INCREASING JOY IN MEDICINE

ICPH 2016 | INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH™
Poster presentations

Sunday, September 18, 2016

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.
Recent research indicates that burnout among medical residents is reaching alarming levels. In an effort to better understand resident wellness at the University of Kansas Medical Center (KUMC), and where to focus its improvement efforts, the KUMC Graduate Medical Education Committee surveyed its residents in the Spring of 2015.

**Methods**

A 77-item electronic wellness questionnaire was administered to all 532 residents and fellows at KUMC. The survey instrument was originally developed at Stanford University Medical Center. Approval from the Institutional Review Board was obtained and appropriate measures were taken to ensure anonymity.

**Results**

390 (73.3%) residents and fellows completed the questionnaire, including 151 females (39.0%) and 236 (61.0%) males, mirroring the gender demographic of the KUMC residents and fellows as a whole. Descriptive statistics, contingency table analysis and differences in rates are reported.

Although not quite statistically significant, self-reported burnout was:
- higher among females (p=0.123, chi-square test) (Fig. 1)
- higher among PGY 2 residents, especially females (p=0.076, chi-square test) (Fig. 2)

Of statistical significance, those that “never” find time to work out were more likely to report burnout (p=0.002, chi-square test) compared to those who work out 4 to 7 times per week (Fig. 3).

**Conclusions**

The results suggest that PGY 2 residents, particularly females, could potentially benefit from targeted wellness initiatives. The results also suggest that subsidized gym memberships and other initiatives aimed at encouraging exercise could reduce resident burnout. KUMC recently repeated the survey and is currently in the process of analyzing the results. Additional research could include a follow-up survey of PGY 2 residents to better understand the unique stresses they face.
Increasing Joy in Academic Medicine: Identifying Challenges and Planning Support for Academic Faculty

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Background

Over 50% of physicians nationwide have significant symptoms of burnout (1) and about 25% of faculty in academic medical centers are considering leaving academic medicine (2). Chairs of medical school departments are well positioned to affect faculty and may be able to help address faculty burnout and retention. We designed a survey to elucidate faculty’s perception of challenges at our medical school and support strategies employed by chairs and school administration. This survey also included the Maslach Burnout Inventory. The results will guide a school-wide strategy to support medical school faculty well-being.

Learning Objectives

1. Describe common challenges faced by medical school faculty
2. Describe factors that support faculty well-being
3. Develop ideas to increase joy in academic medicine

Results

The response rate was 39%. Most respondents were clinicians (63.9%), full-time faculty (85.5%), working 50 or more hours per week (71%). The prevalence of respondents seriously considering leaving the institution in the past year was 55.7%, representing at least 22% of the faculty body. Overall, 39.8% of respondents reported feeling burnt out (45.7% for clinicians and 29.2% for non-clinicians), with more burnout noted in faculty age 40-59 y.o. There was agreement between Chairs and faculty in regard to challenges faced and support needed by faculty. While support strategies by both school and chairs were important, more importance was given to the role of the chair.

Challenges

Chair’s Support

Conclusions

This survey points to the importance of chair engagement in the planning of school support for faculty. Hence, we will hold meetings of chairs and school leadership to discuss survey results and plan support strategies, followed by monthly discussions to promote a school culture that champions faculty well-being.

Methods/Approach/Future Direction

- Conduct pilot survey
- Pilot, refine and customize survey to our school. Includes the Maslach Burnout Inventory
- 534 faculty; begin Nov. 2015; focus on burnout levels, perception of challenges and support compared to chair’s views
- Fall 2016: Open discussion about school challenges; sharing of supportive approaches
- Each chair: A plan of action to support faculty well-being in their department
- On-going discussions, report on plan of action, maintain momentum, promote culture change
- Review repeat survey results with chairs and leadership
- Discuss next steps for the school, disseminate

- Conduct & analyze survey
- Present results to chairs, leadership
- chair’s department plan
- Monthly chairs’ meetings
- Repeat survey one year later
- Plan next steps

- Meet department chairs
- Conduct & analyze survey
- Conduct pilot survey
- Introduce the topic, identify challenges and current support for faculty well-being; for survey development
- Annotated bibliography; for survey development

- Literature review
Physicians Drinking Well  
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Director, Addiction Psychiatry Fellowship Program

