Oral presentations

Monday, September 19, 2016
10:30 am - noon

Note: All presentations may not be included as we are still collecting the final presentations from presenters, some may have been omitted for copyright purposes. Check back periodically for updates.
The Resilient Physician: Institutional Changes to Promote Whole Physician Health

Eileen Barrett, MD, MPH, FACP
Elizabeth Lawrence, MD, FACP
Catherine Cheng, MD, FACP
Introduction

What is burnout?

What is physician wellness?

What is resiliency?
Introduction

What is burnout?

Depersonalization, feeling of reduced accomplishment

What is physician wellness?

Emotional, spiritual, physical health

What is resiliency?

Capacity to bounce back, “toughness”
Introduction

What is whole physician health?

*The whole person of the physician, as well as our milieu:*

- Physical
- Mental
- Emotional
- Spiritual
- Professional
- Environmental
Introduction Exercise

What is one strategy you use to promote whole physician health on your team?
What have other practices done to promote whole physician health?

- Protected time for reflection
- Resiliency training
- Peer support
- Healthy foods
- Improve the physical environment


What have other practices done to promote whole physician health?

- Workplace wellness programs
- Protecting us from unnecessary challenges
- Engaging leaders who are committed to supporting whole physician health
Protecting Us from Unnecessary Challenges

- Reduce pressure, increase control
  - Longer appointment times
  - All staff work at the highest level of their licensure
  - Consider scribes, MA order entry
  - Take the pledge against “it’s just three more clicks”
Increasing Support: providing skills and tools for overcoming challenges

• Support healthy lives
  – Support caregiving clinicians
  – Offer flexible/part-time work options
  – Limit EMR time at home
  – Healthy foods
  – Promote exercise
Protecting Us from Unnecessary Challenges

- More control, less chaos
  - Support team work and care coordination:
    - pre-visit planning, huddles, care protocols, standing orders
  - Consider unique schedules

Leadership Support

- Promote shared values
  - Tie the work we do to our values
  - Provide resources for a wellness committee
  - Ensure that organizational metrics for success include satisfaction and well-being
 Reasons leaders should care about physician health:

• Unhappy, exhausted physicians leave
• Tough to recruit to an unhappy practice
• It costs ~$250,000 to replace a primary care physician
• Float pools and dedicated time for passion projects are cost-effective
Making Your Case for Organizational Change

Reasons leaders should care about physician health:

- Our organizations can model health for our communities
- Care quality can suffer
- Patient safety can suffer
- Patient satisfaction can suffer
- Basic human decency
Preventing physician burnout

Mark Linzer MD, FACP
Hennepin County Medical Center

Laura Guzman-Corales, MPH
Hennepin County Medical Center

Sara Poplau Hennepin County Medical Center

STEPSForward.org
**WELLMD**

*Doctors who take care of themselves:*

- Are better role models for their patients.
- Are better role models for their children.
- Have higher patient satisfaction and safety scores.
- Experience less stress and burnout.
- Live longer.

*Use this Web site to find what works for you.*
CENTERS AND PROGRAMS

PHYSICIAN WELL-BEING PROGRAM

OVERVIEW

Overview
Faculty
About the Program
Focus Areas
Publications
Contact
Group Exercise

How do we advocate for change in our organizations?
https://www.ted.com/speakers/nancy_duarte
Group Exercise

How do we advocate for change in our organizations?
Joy to the Word: Combining Emotional and Intellectual Engagement to Build Workplace Pleasure Among Physicians

Lois Leveen, Ph.D.
Kienle Scholar in the Medical Humanities, Penn State University
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Lori Wiviott Tishler, M.D.
Medical Director, Phyllis Jen Center, Brigham and Women’s Hospital
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Nothing to disclose
Joy to the Word: Combining Emotional and Intellectual Engagement to Build Workplace Pleasure Among Physicians

Lois Leveen, Ph.D.  llois@humanitiesforhealth.org
Lori Wiviott Tishler, M.D.  ltishler@partners.org

• Welcome, introductions, overview
• Facilitated discussion of humanities content using humanities approaches
• Structured reflections by workshop participants
• Facilitated discussion of opportunities, best practices, and challenges for implementation of similar workshops within (or outside of) healthcare settings to promote physician joy.
Obama to Leave the White House a Nerdier Place Than He Found It

White House Letter
By GARDINER HARRIS  JULY 31, 2016

Joey Hudy demonstrated his marshmallow cannon for President Obama at the White House Science Fair in 2012. Stephen Crowley/The New York Times
Peer Support Trumps Time Off in Preventing MD Burnout

Kate Johnson
November 06, 2012

MONTREAL, Canada — One hour of facilitated peer support every other week during working hours significantly improved certain measures of physicians' job satisfaction and burnout compared with the same amount of unsupervised time off, a randomized controlled trial shows.

"From this we conclude that a small amount of protected time during the workday did result in improved meaning from work and reduction in burnout. This was true in both arms of the study, but the effects were larger in the facilitated small group arm," said lead investigator Colin West, MD, Mayo Clinic, in Rochester, New York, who presented the findings here at the 2012 AMA/CMA/BMA International Conference on Physician Health (ICPH).
Can arts and meditation reduce stress?

Dr. Odunukan created a pilot project that revealed that internal medicine residents who participated in one hour of art class were less fatigued and had improved work-related motivation when compared to their colleagues who participated in the usual noon conference.

He then followed up with a three-month study that included arts and humanities activities every two weeks, which replicated his initial finding. Afterward, he ran a randomized, crossover study that compared the impact of art and meditation on reducing stress and fatigue.

The results showed that group participation in arts led to improved bonding with colleagues, while meditation was more effective for lowering stress and fatigue.

“They were complimentary to each other,” Dr. Odunukan said.
Part one:
Discussing humanities content, using humanities approaches
Part one:
Discussing humanities content,
using humanities approaches

**Humanism:** connection, caring, interaction.
This is a goal.

**Humanities:** study of literature, art, philosophy, music.
This is methodology.
Talking to Grief

Ah, Grief, I should not treat you
like a homeless dog
who comes to the back door
for a crust, for a meatless bone.
I should trust you.

I should coax you
into the house and give you
your own corner,
a worn mat to lie on,
your own water dish.

You think I don't know you've been living
under my porch.
You long for your real place to be readied
before winter comes. You need
your name,
your collar and tag. You need
the right to warn off intruders,
to consider
my house your own
and me your person
and yourself
my own dog.

--Denise Levertov
Wrap

I don't mean when a movie ends, as in, it's a! Nor tortillas splitting with the heavy wet of bean.
And I don't mean what you do with your lavender robe all fluff and socks to snatch the paper from the shrubs. Nor the promise of a gift, the curl and furl of red ribbon just begging to be tugged. What I mean is waiting with my grandmama (a pause in the Monsoon) at the Trivandrum airport for a jeep. Her small hand wraps again the emerald green pallu of her sari tucked in at her hips, across her breast, and coughs it up over her shoulder a hush of paprika and burnt honey across my face.

--by Aimee Nezhukumatathil
Keeping Quiet

Now we will count to twelve and we will all keep still.

This one time upon the earth, let's not speak any language; let's stop for one second, and not move our arms so much.

It would be a delicious moment without hurry, without engines; we would all be together in a sudden strangeness.

Fishermen in the cold sea would not harm whales and the man gathering salt would look at his hurt hands.

Those who prepare green wars, wars with gas, wars with fire, victories with no survivors, would put on clean clothes and walk about with their brothers in the shade, doing nothing.

What I want should not be confused with total inactivity.
Life is what it is about; I want no truck with death.

If we were not so single-minded about keeping our lives moving, and for once could do nothing, perhaps a huge silence might interrupt this sadness of never understanding ourselves and of threatening ourselves with death.

Perhaps the earth can teach us as when everything seems dead and later proves to be alive.

Now I'll count up to twelve and you keep quiet and I will go.

—Pablo Neruda, translated by Alastair Reid?
Part two:

Structured reflections
Part two:

Structured reflections

How is looking at visual art different from looking at a poem? How are they the same? What do we get out of doing both together?

What other types of humanities content would you want to try this with?
Part two:

Structured reflections

(How) does this bring joy?

(How) does/could this conversation connect to some aspect of your life?
Part three: Opportunities, challenges, and best practices for implementation of humanities engagements

How can we help people understand this as valuable? How can we draw in the folks who aren't in the room?

How can you take this with you when you go back to work?
Written reflection

Describe 1 or 2 ways that this workshop changed your understanding of the value of incorporating discussion of humanities content into medical training and/or practice.

(if you want to continue this conversation, please include your name and email)
Joy to the Word: Combining Emotional and Intellectual Engagement to Build Workplace Pleasure Among Physicians

Lois Leveen, Ph.D.
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How can we as facilitators effectively follow-up with you:

- ongoing humanities content/prompts or other conversation through listserv or other asynchronous (or synchronous) virtual meetings?
- drop-in to lead in-person workshops?
INCREASING JOY IN MEDICINE

AMERICAN MEDICAL ASSOCIATION • CANADIAN MEDICAL ASSOCIATION • BRITISH MEDICAL ASSOCIATION

ICPH 2016 | INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH™
Feeling Burned Out?

Using Science and Wisdom of Contemplative Practices to Manage Your Stress and Reduce Burnout

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Nothing to disclose
Goals

• Understand the syndrome of burnout
• Be familiar with the basic concept and exercises in mindfulness and compassion cultivation as a potential tool to prevent burnout
• Apply these concepts to your personal and professional areas
What is burnout?

- **Emotional exhaustion**
  - Emotionally overextended
  - Losing enthusiasm for work
  
  *Hallmark of Burnout*

- **Depersonalization**
  - Negative, cynical attitude, treating patients as objects

- **Reduced sense of personal accomplishment**
  - Having a sense that work is no longer meaningful

Maslach, 1981; Shanafelt, 2009
Other symptoms of burnout

- **Neglecting needs**: non-medical interests put on “back burner”, poor self care, poor sleep
- **Interpersonal conflicts**: less tolerant to colleagues/trainees, avoidance of emotionally difficult clinical situations, socially isolated, cutting corners at work, *sarcasm*, blame increasing problems on time pressure and work (vs how they engage)
- Wish they are sick so not to come to work, thinking often about quitting, retiring, changing career (often to a non-clinical area)
- **Psychiatric symptoms**: addictive behaviors, mood, PTSD, somatic symptoms can lead to full clinical syndromes including suicide

How common is burnout?

- More than 1 of every 3 physicians is experiencing burnout at any given time.
- Situation is worsening over past few years:
  - 54.4\% (n=3680) of the physicians reported at least 1 symptom of burnout in 2014 compared with 45.5\% (n=3310) in 2011.
- Highest rates: emergency med, internal med, family med, neurology, radiology - even after adjustment.
- Physician are at higher risk for burnout and less likely to be satisfied with work-life balance compared to US working population.

Impact

Negative effects on

- Patient-physician relationship, empathy
- Quality of care
- Patient outcomes, satisfaction
- Professionalism, behaviors
- Personal /family/ career decision
• Causes of burnout are multifactorial
• Management/prevention encompasses many levels, areas—organizational changes, education, coping strategies, support, etc

Could it also be from how we are relating with suffering in others and ourselves?
Yassen (1995) sees prevention as a multi-pronged approach encompassing strategies at the individual level (personal & professional) and strategies at the environmental level (societal & organizational). This model is a framework for planning that addresses the impact of vicarious trauma.
• SELF CARE
  • eat, sleep, rest, exercise, socialize, laugh, play, “pray” WELL

• SUPPORT/ENGAGEMENT
  – Create a community at work, with positive interpersonal interactions, find support & mentoring

• FIND MEANING & JOY
  – Identify what is meaningful to you in your job and do that at least a day a week (more is better!)

• Learn techniques to reduce stress and to be “present”
  – Mindfulness

Kearney 2009, Shanafelt, 2009 Nedrow 2013
Reflect on what is your “calling”

http://ideas.ted.com/7-lessons-about-finding-the-work-you-were-meant-to-do/
Based on the book Callings, by Dave Isay
Burnout
Compassion
fatigue
Depression

Engagement
Empathy
Compassion

Self-Awareness

Pity
Anger
Avoidance
Mindlessness
Self-awareness

• combination of self- knowledge and development of “dual-awareness”
  – simultaneously attend to and monitor the needs of the patient, the work environment, and his or her own subjective experience – without reacting (or with awareness of our reactivity or needs)

• “presence” / “compassionate presence”
• “mindfulness”

Kearney MK in Hutchinson (ed) : “Whole Person Care”
What is mindfulness?

“The awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment to moment”

(Kabat-Zinn, 2003)
Space between stimulus and response

“Between stimulus and response there is a space. In that space is our power to choose our response. In our responses lies our growth and our freedom.”

Viktor E. Frankl
Man’s Search for Meaning
Teaching Doctors to Be Mindful

By PAULINE W. CHEN, M.D.

Doctors from across the world gather at the Chapin Mill Retreat Center in Batavia, N.Y., to bring intention, attention and reflection to clinical practice.

