WEIGHT LOSS FOR BUSY PHYSICIANS

with Katrina Ubell, MD

Katrina Ubell: Hey, my friend. Welcome back to the podcast. How are you? How are things going? Are you enjoying this beautiful fall? It's so nice. Here it's September when I'm recording this, and it's been super hot. It's been kind of crazy how hot it's been. August was cold. September's hot. Who knows? We'll take it. We're loving it. It's been so great. Hey, listen, thanks so much for the iTunes reviews if you've left me one. We are getting up there. I really appreciate how many of you are going over and leaving me a review.

Listen, I know there's so many more of you out there who are listening every week and really enjoying this podcast and getting so much out of it and have not left me a review yet. If you would please be so kind as to go onto iTunes or in your podcast app and leave me a review, I would really, really appreciate that. It really helps other people to find this podcast. It's really actually very important for the podcast. If you wouldn't mind doing that, I really would appreciate it. I have told you before how to do it, so I don't want to take up too much time explaining that. You can for sure go to the show notes page for this episode, which you can find at KatrinaUbellMD.com/40, and you can find a link that will tell you how to do it from your mobile phone, from your desktop, all of it. It's going to be so easy to do. You just have to put something real quick. Just let me know, or let iTunes know, how this podcast has been helping you, what your honest thoughts are. Love to hear about it.

Okay, you guys. Today we're talking about fatigue. I've talked a little bit about this before just recently, about what our thoughts are about being tired, and things like that. I'm going to really delve into it a lot more deeply today. This is how I found out most of the information that I'm going to be sharing with you. I ended up figuring out a couple weeks ago, one of these random things, that I was in need of a significant number of CME credits. Has that ever happened to you? Super fun. If you're not a doctor, CME stands for Continuing Medical Education. We have to keep up with our education and get a certain number of credits. What you need and how much you need varies per state. In our state, in Wisconsin, every two years you need a certain number of credits.

I thought that I was good because for my board certification, for all of you who are physicians you know what I'm talking about, for the MOC, Maintenance of Certification, I am all good to go. In fact, I have to re-up that at the end of this year to keep my board certification. I have done more than enough CME to keep up my board certification, so I thought I was all good. The state of Wisconsin sent something out a couple months ago that for this biennium, so this two years and the following two years, we have to do a couple of credits related to opioids and narcotics addiction and things like that. I knew I didn't have anything that would cover that, so I spent some time finding a CME course that I could do that would cover that. I found one and did it, and it was actually really fascinating.

I did all that, and then I thought to myself, "You know, I should probably just double check that I have enough CME credits for this biennium," because what had happened was, when I re-upped my board certification last time, I thought, "You know what? I'm just going to bang a bunch of this stuff out and get it done early so that I don't have this hanging over me at the end and I'm rushing to try to get it all done. I'm just going to try to get as much done as I can." I had almost all of it done anyway earlier this year. Then I did another, I don't know, 15 credits or something to just make sure that I finished that all up. I thought I was good. No. In fact, I was a considerable number of CME credits shy. I was like, "Oh my gosh. This is so frustrating," because I'd already paid for all this stuff and it still wasn't good enough.

It's fine. I immediately changed my thinking about it, as you can imagine. Coached myself into knowing that it was just fine. It was just a good opportunity to learn something new, something interesting. All of the CME that I have to do for my board certification has to be pediatrics-related, so I thought, "Well, this is a good opportunity for me to learn about some other things that don't qualify for MOC credit." I did my opioid CME, and that was all fine. I thought, "Okay, well, I need to find some things that will get me some more CME credit."

Then I remember that amazing client of mine who lives in the state of Texas had told me months and months ago, earlier this year, about this CME that she had done that was through the Texas Medical Association. She lives in Texas. They require a certain number of ethics credits every year or two years, or however they run it. She had done one on ... I think it was something like well-being and physician health and well-being, or work-life balance, or something like that, and she thought it was great. She had told me about it. I checked it out. I'd actually even asked the American Board of Pediatrics if they would let me use it for MOC credit, and they had denied me, so I hadn't done it. I thought, "Well, this is the perfect time to go back and go over that again."I found some really great health and well-being for physicians CME. I ended up getting about five credits' worth of programs from the Texas Medical Association. You don't have to live in Texas and you don't have to be a member of their association to do their CME.

