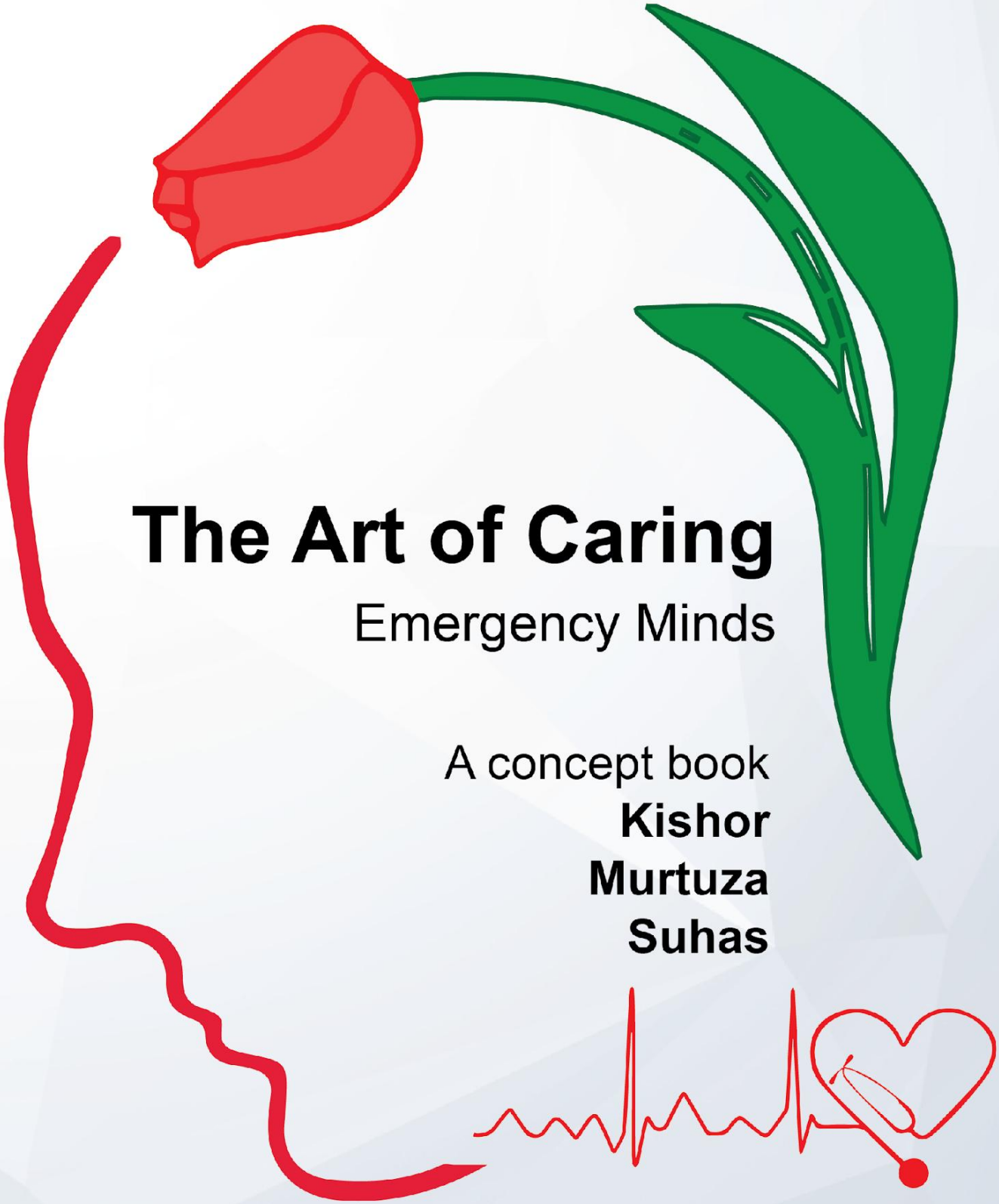

The Art of Caring

Emergency Minds

A concept book

Kishor
Murtuza
Suhas

Revised edition : 2022

Supported by
Indian Psychiatric Society Combat Depression Task Force
Emergency Medicine Association

FOREWORD

It was not until a new resident in the Emergency Department (ED) burst into tears in front of me, did I realise the toll that residency in this department takes on a residents' overall well-being. The ED work culture is unlike any other department. Physicians have to deal with numerous responsibilities and at once- managing patients and their attendants, difficult cross consultations, academic pressures and administrative complaints. Sometimes, these pressures can bring residents to their breaking point. This makes the physician, the patient, and the whole environment suffer. A culture change is needed to educate doctors about their own wellness and focus on resilience.

Feeling the need to address this issue specifically, we decided to introduce a session on stress management in the ED in one of our CMEs. Dr Murtuza Ghiya, an Emergency physician, also a member of Emotional well-being committee under Indian Medical Association (IMA), was invited for this lecture while Dr M.Kishor, Professor and Head of Psychiatry at JSSAHER & Convener of Indian Psychiatric Society "Combat Depression-Task Force", chaired the session. This initiative and the EM MINDS e-book is the outcome of this meeting of the two minds.

Dr. Akkamahadevi P

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We sincerely appreciate the effort put in for the
Wonderful Art work, Cover Page and formatting by
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PREFACE

It is indeed a sheer delight that we have brought together so many individuals from different specialities with a common interest in learning and contributing towards EM. Personally from chairing a session at EMD CME to working for EM MINDS network, consisting of Psychiatry & EM professionals, is an interesting journey & a professionally satisfying addition to my life. I firmly believe EMD & Psychiatry professionals should interact & bring in innovative strategies that benefit the profession & patient care. This book is inspired by our earlier book for MBBS Students based on Dr Suhas Chandran's idea. I am happy as the convener of the Indian Psychiatric Society task force on "combat depression that I could meaningfully contribute to the wellness of the residents. I have no doubt that as a "mindful" reader, a "mindful" EMD professional would immensely benefit from this book, while also helping us to pay our respect for patients. Doctors, irrespective of speciality shall strive hard to remain humble in the service to mankind, to continue learning, to collaborate with different specialities, to acknowledge our limitations and to seek help in distress.

I am immensely thankful to Prof Akkamma, to our new partners at EM Dr Ghiya, Dr Rohan & their team, to my dear student & a colleague now, Dr Suhas Chandran.

With Warm Regards

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Convener, Indian Psychiatric Society "Combat Depression" Task force.

This book is unique, as most "soft" topics discussed here are seldom covered in standard EM textbooks which focus only on "Hard Facts". Let's always remember- Medicine is not merely a Science, it's also an Art! Objectives of Emergency Minds initiative:

1. To help ED physicians work with enthusiasm which in turn would improve patient care.
2. To teach soft skills - which forms the platform for the smooth functioning of the EM department.
3. To stress the importance of healthy de-stressing methods and physician well-being strategies.
4. To help collaborate and form partnerships between individuals working for the same cause.
5. To help residents contact mentors/authors for discussions in their areas of interest.

We welcome you to be a part of this initiative and help incorporate these topics in formal medical education, thus leading to better patient care!

One way to help the community (and this cause) would be with your honest, critical feedback. We also look forward to your collaboration for future projects.

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The book consists of insights of clinician experiences in crisis situations, and how they can be dealt with in humane and compassionate ways while protecting themselves from the resultant stress that is a natural consequence of dealing with illness, life and death on a regular basis. This unique association between Emergency physicians and Psychiatrists is hopefully just the start of a long-lasting partnership and this initiative, only a first of many.

I want to express my gratitude to my teacher Dr Kishor M, for providing me with this opportunity, to my friend Dr Murtuza Ghiya for all his invaluable insights, Dr Rohan and Dr Manasa for their help. This was truly a team effort and will hopefully have a learning point that applies to each and every reader.

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CONTENTS

1. Foreword
2. Preface
3. Content Page

Introductory Chapters

4. Joy Of Being In The Emergency Medicine Legacy
5. Malady Of Being God
6. Words Of Wisdom From The Veteran
7. PG Yesterday ,Consultant Today
8. Through The Eyes Of An EM Nurse
9. My Story – The Naked Truth

Soft Skills Chapters

10. Art Of Cross-Consultation And Difficult Referrals
11. Conflict Resolution- ABC Model
12. Power Of Professional Etiquette
13. Leadership- The Back Bone Of EM
14. Law Of The Land- Black Coat, The White Coat And The Grey Zone
15. Incessant Interruptions- How To Deal With Them
16. Balancing Work And Family Life
17. Dealing With Death In The ED
18. Managing The Violent Patient
19. Ethics And Emergency Medicine

Well-Being Chapters

20. Depression In Our Profession
21. Burnout And Ways To Burn The Burnout
22. 60 Seconds To Relax On A Busy Shift
23. Physical Fitness And Exercise
24. Nutrition And Hydration
25. Formal Resident Well-Being Strategies
26. Sleep Disturbances And Coping Strategies

Conclusion Chapters

27. Upgradation Of Skills –NHS, UK Perspective
28. Pursuit Of Excellence
29. The Way Forward
30. Patient's Perspective

JOY OF BEING IN THE EMERGENCY MEDICINE LEGACY

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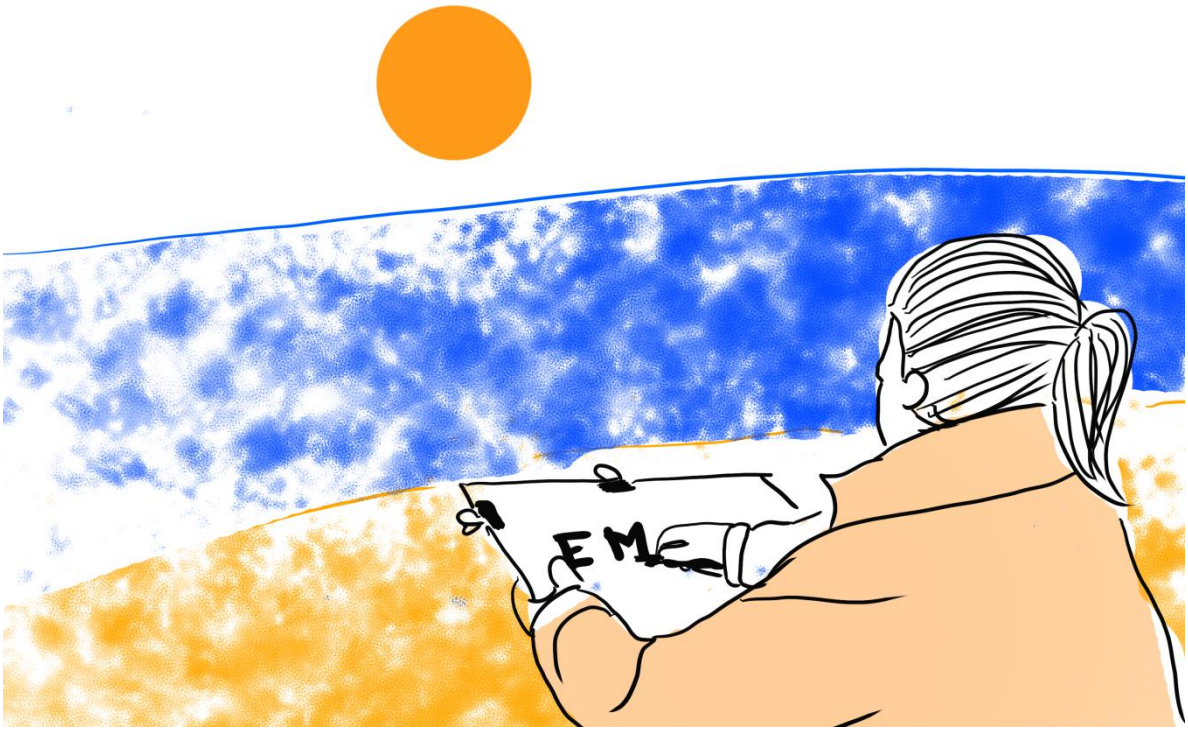

Four Reasons why you should enjoy being in the EM family

1. EM- A balanced speciality

A) The balance between family and work

While you may have to stand and slog intensively on your shift under significant stress, once it's over you are free for the day and can make other social plans without worrying about an on-call pager or having to come back to the hospital for your patient; it will be effectively managed by the next shift. This is very useful for those doctors who got over-involved with patient care and 'lived in the hospital' during their internship.

