I have no financial disclosures.
OBJECTIVES

• Discuss the significance of the opiate epidemic

• Name 2 recommendations from the CDC guidelines on opiate prescribing

• Name one clinical manifestation of Neonatal Abstinence Syndrome
OPIATES

- Heroin
- Codeine
- Fentanyl
- Morphine
- Methadone
- Oxycodone
- Meperidine
- Hydromorphone
- Hydrocodone
- Propoxyphene
- Buprenorphine
TERMS TO KNOW:

- Abuse
- Opiate Use Disorder
- Dependence
- Tolerance
- Addiction
- Withdrawal
- Overdose
A maladaptive pattern of substance use resulting in significant negative physical, social, interpersonal or legal consequences.
DEPENDENCE

- Physical dependence - is a physiological state of adaptation to a substance, the absence of which produces symptoms and signs of withdrawal.

- Psychological dependence – Mentally dependent upon a substance.

- DSM-V definition – Substance use disorder, may include physical dependence, but additional criteria are required.
OPIATE USE DISORDER (OUD)

- A problematic pattern of opioid use that causes clinically significant impairment or distress. A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use, as well as use resulting in social problems and a failure to fulfill obligations at work, school, or home. Opioid use disorder has also been referred to as “opioid abuse or dependence” or “opioid addiction.”
TOLERANCE

- A condition in which higher doses of a drug are required to produce the same effect experienced during initial use.
ADDICTION

- Chronic relapsing brain disease characterized by compulsive drug seeking and use, despite harmful consequences.

- Four C’s
  - Craving
  - Control
  - Compulsion
  - Consequences
WITHDRAWAL

- A constellation of symptoms and signs that a person experiences when after a period of regular use, the quantity of available substance to the brain is reduced.
OVERDOSE

- Injury to the body that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.
In 2015...

- **12.5 million** People misused prescription opioids
- **2.1 million** People misused prescription opioids for the first time
- **2 million** People had prescription opioid use disorder
- **33,091** People died from overdosing on opioids
- **15,281** Deaths attributed to overdosing on commonly prescribed opioids
- **828,000** People used heroin
- **9,580** Deaths attributed to overdosing on synthetic opioids
- **135,000** People used other illicit opioids
- **12,989** Deaths attributed to overdosing on heroin
- **$78.5 billion** In economic costs (preliminary data)

91 AMERICANS die every day from an opioid overdose (that includes prescription opioids and heroin).
Overdose Deaths Involving Opioids, United States, 2000-2015

- **Any Opioid**
- **Commonly Prescribed Opioids** (Natural & Semi-Synthetic Opioids and Methadone)
- **Heroin**
- **Other Synthetic Opioids** (e.g., fentanyl, tramadol)

WOMEN AND OPIATES – HIGH RISK ALERT

• About 18 women die every day of a prescription painkiller overdose in the US, more than 6,600 deaths in 2010. Prescription painkiller overdoses are an under-recognized and growing problem for women.

• The 2015 National Survey on Drug Use and Health found that 4 percent of females age 12 and older misused prescription pain relievers in the last year.
Women are more likely than men to have chronic pain, to be prescribed prescription pain relievers, to be given higher doses, and to use them for longer time periods.

Women may become dependent on prescription pain relievers more quickly than men and may experience more cravings than men.

Psychological and emotional distress are risk factors for opioid misuse among women, but not among men.
Women are more likely to be introduced to substances by a partner; men are more likely to be introduced by a peer.

Rates of childhood and adult sexual abuse, risk factors for substance misuse, are higher among women than men.

Women are more likely than men to have co-occurring mental health and substance use disorders.
Women between the ages of 25 and 54 are most likely to go to the emergency department because of prescription painkiller misuse or abuse.

Every 3 minutes, a woman goes to the emergency department for prescription painkiller misuse or abuse.
WHAT CAN WE DO?

• Recognize that women are at risk of prescription painkiller overdose.
• Follow guidelines for responsible prescribing, including screening and monitoring for substance abuse and mental health problems.
• Use prescription drug monitoring programs to identify patients who may be improperly obtaining or using prescription painkillers and other drugs.
NEONATAL ABSTINENCE SYNDROME (NAS)

• Incidence 55-94% in mothers with opioid abuse
• National prevalence increasing (doubled in less than 10 years)
NAS in the United States

Data source: AHRQ/HCUPnet available at http://hcupnet.ahrq.gov/
Case definition: 779.5 Dx code on hospital discharge record
Every hour, 1 BABY is born suffering from opiate withdrawal.

