The Art of Staying Focused

Staying focused on the task at hand or the patient in front of you can be a challenge with the constant interruptions and emergencies that seem an inevitable part of a busy medical practice.

Chapter in Brief:

- *Interruptions are unavoidable in a busy medical practice. How you handle them can make all the difference in managing your time effectively.*
- *Make sure you and your staff agree on the meaning of "urgent" and appropriate interruptions. This can help reduce the number of interruptions.*
- *Staying focused is much easier when you are rested and alert than when tired and groggy. Being aware of when you are most effective at certain tasks may be one of the best time management techniques around.*
- *Late each afternoon, review your schedule for the following day. This is a good time to catch—and correct—scheduling mistakes.*

How many people, policies, and procedures required your attention today? There were the patients, of course, and the office staff. Probably a few colleagues called with referrals, too. There were lab results to review, and paperwork to fill out, and schedules to keep, and isn't that your Blackberry ringing? Maybe it's your spouse e-mailing to coordinate a meeting next week, or your child's school calling to say your son is not feeling well.

TREAT HEARTBURN AND BEYOND

Prescribe ACIPHEX to relieve heartburn & other symptoms of nonerosive GERD—regurgitation, belching & early satiety, because...

TREAT HEARTBURN AND BEYOND AcipHex® rabeprazole sodium

INDICATION

ACIPHEX 20 mg is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD in adults and adolescents 12 years of age and above.

IMPORTANT SAFETY INFORMATION

In clinical trials the most common side effect assessed as possibly or probably related to ACIPHEX with a frequency greater than placebo was headache (2.4% vs 1.6% for placebo).

Symptomatic response to therapy does not preclude the presence of gastric malignancy. ACIPHEX is contraindicated in patients with known hypersensitivity to rabeprazole,substituted benzimidazoles, or to any component of the formulation. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

PLEASE SEE BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION ON REVERSE.

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Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc.

Raritan, NJ 08869-0602

01AX1804 Sep. 2008

ACIPHEX®

(rabeprazole sodium)
Delayed-Release
Tablets

BRIEF SUMMARY

Before prescribing ACIPHEX®, please see full prescribing information.

INDICATIONS AND USAGE

Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)

ACIPHEX is indicated for short-term (4 to 8 weeks) treatment in the healing and symptomatic relief of erosive or ulcerative gastroesophageal reflux disease (GERD). For those patients who have not healed after 8 weeks of treatment, an additional 8-week course of ACIPHEX may be considered.

Maintenance of Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)

ACIPHEX is indicated for maintaining healing and reduction in relapse rates of heartburn symptoms in patients with erosive or ulcerative gastroesophageal reflux disease (GERD Maintenance). Controlled studies do not extend beyond 12 months.

Treatment of Symptomatic Gastroesophageal Reflux Disease (GERD)

ACIPHEX is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD in adults and adolescents 12 years of age and above.

Healing of Duodenal Ulcers

ACIPHEX is indicated for short-term (up to four weeks) treatment in the healing and symptomatic relief of duodenal ulcers. Most patients heal within four weeks.

***Helicobacter pylori* Eradication to Reduce the Risk of Duodenal Ulcer Recurrence**

ACIPHEX in combination with amoxicillin and clarithromycin as a three drug regimen, is indicated for the treatment of patients with *H. pylori* infection and duodenal ulcer disease (active or history within the past 5 years) to eradicate *H. pylori*. Eradication of *H. pylori* has been shown to reduce the risk of duodenal ulcer recurrence. {See ***CLINICAL STUDIES*** **(14.5)** and ***DOSAGE AND ADMINISTRATION*** **(2.5)** in full prescribing Information}.

In patients who fail therapy, susceptibility testing should be done. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted. {See ***CLINICAL PHARMACOLOGY, Microbiology*** **(12.2)** in full prescribing Information and the clarithromycin package insert, ***CLINICAL PHARMACOLOGY, Microbiology.***}

Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome

ACIPHEX is indicated for the long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome.

CONTRAINDICATIONS

Hypersensitivity to rabeprazole

Rabeprazole is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles or to any component of the formulation.