B) The balance between 'soft' and 'hard' skills

EM is not just about managing patients, knowing guidelines and life-saving procedures. That is only half the job. In contrast with other specialties, soft skills play a significantly more significant role in EM - e.g., good leadership and communication skills to lead a code blue/ polytrauma, good diplomacy & body language to diffuse violent situations, good administrative skills to prioritize managing an unlimited number of patients with limited human and material resource. Sometimes these skills make or break a patient as much as the clinical skills do! You may appear like a circus

director controlling a chaotic ED1. So if you enjoy wearing multiple hats all at one time, you are in for a joy ride!

C) The balance between medical and surgical fields

If you were confused after internship wondering- 'should I pick a surgical specialty or a medical one? I fall somewhere in between both, then welcome to EM. This specialty has a healthy mix of both, although the degree of involvement may vary from one setup to another and also depend on your competencies!

2. EM -Opportunities galore

Since EM is in its budding stages in India, you will find plenty of job opportunities. You could pick a hospital and city of your choice, and you will rarely hear 'sorry no vacancies now'; unlike other specialities that are saturated in the metros. Also, there are many opportunities to work overseas, like the Middle East and the UK where there is a shortage of EPs. Finding a well-paying EM job in nearly any geographic location is relatively easy1. Additionally, you could explore exciting subspecialties that you can catapult into like wilderness medicine, pre-hospital medicine, disaster medicine etc.

3. EM-High Adrenaline state

Stabilising multiple unstable patients within a few minutes can be overwhelming, to begin with. But once you start understanding key concepts of EM, start applying them and see how it benefits patients, you will begin to enjoy the adrenaline rush. As some EPs have confessed, the thrill of rapid resuscitation can be addictive- regaining a pulse after CPR gives you more of a high than a glass of bubbly by the beach!

4. EM – A never-ending Challenge

You will never find any emergency consultant, no matter how senior, who will confidently say- 'I have seen it all! I am done with EM'. EM has a vast spectrum and includes not just management of critical patients, but also an endless variety of minor cases. It involves a continually updated knowledge of all specialities and subspecialties. One may conquer small islands of complacency, but one can never conquer the ocean of Emergency medicine; hence they just keep sailing along!

We welcome you all the wonderful world of Emergency Medicine- where the dead teach you the value of life!!

MALADY OF BECOMING GOD!!

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In the perception of many a humble man, doctors are considered akin to Gods. This is especially so during the time of an emergency where split-second decisions and interventions are carried out. Most often the dramatic recovery can be overwhelming for patients and family members. They praise the treating doctor so much that they equate them with gods and revere them. Although the frequency of assault on doctors is rising this does not outnumber the times that doctors are worshipped!! This glorification of doctors has continued to attract thousands of students towards medical sciences. The problem arises when glory not only brings courage in emergency personnel but also adds up to too much of "I should" & "I can". This is nothing but the malady of 'becoming god'- this double-edged sword needs to be constantly reflected upon and relooked at, right from the very foundation of a medical profession: What does it mean to be a doctor?

The word doctor means "to teach". To teach, first, we have to learn!! The next question is what should be learnt? For hundreds of years, people have pondered over what should be learnt. The answer is simple but most challenging to imbibe: 'being humble'. Being humble is one of the most important virtues one can achieve. The humbleness comes from immense knowledge that human beings are just one aspect of nature. Human beings have serious limitations despite their perceived supremacy over nature. Doctors are just facilitators of healing in fellow human beings. Nature is far less understood, far more powerful and far more vast than we can imagine, if that were not so we

wouldn’t have challenges every day, challenges in every other person with the same illness, challenges with treatment in the same person at different phases of the same illness. This understanding is important for emergency medicine professionals so that they pursue with zeal, the motto ’to remain humble’ in all aspects of patient care, at all times, at all phases of their life and to see themselves as nothing but the closest facilitators of healing that is subjected to nature, the supreme authority of life & beyond .

One must politely correct patients who say or hint at this by saying ‘we are merely professionals, and at best agents of God who help in the healing process, but the outcome is not entirely in our hands, but HIS. This can help in patients and relatives having realistic expectations from us and as a consequence prevent any undue anger upon failure of treatment.

WORDS OF WISDOM FROM THE VETERAN

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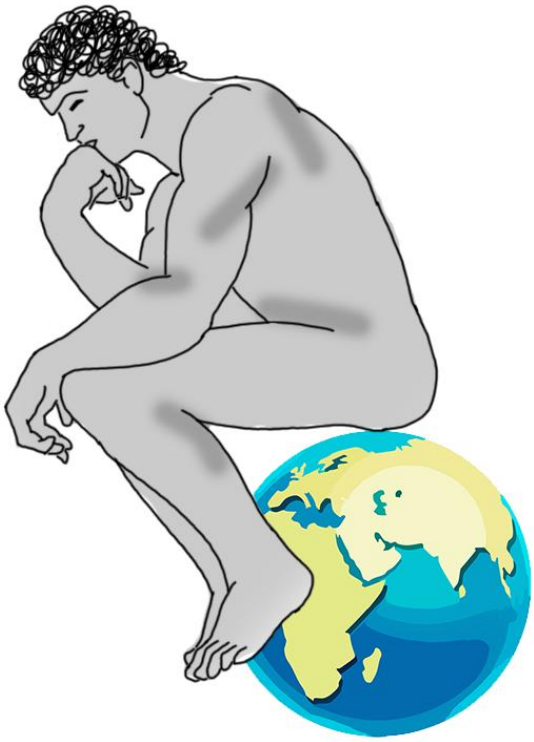

A 17-year-old girl is rushed in with attempted hanging – in hypoxic encephalopathy, thrashing around. You sedate, intubate and stabilise her.
Next is a 24-year-old motorcycle pillion rider, crushed by a bus – severe traumatic brain injury, pupils dilated and fixed. You have to counsel his distraught disbelieving mother...
A patient's son advances belligerently towards you – why is his mother's MRI taking so long? What kind of a hospital is this? ...
And you get a phone call from the surgery resident – "How dare you admit this cellulitis to our ward without me seeing the patient first?"

All in a day's work for an Emergency Medicine resident – or so we think. The general perception is that EM residents/physicians are born with the inherent capability to cope with the multiple stressful situations that the speciality throws at you every day. Whether you have chosen EM above all specialities because you are passionate about it, or have entered it unwillingly or without knowing what to expect, surviving on the ED floor is an art that has to be taught from the beginning of residency. It is well-known that there is a high incidence of work stress and burn-out among EM residents and physicians – this can be avoided by adopting strategies to deal with them early. (1) One of my colleagues decided to quit EM after a long span of 8 years – when I asked him why, he

said “When I go to the graveyard to pay tribute to late family/friends, tears just don’t fall from my eyes” – a clear example of loss of emotions/empathy which had not been addressed earlier by discussion and sharing of feelings.

Looking back to 17 years ago when I began my journey in EM, I was ill-equipped to deal with many situations – my positive points were probably age and maturity which helped me face many issues which would typically cause immense stress to someone less experienced. Also, having young children and pets at home was a huge stress-buster!
But obviously we cannot wait until we mellow with age – a more active approach has to be taken to mitigate the stress of working in EM.

The solutions I think fit to add here are the following:

1. Fostering good teamwork in a friendly open atmosphere - Acceptance of mistakes/errors of judgement as part of the learning curve, at the same time encouraging responsibility and accountability.
2. Modification of medical hierarchy – senior consultants, should be approachable, sympathetic. In other branches, the more senior the professor, the more distant they become to residents. Instead, senior professors in EM should play a more active role formally as mentors.
3. Periodic meetings to discuss daily issues of wellbeing.
4. A special note regarding female residents – Across the world, female physicians do face more problems of stress, guilt and isolation and EM has its own extra stressors. (4) To overcome these, adequate support is needed from heads of departments and colleagues especially during pregnancy, breastfeeding and illness of young children, to avoid more attrition of female EM physicians.

PG YESTERDAY, CONSULTANT TODAY

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Getting into a PG residency in India has often been compared to going to a public washroom, you can't wait to get in at the same time you can't wait to get out!

My journey was different, as I chose a speciality which was not mainstream (medicine/surgery) and was thrown into the deep end right from the word 'go'.

Looking back at my residency here's a cheat code for you-

1. WORK HARD WORK SMART

You see patients at their worst which requires you to fly out in top gear almost always, in order to make a difference to that patient. Being tardy and sluggish can lead to disastrous consequences, so bring your A-game always1. One of the major lessons I learnt was to give my 100% during shifts, (quick history, rapid, focused examination, and management of the patient) but also to take adequate breaks, refuel and disconnect from work and not carry unnecessary emotions back home(2)

2. HUSTLE LOYALTY AND RESPECT

Have you ever felt, that working in EM you are the only one working hard for the patients, while everyone around you is just not doing enough? (3)

Every department is busy and has their own stressors, right from the radiologists to the nursing staff to the janitor. Be loyal to your work at the same time respect people around you for their efforts. “EM is a team sport, and the more team spirit you create, the more willing people will be to bend over backwards and help you out.” (3)

3. (OVER) CONFIDENCE

As I moved through my residency I became more confident in my approach to patients and management protocols, however, it is important to always seek help when required and also not to be stubborn about your decisions. Trust your gut but don’t be blinded by your overconfidence.

4. TO ERR IS...

In spite of your best efforts mistakes will creep in. Don’t beat yourself up for it! Instead, discuss with your mentors and make every patient an overall learning experience rather than just another diagnosis.

5. EFFECTIVE COMMUNICATION

Improper conduct with patients and unprofessional behaviour can lead to unnecessary conflicts with attenders (4)

Listen and empathise. It's essential for an emergency physician to develop soft skills to interact better to diffuse volatile situations.

