

# the REPORTER

## CME: PHYSICIAN WELLNESS: MENTAL HEALTH CARE IS HEALTH CARE

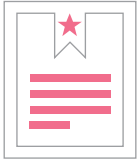
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LONE STAR  
ALLIANCE  
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Quarter 2, 2023



CONTINUING  
MEDICAL  
EDUCATION

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# CME

# PHYSICIAN WELLNESS: MENTAL HEALTH CARE IS HEALTH CARE

by Wayne Wenske, Senior Marketing Strategist

## OBJECTIVES

Upon completion of this educational activity, the participant will be able to:

1. discuss the difference between mental health and mental illness;
2. summarize the role of stigma in hampering mental health care;
3. describe the various stressors that may contribute to physician stress and burnout;
4. list a variety of techniques and resources to help individual physicians combat stress and burnout; and
5. discuss the benefits of mindfulness and self-compassion.

## COURSE AUTHOR

Wayne Wenske is Senior Marketing Strategist at Texas Medical Liability Trust (TMLT).

## DISCLOSURE

Wayne Wenske has no relevant financial relationship(s) with ineligible companies to disclose. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with ineligible companies to disclose.

## TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in learning more about the differences between mental health and mental illness; how COVID-19 has affected the mental health of both the patient and physician populations; and available resources to help nurture a sense of peace, calm, and good mental health.

## CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit(s)*<sup>™</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

## ETHICS CREDIT STATEMENT

This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

## TEST

To receive credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 1 CME credit.

## PRICING

The following fee will be charged when accessing this CME course online at <http://lonestara.inreachce.com>.

*Policyholders: \$10*

*Non-policyholders: \$75*

## INSTRUCTIONS

CME test and evaluation forms must be completed online. After reading the article, go to <http://lonestara.inreachce.com>. Follow the online instructions to complete the forms and download your certificate.

## RELEASE/REVIEW DATE

This activity is released on June 1, 2023 and will expire on June 1, 2026. Please note that this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

## INTRODUCTION

On May 8, 2023, the World Health Organization (WHO) announced the end of the COVID-19 global health emergency. Without question, the end of COVID-19 as a global health emergency is something we have all waited for. But WHO is quick to point out that COVID-19 is still a threat, and they reserve the right to reinstate the global health emergency status

and accompanying safety measures as circumstances dictate. WHO and other entities also recognize that COVID-19 has "changed the way we live, work and socialize, and everyone on the planet has been affected by this pandemic."<sup>1,2</sup>

Less than a week before the WHO announcement, the U.S. Surgeon General Dr. Vivek Murthy issued

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an advisory about a new major health issue related to COVID-19: an epidemic of loneliness exacerbated by the public isolating from one another during the pandemic. This disconnection “fundamentally affects our mental, physical, and societal health. In fact, loneliness and isolation increase the risk for individuals to develop mental health challenges in their lives, and lacking connection can increase the risk for premature death to levels comparable to smoking daily.”<sup>3</sup>

Dr. Murthy provided a framework for a national strategy to combat loneliness because “loneliness and isolation are risk factors for several major health conditions (including heart disease, dementia, depression) as well as for premature death.”<sup>3</sup> With this advisory, the U.S. Department of Health and Human Services (HHS) makes a direct correlation between a patient’s mental health (isolation and loneliness) and physical health (comparing lack of social interaction to smoking daily).

This article will further explore the concept of mental health being tied to physical health; identify the primary causes and consequences of stress and burnout for physicians; provide a variety of resources available to help reduce stress and burnout; and offer practical instruction on such stress-reducing tactics and exercises as mindfulness, meditation, and self-compassion.

## **MENTAL HEALTH VS. MENTAL ILLNESS**

According to the Centers for Disease Control and Prevention (CDC), “mental health” is a combination of our “emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices.”<sup>4</sup>

The American Psychiatric Association states that mental health is the foundation for thinking, communication, emotions, learning, and self-esteem.<sup>5</sup> Typically, individuals with good mental health are:

- productive in work or school;
- have lasting and satisfying relationships;
- are able to adapt to change without too much hardship;
- do not become overwhelmed by emotions; and
- are able to accept any challenges or hardships they encounter.

Yet, good mental health is more complicated than appearing to function “normally.”

Mental health is not simply the absence of a mental illness or disorder. There are many ways individuals can be mentally healthy or ill, just as there are many ways to be physically healthy or unhealthy.

Much of the literature states that mental health and mental illness exist as states of being on a spectrum. Mental health and mental illness are both experienced differently from one person to the next, with varying degrees of severity throughout a lifetime.

For example, one person may have a mild fear or phobia that is experienced in specific circumstances, such as a fear of deep water when swimming or “white coat syndrome” when visiting a physician. Another person may have severe depression or suicidal ideation that is experienced daily and may require care in a hospital. And all conditions may change in severity, depending on a variety of physical, mental, and environmental factors — such as illness, stress, or being isolated during a global pandemic.

While mental health involves effective functioning in daily life, mental illness “refers collectively to all diagnosable mental disorders — health conditions involving:

- Significant changes in thinking, emotion, and/or behavior.
- Distress and/or problems functioning in social, work or family activities.”<sup>5</sup>

Because mental health is so variable, the signs or behaviors that a patient needs help can be overlooked. As such, many individuals with poor mental health may not be formally diagnosed with a mental illness. It may not always be clear when a problem with mood or thinking has become serious enough to be a health concern. For example, depression or excessive sadness is considered “normal” when an individual is going through a divorce or grieving the death of a loved one.

But if that sadness or depression becomes chronic or interferes with a person’s ability to work, sleep, or interact with others, that person may benefit from professional health care. In addition, family members or friends may recognize changes or issues that a person may not see in themselves.

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Circumstances that may put an excessive burden on an individual's ability to cope and affect his or her mental health include:

- illness;
- pain;
- chronic physical conditions;
- physical abuse, trauma, or neglect;
- bereavement;
- experiencing discrimination, including sexism and racism;
- physical or sexual assault;
- being overworked or working long hours;
- caregiving for a loved one;
- losing employment;
- economic hardship or excessive debt;
- long-term stress; and
- social isolation and loneliness.

### **MENTAL HEALTH: THE STATISTICS**

According to the CDC, “mental illnesses are among the most common health conditions in the United States.