Average length or cost of hospital stay:

<table>
<thead>
<tr>
<th>Newborns</th>
<th>Days</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>with NAS</td>
<td>16.4</td>
<td>$53,400</td>
</tr>
<tr>
<td>w/o NAS</td>
<td>3.3</td>
<td>$9,500</td>
</tr>
</tbody>
</table>

NAS and maternal opiate use on the rise:

- Newborns suffering from opiate withdrawal
- Maternal opiate use

Source: Patrick et. al., JAMA 2012
NEONATAL ABSTINENCE SYNDROME (NAS)

Central Nervous System
- Seizure activity
- Irritability
- Exaggerated Moro reflex
- Increased muscle tone

Gastrointestinal Dysfunction
- Vomiting
- Diarrhea
- Poor weight gain
- Feeding difficulties
NEONATAL ABSTINENCE SYNDROME (NAS)

- Tx: Tincture of opium
- Similar with methadone or buprenorphine
- Longer hospitalization for neonate
- Buprenorphine and NAS:
  - MOTHER trial – Severity of NAS (treatment dose, hospital stay, NAS score) – Less with buprenorphine vs. methadone
  - Lower concentrations in fetal circulation compared with methadone (50% less drug exposure).
Mothers' Buprenorphine Treatment During Pregnancy Benefits Infants

Hospital Stay

Duration of Withdrawal (Neonatal Abstinence Syndrome) Treatment

Total Dose of Morphine

Days

Morphine (mg)

Medication Mother Received During Pregnancy

- Methadone (n=73)
- Buprenorphine (n=58)
Does it matter?

- During pregnancy, 10% (55) of women drink alcohol (4% binge, i.e., had ≥5 alcoholic drinks on the same occasion on at least 1 day in the past 30 days), 15% (23) smoke cigarettes, and 5% (10) use an illicit substance.

- Substance use is as or more common than many conditions routinely screened for and assessed during prenatal care (PNC), such as cystic fibrosis, gestational diabetes, anemia, postpartum depression, or preeclampsia.
REGULATIONS AND PRESCRIBING
NEED FOR OPIOID PRESCRIBING GUIDELINES

- Previous opioid prescribing guidelines have been developed by several states and agencies but were inconsistent
- Most recent national guidelines are several years old and don’t incorporate the most recent evidence
- Need for clear, consistent recommendations
CHRONIC PAIN AND PRESCRIPTION OPIOIDS

- 11% of Americans experience daily (chronic) pain
- Opioids frequently prescribed for chronic pain
- Primary care providers commonly treat chronic, non-cancer pain
  - account for ~50% of opioid pain medications dispensed
  - report concern about opioids and insufficient training
PURPOSE, USE, AND PRIMARY AUDIENCE

- **Primary Care Providers**
  - Family medicine, Internal medicine
  - Physicians, nurse practitioners, physician assistants
- **Treating patients \( \geq 18 \) years with chronic pain**
  - Pain longer than 3 months or past time of normal tissue healing
- **Outpatient settings**
- **Does not include active cancer treatment, palliative care, and end-of-life care**
OPIOID PRESCRIPTIONS AND INCREASING DEATHS
ROLE OF PRESCRIBING OPIOIDS AND OVERDOSE DEATHS

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN
The 12 recommendations are grouped into three conceptual areas:

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use
DETERMINE WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN
Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.

Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

(Recommendation category A: Evidence type: 3)
OPIOIDS NOT FIRST-LINE OR ROUTINE THERAPY FOR CHRONIC PAIN

- Use nonpharmacologic therapy such as exercise or cognitive behavioral therapy (CBT) to reduce pain and improve function.

- Use nonopioid pharmacologic therapy (nonsteroidal anti-inflammatory drugs, acetaminophen, anticonvulsants, certain antidepressants) when benefits outweigh risks, combined with nonpharmacologic therapy.

- When opioids used, combine with nonpharmacologic therapy and nonopioid pharmacologic therapy to provide greater benefits.
Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.

Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

(Recommendation category A: Evidence type: 4)
ESTABLISH AND MEASURE PROGRESS TOWARD GOALS

- Before initiating opioid therapy for chronic pain
  - Determine how effectiveness will be evaluated.
  - Establish treatment goals with patients.
    - Pain relief
    - Function
- Assess progress using 3-item PEG Assessment Scale*
  - Pain average (0-10)
  - Interference with Enjoyment of life (0-10)
  - Interference with General activity (0-10)
*30% = clinically meaningful improvement
RECOMMENDATION #3

- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(Recommendation category A: Evidence type: 3)
ENSURE PATIENTS ARE AWARE OF POTENTIAL BENEFITS, HARMs, AND ALTERNATIVES TO OPIOIDS

- Be explicit and realistic about expected benefits.
- Emphasize goal of improvement in pain and function.
- Discuss
  - serious and common adverse effects
  - increased risks of overdose
    - at higher dosages
    - when opioids are taken with other drugs or alcohol
  - periodic reassessment, PDMP and urine checks; and
  - risks to family members and individuals in the community.
OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION
RECOMMENDATION #4

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

(Recommendation category A: Evidence type: 4)
In general, avoid the use of immediate-release opioids combined with ER/LA opioids.

Methadone should not be the first choice for an ER/LA opioid.
- Only providers familiar with methadone’s unique risk and who are prepared to educate and closely monitor their patients should consider prescribing it for pain.

Only consider prescribing transdermal fentanyl if familiar with the dosing and absorption properties and prepared to educate patients about its use.
RECOMMENDATION #5

- When opioids are started, clinicians should prescribe the lowest effective dosage.
- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

(Recommendation category A: Evidence type: 3)
Start with lowest effective dosage and increase by the smallest practical amount.

If total opioid dosage ≥50 MME/day
  - reassess pain, function, and treatment
  - increase frequency of follow-up; and
  - consider offering naloxone.

Avoid increasing opioid dosages to ≥90 MME/day.

If escalating dosage requirements
  - discuss other pain therapies with the patient
  - consider working with the patient to taper opioids down or off
  - consider consulting a pain specialist.
IF PATIENT IS ALREADY RECEIVING A HIGH DOSAGE

▪ Offer established patients already taking ≥90 MME/day the opportunity to re-evaluate their continued use of high opioid dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.

▪ For patients who agree to taper opioids to lower dosages, collaborate with the patient on a tapering plan.
RECOMMENDATION #6

- Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
- 3 days or less will often be sufficient; more than 7 days will rarely be needed.

(Recommendation category A: Evidence type: 4)
WHEN OPIOIDS ARE NEEDED FOR ACUTE PAIN

- Prescribe the lowest effective dose.
- Prescribe amount to match the expected duration of pain severe enough to require opioids.
- Often ≤ 3 days and rarely more than 7 days needed.
- Do not prescribe additional opioids “just in case”.
- Re-evaluate patients with severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly.
- Do not prescribe ER/LA opioids for acute pain treatment.
RECOMMENDATION #7

- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
- Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
- If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

(Recommendation category A: Evidence type: 4)
FOLLOW-UP

- Re-evaluate patients
  - within 1-4 weeks of starting long-term therapy or of dosage increase
  - at least every 3 months or more frequently.
- At follow up, determine whether
  - opioids continue to meet treatment goals
  - there are common or serious adverse events or early warning signs
  - benefits of opioids continue to outweigh risks
  - opioid dosage can be reduced or opioids can be discontinued.
TAPERING OPIOIDS

- Work with patients to taper opioids down or off when
  - no sustained clinically meaningful improvement in pain and function
  - opioid dosages ≥50 MME/day without evidence of benefit
  - concurrent benzodiazepines that can’t be tapered off
  - patients request dosage reduction or discontinuation
  - patients experience overdose, other serious adverse events, warning signs.

- Taper slowly enough to minimize opioid withdrawal
  - A decrease of 10% per week is a reasonable starting point

- Access appropriate expertise for tapering during pregnancy

- Optimize nonopioid pain management and psychosocial support
ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE
RECOMMENDATION #8

- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
- Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (>50 MME/day), or concurrent benzodiazepine use, are present.