6. PERSONAL WELLNESS

PG programs never focus on how to handle work pressure. Residents are taught to suck it up and “get on with it”, resulting in disastrous consequences (5) Find what keeps you afloat and do something for yourself every day.

Your residency will be nothing less than a rollercoaster ride, enjoy it while it lasts and make it meaningful. As I move into my new phase as a consultant, I am filled with exactly the same feelings of fear and anxiety that I came with when I started my residency, except that I am better equipped and more hopeful. I wish you the best for the fascinating journey that lies ahead.

ONWARDS AND UPWARDS…

THROUGH THE EYES OF AN EM NURSE

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Working in the ED is considered a privilege and the swiftest nurses are always among the most preferred to be a part of the ED team. It's a dream come true- Resuscitation, Triage, a plethora of protocols, and above all, to be one among the few nurses to practice BLS, ACLS and ATLS on a daily basis.

However, burnout is rampant among emergency nurses as they need to act quickly and effectively with little information. Up to 65% of the nurses suffer from high emotional stress which increases medical errors and affects both their clinical practice and personal lives.

An Overload of patients with understaffing and scarce resources, long hours of work, abusive and demanding patients, encounters with death, conflicts, workplace harassment, night shifts, constant discouragement, all lead to stress among nurses who are, on most occasions, ill-prepared to meet the demands of the situation. They are also tasked with asking family members of a critical or deceased patient to settle the bill or replace medication that was used!!

Amidst their busy schedule, doing non-nursing activities- like billing and fighting for ward/ICU beds only adds to the stress levels!

To make things worse “Nurses eat their young”. At least 85% of nurses have been verbally abused by a fellow nurse. There is an alarming culture of bullying and hazing.
Nurse attrition and turnover are rampant, leaving the institution, with fresh, untrained staff round the year- adding to the stress of the old staff- who then resign and the vicious cycle continues.
Nurses are torn between the patients, their colleagues and the doctors. At the end of the day, the nurse, that we want to be is lost in the midst of stress, increasing workload and an overall loss of satisfaction.

What doctors can do for us?
Reprimand less, Empathize more. We are going through the same situations as you are. Prioritise- One instruction at a time- Not a barrage of multiple things to do in 1 minute. We feel lesser stress when working with a confident doctor, who knows what he/she is doing.

What the organisation can do for us?
The medical profession has neglected the wellbeing of its own personnel and focused only on patient care4. Improving nurse-to-patient ratios, staff scheduling, increasing nursing wages along with a stress allowance, investing in nursing education with fellowships for Emergency Nursing.

What we can do for ourselves?
The first step to solving any problem is acknowledging it. Accept the fact, that we are human and there’s a limit to what we can handle. Nursing, which is a woman-dominated profession, has an issue of taking ‘everything in their stride’, the group never, or they are never trained to say, without feeling guilty that “Enough is enough’.

Accept & embrace yourself, seek help when needed. Only if we ask, will we receive!!

MY STORY – THE NAKED TRUTH

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This is a story of my transformation:

Transformation From -	⇒	Transformation To -
A proud & exuberant 1st year EM PG	⇒	A disgraceful 3rd year PG seeing no esteem in EM
A cheerful, kind team player	⇒	A grumpy bully insulting doctors and nurses
A pleasant doctor helping patients	⇒	An angry man lacking empathy for dying patients
Social extra-curricular enthusiast	⇒	An isolated anhedonic
Encouraging interns to take up EM	⇒	Dissuading interested interns –'EM is a hellhole'

I was over-worked, I worked even after my shift was over- not because my seniors demanded it, but because I was obsessed with my work. I came well before time and left well after. And soon, I expected everyone to do the same. I felt I was the only one working while the rest of the hospital was relaxing. I did not eat or drink on my shift, because 'there are still some patients to be seen in the ED, and the world will come to an end if I take a 5 minute break, right?' I stopped others from taking breaks.

I realized that I was fighting too many wars, most of which were not meant for a PG student, but for an administrator. I lost the ability to comprehend my failures, despite my kind seniors' advice.

And for the little time I spent out of work- I indulged in unhealthy "de-stressing" activities:

“ De stressing” strategy	**My rationale**
4 hour sitcom sagas with junk food	I should relax in a fantasy world, away from EM
Lack of any physical exercise	I was too ‘physically exhausted’ for it
No meditation/yoga	No time for such a boringly slow activity
Inadequate sleep < 6 hours	I don’t feel sleepy & heroes don’t sleep!
Not talking about my issues at home	They just won’t understand
E2H50H SOS	When you can’t fight it , forget it-temporarily

I sought help from a psychologist. I practiced and preached burnout and wellbeing strategies during the subsequent years.

This is now a story of my survival. Of hope. Of a Purpose- to help other residents, before they transform.

P.S-
Fear not, this does not happen to all residents, just a few vulnerable ones who do not take care of themselves. So let’s invest some time and energy in taking care of ourselves and our friends- to be healthy and happy in this magic world of EM.

ART OF CROSS-CONSULTATION & DIFFICULT REFERRALS

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Scene #1

A post-cardiac arrest resuscitation patient has an ECG with minimal ST segment depressions with low Haemoglobin and raised creatinine!

In today's corporate-driven health industry, one might end up giving three or four super speciality consultations whereas in centres without them, you might end up calling shots yourself. On the one hand, you have eager consultants wanting admissions, on the other you have upset consultants deferring them.

Scene #2

10% superficial burns in a child and you end up in charades of cross-consultation after every department (could be Paediatrics, surgery, plastic or paediatric surgery) declines admission and wants you to refer the child to a burns centre!

Some referrals- are patient-centric and others eccentric, some defensive and a few offensive! Friendship, associations, enmity and ego - between various specialists are inevitable variables. You

may be at the receiving end of the annoyance from consultants on being disturbed in the middle of the night.

Indications:

Why exactly do you need a referral, is it required after all? You must have the best knowledge about the indications for consultations and immense exposure to the most acute cases on the floor to hold fort upon discussion with other specialists.

If you are unsure of "what's happening to your patient", then, you must definitely consult a specialist regardless of ego, in the best interest of your patient. If the patient's condition is critical, forget the hierarchy, consult the most qualified person at the earliest.

Documenting the consultation as resulting from 'patient preference' and investigations ordered by such consultants 'as discussed with the patient and the treating doctor' helps you wriggle out of unwanted controversies.1, 2, 3

Contra-indications:

DO NOT consult multiple departments while staying away from your patient's bedside. Remember- 'too many cooks spoil the broth'. If multiple consultants come up with biased opinion, it will end up in a game of ED soccer! You are the best person to guide the patient to the 'most appropriate' department for further care. It would be prudent that you write down the rationale for reference and time on the case sheet.

You could identify selected patients as opportunities for yourself to 'resolve more' and 'refer less' for patient beneficence. The fact that you could perform minor procedures without consultation aids both the patient as well as in boosting your self-esteem and confidence!

Once you have completed the acute management in minor cases, you could defer a consultation by means of observation or referral to OPDs. Be sure to educate patients about probable 'red flag signs' and offer safety netting before discharge.2, 4

A skill one must develop is the art of effective communication and briefing both the patient attenders as well as other doctors for effectively navigating through the consultation process!

CONFLICT RESOLUTION - ABC MODEL

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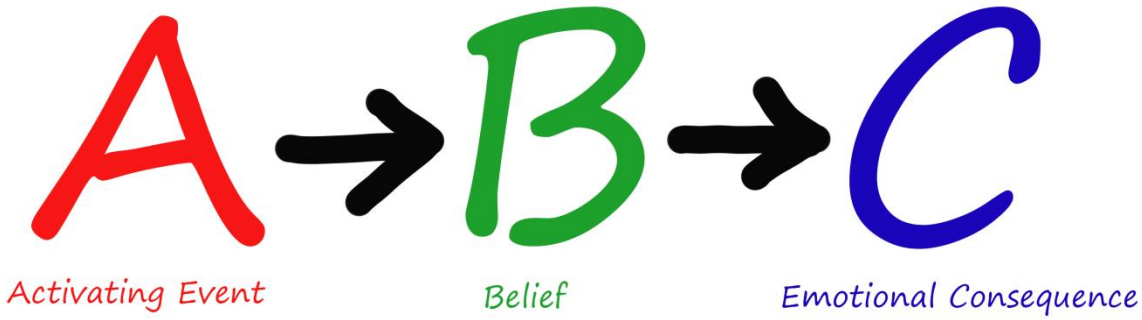

Emergency medicine involves clinicians working in a high-intensity work environment. They often encounter adverse events such as an abusive or rude caregiver, unfavourable patient outcome or conflicts with co-workers.

- A belief of being treated unjustly or disrespectfully by the caregivers can lead to feelings of anger and resentment.
- A feeling of guilt due to the loss of a patient.
- A belief that something negative is going to happen (that a peer or superior might retaliate) leaves us anxious and fearful.

The immense pressure in these situations might push us to react spontaneously rather than with thoughtful foresight. Inevitably, these spontaneous reactions itself can have further consequences.

- Anger leads to shouting or lashing out at staff, patients or peers.
- Sadness makes us withdrawn and isolated.
- Anxiety leads to avoidance of people or even a change of shift or job.

All or any of the 3 can result in impaired judgment, work efficiency and compromise patient care.

If we examine closely it is not the situation, event or person that makes us feel a certain way but our interpretation of the same. Our beliefs about the cause of the adversity set off our reactions, how we feel and what we do. Sometimes our beliefs about a situation are not accurate, and our reactions undermine resilient responses.

Psychologist Dr.Albert Ellis's ABC model helps us understand the meaning of our reactions.

- A is the Antecedent, the adverse external event that came first.
- B is our Belief—our explanation about why the situation happened.
- C is the Consequence—the feelings and behaviours that our belief causes.

The ABC model can be used to identify our beliefs and, if necessary, challenge whether they are true. We cannot change the event (A), or go back in time and make the caregiver not abuse us, but we can

change our interpretation of that event (B) and turning an irrational belief about it into rational beliefs can avoid negative consequences(C).(Table 1) . The regular practice of the cognitive ABC model in residency can help increase resiliency and decrease stress levels.

Table 1:

Irrational assumptions	**Possible alternatives**
We should be thoroughly competent and achieving in all possible respects.	Prefer to do well rather than always need to do well. Accept ourselves as a quite imperfect creatures with human limitations and specific frailties.
It is catastrophic when things are not the way we want them to be. There is a perfect solution to all problems, and it's a disaster if we don't find it.	Many external factors are outside our control. Problems usually have many possible solutions. It is better to stop waiting for the perfect solution and get on with the best available.
If something is fearsome we should be terribly upset and endlessly obsess about it.	Better face the situation and render it non-dangerous. Avoiding problems is only easier in the short term & can make them worse later on.

POWER OF PROFESSIONAL ETIQUETTE

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Introduction

Emergency Departments (ED) across the world are considered to be in high-stress environments which sometimes brings out a 'spiteful attitude' amongst the ailing and the health care providers. A code of professional conduct and a sense of mutual respect will ensure a healthy working environment.