One of the ones I signed up for was called Addressing Fatigue in Physicians. It's just one little credit. Usually it's like this little one-measly-little-credit ones that you're like, "Is this even worth my time?" But I have been really wanting to address fatigue in physicians for quite some time. I thought, "Well, this would be really, really good. I'm going to learn some more about this and see what I get out of it." I'm going to put a link to this specific CME course at the show notes, in the show notes, so you can find that and do it for yourself if you want to get that one CME credit. Again, you can find that at KatrinaUbellMD.com/40. After I talk about all of this, if you're thinking, "Hey, that was so great. I'm going to go do this CME really quick and get my one credit," then you will be able to do so. You do have to pay for it, just so you know. It is not free, but it wasn't expensive.

What I'm going to do is give you a bit of a review of the main points of what they talk about, but then I'm also going to give you a little bit of my own take on lack of sleep and us advocating for what our needs are, because I've heard from many of you that you've wanted to know how to handle this lack of sleep issue. I also want to just mention, if anybody knows a sleep specialist who has a special interest in sleep in healthcare workers, please hook me up. I would absolutely love to bring somebody like that onto the podcast. If that's you, please send an e-mail to hello@katrinaubellmd.com and let me know, because I would really, really love to delve into this even further, because there are so many different complications in schedules and things that I would love to discuss with somebody and do that so that you guys can all benefit.

This I found very, very interesting. Prior to the widespread use of electric lights, there was a study in the early 1900s, so 1910, on how many hours the average adult slept per night, and it was nine hours. Then, in 2011, so 100 years later, they did the same study, and guess what? Now it's down to seven to seven-and a-half hours per night. That is a significant reduction. Nine hours to seven to seven-and-a-half hours per night. I think that's on a good night, don't you think? Seven to seven-and-a-half hours. I'm like, great. We're doing well if we get that much sleep. It's so fascinating how much the electricity and electric lights has changed everything for us.

Now, fatigue leading to human error is not new. This has played a significant role in many catastrophes, such as Chernobyl, Three Mile Island, the grounding of the Exxon Valdez, which led to a massive oil spill, and the Challenger Space Shuttle explosion. Remember that? I was in fourth grade. I'll never forget it. Every year there's more car crashes and deaths that are attributed to excessive somnolence, drowsiness, and falling asleep behind the wheel, than to drunk driving and other forms of intoxication. Nobody's talking about this. Think of all the anti-drunk-driving information that's out there. There's a little bit of information I see, but ... anti-texting. These are all great things to push for, don't get me wrong, but we are just not talking enough about fatigue and lack of sleep.

How does this all begin for us? For some of us, it really even starts in high school and college with staying up too late and all-nighters. But we're still in a position where we can make up that sleep a little bit better, where we're able to really take time at times and sleep in and catch up. But then we hit the residency model, and things change. That model of staying up so much and these long, long calls was historically designed so that residents lived at the hospital, which is why they were called "residents." They worked around the clock. They had very few opportunities for sleep and rest. At that time, it just wasn't known that working like this increases the chances of medical errors, worsens health and well-being, and overall just takes away from our education and our actual experience of taking care of patients, learning, and developing experience.

Then, there was a landmark case in 1984, where there was an 18-year-old woman named Libby Zion who died in New York after being cared for by a fatigued, unsupervised intern. The intern misdiagnosed her and then gave her medications that had toxic interactions with other drugs she was taking, and then she ultimately died. She was the daughter of an attorney who worked for the New York Times. Then, after some inquiry into the case, they found that chronic fatigue in combination with lack of supervision and sleep deprivation that evening led to the medical errors which ultimately resulted in her death. This kick-started the push to change the ACGME rules on on-duty hours for residents.

Over the course of time, resident work hours have been limited more and more. My intern year was the last year that we had before we had what was known as the 80/30 work hour restrictions, meaning you could only work up to 80 hours per week and up to 30 hours in one stretch. Some of you may recall that. Some of you might be a little too young to recall that. Some of you might go, "What? No. We didn't have any 80/30 when I was a resident." But it was really interesting how much I at the time felt like it was better not to have those work hour restrictions. I felt like being pushed and rushed to leave the hospital after 30 hours was sometimes really annoying, and not being able to do some things sometimes. But what's so interesting is that there's been so much data supporting this.

Then, in 2011, the ACGME further limited the hours to 16 consecutive hours of work for interns and 24 hours at a time for second-year residents and up. They also now require either safe transportation home or sleeping facilities for exhausted post-call residents. So interesting. I think that's great.