Use of Clarithromycin and hypersensitivity to macrolide antibiotics

Clarithromycin is contraindicated in patients with known hypersensitivity to any macrolide antibiotic.

Concomitant use of Clarithromycin with pimozide and cisapride

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. There have been post-marketing reports of drug interactions when clarithromycin and/or erythromycin are co-administered with pimozide resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsade de pointes) most likely due to inhibition of hepatic metabolism of pimozide by erythromycin and clarithromycin. Fatalities have been reported. (Please refer to full prescribing information for clarithromycin.)

Amoxicillin and hypersensitivity to penicillin

Amoxicillin is contraindicated in patients with a known hypersensitivity to any penicillin. (Please refer to full prescribing information for amoxicillin.)

WARNINGS AND PRECAUTIONS

Clarithromycin use in pregnant women

CLARITHROMYCIN SHOULD NOT BE USED IN PREGNANT WOMEN EXCEPT IN CLINICAL CIRCUMSTANCES WHERE NO ALTERNATIVE THERAPY IS APPROPRIATE.

If pregnancy occurs while taking clarithromycin, the patient should be apprised of the potential hazard to the fetus. (See *WARNINGS* in prescribing information for clarithromycin.)

Anaphylactic reactions associated with antibiotic use

Amoxicillin: Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens.

There have been well-documented reports of individuals with a history of penicillin hypersensitivity reactions that have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before initiating therapy with any penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillin, cephalosporin, and other allergens. If an allergic reaction occurs, amoxicillin should be discontinued and the appropriate therapy instituted. (See *WARNINGS* in prescribing information for amoxicillin.)

SERIOUS ANAPHYLACTIC REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Pseudomembranous colitis associated with antibiotic use

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin and amoxicillin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of "antibiotic-associated colitis".

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluid and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *Clostridium difficile colitis*.

Presence of gastric malignancy

Symptomatic response to therapy with rabeprazole does not preclude the presence of gastric malignancy.

Patients with healed GERD were treated for up to 40 months with rabeprazole and monitored with serial gastric biopsies. Patients without *H. pylori* infection (221 of 326 patients) had no clinically important pathologic changes in the gastric mucosa. Patients with *H. pylori* infection at baseline (105 of 326 patients) had mild or moderate inflammation in the gastric body or mild inflammation in the gastric antrum. Patients with mild grades of infection or inflammation in the gastric body tended to change to moderate, whereas those graded moderate at baseline tended to remain stable. Patients with mild grades of infection or inflammation in the gastric antrum tended to remain stable. At baseline 8% of patients had atrophy of glands in the gastric body and 15% had atrophy in the gastric antrum. At endpoint, 15% of patients had atrophy of glands in the gastric body and 11% had atrophy in the gastric antrum. Approximately 4% of patients had intestinal metaplasia at some point during follow-up, but no consistent changes were seen.

Concomitant use with warfarin

Steady state interactions of rabeprazole and warfarin have not been adequately evaluated in patients. There have been reports of increased INR and prothrombin time in patients receiving a proton pump inhibitor and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

ADVERSE REACTIONS

Worldwide, over 2900 patients have been treated with rabeprazole in Phase II-III clinical trials involving various dosages and durations of treatment.

Because clinical trials are conducted under varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Clinical Studies Experience

The data described below reflect exposure to ACIPHEX in 1064 patients exposed for up to 8 weeks. The studies were primarily placebo- and active-controlled trials in patients with Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD), Duodenal Ulcers and Gastric Ulcers. The population had a mean age of 53 years (range 18-89 years) and had a ratio of approximately 60% male/ 40% female. The racial distribution was 86% Caucasian, 8% African American, 2% Asian and 5% other. Most patients received either 10 mg, 20 mg or 40 mg/day of ACIPHEX.

An analysis of adverse reactions appearing in ≥ 2% of ACIPHEX patients (n=1064) and with a greater frequency than placebo (n=89) in controlled North American and European acute treatment trials, revealed the following adverse reactions: pain (3% vs. 1%), pharyngitis (3% vs. 2%), flatulence (3% vs. 1%), infection (2% vs. 1%), and constipation (2% vs. 1%). The 3 long-term maintenance studies consisted of a total of 740 patients; at least 54% of patients were exposed to rabeprazole for 6 months while at least 33% were exposed for 12 months. Of the 740 patients, 247 (33%) and 241 (33%) patients received 10 mg and 20 mg of ACIPHEX, respectively, while 169 (23%) patients received placebo and 83 (11%) received omeprazole.