- More than 1 in 5 U.S. adults live with a mental illness.
- Over 1 in 5 youth (ages 13-18) either currently or at some point during their life, have had a seriously debilitating mental illness.
- About 1 in 25 U.S. adults lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression.”<sup>4</sup>

A 2023 report from Mental Health America shows that 21 percent of U.S. adults — approximately 50 million individuals — currently experience mental illness. Additional statistics from the report include:

- 4.8 percent of adults — over 12 million individuals — reported suicidal ideation;
- 55 percent of adults with mental illness, about 25 million individuals, do not receive treatment;
- most adults report “high costs” as the primary reason they do not receive treatment; and
- 11 percent of adults with mental illness, about 6 million individuals, do not have health insurance.<sup>6</sup>

In addition to these statistics on adults, a 2021 CDC report on teenage health indicates that nearly 60 percent of female high school students and nearly 70 percent of high school students who identify as LGBTQ+ experience “persistent feelings of sadness

and hopelessness.” Ten percent of female students and more than 20 percent of LGBTQ+ students have attempted suicide.<sup>7</sup>

The report also stated that 42 percent of all high school students “felt so sad or hopeless almost every day for at least two weeks in a row that they stopped doing their usual activities.” Poor mental health among teenagers increases risks of illicit drug use; sexually transmitted diseases, including HIV; unintended pregnancy; and suicide or suicide attempts that not only put a young person's life at risk but also at risk for trauma and other mental health issues that can continue into adulthood.<sup>7</sup>

WHO reports that more than 700,000 people die by suicide annually, and account for 1 in every 100 deaths worldwide. WHO also lists suicide as the fourth leading cause of death in individuals aged 15 to 29 years old.<sup>8</sup>

### **MENTAL HEALTH CARE /S HEALTH CARE**

As an environmental factor of mental health, a global pandemic has become a proven contributor to mental illness. We can probably all point to examples from our daily lives of the stress we are all under and how it contributes to negative feelings and behaviors not typically observed in our colleagues, family, friends, and ourselves.

Throughout the pandemic, physicians have seen a heightened mental health strain among their patients, through such disruptive behaviors as increased anger, fear, aggression, name-calling, impatience, and general anti-social behaviors. Unfortunately, dealing with disruptive patients has now become an expected part of the workday for physicians and their employees.

Patients experiencing stress, pain, illness, or chronic conditions may also exhibit symptoms of mental illness. Depression is common among patients with diabetes, multiple sclerosis, cancer, Alzheimer's disease, coronary heart disease, HIV/AIDS, hypothyroidism, and other autoimmune diseases.

According to the CDC, “mental and physical health are equally important components of overall health. For example, depression increases the risk for many types of physical health problems, particularly long-

lasting conditions like diabetes, heart disease, and stroke. Similarly, the presence of chronic conditions can increase the risk for mental illness.”<sup>4</sup>

Research also shows that depression has a negative effect on several bodily functions that can affect physical health, including increased inflammation; changes in the control of heart rate and blood circulation; and changes in metabolism. Nearly one in three people with a long-term physical health condition also has a mental health problem, most often depression or anxiety.<sup>9</sup>

Mental health and physical health are entwined, often in ways that go unseen or undiagnosed. And when a patient’s mental health is brought into question, there is often stigma attached to the possibility of mental illness and its treatment.

## STIGMA AS A CONTRIBUTING FACTOR TO HEALTH OUTCOMES

According to the American Psychiatric Association, more than half of those with mental illness do not receive help for their conditions. “Often, people avoid or delay seeking treatment due to concerns about being treated differently or fears of losing their jobs and livelihood. That’s because stigma, prejudice and discrimination against people with mental illness is still very much a problem.”<sup>10</sup>

Stigma can also make symptoms worse due to the reduced likelihood of seeking treatment. Harmful effects of stigma can include lower self-esteem; difficulties with social and professional relationships; escalating symptoms of mental illness; and increased social isolation — again, noted as one of the most significant contributors to mental and physical illness during the COVID-19 pandemic.<sup>10</sup>



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*The Lancet* has established a COVID-19 Commission to explore the scope of the pandemic and its long-term consequences. One consequence being examined is the current and probable long-term mental health crisis. The commission wrote that the COVID-19 pandemic “offers a critical opportunity to invest in and strengthen mental health care systems to achieve a ‘parity of esteem,’ meaning that someone who is mentally ill should have equal access to evidence-based treatment as someone who is physically ill.”<sup>11</sup>

But health care — mental and physical — is for all. Physicians deserve the same kind of latitude afforded their patients, a freedom from structural barriers and stigma. Physicians should be able to access the same high-quality care that they provide.

### **PHYSICIANS NEED HELP, TOO**

While our communities have experienced heightened levels of anxiety and fear during the COVID-19 pandemic, physicians have faced additional stressors unique to their professions and environments: longer work hours, leading to an out-of-proportion work/life balance; decision-making with potentially devastating consequences; difficult conversations with patients or their families; potential malpractice claims; and increased fears of patient death due to COVID-19.

Unfortunately, these stress points — and more — have contributed to a growing epidemic of physician stress and burnout. The American Medical Association (AMA) reports that 63 percent of U.S. physicians are experiencing professional burnout, while a 2022 study indicates that U.S. physicians are at greater risk of professional burnout compared to workers in other fields.<sup>12,13</sup>

In a 2022 report by Medscape, physicians who were experiencing depression and burnout were asked, “Have you used the services of companies, individuals, or coaches who offer programs to reduce burnout?” Forty-three percent answered, “No, and will not consider using.” In the same report, 43 percent of physicians said they did not seek help for burnout or depression because they feared their medical board would find out; 25 percent were concerned about colleagues finding out.<sup>14</sup>

### **PHYSICIAN STRESS AND BURNOUT: KNOWING THE DIFFERENCE**

In simple terms, feelings of stress are often the result of “too much” — too many daily pressures, responsibilities, tasks, activities, or meetings. People who are under stress usually feel that they are still in control of their situation, and reducing stress is well within the realm of possibility. Stress is often relatively short-term; however, prolonged stress can lead to a number of ailments ranging from loss of energy and headaches to high blood pressure and anxiety disorders.<sup>15</sup>

Stress can also take a costly toll on the economy. According to one study, work-related stress is estimated to cost the U.S. economy more than \$300 billion annually as a result of stress-related absenteeism, accidents, and diminished productivity.<sup>16</sup>

Stress can also lead to burnout. While stress comes from feelings of “too much to handle,” burnout can come from feelings of “not enough to give.” Being burned out means feeling empty, unmotivated, and uncaring. People who feel burned out feel like they do not have any control, and they feel little hope that they can change the sources of their burnout.

