

# Personal Growth Feeds Professional Development

Physicians—surrounded by patients who present with interesting problems and colleagues who challenge them to deliver the highest quality of care—have the opportunity for personal growth on a daily basis.

## Fast Facts

- ▲ *A study conducted at the University of Michigan Health System revealed that physicians are more likely to experience burnout due to lack of control over their work hours and schedule than from other difficulties and challenges. Page 36*
- ▲ *According to the American College of Physicians, physicians who attend meetings and network with their peers report that they come away feeling refreshed, invigorated, and motivated to put what they've learned into practice. Page 36*
- ▲ *Career coaches recommend keeping a record of how each hour is spent during a week, then analyzing the log to see whether the time devoted to each activity reflects its value in your life. Page 40*

As recently as two decades ago, most physicians typically completed training, joined or opened a practice, established themselves professionally, stayed put for a long time, and then retired—satisfied, respected, often with a tidy nest egg. Some physicians still follow this pattern, but they are becoming fewer. Today it's not unusual for physicians to have several jobs or practices over the course of a career, to work in non-traditional settings, or even to change careers entirely.

Television medical dramas would have their viewers believe that life as a doctor is just one day of excitement after another.



Sleep the night.

Seize the day.

LUNESTA—  
Helps your patients  
with insomnia  
sleep through the night...  
for a fresh start

A better tomorrow  
begins tonight

Lunesta<sup>®</sup>  
(eszopiclone)<sub>hcl</sub>  
1, 2 AND 3 MG TABLETS

LUNESTA is indicated for the treatment of insomnia. In controlled outpatient and sleep laboratory studies, LUNESTA administered at bedtime decreased sleep latency and improved sleep maintenance.

#### Important Safety Information

LUNESTA, like other hypnotics, has CNS-depressant effects. Because of the rapid onset of action, LUNESTA should only be ingested immediately prior to going to bed or after the patient has gone to bed and has experienced difficulty falling asleep. Patients should not take LUNESTA unless they are prepared to get a full night's sleep. As with other hypnotics, patients receiving LUNESTA should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination (eg, operating machinery or driving a motor vehicle) after ingesting the drug, including potential impairment of the performance of such activities that may occur the day following ingestion of LUNESTA. In clinical trials, the most common adverse events associated with LUNESTA were unpleasant taste, headache, somnolence, dizziness, dry mouth, infection, and pain.

LUNESTA has been classified as a Schedule IV controlled substance. Sedative hypnotics have produced withdrawal signs and symptoms following abrupt discontinuation. The risk of abuse and dependence increases with the dose and duration of treatment and concomitant use of other psychoactive drugs. The risk is also greater for patients who have a history of alcohol or drug abuse or history of psychiatric disorders. These patients should be under careful surveillance when receiving LUNESTA or any other hypnotic. Sedative/hypnotic drugs should be administered with caution to patients exhibiting signs and symptoms of depression. Suicidal tendencies may be present in such patients, and protective measures

may be required. Intentional overdose is more common in this group of patients; therefore, the least amount of drug that is feasible should be prescribed for the patient at any one time.

Coadministration of eszopiclone 3 mg and olanzapine 10 mg produced a decrease in DSST scores. The interaction was pharmacodynamic; there was no alteration in the pharmacokinetics of either drug. Coadministration of eszopiclone 3 mg to subjects receiving ketoconazole 400 mg resulted in a 2.2-fold increase in exposure to eszopiclone, but no impact on drug levels of ketoconazole.

Impaired motor and/or cognitive performance after repeated exposure or unusual sensitivity to sedative/hypnotic drugs is a concern in the treatment of elderly and/or debilitated patients. The recommended starting dose of LUNESTA for these patients is 1 mg.

As with all sedative/hypnotic drugs, somnambulism (sleepwalking), including eating or driving while not fully awake, with amnesia for the event, has been reported. Additionally, rare cases of severe allergic reactions have been reported. Patients who report these events should discontinue treatment and should not be rechallenged with the drug.

The failure of insomnia to remit after 7 to 10 days of treatment should be medically evaluated.

*Please see brief summary of complete prescribing information.*

# Lunesta®

(eszopiclone) c

1, 2 AND 3 MG TABLETS

## BRIEF SUMMARY

### INDICATIONS AND USAGE

LUNESTA is indicated for the treatment of insomnia. In controlled outpatient and sleep laboratory studies, LUNESTA administered at bedtime decreased sleep latency and improved sleep maintenance.

### CONTRAINDICATIONS

None known.

### WARNINGS

Because sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Worsening of insomnia or the emergence of new thinking or behavior abnormalities may be the consequence of an unrecognized psychiatric or physical disorder. Such findings have emerged during the course of treatment with sedative/hypnotic drugs, including LUNESTA. Because some of the important adverse effects of LUNESTA appear to be dose-related, it is important to use the lowest possible effective dose, especially in the elderly (see **DOSE AND ADMINISTRATION in the Full Prescribing Information**).

A variety of abnormal thinking and behavior changes have been reported to occur in association with the use of sedative/hypnotics. Some of these changes may be characterized by decreased inhibition (e.g., aggressiveness and extroversion that seem out of character), similar to effects produced by alcohol and other CNS depressants. Other reported behavioral changes have included bizarre behavior, agitation, hallucinations, and depersonalization. Complex behaviors such as "sleep-driving" (i.e., driving while not fully awake after ingestion of a sedative-hypnotic with amnesia for the event) have been reported. These events can occur in sedative-hypnotic-naïve as well as in sedative-hypnotic-experienced persons. Although behaviors such as sleep-driving may occur with LUNESTA alone at therapeutic doses, the use of alcohol and other CNS depressants with LUNESTA appears to increase the risk of such behaviors, as does the use of LUNESTA at doses exceeding the maximum recommended dose. Due to the risk to the patient and the community, discontinuation of LUNESTA should be strongly considered for patients who report a "sleep-driving" episode. Other complex behaviors (e.g., preparing and eating food, making phone calls, or having sex) have been reported in patients who are not fully awake after taking a sedative-hypnotic. As with sleep-driving, patients usually do not remember these events. Amnesia and other neuropsychiatric symptoms may occur unpredictably. In primarily depressed patients, worsening of depression, including suicidal thinking, has been reported in association with the use of sedative/hypnotics.

It can rarely be determined with certainty whether a particular instance of the abnormal behaviors listed above are drug-induced, spontaneous in origin, or a result of an underlying psychiatric or physical disorder. Nonetheless, the emergence of any new behavioral sign or symptom of concern requires careful and immediate evaluation.

Following rapid dose decrease or abrupt discontinuation of the use of sedative/hypnotics, there have been reports of signs and symptoms similar to those associated with withdrawal from other CNS-depressant drugs (see **DRUG ABUSE AND DEPENDENCE**).