The safety profile of rabeprazole in the maintenance studies was consistent with what was observed in the acute studies.

Other adverse reactions that were seen in controlled clinical trials which do not meet the above criteria (≥ 2% of ACIPHEX treated patients and > placebo) and for which there is a possibility of a causal relationship to rabeprazole include the following: headache, abdominal pain, diarrhea, dry mouth, dizziness, peripheral edema, hepatic enzyme increase, hepatitis, hepatic encephalopathy, myalgia, and arthralgia.

In a multicenter, open-label study of adolescent patients aged 12 to 16 years with a clinical diagnosis of symptomatic GERD or endoscopically proven GERD, the adverse event profile was similar to that of adults. The adverse reactions reported without regard to relationship to ACIPHEX that occurred in ≥ 2% of 111 patients were headache (9.9%), diarrhea (4.5%), nausea (4.5%), vomiting (3.6%), and abdominal pain (3.6%). The related reported adverse reactions that occurred in ≥2% of patients were headache (5.4%) and nausea (1.8%). There were no adverse reactions reported in these studies that were not previously observed in adults.

Combination Treatment with Amoxicillin and Clarithromycin: In clinical trials using combination therapy with rabeprazole plus amoxicillin and clarithromycin (RAC), no adverse reactions unique to this drug combination were observed. In the U.S.

multicenter study, the most frequently reported drug related adverse reactions for patients who received RAC therapy for 7 or 10 days were diarrhea (8% and 7%) and taste perversion (6% and 10%), respectively.

No clinically significant laboratory abnormalities particular to the drug combinations were observed.

For more information on adverse reactions or laboratory changes with amoxicillin or clarithromycin, refer to their respective package prescribing information, **ADVERSE REACTIONS** section.

Postmarketing Experience
The following adverse reactions have been identified during postapproval use of ACIPHEX. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure: sudden death; coma, hyperammonemia; jaundice; rhabdomyolysis; disorientation and delirium; anaphylaxis; angioedema; bullous and other drug eruptions of the skin; severe dermatologic reactions, including toxic epidermal necrolysis (some fatal), Stevens-Johnson syndrome, and erythema multiforme; interstitial pneumonia; interstitial nephritis; and TSH elevations. In addition, agranulocytosis, hemolytic anemia, leukopenia, pancytopenia, and thrombocytopenia have been reported. Increases in prothrombin time/INR in patients treated with concomitant warfarin have been reported.

DRUG INTERACTIONS

Drugs metabolized by CYP450
Rabeprazole is metabolized by the cytochrome P450 (CYP450) drug metabolizing enzyme system. Studies in healthy subjects have shown that rabeprazole does not have clinically significant interactions with other drugs metabolized by the CYP450 system, such as warfarin and theophylline given as single oral doses, diazepam as a single intravenous dose, and phenytoin given as a single intravenous dose (with supplemental oral dosing). Steady state interactions of rabeprazole and other drugs metabolized by this enzyme system have not been studied in patients.

Warfarin
There have been reports of increased INR and prothrombin time in patients receiving proton pump inhibitors, including rabeprazole, and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. {See *WARNINGS AND PRECAUTIONS*}.

Cyclosporine
In vitro incubations employing human liver microsomes indicated that rabeprazole inhibited cyclosporine metabolism with an IC_{50} of 62 micromolar, a concentration that is over 50 times higher than the C_{max} in healthy volunteers following 14 days of dosing with 20 mg of rabeprazole. This degree of inhibition is similar to that by omeprazole at equivalent concentrations.