Beginning a Shift in ED

- **Punctuality** – no one likes to be kept waiting after their due shift hours.
- **Amiability** – greet your colleagues with a warm smile.

Try to begin each shift on a positive note. Two key factors which can help you attain this are:

Interaction with Colleagues (junior doctors, nurses and support staff)

- It is desirable to know your team by their names to encourage teamwork.
- Address your colleagues with due respect and dignity. Be firm if required but do not make them feel intimidated or subdued.
- Conflicts should be resolved in a way that ensures the best outcome for the patient. If this fails, escalate the matters to the senior most on the shift.
- Listen actively to your colleague's opinions, without interrupting.

- ➢ If you find that a colleague is incompetent, appropriate remedial measures may be adopted with discretion and sensitivity.

Interaction with Consulting (Specialty) Physicians

Ensuring good rapport with other specialties also improves the patient care within the ED and reduces transit times.

- ➢ **Cordiality** – Introduce yourself with a warm greeting or a firm handshake. This will slacken the tension and help ease further communication.
- ➢ **Communication** – Follow a protocol for good communication (e.g. SBAR Protocol). Let the physician know why he/she is required and how he/she will be of assistance. Respect any comments that the physician may have to offer. If you have any discord on any opinions, discuss it politely, preferably in private and let him/her know how you would do it differently.
- ➢ **Complimenting** – Be courteous and never forget to thank them. This will also help to maintain a lasting rapport.

Interaction with Patients

- ➢ Begin by greeting the patient and his/her relatives and introducing yourself.
- ➢ Before clinical evaluation, ensure that the patient is comfortable and relaxed, offer analgesia. Ensure adequate privacy and a chaperone if necessary.
- ➢ Patiently listen to your patient's complaints and do not be expediting.
- ➢ Be empathetic and use simple language, avoiding medical jargon.
- ➢ Involve the patient in the decision making- provisional diagnoses and the intended course of management. Take time to clarify doubts.
- ➢ Respect patient's autonomy and do not impose an option on the patient because you think it is right.
- ➢ Thank the patient before you leave.

Concluding a Shift

- ➢ Greet the incoming faculty and staff; brief them on the day's proceedings and share interesting facts from the day.
- ➢ Give a proper hand-over with clear plans of clinical details with further plans.
- ➢ Regroup your team and debrief them of the day's events.
- ➢ Finally, thank all your colleagues and all the supporting staff before you leave.

LEADERSHIP- THE BACK BONE OF EM

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Is a leader necessary?
Who should be the leader?
Is a leader born or made?

Any task involving a group of people is performed better when it has a leader, even if the group consists of only two individuals!
A manager functions best while trying to achieve a set of given goals and improve the efficiency of a system by application of tested management principles, while a leader is essential in trying to implement change and achieve excellence. For this, a leader should possess certain characteristics:

Vision
A leader is able to assess the status quo is able to envision an alternate status. This vision is directed by the character, knowledge, ability, and integrity of the leader, which in turn earns the respect and the willingness of the team to follow.

Communication
The visionary should be able to effectively communicate the current status and the need for change to all the members of the team. This is the stage of inspiring and stitching together a set of people with diverse ability and personal goals into a team with a common goal. Communication has to be clear, concise, continuous and creative. The language and the expression the leader uses with his

team members may differ (depending upon the individual's response), but the message delivered has to stay uniform.

Decision making and taking action

Listening is an integral part of the communication process. New options and avenues for progress may emerge from the leader or members of the team themselves. It is, however, the characteristic of a good leader to be able to generate or gather various options and quickly and definitively choose and then act on the option that they believe takes them closer to the desired outcome.

Reflection

Pausing and reflecting on the progress made is another characteristic of a great leader. This allows a review of the direction of movement, the proximity to goals, the emerging threats and the opportunities, and course corrections that may be required.

Responsibility

Any success is an opportunity to give credit to the team members which in turn sows the seed for more success. Alternatively, the process of review may suggest that decisions taken were not entirely correct. In such situations, a good leader takes responsibility and never lets the fear of getting it wrong work as a paralytic!

Leadership is not a position or title. All aspects of being a leader need mindful training and constant improvement just like any other skill. Learning from ones juniors also motivates a leader as 'Imitation is the highest form of appreciation'. The leader should also be able to see potential in his team members and encourage them to polish their traits of becoming a leader. Good leadership is essential in all fields of Medicine, but most crucial, almost inevitable in Emergency Medicine due to the dynamic nature of events, involving a broad spectrum of professionals.

LAW OF THE LAND- BLACK COAT, THE WHITE COAT AND THE GREY ZONE

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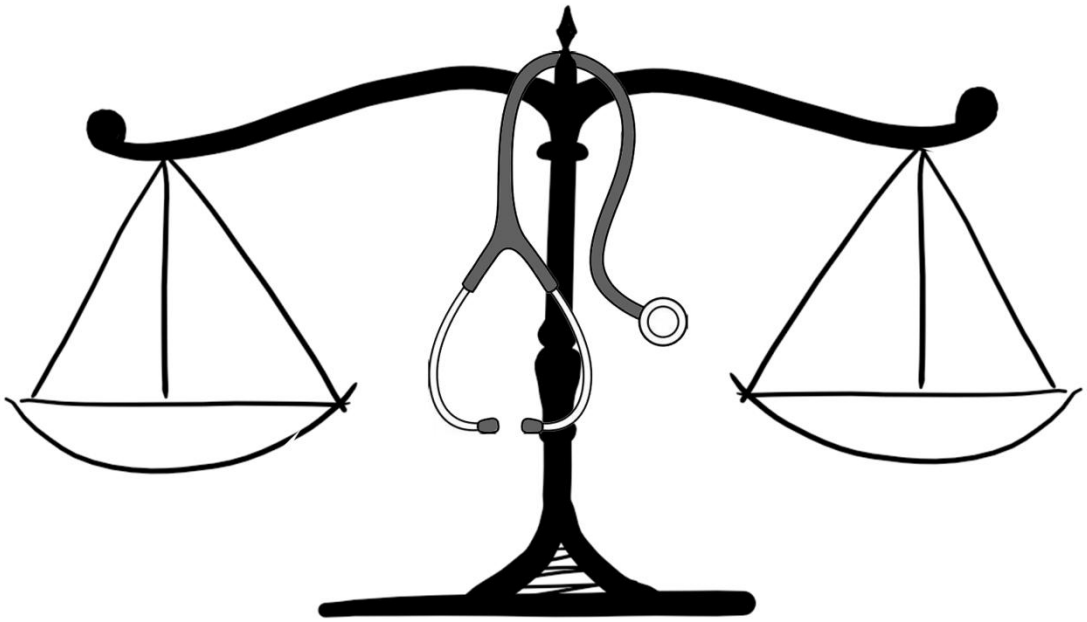
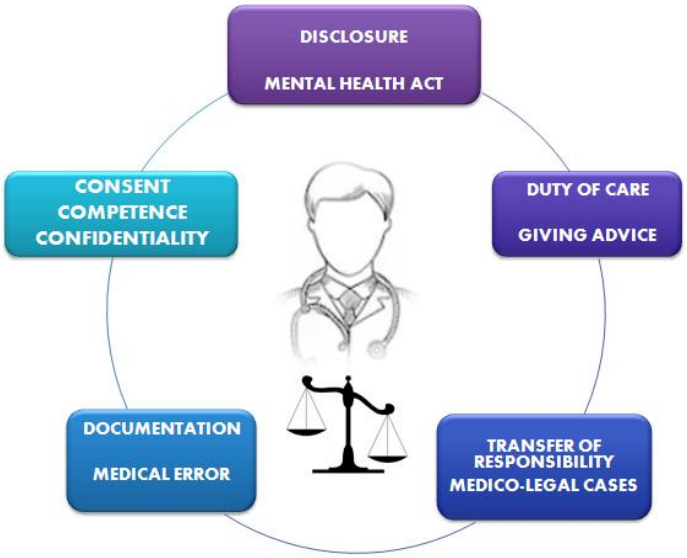


As Emergency physicians, we are under constant scrutiny by administrators, colleagues from other specialities and patients too.
So what does it take? A book, a CME or a WhatsApp forward to empower today's young emergency residents with just enough legal knowledge to thrust aside the fear of a lawsuit. As simplicity is the ultimate sophistication, let's discuss the what, why and how of legal issues in emergency medicine.

The What

It is impossible for us to know the nitty- gritties of every health law, but the prudent thing to do is to at least be aware of the legal aspects of the day-to-day functioning in the ED.



Domains of learning legal issues in Emergency Medicine

The Why

Lawsuits and litigations are now commonplace, whether justified or not. It is undeniable that it causes an immense amount of stress and creates an environment of fear among doctors. For emergency residents, this is more relevant than ever because the fear of litigation is one of the factors leading to burnout. We fear what we do not know and thus it follows that being aware of the relevant legal issues and constitutional framework will make us work better.

A common misconception is that residents are immune from legal action. Although vicarious liability is pertinent, we forget that even as residents we are registered medical practitioners from whom a certain degree of legal responsibility is expected.

The How

Of course, reading the many articles available online is helpful. The major drawback of such learning is the lack of understanding of the legal system itself and failure to address our relationship with the law in a positive and pragmatic manner. We must never disregard the fact that the law also protects us, provided we know how to use it. Therefore a few methods I would recommend are:

- Discussion in resident teaching programs of court cases where some aspects of emergency care and its legal implications were involved.
- Creating a training module for medical law for emergency physicians under EMA (Emergency Medicine Association).
- Undergoing formal training , for example ,a PG diploma in Medical Law and Ethics

I am doing this course through distance education department of National Law School and it has been immensely helpful.

We must develop holistically and that alone will ensure that our specialty thrives and this responsibility must be collectively shouldered by all of us.