It was 6:40 in the morning and nearly all of the doctors attending the medical conference had assembled for the first session of the day. But there were no tables and chairs in sight, no lectern, no run-throughs of PowerPoint presentations. All I could make out in the early morning darkness were the unmoving forms of my colleagues, cross-legged on cushions and raised platforms, eyes closed and hands resting with palms upward in their laps.
The Impact of a Program in Mindful Communication on Primary Care Physicians

Howard B. Beckman, MD, Melissa Wendland, Christopher Mooney, MA, Michael S. Krasher, MD, Timothy E. Quill, MD, Anthony L. Suchman, MD, and Ronald M. Epstein, MD

Abstract

Purpose
In addition to structural transformations, deeper changes are needed to enhance physicians’ sense of meaning and satisfaction with their work and their ability to respond creatively to a dynamically changing practice environment. The purpose of this research was to understand what aspects of a successful continuing education program in mindful communication contributed to physicians’ well-being and the care they provide.

Method
In 2008, the authors conducted in-depth, semistructured interviews with primary care physicians who had recently completed a 52-hour mindful communication program. The interviews were transcribed and analyzed qualitatively. The authors identified salient themes from the interviews.

Results
Participants reported three main themes: (1) sharing personal experiences from medical practice with colleagues reduced professional isolation, (2) mindfulness skills improved the participants’ ability to be attentive and listen deeply to patients’ concerns, respond to patients more effectively, and develop adaptive reserve, and (3) developing greater self-awareness was positive and transformative, yet participants struggled to give themselves permission to attend to their own personal growth.

Conclusions
Interventions to improve the quality of primary care practice and practitioners’ well-being should promote a sense of community, specific mindfulness skills, and permission and time devoted to personal growth.

High quality, cost-effective health care has been linked to the availability of primary care services; yet primary care in the United States is at considerable risk. Job satisfaction for primary care physicians is strongly linked to their relationships with patients, which have been impaired by increasing time and productivity pressures and administrative burdens. These factors, plus physicians’ social isolation and low sense of control over their work environment, contribute to a high prevalence of burnout. Burnout, in turn, is related to poorer quality of care and poorer relationships with their patients. These dynamics likely contribute to the declining interest in primary care careers.

The program significantly improved indicators of patient-centered care (e.g., empathy, psychosocial orientation) while also enhancing physicians’ well-being (e.g., decreased burnout, improved mood). These changes were mediated by changes in physicians’ mindfulness.

This report describes the results of qualitative interviews we conducted with a subsample of participants in the Mindful Communication course. Our goal was to understand in greater depth what aspects of their experience contributed to their improvements in well-being and patient-centered care.
Sounds good! How do I learn that?

- Mindfulness is also a skill that gets better with practice.
How to Meditate

by David Gelles @dgelles
What is compassion?

• A basic kindness, with deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it. (Paul Gilbert, PhD)

• CCARE’s multi-stage model:

1. Recognition of suffering
2. A feeling of concern and connection
3. A desire to relieve suffering
4. A willingness to act
3 Components of Compassion for Self and Others

• **Mindfulness**
  - noticing suffering of self/others
    without avoidance, aversion, or overidentification

• **Kindness**
  - treating self/others with care and understanding
  - soothing, comforting, mentoring

• **Common Humanity**
  - recognizing that human condition is imperfect.
  - seeing the experience of self/others as part of larger human experience
Self-compassion

- Self Acceptance, Self care
- NOT self-indulgence, letting off the hook

- “Heart must first pump blood to itself”
“At a cardiac arrest, the first procedure is to take your own pulse.”

Law #3 from The House of God: Samuel Shem
“open” your heart to the suffering

“We cannot selectively numb emotions, when we numb the painful emotions, we also numb the positive emotions.”

Brené Brown, The Gifts of Imperfection
"if a living system is suffering from ill health, the remedy is to connect it with more of itself."

- Francisco J Varela
Shared common humanity

“appreciation that what you are going through are also being felt by millions people in the world”

- Interconnectedness
- Commonalities > Differences
- Suffering is the same
- We are all in this together
“**Compassion** is not a relationship between the healer and the wounded. It's a relationship between **equals**. Only when we know our own darkness well can we be present with the darkness of others. Compassion becomes real when we recognize our **shared humanity**.”

Suffering → Compassion

- Sadness
- Shame
- Anger, schadenfreude
- Pity
- Avoidance
Our energy, will power, empathy are limited

- suffering is draining

• Manage by using it smarter not harder
  – narrowing the input of suffering – good idea?

• Replenish the tank
  – rest, play, exercise, hobby, connection
  – mindfulness/compassion/gratitude/meaning as a way to auto-replenish.
  – change your relationship with suffering which transform it into positive energy
“The quality of compassion is inborn, **the inheritance of every human being**; whether one is a believer or not, on this level there is no difference. What the teachings of the world’s religions seek to do is **help us recognize** this heritage and provide us with a **systematic means** to foster it, enhance it, and bring it to perfection.”

*HHDL. Towards a True Kinship of Faiths: How the World's Religions Can Come Together*
Cultivating Compassion

- Evidence suggests compassion can be strengthened through targeted exercises and practice
- Components of Compassion training programs
  - Mindfulness training
  - Self-compassion component
  - Guided experiential practices
  - Delivered in group setting with interactive format
  - Home work, meditation
8 WEEK TRAINING

Mindfulness/Settling the Mind  Compassion for Loved One  Compassion for Self  Loving Kindness for Self

Shared Common Humanity  Compassion for Others  Active Compassion  Integrated Compassion

Leah Weiss, PhD : CCARE
• **Pause and check in with your body** throughout the day or during the transition

• Remind yourself often of your **intention**

• **Breathe** through the suffering
Embodiment

Use your body sensation as an “anchor”

• Walking
• Sitting
• Stretching
5-3-1

5 | MEDITATE
Meditate for 5 minutes

3 | GRATITUDE
Write down 3 good things

1 | KINDNESS
Do 1 act of kindness

#MakeTheWorld

http://centerhealthyminds.org/join-the-movement/try-the-5-3-1-practice
Photo:https://pbs.twimg.com/media/CpLam7DXYAArVvK.jpg
Summary

• Burnout – occupational risks
• How we engage/relate to the suffering can make a difference
• Suggestion:
  – Reflection on your priorities, make changes where you can
  – Establish a practice and community of support
• Mindfulness/Compassion is a muscle that must be exercised to be strong
“In the sea of equanimity with loving kindness as moisture, the seed of compassion grows into a tree of true altruism”.
Thank You
Recommendations from a Conference on
Advancing Compassionate,
Person- and Family-Centered Care
Through Interprofessional Education
for Collaborative Practice
Advancing Compassionate, Person- and Family-Centered Care Through Interprofessional Education for Collaborative Practice

Conference Executive Summary

Compassion is essential for effective collaboration among healthcare professionals, staff, patients and families. But despite evidence supporting the importance of compassionate healthcare, the concepts and skills related to empathy and compassion, and that are needed to provide person-/family-centered and relationship-based care, are not routinely taught, modeled and assessed across the continuum of learning and practice. To change this paradigm, the Schwartz Center for Compassionate Healthcare and The Arnold P. Gold Foundation, in collaboration with the Josiah Macy Jr. Foundation and the Bucksbaum Institute for Clinical Excellence at the University of Chicago convened 84 healthcare experts — from patients, family members and advocates to clinicians, health professions educators, licensure and accreditation agency representatives, funders and administrators — with the goal of discussing and recommending timely steps to integrate compassion and collaboration into health professional education and clinical care.

Participants agreed that compassionate, collaborative care, or “The Triple C,” is essential if we are to achieve “The Triple Aim” of improving health and experiences of care while controlling costs. They shared their own experiences, listened to and discussed patient, family member and provider stories and cases and commented on a prepared discussion paper and a Compassionate, Collaborative Care Competency Framework of requisite attributes and behaviors. During the conference, they formulated four actionable recommendations to advance “The Triple C” — details are summarized in the full conference report:

1. Involve patients and families as partners in health professional education, their own care and in co-designing healthcare delivery;

2. Educate patients, families, professionals and staff about the importance of “The Triple C” and align salient competencies with existing education, assessment and standards;

3. Conduct research to measure “The Triple C” at all levels (individuals, teams and organizations) and to study its outcomes;

4. Incentivize and reward “The Triple C.”
“The Triple C,” like “The Triple Aim,” is what practitioners want to provide and what patients and families want and need. The work ahead lies in understanding and leveraging the support needed to make “The Triple C” the standard of care in every healthcare organization and system — and in every encounter. Our organizations look forward to working with various stakeholders, including health professions educators, accreditation and licensure organizations, clinicians and administrators, and patient and family advocates to make this a reality.
Advancing Compassionate, Person- and Family-Centered Care through Interprofessional Education for Collaborative Practice

**COMPASSIONATE, COLLABORATIVE CARE MODEL AND FRAMEWORK**

*Framework Development Group:
Beth Lown, Sharrie Mcintosh, Kathy McGuinn, Carol Aschenbrener, DeWitt (Bud) Baldwin, Calvin Chou, Hala Durrah, Mira Irons, Ann King, Joanne Schwartzberg

*Framework Advisory Group:
Liz Crocker, Maryellen Gusic, Eric Holmboe, Mira Irons, Kathy McGuinn, Laura Morrison, Deborah Trautman

**Background:**
In our increasingly complex healthcare environments, collaboration is essential if we are to progress toward the “Triple Aim” of creating positive patient and family experiences and better health at lower cost. Interprofessional education (IPE) is an important strategy towards that goal. Much progress has been made: the Interprofessional Education Collaborative’s (IPEC) Core Competencies for Interprofessional Collaborative Practice have been endorsed by a number of health professions as foundational, many health professions have adopted accreditation standards that require meaningful IPE, 120/140 medical schools now have required IPE experiences, and, to date, more than 225 schools of health professions have sent a total of 249 teams to one of the seven IPEC Faculty Development Institutes that began in May 2012. A National Center for Interprofessional Education and Practice in Minnesota was established with support from a Health Resources and Services Administration Cooperative Agreement Award and several visionary philanthropic organizations including the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation and the Gordon and Betty Moore Foundation.

At a recent conference, we built on this work and asked the question, “What role do empathy and compassion play in collaborative care?” Without empathy and compassion, care may be technically excellent but depersonalized, and will fail to address the unique emotional, psychological and social needs of the person who seeks health and care. As one mother of a chronically ill child said to us recently, “Care can be collaborative without necessarily being compassionate,” and the opposite is also true. We begin with the assumption that, in truly collaborative care, whatever one’s role in the moment, everyone is a member of the healthcare team — patients, family members, clinicians, staff, administrators, managers, leaders alike. To ground us in common language, we offer the following definitions and premises:

**Compassion** is the recognition, empathic understanding of and emotional resonance with the concerns, pain, distress or suffering of others coupled with motivation and relational action to ameliorate these conditions.

**Care that is compassionate and collaborative is based on** (1) the ability to experience and to act on one’s compassion, (2) the ability to collaborate, communicate and partner with patients and family members to the extent they need and desire, (3) the commitment of all who provide and support healthcare to communicate and collaborate with each other, and (4) the resilience and wellbeing of professional and family caregivers.

**Goals and purpose of this document:**
Our ultimate goal is to enhance healthcare professionals’ ability to partner with each other, patients, families and communities to co-create and implement compassionate, collaborative care. We drafted this document to deepen our collective understanding of the antecedents and components of empathy and compassion and to articulate how these are, or can be, interwoven with existing competencies, particularly for those who aspire to teach, model and assess such care in clinical settings. These competencies are not “add-ons” but rather, map directly onto existing competencies for patient care, professionalism and interpersonal and communication skills. Indeed, the components in Table 1 are derived directly from a review of IPEC competencies, ACGME milestones, Core Entrustable Professional Activities for Entering Residency, the Hospice and Palliative Medicine Milestone Project, and nursing competencies, published literature on communication, along with formulation of empathy and compassion-focused competencies by the Schwartz Center for Compassionate Healthcare and The Arnold P. Gold Foundation.

A parallel goal is to provide a framework that can guide patients’ and families’ expectations of the care they should receive and empower them to communicate
their needs and advocate for their wishes. Our hope is that this document will be used in at least four ways:

1. As a resource to create learning objectives and to implement educational curricula and programs that promote compassionate, collaborative care;
2. To use the Framework’s behavioral descriptors in assessment tools;
3. To expand the representation of these constructs in competencies, milestones,entrustable and observable professional activities, and other benchmarks of professional developmental for licensure and accreditation processes across professions;
4. To help organizations, institutions, systems and communities implement compassionate, collaborative care in practice, realizing that a supportive organizational culture and systems-change will be necessary to do so.

How to use this document and caveats:
This document includes the concepts and skills we think are important for unsupervised compassionate and collaborative practice. We recognize that this will likely undergo iterative changes over time. The work of describing a developmental approach to these concepts and skills and providing sufficient granularity for assessment must follow after first laying this groundwork and inviting further discussion.

There are numerous models, frameworks, and assessment tools to teach and assess “patient/family-centered communication,” which is essential to provide compassionate, collaborative care. A detailed discussion of these resources, however, is beyond the scope of this document. Educators, researchers and evaluators agree that experiential methods must be used to teach these skills and direct observation by multiple observers, on multiple occasions, from multiple points of view are required to assess them.
Advancing Compassionate, Person- and Family-Centered Care through Interprofessional Education for Collaborative Practice

**COMPASSIONATE, COLLABORATIVE CARE MODEL AND FRAMEWORK**

*Framework Development Group:*
Beth Lown, Sharrie McIntosh, Kathy McGuinn, Carol Aschenbrener, DeWitt (Bud) Baldwin, Calvin Chou, Hala Durrah, Mira Irons, Ann King, Joanne Schwartzberg

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**Figure 1. Context and outcomes of compassionate, collaborative care**

Legend:
This figure depicts person-/family-centered and relationship-based care resulting from the intersection of compassion and collaboration. Such care incorporates the attributes described in the table that follows. Working towards “The Triple Aim” and “The Quadruple Aim” (which includes supporting healthcare professionals’ wellbeing) is essential if we are to realize positive outcomes related to the health and wellbeing of all members of the healthcare “team,” including patients and family caregivers, healthcare professionals and staff. This intersection occurs within complex educational and healthcare systems and needs to be supported and promoted by such systems in order to achieve these positive outcomes.
### TABLE 1.

