2). Again, these examples may not affect some people and may precipitate PTSD in others. Never judge a person according to the reason for having PTSD, as an event that may not be a big deal to you could be scarring to others.

What are the symptoms of PTSD?
"Normal" stress and discomfort from a triggering event are usually short-term; people are able eventually to cope and move on. By contrast, PTSD can last for months or years, and people cannot simply "move on" from it. Furthermore, PTSD can arise months or even years after the triggering event. Some symptoms include: hyperarousal (better known as fight-or-flight), avoidance, intrusive memories (flashbacks), negative mood and thinking, high anxiety and depression, and changes in cognition (such as distorted memories and feeling guilt) (1,2,3). In children with PTSD, the symptoms can include wetting the bed, acting out the scary events, changes in the ability to speak, and excessive clinginess (1).

How is PTSD treated?
PTSD can be treated by removing the trigger, by medication, or by psychotherapy ("talk" therapy) (1). If the object that is causing the triggering is ongoing, such as substance abuse or an abusive relationship, the first step is to address this problem (1). Then, a person with PTSD should consult with a health care provider who is well versed in PTSD and other mental disorders. Through discussion and understanding, an individualized treatment plan can be determined. People with PTSD can heal in different ways, so it's important to discover which treatment plan is best: medication, psychotherapy, or a combination of the two (1). Some people even prefer exposure therapy, which is a form of psychotherapy that involves slowly exposing the subject to the the trauma in a controlled and safe way (1). Talk to a doctor for treatment options and plans.

Why PTSD awareness is essential.
PTSD can arise in anyone, at any age, due to any triggering event, at any time. People with PTSD should not be seen as broken or weak. Instead, we as a community should better understand PTSD and the people who have it in order to aid them with the healing process. It is like any other disorder: it needs to be acknowledged and addressed. Out of the 70% of Americans who experience a traumatic event, about 20% develop PTSD; also, "[a]n estimated 8% of Americans- about 24.4 million people- have PTSD at any given time" (4). These are not insignificant numbers, and should not be treated as such. Whether it's the veteran in your family, a friend at school who experienced a hurricane, or the coworker who witnessed continuous verbal abuse in their childhood, work on encouraging them through their healing process. Learn their boundaries, find out what they need--whether it's a discussion or a ride to the psychotherapist-- and support the ongoing research on PTSD.

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(4). PTSD Statistics. PTSD United. 2013, http://www.ptsdunited.org/ptsd-statistics-2/.

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Don't suffer needlessly. There is no reason not to TRY!

Confidential professional services available in Amarillo:

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You're not alone! Confidential help is available for free
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Prevention programs

National Suicide Prevention Lifeline Call 1-800-273-8255 (1-800-TALK) or 1-800-784-2433 (1-800-SUICIDE) Available 24 hours every day. Live chats also available.
https://suicidepreventionlifeline.org/

American Foundation for Suicide Prevention – afsp.org
OR CALL 1-800-333-AFSP (2377)
Interactive Screening Program (ISP) – AFSP's signature intervention program, the ISP is an online tool to encourage healthcare providers to utilize available mental health services before crises emerge. ISP is listed as a Best Practice for Suicide Prevention afsp.org/wp-content/uploads/2018/11/Mortali-Moutier.-Facilitating-Help-seeking-Behavior-in-Physicians-Using-ISP-JMR-2018.pdf

Key Principals:

1. Participant anonymity and confidentiality
2. Personalized contact with counselors – not computerized feedback, but one on one conversation with a counselor
3. Connection to a participant's experience – rather than suggesting diagnosis or forcing the idea of "needing treatment"
4. Interactive engagement – counselors answer questions about available services and help select an option that best suits needs and comfort level

UC San Diego Healer Education Assessment and Referral (HEAR) Program (uses ISP).
Update on the UC San Diego Healer Education Assessment and Referral (HEAR) Program – http://afsp.org/wp-content/uploads/2018/11/HEAR.Update.JMR-Aug-2018.pdf

Web-Based Cognitive Behavioral Therapy for Medical Trainees (Guille C., et al., *JAMA Psychiatry*, 2015)

Intervention to Promote Physician Well-being Article in JAMA Internal medicine 2014 jamanetwork.com/journals/jamainternalmedicine/fullarticle/1828744

Stanford's Burnout Prevention Approach www.washingtonpost.com/news/inspired-life/wp/2015/08/20/the-innovative-stanford-program-thats-saving-emergency-room-doctors-from-burnout

"Struggling in Silence: Physician Depression and Suicide" PBS Documentary
www.everydayhealth.com/columns/zimney-health-and-medical-news-you-can-use/struggling-in-silence-physician-depression-and-suicide

International Association for Suicide Prevention - IASP.
https://www.iasp.info/

National Action Alliance for Suicide Prevention: Home Page
https://theactionalliance.org/

American Association of Suicidology
https://www.suicidology.org/

| *continued on page 44*

The Suicide Prevention Action Network USA (SPAN USA) – https://www.iasp.info/.../the-suicide-prevention-action-network-usa-span-usa-51.htm

8 Suicide Prevention Organizations to Know During Suicide https://www.bustle.com/.../8-suicide-prevention-organizations-to-know-during-suicide...