INCESSANT INTERRUPTIONS - HOW TO DEAL WITH THEM

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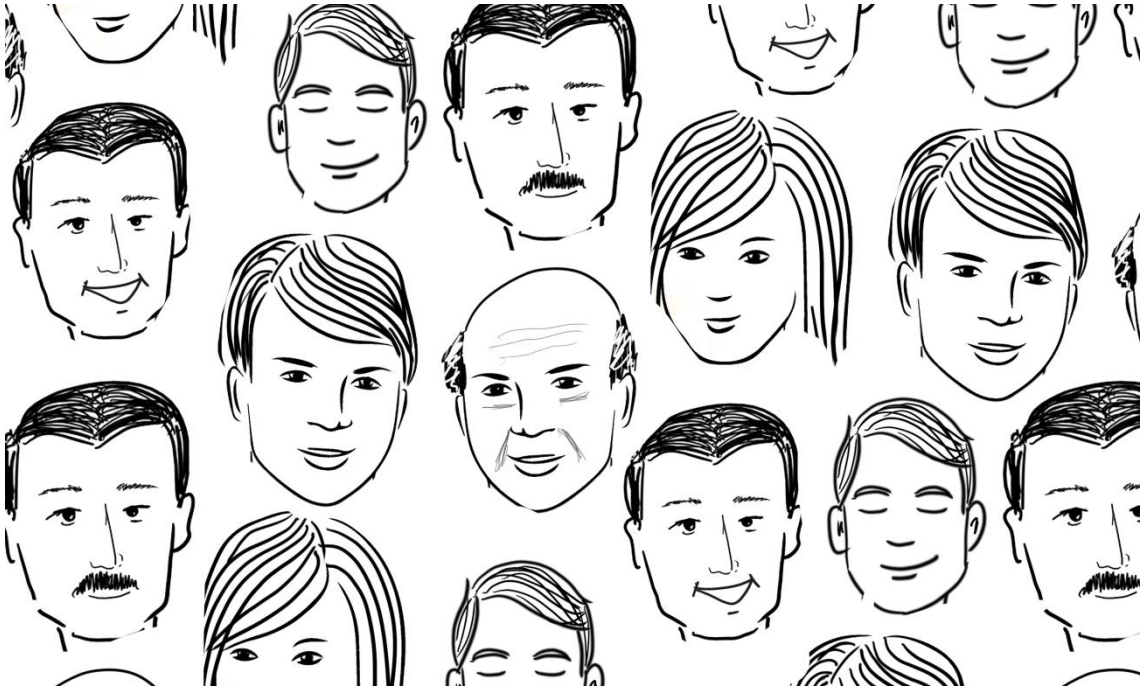

The emergency room(ER) is a turbulent hive of activity. Unlike most professions, emergency medicine requires constant attention toward multiple critical deeds on a daily basis. The key factor that has been implicated in causing errors in the ER is task interruption. A physician whose attention is constantly flitting from task to task may not think critically enough to see the bigger picture. It causes a substantial threat to thought flow and job efficiency. Workplace interruptions are found to increase the physician's stress, causing sleep disturbances and lower job satisfaction.

The brain computes a series of components in a specified order to complete a task at hand. The memory representation in the brain for a task that is completed differs distinctly from a task that is incomplete. Task interruptions disrupt this brain process leading to a higher likelihood of errors. They also increase the load on the brain proportionately. This takes a toll on productivity, creating mental exhaustion, piling of other less important tasks which in turn leads to anxiety and frustration. AAFP (American Academy of Family Physicians) recommends some strategies for all specialties to deal with interruptions:

1) Choose your course breakpoint i.e. buy yourself a little time to get to a good stopping point in the task that you're involved in.

2) Use environmental cues - While preparing to respond to an interruption, use any simple environmental cue to remind you of the task when you come back. For example, tie a BP cuff to the patient before you begin responding to an interruption so that when you switch back your attention, you quickly continue to measure the vitals without any delay.

3) Take a second or two to repeat the main task mentally to yourself. For example, you're just about to enter dose information and you get interrupted. Mentally say to yourself, 'enter dose, enter dose, enter dose' to improve your ability to come back to that task when you resume.

4) Memory rehearsal - this involves mentally recalling your previous activity, such as "I was working on dosing," while engaged in the interruption.

5) Postpone - some situations require intense focus. If you are in the middle of prescribing a high-risk medication, there's absolutely nothing wrong with telling the individual starting to interrupt, 'Wait a moment while I finish what I'm doing'.

The ER team should be trained in ways to deal with possible interruptions. What qualifies as worthy for interruption and what can wait needs to be discussed. Based on the resources and constraints each team should have their own organisational plan to create a fulfilling work environment.

BALANCING WORK AND FAMILY LIFE

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We often underestimate the importance of family and take them for granted because they are always there to support us, both at times of happiness and at times of need. However, they can only do this effectively when they feel that their support is desired and valuable. Sometimes, families can give you a difficult time themselves, if they are not managed well and this can lead to stress in both one's professional and personal life.

As a practicing ENT surgeon, serial medical devices innovator, author and a stand-up comedian who is married and has a child, balancing work and family has been a daunting, yet very important task for me. I strike a balance between work and family, by following three key principles

1. Understanding one's capabilities: We often think we can do more than what we actually can or vice-versa. This could be because of peer pressure or the need to prove that we are more than what we think. Knowing what cannot be done, by strictly analyzing our schedules and priorities is very important to understand and accept.

2. Setting realistic expectations very early: This is key. Most of us think, why be negative and say "I don't think I can take this task, I have too much on my plate already" and pose an image of incompetence. We, therefore, take the task which is eventually not finished on time or is ineffective. This holds true for both work and family activities. The communication regardless of which side it falls must be immediate and clear. Either say "I have a lot of unfinished things and I cannot take this task up right now," or, "I will need longer time and some help to finish this effectively". People value

pre-communication more than failed delivery. It's a sign of respect of time, trust and self-understanding. The truth is that it won't be looked at negatively.

3. Prompt and continuous communication: Both family and work need to be kept posted on delays, sudden changes and progress. It shows respect and value of their role in your life. I follow this a lot and my colleagues and family are very supportive because they are aware that I am trying to do my best and letting them know where I stand. They feel involved and often understand rather than getting upset and frustrated.

DEALING WITH DEATH IN THE EMERGENCY DEPARTMENT

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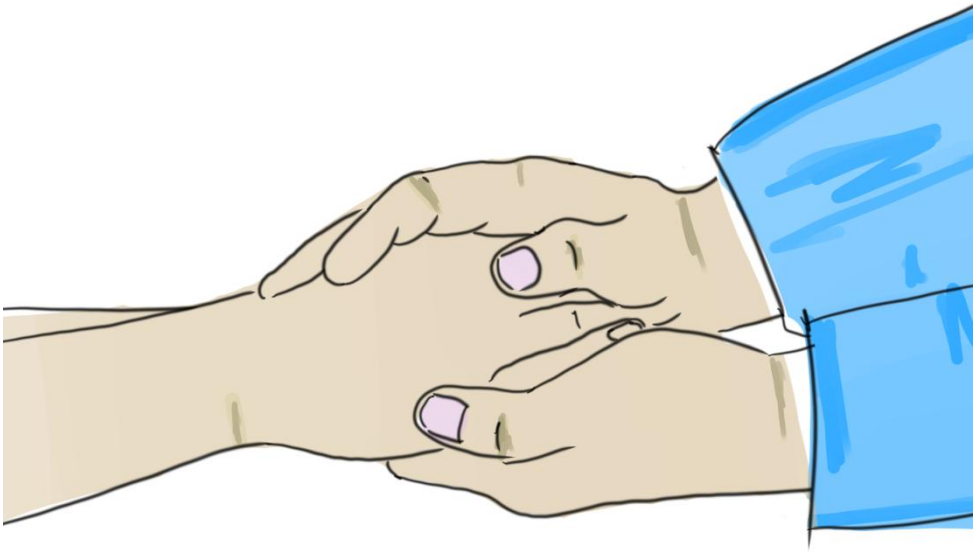

Sudden, unexpected death is a crisis which taxes an emergency physician's technical expertise and emotions. This requires utmost sensitivity and expertise in communication, which, to a large extent may reverse the nightmarish experiences arising with a sudden death in an emergency setting. Handling death in an emergency setting poses unique challenges when compared to a ward setting in view of suddenness and lack of anticipation of death and lack of familiarity of the relatives to the treating team.

Breaking bad news:

1. Meet the family members as soon as possible after their arrival and provide preliminary information. A poorly handled arrival generates hostility among family members. Request the family to be seated, preferably in a private place which conveys an unrushed willingness to remain with the family and answer their queries.
2. Introduce yourself to the family which helps to build a rapport. Initial few moments should be spent on discussing the patient's premorbid condition and circumstances around death, which prepares the family towards acceptance of the mortality.

3. Describe the treatment from the time of arrival until death using simple terminology. It is of utmost importance to express sympathy and be empathetic to the family's emotional responses. Do not be apologetic as this may install doubts of negligence by hospital staff.

4. Most relatives recall the attitude and demeanour of the physician after returning home, for days to come after the dear one's death, and hence the tone and posture during communication assumes utmost importance.

The grieving family:
Kubler-Ross has described 5 stages in grieving which may fluctuate from time to time:

1	Denial	Nongrieving behaviours, inability to comprehend facts
2	Anger	Shouting, aggression.
3	Bargaining	With supernatural forces
4	Depression	Uncontrollable crying, sadness, guilt
5	Acceptance	of death

An understanding of these stages and behaviours helps in avoiding a show of defensiveness or negativity towards the family. It is important to reflect the family's emotions and feelings in a conducive atmosphere which will make the family understand the situation and diffuse any chances of aggression. Allowing families to view the corpse if possible is also a good way to work through denial and allow for ventilation of emotions.

The physician's reactions to death:
Physicians, like the family, also undergo emotional upheaval following a patient's death. There may be feelings of discouragement, blaming other staff, helplessness or a sense of failure. Physicians should normalise their feelings and explore them with their colleagues. Many staff develop an apparent insensitivity towards death which manifests as inappropriate humour, anger or sarcasm which may create discontent and hostility amongst staff. This can be dealt with, by holding staff meetings where they may be allowed to vent their emotions and support can be provided. These emotions can spill over to a physician's personal life thus causing significant psychological issues at which point they should not hesitate to meet a mental health professional for help.

MANAGING THE VIOLENT PATIENT

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Violence is defined as the use of physical force, verbal abuse, threat or intimidation, which can result in harm or injury to another person.

Patient-related causes for violence include delirium, dementia, psychosis, intellectual disability, personality disorder, grief, anxiety, frustration, unpleasant symptoms (pain, sleep deprivation) and history of crime or aggression.

The Hospital environment can also provoke aggressive behaviour - being noisy, busy, crowded, unfamiliar as well as the long periods of inactivity, wait times, restricted movement leading patients or relatives to believe they lack control over events.

Prevention of an act of aggression:

1. Assume that any aggression indicates a patient's distress, or an attempt to communicate unmet needs. Prevention means understanding the reasons for distress, anticipating and meeting needs. Prevention needs good communication and relationship-building based on meeting physical, psychological and emotional needs.

2. Introducing oneself, starting with a few words of general conversation to create rapport, being polite, using simple language and checking the extent to which it is understood, having conversation with the patient at the same physical level, giving a running commentary on what one is doing may allay misunderstanding or fear. Do not contradict, confront, embarrass or humiliate, even when the person is disorientated and mistaken.

3. Prevention by modifying environmental factors: Zero tolerance policy (communication to patient and relatives that violence is never acceptable), establishment of a rapid response team (security/police response), mechanism to alert staff when perpetrators revisit the ED, quiet/special area for aggressive individuals/criminals, procedure for investigating and reviewing violent event.

Responses in escalating situations

1. De-escalation includes acknowledging the distress without making accusations.
2. Leave and return strategy (giving physical and emotional space)
3. Avoid provocation, promote collaboration and positive engagement (asking the patient how to defuse the situation).