LUNESTA, like other hypnotics, has CNS-depressant effects. Because of the rapid onset of action, LUNESTA should only be instated immediately prior to going to bed or after the patient has gone to bed and has experienced difficulty falling asleep. Patients receiving LUNESTA should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination (e.g., operating machinery or driving a motor vehicle) after ingesting the drug, and be cautioned about potential impairment of the performance of such activities on the day following ingestion of LUNESTA. LUNESTA, like other hypnotics, may produce additive CNS-depressant effects when coadministered with other psychotropic medications, anticonvulsants, antihistamines, ethanol, and other drugs that themselves produce CNS depression. LUNESTA should not be taken with alcohol. Dose adjustment may be necessary when LUNESTA is administered with other CNS-depressant agents, because of the potentially additive effects.

### Severe Anaphylactic and Anaphylactoid Reactions

Rare cases of angioedema involving the tongue, glottis or larynx have been reported in patients after taking the first or subsequent doses of sedative-hypnotics, including LUNESTA. Some patients have had additional symptoms such as dyspnea, throat closing, or nausea and vomiting that suggest anaphylaxis. Some patients have required medical therapy in the emergency department. If angioedema involves the tongue, glottis or larynx, airway obstruction may occur and be fatal. Patients who develop angioedema after treatment with LUNESTA should not be rechallenged with the drug.

### PRECAUTIONS

#### General

**Timing of Drug Administration:** LUNESTA should be taken immediately before bedtime. Taking a sedative/hypnotic while still up and about may result in short-term memory impairment, hallucinations, impaired coordination, dizziness, and lightheadedness.

**Use in the Elderly and/or Debilitated Patients:** Impaired motor and/or cognitive performance after repeated exposure or unusual sensitivity to sedative/hypnotic drugs is a concern in the treatment of elderly and/or debilitated patients. The recommended starting dose of LUNESTA for these patients is 1 mg (see **DOSE AND ADMINISTRATION in the Full Prescribing Information**).

**Use in Patients With Concomitant Illness:** Clinical experience with eszopiclone in patients with concomitant illness is limited. Eszopiclone should be used with caution in patients with diseases or conditions that could affect metabolism or hemodynamic responses.

A study in healthy volunteers did not reveal respiratory-depressant effects at doses 2.5-fold higher (7 mg) than the recommended dose of eszopiclone. Caution is advised, however, if LUNESTA is prescribed to patients with compromised respiratory function.

The dose of LUNESTA should be reduced to 1 mg in patients with severe hepatic impairment, because systemic exposure is doubled in such subjects. No dose adjustment appears necessary for subjects with mild or moderate hepatic impairment. No dose adjustment appears necessary in subjects with any degree of renal impairment, since less than 10% of eszopiclone is excreted unchanged in the urine.

The dose of LUNESTA should be reduced in patients who are administered potent inhibitors of CYP3A4, such as ketoconazole, while taking LUNESTA. Downward dose adjustment is also recommended when LUNESTA is administered with agents having known CNS-depressant effects.

**Use in Patients With Depression:** Sedative/hypnotic drugs should be administered with caution to patients exhibiting signs and symptoms of depression. Suicidal tendencies may be present in such patients, and protective measures may be required. Intentional overdose is more common in this group of patients; therefore, the least amount of drug that is feasible should be prescribed for the patient at any one time.

**Information For Patients:** Patient information is printed in the complete prescribing information.

### SPECIAL CONCERNS "Sleep-Driving" and other complex behaviors

There have been reports of people getting out of bed after taking a sedative-hypnotic and driving their cars while not fully awake, often with no memory of the event. If a patient experiences such an episode, it should be reported to his or her doctor immediately, since "sleep-driving" can be dangerous. This behavior is more likely to occur when LUNESTA is taken with alcohol or other central nervous system depressants (see **WARNINGS**). Other complex behaviors (e.g., preparing and eating food, making phone calls, or having sex) have been reported in patients who are not fully awake after taking a sedative-hypnotic. As with sleep-driving, patients usually do not remember these events.

**Laboratory Tests:** There are no specific laboratory tests recommended.

### Drug Interactions

#### CNS-Active Drugs

**Ethanol:** An additive effect on psychomotor performance was seen with coadministration of eszopiclone and ethanol 0.70 g/kg for up to 4 hours after ethanol administration.

**Paroxetine:** Coadministration of single doses of eszopiclone 3 mg and paroxetine 20 mg daily for 7 days produced no pharmacokinetic or pharmacodynamic interaction.

**Lorazepam:** Coadministration of single doses of eszopiclone 3 mg and lorazepam 2 mg did not have clinically relevant effects on the pharmacodynamics or pharmacokinetics of either drug.

**Olanzapine:** Coadministration of eszopiclone 3 mg and olanzapine 10 mg produced a decrease in DSST scores. The interaction was pharmacodynamic; there was no alteration in the pharmacokinetics of either drug.

**Drugs That Inhibit CYP3A4 (Ketoconazole):** CYP3A4 is a major metabolic pathway for elimination of eszopiclone. The AUC of eszopiclone was increased 2.2-fold by coadministration of ketoconazole, a potent inhibitor of CYP3A4, 400 mg daily for 5 days.  $C_{max}$  and  $t_{1/2}$  were increased 1.4-fold and 1.3-fold, respectively. Other strong inhibitors of CYP3A4 (e.g., itraconazole, clarithromycin, nefazodone, troleanandomycin, ritonavir, neflavinir) would be expected to behave similarly.

**Drugs That Induce CYP3A4 (Rifampicin):** Racemic zopiclone exposure was decreased 80% by concomitant use of rifampicin, a potent inducer of CYP3A4. A similar effect would be expected with eszopiclone.

**Drugs Highly Bound to Plasma Protein:** Eszopiclone is not highly bound to plasma proteins (52-59% bound); therefore, the disposition of eszopiclone is not expected to be sensitive to alterations in protein binding. Administration of eszopiclone 3 mg to a patient taking another drug that is highly protein-bound would not be expected to cause an alteration in the free concentration of either drug.

#### Drugs With A Narrow Therapeutic Index

**Digoxin:** A single dose of eszopiclone 3 mg did not affect the pharmacokinetics of digoxin measured at steady state following dosing of 0.5 mg twice daily for one day and 0.25 mg daily for the next 6 days.

**Warfarin:** Eszopiclone 3 mg administered daily for 5 days did not affect the pharmacokinetics of (R)- or (S)-warfarin, nor were there any changes in the pharmacodynamic profile (prothrombin time) following a single 25-mg oral dose of warfarin.