Burnout often takes place over a long period and can be characterized by feelings of hopelessness, detachment, and depression. And while one is usually aware of being under a lot of stress, recognizing burnout may not be obvious when it happens.<sup>15</sup>

In health care, the consequences of burnout can equate to lower quality of care, increased errors, a decreased ability to empathize with patients, and a growing number of physicians either retiring early or leaving the medical field.

### **ASSESSING PHYSICIAN BURNOUT USING THE MASLACH BURNOUT INVENTORY**

Burnout in physicians is “characterized by emotional exhaustion, finding work no longer meaningful, feelings of ineffectiveness, and a tendency to view patients, students, and colleagues as objects rather than as human beings.”<sup>17</sup>

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Studies published by the Mayo Clinic have been comparing physician burnout and work-life integration satisfaction relative to 2011, 2014, 2017 and 2020 using the Maslach Burnout Inventory (MBI), considered the most widely used measurement system for assessing burnout.<sup>13,18</sup>

To create an MBI score, three general scales corresponding to the three components of burnout are measured:

- “Emotional exhaustion measures feelings of being emotionally overextended and exhausted by one’s work.
- Depersonalization measures an unfeeling and impersonal response toward recipients of one’s service, care treatment, or instruction.
- Personal accomplishment measures feelings of competence and successful achievement in one’s work.”<sup>19</sup>

The results of the 2020 study, when looking at each component, showed 33.6 percent of U.S. physicians were measured with high emotional exhaustion and 23.2 percent with high depersonalization. In aggregate, 38.2 percent of the physicians had at least one symptom of burnout. (The researchers behind the study considered physicians with a high score on the depersonalization and/or emotional exhaustion subscales as having at least one manifestation of professional burnout.)<sup>13</sup>

In addition, only 46.1 percent of U.S. physicians were satisfied with their work-life integration; 17.5 percent were neutral on this matter.<sup>13</sup>

Burnout also varied by specialty, with the highest rates of burnout seen in 1.) emergency medicine, 2.) urology, 3.) family medicine, and 4.) general internal medicine.<sup>13</sup>

The lowest rates of burnout in the 2020 study were in 1.) ophthalmology, 2.) general surgery subspecialty, 3.) radiation oncology, 4.) pathology, and 5.) preventative medicine/occupational medicine. In 2019, the lowest rates of burnout were in 1.) public health and preventative medicine, 2.) nephrology, 3.) pathology, 4.) ophthalmology, and 5.) otolaryngology.<sup>13,18</sup>

In a separate 2022 study by Medscape, the highest rates of burnout were in 1.) emergency medicine, 2.) critical care, 3.) obstetrics-gynecology, 4.) infectious diseases, and 5.) family medicine.<sup>14</sup>

## WHAT ARE THE PRIMARY CAUSES OF STRESS AND BURNOUT FOR PHYSICIANS?

In the Medscape study, more than 13,000 physicians were asked: “What contributes most to your burnout?” “Too many bureaucratic tasks (e.g., charting, paperwork)” was the leading cause at 60 percent. This was followed by “lack of respect from administrators/employers, colleagues or staff” at 39 percent; “too many hours at work” at 34 percent; “lack of control/autonomy over my life” at 32 percent; and “insufficient compensation/reimbursement” at 28 percent.<sup>14</sup>

Most physicians face chronic and substantial stressors in their work environment, which can result in depression and decreased job satisfaction. Traditionally, stressors for physicians have included:

- length of school or training;
- working in acute, chaotic, or high-pressure environments, such as an emergency department or neonatal intensive care unit;
- difficulty in creating a satisfying work/life balance;
- long working hours, enormous workloads, and high patient volume;
- being sleep deprived;
- a lack of autonomy or limited control over the provision of medical services;
- excessive administrative tasks;
- feeling isolated or not having time to connect with colleagues;
- lack of close, supportive relationships;
- lack of recognition or reward for good work;
- inefficient and/or hostile work environment;
- increased threats of litigation; and
- grief and/or guilt about a patient prognosis, unsatisfactory outcome, or death.<sup>20,21,22</sup>

A 2022 study at the University of North Carolina at Chapel Hill adds the following stressors most frequently cited by physicians during the first wave of the COVID-19 pandemic:

- concerns about being exposed to COVID-19 and/or infecting family members;
- the volume and burden of patient deaths;
- the volume of patients/workload;
- medical uncertainty over how to care for COVID-19 patients;
- caring for patients without family support; and
- patients’ mistrust toward physicians/COVID skepticism.<sup>23</sup>

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## WORK HABITS AND CONDITIONS CONTRIBUTING TO STRESS AND BURNOUT

Long hours and lack of control over one's schedule during medical school, residency, and fellowship have also instilled in physicians a set of work habits that are inconsistent with creating a satisfying work/life balance — even after training is complete.

During their academic lives, many medical students adopt the coping strategy of putting their personal lives on hold until they finish their residencies. A mentality of “delayed gratification” is fostered that can carry over into their professional careers. Unfortunately, many physicians who maintain this strategy of delayed gratification in their careers may never be able to reclaim a personal life.<sup>9</sup>

A 2015 AMA article reported that while most physicians work between 40 and 60 hours per week, nearly one-quarter of physicians work 61 to more than 80 hours per week.<sup>24</sup>

The article also cites a 2011 research letter that noted “specialists caring for more acutely ill patients or those requiring intensive monitoring, usually in hospital settings, work longer hours than physicians focused on more stable, chronically ill patients... in ambulatory settings.” The letter also stated that “exceptions were physicians practicing emergency medicine or hospital medicine because both of these specialties are characterized by fixed hourly shifts.”<sup>24</sup>

Not surprisingly, the specialties that require working longer hours were found to have lower physician job satisfaction, and vice versa.<sup>24</sup>

A 2019 Medscape survey corroborates the rise in burnout based on hours worked. Forty-eight percent of surveyed physicians who worked 51-60 hours reported feelings of burnout; 50 percent of physicians who worked 61-70 hours reported feelings of burnout; and 57 percent of physicians who worked 71 or more hours reported feelings of burnout.<sup>25</sup>

More recent research from the AMA shows that the COVID-19 pandemic affected physician mental health and retention. Of approximately 14,000 physicians surveyed, burnout rates rose from 45 percent in 2019 to 60 percent in 2021, with an intent to leave medical practice increasing from 30 percent in 2019 to more than 40 percent in 2021. A “persistent

lack of control of workload, chaotic environments, challenges with teamwork, and a lack of feeling valued by organizations may have contributed to worsening burnout and a rise in intent to leave.”<sup>26</sup>