Responses in crises situations

1. Clearing the scene, as crowds can exacerbate the sense of threat. One person should take charge, with support from staff.
2. Immediate physical separation (scoop and go- two staff members working from behind, lifting by the shoulders)
3. Avoid retaliation against the aggressor.
4. De-escalation should be continued, including strategies such as talking, reassuring, negotiating, trying to make compromises.
5. Restraint (physical, pharmacological or environmental) is allowed so long as it is necessary and proportionate to the risk of harm, and is the least restrictive alternative.
6. Physical restraint should be the minimum necessary for the shortest period of time, best done seated on a bed or kneeling. Avoid taking the patient to the ground, but if not possible, protect the head from injury and restraint in the supine position not prone. Ensure patent airway and monitor SPO2.
7. Rapid tranquillisation is sedation by giving enough drug to get a rapid effect. Following table lists the drugs and indications for their use.

Patient group	Try first	Try second	Maximum dose in first 24h[+]
Highly aroused, physically robust adult, including those already on antipsychotic drugs	Lorazepam 2 mg	Repeat, then try haloperidol 5 mg[*]	Lorazepam 4 mg Haloperidol 12 mg[++]
Alcohol withdrawal	Lorazepam 2 mg	Repeat	Lorazepam 8 mg
Frail older people or severe respiratory disease	Haloperidol 2.5 mg	Lorazepam 0.5–1mg	Haloperidol 10 mg Lorazepam 4 mg
Dementia with Lewy bodies, Parkinson's disease	Lorazepam 0.5–1 mg	Repeat	Lorazepam 4 mg
Delirium	Haloperidol 2.5 mg	Repeat	Haloperidol 12 mg[++]

*NICE guidance recommends combining haloperidol with intramuscular promethazine 25–50 mg; maximum 100 mg in 24 h; the evidence for this is quite weak and the injection is painful

[+]British National Formulary maximums should only be exceeded if clinically necessary, and after review by a senior doctor. If control is not achieved with maximum doses consult a senior doctor. Consider intravenous midazolam 1–2 mg boluses at 2 min intervals, maximum 20mhg. Move to critical care

[++]The Summary of Product Characteristics for intramuscular haloperidol gives a maximum of 18 mg/d. The British National Formulary recommends a maximum of 12 mg/d. At the time of writing the discrepancy has not been resolved.

Do not forget- Documentation is important as these situations can be contentious. Record the rationale, non-pharmacological de-escalation measures and pharmacological agents used for the purpose.

ETHICS AND EMERGENCY MEDICINE

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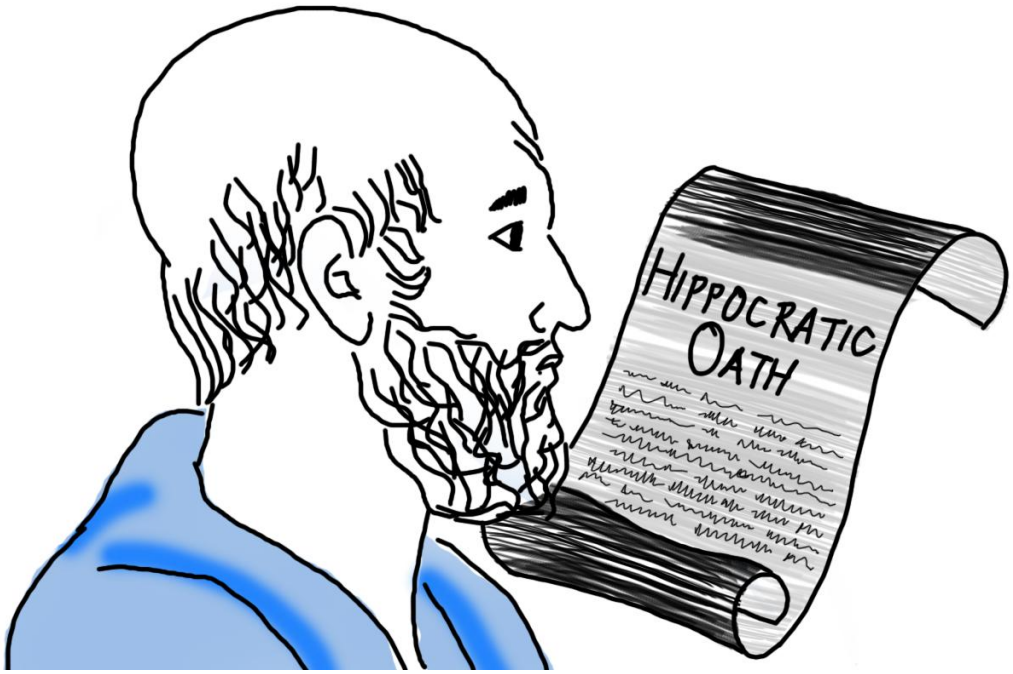

Ethical dilemmas are part and parcel of most cases in Emergency Medicine. These dilemmas are often complex and revolve around issues of consent, refusal of care, resuscitation, with-holding ventilation, withdrawing life support, futile therapy, communicating bad news, confidentiality, triaging and allocation of scarce resources.

Many theoretical approaches are available to guide ethical decision-making. The dominant Principle-based approach of Respect for persons (Autonomy), Beneficence, Non-Maleficence and Principles of Distributive Justice form a sound basis for ethical reasoning and decision making.

Dealing with the complex dilemmas requires:

1. Sensitivity to be able to recognise a dilemma
2. Formal Training and experience to handle such dilemmas.
3. Good communication skills.
4. Ability to remain calm and coherent under the onslaught of queries from relatives.
5. Familiarity with the relevant legal aspects
6. Remaining unbiased and unprejudiced on issues of age, race, religion, patient vices, disease conditions and social position of the patient.

Solutions:

1. Mechanisms should be available to enable the patient or their surrogates to make informed decisions regarding treatment options, as far as possible.
2. Medico-social workers or counsellors can be co-opted into the Emergency room team to focus on counselling.
3. Clearly laid-out hospital policies on commonly encountered issues.
4. Hospital ethics committees can be set-up to discuss more difficult cases and arrive at a consensus.

When terminally ill patients have a medical emergency and further treatment options are considered to be futile, dilemmas related to withdrawal or withholding of life support arise. In March 2018, the Supreme court of India issued guidelines in recognition of the 'Living Will' made by the patients. A living will in the form of a written document is a more legally accepted and valid indication of the patient's wishes, unlike verbal requests conveyed by relatives.

Lastly, the importance of documenting the decisions that have been taken cannot be stressed enough. Documentation is important not merely for legal purposes, but also to provide a reference to review patient's wishes but also to ensure a fair process of decision-making. Ethical decision-making goes a long way in ensuring less conflict and more harmony in the doctor-patient relationships.

DEPRESSION IN OUR PROFESSION

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Introduction:

The prevalence of depression and the incidence of suicide and suicide attempts among medical professionals are well-known, but infrequently discussed, due to various reasons. Furthermore, related studies and steps taken to prevent such happenings are also meagre at best. An estimated 12% of males and 19.5% of females in the medical profession suffer from depression with an even higher incidence among medical students. About 15-30% of students and residents screen positive for depression. Studies also have shown that 1 in 16 trainees report suicidal ideation. This alarming situation demands immediate attention because it has impact on the entire community.

Risk factors associated:

a) Inadequate doctor population ratio (1:1596) leading to work overload.
b) Long working hours with inadequate rest leading to burnout.
c) Frustration due to various reasons - mainly due to loss of quality time with family and lack of healthy interpersonal relationships.
d) Inadequate training and infrastructure leading to improper management of patients.
e) Stress related to academic pursuits.
f) Easy access to lethal drugs.
g) Doctors are less likely to readily seek out mental health services compared to general population.

Prevention and management:

a) Screening of medical students for psychological stability. Accordingly, suitable counselling and better coping skill training.
b) Setting up wellness centres for doctors and regular stress management programs will be helpful. Easy access to well-qualified counsellors and support groups should be made available within the campus. Independent helpline number for medical professionals would be ideal.
c) Encouraging yoga, recreational activities as well as physical exercises to maintain a stress-free and healthy life – to be arranged on campus.
d) **S**tigmatization of mental illness is reduced by regular educating sessions and group activities.
e) Maintaining a strict system that monitors usage of lethal drugs.
f) Recruitment of an adequate number of medical professionals and ensuring that work is divided and no staff is overworked. Recognising and appreciating sincere efforts carry a lot of positive value.
g) Ensuring adequate breaks and rest for all the staff.
h) Appropriate management in terms of providing reassurance, evaluation of other precipitating factors and psychopharmacological management should be done for those diagnosed with mental illness.

BURNOUT AND WAYS TO BURN THE BURNOUT!

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Definition of burnout:

Maslach and Jackson conceptualised burnout as a type of prolonged response to chronic emotional and interpersonal stressors on the job & described it in a three-dimensional construct of :

1. **Emotional Exhaustion** (state of feeling emotionally exhausted by work)
2. **Depersonalisation** (negative, cynical attitudes and a sense of emotional distance from one's patients or job)
3. Reduced **Personal Accomplishment** (decreased sense of self-worth or efficacy related to work).

According to a recent JAMA Internal medicine study, emergency physicians are at the top of all specialities, with over 65% respondents reporting burnout. It affects 1 out of 3 physicians at any given time.

Causes for burnout:

1. Conditioning of medical education- to be workaholics, superheroes and perfectionists- 'patient comes first', 'never show your weakness.'

2. Increased workload- understaffed, disorganized departments with never-ending patient flow. No administrative backing.
3. Interpersonal conflicts- with colleagues and patients/relatives
4. Litigation stress- leads to fear for oneself before caring for patients- “defensive medicine”
5. Lack of work-life balance
6. Unregulated night shift work
7. Poor Food habits and hydration.
8. Substance abuse

Clinical presentation:

Burnout can be insidious. Consequently, emergency physicians may find themselves far down the path to burnout before they realise it. Common symptoms are:

1. Fatigue, even with adequate sleep
2. Sadness; Avoiding personal & social interaction
3. Difficulty in concentration; forgetfulness
4. Work dissatisfaction
5. Irritability

Consequences:

1. Deteriorating work performance
2. Absenteeism & job withdrawal
3. Impaired personal and social life.

Ways to burn the burnout:

The first step in the development of a strategy to prevent burnout is to embrace the idea that “one is needed”.

1. **Individual level: Assume** responsibility, for recognizing stress & take appropriate steps to reduce it. This book contains individual chapters on how to deal with each factor in detail.
2. **Environment level** strategies should aim to create awareness, remove stigma, empower professionals and to provide social support.

Conclusion

Burnout is a preventable -fought by building resilience. Resilience is a choice to weather the storm & make the most of it, a skill to be learned & nurtured. Every moment spent in practising EM is an exercise in either resilience or burnout. As Victor Frankl wrote in his book - *Man’s search for meaning* “Everything can be taken from a man but one thing, to choose one’s attitude in any given set of circumstances, to choose one’s way”.

60 SECONDS TO RELAX ON A BUSY SHIFT

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'Stress immunity' is the core characteristic expected from an emergency physician. Remember that the time to relax is when we don't have time for it. Hence, a few relaxation techniques, as a part of self-care, will come in handy.