### Carcinogenesis, Mutagenesis, Impairment of Fertility

**Carcinogenesis:** In a carcinogenicity study in Sprague-Dawley rats in which eszopiclone was given by oral gavage, no increases in tumors were seen; plasma levels (AUC) of eszopiclone at the highest dose used in this study (116 mg/kg/day) are estimated to be 80 (females) and 20 (males) times those in humans receiving the maximum recommended human dose (MRHD). However, in a carcinogenicity study in Sprague-Dawley rats in which racemic zopiclone was given in the diet, and in which plasma levels of eszopiclone were reached that were greater than those reached in the above study of eszopiclone, an increase in mammary gland adenocarcinomas in females and an increase in thyroid gland follicular cell adenomas and carcinomas in males were seen at the highest dose of 100 mg/kg/day. Plasma levels of eszopiclone at this dose are estimated to be 150 (females) and 70 (males) times those in humans receiving the MRHD. The mechanism for the increase in mammary adenocarcinomas is unknown. The increase in thyroid tumors is thought to be due to increased levels of TSH secondary to increased metabolism of circulating thyroid hormones, a mechanism that is not considered to be relevant to humans.

In a carcinogenicity study in B6C3F1 mice in which racemic zopiclone was given in the diet, an increase in pulmonary carcinomas and carcinomas plus adenomas in females and an increase in skin fibromas and sarcomas in males were seen at the highest dose of 100 mg/kg/day. Plasma levels of eszopiclone at this dose are estimated to be 8 (females) and 20 (males) times those in humans receiving the MRHD. The skin tumors were due to skin lesions induced by aggressive behavior, a mechanism that is not relevant to humans. A carcinogenicity study was also performed in which CD-1 mice were given eszopiclone at doses up to 100 mg/kg/day by oral gavage; although this study did not reach a maximum tolerated dose, and was thus inadequate for overall assessment of carcinogenic potential, no increases in either pulmonary or skin tumors were seen at doses producing plasma levels of eszopiclone estimated to be 90 times those in humans receiving the MRHD—i.e., 12 times the exposure in the racemate study.

Eszopiclone did not increase tumors in a p53 transgenic mouse bioassay at oral doses up to 300 mg/kg/day.

**Mutagenesis:** Eszopiclone was positive in the mouse lymphoma chromosomal aberration assay and produced an equivocal response in the Chinese hamster ovary cell chromosomal aberration assay. It was not mutagenic or clastogenic in the bacterial Ames gene mutation assay, in an unscheduled DNA synthesis assay, or in an *in vivo* mouse marrow micronucleus assay.

(S)-N-desmethylozanapine, a metabolite of eszopiclone, was positive in the Chinese hamster ovary cell and human lymphocyte chromosomal aberration assays. It was negative in the bacterial Ames mutagenicity assay, in an *in vitro* <sup>32</sup>P-postlabeling DNA adduct assay, and in an *in vivo* mouse marrow chromosomal aberration and micronucleus assay.

**Impairment Of Fertility:** Eszopiclone was given by oral gavage to male rats at doses up to 45 mg/kg/day from 4 weeks pre-mating through mating and to female rats at doses up to 180 mg/kg/day from 2 weeks pre-mating through day 7 of pregnancy. An additional study was performed in which only females were treated, up to 180 mg/kg/day. Eszopiclone decreased fertility, probably because of effects in both males and females, with no females becoming pregnant when both males and females were treated with the highest dose; the no-effect dose in both sexes was

5 mg/kg (16 times the MRHD on a mg/m<sup>2</sup> basis). Other effects included increased preimplantation loss (no-effect dose 25 mg/kg), abnormal estrus cycles (no-effect dose 25 mg/kg), and decreases in sperm number and motility and increases in morphologically abnormal sperm (no-effect dose 5 mg/kg).

#### Pregnancy

**Pregnancy Category C:** Eszopiclone administered by oral gavage to pregnant rats and rabbits during the period of organogenesis showed no evidence of teratogenicity up to the highest doses tested (250 and 116 mg/kg/day in rats and rabbits, respectively; these doses are 800 and 100 times, respectively, the maximum recommended human dose [MRHD] on a mg/m<sup>2</sup> basis). In the rat, significant reductions in fetal weight and evidence of developmental delay were seen at maternally toxic doses of 125 and 150 mg/kg/day, but not at 62.5 mg/kg/day (20 times the MRHD on a mg/m<sup>2</sup> basis). Eszopiclone was also administered by oral gavage to pregnant rats throughout the pregnancy and lactation periods at doses of up to 180 mg/kg/day. Increased post-implantation loss, decreased postnatal pup weights and survival, and increased pup sternal resorption were seen at all doses; the lowest dose tested, 60 mg/kg/day, is 200 times the MRHD on a mg/m<sup>2</sup> basis. These doses did not produce significant maternal toxicity. Eszopiclone had no effects on other behavioral measures or reproductive function in the offspring.

There are no adequate and well-controlled studies of eszopiclone in pregnant women. Eszopiclone should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Labor And Delivery:** LUNESTA has no established use in labor and delivery.

**Nursing Mothers:** It is not known whether LUNESTA is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when LUNESTA is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness of eszopiclone in children below the age of 18 have not been established.

**Geriatric Use:** A total of 287 subjects in double-blind, parallel-group, placebo-controlled clinical trials who received eszopiclone were 65 to 86 years of age. The overall pattern of adverse events for elderly subjects (mean age = 71 years) in 2-week studies with nightly dosing of 2 mg eszopiclone was not different from that seen in younger adults. LUNESTA 2 mg exhibited significant reduction in sleep latency and improvement in sleep maintenance in the elderly population.

#### ADVERSE REACTIONS

The premarketing development program for LUNESTA included eszopiclone exposures in patients and/or normal subjects from two different groups of studies: approximately 400 normal subjects in clinical pharmacology/pharmacokinetic studies, and approximately 1500 patients in placebo-controlled clinical effectiveness studies, corresponding to approximately 263 patient-exposure years. The conditions and duration of treatment with LUNESTA varied greatly and included (in overlapping categories) open-label and double-blind phases of studies, inpatients and outpatients, and short-term and longer-term exposure. Adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tabulations that follow, COSTART terminology has been used to classify reported adverse events.

The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while the patient was receiving therapy following baseline evaluation.

#### Adverse Findings Observed in Placebo-Controlled Trials

**Adverse Events Resulting in Discontinuation of Treatment:** In placebo-controlled, parallel-group clinical trials in the elderly, 3.8% of 2007 patients who received placebo, 2.3% of 215 patients who received 2 mg LUNESTA, and 1.4% of 72 patients who received 1 mg LUNESTA discontinued treatment due to an adverse event. In the 6-week parallel-group study in adults, no patients in the 3 mg arm discontinued because of an adverse event. In the long-term 6-month study in adult insomnia patients, 7.2% of 195 patients who received placebo and 12.8% of 593 patients who received 3 mg LUNESTA discontinued due to an adverse event. No event that resulted in discontinuation occurred at a rate of greater than 2%.

**Adverse Events Observed at an Incidence of ≥2% in Controlled Trials.** The following lists the incidence (% placebo, 2 mg, 3 mg, respectively) of treatment-emergent adverse events from a Phase 3 placebo-controlled study of LUNESTA at doses of 2 or 3 mg in non-elderly adults. Treatment duration in this trial was 44 days. Data are limited to adverse events that occurred in 2% or more of patients treated with LUNESTA 2 mg (n=104) or 3 mg (n=105) in which the incidence in patients treated with LUNESTA was greater than the incidence in placebo-treated patients (n=90).