The Joint Commission has also gotten involved in this. In 2011, they published a sentinel event alert on healthcare worker fatigue and patient safety. In this alert article, they cite an article from 2007 that reported that residents who work traditional schedules with recurrent 24-hour shifts, which is totally more than normal for when I was doing my training, they make 36% more serious preventable adverse events than individuals who work no more than 16 consecutive hours. They make fives times as many serious diagnostic errors. They have twice as many on-the-job attentional failures at night. They experience 61% more needle-stick and other sharps injuries after their 20th consecutive hour of work. They experience a one-and-a-half to two standard deviation deterioration in performance relative to baseline rested performance on both clinical and non-clinical tasks. And they report making 300% more fatigue-related preventable adverse events that led to a patient's death. Holy moly, you guys.

Another article from a 2009 study showed an increased rate of complications among post-nighttime surgical procedures performed by attending physicians who had slept less than six hours. It's not just about the residents anymore.

There is an MD/MPH named Christopher Landrigan who is the director of the Sleep and Patient Safety Program at Boston Children's Hospital. He's quoted as saying, "We have a culture of working long hours, and the impact of fatigue has not been a part of our consciousness. Most are unaware of sleep and circadian biology and the degree that it affects performance, and most do not realize how much research supports the need to make changes." I am taking this opportunity to help you to understand how we need to make changes.

The causes of fatigue obviously include how many hours of sleep you get as well as the quality of the sleep you get. They also mention other causes of fatigue, including health conditions like diabetes, heart disease, autoimmune disorders, and depression, and then also environmental and social factors such as ambient noise, administrative support, relationships, and commute. They also mention workload and level of physician burnout. If you are not aware, the definition of physician burnout involves having three specific factors present: emotional exhaustion, low sense of personal accomplishment, and perceived clinical ineffectiveness.

We know what causes it, but what are the signs of fatigue? Number one, irritability. Sound familiar? I hear this from my clients all the time, that they're just irritable. They're just cranky. Being unmotivated. That shows up in so many ways. Not keeping up with charts, or preparing the talks that we have coming up, or writing textbook chapters that we're supposed to be doing. Then, being unmotivated at home too. Unmotivated to keep up with the laundry, to follow your eating plan, to make sure that the groceries get shopped for or delivered to the house, to stay motivated with engaging with your family in the way that you want to. Also, exhibiting less empathy and compassion. Totally happens. It's that depersonalization, where the patient starts just turning into another task, another thing you need to do, another thing to check off on the list, rather than really understanding and remembering that this is a person who is scared and has needs and needs help.

Daytime somnolence. Who has not fallen asleep standing up leaning against the wall during rounds? Either as a med student or a resident or maybe even now. I swear, the people who can fall asleep the fastest, I think, at any moment, are the obese. You guys, it is really a skill, or it means that you're so incredibly chronically exhausted that maybe it's a skill you shouldn't have.

Also, decreased sleep latency. If you fall asleep very quickly, like less than five minutes, then that is a problem. It normally takes the average person 10 to 20 minutes to fall asleep. That's what should be happening. You can have difficulty in memory and concentration. That totally happens. You have that lack of remembering what you want to say, or you can't remember the name of some medical problem ... what I'm having right now, where you're basically just at a loss for words. You can't think of what the words are that you're trying to express. You know they're in there in your brain, and you just can't bring them to the forefront.

Then, finally, diminished fine motor skills and coordination. That can be in procedures that you're doing, or it can include even increased distractibility and reduced reaction time, which increases the risks of accidents when driving.

There's actually an eight-question questionnaire called the Epworth Sleepiness Scale, which can be used to assess the degree of daytime sleepiness someone has. You can find that at EpworthSleepinessScale.com. I'll also put a link to that in the show notes page. That's something that's very inexpensive that you could even bring to your hospital system, that you could incorporate into a program that somebody's developing on awareness of fatigue.

There are studies that have shown that, in terms of psychomotor performance, after 24 hours without any sleep, people perform comparably to those with a blood alcohol level of 0.1%. That is scary. The next one was really surprising to me. Research has shown that sleeping only six hours per night for 14 consecutive nights affects cognitive functions similarly to losing a full night's sleep. You might as well have just pulled an all-nighter. Six hours per night for two weeks, who hasn't done that? That's so normal. This is really, really impacting us.