While it is assumed that all relaxation techniques are elaborate and time-consuming, there are a lot of techniques which are simple and easy to practice. 'Mindfulness' is one such technique that is widely recommended. Being mindful means 'being here and now'; focusing on the present. Mindfulness is the awareness that emerges through paying attention in the present moment, purposefully and non- judgmentally. Let's consider two techniques of mindfulness which induce relaxation in 60 seconds*:

1. Tuning in to the breath:

Take a few moments to consciously focus on your breath. Feel three to five breaths move in and out of the body. Remember not to control your breathing, but to simply observe (Being mindful).Your mind will wander. Use the breath as an anchor to re-focus on breathing. Then slow down the exhalation to help trigger the relaxation response. This technique will activate the parasympathetic nervous system which helps you feel more relaxed and think more clearly.

2. The five senses:

Our five senses can be powerful tools to help us relax. Sit upright, for a minute tune into your senses, listen to the sounds in the room, visualize a soothing colour, focus on the pleasant odours in the room (You can also evoke the memory of a pleasant odour), feel the space you are in, feel your feet touching the ground, chew a gum or eat a candy and experience its taste.

3. Taking in a deep breath:

This is another widely practised relaxation technique, although it does not come under the realm of mindfulness. It goes with a count of 4-2-4 (one count = one second). Sit upright. Breathe in for 4 counts, hold your breath for 2 counts and breathe out for 4 counts. This can be repeated 4-5 times for instant relaxation. The pace of the breathing increases on count during inhalation and decreases on count during exhalation. (Note: The belly should protrude on inhalation and vice versa)

PHYSICAL FITNESS AND EXERCISE

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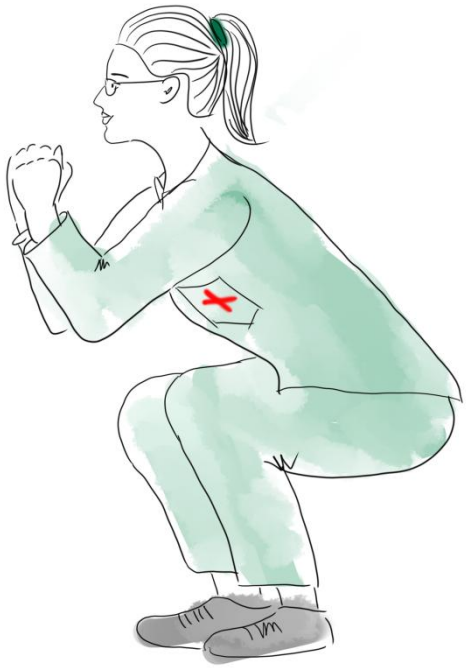

EMD: Exercise Meets Doctoring

The lack of exercise and poor dietary choices have negative consequences on the physical and mental health of doctors working in the EMD. Exercising helps relieve stress and maintain a good quality of life. Virtually any form of exercise can act as a stress reliever and is advocated for everyone. Although it sounds easy, and everyone wants to exercise but owing to a lack of time and a busy schedule finding time to exercise can be a challenge especially when working in the EMD.

Short exercises at work can help us deliver better health care with improvement in decision making and helping with working under stressful situations. Small changes like walking to work if possible, or parking the vehicle at the far end of the parking could act as a starter for a change. Others like taking a brisk walk, hiking a few flights of stairs, gentle stretching can also help. More specific exercises which can be performed are:

1. Hamstring curl (Bend arms at the elbow. Bring one foot up toward your rear end while straightening your arms so that your hands are down when your foot is up),
2. Knee lift (Just like hamstring curls, except you lift your knee up in front as your arms go down)
3. Hallelujah (Sweep arms above your head and down again as you step side-to-side. Actually yelling ''Hallelujah!'' is optional),
4. Punching (While rocking foot to foot, punch with alternating arms. To reduce elbow stress, try not to fully straighten your arm).

5. Desk push up (Place hands on the edge of a desk, shoulder width apart, legs out behind you. Push off with as much force as you can),
6. Side lunge (Place hands on the edge of a desk, shoulder width apart, legs out behind you. Push off with as much force as you can).
7. Jump squats and Chair dips are a few others which can be tried.

Some of these suggestions might sound funny or seem embarrassing but the involvement of colleagues, forming teams; setting challenges creates an atmosphere in the department where importance is given to fitness and may help loosen one's inhibitions. So if you are working in the EMD (yes you are!!!), if you are busy (of course you are!!!), unable to hit the gym (definitely!!!) or spend time at the yoga classes (Naah!!!) Try out these exercises to keep yourself fit and keep out stress.

NUTRITION AND HYDRATION

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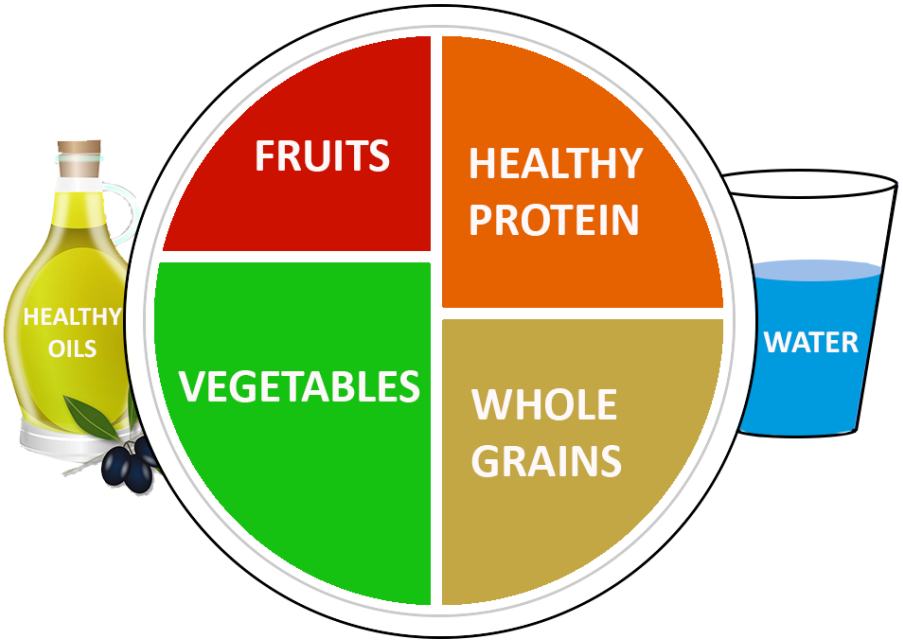

Ask any EMD resident or professional: Is eating healthy important for one's physical and mental well-being? While it is understandable that the first casualty of such a hectic lifestyle is proper nutrition (since the negative consequences are over the long-term), poor nutrition is unacceptable with the view of achieving high work performance, happiness and holistic well-being. With this view in mind, here are three nutritional guidelines for the busy EMD professional that are quick and easy to implement.

1. As a top priority, it is imperative to keep oneself constantly hydrated by drinking plenty of healthy beverages such as water and moderate amounts of unsweetened fresh fruit juices, while avoiding commercially processed beverages with excessive sugar and unrestricted caffeine consumption. It may be practical to fix an arbitrary target of finishing a 1L bottle of water every shift.

2. Maintain consistent sleep and eating patterns. Shift work can disrupt the circadian rhythm that regulates metabolic, hormonal and cardiovascular systems, and is associated with a greater risk of obesity, type 2 diabetes mellitus, metabolic syndrome and cardiovascular diseases. Therefore, while meal frequency, which pertains to fewer (2-3) v/s larger (4-7) number of meals per day is a personal choice, maintaining consistent eating habits is important. More so during night shifts- one must have 3 meals by reversing the eating times (am for pm). For example, have a good 'breakfast' at 7pm and then 'lunch' at 2am and finally a light 'dinner' at 9am before sleeping through the day

3. Thirdly, food choice matters. Mostly avoid processed, deep-fried, sugary and greasy foods Instead, opt for healthy filling foods which have low glycaemic load and are rich in fibre and micronutrients: fruits, nuts, veggies, salads, natural yoghurt and complex-carbohydrate based foods. Also, make sure you have plenty of protein in your 'breakfast'/'lunch to prevent drowsiness during the shift.

While these guidelines are no surprise to most healthcare professionals, actively implementing these in one's life, especially for those working in hectic departments such as emergency medicine, may go a long way towards achieving optimal mental and physical health, which in turn benefits the entire society.

Yes, advice is helpful, but the department leadership in collaboration from the institute should formulate practical strategies to make compliance successful. Providing a departmental wending machine with above mentioned healthy food, encouraging timely drinks/food breaks could be one way to get the wheel rolling.

FORMAL RESIDENT WELLBEING STRATEGIES

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Residency is the most stressful period in medical practice from long working hours to straining relationships with friends and family. Knowledge of the methods to cope the stress, which comes as a resident, especially in a highly demanding speciality like emergency medicine is an important part of survival.

Resident well-being in recent years has been identified as an integral part of training, as the strategies learnt during the residency period can be adopted as a consultant. In developed countries, where emergency medicine is an established speciality many of the residency programs have started incorporating resident wellbeing as a part of the curriculum. In India, however, most of the residents go into an eat-sleep-work cycle for 3 years, which is very unhealthy. We need to pay attention to resident well-being before it creates a generation of emotionally numb doctors who do not care about themselves or their patients!

Wellness in residency stems from two distinct paths:

1. At a personal level:

a) Residents should themselves take an active role -“ME” time, to focus on their routine outside the department, the sleep cycle and nutrition are very important but neglected.

b) Having a short but steady fitness regime helps in improving physical and mental health.

c) Maintaining a steady glycaemic state with intermittent small snacks

d) Relaxation through various disciplined techniques of meditation.

e) Improve self-worth by a ‘virtual pat’ on the back and writing down the positives/achievements during the shift- to stay motivated.

f) “WE” time, where you get to know each other personally and spend time by engaging in social activities. The bond created outside the working environment will have a positive impact at work as EM is always a team event. It can also help in early identification if a team member is facing undue stress and offer help.

2. Institutional/policy level:

a) The residency programs should be structured in a way to help the residents attain a balance between training as well as personal wellbeing.

b) Mentorship programs - A senior faculty with whom the residents can confide in, both professional and personal, will help them feel that they are part of a family.

c) Periodic evaluation of the residents’ work ethos through the rest of the staff to identify whether there is a desired change in the attitude.

d) Regular debriefing about their performances, feedback on how to improve their skills and offering positive reinforcement.

SLEEP DISTURBANCES AND COPING STRATEGIES

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A good night's sleep is the most potent rejuvenator of the human mind and body. With the advent of modern society -emergency services are indispensable with unnatural and demanding schedules atx night.

What are the common symptoms and problems?

- The most common are sleepiness during night and insomnia during an intended day-after work- sleep.
- Fatigue, vague headaches and body aches, cramps, lack of energy and enthusiasm.
- Difficulty in concentrating, thinking and forgetfulness
- Frequent unintentional errors.
- Predisposition to stress and anxiety related disorders, depression and suicidality.
- An increased risk of falling asleep during driving and road traffic accidents especially while commuting after the shift
- Addiction to stimulants as well as sleeping pills and substance abuse
- Relationship problems for not being able to spend quality time with the family and friends.