SAVE: Suicide Prevention, Information, and Awarenes https://save.org/

Yellow Ribbon Suicide Prevention Program https://yellowribbon.org/

Amarillo College - Suicide Awareness https://www.actx.edu/mentalhealth/suicide-awareness

For More Information about Physician Depression, Health, and Suicide

Why "Happy" Doctors Die - opmed.doximity.com/articles/why-happy-doctors-die-by-suicide

Physician suicide information website - https://afsp.org/our-work/education/healthcare-professional-burnout-depression-suicide-prevention/

Accreditation Council for Graduate Medical Education (ACGME) Resources – Resources to share with programs, institutions, residents, and fellows that promote a culture of physician well-being and provide support in the case of burnout, depression, or suicide.

Breaking the Culture of Silence on Physician Suicide – A sharable graphic and information about physician suicide from the National Academy of Medicine.

Creating a Safety Net: Preventing Physician Suicide – An article by AFSP Chief Medical Officer Christine Moutier, M.D., for the Association of American Medical Colleges' *AAMC News.*

Reducing the Stigma: Faculty Speak out about Suicide Rates among Medical Students, Physicians – An article by Dana Cook Grossman, for the Association of American Medical Colleges' *AAMC News.*

Preventing Suicide in Physicians, Residents and Medical Students (Video) – Dr. Christine Moutier addresses the American Psychiatric Association, May 20, 2016.

Symposium on Physician Well-Being – A symposium held on November 17-18, 2015 by The Accreditation Council for Graduate Medical Education (ACGME).

Leaders in Academic Medicine Address Physician Well-being and Resilience – A news release from the Association of American Medical Colleges.

Preventing Physician Distress and Suicide – Tools for identifying at-risk physicians and facilitating access to care from the American Medical Association.

Make the Difference: Preventing Medical Trainee Suicide (Video) – A 4-minute PSA from Mayo Clinic and the American Foundation for Suicide Prevention that explains how everyone can help prevent suicide by being alert for the signs of depression and escaping stress and how to be most helpful.

Why Physicians Die by Suicide – Dr. Michael Myers guides readers through the variety of factors that contribute to physician suicide. He then makes practical, across-the-board recommendations in an effort to prevent this tragedy, arriving at the encouraging conclusion that everyone has a role to play in saving a doctor's life.

Struggling in Silence: Physician Depression and Suicide (DVD) An award-winning, one-hour documentary from AFSP that sheds light on the topic of physician mental health and suicide prevention, featured on public television stations nationwide.

Struggling in Silence/Out of the Silence (DVD) – Two short videos (15 minutes each) describing physician and medical student depression and suicide risk. A printable resource guide and slide set are available for both films.

Collateral Damage DVD: The Impact of Patient Suicide on the Physician, a DVD film of several physicians speaking about their experience of patient loss to suicide, with group discussion. Psychiatrists featured in this educational film include Drs. Glen Gabbard, Sidney Zisook, and Jim Lomax. This resource can be used to facilitate an educational session for physicians, psychologists, residents or other trainees. Please contact education@afsp.org to request the DVD.

American Medical Student Association – The oldest and largest independent association of physicians-in-training in the United States.

Suicide Risk in Physicians – Emergency Physician Dr. Mel Herbert produces a popular podcast called EMRAP for healthcare professionals www.emrap.org/episode/suicideriskin

- University of Michigan Comprehensive Depression Center
- UC San Diego Healer Education Assessment and Referral (HEAR) Program

Physician Mental Health: An Evidence-Based Approach to Change – Article afsp.org/wp-content/uploads/2018/11/Moutier.-Physician-Mental-Health-and-SP-JMR-2018.pdf

2018 National Physician Suicide Awareness Day | AAEM - https://www.aaem.org/current-news/2018-national-physician-suicide-awareness-day
CORD **website** for more **information**

Physician Suicide: Overview, Depression in Physicians, Problems https://emedicine.medscape.com/article/806779-overview

Preventing Physician Suicide: Recognizing Symptoms, Improving Support Article from American Association for Physician Leadership www.physicianleaders.org/news/-preventing-physician-suicide-recognizing-symptoms-improving-support

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