<table>
<thead>
<tr>
<th>ATTRIBUTES OF COMPASSIONATE, COLLABORATIVE CARE</th>
<th>VALUES AND BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIRECTS AND FOCUSES ONE'S ATTENTION</td>
<td><strong>Sub-skills:</strong></td>
</tr>
<tr>
<td></td>
<td>• Prepares ahead for the encounter or meeting when possible</td>
</tr>
<tr>
<td></td>
<td>• Pauses to clear one's mind before engaging with others</td>
</tr>
<tr>
<td></td>
<td>• Sets aside distractions</td>
</tr>
<tr>
<td></td>
<td>• Makes eye contact when culturally appropriate</td>
</tr>
<tr>
<td></td>
<td>• Sets aside distractions and barriers to eye contact and proximity</td>
</tr>
<tr>
<td>RECOGNIZES NONVERBAL CUES</td>
<td><strong>Sub-skills:</strong></td>
</tr>
<tr>
<td></td>
<td>• Accurately interprets facial and bodily expressions of emotion</td>
</tr>
<tr>
<td></td>
<td>• Notices and interprets significance of speech pace, pitch, word choice and sequence</td>
</tr>
<tr>
<td>ACTIVELY LISTENS</td>
<td><strong>Sub-skills:</strong></td>
</tr>
<tr>
<td></td>
<td>• Can be silent while maintaining presence and focus on the other person</td>
</tr>
<tr>
<td></td>
<td>• Uses head nods, “continuers” (e.g., uh huh)</td>
</tr>
<tr>
<td></td>
<td>• Uses reflective listening skills (simple and complex reflections or reframing)</td>
</tr>
<tr>
<td></td>
<td>• Bases comments on what’s just been said</td>
</tr>
<tr>
<td></td>
<td>• Summarizes what has been said to ensure understanding</td>
</tr>
<tr>
<td>ELICITS INFORMATION: SHOWS INTEREST IN THE “WHOLE PERSON”</td>
<td><strong>Overarching communication skills:</strong> Asks open and closed clarifying questions, provides reflective comments and summarizes to ensure accurate understanding using language the patient understands</td>
</tr>
<tr>
<td></td>
<td><strong>Explores patient’s and family’s social, cultural, context, linguistic and literacy needs as they relate to patient’s illness</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Sub-skills and examples of tools to use with patients/families:</strong></td>
</tr>
<tr>
<td></td>
<td>• Cultural sensitivity and competence skills</td>
</tr>
<tr>
<td></td>
<td>• Health literacy screening skills/tools</td>
</tr>
<tr>
<td></td>
<td><strong>Explores patient’s and family’s spiritual/religious practices as they relate to patient’s illness</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Sub-skills and examples of tools to use with patients/families:</strong></td>
</tr>
<tr>
<td></td>
<td>• FICA Spiritual Assessment Tool</td>
</tr>
</tbody>
</table>
## TABLE 1.

<table>
<thead>
<tr>
<th>ATTRIBUTES OF COMPASSIONATE, COLLABORATIVE CARE</th>
<th>VALUES AND BEHAVIORS</th>
</tr>
</thead>
</table>
| NONJUDGMENTALLY VALUES EACH PERSON             | Embraces the spectrum of diversity and the uniqueness of each individual:  
- Behaves and speaks respectfully to others always  
- Recognizes when assumptions and bias are influencing interactions and decisions  

Explores explanations/explanatory models as it relates to patient's illness:  
- FIFE model xiii  
- Kleinman 8-question model xiv |
| ASKS ABOUT EMOTIONS, CONCERNS AND DISTRESS     | Overarching communication skills: Asks open and closed clarifying questions, provides reflective comments and summarizes to ensure accurate understanding using language the patient understands  

Screens for and explores impact of illness on patient's daily activities and quality of life  
Sub-skills and examples of tools to use with patients/families:  
- HRQOL, functional and mental status instruments xv  
- Symptoms of distress xvi |
| RESPONDS TO EMOTIONS, CONCERNS AND DISTRESS    | Responds in ways that convey care and concern  
Sub-skills:  
- Reflects or names and validates the emotion, expresses respect, support and partnership (e.g., NURS model) xvii  
- Uses culturally/gender-appropriate touch to support or reassure  
- Addresses and continuously manages patients' symptoms of distress xvi |
## TABLE 1.

<table>
<thead>
<tr>
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<th>VALUES AND BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHARES INFORMATION AND DECISION-MAKING</td>
<td></td>
</tr>
<tr>
<td>Overarching communication skills: Asks open and closed clarifying questions, provides reflective comments, summarizes to ensure accurate understanding using language the patient understands</td>
<td></td>
</tr>
<tr>
<td>Accepts each team member as knowledgeable in his/her life or discipline</td>
<td></td>
</tr>
<tr>
<td>Engages in shared decision-making with patients, family members/surrogate decision-makers and clinical care colleagues</td>
<td></td>
</tr>
<tr>
<td>Sub-skills: xviii xix xx</td>
<td></td>
</tr>
<tr>
<td>• With patient or family/surrogate decision-maker, defines/explains the problem or issue</td>
<td></td>
</tr>
<tr>
<td>• Establishes/reviews patient’s capacity and preferred role in decision-making</td>
<td></td>
</tr>
<tr>
<td>• Actively encourages patient’s participation and communicates its importance</td>
<td></td>
</tr>
<tr>
<td>• Elicits/responds to ideas, values, concerns, expectations, goals</td>
<td></td>
</tr>
<tr>
<td>• Shares information about potential options and choices</td>
<td></td>
</tr>
<tr>
<td>• Discusses risks and benefits, pros and cons and alternatives</td>
<td></td>
</tr>
<tr>
<td>• Helps patient/family reflect on and assess impact of options on values, goals, health behaviors, quality of life</td>
<td></td>
</tr>
<tr>
<td>• Elicits patient/family’s values and preferences</td>
<td></td>
</tr>
<tr>
<td>• Discusses patient/family’s ability/self-efficacy to act on decisions</td>
<td></td>
</tr>
<tr>
<td>• Health professionals share recommendations, experience, evidence</td>
<td></td>
</tr>
<tr>
<td>• Checks/clarifies understanding of information and options</td>
<td></td>
</tr>
<tr>
<td>• Makes decisions with appropriate input</td>
<td></td>
</tr>
<tr>
<td>• Is explicit about deferral of decision(s) when appropriate</td>
<td></td>
</tr>
<tr>
<td>• All members of the team, including patient/family, offer input and agree on plans of care to implement decision(s), follow-up, and timeline</td>
<td></td>
</tr>
<tr>
<td>• Asks patient/family to restate plans in his/her own words or to demonstrate a newly learned skill</td>
<td></td>
</tr>
</tbody>
</table>
## Table 1

<table>
<thead>
<tr>
<th>Attributes of Compassionate, Collaborative Care</th>
<th>Values and Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demonstrates Trustworthiness</strong></td>
<td>• Acts with honesty and integrity</td>
</tr>
<tr>
<td></td>
<td>• All team members share responsibility for outcomes related to mental and physical health and quality of life</td>
</tr>
<tr>
<td></td>
<td>• Acts consistently to maximize patients' wellbeing, health and quality of life</td>
</tr>
<tr>
<td></td>
<td>• Consistently follows through on commitments, agreed-upon decisions</td>
</tr>
<tr>
<td></td>
<td>• Health professionals advocate for, and help patients and family members navigate the healthcare system</td>
</tr>
<tr>
<td></td>
<td>• Health professionals take responsibility and apologize for errors, demonstrate accountability in addressing causes of errors</td>
</tr>
<tr>
<td><strong>Communicates With Colleagues and Adjusts Actions</strong></td>
<td>• Communicates about the plan of care with patient/family and each other to ensure care coordination and continuity across settings</td>
</tr>
<tr>
<td></td>
<td>• Reflects on and adjusts behaviors to ensure compassion and collaboration</td>
</tr>
<tr>
<td></td>
<td>• Reflects on and engages team members' expertise to inform/revise plans</td>
</tr>
<tr>
<td></td>
<td>• Engages in continuous improvements in processes and systems to ensure compassion, collaboration, safety, effectiveness</td>
</tr>
<tr>
<td></td>
<td>• Shares reactions to the impact of illness on patients, family members and oneself</td>
</tr>
<tr>
<td></td>
<td>• Supports and promotes colleagues self-care</td>
</tr>
<tr>
<td><strong>Practices Self-Reflection</strong></td>
<td>• Regularly elicits feedback from colleagues</td>
</tr>
<tr>
<td></td>
<td>• Reflects on one's values, skills, behaviors and performance</td>
</tr>
<tr>
<td></td>
<td>• Consistently acts on feedback and self-reflections to improve one's practice and care</td>
</tr>
<tr>
<td><strong>Fosters Wellbeing and Resilience</strong></td>
<td>Resilience is the ability of an individual to respond to stress in a healthy, adaptive way such that personal and professional goals are achieved with minimal psychological and physical cost</td>
</tr>
</tbody>
</table>

*Framework Development Group:
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*Framework Advisory Group:
Liz Crocker, Maryellen Gusic, Eric Holmboe, Mira Irons, Kathy McGuinn, Laura Morrison, Deborah Trautman
Advancing Compassionate, Person- and Family-Centered Care through Interprofessional Education for Collaborative Practice

COMPASSIONATE, COLLABORATIVE CARE MODEL AND FRAMEWORK

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<th>VALUES AND BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTENDS TO RELATIONSHIPS</td>
<td>Builds partnerships, caring relationships and teamwork</td>
</tr>
<tr>
<td></td>
<td>Healthcare professionals create a safe environment for all to express their knowledge, emotions, and opinions:</td>
</tr>
<tr>
<td></td>
<td>• Respects the unique cultures, values, expertise, roles/responsibilities of patients, family members, professionals and staff</td>
</tr>
<tr>
<td></td>
<td>• Understands the roles and responsibilities of patients, family members, professionals and staff</td>
</tr>
<tr>
<td></td>
<td>• Recognizes how power and hierarchy influence relationships and patient care</td>
</tr>
<tr>
<td></td>
<td>• Respectfully acknowledges differences in perspectives and opinions</td>
</tr>
<tr>
<td></td>
<td>• Engages self and others to constructively manage disagreements</td>
</tr>
<tr>
<td></td>
<td>• Models compassionate, collaborative management and integration of discordant preferences and recommendations</td>
</tr>
<tr>
<td></td>
<td>• Fosters, offers/receives caring and support among team members</td>
</tr>
<tr>
<td></td>
<td>• Refrains from practices that would compromise relationships and performance at work</td>
</tr>
<tr>
<td></td>
<td>• Encourages self-care among patients, family members, professionals and staff</td>
</tr>
</tbody>
</table>

|                                                  | Each team member recognizes his/her limitations and engages others to complement his/her expertise, empathy, and compassion capacity: |
|                                                  | • Partners with other team members to meet patients’ and families’ needs |
|                                                  | • Forges interdependent learning and mentoring relationships |
### TABLE 1. ATTRIBUTES OF COMPASSIONATE, COLLABORATIVE CARE

<table>
<thead>
<tr>
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<th>VALUES AND BEHAVIORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATTENDS TO ONE’S OWN WELLBEING</strong></td>
<td><strong>Practices self-monitoring and self-regulation:</strong></td>
</tr>
<tr>
<td></td>
<td>- Recognizes personally held attitudes about working with others from different backgrounds (ethnic, social, cultural and others)</td>
</tr>
<tr>
<td></td>
<td>- Pauses, seeks assistance when one recognizes that emotional/cognitive biases are influencing decisions or care</td>
</tr>
<tr>
<td></td>
<td>- Reflects on appropriate boundaries and monitors oneself for signs of both over-identification and detachment</td>
</tr>
<tr>
<td></td>
<td>- Educates oneself and others about, recognizes and seeks appropriate assistance for symptoms of mental health issues, burnout, compassion fatigue and moral and personal distress</td>
</tr>
<tr>
<td></td>
<td><strong>Practices self-care; takes action to maintain wellbeing and personal health and to promote one’s personal development:</strong></td>
</tr>
<tr>
<td></td>
<td>- Accepts personal limitations</td>
</tr>
<tr>
<td></td>
<td>- Sets appropriate limits on self-expectations and others’ expectations and demands</td>
</tr>
<tr>
<td></td>
<td>- Implements a self-care plan and continuously re-evaluates its effectiveness</td>
</tr>
<tr>
<td></td>
<td>- Recognizes and works to process personal and professional grief and loss</td>
</tr>
<tr>
<td></td>
<td>- Engages in supportive relationships and communities</td>
</tr>
<tr>
<td></td>
<td>- Engages in activities that bring joy, fulfillment and a sense of renewal</td>
</tr>
<tr>
<td></td>
<td><strong>Practices self-compassion:</strong> xxii</td>
</tr>
<tr>
<td></td>
<td>- Demonstrates openness to one's own suffering, not avoiding or disconnecting from it</td>
</tr>
<tr>
<td></td>
<td>- Offers nonjudgmental understanding to one's pain, inadequacies and failures</td>
</tr>
<tr>
<td></td>
<td>- Sees one's experience as part of the larger human experience</td>
</tr>
</tbody>
</table>
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COMPASSIONATE, COLLABORATIVE CARE MODEL AND FRAMEWORK

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Deborah Trautman, PhD, RN, American Association of Colleges of Nursing

* Please note that participation by the individuals listed does not necessarily constitute endorsement of the content of this document by the organizations with which they are affiliated.
Advancing Compassionate, Person- and Family-Centered Care through Interprofessional Education for Collaborative Practice

*COMPASSIONATE, COLLABORATIVE CARE MODEL AND FRAMEWORK*

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Oral presentations

Monday, September 19, 2016
1pm – 2pm

Note: All presentations may not be included as we are still collecting the final presentations from presenters, some may have been omitted for copyright purposes. Check back periodically for updates.
INCREASING JOY IN MEDICINE

ICPH 2016 | INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH™
Transform the Healthcare System to Increase Joy in Medicine!