**Body as a whole:** headache (13%, 21%, 17%), viral infection (1% or 3%), **Digestive system:** dry mouth (3%, 5%, 7%), dyspepsia (4%, 4%, 5%), nausea (4%, 5%, 4%), vomiting (1%, 3%), **Nervous system:** anxiety (0%, 3%, 1%), confusion (0%, 0%, 3%), depression (0%, 4%, 1%), dizziness (4%, 5%, 7%), hallucinations (0%, 1%, 3%), libido decreased (0%, 0%, 3%), nervousness (3%, 5%, 0%), somnolence (3%, 10%, 8%), **Respiratory system:** infection (3%, 5%, 10%), **Skin and appendages:** rash (1%, 3%, 4%), **Special senses:** unpleasant taste (3%, 17%, 3%), **Urogenital system:** dysmenorrhea\* (0%, 3%, 0%), gynecostasia\*\* (0%, 3%, 0%).

\*Gender-specific adverse event in females

\*\*Gender-specific adverse event in males

Events for which the LUNESTA incidence was equal to or less than placebo are not listed, but included the following: abnormal dreams, accidental injury, back pain, diarrhea, flu syndrome, myalgia, pain, pharyngitis, and rhinitis.

Adverse events that suggest a dose-response relationship in adults include viral infection, dry mouth, dizziness, hallucinations, infection, rash, and unpleasant taste, with this relationship clearest for unpleasant taste.

The following lists the incidence (% placebo, 1 mg, 2 mg, respectively) of treatment-emergent adverse events from combined Phase 3 placebo-controlled studies of LUNESTA at doses of 1 or 2 mg in elderly adults (ages 65-86). Treatment duration in these trials was 14 days. Data are limited to events that occurred in 2% or more of patients treated with LUNESTA 1 mg (n=72) or 2 mg (n=215) in which the incidence in patients treated with LUNESTA was greater than the incidence in placebo-treated patients.<sup>1</sup>

**Body as a whole:** accidental injury (1%, 0%, 3%), headache (14%, 15%, 13%), pain (2%, 4%, 5%), **Digestive system:** diarrhea (2%, 4%, 2%), dry mouth (2%, 3%, 7%), dyspepsia (2%, 6%, 2%), **Nervous system:** abnormal dreams (0%, 3%, 1%), dizziness (2%, 1%, 6%), nervousness (1%, 0%, 2%), neuralgia (0%, 3%, 0%), **Skin and appendages:** pruritus (1%, 4%, 1%), **Special senses:** unpleasant taste (0%, 8%, 12%), **Urogenital system:** urinary tract infection (0%, 3%, 0%).

Events for which the LUNESTA incidence was equal to or less than placebo are not listed, but included the following: abdominal pain, asthenia, nausea, rash, and somnolence.

Adverse events that suggest a dose-response relationship in elderly adults include pain, dry mouth, and unpleasant taste, with this relationship again clearest for unpleasant taste. These figures cannot be used to predict the incidence of adverse events in the course of usual medical practice because patient characteristics and other factors may differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators.

The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contributions of drug and non-drug factors to the adverse event incidence rate in the population studied.

**Other Events Observed During The Premarketing Evaluation Of LUNESTA.** Following is a list of modified COSTART terms that reflect treatment-emergent adverse events as defined in the introduction to the **ADVERSE REACTIONS** section and reported by approximately 1500 subjects treated with LUNESTA at doses in the range of 1 to 3.5 mg/day during Phase 2 and 3 clinical trials throughout the United States and Canada. All reported events are included except those already listed here or listed elsewhere in labeling, minor events common in the general population, and events unlikely to be drug-related. Although the events reported occurred during treatment with LUNESTA, they were not necessarily caused by it.

Events are listed in order of decreasing frequency according to the following definitions: **requent** adverse events are those that occurred on one or more occasions in at least 1/100 patients; **infrequent** adverse events are those that occurred in fewer than 1/100 patients but in at least 1/1,000 patients; **rare** adverse events are those that occurred in fewer than 1/1,000 patients. Gender-specific events are categorized based on their incidence for the appropriate gender.

**Frequent:** chest pain, migraine, peripheral edema.

**Infrequent:** acne, agitation, allergic reaction, alopecia, amenorrhea, anemia, anorexia, arthralgia, arthritis, asthma, ataxia, breast engorgement, breast enlargement, breast neoplasm, breast pain, bronchitis, bursitis, cellulitis, cholelithiasis, conjunctivitis, contact dermatitis, cystitis, dry eyes, dry skin, dyspnea, dizziness, eczema, ear pain, emotional lability, epistaxis, face edema, female lactation, fever, haitosis, heat stroke, hematuria, hernia, hiccup, hostility, hypercholesterolemia, hypertension, hypertonnia, hypesthesia, incoordination, increased appetite, insomnia, joint disorder (mainly swelling, stiffness, and pain), kidney calculus, kidney pain, laryngitis, leg cramps, lymphadenopathy, malaise, menses, melena, memory impairment, menorrhagia, metrorrhagia, mouth ulceration, myasthenia, neck rigidity, neuritis, nystagmus, otitis externa, otitis media, parasthesia, photosensitivity, reflexes decreased, skin discoloration, sweating, thinking abnormal (mainly difficulty concentrating), thirst, tinnitus, twitching, ulcerative stomatitis, urinary frequency, urinary incontinence, urticaria, uterine hemorrhage, vaginal hemorrhage, vaginitis, vertigo, vestibular disorder, weight gain, weight loss.

**Rare:** abnormal gait, arthralgia, colitis, delirium, dysphagia, erythema multiforme, euphoria, furunculosis, gastritis, gout, hepatitis, hepatomegaly, herpes zoster, hirsutism, hyperacusis, hyposthesia, hypokalemia, hypokinesia, hypokinesia, iritis, liver damage, maculopapular rash, mydriasis, myopathy, neuritis, neuropathy, oliguria, photophobia, ptoxis, pyelonephritis, rectal hemorrhage, stomach ulcer, stomatitis, stupor, thrombophlebitis, tongue edema, tremor, urethritis, vesiculobullous rash.

#### DRUG ABUSE AND DEPENDENCE

**Controlled Substance Class:** LUNESTA is a Schedule IV controlled substance under the Controlled Substances Act. Other substances under the same classification are benzodiazepines and the nonbenzodiazepine hypnotics zaleplon and zolpidem. While eszopiclone is a hypnotic agent with a chemical structure unrelated to benzodiazepines, it shares some of the pharmacologic properties of these benzodiazepines.