However, it is important to point out that this study showed a leveling off or “lack of increase in burnout” during 2020, at the height of the COVID-19 pandemic, and “may indicate a sense of determination and purpose among these professionals.”<sup>26</sup>

The study determines that despite the high levels of burnout before COVID-19 and the clear heavy toll taken by physicians and other health care professionals during the pandemic, many organizations and individuals may not know how to effectively reduce stress and burnout. It concludes with the hope that a national dialogue will begin that will address physician stress, burnout, morale, retention, and “ultimately, the quality of patient care.”<sup>26</sup>

## DEPRESSION AND SUICIDE RISK FOR PHYSICIANS

Several studies show that physicians have a far greater suicide completion rate than the general public. Completion rates are often attributed to physicians having a greater knowledge of and better access to lethal means. Alarming statistics show that “male doctors have suicide rates as much as 40% higher than the general population, and female doctors up to 130% higher... This is likely attributable to doctors’ immense professional burden and (encouraged) neglect of their own well-being.”<sup>27</sup>

Unfortunately, physicians are often reluctant to seek treatment for personal illness; this may be especially true in the case of mental illness involving depression or suicidal thoughts. According to a 2018 Medscape article on physician depression, “A survey of American surgeons revealed that although 1 in 16 had experienced suicidal ideation in the past 12 months, only 26% had sought psychiatric or psychologic help.”<sup>16</sup>

The article also explored the reasons physicians may not ask for help. “They may feel an obligation to appear healthy, perhaps as evidence of their ability to heal others.” There is also reluctance among physicians to recognize symptoms of depression or burnout in their colleagues. To reach out, unsolicited,

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to a colleague who seems troubled “may seem like an affront to a colleague’s self-sufficiency.”<sup>16</sup>

Physicians are considered a “high control” population (along with law enforcement, lawyers, and clergy). Situations, such as increased workload and regulatory requirements, that decrease a physician’s ability to control his or her environment, workplace, or employment conditions can lead to higher levels of stress, job dissatisfaction, burnout, and depression.<sup>28</sup>

## PUTTING STIGMA ASIDE

As described earlier in this article, one of the biggest barriers to mental health care is stigma. Common stereotypes associated with mental illness include being weak, unreliable, incompetent, and dangerous — to oneself and to others. Stereotyping often leads to bias and discrimination. For those with mental illness, this may result in a “snowball effect” of societal and personal losses, such as more limited employment or advancement opportunities, leading to a lack of stable housing, loss of health insurance, loss of parental rights or control, and loss of respect from others and oneself.

These societal censures collectively make up “structural stigma,” and move prejudice or bias from beyond a possible one-on-one interpersonal conflict to putting a person with mental illness outside of cultural and societal norms. Repeated encounters with stigma often lead those with mental illness to internalize these biases, a phenomenon known as “self-stigma.” These individuals may avoid looking at their own mental health symptoms and either delay or not seek help. This can exacerbate the problem, leading to increased symptoms, shame, and hopelessness. Over time, increasing levels of self-stigma have been associated with suicidal ideation.<sup>29</sup>

Education about mental health has proven to be a key factor in reducing stigma. Studies have shown that one of the most effective ways to reduce mental health stigma has involved personal interactions between those with a mental illness and those individuals who may still hold a bias or prejudice against them. Hearing or discussing an individual’s own struggles can help to normalize a condition; personal testimonies often show others that mental health conditions such as depression, anxiety, or

addiction are as common and treatable as such physical health conditions as diabetes, heart disease, or asthma.<sup>29</sup>

## RESOURCES FOR PHYSICIANS

Coming out of the COVID-19 crisis, many physicians have experienced higher levels of depression, anxiety, stress, and burnout. Thankfully, there are several resources and practical steps physicians can take to help nurture a stronger sense of well-being in their work life.

### *Stanford Medicine WellMD website*

Stanford University offers the WellMD & WellPhD website at <https://wellmd.stanford.edu/>. This site is dedicated to the professional fulfillment, personal health, and work/life balance of its on-staff physicians and scientists, but the site and its services are available to all visitors.<sup>30</sup>

The website includes several online tools such as self-assessment tests, contact information for support groups and classes, videos, a toolkit for organizations, and resources to help promote mindfulness, physical fitness, and resilience.

The “Test Yourself” page invites physicians to take anonymous self-tests with links to various sites.<sup>31</sup> Topics include depression, burnout, empathy, mindfulness, and work-life balance. Tools include the following short self-assessments courtesy of Mental Health America:

- The Stress Screener quiz is available at <https://mhanational.org/get-involved/stress-screener>. Sample questions on this short quiz include:
  - Do you ever have trouble sleeping?
  - Are you experiencing any digestive problems, such as indigestion, irritable bowel syndrome, or ulcers?
  - Do you have a supportive social network, and take time for relationships in your life?<sup>32</sup>
- An anxiety test is available at <https://screening.mhanational.org/screening-tools/anxiety>. It asks visitors to consider their feelings and behaviors over the last two weeks to produce a rating for anxiety levels. Sample questions include:

- Are you easily annoyed or irritable?
  - Do you often feel so restless that you find it hard to sit still?
  - Are you not able to stop or control worrying? <sup>33</sup>
- A depression screen is available at <https://screening.mhanational.org/screening-tools/>. Sample questions include:
    - Are you having trouble concentrating on things, such as reading the newspaper or watching television?
    - Are you having thoughts that you would be better off dead, or of hurting yourself?
    - Are you having trouble falling or staying asleep, or sleeping too much? <sup>34</sup>

This site includes other short self-assessments on such conditions as post-traumatic stress disorder, post-partum depression, and addiction. <sup>35</sup>

## MINDFUL MEDITATION

“Mindfulness” is rooted in 2,500-year-old Buddhist meditation practices that are used to help one pay attention and be fully present or engaged in the moment. Rather than worrying about the future or dwelling on the past, “mindful meditation” helps you maintain a focus on what’s happening right now.

Studies have shown that physicians who practice mindful meditation have seen short-term and sustained improvements in their physical and mental well-being, and demonstrated improvements in interpersonal characteristics, such as empathy, associated with better patient care. <sup>36, 37, 38</sup>

Mindful meditation can be used to reduce stress, anxiety, fear, depression, or other negative thoughts or feelings. Mindfulness also improves physical health by helping to lower blood pressure, improve sleep, and reduce chronic pain. Focusing on a single repetitive action, such as breathing, a few repeated words or a mantra, or a flickering candle can help bring you to a peaceful place where distractions are gone, and you are fully in the moment. Other forms of mindful meditation may involve concentration on walking, eating, or exercising.