Compounds dependent on gastric pH for absorption
Rabeprazole produces sustained inhibition of gastric acid secretion. An interaction with compounds which are dependent on gastric pH for absorption may occur due to the magnitude of acid suppression observed with rabeprazole. For example, in normal subjects, co-administration of rabeprazole 20 mg QD resulted in an approximately 30% decrease in the bioavailability of ketoconazole and increases in the AUC and C_{max} for digoxin of 19% and 29%, respectively. Therefore, patients may need to be monitored when such drugs are taken concomitantly with rabeprazole. Co-administration of rabeprazole and antacids produced no clinically relevant changes in plasma rabeprazole concentrations.

Concomitant use of atazanavir and proton pump inhibitors is not recommended. Co-administration of atazanavir with proton pump inhibitors is expected to substantially decrease atazanavir plasma concentrations and thereby reduce its therapeutic effect.

Drugs metabolized by CYP2C19
In a clinical study in Japan evaluating rabeprazole in patients categorized by CYP2C19 genotype (n=6 per genotype category), gastric acid suppression was higher in poor metabolizers as compared to extensive metabolizers. This could be due to higher rabeprazole plasma levels in poor metabolizers. Whether or not interactions of rabeprazole sodium with other drugs metabolized by CYP2C19 would be different between extensive metabolizers and poor metabolizers has not been studied.

Combined Administration with Clarithromycin
Combined administration consisting of rabeprazole, amoxicillin, and clarithromycin resulted in increases in plasma concentrations of rabeprazole and 14-hydroxyclarithromycin. {See ***CLINICAL PHARMACOLOGY, Combination Therapy with Antimicrobials*** **(12.3)** in full prescribing information}.

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. (See *PRECAUTIONS* in prescribing information for clarithromycin.) (See *PRECAUTIONS* in prescribing information for amoxicillin.)

USE IN SPECIFIC POPULATIONS

Pregnancy
Teratogenic Effects. Pregnancy Category B: Teratology studies have been performed in rats at intravenous doses up to 50 mg/kg/day (plasma AUC of 11.8 µg•hr/mL, about 13 times the human exposure at the recommended dose for GERD) and rabbits at intravenous doses up to 30 mg/kg/day (plasma AUC of 7.3 µg•hr/mL, about 8 times the human exposure at the recommended dose for GERD) and have revealed no evidence of impaired fertility or harm to the fetus due to rabeprazole. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers
Following intravenous administration of ^{14}C-labeled rabeprazole to lactating rats, radioactivity in milk reached levels that were 2- to 7-fold higher than levels in the blood. It is not known if unmetabolized rabeprazole is excreted in human breast milk. Administration of rabeprazole to rats in late gestation and during lactation at doses of 400 mg/kg/day (about 195-times the human dose based on mg/m^2) resulted in decreases in body weight gain of the pups. Since many drugs are excreted in milk, and because of the potential for adverse reactions to nursing infants from rabeprazole, a decision should be made to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use
Use of ACIPHEX in adolescent patients 12 years of age and above for short-term treatment of GERD is supported by a) extrapolation of results from adequate and well-controlled studies that supported the approval of ACIPHEX for adults {see ***CLINICAL STUDIES*** **(14.1, 14.2, 14.3)** in full prescribing Information and ***INDICATIONS AND USAGE***}; b) safety and pharmacokinetic studies performed in adolescent patients {see ***Pharmacokinetics, Pediatric*** **(12.3)** in full prescribing information}. The safety and effectiveness of ACIPHEX for the treatment of GERD patients <12 years of age have not been established. The safety and effectiveness of ACIPHEX for other uses have not been established in pediatric patients.

In a multicenter, randomized, open-label, parallel-group study, 111 adolescent patients 12 to 16 years of age with a clinical diagnosis of symptomatic GERD or suspected or endoscopically proven GERD were randomized and treated with either ACIPHEX 10 mg or ACIPHEX 20 mg once daily for up to 8 weeks for the evaluation of safety and efficacy. The adverse event profile in adolescent patients was similar to that of adults. The related reported adverse reactions that occurred in ≥ 2% of patients were headache (5.4%) and nausea (1.8%). There were no adverse reactions reported in these studies that were not previously observed in adults.