#### Abuse, Dependence, and Tolerance

**Abuse and Dependence:** In a study of abuse liability conducted in individuals with known histories of benzodiazepine abuse, eszopiclone at doses of 6 and 12 mg produced euphoric effects similar to those of diazepam 20 mg. In this study, at doses 2-fold or greater than the maximum recommended doses, a dose-related increase in reports of amnesia and hallucinations was observed for both LUNESTA and diazepam.

The clinical trial experience with LUNESTA revealed no evidence of a serious withdrawal syndrome. Nevertheless, the following adverse events included in DSM-IV criteria for uncomplicated sedative/hypnotic withdrawal were reported during clinical trials following placebo substitution occurring within 48 hours following the last LUNESTA treatment: anxiety, abnormal dreams, nausea, and upset stomach. These withdrawal events occurred in less than 2% of patients. Use of benzodiazepines and other CNS depressants may lead to physical and psychological dependence. The risk of abuse and dependence increases with the dose and duration of treatment and concomitant use of other psychoactive drugs. The risk is also greater for patients who have a history of alcohol or drug abuse or history of psychiatric disorders. These patients should be under careful surveillance when receiving LUNESTA or any other hypnotic.

**Tolerance:** Some loss of efficacy to the hypnotic effect of benzodiazepines and benzodiazepine-like agents may develop after repeated use of these drugs for a few weeks.

No development of tolerance to any parameter of sleep measurement was observed over six months. Tolerance to the efficacy of LUNESTA 3 mg was assessed by 4-week objective and 6-week subjective measurements of time to sleep onset and sleep maintenance for LUNESTA in a placebo-controlled 44-day study, and by subjective assessments of time to sleep onset and WASO in a placebo-controlled study for 6 months.

#### OVERDOSAGE

The limited premarketing clinical experience with the effects of an overdose of LUNESTA. In clinical trials with eszopiclone, one case of overdose with up to 36 mg of eszopiclone was reported in which the subject fully recovered. Individuals have fully recovered from racemic zopiclone overdoses up to 340 mg (56 times the maximum recommended dose of eszopiclone).

**Signs And Symptoms:** Signs and symptoms of overdose effects of CNS depressants can be expected to present as exaggerations of the pharmacological effects noted in preclinical testing. Impairment of consciousness ranging from somnolence to coma has been described. Rare individual instances of fatal outcomes following overdose with racemic zopiclone have been reported in European postmarketing reports, most often associated with overdose with other CNS-depressant agents.

**Recommended Treatment:** General symptomatic and supportive measures should be used along with immediate gastric lavage where appropriate. Intravenous fluids should be administered as needed. Flumazenil may be useful. As in all cases of drug overdose, respiration, pulse, blood pressure, and other appropriate signs should be monitored and general supportive measures employed. Hypotension and CNS depression should be monitored and treated by appropriate medical intervention. The value of dialysis in the treatment of overdose has not been determined.

**Poison Control Center:** As with the management of all overdoses, the possibility of multiple drug ingestion should be considered. The physician may wish to consider contacting a poison control center for up-to-date information on the management of hypnotic drug product overdose.

Rx only.



April 2007

But physicians who have been at it for a while know that even the most interesting work can become routine over the course of time. How can physicians stay motivated, fresh, and energized about practicing medicine? Identifying what you want out of medicine—and what you don't—can help a lot.

While physicians usually understand the value of professional development—keeping up with medical breakthroughs and scientific discoveries—what may not be as clear is the effect of *personal* growth and development on success in their chosen field. Personal development is important for physicians who want to have a fulfilling career that is also part of a satisfying and meaningful life.

### The Control Factor

Enthusiasm for personal development tends to ebb and flow. Personal growth spurts are most likely to occur during times of transition, stress, or change—times when the physician may not have as much control as he or she wishes.

“Most of us [physicians] are highly controlling,” says Peter Moskowitz, MD. Dr. Moskowitz is a career and life coach for physicians and Founder and Executive Director of the Center for Professional and Personal Renewal in Palo Alto, Calif. He is also a practicing radiologist and clinical professor at Stanford University School of Medicine. “Because we [physicians] tend to feel uncomfortable in situations where we cannot anticipate the outcome, many of us won't even start a new activity unless we can predict whether we'll succeed or not,” he says. This risk-averse approach can be quite limiting.

Dr. Moskowitz advises physicians to establish a career plan, set goals, pursue their dreams, and hold themselves accountable as they move forward. At the same time, he says, they should remain flexible. That can be a tall order.

While there are no hard statistics available on how many physicians are opting out of clinical medicine and why they are doing so, the reasons seem connected, in one way or another, to regaining control. “Having everyone tell them how to practice, having their practices under a microscope, and all sorts of external reviews. . . this becomes trying and leads to quicker burnout,” says Patrick C. Alguire, MD, FACP, Director of Edu-

cation and Career Development at the American College of Physicians (ACP).

## Values Exercise

Are you spending your precious time in a way that is in alignment with your most closely held values? What motivates you? What drives you to live with purpose and passion? To help answer these questions, try this simple values exercise. First, read through all the words below. Note that some are similar. Circle 10 things that you want in your life—either those that you already have and wish to maintain, or that you don't have but would like to gain.

Accomplishment	Health/fitness/ exercise	Presence
Adventure	Hobbies	Productivity
Authenticity	Home	Purpose
Authority	Honesty	Recognition
Beauty/aesthetics	Humor	Relationships
Community	Independence	Religion
Consistency	Integrity	Research
Contribution	Intimacy	Risk taking
Control	Learning	Routine
Creativity	Leisure	Security
Education	Life balance	Serving others
Entrepreneurship	Love	Sexuality
Excellence	Marriage/ commitment	Simplicity
Excitement	Mentoring	Spirituality
Family	Money	Spontaneity
Financial freedom	Mystery	Success
Flexibility	Nurturing	Teaching
Friendships	Partnership	Teamwork
Fun	Peace	Tradition
Generosity	Personal growth	Travel
Goals	Personal safety	Trust
Good parenting	Power	Volunteering
Happiness		Wisdom

Now narrow the list to your five most important values. Then, if you can (and this isn't easy), choose the top two or three. This exercise should give you personal insight into what is most important in your life and in your work. Are you living your values?

A nationwide survey of 935 primary care physicians, surgeons, and obstetrician/gynecologists conducted by the University of Michigan supports this idea. The survey results, published in the April 2007 issue of the *Journal of Obstetrics & Gynecology*, revealed that physicians are more likely to experience burnout due to lack of control over their work hours and schedules than to other difficulties and challenges.

A healthy approach to professional and personal development, says Dr. Moskowitz, is to accept that not everything in life is controllable. He observes that “people who tend to be happier in their lives and in their careers have...a sense of trust that things happen for a reason, that it’s often not clear at the time why

### In It for the Long Haul: Avoiding Burnout

Much has been written about physician stress and burnout—recognizing the signs and symptoms; what to do about it; how to regroup, reassess, reevaluate and get back on track. But the best course is to avoid burnout in the first place. Here are some tips:

*Be clear about what you want.* Were you told early in your career that you must do research and publish in order to be a respected physician? Do these really interest you? If not, set them aside and focus on direct patient care as your calling. For some physicians, being an owner/partner in a group is the very definition of “success.” If you prefer to work per diem, part time, do locums, or change jobs several times over the course of your career, then do so.