A basic mindfulness exercise:

1. Sit on a straight-backed chair or cross-legged on the floor.
2. Focus solely on your breathing. Pay attention to the experience of air flowing into your nostrils and out of your mouth, or your chest rising and falling as you inhale and exhale.
3. Once you've narrowed your concentration to your breathing, begin to widen your focus. Become aware of sounds in the room, such as the sound of the air conditioning; sensations, like the feeling of the floor on the soles of your feet; and any ideas you have about the current experience of the exercise.
4. Embrace and consider each thought or sensation without judging it as good or bad. If your mind starts to race or become distracted by worrying thoughts, return your focus to your breathing. Then try to expand your awareness again. <sup>39</sup>

## RESOURCES FOR MINDFUL MEDITATIONS

*The Yoga Journal* magazine and website offers a useful resource for guided mindful meditations. The website offers a beginner's guide to meditation; a get-started guide to help you identify a meditation style that's best for you and even how to sit for meditation; meditation basics, such as how to start a daily routine; and guided meditations for deep sleep, improving memory, and “finding inner balance.” These resources are found at [www.yogajournal.com/category/meditation/](http://www.yogajournal.com/category/meditation/).

Stanford's WellMD website has a page devoted to mindfulness with a self-assessment; a series of videos; and tips on being more mindful including “How to practice mindfulness throughout your workday,” “Opportunities for ‘pausing’ during the day,” and “Mindful eating.” This site also offers “Mindfulness for physicians,” compassion cultivation, and stress reduction in medicine. <https://wellmd.stanford.edu/healthy/mindfulness.html>

The University of California at Los Angeles (UCLA) also offers free guided meditations on its UCLA Health website in English, Spanish, Mandarin, Arabic, and other languages. Meditations, part of the UCLA Mindful Awareness Research Center, include “Breath, sound, body meditation,” “Working with difficulties,” “Loving kindness,” and “Body scan for sleep.” <http://marc.ucla.edu/mindful-meditations>

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There are also several apps that can be downloaded to your mobile device to help reduce stress and burnout, including Calm, Insight Timer, Headspace, Aura: Meditation & Sleep, and Buddhify.

## SELF-CARE AND COMPASSION

Practicing mindful meditation is only one strategy to help you mitigate stress and burnout and promote well-being. There are a number of meaningful strategies you can use to increase your own well-being through self-care and compassion.

“Having compassion for oneself is really no different than having compassion for others,” writes Kristin Neff, PhD on her website [Self-Compassion.org](http://Self-Compassion.org). “When you see a person struggling —emotionally, financially, physically — you may feel a need to help them, to take away their pain or difficulty. Struggle is human, and we are all human. To care for oneself is to recognize your own humanity, and your own need for help.”<sup>40</sup>

Self-compassion involves responding the same way to yourself in times of difficulty as you would to a patient under your care. Dr. Neff continues, “Instead of mercilessly judging and criticizing yourself for various [perceived] inadequacies or shortcomings, self-compassion means you are kind and understanding when confronted with personal failings — after all, who ever said you were supposed to be perfect?”<sup>40</sup>

Dr. Neff includes a variety of exercises and tips for practicing self-compassion. One exercise called “How would you treat a friend?” asks you to think of a time when a friend was struggling in some way and to write down a description of your response, what you might have said, and in what tone.

Next, think of a time when you were personally struggling or having negative feelings; write down how you responded, including what you may have said to yourself and in what tone. Then compare your responses — to your friend and to yourself. What are the differences? Did you treat your friend with more kindness or compassion?

The last portion of the exercise is to describe how your actions, attitude, and results may have differed if you had responded to yourself in the same way

you would have typically responded to a struggling friend.<sup>41</sup>

Other ways to ensure you are taking care of yourself in your professional life and personal life include the following.

- Identify the people, places, and activities in your life that you enjoy. Stay away from people or relationships that drain you.
- Take breaks throughout the day, even if you have to schedule them. Use a quick 10-minute break to do a mindful meditation or to step outside and get some fresh air.
- Allow yourself enough time to get to appointments. The added stress of not giving yourself enough time to complete a task or to meet with a patient increases your stress and can reduce your efficiency.
- Set boundaries. Don’t overcommit yourself. If possible, cut activities out of your schedule that cause you stress, such as attending unnecessary meetings. Learn to say, “No.”
- Do something for yourself each day. Eat well and get enough sleep and exercise.
- Take time off. Go on vacation and “recharge your batteries.”
- Gain control where you can. This can mean keeping simple goals, such as being on time to work, taking the stairs at work, or maintaining a weekly “standing date” with a friend or partner. For example, have dinner every Friday at 6 with your best friend.

Practicing self-compassion is a way to remind yourself that there will be times that you will need to take care of yourself to avoid stress and burnout and maintain a high level of patient care.

## ADDITIONAL RESOURCES

Several resources, in the form of books, websites, blogs, videos, and articles, are available to help you or your colleagues manage stress and burnout.

### Websites and blogs

- [StressRemedy.com](http://StressRemedy.com), a website with guided meditation audio clips hosted by Jay Winner, MD, Available at: <http://stressremedy.com/audio/>.
- The Federation of State Physician Health Programs provides a list of physician health



programs by state. Available at <http://www.fsphp.org/state-programs>.

- The American College of Emergency Physicians (ACEP) has a Wellness resource page on its website with several papers and resources compiled by its own Well-being Committee. Available at <https://www.acep.org/life-as-a-physician/wellness/>.
- Self-Compassion.org by Associate Professor Kristin Neff at The University of Texas at Austin offers guided meditations and help for practicing self-compassion. Available at <http://self-compassion.org>.
- HelpGuide.org provides tools, FAQs, and information to help users strengthen their mental and emotional health. Available at <https://www.helpguide.org/>.
- The American Academy of Family Physicians website includes a page on Physician Well-being. Available at <https://www.aafp.org/family-physician/practice-and-career/managing-your-career/physician-well-being.html>.

### **Books**

The following books can help you assess your current levels of stress and burnout, identify the sources, and find solutions to help you rediscover your passion for helping others.