As you get more fatigued, cognitive function goes first before your physical performance. People who are tired exhibit impaired learning and thought processes, memory deficits, and interpersonal dysfunction. We feel relatively okay physically, but clearly our brains are not functioning like they should. We might tune in and go, "Well, I don't know. How tired am I? Physically I feel like I could just power through and keep going," but cognitively your brain is just screaming for a break and for some sleep. The symptoms of sleep deprivation become apparent if a person gets fewer than five hours of sleep within 24 hours. It's not that little.

Here are some more studies that are quite the wake-up call, no pun intended. When nurses work more than 12-and-a-half hours in a shift, they have decreased vigilance on the job and increased risk of occupational injury and of committing errors. When residents who work more than 24 hours are compared with those who work only up to 16 hours, the longer-working residents have increased incidences of occupational sharps injuries, more motor vehicle accidents on their trip home, and increased rate of medical errors, two times as many attention failures, and 36% more serious medical errors. This is a really big deal.

With residents needing to go home or have time to rest, the solution in a lot of organizations has been to have attendings take more in-house call. But older physicians have an even harder time obtaining that recovery sleep they need after they have circadian disruption, as it's called, and are more vulnerable to the effects of a series of night shifts. Those of us who are older may tolerate the occasional night of sleep deprivation well enough to function without any impairment, but evidence really suggests that repeated nights of disrupted sleep are extremely detrimental.

There's a health impact of fatigue related to short sleep duration and night shift work, and it is pretty shocking. When this happens to you, you have higher rates of diabetes and metabolic syndrome, hypertension, cardiovascular disease, adverse reproductive outcomes, obesity, and certain cancers. Being exposed to artificial light at night suppresses melatonin and leptin. Leptin is what your fat secretes to let your brain know it doesn't need to be so hungry. If it's suppressed, then you become hungrier. And it elevates cortisol.

This sounds terrible, right? What do we do? There's a two-component solution. You're responsible for managing your personal fatigue, and your system is responsible for providing an environment that supports you. Let's talk about the personal parts first. Number one is your sleep hygiene. Maintaining a consistent sleep-wake schedule is important. A consistent bedtime and wake-up time is important. I can hear those of you who have a rotating schedule already telling me, "Well, what about this? What about that? What do I do here? What do I do there?" Clearly this is just not going to be able to be a part of your sleep hygiene. We'll get into talking about what you can maybe do about that in a minute.

You want to avoid alcohol, nicotine, and caffeine, especially before bed. So many of us think that alcohol relaxes us and helps us to get to sleep, but it actually reduces the quality of the sleep you do get. Yeah, you fall asleep, but your sleep is not as refreshing. Having that nighttime glass of alcohol, glass of wine, you should really, really think about what effect that might be having for you. You might also really want to take a break from it and see how different you feel.

I always recommend no caffeine after noon, based on what the half-life is of caffeine and when most people want to be able to go to sleep. But you may want to even consider getting off of it on a regular basis. I know that's kind of heresy, and a lot of you will be like, "Oh my god! I can't survive!" I'm not saying you need to get off coffee, though, okay? But I'm just saying you may want to switch over to decaf. The reason for that is that, first of all, when you're on caffeine on a regular basis, it actually doesn't do as much for you. It doesn't really give you that same kick that you're wanting or needing when you're tired. Getting off of it allows your body to actually have that response to caffeine, so when you do have those days where you need that extra kick, you can utilize caffeine in that way.

There's something called strategic napping. I call it a caffeine nap. I do it actually ... not too often, but sometimes. What that entails is that you drink a caffeinated beverage, so it should be pretty small. I have a little Nespresso machine at home, so I will usually just make a little espresso, so it's just a quick couple of sips to get that caffeine down. Then you immediately go try to take a nap, but only for 30 minutes. You drink your caffeine, go lay down for 30 minutes and try to sleep. By then, the caffeine's kicked in, you've gotten a little power nap, and that can really, really energize you. But definitely do not do this at four in the afternoon. You will not be able to sleep that night at all.

You might really want to consider just gradually going off of caffeine. Some of you may not be like me. For me with caffeine, when I try to go off of it when I'm addicted, oh my gosh, it's terrible. I get addicted very quickly and I have terrible withdrawal symptoms. Every time I've gotten off of it, I've just done it very, very gradually, where I've mixed the beans at home with the decaf and the regular, and then just gradually reduced the amount to get myself off and just wean myself off of that. But I still definitely drink decaf coffee, no problem. Getting off of that really helps you to have much more even energy and doesn't interfere with your sleep at all or your ability to get tired.