International Conference on Physician Health
September 19, 2016

Steven A. Adelman, MD
Director, Physician Health Services, Inc. and
Clinical Associate Professor of Psychiatry,
University of Massachusetts School of Medicine

Harris Berman, MD
Dean, Tufts University School of Medicine and
Professor of Public Health and Community Medicine
Main Points

• Health care is a complex system.

• The health care system has inadvertently become configured to produce the joylessness and burnout that it is currently prevalent.

• Increasing joy and diminishing burnout and joy are most likely to be achieved by implementing large-scale, transformational systemic changes that can be envisioned.

• Eight possible transformational approaches to system change have been envisioned by the authors.

• Preliminary survey results of others are shared.

• Where do we go from here?
The Ask

We have identified a number of high level system approaches, which, if pursued in earnest, have the potential to lead to significant improvements in the professional and personal well-being of practicing physicians. Please rate each of these approaches in terms of your opinion as to the relative importance of the approach and the relative difficulty of implementing the approach.
RESPONDEES (N = 425)

- Health care executive  N = 46
  (high-ranking “decision maker”)
- Clinical leader  N = 84
  (a leader of clinicians, physicians and/or non-physicians)
- Practicing physician  N = 284
  (you deliver patient care)
- Practicing non-physician clinician  N = 5
  (you deliver patient care)
- Physician, not currently practicing  N = 47
- Medical school administrator  N = 8
- Medical school faculty member  N = 60
  (patient care and/or teaching and/or research)
- Physician Health Program (PHP) professional  N = 26
  (you assist physicians at a PHP)
- Other  N = 28
RATING THE APPROACHES

Importance

- Unimportant = 1
- Somewhat important = 2
- Very Important = 3
- Extremely Important = 4

Difficulty of implementation

- Easy to implement = 1
- Somewhat difficult to implement = 2
- Very difficult to implement = 3
- Extremely difficult to implement = 4

\[ R = \frac{\text{Importance}}{\text{Difficulty of Implementation}} \]
Approach #1: UPGRADE MEDICAL SCHOOL ADMISSIONS PROCESS

Place a greater emphasis on identifying emotional intelligence (EI) in the medical school admissions process. [Definition of EI: “The capacity to be aware of, control, and express one's emotions, and to handle interpersonal relationships judiciously and empathetically.”]

Importance = 2.95
Difficulty of Implementation = 2.5
R = 1.18
Approach #2: REDUCE MEDICAL SCHOOL DEBT BURDEN

Reorganize the funding of medical education to diminish burdensome debt for early career physicians

Importance = 3.18

Difficulty of Implementation = 2.66

R = 1.20
Approach #3: INCREASE GME FOCUS ON PRIMARY CARE

Rebalance the funding and focus of graduate medical education to produce a greater proportion of ambulatory-based primary care physicians and a smaller proportion of physicians who focus on procedures and/or facility-based levels of care.

Importance = 2.74
Difficulty of Implementation = 2.54
R = 1.08
Approach #4: MORE $ FOR PRIMARY CARE & HEALTH MAINTENANCE

Significantly increase the earnings of practicing physicians who focus on health maintenance and primary care.

Importance = 3.0

Difficulty of Implementation = 2.54

R = 1.18
Approach #5: MIGRATE FROM FFS TO VALUE-BASED-CARE

Accelerate system migration away from fee-for-service care to value-based care. [In value-based care models, doctors, medical groups and hospitals are paid for helping keep people healthy and for improving the health of those who have chronic conditions in an evidence-based, cost-effective way. The fee-for-service reimbursement system rewards the volume of care delivered.]

Importance = 2.66
Difficulty of Implementation = 2.85
R = .93
Approach #6: PROMOTE WORK-LIFE BALANCE & SELF-CARE

Make a concerted effort to restructure physician work-life in ways that promote better self-care and better work-life balance.

Importance = 3.30

Difficulty of Implementation = 2.65

R = 1.25
Approach #7: **DECREASE TECHNOLOGICAL DEGRADATION OF CARE EXPERIENCE**

Improve and upgrade technology (including, but not limited to, the EHR) in order to decrease clicking, screen time, and other non-value-added clerical work. [The goal of this approach is to enrich the doctor-patient relationship and enhance each physician’s ability to work at “top of license” in the realms of medical knowledge, technical skill and effective, patient-centered care.]

**Importance** = 3.56

**Difficulty of Implementation** = 2.46

*R* = 1.45
Approach #8: PROMOTE COMPREHENSIVE TEAM-BASED-CARE

Address and modify systemic factors (including, but not limited to, the traditional physician-centric approach to reimbursement and medical malpractice) that impede physicians’ ability to deliver care in a fashion that is genuinely and comprehensively team-based. [A major goal of this approach is to shift the massive burden that many physicians currently experience as being “almost entirely on their shoulders,” such that it is shared, as appropriate, with other members of high-functioning multidisciplinary care teams.]

**Importance = 2.91**

**Difficulty of Implementation = 2.63**

*R = 1.11*
\[ R \text{ Score} = \frac{\text{Importance}}{\text{Difficulty of Implementation}} \]
## Perceptions of Approaches for Enhancing Joy in Medicine

Ratio of (Importance)/(Difficulty of Implementation)

<table>
<thead>
<tr>
<th>Q#</th>
<th>Description</th>
<th>All (427)</th>
<th>Practicing MDs (305)</th>
<th>Clinical Leaders (95)</th>
<th>Executives (26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>FFS &gt; Value-Based Care</td>
<td>0.93</td>
<td>0.93</td>
<td>0.95</td>
<td>1.14</td>
</tr>
<tr>
<td>3</td>
<td>Train More PCPs</td>
<td>1.09</td>
<td>1.14</td>
<td>1.01</td>
<td>1.22</td>
</tr>
<tr>
<td>8</td>
<td>Promote Team Care</td>
<td>1.10</td>
<td>1.04</td>
<td>1.08</td>
<td>1.38</td>
</tr>
<tr>
<td>4</td>
<td>Increase PC &amp; HM $</td>
<td>1.18</td>
<td>1.18</td>
<td>1.08</td>
<td>1.33</td>
</tr>
<tr>
<td>1</td>
<td>Upgrade MS Admissions</td>
<td>1.18</td>
<td>1.16</td>
<td>1.14</td>
<td>1.46</td>
</tr>
<tr>
<td>2</td>
<td>Reduce Debt Burden</td>
<td>1.20</td>
<td>1.18</td>
<td>1.18</td>
<td>1.18</td>
</tr>
<tr>
<td>6</td>
<td>Enhance W-L Balance</td>
<td>1.25</td>
<td>1.24</td>
<td>1.19</td>
<td>1.27</td>
</tr>
<tr>
<td>7</td>
<td>EHR Degradation Stops</td>
<td>1.45</td>
<td>1.46</td>
<td>1.33</td>
<td>1.42</td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td>1.18</td>
<td>1.17</td>
<td>1.12</td>
<td>1.30</td>
</tr>
</tbody>
</table>
Difficult Questions

• How do we actually change the complex health care system?

• Is anybody in charge?

• What about piecemeal changes? Incremental change?

• Can we anticipate unintended consequences?

• Is there a role for “the guild?”
A tale of two countries: Innovation and Collaboration Aimed at Changing the Culture of Medicine in Uruguay

• Juan J Dapueto, MD, PhD, Professor of Medical Psychology
• Mercedes Viera, LicPsyc, Profesora Adjunta, Departamento de Psicología Médica, Facultad de Medicina, Universidad de la República
• Charles Samenow, MD, MPH Associate Professor, Department of Psychiatry and Behavioral Sciences, George Washington University School of Medicine
• William H. Swiggart, MS, LPC/MHSP Co-Director, Center for Professional Health, Vanderbilt University Medical Center
• Jeffrey Steiger Visiting Scholar and Instructor of Clinical Psychiatry, George Washington University School of Medicine

Nothing to disclose
Three learning goals:

• Identify three strategies followed through a collaboration of multinational institutions to enhance physician wellness and professional behavior
• Discuss the educational activities developed and impact on the culture
• Discuss the barriers encountered and future strategies to promote change
Context and Background

• Through 5 year collaboration between the George Washington University School of Medicine, Vanderbilt University Center for Professional Health and the Faculty of Medicine of the Universidad de la República, Uruguay we achieved sustained cultural change.

• Using traditional didactics, interactive theater, site visits/observations and professional development workshops, we were able to address three pillars of physician health – physician wellness/self-care, professional behavior and patient safety.
Approach

The interventions consisted of four rounds of activities between 2010 and 2015:

1) traditional didactics and meetings with key stakeholders (2010)
2) an interactive theatrical presentation to raise awareness and spark dialogue (2013)
3) site visits to identify best practices (2012 and 2014)
4) skills-based workshops to promote change (2015).

Participants included faculty members, doctors in general practices, stakeholders, and other health professionals (nurses, psychologists, social workers).
Naming the Issues
Identify Champions

Didactics 2010

Identify Best Practices
Develop Programs
Establish Resources

Skills 2015

Foster Dialogue
Raise Awareness

Theater 2013

Site Visits 2012 2014

Wellness, Professionalism, Safety
Didactics

• Definition of Disruptive Behavior
• Etiologies and Types of Disruptive Behaviors
• Impact of Disruptive Behaviors
• Management and Resources for Disruptive Behaviors
Theater

- Portrayal of Physician Health, Behavior and Professionalism in a Safe Space
- Audiences of students, residents, nurses, physicians and administration
- Dialogue and Change
Site Visits

• 2 week visit to the George Washington University
  – Standardized Patient Program
  – Preclinical and Clinical Curriculum
  – Meetings with students, teachers and administrators

• 1 week visit to the Vanderbilt Center for Professional Health
  – Observation of the “Program for Distressed Physician”
  – Meeting with Physician Wellness Committee and Occupational Health Staff
Skills Training

- Communication and Assertiveness
- Identifying Triggers and Emotional Flooding
- Mindfulness and Grounding
- Family of Origin
- Professional Boundaries
Findings (1)

• These educational interventions were rated as satisfactory or very satisfactory by participants (n = 359) in the following categories: relevance (89.7 %), applicability (60.2 %), quality (82.1 %), and global quality of activities (83.6 %).
Findings (2)

The initial presentations,
1) contributed to elevated consciousness on these issues among faculty members and the medical community,
2) helped identify and empower local champions,
3) promoted the creation of a network between the Faculty of Medicine, medical associations, the Medical College of Uruguay, policy makers and stakeholders,
Findings (3)

4) sparked changes in the curriculum with the inclusion of a code of conduct in the first year and the implementation of a workshop on professional health and behavior in the last year of medical school,

5) launched the Observatory of Professional Behavior, a working group that strives to improve the quality of the relational environment between faculty members and students in the different settings and learning environments.
Partnership

- Raised Awareness
- Local Champs
- Curricular Changes
- Code of Conduct
- Future CME
- Observatory for Professional Behavior
- Networks with National Patient Safety Initiatives

Raised Awareness

Partnership
Conclusions

• A multinational collaboration using a variety of creative approaches can help promote sustained changes in physician health, behavior and patient safety.
Questions/Discussion
INCREASING JOY IN MEDICINE

AMERICAN MEDICAL ASSOCIATION | CANADIAN MEDICAL ASSOCIATION | BRITISH MEDICAL ASSOCIATION

ICPH 2016 | INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH™
FINDING JOY IN MEDICINE BY SERVING THE UNDERSERVED

Personal Reflections from Volunteering in the USA and Haiti

ICPH 2016 International Conference On Physician Health
SELAMAT SIANG!
Finding Joy in Medicine By Serving the Underserved

Personal Reflections from Volunteering in the USA and Haiti
Monika Kusuma-Pringle, MD
Mary Zemyan Polito, CRNP, DNP

Nothing to disclose
MARY’s Messages
Who Am I?

- International Medical Graduate from Trisakti University Faculty of Medicine, Jakarta, Indonesia. Psychiatry Internship at Diponegoro University Faculty of Medicine, Semarang, Indonesia.
- Born and Raised in Jakarta, Indonesia
- Married and Moved to Johnstown, PA, USA in 2006
- Volunteers at JFMC since 2007, local hospital since 2013
Why Am I Here?