- *Mayo Clinic Strategies To Reduce Burnout: 12 Actions to Create the Ideal Workplace* by Stephen Swensen, MD, MMM and Tait Shanafelt, MD
- *The Doctor is Burned Out: A Physician's Guide to Recovery* by Jeff Moody, MD
- *When the Body Says No: Exploring the Stress-Disease Connection* by Gabor Maté, MD
- *Attending: Medicine, Mindfulness, and Humanity* by Ronald Epstein, MD
- *Physician Burnout: A Guide to Recognition and Recovery* by Tom Murphy, MD
- *Stop Physician Burnout: What to Do When Working Harder Isn't Working* by Dike Drummond, MD
- *Remedy for Burnout: 7 Prescriptions Doctors Use to Find Meaning in Medicine* by Starla Fitch, MD
- *Preventing Physician Burnout: Curing the Chaos*

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*and Returning Joy to the Practice of Medicine*  
by Paul DeChant, MD, MBA and Diane W.  
Shannon, MD, MPH

- *Wherever You Go, There You Are* by Jon Kabat-Zinn
- *Relaxation on the Run: Simple Methods to Reduce Stress in Seconds Plus Practical Lifestyle Tips for a Happier and Healthier Life* by Jay Winner, MD

### Videos

The following videos are available on Ted.com.

- "How to make stress your friend" with psychologist Kelly McGonigal. 14 minutes. Available at [http://www.ted.com/talks/kelly\\_mcgonigal\\_how\\_to\\_make\\_stress\\_your\\_friend](http://www.ted.com/talks/kelly_mcgonigal_how_to_make_stress_your_friend).
- "The mental health benefits of storytelling for health care workers" features Laurel Braitman, PhD. 10 minutes. Available at [https://www.ted.com/talks/laurel\\_braitman\\_the\\_mental\\_health\\_benefits\\_of\\_storytelling\\_for\\_health\\_care\\_workers](https://www.ted.com/talks/laurel_braitman_the_mental_health_benefits_of_storytelling_for_health_care_workers).
- "What's normal anxiety—and what's an anxiety disorder?" with Jen Gunter, MD. 5 minutes. Available at [https://www.ted.com/talks/jen\\_gunter\\_what\\_s\\_normal\\_anxiety\\_and\\_what\\_s\\_an\\_anxiety\\_disorder](https://www.ted.com/talks/jen_gunter_what_s_normal_anxiety_and_what_s_an_anxiety_disorder).
- "All it takes is 10 mindful minutes" with Andy Puddicombe. 9 minutes. Available at [http://www.ted.com/talks/andy\\_puddicombe\\_all\\_it\\_takes\\_is\\_10\\_mindful\\_minutes](http://www.ted.com/talks/andy_puddicombe_all_it_takes_is_10_mindful_minutes).
- "How to stay calm when you know you'll be stressed," featuring neuroscientist Daniel Levitin, PhD. 12 minutes. Available at [http://www.ted.com/talks/daniel\\_levitin\\_how\\_to\\_stay\\_calm\\_when\\_you\\_know\\_you\\_ll\\_be\\_stressed](http://www.ted.com/talks/daniel_levitin_how_to_stay_calm_when_you_know_you_ll_be_stressed).
- "An ER doctor on triaging your 'crazy busy' life," with emergency physician Darria Long. 11 minutes. Available at [https://www.ted.com/talks/darria\\_long\\_an\\_er\\_doctor\\_on\\_triaging\\_your\\_crazy\\_busy\\_life](https://www.ted.com/talks/darria_long_an_er_doctor_on_triaging_your_crazy_busy_life).

### Additional resources

- AMA, "The 12 factors that drive up physician burnout" by Sara Berg. Available at <https://www.ama-assn.org/practice-management/physician-health/12-factors-drive-physician-burnout>.
- AMA 2-part podcast series, "Is there a vaccine for burnout?" Available at <https://podcasts.apple.com/us/podcast/is-there-a-vaccine-for-burnout-part-1/id1428853046?i=1000447413198>.

- AMA, "Burnout busters: How to boost satisfaction in personal life, practice" by Lyndra Vassar. Available at <https://wire.ama-assn.org/ama-news/burnout-busters-how-boost-satisfaction-personal-life-practice>.
- Mayo Clinic, "Job burnout: How to spot it and take action." Available at <http://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/art-20046642?pg=1>.
- The Happy MD, "Physician burnout—the three symptoms, three phases and three cures" by Dike Drummond, MD. Available at <https://www.thehappymd.com/blog/bid/290755/physician-burnout-the-three-symptoms-three-phases-and-three-cures>.
- The Happy MD, "Physician burnout: Why it's not a fair fight" by Dike Drummond, MD. Available at <https://www.thehappymd.com/blog/bid/295048/Physician-Burnout-Why-its-not-a-Fair-Fight>.
- U.S. News & World Report, "Doctor burnout, stress and depression: Not an easy fix" by Elaine Cox, MD. Available at <http://health.usnews.com/health-news/patient-advice/articles/2016-04-12/doctor-burnout-stress-and-depression-not-an-easy-fix>.
- The American Medical Association hosts a webpage called "Caring for our caregivers during COVID-19" that provides resources for health care leadership, including advice on institutional policies designed to address stress in the workplace. Available at <https://www.ama-assn.org/delivering-care/public-health/caring-our-caregivers-during-covid-19>.
- The Center for the Study of Traumatic Stress offers a variety of fact sheets and guides for health care workers. Available at <https://www.cstsonline.org/resources/resource-master-list/coronavirus-and-emerging-infectious-disease-outbreaks-response>.

If you feel overstressed or if you're experiencing burnout or depression, you can find help by calling your county medical society or your hospital risk manager. If available, contact your hospital's physician wellness committee.

Texas Medical Liability Trust (TMLT) policyholders may also contact TMLT's Risk Management department by calling 800-580-8658. "If you find yourself frustrated or becoming stressed by your day-to-day operations, TMLT is here to help," said

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Robin Desrocher, Director of Risk Management. “We can help you with researching and finding the right resource or service for you and your specific needs.”

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CLOSED  
CLAIM  
STUDY

# FAILURE TO DIAGNOSE IMPENDING STROKE

by Laura Hale Brockway, ELS, Vice President, Marketing



*This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.*

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## PRESENTATION

On November 24, a 41-year-old woman came to a family physician for ear pain and fluid in her ears. Her medical history included diabetes, stroke, myocardial infarction, alcoholism, obesity, and high cholesterol. She reported allergies to codeine, sulfamethoxazole/trimethoprim, erythromycin, latex, and nuts.

The family physician diagnosed acute sinusitis and prescribed amoxicillin/clavulanate. This was the patient's first visit with the family physician, who was providing "concierge" medical services to her.

## PHYSICIAN ACTION

The events related to this claim occurred from January 7 to February 3, summarized below.