Geriatric Use
Of the total number of subjects in clinical studies of ACIPHEX, 19% were 65 years and over, while 4% were 75 years and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Gender
Duodenal ulcer and erosive esophagitis healing rates in women are similar to those in men. Adverse reactions and laboratory test abnormalities in women occurred at rates similar to those in men.

OVERDOSAGE
Because strategies for the management of overdose are continually evolving, it is advisable to contact a Poison Control Center to determine the latest recommendations for the management of an overdose of any drug. There has been no experience with large overdoses with rabeprazole. Seven reports of accidental overdosage with rabeprazole have been received. The maximum reported overdose was 80 mg. There were no clinical signs or symptoms associated with any reported overdose. Patients with Zollinger-Ellison syndrome have been treated with up to 120 mg rabeprazole QD. No specific antidote for rabeprazole is known. Rabeprazole is extensively protein bound and is not readily dialyzable. In the event of overdosage, treatment should be symptomatic and supportive.

Single oral doses of rabeprazole at 786 mg/kg and 1024 mg/kg were lethal to mice and rats, respectively. The single oral dose of 2000 mg/kg was not lethal to dogs. The major symptoms of acute toxicity were hypoactivity, labored respiration, lateral or prone position and convulsion in mice and rats and watery diarrhea, tremor, convulsion and coma in dogs.

PATIENT COUNSELING INFORMATION
How to Take ACIPHEX
Patients should be cautioned that ACIPHEX delayed-release tablets should be swallowed whole. The tablets should not be chewed, crushed, or split. ACIPHEX can be taken with or without food. {See ***PATIENT COUNSELING INFORMATION*** **(17)** in full prescribing information.}

For prescription only

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Pam Vaccaro, nationally recognized speaker and owner of Designs On Time, a consulting firm in St. Louis, Mo., has a name for this problem: "Focus Deficit Disorder," a syndrome that actually has more to do with the external environment than any internal deficiency. Ms. Vaccaro defines this condition as the inability to focus for any length of time before someone or something wants your attention. Sound familiar?

"Too many requests for our attention are what drains us," says Ms. Vaccaro, adding that physicians have to protect themselves from being pulled in too many directions today more than ever because they are technologically tethered with cellphones, e-mail, and text messaging.

Maintaining Focus Throughout Your Day

Learning to stay focused on the task at hand—or the patient in front of you—requires skill and discipline especially when there are other things competing for your attention. It can also take practice and effort. Focus doesn't come naturally in this type of situation.

If you've ever tried meditation, you know how quickly and easily the mind wanders. Meditation teachers offer a simple (but not necessarily easy) remedy for the wandering mind: take notice of your drifting attention, then gently return your focus to your breathing and to the moment. This technique can also be used to develop the habit of staying focused when you are with a patient, or engaging in any other activity that will require your full attention.

Here's how it works in medical practice: When you find yourself distracted, glancing at your watch, overhearing a conversation in the hallway, or thinking about what would be good for lunch when you are supposed to be listening to your patient or analyzing lab results, simply notice the behavior, then gently bring yourself back to the present moment. If you do this often enough, staying present and fully focused will become a habit. Simple—but not easy.

This step will help you manage your internal distractions. But you'll need to do more in order to manage external distractions—like unnecessary interruptions from staff, colleagues, or family members. The best way to do this is to implement poli-

cies and procedures in the office to reduce such interruptions. For example, if you are routinely pulled out of an exam room to take "urgent" phone calls that end up being not so urgent, it's time to review with staff your definition of "urgent."

Some physicians always take calls from other doctors or from a close family member. For others, even those high-priority callers are asked to hold and wait for a return call between patients or at another natural break. Some physicians specify that if they are dictating patient notes, that's "sacred" time. Others are comfortable with an interruption by staff.

Make a list for a full week of all the ways you are pulled away from your immediate tasks. Look for patterns. Decide if there is a better way to handle interruptions. Once you come up with your own priorities, work with your staff to implement the necessary changes.

The Physiology of Rest and Productivity

Staying focused is much easier when you are rested and alert than when tired and groggy. Being aware of when you are most effective at certain tasks may be one of the best time management techniques around. Ms. Vaccaro says that combining the 80/20 rule (i.e., that 20 percent of efforts produce 80 percent of results) with knowing when you are at your best results in your highest level of effectiveness. "There is a chronobiological pattern in all of us that we know instinctively—those three to four hours when we're on top of our game," says Ms. Vaccaro.