*Teach and mentor.* “We hear from lots of physicians who teach—whether to medical students or residents—that teaching really helps them enjoy their careers,” says Patrick C. Alguire, MD, FACP, Director of Education and Career Development at the American College of Physicians. “They see teaching as an opportunity to give back to the profession, as a way to remember what it was like when they started. They feel good about what they offer the learners, and it forces them to keep up.” Dr. Alguire says there is no shortage of teaching opportunities for physicians who are interested. “Most medical schools and residency programs are begging for volunteers,” he says.

*Get out of the office.* According to the ACP, physicians who get out of their offices to attend meetings and network with their peers claim that they come away from those meetings refreshed, invigorated, and motivated to get back to their offices and put what they’ve learned into

something is happening, and that things tend to work out for the best. Our job,” continues Dr. Moskowitz, “is to go with the flow. That’s a difficult task for most physicians, myself included.”

In this case, “going with the flow” doesn’t denote a lackadaisical approach to life or practice. It means fitting one’s talents, skills, and creativity into the larger scheme of things.

Mihaly Csikszentmihalyi has become the authority on “flow.” In his book, *Finding Flow: The Psychology of Engagement with Everyday Life* (Basic Books, 1998, New York), the psychologist and author describes the flow state as when “a person faces a clear set of goals that require appropriate responses.” Imagine the perfect tennis match with an opponent whose skills are

practice. “Staying in medicine and not getting out and networking with like-minded physicians are probably detrimental to the 30-year career,” says Dr. Alguire.

*Stay positive.* Internist Timothy McNichols, MD, at Ferrell-Duncan Clinic in Springfield, Mo., has noticed that some doctors are always miserable, no matter where they work or what they’re doing. Dr. McNichols tries to avoid those doctors whenever possible. “Don’t surround yourself with unhappy people,” he says. Another tip: Dr. McNichols saves every thank-you note he’s received from his patients over the last seven years of practice. If he has a down day, he gets them out and reads them. “I don’t try to meet quotas or hang my hat on producing RVUs [Relative Value Units],” continues Dr. McNichols. “I focus intently on treating patients the way I’d want to be treated or have my family treated.”

*Take the lead.* Time is extremely valuable to physicians—there never seems to be enough of it—yet a study reported in the November 22/29, 2006, issue of *Journal of the American Medical Association* revealed that about 2/3 of all physicians who responded to the study had participated in at least one “public role” during the previous three years. The possibilities for leadership roles are nearly endless. You can coach your kid’s soccer team, volunteer at your church or temple, run for school board or city council, serve on your homeowner’s association board, or volunteer to help out at a charity event. Those who want to contribute within their career realm may want to take on a leadership position either within their own medical group or at their hospital.



equivalent to your own. Imagine playing a Beethoven sonata from beginning to end and feeling completely connected with the music and the instrument. With focused attention, a challenging task, and clear purpose, time seems to disappear. That's flow. Being in flow at all times throughout a busy day isn't possible. Mr. Csikszentmihalyi says in his book, "A typical day is full of anxiety and boredom. Flow experiences provide the flashes of intense living against this dull background." Simply noticing when you find yourself in a state of flow can be a step toward achieving it more frequently.

When Dr. Moskowitz works with physicians in his coaching practice, the concept of purpose is one of the early topics for discussion. "It's one of the first questions to come up, and invariably there is a pause because I've caught them off guard," says Dr. Moskowitz. Most physicians have not thought about their life purpose since they were quite young and deciding on a career path. When physicians do answer, says Dr. Moskowitz, the reply is likely to be either "to be the best doctor I can be" or "to help people." Dr. Moskowitz says those are good answers, but he wants clients to go deeper. "I ask them what it is about their work that vibrates in them, what gets them out of bed in the morning, and why it's important to them that they're doing what they're doing." Dr. Moskowitz adds that the answers to those questions get you closer to your true purpose.

What gives meaning and purpose to the practice of medicine? It's different for each physician. For one practitioner, being involved in cutting-edge research and publishing in prestigious medical journals may generate the spark. For another, developing close relationships with patients by providing continuous care makes the work rich and meaningful. For others, it may be the camaraderie of working with outstanding colleagues, the opportunity for community or political involvement, volunteering, or teaching and mentoring.

## **The Art of Work-life Balance**

Finding work-life balance is a challenge, and mastering it is an art. Here again, a sense of purpose can help. What are your priorities? Does your day-to-day schedule reflect those priorities?

Physicians in training and during the first decade of practice

are often juggling the obligations of young families as well as new careers. They're working hard to develop a practice, establish a reputation, and earn money to pay off student loans, buy first homes, and pay for childcare. Later in their careers, physi-

### Are You Working on Purpose?

For each of the statements below, rate how true it is for you. A "5" means you strongly agree that the statement describes you while a "1" means you strongly disagree.

Statement	Score
I wake up most Mondays feeling energized to go to work.	_____
I have deep energy—feel a personal calling—for my work.	_____
I am clear about how I measure my success as a person.	_____
I use my gifts to add real value to people's lives.	_____
I work with people who honor the values I value.	_____
I speak my truth in my work.	_____
I experience true joy in my work.	_____
I make a living doing what I most love to do.	_____
I speak my purpose in one clear sentence.	_____
I go to sleep most nights feeling that "this was a well-lived day."	_____
<b>Your total score</b>	_____

Tally your score to get an idea of whether you are working on purpose. The average score is 29. If you scored above 40, you're doing fine. If you scored below 20, consider doing some introspective work. To take this quiz online, or for a more complete analysis of your score, visit [www.inventuregroup.com](http://www.inventuregroup.com).

*Source: Working on Purpose Quiz from The Power of Purpose: Creating Meaning in Your Life and Work, by Richard J. Leider (Berrett-Koehler Publishers, 1997.) Reprinted with permission from the author.*

cians may find themselves wearing a different collection of hats: clinician, entrepreneur, committee member, department chair, or faculty member. No matter the career stage, the demands on physicians' time are great.

When his clients are struggling with time management and work-life balance issues, Dr. Moskowitz gives them a homework assignment. He asks clients to track all 168 hours in a week and then break them into categories. "Having to account for 168 hours and see them in chart form is an eye-opening experience," he says. "They discover they're sequestering time in areas where

### Add Purpose through Mentoring

Brian Sabowitz, MD, FACP, started mentoring medical students in his office each summer the year after he opened his internal medicine practice in Lake Havasu City, Ariz., a resort community about 3½ hours from Phoenix. He started because he remembered how important this type of experience was to him when he was in medical school at the University of New Mexico.