(Recommendation category A: Evidence type: 4)
CERTAIN FACTORS INCREASE RISKS FOR OPIOID-ASSOCIATED HARMs

- Avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing when possible.
- During pregnancy, carefully weigh risks and benefits with patients.
- Use additional caution with renal or hepatic insufficiency, aged ≥65 years.
- Ensure treatment for depression is optimized.
- Consider offering naloxone when patients
  - have a history of overdose
  - have a history of substance use disorder
  - are taking central nervous system depressants with opioids
  - are on higher dosages of opioids (≥ 50 MME/day).
RECOMMENDATION #9

- Clinicians should review the patient’s history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose.
- Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

(Recommendation category A: Evidence type: 4)
IF PRESCRIPTIONS FROM MULTIPLE SOURCES, HIGH DOSAGES, OR DANGEROUS COMBINATIONS

- Discuss safety concerns with patient (and any other prescribers they may have), including increased risk for overdose.
- For patients receiving high total opioid dosages, consider tapering to a safer dosage, consider offering naloxone.
- Consider opioid use disorder and discuss concerns with your patient.
- If you suspect your patient might be sharing or selling opioids and not taking them, consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal.
- Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions.
RECOMMENDATION #10

- When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

(Recommendation category B: Evidence type: 4)
USE UDT TO ASSESS FOR PRESCRIBED OPIOIDS AND OTHER DRUGS THAT INCREASE RISK

- Be familiar with urine drug testing panels and how to interpret results.
- Don’t test for substances that wouldn’t affect patient management.
- Before ordering urine drug testing
  - explain to patients that testing is intended to improve their safety
  - explain expected results; and
  - ask patients whether there might be unexpected results.
- Discuss unexpected results with local lab and patients.
- Verify unexpected, unexplained results using specific test.
- Do not dismiss patients from care based on a urine drug test result.
Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

(Recommendation category A: Evidence type: 3)
Avoid concurrent opioids and benzodiazepines whenever possible

- Taper benzodiazepines gradually.
- Offer evidence-based psychotherapies for anxiety.
  - cognitive behavioral therapy
  - specific anti-depressants approved for anxiety
  - other non-benzodiazepine medications approved for anxiety
- Coordinate care with mental health professionals.
RECOMMENDATION #12

- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

(Recommendation category A: Evidence type: 2)
IF YOU SUSPECT OPIOID USE DISORDER (OUD)

- Discuss with your patient and provide an opportunity to disclose concerns.
- Assess for OUD using DSM-5 criteria. If present, offer or arrange MAT.
  - Buprenorphine through an office-based buprenorphine treatment provider or an opioid treatment program specialist
  - Methadone maintenance therapy from an opioid treatment program specialist
  - Oral or long-acting injectable formulations of naltrexone (for highly motivated non-pregnant adults)
- Consider obtaining a waiver to prescribe buprenorphine for OUD (see [http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management](http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management))
Checklist for prescribing opioids for chronic pain
For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

**RECOMMENDATION long-term opioid therapy**
- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse, discuss risk factors with patient.
- Check prescription drug monitoring program (PDMP) data.
- Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

**IF RENEWING without patient visit**
- Check that return visit is scheduled ≤ 3 months from last visit.

**WHEN REASSESSING at return visit**
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- Assess pain and function (eg, PEG), compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
  - If yes: Taper dose.
- Check PDMP.
- Check for opioid use disorder if indicated (eg, difficulty controlling use).
- If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up, consider offering naloxone.
  - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤ 3 months).

**REFERENCE**

**EVIDENCE ABOUT OPIOID THERAPY**
- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

**NON-OPIOID THERAPIES**
Use alone or combined with opioids, as indicated.
- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

**EVALUATING RISK OF HARM OR MISUSE**
Known risk factors include:
- Illegal drug use, prescription drug use for non-medical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

**ASSESSING PAIN & FUNCTION USING PEG SCALE**
Pain score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

**Q1:** What number from 0–10 best describes your pain in the past week?
0 = “no pain”, 10 = “worst you can imagine”

**Q2:** What number from 0–10 describes how, during the past week, pain interfered with your enjoyment of life?
0 = “not at all”, 10 = “complete interference”

**Q3:** What number from 0–10 describes how, during the past week, pain interfered with your general activity?
0 = “not at all”, 10 = “complete interference”

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
www.cdc.gov/drugoversight/prescribing/guideline.html
March 2016

TO LEARN MORE
BURNOUT STATISTICS

- Over 54% of physicians affected
- >400,000 people
- All specialties
- Effects all levels of the medical hierarchy
  (students, residents, and attendings)
54% of doctors say they are burned out.¹

88% of doctors are moderately to severely stressed.²

59% of doctors wouldn’t recommend a career in medicine to their children.³

burnout:

exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration
What Percentage of Family Physicians Are “Burned Out?”