A busy practicing physician may not have the luxury of working only at peak energy level and focus, but even he or she can take steps to increase alertness and productivity. Matthew Edlund, MD, a psychiatrist and sleep medicine specialist in Sarasota, Fla., says that doctors often don't get enough sleep and don't regard rest for what it is—a period for renewal and regeneration. "A lot of physicians are like Wile E. Coyote. They run, run, run all day and then splat against the wall, expect to fall asleep in ten seconds, then get up refreshed and ready to go again," says Dr. Edlund. This is not a recipe for good health, much less optimal productivity, he points out.

Dr. Edlund says that most people are at their best during the mid-to-late-morning hours and then again in the early evening.

Running a Sleep Deficit?

Psychiatrist and sleep medicine specialist Matthew Edlund, MD, of Sarasota, Fla., says that, as a society, we're getting an average of 90 minutes less sleep per night then we did 40 years ago. "We've managed to eviscerate rest," he says. Many physicians get by on six or seven hours of sleep each night, and some even wear that habit as a badge of honor. But we might be giving up more than shut-eye with this late-to-bed-early-to-rise schedule, Dr. Edlund says.

"Studies of diaries from before we had electric light show that people used to wake up in the middle of the night and think about their dreams. But we regard waking up in the middle of the night as an abomination," says Dr. Edlund. In giving up sleep, we may be sacrificing creativity and productivity.

Here are a few tips for developing good sleep hygiene, taken from Dr. Edlund's book, *The Body Clock Advantage* (Circadian Press, 2003).

Give yourself enough time to rest. Rearrange your schedule if needed, and cut back on activities so that you routinely get as much sleep each night as you do "naturally" when you're on vacation.

Create a good environment for sleep. Invest in a great mattress set; and sleep in a cool, comfortable, relaxing room.

Become a creature of habit. Get up and go to bed as close to the same time as possible each evening and morning, even on weekends.

Avoid stimulants. Coffee and other caffeinated beverages keep most people awake.

Move your body. Exercising in the late afternoon or early evening may help you sleep better at night. (Some people have trouble sleeping within two hours of exercise—experiment and see what works best for you.)

Hide the clock. Especially if you have trouble falling asleep, don't keep a clock in view.

"The brain is 'cold' early in the morning and needs to warm up," he says. Light and physical activity both serve to warm and wake the brain. "Early to mid-afternoon is a down time for most people," adds Dr. Edlund. During this period, he says it's important for physicians to take time to rest. Even thirty to sixty seconds of deep breathing can make a difference. Taking three minutes to "reset" yourself by walking outside or preparing a cup of tea can be refreshing in the middle of a chaotic day. "Physicians should spell themselves, especially when things get really

crazy," says Dr. Edlund. He also recommends taking short naps in the middle of the workday if possible. "Five to ten minutes can help," he says.

Getting proper rest makes physicians more alert and less likely to make medical errors. Evidence to that effect recently convinced the Institute of Medicine to recommend shorter (although still long) work shifts for medical residents. There's also evidence that our tendency to try to multitask may not actually lead to greater productivity.

"Busyness has taken over for effectiveness," says Dr. Edlund. "We're pretty bad at [multitasking], especially in mid-afternoon. You see more mistakes then." Dr. Edlund suggests that physicians plan their days to engage in activities that require the most attention (e.g., seeing a heavy patient load) when they are most likely to be at their peak. "Schedule paperwork and other things that don't require creativity in the mid-afternoon" when energy may flag, he recommends.

Sleep, while critical, is not the only kind of rest available. Dr. Edlund says that rest comes in four varieties: physical, mental, social, and spiritual. "There are many ways of resting. If you walk with your colleagues after a meal, even though you are physically active, you're socially and mentally resting," he offers as one example.