Other things. Don't eat a heavy meal within three hours of going to bed. That can be hard if you've worked late. You might want to think about just having more like a heavy snack and getting the sleep and then having a bigger breakfast, or just fasting if you're able to do that. Avoid bright light exposure, including screens, for an hour before going to sleep. So many of us are terrible at this. We need to shut the TV off. We need to just read a book for fun. Don't think you should be reading your journals. Everybody says, "Oh yeah, I should just read my journals." But really, you're going to not watch Netflix so you can go read a journal? No. You should have some trashy novel that you love, that you can't wait to figure out what the next thing is that's going to happen, because that actually will be a nice trade. You will probably be willing to turn Netflix off in order to go read a chapter of that, or maybe just a couple of pages.

What I find, though, is when I read and I'm tired, I'll be totally on my phone, no problem, watching TV, no problem. I'll get into bed, I read one to two pages of a book, and I can't even keep my eyes open. It's so interesting how much that bright light on our screens, even when you have the dimming function and all of that, how much that impacts and reduces our ability to feel tired.

You also want to avoid exercising within three hours of bedtime. If you can develop a consistent, relaxing bedtime routine for the last half hour of your time before you go to bed, that is ideal, because it really helps your body to know and your brain to know sleep is coming. It's time to get tired. Then, also, sleeping in a dark, quiet, cool room with earplugs. You might need some white noise. You might need to have a fan on in your room.

Exposing yourself to bright light in the morning or when you wake up is really helpful. Spending some time outside every day is really helpful. Then, keeping a sleep journal is really helpful as well. You want to notice any sleep behaviors that you have or any patterns that you have. Similarly, too, food journaling. When you see how much sleep you've had and you add that up and you go, "Oh, no wonder I'm struggling so much. Okay. Wow. This is really a problem. I really do need to make some changes." Otherwise, we have no idea how much we slept. We don't pay attention at all.

Then, you also want to avoid driving after sleep deprivation so you don't get in a car accident. For those of you who work these 24-hour shifts, or for those of you who are working these crazy ER shifts where you're rotating all around, and then you have meetings, and you're not getting the sleep that you need, just consider taking an Uber or a Lyft home. You can just take one back in the morning, and there is your car again. It's not a problem. Then, obviously get treated for any medical problems that might contribute, like sleep disorders, diabetes, and any psych disorders that might be going on.

As far as the system is concerned, what our systems should be doing is following the ACGME standards for the residency programs, assessing the overall organization for fatigue-related risks, like excessive time on shifts and poor patient handoff procedures. Overall, they really should do an environmental assessment to make sure that the lighting changes between the day and night shifts, to make the hospital quieter. I know a lot of hospitals have a big push to make it quieter all the time because that's better for healing for patients. They really should be providing a private, soundproof, cool, and dark sleep corridors for on-call staff. Then, they also need to provide education about the risks of fatigue and how it can be managed and minimized. They should be promoting alertness strategies and overall recognition of fatigue as a problem.

What can you do, though? So many of us then think, "Well, great, but my hospital system's not going to do that," or, "I don't work for a big system. I just work for a small practice, and nobody's taken the lead on that." You can take the lead in developing a policy to minimize fatigue. You can start the conversation, even if you don't want to develop a policy. If that's not your thing, you can just start the conversation, especially if you have a rotating schedule, like the people do in an emergency department, or people who are taking a lot of call and staying up all night a lot of nights. Take a look and see what other programs are doing with their schedules and see how it's working for their physicians. You don't necessarily have to reinvent the wheel. Other programs are working through this, so start figuring out what they're doing and see if that might work for your program.

Then, you also really have to take personal responsibility for yourself and your rest. Be careful of stories you're telling yourself about how things can't change, nobody will listen to you, they'll all think you're a wimp and a complainer, and things like that. You are taking your thoughts about yourself and projecting them onto others. But, as a point, instead of just complaining, do some research. Come up with some solutions first before bringing it up with other people.

Just like with any challenging conversation, decide how you want to feel ahead of time, before you strike up the conversation or go into a meeting with somebody important about the subject. Make sure that that emotion will drive you to take the actions you want to take, so you show up in the way that you want to and have the discussion you want to have. Determine what the results of those actions will be for you, and then create a thought or two or three that feel true and believable, that create that emotion for you.