My Objectives are:
→ Inspire
→ Encourage
→ Motivate
→ Find Joy within yourself

Let’s Start!
A Journey…

Johnstown, PA, USA

Jakarta, Indonesia

10552 miles (16177 km/8725 nautical miles)
Johnstown, PA
World’s Steepest Vehicular Inclined Plane

From the top of the Incline
Johnstown, PA

  - Total population: 136,411
  - Per capita income: $37,536
  - Unemployment rate: 6.7%
Johnstown, PA

- Uninsured and Underserved area
- Need a lot of help in medical care
- Johnstown Free Medical Clinic → Highlands Health Laurel Highlands Free and Charitable Medical Clinic
Johnstown Free Medical Clinic

• The Johnstown Free Medical Clinic is a legacy to its founder, Dr. George Katter. During the Johnstown Flood of 1977, he ran a medical clinic at a former elementary school to treat flood victims. In 1998, he recognized that the need for medical services was greater than any one physician could provide. Dr. Katter teamed up with a newly formed group, the Johnstown Free Medical Clinic (JFMC). He donated his office and all the equipment to JFMC. Dr. Katter passed away May 24, 2013. Dr. Katter thrived on his ability to serve the poor, working tirelessly to provide all patients with top medical care. His spirit and enthusiasm for healing others has been one of my inspiration.
Volunteers in Action
Life as a Volunteer
Medical Mission Trip
Serving The People

Outpatient Clinic

Mountain area
Pros and Cons

Pros
• Learn something new
• Giving back/pay it forward
• Finding Happiness or new purpose in life
• Meeting new friends

Cons
• Time
• Limited Resources
• Financial Benefit
• Inner Conflicts
THE SMILE
Five Inspiring People I’ve Met
Pertanyaan? Questions?
Terima kasih! Thank you very much!

Monika Kusuma-Pringle
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Nothing to disclose
Aha!...hahaha:
Attending Physicians Use Humor on Medical Teaching Units

Jane Lemaire MD, Kristen Desjarlais-deKlerk PhD, Alicia Polachek MA
Background

- Hospital wards within university hospitals (i.e., medical teaching units) are key settings to train doctors.

- Attending physicians on the hospital wards (i.e., preceptors) are accountable for:
  - Patient care
  - Medical education
  - Leadership of a multidisciplinary team

- The use of humor is recognized as an important coping strategy for physicians.
Objectives

- To identify how preceptors use humor in their role
- To describe how preceptors and other MTU stakeholders view preceptors’ use of humor
Methods

• Qualitative study
  – 93.5 hours of observations of 24 preceptors
  – 73 semi-structured interviews with preceptors, patients, learners, nurses, and multidisciplinary team members
  – Two hospital sites of a Canadian medical teaching center in 2013

• Constructivist approach, inductive thematic data analysis
Results – Observations

• Preceptors frequently use humor
  – Sharing jokes with patients, learners, and other team members
  – Enduring good-natured jokes directed toward them
  – Finding absurdity even in trying circumstances
  – Adopting a light-hearted approach with anxious patients
  – Adding humor to collegial support
Preceptors frequently use humor

The pharmacist jokes about how they constantly bombard doctors with questions. Preceptor laughs and assures pharmacist that it is the other way around. (Field note)

Preceptor made one well received joke to illustrate teaching point about penetrance of an antibiotic, “flagyl will penetrate the patient in the next room!” (Field note)
Preceptors frequently use humor

A young patient is admitted with a rotator cuff tear and has an extremely elevated blood pressure

...Preceptor sees the patient with an iPad in his lap and says to him “it’s your job to relax right now, so chamomile tea, meditation, romantic comedies – whatever it takes. Today is all about being Feng Shui. Meditate it off bro. No checking email, no games, no shoot ‘em ups. (Field note)
Preceptors frequently use humor

Preceptor shows colleague photos of child on smart phone

He’s on the verge of having a hockey mullet, but I haven’t had a chance to take him for a haircut yet. You can’t get anything done while you’re on [MTU] right? I really don’t trust my [spouse] with this job. Both docs laugh. (Field note)
Results - Observations

- Preceptors' use of humor appears to have impact
  - Ease tensions amongst team members and patients
  - Lighten difficult situations
Preceptors’ use of humor appears to have impact

*Preceptor used humor to summarize some GI mechanics and physiology...The team had been discussing a particularly tense case, and the joke seemed to ease the tension amongst the team members. (Memo on field note)*
Preceptors’ use of humor appears to have impact

Charge nurse informs preceptor s/he has to “write the order yourself to allow the home care nurse to inject the insulin...The system won’t let me do it. This is really stupid. With the heart failure patients I can initiate all sorts of orders on my own.” Preceptor obliges...enters the order...and they joke about the arbitrariness of this system idiosyncrasy (Field note)
Results – Interviews

• Preceptors use humor as a coping strategy
  – Offsets stressful work situations
  – Buffers clinical work demands

• Humor contributes to mastery in the preceptor role
  – Promotes productivity and improves overall performance
  – Promotes communication and teamwork
  – Positively affects the learning environment
Preceptors use humor as a coping strategy

We’re dealing with people’s lives, and {sigh}, [preceptors] cannot NOT be affected by this job...You have to find humor in some of the stuff that we deal with, otherwise it’ll kill ya. It’s really intense (Allied healthcare provider)
Preceptors use humor/contributes to mastery

Well I use humor. That’s the only way I can get [through] MTU,...pick and choose...things that are funny, that you can laugh about...the ridiculousness in some of what we do. I’m the first person to make fun of myself and that usually gets all the residents and medical students laughing...we have a good time...When you’re smiling and laughing you can be a lot more productive than when you’re slogging through the grind. (Preceptor)

Humor used as a tactic for coping, teamwork, and productivity
Humor contributes to mastery in the preceptor role

...Some of them [preceptors]...[working with them]...was stressful and some of them were maybe happy, happy ones...Someone with a good sense of humor, someone who’s just generally happy, it always helps to have an attending like that (Resident)
Humor contributes to mastery in the preceptor role

The amount of knowledge that they’re [learners] getting...if it’s always stern and no smiles and no laughter, then how can you ever relax enough to [learn]...So a sense of humor I think is key. And we have a lot of physicians on staff that are very funny...they’ll always get their message across because they’re able to relax in their environment (Allied healthcare provider)
Results – Interviews

• Use of humor is impacted by the work environment
  – Work context influences ability and likelihood of using humor
• Stressful work situations reduce use of humor at home
Use of humor impacted by work environment

When I feel like the dynamics are good on the team, I...can be a great teacher...I have a good sense of humor, I can facilitate everybody being the best that they could be. But if there’s one rotten apple in the group...it’s difficult to turn on and off [humor] depending on who I’m talking to. (Preceptor)
Going on [MTU] is very stressful...I start noticing it because you go home in the evening and you...don’t smile as much cause all those things going [on], you don’t laugh as much...It feels much better after you’re done. (Preceptor)
Limitations

- We did not specifically target humor, HOWEVER, it emerged frequently as a theme
- Use of humor with negative consequences may have been missed
- Preceptors were aware of being observed
- The observations focused on preceptor’s actions not intention
- Individual personality traits may influence use of humor
Conclusions

- MTU preceptors appear to deliberately and successfully use humor as an important work tactic.

- Their use of humor may:
  - promote productivity, communication, and teamwork
  - enhance mastery in the role
  - support emotional wellness in themselves, their learners, their team, and their patients

- Their use of humor in the workplace and at home may be influenced by the work context.
Michael F Myers, MD

Speaker for Medical Education Speakers Network 2-3 times per year since 2014 on physician health and wellness
Toward Preventing Physician Suicide
Incorporating the Insights of Those They Leave Behind
Learning Objectives

1. Understand the ways in which stigma works against timely and effective life-saving treatment of suicidal physicians
2. Discuss the insights gleaned from the loved ones of doctors who have killed themselves
3. Describe systemic, diagnostic, and therapeutic changes that will help to save lives of symptomatic physicians
Methods/Approach

- Qualitative study of “survivors” of 27 physician decedents
- Survivors = family members, medical colleagues, employers, training directors, therapists and patients of decedents
- 42 interviews (13 in person, 29 by telephone)
- Interview duration 45 minutes to 2 hours
- Signed release obtained from all interviewees
Findings/Results
Physicians who received no treatment

• “I pleaded with my wife to get help and she kept saying, over and over again ‘No, I’ll be fine, just give me time, this will all go away. Sure I’m depressed…but this is a very busy and demanding rotation…I’ve only got a few more weeks then whoopee – vacation, can’t wait’. I knew she had seen a shrink in medical school and that went badly. The asshole came on to her. So she was leary, scared. I couldn’t change her mind.”

• Words of Dr Doe. He lost his wife Dr Kay to KCl infusion in 1998
Physicians who received no treatment

• “My husband took pills and scotch, the pills were self-prescribed, there was a bill from the pharmacy after he died. He did it in his office. Just like his father, he was a doctor too. But the family covered it up. They said it was cancer. He couldn’t live in the real world. Problems with his kids weighed on him. He got depressed and refused to see a psychiatrist. He just withdrew into a dream world. Then he was gone.”

– The words of Mrs Hill. Her husband killed himself in 1989.
Physicians who received no treatment

• “My partner and I were together for 17 years. He told me after several months that he had tried to kill himself in medical school. But he was fine then and for a long time until AIDS hit. He was a ground zero doctor. He came home crying almost every night ‘my patients have so much I can’t fix’. Then our friends got sick and died. He withdrew and pushed me away. He swallowed Tylenol pills and used booze to cope. I watched him slowly die. There was no way he’d go for help. I pleaded with him. He just wanted to die”
  • The words of Mr RT who lost his partner to suicide in the 1990s
Stigma, Rx alliance and Rx adherence

• “A good friend told me about her death. We didn’t know right away that it was suicide. It was horrible to hear the truth. It came out that she had been struggling. Why is there so much stigma? Why is there that message of ‘don’t show any weakness’ in the everyday world of medicine?”
  – The words of Pam Swift, MD, author of “Doctor’s Orders. One Physician’s Journey Back to Self” interviewed about the loss of a doctor colleague to suicide.
Stigma, Rx alliance and Rx adherence

• “My dad never really stuck to the treatment you provided for him, Dr. Myers. He just hated being a patient. He felt so ashamed. I tried hard too, but even my support wasn’t enough”
  – Words spoken to me by the medical student son of my patient, a psychiatrist, at the memorial service after his death by suicide
Perceived shortcomings of PHPs

• “My son didn’t meet criteria for depression, I think he panicked, he had a history of anxiety and panic. He was treated for substance dependence in medical school. He never really accepted it. He had relapsed toward the end. I think he died of shame. The PHPs vary across the country. At his, there was no psychiatric consultation, no notion of co-morbidities, no internal review of conflicts-of-interest. I think the APA needs to mandate a model program”
  – The words of psychiatrist Dr Karen Miday who lost her son Greg, an oncology fellow, age 29, in 2012
The downside of split treatment

• “I didn’t realize until after our son’s suicide that there really wasn’t much communication between his psychiatrist and therapist. She prescribed the medication and saw him only briefly every couple of weeks at first then every month and every 3 months. Not much of a relationship despite the awesome responsibility. It’s his therapist who really knew him. I think our boy fell through the cracks of psychiatric practice of the 21st century”
   – The mother of Dr Sills who died in 2010 at age 31
Under diagnosis of suicidal despair

• “I think the biggest trigger in my dad’s illness was my grandfather’s passing away a little more than a year before he himself died. I spent a week with him at Christmas about 5 months before he died. He was not himself. There was a personality change. He was normally very decisive. He became incapable of making even minor decisions. He didn’t want to go out to restaurants and he used to love that. Then my sister passed away. He was clearly depressed. I confronted him. He disagreed. I told him he needed an antidepressant. He said they were dangerous! But he finally agreed and talked to his doctor the next day and started one about one week later. Friends have said that they think he had a psychotic depression that maybe wasn’t fully picked up.”
  – The words of Frank Watanabe who lost his father Dr August Watanabe to suicide June 9, 2009
Physician loved ones not interviewed

• Spouses should be included as far as practically possible in the care of their partner, they should be acknowledged as their ‘unofficial carer’ and not viewed as an appendage or positioned on the periphery of any planned care and treatment programmes; spouses should be seen as another resource in monitoring the health of their partner, to be primed in recognizing signs of a relapse of their partner’s illness, and in effect be the eyes and ears of the responsible medical officer in the interim period between regular and planned appointments.
  – The words of Dave Emson who lost his wife Dr Daksha Emson and daughter Freya to ‘extended suicide’ in London in 2000
Emergent psychosis

• “My dad was kind, funny, smart and sweet. He was a radiologist. He was 42 when he killed himself. This was January 22, 1972. I was 16. I was told that he had had an earlier episode of depression in college or medical school. And my mother thinks he had a hypomanic episode before too. The summer before he died, he lost his sparkle, he became more and more a shadow of himself. I remember sitting with him one evening and he wasn’t making any sense. He was seeing a psychiatrist and he was prescribed medication but I don’t know if he was taking it. He hung himself in the basement of his office.

  – Dr Dunbar is a psychiatrist whom I interviewed by telephone on July 24, 2015.
Emergent psychosis

• “My husband died by his own hand – literally, by injection of a painkiller – quite a few years ago. He had never been depressed before but his father had bipolar illness and he lived with a lot of shame and stigma. He was stressed and acting kind of bizarrely before he died. He did not seek any treatment. For my husband, medicine was kind of a calling, a legacy. I am different. I think it is really important for doctors to know that medicine is really just a job, the world will go on without us. I think this would take a lot of pressure off all of us if we accepted this belief.”