- **January 7** — The patient came to the office reporting that she had nearly fainted earlier that day. The family physician diagnosed malaise and fatigue due to an adverse reaction to diphenhydramine. He told the patient to return for a physical exam and fasting labs at her convenience.
- **January 10** — The patient texted the family physician reporting nausea and diarrhea after eating bad seafood. The family physician prescribed ondansetron. Later in the day, the patient reported feeling better, but was weak and dizzy.
- **January 13** — The patient texted the family physician a photo of what she described as a swollen tongue.
- **January 14** — The family physician saw the patient for a swollen tongue. She reported that she did not feel well and that she had leg cramps at night. The family physician noted that her tongue looked normal and that she had mild acanthosis on her neck, but no lymphadenopathy. He ordered a lipid panel, an A1C, and lab work to check her iron and Vitamin B and D levels. He documented that her leg cramps were likely associated with sleep. There was no mention of a follow-up appointment.

- **January 17** — The family physician notified the patient by text that her lab results were ready. He explained that there were some abnormalities with her results and that he wanted her to come to the office to discuss. He told her "It is not emergent or urgent. But it is important."

The patient's glucose was 343 mg/dL; A1C was 11.4%; triglycerides were 193 mg/dL.

The patient texted back that she was in Florida for the week. She asked if she should see a doctor right away or if her glucose was manageable for a week. The family physician explained that she had probably had a similar glucose value for a while. He explained that he could prescribe a monitor and oral medications that she could start taking before she could see him in one week.

The patient requested the prescriptions be sent to a pharmacy in Florida. The family physician advised that a prescription for metformin had been sent to the pharmacy and requested that the patient keep him updated.

- **January 25** — The patient came to the family physician to discuss her medication. At this visit her blood pressure was 129/95 mm Hg and her pulse was 92 bpm. The family physician noted the high blood pressure reading. He prescribed ertugliflozin and noted that it may have anti-hypertensive effects.
- **January 27** — The patient texted the family physician to report tightness in her chest. The family physician called the patient that morning about her symptoms. Her blood sugar that day was 233 mg/dL and her blood pressure was 132/82 mm Hg.
- **January 28** — During a phone conversation, the patient told the family physician that she was "the same as normal but no chest pain." She did report pain in her right hand and both feet. The family physician told her to continue taking ertugliflozin until her diabetes reversed completely. There was also a note in the record that she could stop taking ertugliflozin for a while if she wished to.

- **February 3** — The patient texted the family physician to advise that her blood sugar level was 122 mg/dL and blood pressure was 117/92 mm Hg. Her pulse was 112 bpm. She also reported that she was having “very bad” issues with her right hand falling asleep. She asked the family physician if that was normal. The family physician did not text back and he could not recall if he called the patient back.

On February 4, the patient’s right leg became weak and she began having trouble walking that afternoon. She flew from Texas to Florida that evening. By the time the plane landed, she had numbness of her right leg and arm and worsening speech.

The patient was taken by ambulance to a large hospital on February 5. An MRI of the head and neck showed significant segmental narrowing of the left MCA, M1 segment. The vessel was not completely occluded and the left MCA M2 branch vessels were seen. There was no significant carotid disease detected. The cerebral angiogram showed bilateral MCA stenosis, mild right proximal M1 stenosis and moderate to severe left M1 stenosis.

The patient spent 12 days in the hospital before being transferred to an inpatient rehab facility. While in the hospital, the stroke team was unable to determine what caused the patient’s stroke. After one month in the rehab facility, the patient reported that she was happy with how her memory, her facial asymmetry, and the mobility of her right hand were improving.

### ALLEGATIONS

A lawsuit was filed against the family physician, alleging:

- failure to note the symptoms of the patient’s emerging stroke;
- failure to treat the patient’s diabetes, hypertension, and high cholesterol; and
- proper treatment of the patient’s diabetes, hypertension, and high cholesterol would have prevented the patient’s stroke.

### LEGAL IMPLICATIONS

The plaintiffs argued through their expert that the patient’s waxing and waning neurologic symptoms should have been recognized as transient ischemic attacks (TIAs) and precursors to her stroke. This



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expert believed the patient's symptoms warranted a stat EKG and a complete lab workup, along with a referral for a stat evaluation by neurology and cardiology. He also faulted the defendant's "non-aggressive" treatment of the patient's diabetes and hypertension.

Physicians who reviewed this case for the defense — including a stroke specialist — said the defendant did a good job managing the patient's diabetes, hypertension, and obesity. The defendant's follow up was good and the patient continually reported improvement. They also stated that the patient had atypical symptoms of stroke and that the standard of care did not require him to make this diagnosis.

Regarding the text message from the patient on February 3 in which she reported hand numbness for two days, there was no record of how the family physician responded to this message. The family physician believed he called her from an office phone, but did not have the phone records. He also did not document this phone call in the medical record. The experts reviewing this case did question the actions of the defendant regarding this text message.

## **DISPOSITION**

This case was settled on behalf of the family physician.

## **RISK MANAGEMENT CONSIDERATIONS**

The physicians reviewing this case expressed concerns about the family physician's ongoing text correspondence with the patient. It can be risky to communicate about symptoms and diagnoses with patients through text messages. Information sent via text could be misinterpreted due to brevity or the lack of verbal and nonverbal cues that often support communication.

In this case, the patient sent a message reporting numbness in her hand on February 3 and found no reply from the family physician. Because she did not receive a reply, she may have assumed that her symptoms were not urgent. Yet according to physicians reviewing the case, her symptoms were urgent and should have been "emergently evaluated."

Additionally, there was no indication in the patient record whether the texts were sent in a HIPAA-compliant or secure method. Ensuring electronic device security is essential to HIPAA-compliance. It is also important to note that not all smartphone devices are encrypted and could result in correspondence not being secure. One consideration would be to use a HIPAA-compliant electronic health record (EHR) portal or app to securely correspond with patients. It is also a good practice for a physician to encrypt their smartphone devices.<sup>1</sup>

All communications between physicians and patients that contain clinically significant information should be added to the medical records in a timely manner. This includes correspondence by text or electronic messaging, which is considered part of the medical record and should be saved appropriately. Communications via text, portal, email, or messaging apps are just as important to retain as any other exchanges of patient information.

The patient first came to the family physician through her membership in a concierge medicine service. These concierge arrangements between physicians and patients also come with risks. Patients may have heightened expectations about their access to the physician or about the care they will receive. Marketing materials for these concierge services may promise more than any physician or practice could deliver.

It is good risk management practice to approach concierge provider arrangements with caution. Make sure you understand the contractual obligations and whether you can realistically meet them.