How does one cope with it?

1. Sleep Hygiene - Sleep hygiene is a practice involving behavioural and environmental modification to ensure adequate sleep. It includes

- Bed-time scheduling – Constant bed time.
- Setting up an optimal sleep environment with less disturbances and better comfort
- Adhering to right diet - Light food with less calories and liquid
- Appropriate pre-sleep activities – avoiding strenuous and mentally challenging tasks
- Avoiding Stimulants and narcotics
- Adequate relaxation

2. Tuning your clock

- Using bright light exposure to signal and maintain the wake time and avoiding the same to indicate sleep time
- Melatonin and intermediate-acting sedatives can be timed appropriately. Stimulants like modafinil and caffeine may help to maintain alertness but not always helpful.

3. Planning shifts

- Avoiding abrupt change in shifts
- Clustering of same shifts
- On the transition off- days, Shorter Day-sleep after the last night shift and late afternoon/evening short naps before the night shifts would be beneficial.

Simple, but often ignored formula is

Awareness – of symptoms and its probable cause as sleep disturbances

Openness – to accept and change the behaviour and environment

Reach out – Share and seek help at fellow professionals.

UPGRADATION OF SKILLS - NHS, UK PERSPECTIVE

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Being a trained emergency physician in a developing country with all the available clinical case variety to learn, I was confident that in a developed world, where there is a well-structured system which is fully functional, it should be a cakewalk practicing emergency medicine.

It didn't take long for me to realise that there is more to EM apart from being able to deal with clinical management. When I walked into my first night shift, the department was so crowded that we had up to 80-90 patients, however the nursing staff kept updating them on the waiting time. I learnt through formal and informal training while watching my senior colleagues; Simple things like humbly apologising for the delay and demonstrating empathy could help alleviate the anxiety and anger among patients and their families. If people want to lodge a formal complaint, acknowledge that they have all the right to do so and guide them through the process. Also to make an incident report for the same to be investigated and see how you could improve your department.

Liaising with the lead nurse remains one of the key roles. He/She is a resourceful person in escalating any unwell patients picked form triage while also helping with calming agitated patients down and counselling those who have lost a loved one. This leadership opportunity given to nurses, redefining their role, was particularly impressive.

Emergency medicine training in the UK has a vast curriculum - Apart from the progress in clinical aspects, it is the acquisition of non-technical skills which I would emphasise, especially for overseas doctors. Following are a few examples of OSCE stations that are included in the FRCEM exams-

1. The difficult referral
2. Breaking bad news
3. Managing an angry patient/relative
4. Supporting a junior doctor who had erred and the patient had a complication
5. Patient education on a particular ED presentation, demanding DAMA
6. Teaching an Advanced nurse practitioner while examining the patient
7. Leading and managing a challenging team in a resuscitation scenario

Additionally, I found these initiatives in the UK could be modified and applied in the Indian scenario:

1. Reporting untoward or significant events through an appropriate channel (Datix, a confidential web-based incident reporting and risk management software for healthcare organizations)
2. Conduct audits of personal and departmental performance Errors / discrepancy meetings, quality improvement projects, instead of random redundant topics for 'thesis' research.
3. Annual mandatory, confidential feedback from colleagues for renewal of registration to practice.
4. Being a good team leader – Insights from leadership courses, run by RCEM annually - "Leading and managing your ED."

PURSUIT OF EXCELLENCE

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The emergency department provides a unique educational experience that is distinct from both inpatient and ambulatory care settings. Hectic schedules, rapid turnover shifts of duties, unpredictability and overcrowding makes it a difficult place for learning as well as teaching. Pursuing excellence in learning seems to be challenging but achievable goal with some flexibility, creativity and innovative strategies. This requires work on mainly three domains, the education system, the learner and the institution system.

1. The Educator: Faculty must have good teaching Skills, should be encouraged to attend faculty development programs and courses to hone their teaching skills. There should be bedside teaching with the demonstration of various clinical signs, converting work-related activities into educational experiences. This as well as the verbalization of realtime thought processes to the learner, holding case discussion beyond shift rotation and the use of multimedia all can robustly enhance the learning.

2. **The Student**: An effective educational relationship requires not only skilled teachers but also receptive learners. Mature learning should be self-directed. The Student should focus on the following points:

a. Clear learning objectives: The ED is the place to learn patient care and medical knowledge
b. Soft Skills: Communication, resilience and leadership result in better therapeutic outcome.

c. ity to learn from mistakes, and approach them positively.
d. Self-possession: continuous reinforcement to keep up the motivation

3. **The Institutional System:** Institutes should have dedicated teaching programs in such a way to minimize interruption in clinical areas. The Learner should be given clinical responsibilities while a faculty or senior resident manage their patient. Additional attending physicians or residents who do not have any patient care responsibility, can be assigned on shift to serve purely as a teaching resource for the learners (4).

THE WAY FORWARD

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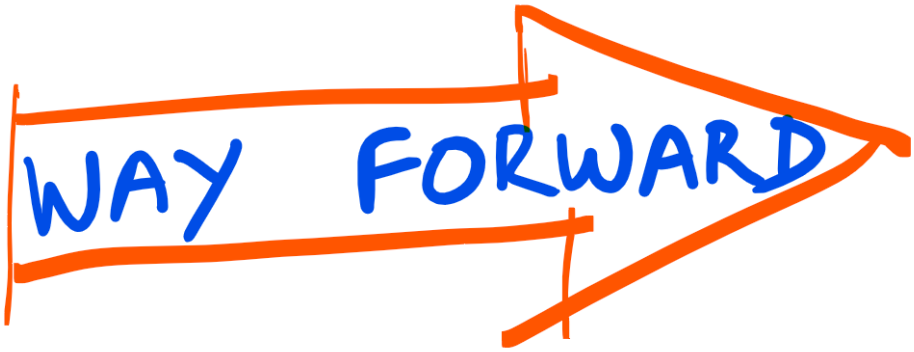

This project started as one to increase awareness and start conversations on a highly tabooed topic in clinical medicine. It feels almost paradoxical that a person who chose an alternate route rather than medicine should be taking up this cause, but my pulpit on the periphery of clinical medicine lets me bring it up without worrying about my clinical practice or professional reputation. There were a number of critical challenges we identified with burnout and well-being in India:

- The stigma associated with it within and outside the medical fraternity
- The inability to thus far quantify the perils of physician burnout (Largely been a subjective phenomenon so far)
- The erroneous focus on only the individual rather than the entire system

The USA, Australia and Europe have all accepted that they lie in the midst of a physician burnout crisis. However, none of the medical systems is rushing to fix the problem. Besides the obvious deleterious effects that this can have on personal health, family well-being and patient outcomes, an equally important consideration is a tremendous financial loss for any medical practice or healthcare system. However, in a country already struggling to cope with a severe supply-demand issue in healthcare delivery can we afford to add further obstacles in the race towards improving access and quality of healthcare in India?

The vision of this entire project is to tackle physician burnout at a systemic level. Mindfulness, yoga and other tactics work wonderfully well on an individual level but to achieve scale and sustainability, changes in policy, mind-set and behaviour are necessary. If pilots are not allowed to operate heavy machinery and fly passengers due to 'Pilot Fatigue', how are physicians and surgeons expected to maintain the quality of care after never-ending unearthly hours on the hospital floor? There is no quick fix but one step at a time we hope to make clinical care a profession that is respected and sustainable. Initiatives such as –'EM minds', a collaboration between EMA and IPS is a step in the right direction.

Burnt out physicians can seek greener pastures elsewhere, cut back on the number of patients seen, continue to trudge on while suffering terribly with low productivity or, as I did, quit clinical medicine altogether. All these have significant costs, be it for the hospital/provider, the system, the patient and/or the practitioner. There are short and long term interventions that we have detailed and are currently being executed with various partners across the country. Each and every author in this book is fighting relentlessly to help tackle this deeply ingrained issue.

I did not see the same enamour, nor felt the passion that my peers felt in treating patients. It felt unfair to pursue this honourable profession without the right bent of mind, and that lead me to explore avenues outside of clinical practice. I have still remained deeply rooted in healthcare having worked in pharmaceuticals, medical devices, digital health, medical innovation and medical writing. There are various ways to contribute toward the eventual goal of improving healthcare outcomes in India, and I take it upon myself to help those who have the same vision but search for alternative routes to reach that destination. Through my website, doctorness.com, I run a project called 'The Career Cell' to provide tools and career counselling to those who after their medical degree chose to look at alternate avenues other than clinical practice to contribute to the goal of value-based healthcare in India.

PATIENT'S PERSPECTIVE

K. Laxmi Manjesh,
(Patient's wife)

When a patient is in deep distress, so are his/her family members. I have had to take my husband, who was a cancer patient, to the ED four times in the past two years. On each of these occasions, both my husband and I were well taken care of by the ED team. Although my husband was being treated in cancer speciality hospitals for his main treatment, there were times when he was in need of emergency medical support due to sudden infections and uncontrollable bleeding.

Sometimes my husband had to be taken on a stretcher, on other occasions, he was well enough to be taken in a wheelchair. The ED was well equipped with both these facilities, and we were provided reliable assistance by the staff. The residents then collected previous medical records and inquired about the current medical condition and quickly got into action. If need be, they took advice from their seniors. After preliminary investigations and treatment, they would inform the concerned specialist doctors. Depending on the nature of advice, the patient was either kept for observation in the yellow zone, taken to a ward for further treatment, or discharged. Throughout this time, one family member was allowed to be around the patient and was kept informed about the progress of the treatment. The patient was in safe hands through this time as there was a clear chain of command, and a team of dedicated doctors and nurses, who monitored the patient round the clock.

However, despite these positive aspects about the emergency department, I have a few concerns as well. My main concern is that there is a lot of chaos inside the ED. Although this is to be expected given the situation for multiple patients, in times of deep distress, this causes additional anxiety to patients and their attendants. Sometimes, more than one attendant per patient is allowed inside the unit, and this not only increases chaos but may also expose delicate patients to infections. Further, at times, there is a communication gap between various doctors, nurses and family members, requiring the patient or their attendant to explain the same problem over and over again, which proves to be irksome. I also feel that it might be better for the morale of the patient if difficult diagnosis is not revealed to them immediately and routinely in the stressful setting of the emergency ward, instead waiting to let them know when they are out of the emergency ward or allowing the attendants to do so, or to do so more sensitively. Another additional stress is that the attendant is required to procure medicines from the pharmacy which is common to inpatients and outpatients and is hence always time-consuming. It might be useful to have a dedicated pharmacy for the emergency department or at least a separate queue in the existing one. It might also be a small but significant step to draw curtains around patients at all times in order to protect their privacy and to ensure that they do not have to see each other's suffering.

To conclude, the ED is a reliable place for emergency medical conditions. Although there is scope for improvement, I am confident that in time, my concerns will be addressed.

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