– Dr Stanhope (pseudonym) whom I interviewed February 23, 2015
After the suicide....the good

• “My husband’s psychiatrist was wonderful...not only in the exemplary – and honest – care he gave my husband but also after his suicide. He was so comforting. He said ‘It was only by the grace of god that John was the patient and I wasn’t’
  – The words of Virginia Leary-Majda whose husband Dr John Majda killed himself May 28, 2007
After the suicide....the good

“The unbearable has happened at the University of Kentucky. Last Friday we discovered that one of our residents was tragically taken from us. It appears that the resident took their own life. This is a catastrophic loss for our program and for his family and friends. While I am immensely embarrassed that I lost a resident "on my watch" and guilty that I didn’t see this coming, this needs to be said. We must "speak its name". We must learn about it and talk about it. I encourage all of you to renew your efforts on resident wellness and to carefully assess your residents who appear to be struggling or appear to be depressed. I will be clearly renewing my efforts to focus on resident wellness for my trainees and EM residents across the country. Perhaps that will be the legacy left by this tragic loss of this caring, promising, handsome, smart, successful, young man.

– Excerpts from email sent by Dr Chris Doty PD Emergency Medicine 2016
“I learned of this on March 9th of this year, I was rounding uptown at St Lukes – got a call from GME office around 10:30 in the morning – they mentioned that someone jumped from a high window, all I was told was that it was one of our residents. It was surreal to me. This should not happen to anyone, especially someone so bright as her. I knew this would change the program, only later did I know how much it would change me. I’ve had a lot of support – I was taken off service for awhile – we met with all the residents, I checked on them very closely at first, I brought them food, We took her close resident friends off service too.”

The words of Dr Tejas Patel, Program Director Internal Medicine, Mt Sinai West NYC. In person interview 7.12.2016
After the suicide….the not good

“Our daughter was born on December 22, 1952 and died on June 17, 1987. She was board certified in internal medicine and rheumatology. She was 34 when she ended her life, she was an academic physician, she didn’t have other things in her life besides medicine. She was a sensitive woman. Her death is still so fresh even after 28 years. You never really get over it. We called her psychiatrist after she died. He never called us back. Was he afraid of a lawsuit? All we wanted were some answers.”

– Excerpts from my interview with Elsie and Jerry Weyrauch on April 17, 2015. They are the parents of Terri Ann Weyrauch, MD
Interviewee commitment to prevention

• Virginia Leary-Majda and Dr Lev Gertsik - The John A Majda, MD Memorial Fund at the UCSD School of Medicine

• Dr Margaret “Peg” Watanabe – Indiana University Foundation BOD + other philanthropy in suicide prevention

• Dr Pamela Wible – author of “Physician Suicide Letters Answered” and tireless advocate and blog writer
Conclusions

• An overriding theme from most interviewees was the pressing need for more basic education about the warning signs of worsening illness and suicide – for doctors themselves and their families

• Almost all interviewees talked about the crippling and pernicious effects of stigma in ill physicians and the urgent need for an anti-stigma campaign in the house of medicine
Conclusions

• Interviewees strongly believe that mental health professionals treating seriously ill physicians NOT expect that their patients will convey what transpires in session, rationale for medication changes and other issues to their loved ones.

• They recommend being invited in to face-to-face meetings and/or telephoned re guidance at home.

• Doctor-patients are like lay patients and warrant the same level of explanation, support and monitoring.
In appreciation

• To all the individuals who have been interviewed for their generosity and commitment to prevention
• To all my colleagues and friends in the physician health movement and the field of suicidology
• To all of you for coming. Please share your insights with your colleagues who can’t be here today.
• To the many physicians whose tragically interrupted lives have informed this work

• Contact: 718 270-1166 or michael.myers@downstate.edu
Elizabeth A. Rider, MSW, MD, FAAP

An education grant from Josiah Macy, Jr. Foundation supported part of this work.
Fostering Caring Cultures: Faculty Education Fellowship in Medical Humanism and Professionalism

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Chair, Medicine Academy, National Academies of Practice

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Division of General Internal Medicine and Geriatrics,
Department of Medicine, Emory University School of Medicine
Director, ‘Passing the Torch: Fostering Medical Humanism Through Faculty Role Models’ faculty development project

2016 International Conference on Physician Health (ICPH) – Boston, MA, USA
Learning Objectives

Participants will

- Explore opportunities to foster a culture of medical humanism and professionalism
- Learn about a faculty development project aimed at creating more humanistic organizational cultures and learning environments by developing faculty members committed to humanistic values
- Examine approaches to implement the program via a faculty fellowship model
Background

- Learning environments significantly influence professional identity formation of trainees
- The hidden curriculum persists despite calls from regulatory organizations for increased attention to professionalism and the human dimensions of care
Background

- Branch and colleagues developed a multi-institutional faculty development project: “Passing the Torch: Fostering Medical Humanism through Faculty Role-Models”
- Dr. Branch is Director and PI for the project
Passing the Torch: Fostering Medical Humanism through Faculty Role-Models

- A faculty development program designed to create humanistic physicians and faculty role models who will pass their caring and compassion for patients to the next generation of physicians.

- Aims to develop faculty committed to promoting humanistic values in learning environments, to serve as positive influences on institutional cultures, and to mitigate the effects of the hidden curriculum.
## Passing the Torch: Multi-Institution Faculty Development Project

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<tr>
<th>Iteration</th>
<th>1&lt;sup&gt;st&lt;/sup&gt;</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt;</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt;</th>
<th>IPE Pilot</th>
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<tbody>
<tr>
<td><strong>Medical Schools</strong></td>
<td>5 schools</td>
<td>8 additional schools</td>
<td>10 additional schools</td>
<td>1 school</td>
<td>7 schools</td>
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| **Comments** | • Curriculum developed  
• Schools completed curriculum in 2006 | • Curriculum additions  
• Schools completed curriculum in 2011 | • 42 medical schools applied,  
• 10 selected  
• Several volunteered without funding  
• 8 continuing | • Successful inter-professional pilot at Emory University School of Medicine | 7 schools selected;  
• Site leaders drawn from previous  
• Revised curriculum |

Dr. Branch is Director of the project and PI for each of the grants.
Passing the Torch: Research

- Curriculum evaluated twice using prospective study for each

- Faculty were evaluated by their learners using validated scale designed to assess humanistic teaching and practice
  - Humanistic Teaching Practices Effectiveness Questionnaire (HTPE)
Passing the Torch: Research

- Faculty program participants significantly outperformed their peer controls as humanistic teachers and role models – on all 10 items of the HTPE

- Ongoing research
  - Studies of the learning climate and culture of humanism at twelve additional schools
  - Supported by the Josiah Macy, Jr. Foundation and the Arnold P Gold Foundation.
Passing the Torch: Current Project Schools

- Boston Children’s Hospital / Harvard Medical School
- Stanford University School of Medicine
- Medical College of Wisconsin
- Yale School of Medicine
- Indiana University School of Medicine
- University of North Carolina, Chapel Hill, School of Medicine
- University of Virginia School of Medicine
- University of Colorado School of Medicine
Passing the Torch: Curricular Content

• Appreciative Inquiry Narratives and Reflection
• Active Role Modeling
• Teaching at the Bedside
• Basic Feedback / Difficult Feedback
• Error Disclosure / After the Error
• Team-Building Exercises / Highly Functioning Teams
• Boundary Transgressions
• Teaching Caring Attitudes I & II
• Well-Being and Renewal
• Mindfulness
• Learner-Centered Skills Sessions
Curriculum Implementation at Boston Children’s Hospital / Harvard Medical School

- One of 10 US institutions, and the first pediatric site, selected to implement this curricula.
Passing the Torch: Implementation at Boston Children’s / Harvard

Goals:

- To successfully implement and sustain the curriculum at Boston Children’s Hospital
- Adapt curriculum for pediatrics
- To develop new curricula on values
- To develop faculty committed to promoting humanistic values in learning environments and in the institution as a whole
Implementation Strategies: Buy-In and Long-term Sustainability

- Created a unique 1-year fellowship for faculty
  *The Faculty Education Fellowship in Medical Humanism and Professionalism*

- To increase institutional impact and buy-in, we sought collaborators

- Set up Advisory Board of Education Leaders
Implementation Strategies

➢ Sponsor:

➢ Co-sponsors:
  • Office of Faculty Development
  • Office of Graduate Medical Education
  • The Academy for Innovation in Education at Boston Children’s Hospital
Fellowship Selection

- Developed an application process including:
  - Short narratives on career goals, learning goals for Fellowship
  - Signature of department chair / division chief

- 1st Cohort: 21 faculty applied for 8 positions – accepted 10 Fellows

- 2nd Cohort – 11 fellows
Who are the Faculty Education Fellows?

- Many in educational leadership roles
  - Residency program directors, medical student clerkship director, associate fellowship program directors, directors of clinical and consultation programs
- All in teaching and precepting roles
- Both cohorts from across the institution:
  - Adolescent Medicine, Cardiology, GI, Anesthesia, Developmental Medicine, Psychiatry, Primary Care, Pulmonary, Endocrinology, Pain Medicine, Emergency Medicine, Neurology, Neonatology, Hematology/Oncology, Palliative Care, Dentistry
The Faculty Education Fellowship in Medical Humanism & Professionalism

- About
- Fellowship Sponsors
- Faculty Education Fellows
  - NEW Faculty Education Fellows: 2015 – 2016
  - Faculty Education Fellows: 2013 – 2014
- Program Information
- Benefits for Participants
- Participating National Institutions
- Faculty Education Fellows in the News
- Faculty Fellowship Events
- Upcoming Events
- Faculty Education Fellowship – Applications
- Resources

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Passing the Torch: Curriculum

- Appreciative inquiry narrative and reflection sessions generally alternate with skills sessions
- Meet in 1 ½-hour, twice-monthly small-group sessions (24 sessions) over one year
Additional Curriculum Modules

- Developed additional curricula based on the *International Charter for Human Values in Healthcare*
  - Identifying and Sustaining Core Values

- The *Charter* provides a framework for education and practice

© 2011-2012 International Collaborative for Communication in Healthcare; © 2013 International Research Centre for Communication in Healthcare
Identifying ‘Values’: The International Charter for Human Values in Healthcare

- Initiated in early 2011
- Started as a collaborative effort to identify core values that should be present in every healthcare interaction

Aim: to restore the primacy of core values and skilled communication necessary for practicing compassionate, ethical and safe healthcare around the world.

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The International Charter for Human Values in Healthcare: An interprofessional global collaboration to enhance values and communication in healthcare

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Open Access download at: http://dx.doi.org/10.1016/j.pec.2014.06.017
Fellowship provides opportunities for Fellows to:

- Develop **advanced teaching skills and role modeling** in medical humanism and professionalism and overall
- Increase **reflective capacities** and the ability to use these in teaching
- Serve as **inspiring teachers and role models**, and to promote a humanistic culture across the institution
- Participate in an **ongoing small supportive group** of like-minded faculty from other departments/divisions
- “**Short track**” into membership of The Academy for Innovation in Education at Boston Children’s Hospital by participating in the Fellowship and completing an educational project
- Enhance professional development and promotion portfolios
Faculty Education Fellowship: Impact

- Fellows implemented teaching and workshops modeled after program curricula
- The Fellows have continued to meet quarterly following the fellowship; ongoing support
- Currently developing a project to promote humanistic values across the institution.
New Initiative: Faculty Development for the Interprofessional Teaching of Humanism

- 7 national sites
- Groups of 8 – 10 education leaders from at least three professions
- Participate in ongoing Interprofessional Education (IPE) faculty development sessions
- Plan and implement a humanistic IPE project
- Boston Children’s / Harvard site: creating a unique fellowship for faculty – *Faculty Fellowship for Leaders in Collaborative and Humanistic Interprofessional Education*
- Funding: Josiah Macy, Jr. Foundation
New Initiative: Faculty Development for the Interprofessional Teaching of Humanism

The curriculum includes

- Appreciative Inquiry / Narrative Reflection
- Highly functioning teams
- Advanced team formation
- Error disclosure & team formation
- Through the patient’s eye: Empathy
- Well-being and renewal
- Mindfulness
- Interprofessional education

Photo credit: Army Medicine by Foter.com
New IPE Initiative: Participating Schools

- Boston Children’s Hospital / Harvard Medical School
- University of California, San Francisco School of Medicine
- David Geffen School of Medicine at UCLA
- University of Minnesota Medical School
- Yale School of Medicine
- University of Massachusetts Medical School
- Indiana University School of Medicine
References / Resources


- The Faculty Education Fellowship in Medical Humanism and Professionalism. Institute for Professionalism and Ethical Practice, Boston Children’s Hospital, Boston, MA. 2014. Available at: http://ipepweb.org/the-faculty-education-fellowship-in-medical-humanism-and-professionalism/
References / Resources (continued)


“You must be the change you want to see in the world.”