Design a Schedule That Fits Your Life

Catherine Kimball, DO, of Waterville, Me., is one of three family practitioners in her group and routinely sees 90 to 100 patients a week. Somewhat unique for an osteopathic physician today, Dr. Kimball combines conventional family practice with hands-on manipulation, depending on what a patient needs at the moment. "It's second nature for me to do both. I'm an old-fashioned osteopath," says Dr. Kimball, whose father was also a DO. "A lot of younger doctors today find it a challenge to meld family practice and manipulation," she says, adding it can be a scheduling challenge if you are not accustomed to moving flexibly from one modality to the other.

Practicing three long days each week, Dr. Kimball starts her day with 7:00 am appointments, which she says are popular with working patients. Her office uses a typical schedule of 15-

minute appointments for most types of visits and books two slots for physicals. "We each have a 'sick hour' every day," says Dr. Kimball. "Mine is at the end the morning, and it's not supposed to be booked until the afternoon before." The sick hour always fills up, according to Dr. Kimball; and sometimes it's double-booked. This system ensures that patients with acute problems are seen promptly, and it makes full use of the doctor's valuable time.

Because Dr. Kimball's days are on the long side, she designs her schedule to fit her natural energy level. After exercising before work, she's energized and sees patients for a longer block in the morning. She has a shorter block in the afternoon, when her stamina flags a bit.

To manage her full patient load, Dr. Kimball depends on her staff a great deal. The practice uses a triage system whereby patient phone calls go through a medical assistant before getting to a doctor. The practice tried having front-desk staff triage using algorithms, but they found there were too many exceptions for this approach to work properly. "For patients who need me, I call at the end of the day," says Dr. Kimball. She doesn't attempt to handle complex issues by phone. "Those patients get an appointment," she says.

The physicians in the group recently gave up hospital work. "We all three hit the wall at once," says Dr. Kimball, recalling the demands of trying to juggle an office practice and cover two hospitals. Still, giving it up was not an easy decision. "I disliked hospital work the most of all of us, but I grieved it the most." Dr. Kimball and her two partners now share outpatient-only call with two other doctors, resulting in a fairly reasonable one-in-five schedule.

Dr. Kimball, married with one daughter who is a senior in high school, admits that balancing work and family life has been a challenge at times. She recalls a moment of clarity when her daughter was very young. "The school had a Mother's Day tea every year, and [the children] wrote a little poem and card. One year she wrote all about how much I was working," says Dr. Kimball. "It hit me really hard. That's when I changed my hours to be available to her after school. The next year the card was substantially different," she says. Dr. Kimball keeps those two

Ten Simple Ways to Save Time

1. Develop personal templates for routine correspondence.

2. Organize your desk so that staff can drop off and pick up paperwork easily. Set up in and out baskets, a designated place for phone messages that need to be returned, and a special basket for anything that can be done in less than two minutes.

3. Limit time with pharmaceutical representatives to ten minutes. Get the information you need, and get back to your patients.

4. When you're expecting an important call that isn't on the standing "put the call through" list, let the front desk know so you don't play phone tag.

5. Make a list at the beginning of each morning of three to five things that must be done that day. If a few days go by and "must" items are still not complete, perhaps they're not that critical after all. Delete or delegate.

6. Pack a healthy lunch to bring to the office, but resist the urge to save time by eating it at your desk. Get out for some fresh air or, minimally, retreat to the staff lounge for the lunch break.

7. Stop multitasking except for combining the most mundane activities.

8. Start (and end) meetings you are responsible for on time.

9. Late each afternoon, review your schedule for the following day. This is a good time to catch scheduling mistakes, such as accidentally double-booking new or otherwise time-consuming patients. With a little notice, patients can sometimes reschedule.

10. Develop a series of "FAQ" sheets for common diagnosis, treatment regimens, wound care, etc., to reduce the number of between-appointment phone calls from patients.

cards in her office to this day and calls them her "report cards."

Now that her daughter is older, Dr. Kimball finds more time for renewal and relaxation on a regular basis. "Exercise is important. I walk and have a high-energy dog," she says. "My spiritual life serves as rest and rejuvenation," says Dr. Kimball, who is a part-time seminary student working toward a master's degree. "I'm taking one course this semester," she says, noting how she enjoys having an academic pursuit unrelated to medicine.