One that I like is, when my needs are met, I'm able to provide an extraordinary level of care for my patients. Then, think that thought, generate that emotion for yourself as you go into that meeting. Don't forget that, if you find you can't make any progress with your organization, then you can work somewhere else. So many of us think that we are stuck where we are. I've had so many clients who've switched jobs for reasons just like this. There is nothing wrong with looking for a job where the culture of the organization, or even just the department, is to support their physicians, or just a place where you don't have to take overnight call anymore, or at least less overnight call. This is the structure that's changing, where we have nocturnists and we have hospitalists and laborists and all these different kinds of jobs to make it so that everybody can find the job that works for them.

But then, ultimately, we still have to take responsibility for ourselves and go to bed on time. So many of us are so chronically sleep-deprived that we don't even know when we're tired until we're basically passing out or we've been asleep on the couch for an hour.

One big mistake I see in my clients who struggle with this is waiting to go to bed until you feel tired. You're watching TV, you're watching other screens, you're looking at your computer or your phone or your iPad. We think we're relaxing and having "me" time, and so we want more of that. What I want you to do is to stop expecting to want less "me" time. Especially if you're an introvert, you're always going to want more "me" time. It's never going to be enough, and that's okay. It's okay to just always feel like you want a little more time to yourself. We overall then have this hard time generating the activation energy that we need to get ready for bed and actually climb in there.

My husband and I have this joke from way back when, even in med school, where we'd be so tired on the couch, feeling like we couldn't move at all. My husband one time said to me, he was like, "Put me to bed." We still joke about that. We just want someone to pick us up and put us to bed like we're kids, because it just feels like we don't have any energy to even get up and walk up the stairs and get into bed.

I want to encourage you to put your bedtime on the calendar. Even when you're on call, don't stay up late because you're thinking people might page you and wake you up. That's what I always did. I ended up staying up way too late at night on call nights thinking, "Oh, I'll get some other stuff done. This will be so much better. Then I won't get woken up and have a hard time falling back asleep again." That was a terrible idea. That was not a good idea to function that way. It's a good idea to have your phone send you a reminder, maybe a couple of reminders. Bedtime in 45 minutes. Bedtime in 30 minutes. Bedtime in 15 minutes. Finish up what you're doing and start moving up there. Don't expect to want to do it ever. You're always going to have other things that are going to seem more important.

You might find that it doesn't even serve you to ever sit down on the couch. You might find that, if you sit down on the couch or in that comfy chair, you just will never get out of it. You might find that you finish up what you need to do and then already go upstairs, get yourself ready for bed, climb in bed, start reading a book for fun, listen to some music, do something like that. Start reading that book and find how quickly your body is just ready to go to sleep.

Remember what it is that you want. What you want is the result of having slept, because when you've slept how do you feel? You feel great. That's what you want. You'll have to do the hard part initially, which is go to bed. It's the same thing with your food. Why do you want to lose weight? Because when you've lost weight you think you'll feel better, which you might. You probably will. But right now, you want to eat the cookie. You're going to have to say, "No. I'm not going to eat the cookie, because what I want is the result, which is being thin, staying at my ideal weight permanently, and not struggling with food anymore." It's the same thing with sleeping. What you want is the result. The hard part is going to bed. You just have to do the uncomfortable thing, which is cut off the "me" time and go up to bed.

Remember that when you want to stay up late, that is a thought being generated by your primitive brain. Remember, your primitive brain, she is that toddler with a knife. Is it a good idea to let a toddler stay up late because she wants more time to play? Never. The next day, she's a mess. She's cranky. She's irritable. She's so difficult to be around. Guess what? The same goes for you. You're cranky. You're irritable. You're a mess. You're so difficult to be around. You don't even like being around yourself. Just remember, just like a mother puts her child to bed even when the child doesn't want to go to sleep, your prefrontal cortex needs to take these same actions.

Let's keep this conversation going over in the comments on the show notes page. You can find that at KatrinaUbellMD.com/40. Remember, the link to doing the CME for credit is on that page as well. It's called Addressing Fatigue in Physicians. It's the Texas Medical Association. They do some really great CME.
For sure, check them out if you are looking for some CME.

This is such great, important work for us, you guys. As women physicians, we can make a push for change not only in how we care for ourselves but in the whole structure and culture of our organizations by advocating for this for ourselves. It's so, so, so important. With that, I'm going to say goodbye. Have a wonderful, wonderful week. I will talk to you next week. All right. Buh-bye.