Burnout = loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment
What Are the Causes of Burnout?

- Too many bureaucratic tasks
- Spending too many hours at work
- Feeling like just a cog in the wheel
- Income not high enough
- Present and future impact of Affordable Care Act
- Inability to provide patients with quality care they need
- Too many difficult patients
- Lack of professional fulfillment
- Increasing computerization of practice
- Compassion fatigue
- Difficult employer
- Difficult colleagues or staff

1 = Not at all important
7 = Extremely important
SIGNS OF BURNOUT:

- Depleted enthusiasm
- Social isolation
- Emotional volatility
- Patient depersonalization
- Chemical stimulation
- Change in sleeping habits
- Diminished physical activity
<table>
<thead>
<tr>
<th>Stress</th>
<th>Burnout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characterized by overengagement</td>
<td>Characterized by disengagement</td>
</tr>
<tr>
<td>Emotions are over-reactive</td>
<td>Emotions are blunted</td>
</tr>
<tr>
<td>Produces urgency and hyperactivity</td>
<td>Produces helplessness and hopelessness</td>
</tr>
<tr>
<td>Loss of energy</td>
<td>Loss of motivation, ideals, and hope</td>
</tr>
<tr>
<td>Leads to anxiety disorders</td>
<td>Leads to detachment and depression</td>
</tr>
<tr>
<td>Primary damage is physical</td>
<td>Primary damage is emotional</td>
</tr>
<tr>
<td>May kill you prematurely</td>
<td>May make life seem not worth living</td>
</tr>
</tbody>
</table>
CHALLENGES

- Physicians do not reliably self-assess their own distress (Dyrbye 2013)
- How we deal with stress
  - Intellectualize
  - Minimize
  - Intensify
HIGH-RISK CHARACTERISTICS

- Hectic schedule
- Strong achievement orientation
- The inability to say “no”
Balance is not better time management, but better boundary management. Balance means making choices and enjoying those choices.”
FALLOUT FROM BURNOUT

• Decreased patient satisfaction
• Increased job turnover and reduced hours
• Increased medical errors
• Increased malpractice risk
• Increased potential for patient harm
OTHER MANIFESTATIONS

- Disruptive behavior
- Motor vehicle accidents and near-misses
- Depression
- Substance use disorders
- Suicide
Today, somewhere in these United States, a doctor will commit suicide. Another tomorrow, and another the next day. There is general agreement in the literature that 350 - 400 physicians take their own lives each year.
BURNOUT AND PHYSICIAN SUICIDE

• Highest suicide rate of any profession.
• More than twice as likely to commit suicide than non-physicians.
• More attempts and higher success rates than the general population.
  • Males: 40% higher
  • Females: 130% higher
Suicide is the 2nd most common cause of death in medical students.

50% of students met criteria for burnout over the past year.

11% met criteria for suicidal ideation in the past year.

Dyrbye et al, Annals Int Med 2008
KEY DRIVERS:

• Excessive workload
• Inefficient work environment, inadequate support
• Loss of autonomy/flexibility/control
• Loss of meaning in work
• Problems with work-life integration and balance
REMEDIES: WHAT DOES THE LITERATURE SAY?

- Making choices (work/life balance)
- Stress management techniques
- Spiritual nurturing
- Positive life philosophy
- Self-care
- Strive for meaning in work
Scheduling "me" time
YOU CAN’T DO A GOOD JOB IF YOUR JOB IS ALL YOU DO.

ARTIFACT UPRISING
“ONE OF THE MYSTERIES OF ILLNESS IS THAT NO ONE CAN BE HEALED BY ANYONE WHOSE EMPTINESS IS GREATER THAN THEIR OWN.”

Mark Nepo
if your compassion does not include you it is incomplete
- Siddartha Gautama
THANK YOU!

The Art of Books