At that time, first-year students were required to spend eight weeks in a rural practice. "That was the most important eight weeks," says Dr. Sabowitz. "It helped guide me through the rest of medical school. I feel like I owe it to the students because [my own experience in medical school] had a huge impact on me."

Dr. Sabowitz enjoys starting each day over breakfast with the student he's mentoring. "Most of the time we talk about patients from the previous day," he says, adding that he not only teaches but also learns from the young medical students. "It's fun. You get to be an important person for this young kid so it's good for your ego," says Dr. Sabowitz. "But the more exciting thing is when the student comes to the table knowing more than you do about something."

Doctors considering having students rotate in their offices should know that it is a responsibility. Dr. Sabowitz points out that the students must be given tasks appropriate to their level of training, not just mundane duties. One-on-one teaching time is important, ideally with the student asking a lot of questions. This interaction, coupled with what the student learns in the exam room, makes for a rich learning experience.

"We have a responsibility to do this. These will be the kids deciding if we'll go into nursing homes or not," adds Dr. Sabowitz with a laugh.

they'd rather not be, and other areas where they'd like to be spending more time.

"Most physicians let life circumstances control them," Dr. Moskowitz explains. "They work until the work is done, regardless of the impact on their personal lives and families. After clarifying one's values, it becomes much easier to look objectively at the management of this precious resource," he says. Dr. Moskowitz calls this "values-based time management."

Work-life balance goes beyond just making time for family. It's also about making time for you. Self-care can be exercise, participating in a team sport or league, engaging in hobbies, carving out quiet time to read and reflect, spending time alone or with a friend on a weekend excursion, or pursuing any number of other activities or retreats. Take care of yourself, and you may find that you have more energy and patience to handle the physician's demanding lifestyle.

Becoming highly effective at tending to the activities of daily living—chores, errands, meetings, phone calls, e-mails—is a key component in mastering work-life balance. Time wasted—forever searching for things, making lists only to lose them, and feeling constantly behind the eight ball—can be better used to set things in order. In his book *Getting Things Done: The Art of Stress-Free Productivity* (Penguin Books, 2002), author David Allen stresses the importance of (a) capturing everything that needs to be done—now, later, eventually, big things and small things—into one system; and (b) being vigilant about what you let into your life and onto your list. That "b" part gets to the value-based time management that Dr. Moskowitz recommends.

Although many of us pride ourselves on our ability to juggle several simultaneous tasks, multitasking may not be all that it's cracked up to be. Is multitasking the best approach when examining a patient, standing at the operating room table, writing a research paper, or dictating medical records? Isn't time spent having a meal with your spouse, cheering from the sidelines at your kid's baseball game, or having drinks with friends better when thoughts of work or other tasks don't get in the way? By doing many things at once, do we do any of them well?

"I'm constantly teaching people how to live more in the present," says Richard Moss, MD, author of *The Mandala of Being*:

*Discovering the Power of Awareness* (New World Library, 2007) and five other books. After training as a physician, Dr. Moss left active practice and became a spiritual teacher and author. He has worked with hundreds of physicians individually and in the workshops he leads.

Seeing patients as fast as is necessary today isn't fair to anyone, Dr. Moss contends. He says this pace is one reason physicians experience career burnout. The antidote is "presence," or truly being engaged in the moment. "Even if it's a brief time with a patient . . . something is transmitted between human beings when one or both are present," explains Dr. Moss. "The relationship with the patient is actually a healing relationship for the physician. It's a learning relationship, one deeply rooted in how well we can listen." This "brief slowing down and touching something that is fundamental and real and essential" is useful for both patient and physician. Patients will feel grateful not only for the information and treatment given to them by physicians, but also for their attention and the respect it represents.

## How Much Is Enough?

A discussion of personal and professional development goals would not be complete without giving at least a polite nod to the financial side of the equation. Cleveland-based healthcare consultant Jack Valancy spends a lot of his time helping residents and young physicians make decisions about their careers. "Finance is on people's minds," says Mr. Valancy, "and I expect that it influences some decisions." But money, he says, is not the primary driver for most physicians. Mr. Valancy has found, in his experience, that the top four things driving physician satisfaction are these (notice that compensation is on the list, but not at the top):

- (1) The work itself—the specialty, the cases, the patients.
- (2) The culture—a healthy work environment.
- (3) Location—a sense of place and a lifestyle that works.
- (4) Compensation—money and other financial benefits.

Still, income issues influence career path decisions. Michael Glowacki, a certified financial planner based in Los Angeles, works with high-net-worth individuals, including physicians. He hears all too often about the impact of declining reimbursement

in health care. “The stories I hear are that a guy who made four hundred thousand to a million dollars ten years ago is now struggling to make two hundred thousand,” says Mr. Glowacki. So, if reimbursement levels aren’t likely to head upward anytime soon, what’s a physician to do? The answer depends on what motivates the physician to practice medicine.

Mr. Glowacki opens conversations with new clients by getting them to clearly articulate why physicians are doing what they are doing. “Are you doing it for the money? Are you doing it because you want to find a cure for something or help people? Be clear about that,” advises Mr. Glowacki, before doing any planning around money.

But even those whose primary mission is to cure also need to pay the bills and attain their personal financial goals for themselves and their families. Mr. Glowacki says that physicians should have an understanding about how much money they actually need. However, he notes, “the issue of ‘enough’ is complicated.” He uses a model in his financial practice that he calls “above and below the horizon.” Below the horizon are the finan-

### How Much Is Enough? A Reading List

Physicians grappling with the “how much is enough” question may benefit from one of the following books on the topic:

*Money and the Meaning of Life*, by Jacob Needleman (Currency Doubleday, 1994)

*The Number: What Do You Need for the Rest of Your Life and What Will It Cost?*, by Lee Eisenberg (Free Press, 2006)

*The Paradox of Choice: Why More is Less*, by Barry Schwartz (Harper-Collins, 2004)

*The Seven Stages of Money Maturity: Understanding the Spirit and Value of Money in Your Life*, by George Kinder (Dell, 2000)

*The Soul of Money: Transforming Your Relationship with Money and Life*, by Lynne Twist (W. W. Norton & Company, 2003)

*Your Money or Your Life: Transforming Your Relationship with Money and Achieving Financial Independence*, by Joe Dominguez and Vicki Robin (Penguin Group, 1992)

cial vehicles that will help clients reach their goals. Above the horizon are their goals, their vision, what they care about. “Too often people look below the horizon because that’s the easy place to go. Above the horizon requires more introspection, and people are afraid to go there,” says Mr. Glowacki.

When clients have an idea about how much money they really need, both while they are working and after retirement, Mr. Glowacki says they tend to relax and become happier. “Some people go out and make as much as possible, maybe at the sacrifice of other goals that they went into their profession to achieve, because they don’t know the number. They grab for more because they haven’t taken the time to figure out what life is about other than making money.”