– Mahatma Gandhi
Thank you

Elizabeth A. Rider, MSW, MD, FAAP:
Elizabeth_Rider@hms.harvard.edu

William T. Branch, Jr., MD, MACP:
wbranch@emory.edu

Additional information on curriculum available from Dr. Branch: wbranch@emory.edu

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Making Healthcare a Healthy Enterprise: A Leadership Imperative

Focus on the System:
Joe Kimura, MD
Chief Medical Officer, Atrius Health

Focus on the Individual Physician:
Les Schwab, MD
Past CMO, Atrius Health
Les Schwab, MD

Research grant recipient from the Harnisch Foundation, Institute of Coaching (nonprofit)
Organizational Approaches to Joy
### Understand Current State (Dec 2015)

Count (Physicians and APCs) = 241 Internal Medicine Clinicians

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>Max</th>
<th>Min</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel run down and drained of physical or emotional energy</td>
<td>3.41</td>
<td>5.00</td>
<td>2.00</td>
<td>0.56</td>
</tr>
<tr>
<td>I have negative thoughts about my job</td>
<td>3.09</td>
<td>4.00</td>
<td>1.00</td>
<td>0.61</td>
</tr>
<tr>
<td>I am harder and less sympathetic with people than perhaps they deserve</td>
<td>2.26</td>
<td>3.50</td>
<td>1.00</td>
<td>0.47</td>
</tr>
<tr>
<td>I am easily irritated by small problems, or by my co-workers and team</td>
<td>2.43</td>
<td>3.50</td>
<td>1.00</td>
<td>0.53</td>
</tr>
<tr>
<td>I feel misunderstood or unappreciated by my co-workers</td>
<td>2.19</td>
<td>3.50</td>
<td>1.00</td>
<td>0.57</td>
</tr>
<tr>
<td>I feel that I have no one to talk to</td>
<td>2.06</td>
<td>3.18</td>
<td>1.00</td>
<td>0.58</td>
</tr>
<tr>
<td>I feel that I am achieving less than I should</td>
<td>2.54</td>
<td>3.73</td>
<td>1.00</td>
<td>0.61</td>
</tr>
<tr>
<td>I feel under an unpleasant level of pressure to succeed</td>
<td>2.87</td>
<td>4.00</td>
<td>1.00</td>
<td>0.68</td>
</tr>
<tr>
<td>I feel that I am not getting what I want out of my job</td>
<td>2.94</td>
<td>4.00</td>
<td>1.00</td>
<td>0.82</td>
</tr>
<tr>
<td>I feel that I am in the wrong organization or the wrong profession</td>
<td>2.30</td>
<td>3.50</td>
<td>1.00</td>
<td>0.64</td>
</tr>
<tr>
<td>I am frustrated with parts of my job</td>
<td>3.56</td>
<td>4.50</td>
<td>2.00</td>
<td>0.56</td>
</tr>
<tr>
<td>I feel that organizational politics or bureaucracy frustrate my ability to do a good job</td>
<td>3.29</td>
<td>4.09</td>
<td>2.00</td>
<td>0.58</td>
</tr>
<tr>
<td>I feel that there is more work to do than I practically have the ability to do</td>
<td>3.72</td>
<td>4.50</td>
<td>2.00</td>
<td>0.49</td>
</tr>
<tr>
<td>I feel that I do not have time to do many of the things that are important to doing a good quality job</td>
<td>3.56</td>
<td>4.18</td>
<td>2.43</td>
<td>0.42</td>
</tr>
<tr>
<td>I find that I do not have time to plan as much as I would like to</td>
<td>3.53</td>
<td>4.22</td>
<td>2.29</td>
<td>0.49</td>
</tr>
<tr>
<td>How willing are you to change your routine?</td>
<td>3.72</td>
<td>4.50</td>
<td>2.67</td>
<td>0.41</td>
</tr>
</tbody>
</table>
Literature Review: Addressing Burnout as an Organization


Define Conceptual Driver Framework

- Limits on Work Autonomy (Local Practice Flexibility & Control)
- No Meaning & Purpose (Professional Development)
- High Workload & Expectations (Individual Performance Measurement, Accountability & Transparency)
- Social Isolation in Ambulatory Practice (Community of Practice)
- Work Life Imbalance (Time at Work)
- Poor Efficiency of Required Systems (Delivery System & IT Systems)
- Mal-aligned Compensation Models (Payment for Productivity vs Value)

Increasing Incidence & Prevalence Of Clinician Burnout
## Develop Strategic Countermeasures

<table>
<thead>
<tr>
<th>Objective</th>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Individual Clinician Resiliency</td>
<td>Enhance Professional Satisfaction</td>
<td>Promote greater professional fulfillment from work</td>
</tr>
<tr>
<td></td>
<td>Enable Flexibility &amp; Control</td>
<td>Enable more control over day to day work life</td>
</tr>
<tr>
<td>Enhance System Reinforcement of Collective Resiliency</td>
<td>Align Compensation</td>
<td>Belief compensation is fair, aligned, and appropriate</td>
</tr>
<tr>
<td></td>
<td>Build a Sense of Community</td>
<td>Sense of community belonging with other clinicians with shared collaborative culture</td>
</tr>
<tr>
<td>Improve Core Practice Systems that Contribute to Wasted Time</td>
<td>Improve Delivery System Efficiency</td>
<td>Improve the efficiency of care team systems and HIT systems to make day-to-day work easier</td>
</tr>
</tbody>
</table>
Build Structural Foundation to Reinforce Organizational Commitment to People
Summary

• Executive Recognition of Expanding Burn Out Problem
• Understanding of Burnout as a Work Place Syndrome
• Development of Systematic Approach to Prevent & Treat
• Organizational Economic Impact:
  – Direct Costs of Clinician Turnover
  – Clinical Performance (Quality, Safety, Patient Experience)
  – Decrease in Clinical FTE Exacerbates Access to Care
• Threatens Clinician Engagement @ Crucial Time of Change
Making Healthcare a Healthy Enterprise: Focus on the Individual Physician

- Prior attempts to engage our physicians
- Organizational awakening: a comprehensive program in progress
- Approaching the individual – coaching for self-care and self-determination
Drivers and Effects of Burnout

• **Drivers**: per JK: no autonomy, high workload, no meaning/purpose, social isolation at work, inefficient systems, work/life imbalance, misaligned compensation

• **Effects**: personal demoralization, disengagement, personal physical and emotional health problems, disengagement, turnover
Many Drivers, Many Solutions

Personal health: exercise, nutrition, sleep
Mind: emotional health, mindfulness/meditation, resilience/recovery
Spirit: religion, arts, hobbies
Communities: social/personal, learning, civic, sports
Self/System interaction: work/life boundary, delegation/teaming, efficiency, org. engagement
System: per JK
Coaching for self-care and self-determination

- Coaching in distinction to mentoring, therapy
- Coaching in distinction to motivational interviewing
- The course of a coaching engagement
- The course of a coaching session
- Positive psychology coaching
Coaching for primary care physicians: A positive psychology approach for improving well-being and reducing burnout and intentions to leave medical practice

Supported by a research grant from:
The Harnisch Foundation
Institute of Coaching
Mclean Hospital/an HMS Affiliate
## Translation into Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
</table>
| Enable Flexibility & Control  | • Re-Alignment of organizational structure to provide physicians with direct oversight of clinical staff  
                                • Enable clinicians to utilize scribes to support documentation workflow if requested                                               |
| Enhance Professional Development | • Clinical Professional Development Program  
                                • Clinician Resilience Program  
                                • Clinician Leadership Development  
                                • Expanded Teaching & Research  
                                • Medical Ethics Program        |
## Translation into Programs

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Align Compensation**       | Create Comp mechanism to provide wRVU credit for Virtual Care:   
|                               | • Email Care   
|                               | • Telephonic Care   
|                               | • Specialty e-consults   
|                               | • Video Visits |
| **Build a Sense of Community** | - Network Development:   
|                               |   - CAC hosted Specialty/Primary Care   
|                               |   - Quarterly Regional Events   
|                               | - Communication Enhancement   
|                               |   - CEO Forum   
|                               |   - Salesforce Chatter Pilot   
|                               | - Leveraging Education and Clinical Case Conferences   
|                               |   - Grand Rounds Across 22 sites (televised)   
|                               |   - Monthly Case Conferences at Each Site from Residency Programs |
## Translation into Programs

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Delivery System Efficiency</td>
<td>• Implement standard IM Care Model</td>
</tr>
<tr>
<td></td>
<td>• Enhance competency/skills training of practice MA &amp; RNs</td>
</tr>
<tr>
<td></td>
<td>• Full Alignment of Clinical Management Structure (Physician and Nurses)</td>
</tr>
<tr>
<td></td>
<td>• Integration of Specialists into Regional Hubs for Scale/Community</td>
</tr>
<tr>
<td></td>
<td>• Health Informatics / EMR Usability - EPIC SWAT, PEP Mentoring</td>
</tr>
</tbody>
</table>
Using Balint Groups to restore wonder in medicine
EVERYTHING IS CONNECTED
http://balint.co.uk
Oral presentations

Monday, September 19, 2016
4:15pm – 5:15pm

Note: All presentations may not be included as we are still collecting the final presentations from presenters, some may have been omitted for copyright purposes. Check back periodically for updates.
A Recipe for Creating and Implementing a Physician Health and Wellness Strategic Plan in a large Academic Tertiary Care Hospital

Dr. Caroline Gérin-Lajoie

Medical Director, The Ottawa Hospital Physician Health and Wellness Director, Faculty Wellness Program, Faculty of Medicine, University of Ottawa

Nothing to disclose
Co-authors

• Dr. Kerri Ritchie, Clinical and Health Psychologist, The Ottawa Hospital
• Dr. Virginia Roth, MD, FRCPC, Director of Medical Affairs and Patient Advocacy, The Ottawa Hospital
• Dr. Daniella Sandre, Clinical, Health, and Rehabilitation Psychologist, The Ottawa Hospital
The Ottawa Hospital (TOH)

- 1150 bed tertiary-care hospital affiliated with the University of Ottawa
- Approximately 50,000 inpatient admissions
- 160,000 emergency visits
- Over 1.1 million outpatient visits annually

Approximately 1377 physicians and 1358 residents & fellows working at TOH
Importance of Physician Wellness in a Large Academic Tertiary Care Hospital

• Increasing media attention: local papers, Canadian Medical Association Journal

• Administrative perspective:
  – Negative impact on recruitment & retention, workplace productivity, efficiency, quality of patient care and patient safety
  – Should be measured as an indicator of quality of patient care and quality within health-care systems (Lancet, 2009)
  – Intensified oversight of physician health by professional bodies
Importance of Physician Wellness in a Large Academic Tertiary Care Hospital

- **Academic perspective**: inclusion of wellness in teaching curriculums, in resident CanMEDS roles, accreditation processes

- **Research perspective**: an evolving field

There is an opportunity and a responsibility for organizations to invest in the creation of a life/career resilient physician work

The Handbook of Physician Health, AMA
Context and Starting Point for Physician Wellness

A Journey of Excellence and Quality Improvement
• (TOH Strategic Framework May 2009)

• Physician Engagement → Better Patient Outcomes
Physician Engagement Strategies

TOH Physician Engagement Agreement:

“Create an environment that contributes to physical and emotional health”

“Promote physician and staff health and well-being”
Physician Engagement Strategies

Aon Hewitt Physician Engagement Survey 2009 & 2012:

Q: “Physician health and well-being is strongly supported by this organization”

27% (2009)
30% (2012) strongly agree/agree

• *Health and Wellbeing: within the top 5 Positive Engagement Impact Drivers*
Step 1: Designating a Physician Wellness Lead and/or Committee

Formation of **TOH Physician Health and Wellness Committee**, September 2013
- Chair: Caroline Gérin-Lajoie, MD, FRCPC
- Co-Chair: James Chan, MD, FRCPC

• Terms of Reference

**Initial goals:**
• Raising awareness
• Data gathering: reaching out and engaging front line physicians, identifying priorities
Step 2: Data Gathering and Engagement (fall 2013-…)

- **Presentations** to leadership and administration (literature, outcomes, language, feedback gathered)

- **Surveys:** *

TOH Physician H&W Survey (2013)
Top 5 Priorities (RR=22.4%)

• Availability of nutritious food
• Access to a family physician on site
• Improved childcare support
• Improved gym facilities
• Increased number of exercise classes offered
H&W Survey: open ended feedback

- High expectations (department, university, research, TOH goals for excellence and patient satisfaction)
- Relationship with Administration ("top down")
- Loss of staff (budget cuts)
- "Technostress": time lost from administrative processes and technology
- "Productivity pressure" or time efficiency
- Workload is too high!
Step 3: Creating a Strategic Plan (August 2014)

- Based on TOH Strategic Plan 2015-2020
- Supported by the TOH Board and SMT
A New Framework: “PALS” Program

- Advocacy
- Leadership
- Support

TOH Physicians
Strategic Priorities

• **Advocacy** and Relationship between TOH Physicians and Administration

• **Leadership** and Professional Development/Communication

• **Support** and Physician Connections
Year 1 Successes

• Establishment of a robust TOH Physician **H&W Committee** (broad representation, residents)

• Increased **awareness** of Physician H&W issues and resources (email site, Medical Staff Association meetings, focus groups, journals, posters, videos)

• Improvement of **food** quality and access
Year 1 Successes

• Access to **Homewood Health** Physicians and Family Services (Year 1 utilization rate 0.75% - for 1930 staff)

• Access to **Family Physician** for TOH Physicians & Families (collaboration with 2 TOH Family Health Teams)

• **Virtual (Electronic) Platform** for Physician Communication (76% surveyed felt it was important to pursue)

• **Focus Groups** (3)
Year 2 Successes and Goals (2015 to present)

- Focus Groups: “Physician Irritants”, “Technostress”: Disconnecting from Technology
- First Annual TOH Physician Health and Wellness Award

Ongoing projects:
- Pilot the Virtual (Electronic) Platform for TOH Physicians
- Adverse Events and MAID (Medical Aid in Dying) Support Strategies
- Knowledge transfer/research/academics
A tornado warning for Ottawa... Environment Canada has issued a severe advisory. Residents are advised to take...
Step 4: Tracking Outcomes