## **SOURCE**

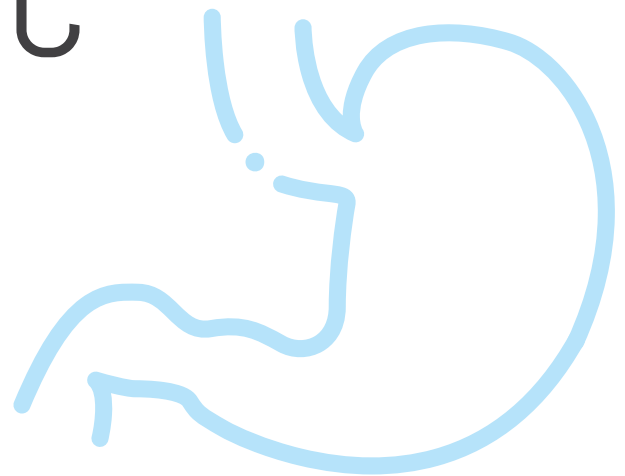
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# FAILURE TO PROPERLY MONITOR AND TREAT A BARIATRIC PATIENT

by Wayne Wenske, Senior Marketing Strategist



*This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.*

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## PRESENTATION

In September 2019, a 38-year-old man was taken to surgery by his bariatric surgeon, Surgeon A, to convert a 2011 gastric band surgery (LAP-Band) to a Roux-en-Y Gastric Bypass. The previous surgery did not accomplish the patient's weight loss goals. The patient's BMI was noted as more than 40, putting him in obesity class III ("severe obesity")<sup>1</sup>

Upon discharge, the patient was noted as having easily tolerated the procedure and doing well. He was given a prescription for vitamin patches and instructed to wear one daily; he was also instructed to take a daily pediatric multivitamin.

On October 11, 2019, the patient returned to Surgeon A with nausea and vomiting for 12 days.

## PHYSICIAN ACTION

A barium swallow study was ordered, and the results were normal. An upper endoscopy revealed a marginal ulcer distal to the gastric jejunal anastomosis. The patient had been taking steroids. Surgeon A discontinued this medication and prescribed anti-ulcer medications. In approximately two weeks, the ulcer healed, but the patient's nausea and vomiting continued and he was unable to tolerate eating.

On October 28, after 12 more days of nausea and vomiting, the patient returned to the emergency department (ED) of the hospital where his surgery took place. He was admitted under the care of Internal Medicine Physician A, who diagnosed dehydration, vomiting, urinary tract infection, hypokalemia, gastrojejunal ulcer, hypertension, and extreme obesity. Surgeon A was consulted, as was a dietician.

Upon examination of the patient, Surgeon A noted that the patient was wearing a vitamin patch as instructed. The patient's thiamine level was 38.1 nmol/L. During the patient's stay at the hospital, Surgeon A never documented that the patient appeared dizzy or that the patient reported dizziness.

The patient was started on intravenous fluid replacement and electrolyte correction. At the time of admission, the patient did not report any

neurologic complaints. The next day, the patient told the nurses he was dizzy upon standing. The nurses noted that the patient had not been complying with recommendations to get out of bed and to eat.

On October 31, an endoscopy was performed that indicated the marginal ulcer had healed. On November 2, the patient was discharged by Internal Medicine Physician A upon receiving consent from Surgeon A and the dietician, but the patient's vomiting and dizziness continued.

On November 5, the patient was admitted to a different hospital with worsening dizziness when standing, nystagmus, memory problems, and diplopia. The hospital's on-call neurologist diagnosed Wernicke's encephalopathy (WE) caused by thiamine deficiency.

## ALLEGATIONS

A lawsuit was filed against Surgeon A and Internal Medicine Physician A for failure to observe, diagnose, and treat WE.

## LEGAL IMPLICATIONS

Consultants for the defense were mixed in their support for Surgeon A. One felt that WE would not have occurred if thiamine levels had been more closely monitored after surgery. This consultant pointed out that Surgeon A specialized in bariatric surgery and carried several years of experience and knowledge to address nutritional deficiency.

Another consultant felt that Surgeon A provided proper and reasonable care, noting that he gave the patient vitamin patches that provided 20 times what was needed for vitamin B1 after bariatric surgery. This consultant questioned whether the patient was compliant with the physician's instruction to wear the patches daily.

A third consultant stated that Surgeon A properly assessed and treated the patient for ulcer, a more common complication following bariatric surgery. This consultant also echoed the previous consultant in his belief that the proper use of the vitamin patches would have made Surgeon A less likely to consider vitamin deficiency.

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Plaintiff's consultants were critical of both Surgeon A and Internal Medicine Physician A for failing to empirically treat the patient with IV vitamins (including thiamine) at several points while under their care. They were also criticized for not obtaining a neurology consult.

Several of the plaintiff's consultants stated that the physicians failed to meet the standard of care by not monitoring the patient postoperatively more closely for nausea, vomiting, and symptoms of dehydration or vitamin deficiency.

The nurses in this case were also criticized for not notifying Surgeon A or Internal Medicine Physician A of the patient's dizziness or advocating for the patient to stay in the hospital until he was stable.

Consultants for both sides were critical of the defendants for discharging the patient even though the patient could not sustain fluids or food. As a result, the patient developed thiamine deficiency due to prolonged post-surgery nausea and vomiting.

## DISPOSITION

The case was settled on behalf of Surgeon A and Internal Medicine Physician A.

## RISK MANAGEMENT CONSIDERATIONS

Nutritional deficiencies and resulting Wernicke's encephalopathy are known complications following bariatric surgery. These complications should always be considered in patients with recurrent vomiting, poor nutritional intake, and non-compliance to vitamin supplementation. Additional symptoms of WE are confusion; ataxia; vision changes, including nystagmus; and diplopia — all symptoms noted in this patient.

WE is the acute, initial phase of Wernicke-Korsakoff syndrome. Immediate and aggressive thiamine supplementation is essential. Most symptoms of WE can be reversed if the condition is diagnosed and treated promptly. However, full recovery is not always achieved. Without treatment, Wernicke-Korsakoff syndrome can lead to disability and death.<sup>2</sup>

Lack of communication between the physicians, the patient, and the nurses was a weakness in this case.

Making an accurate diagnosis requires asking the patient the right questions, conducting a thorough physical exam, and gathering full clinical data. The physicians were unaware of the patient's dizziness and ataxia, and neither consulted with a neurologist for a full diagnostic picture.

Additionally, the physicians did not consult the nursing notes for more information on the patient's progress.

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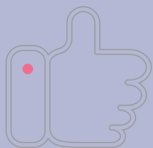
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