### **Career Gone Off the Tracks?**

Clear purpose, careful attention and planning, deft management of resources, and a sense of balance between career and the rest of life can all add up to a long and satisfying career. But what if something isn’t working? What if despite taking these steps, a physician still feels unhappy in his or her profession?

It’s not good to feel “stuck.” So the first response is to recognize the possibility of change. Writers and philosophers remind us that even when we don’t see the way out of a situation, the possibility of change exists.

“We stand on the threshold of radical change at every moment,” Dr. Moss says in his book, *The Black Butterfly: An Invitation to Radical Aliveness* (Celestial Arts, 1986).

“This very moment, we can change our lives. There never was a moment, and never will be, when we are without the power to alter our destiny,” says author Steven Pressfield in his book, *The Art of War: Break Through the Blocks and Win Your Inner Creative Battles* (Warner Books, 2002).

Gandhi is famous for saying, “You must be the change you wish to see in the world.”

The message here is that if you are unhappy with your career, you can do something about it. But outside assistance may be necessary. Dr. Moskowitz sees far too many physicians trying to go it alone when they’re struggling professionally or personally, in part due to the way they are trained. Doctors are supposed to

be the helpers, not the ones who need help. But in this case, “The best thing they can do is reach out and ask for help,” says Dr. Moskowitz.

Transitions are not necessarily easy, but sometimes they are essential. Dr. Moskowitz often works with physicians who are at or near the point of professional burnout. “It’s important to try to uncover with the clients why they ended up in burnout in the first place,” he says. “Otherwise, they are destined to fall back into burnout again. It may be poor self-care, not having sufficient resources in the practice to support the physician, or it may be a mismatch between the physician’s basic values and those of the organization, to name a few.”

When a physician is dissatisfied or burned out, and on the threshold of a practice transition, Dr. Moskowitz says it’s helpful to look back and evaluate why he or she went into medicine in the first place. Dr. Moskowitz asks his clients to keep journals to uncover stories about what led them into the field. Both he and his clients are often surprised at the discoveries made during this process. “Journaling takes you to a deeper level of self-understanding,” he says. It’s the beginning of the process of evaluating the purpose of practicing medicine. These discoveries initiate the decision tree of whether to continue practicing.

“They’re able to come back into real time with this personal insight; and we say, okay, now let’s look at what this means, the feelings, the awareness that you have in your everyday job and how that relates, if at all, to the more basic motivation you started with,” Dr. Moskowitz continues. If an alignment can be found between purpose and practice in daily life, physicians often realize that despite the daily irritations, they are actually still quite satisfied practicing medicine. If, on the other hand, they realize they’ve gotten off track, then they may need to modify, re-engineer, or recreate their practice or career. In some cases it may even mean opting out of clinical medicine or direct patient care.

It’s not an easy choice to make—or to implement.

“You have to be prepared for challenges from everyone around you. The challenges come not only from within your family and immediate circle of friends, but also from other professionals,” says Dr. Moskowitz. One thing that sustains physi-



cians when faced with the opinions of others, says Dr. Moskowitz, is that by the time they've made the decision to change the way they practice medicine or live their lives, they've done enough internal work that their future vision is strongly aligned with their purpose and values. They are resolute and confident about their decisions moving forward.

"Being in transition is a bit scary for everyone," says Dr. Moskowitz. "The only thing physicians have to hold onto—but it happens to be extremely powerful—is their purpose. It's that anchor of knowing that the direction they're moving will bring

### **Purpose, Passion, and Patient Care**

Physicians enter the field of medicine with a passion. That passion may be for the science, the people, the desire to contribute, or the intellectual stimulation offered in a rapidly changing field. For some, the aspects of practicing medicine that turn out to be the passion appear on the radar screen almost by accident.

Upon completing his training, family physician Edward Zuroweste, MD, and two colleagues from his residency set up practice in a small community in Pennsylvania. One of Dr. Zuroweste's first patients was a nurse who was in charge of seeing that the migrant farm workers in the area could access health care. Since many of the workers were Latino, the nurse was looking for healthcare professionals who could speak Spanish. "I told her I could help," recalls Dr. Zuroweste.

Many of these patients, says Dr. Zuroweste, needed care but could not make it to his office during regular daytime hours; they were in the field working. Dr. Zuroweste would see patients all day, and then in the evening he'd see a steady stream of farm workers. Dr. Zuroweste says seeing his after-hours patients—sometimes until midnight—was the best part of his day. "I enjoyed this work more than anything else," says Dr. Zuroweste. "I love talking to people who live these incredibly difficult lives, but who are so generous and caring toward each other." He had found his passion and purpose in patient care.

In 1985, at a medical meeting, Dr. Zuroweste connected with other physicians interested in the same kind of work. Out of that meeting, an organization was formed—Migrant Clinicians Network ([www.migrantclinician.org](http://www.migrantclinician.org)), a grassroots organization founded by primary care physicians. Today Dr. Zuroweste serves as the group's Chief Medical Officer. The mission of the Migrant Clinicians Network is to posi-

them into synchronicity with their values. All the fluff and the money and the ego and the business success drop away. What remains is their new vision for themselves.”

Dr. Moskowitz says career transitions tend to occur in midlife, when physicians have learned to trust their own intuition and other people’s opinions aren’t as important as they once were. When questions do arise during times of transition, Dr. Moskowitz finds his clients “surprisingly able to deal with them because they’re really focused on their passion and grounded in their personal values.”

tively impact the physical, mental, and environmental health of migrants and other mobile, underserved populations. “We do research, advocacy, and education, have an active Website, and provide technical assistance for healthcare providers who care for migrant and seasonal farm workers,” says Dr. Zuroweste.

Today, in addition to Dr. Zuroweste’s role with the Migrant Clinicians Network, he and his wife work as consultants for organizations with federal contracts to support migrant health clinics around the country. Dr. Zuroweste has consulted at migrant health clinics in 31 states.

He also takes students from Johns Hopkins Medical School to Honduras for two-week rotations about three times a year. He does this in coordination with another non-profit organization called Shoulder to Shoulder, Inc. ([www.shouldertoshoulder.org](http://www.shouldertoshoulder.org)), which provides primary care, public health, dental care, nutrition, and education to poor communities in Honduras. “When you’re trying to get people to work with the homeless or with migrant farm workers, it’s hard to recruit primary healthcare providers who are culturally competent to do that work,” says Dr. Zuroweste. “How are you going to fill those slots? You have to mentor students. If you want to have another generation doing what you do, you have to find them now.” One of his dreams for the future is to start a program that would provide paid sabbaticals for providers who want to experience working in clinics internationally without having to use up all of their vacation time.

Practicing medicine with purpose and passion is a way of life for Dr. Zuroweste. “If you really want to be happy as a physician, a lot has to do with your family, your spouse,” he says. “I’ve been very fortunate. My wife and I work with the same organizations; my daughter has gone to Honduras with us; my son spent a year in Mexico and became bilingual during high school. It’s not just a job, it’s the way we live.”