Aon Hewitt Physician Engagement Survey Results

- Q: “Physician health and well-being is strongly supported by this organization”

27% (2009)
30% (2012),
39% (2015) strongly agree/agree
Step 4: Tracking Outcomes

H&W Physician Health and Wellness Survey (2016)

• Q: “Are you satisfied with the H&W Committee’s work? (171 responders)

33% Very Satisfied
The Development of a Departmental Wellness Committee in an Academic Anesthesiology Program

Susan M Martinelli, MD
Associate Professor of Anesthesiology
University of North Carolina School of Medicine

On behalf of: A. Penwarden, MD; B. Chidgey, MD; C. Enarson, MD; L. Johnson, MHA; M. Nanda, MBBS, MPH; D. Dirito, CRNA; B. Paduchowski, CRNA; D. Zvara, MD, S. Martinelli, MD
Susan Martinelli
Associate Professor of Anesthesiology
University of North Carolina

Nothing to disclose
Problem: Burnout

- 50% anesthesiologists¹
- CRNAs similar stressors²
- 28% general public³

Solution: Wellness Committee

Wellness Committee

- Support Staff Subcommittee
- Resident Subcommittee
- Faculty Subcommittee
- CRNA Subcommittee
Parent Wellness Committee

- Chair: Associate Program Director
- Representatives
  - 4 faculty Anesthesiologists
  - 3 residents
  - 2 CRNAs
  - Associate Chair of Administration
  - Nurse practitioner
  - Psychologist

- Meet every other month
Parent Wellness Committee

- Goals & Accomplishments

Personal Wellbeing Initiatives

Wellness Wednesdays

Barbara Fredrickson
Positive Emotions and Health

Samantha Meltzer-Brody
General Wellness

Amy Vinson
Adverse Incident Protocol

Warwick Ames
Long Distance Running
Faculty Subcommittee

• Chair: Faculty Anesthesiologist
• Representatives
  – Six faculty Anesthesiologists
• Meets every other month
Faculty Subcommittee

• Goals & Accomplishments
  – Needs assessment
  – Call equity & reimbursement
  – Resilience retreat

3 Good Things
Resident Subcommittee

• Chair: Associate Program Director
• Representatives
  – 2 faculty Anesthesiologists
  – 3 PGY4 residents
  – 3 PGY3 residents
  – 3 PGY2 residents

• Meets every other month
Resident Subcommittee

• Goals & Accomplishments
  – Needs assessment
  – Didactic schedule
  – Class retreats
CRNA Subcommittee

• Co-Chairs: 2 CRNAs
• Representatives
  – 4 CRNAs
• Meets 2-3 times/year
CRNA Subcommittee

• Goals & Accomplishments
  – Needs assessment
  – Paid time off
  – OR breaks
  – Lactation resources
Support Staff Subcommittee

• Chair: Associate Chair of Administration
• Representatives:
  – IT group
  – HR consultant
  – Support secretary
  – Research division
  – Anesthesia technician

• Meets every other month
Support Staff Subcommittee

• Goals & Accomplishments
  – Potluck lunch
  – Step tracking competition
  – Coping strategies
  – Team building
Outcomes

• Well received
• Not yet been studied

Future Plans

• Departmental Wellness Week
• Peer support following adverse events
Lessons Learned

• Departmental commitment to wellness
• Resource requirements not overwhelming
• Diverse representation
Anthony Omo

Nothing to disclose
Our wider role

- Managing UK Medical Register – approx 260k doctors on register – approx 240k with licence to practise medicine
- Setting standards for doctors
- Responsible for medical education
- Investigating and acting on serious concerns about doctors
Our fitness to practise role

- Not punishment or discipline
- Protecting patients and confidence in medical profession – primary focus on future practice
- Around 9,000 complaints a year - doubled in last 5 years
- Investigate around 2,500 of these and public hearing in around 300
Vulnerable doctors

- Review of suicides during investigation – 23 between 2005-2013
- Multiple stressors – mental illness, police, employer disciplinary, family breakdown, finances – GMC investigation added stressor
- Vulnerable doctors can pose a significant risk to patients – serious conduct/performance, lack of insight, working against medical advice, failure to co-operate/engage with GMC
Steps taken since 2010 to reduce impact on doctors

- Provisional enquiries – more information before investigate - reduce 230 pa – July pilot - reduce 300 more pa
- Meeting doctors at end of investigation – more information before refer hearing – reduce 20 pa – seek legislation to reduce further
- Doctor support service – free confidential emotional support – provided by BMA – represent UK doctors
Recent review of FTP process

- Appointed leading mental health expert, former suicide czar to UK government - to oversee process
- Suicides hard to predict – reduce impact for all doctors
- Particular risks
  - humiliation of high performers
  - feeling trapped by process
Key proposals - General

- Mental health awareness throughout organisation – programme training for staff
- Handling by healthcare provider where possible
- Support better access to mental health services for doctors – working with UK Government – initially for GPs
- Only investigate where necessary
Key proposals - General

- Frontload investigation – senior input early
- Improve tone of communication with doctors under investigation
- Co-ordinate correspondence with doctors under investigation – different departments
- Consensual outcomes wherever possible
- Increase support especially at hearings
Key proposals - Health only cases

- Specialist psychiatric input before open investigation
- Avoid disciplinary, investigative style - assessment and protective measures
- Seek swift consensual outcome
- Specialist team - training sensitive comms
- Single point of contact for doctor throughout - avoid handoffs
INCREASING JOY IN MEDICINE

AMERICAN MEDICAL ASSOCIATION | CANADIAN MEDICAL ASSOCIATION | BRITISH MEDICAL ASSOCIATION

ICPH 2016 | INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH™
Adam Was and Tara Cornaby

Nothing to disclose
The Ideal Gas Lounge:

Boosting Resident Happiness with Empowerment and Common Space Improvements

Adam Was, MD and Tara Cornaby, MD
Monday, September 19, 2016
Learning objectives

1. The physical workplace environment can have a significant effect on employee well-being.

2. The improvement of common spaces represents a high-impact, cost-effective, and evidence-based means of boosting physician happiness.

3. Resident involvement and empowerment increases the acceptance and success of wellness improvement interventions.
Background: PRIME Scholarship

- PRIME: Peer Support and Resiliency in Medicine Program
  - Retreats
  - Wellness sessions
  - Education
  - 2014: Scholarship for resident-driven wellness initiatives
Aims: Why Target Gas Lounge?

- Benefit current & future residents
- Feasible, easily implemented, and cost effective
- Evidence-based: importance of common space design, lighting, noise, color.\(^1\)\(^-\)\(^4\)
- Empower beneficiaries, provide sense of control.
Methods

• Surveyed 79 anesthesia residents regarding:
  – Gas Lounge use and satisfaction
  – Ideas for improvements
  – Permission to choose and implement changes
• Selected interventions based on cost, feasibility, and popularity
• Performed post-intervention survey to assess impact
Initial Survey Results

- 34 respondents (43% response rate)
- Total of 33 potential improvements suggested
Pre-Intervention: Usage

How often do you use the Gas Lounge?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than once a month</td>
<td>3%</td>
</tr>
<tr>
<td>2-3 times a month</td>
<td>12%</td>
</tr>
<tr>
<td>Once a week</td>
<td>21%</td>
</tr>
<tr>
<td>2-3 times a week</td>
<td>44%</td>
</tr>
<tr>
<td>Daily</td>
<td>21%</td>
</tr>
</tbody>
</table>
Pre-Intervention: Limitations

What keeps you from using the Gas Lounge more often?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too small</td>
<td>44%</td>
</tr>
<tr>
<td>Too dirty</td>
<td>35%</td>
</tr>
<tr>
<td>Always forget my key / can't get in</td>
<td>26%</td>
</tr>
<tr>
<td>N/A - I use it all the time</td>
<td>38%</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
</tr>
</tbody>
</table>
Pre-Intervention: Estimated Impact

Would you use the Gas Lounge more often if resident-driven improvements were made to it?

Percent of respondents

- Don't know: 15%
- Probably will: 44%
- Definitely will: 41%
Pre-Intervention: Estimated Impact

Would an improved Gas Lounge help your well-being?

- Probably will not: 6%
- Don’t know: 18%
- Probably will: 18%
- Definitely will: 59%
Potential Improvements

1. Couch (new)
2. Bigger lounge
3. Monthly cleaning
4. Carpet cleaning
5. Window
6. Trash can that gets emptied
7. Badge (keyless) entry
8. Computer (improved)
9. Phone chargers
10. Snacks
11. Chair (new)
12. Printer
13. Coffee table (new)
14. Lighting (new)
15. Hot tub
16. Massage therapist
17. Keurig coffeemaker
18. Pillows and blankets
19. Paint job, with accent wall
20. Ikea storage / shelving units
21. Pictures of CA-3s
22. Bulletin board
23. Art work / wall decorations
24. Fake plants
25. Dry erase board
26. Wall-mounted bookshelves
27. Real plants
28. Light reading
29. Shake weights
30. Zen water garden
31. Zen rock garden
32. Pet fish
33. 3 camels

Suggested cutoff for improvements to implement
Most popular items, by category

<table>
<thead>
<tr>
<th>Can be purchased outright</th>
<th>Requires coordination</th>
<th>Services / ongoing</th>
<th>Unfeasible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couch (1)</td>
<td>Badge entry (7)</td>
<td>Monthly cleaning (3)</td>
<td>Bigger lounge (2)</td>
</tr>
<tr>
<td>Phone chargers (9)</td>
<td>New computers (8)</td>
<td>Carpet cleaning (4)</td>
<td>Window (5)</td>
</tr>
<tr>
<td>Chair (11)</td>
<td>Printer (12)</td>
<td>Trash service (6)</td>
<td>Hot tub (15)</td>
</tr>
<tr>
<td>Coffee table (13)</td>
<td></td>
<td>Snacks (10)</td>
<td>Massage therapist (16)</td>
</tr>
<tr>
<td>Lighting (14)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keurig coffeemaker (17)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pillows &amp; blankets (18)</td>
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</table>

*Of note, many resident-proposed ideas were popular; many original ideas were not.*
Interventions

• Purchases: bought as many items as possible within the available budget
• Ongoing Services: arranged for trash pickup and regular cleaning
• One-time Improvements: Removed trash, deep-cleaned carpet, painted walls
Selected Improvements

- Couch (new)
- Bigger lounge
- Monthly cleaning
- Carpet cleaning
- Window
- Trash can that gets emptied
- Badge (keyless) entry
- Computer (improved)
- Phone chargers
- Snacks
- Chair (new)
- Printer
- Coffee table (new)
- Lighting (new)
- Hot tub
- Massage therapist
- Keurig coffeemaker
- Pillows and blankets
Pictures – Before Improvements
Pictures – Before Improvements
Pictures – After Improvements
Pictures – After Improvements
Follow-up Survey Results

How often do you use the Gas Lounge?

- **Never**
- **Less than once a month**
- **2-3 times a month**
- **Once a week**
- **2-3 times a week**
- **Daily**

The chart shows the distribution of responses before and after a certain intervention or change. The blue bars represent responses before the change, and the red bars represent responses after the change.
Follow-up Survey Results

Will an improved gas lounge help your well-being?

Before | After
--- | ---
Definitely will |
Not |
Probably will |
Not |
Don't know |
Probably will |
Definitely will |
Follow-up Survey Results

Rate your satisfaction with the Gas Lounge

Before (n = 34)  
3.5

After (n = 23)  
7.5
Follow-up Survey: Selected Quotes

• “THANK YOU! The new gas lounge makes our quick breaks during the day so much more pleasant and enjoyable. Wanting to actually be in the gas lounge opens up great opportunities for bonding and time with classmates. “

• "I'm lovin' it."

• “Very important space for residents. The improvements are great so far. Thanks!”

• “Thank you PRIME!”

• “Without having our own workroom like many other specialties have, the gas lounge is the one place where I know I'll be welcomed, have a free seat, and be able to get some work done or relax.”
Follow-up Survey: Selected Quotes

- “it's our hiding place! we need it to escape when patients, cases, or attendings are driving us nuts. plus it's social and i can actually watch cable!”
- “thank you PRIME”
- “I go to the Gas Lounge for nearly every day for lunch because I know I can sit down with the people I love (my co-residents) and get a half hour of socializing and humor. It is also my home base for those long call evenings, and essential for naps while on Cardiac call”
- “Great work; thanks so much”
- “The gas lounge is my home. If we didn't have it I'd be an orphaned child with no roots and no family. I LOVE the new changes. Thank you!!!”
Follow-up: More Improvements

- Delivered final report to anesthesia department leadership and PRIME directors.
- Results were encouraging and well-received.
- Granted significant additional funding to install additional improvements, including another computer, desk, and keyless entry.
Conclusion

• The implementation of resident-selected improvements to the anesthesia gas lounge resulted in more frequent common-space use, significantly increased satisfaction with the space, and overall improved resident well-being.

• The physical workplace environment can have a significant effect on employee well-being.

• The improvement of common spaces represents a high-impact, cost-effective, and evidence-based means of boosting physician happiness.

• Resident involvement and empowerment increases the acceptance and success of wellness improvement interventions.
References


Acknowledgements

• PRIME Scholarship
• Natasha Dehn
• Dr. Alex Macario
• Dr. Ron Pearl
• Dr. Emily Ratner
• Janine Roberts
• Dr. Pedro Tanaka
• Alan Winkleman