Abstract
Alcohol is commonly used in Western cultures to socialize with others and celebrate joyous occasions such as weddings. Moreover, moderate drinking may have some health benefits and be cardioprotective, including physicians (Britton et al 2009). In the U.S, drinking alcohol became a constitutional right in 1933 with passage of Amendment XXI. However, risky drinking is associated with burnout in physicians (Pedersen et al 2016) and alcohol use disorders are a well-known cause of physician impairment. Physicians are expected to be knowledgeable about the effects of alcohol on health and to screen patients for risky and problem drinking; however, our training, confidence, and practice in these areas are frequently deficient (Loheswaran et al, 2015). This presentation is designed to provide a balanced perspective on the social use of alcohol to enhance joy in the lives of our patients as well as our own. Both beneficial and detrimental effects of alcohol on physician health are reviewed. Just as caring for ourselves enhances our care of others, it is concluded that appreciating the joys and concerns of drinking in our own lives facilitates approaching our patients’ drinking in a balanced manner.

Learning Objectives
(1) Cite the criteria and scientific basis for moderate (low-risk) drinking
(2) Acquire a simple approach to screening and educating physicians about drinking well—or not at all in some cases
(3) Understand the potential influence of our own drinking-related histories, attitudes, and habits on our practice with patients

(1) U.S. Criteria for Low-Risk Drinking

U.S. Dietary Guidelines for Americans
- No more than 1 drink per day for women, 2 drinks per day for men
- No drinks (abstinence) if medically contraindicated (e.g., pregnancy, severe alcohol use disorder, cirrhosis)

NIAAA (National Institute on Alcoholism and Alcohol Abuse)
- 3 – No more than 3 drinks in a day for women & older adults
- 4 – No more than 4 drinks in a day for men
- 7 – No more than 7 drinks in a week for women & older adults
- 14 – No more than 14 drinks in a week for men

NIAAA (NIH)
- Recommended by NIAAA (NIH)

(2) Single Item Screen for High-Risk Drinking in Adults

Recommended by NIAAA (NIH)

How many times in the past year have you had...
- 5 or more drinks in a day? (men)
- 4 or more drinks in a day? (women)

If 1 or more days, then:
1. Screen for an alcohol use disorder (e.g., AUDIT-C & full AUDIT, P/E, labs)
2. Educate about low-risk drinking and cutting down, using BP analogy (Brief Intervention)
   a) Higher number = higher risk
   b) When 140/90, you may feel no symptoms and think no problem
3. Provide resources for cutting down; follow-up within 4 weeks
4. If no progress, assess motivation and refer for specialized interventions

References
Available on request
We Are Team Captains—the Tribal Leaders

- Most of us live in what is described as a Stage 3 Tribe. Our attention is focused on ourselves.
- Today is a Stage function fading.
- Physicians stand at the intersection of health and leadership.
- Our moods and attitudes are contagious, and can infect whole organizations.
- This is why self-care is so crucial.

How Excellent Captains Care for the Team:

Appraise: Prioritize self-care
- What do you need to be healthy for your team?

Empathize: Speak the team’s language(s)
- Members of an innovation usually understand the language of the culture directly above and below them. We cannot take someone from Stage 2 directly to Stage 5.
- Think of your favorite teachers—they could relate to learners at all stages of development—at every stage of tribal culture—and lift them up to the next stage.

Inspire: Lead by example
- If someone wants to learn, the leader can display the enthusiasm and model accountability for fellow tribe members.
- When we captains can take our own mistakes in stride, as learning opportunities rather than shameful horrors, we make it safe for our teammates to do the same.

Motivate: Empower team members
- Effective leaders model accountability and model accountability for fellow tribe members.
- Rather than shaming teammates for mistakes or deficiencies, good tribal leaders provide feedback, encouragement, and opportunities for development.
- They take into account each team member’s personal profile, and align them with those of the collection—excellent captains connect individuals to the whole.

How Excellent Captains Elevate Team Morale (Tribal Culture):

Project the Mission
- Like a Bat Signal, illuminating shared purpose and the common path forward in service of the Mission.
- Any team member need only look up to recall the ideal with confidence, passion, and integrity.

Focus on the Endgame, not the Outcomes
- We can only control what we do
- When we work together to do the right things, aligned with our core values and shared mission, the right outcomes will inevitably result.

Focus on All of Us Together, not any one alone
- Effective leaders reject the “we’re great” and embrace “We’re great.”
- It’s not about any one person’s success or failure, but all of the leader’s.
- The strongest leaders tend the glue that sustains the group’s connections. They are not the glue themselves, they simply spread it.

Why Tribal Leaders Need to Connect

Law of Diffusion of Innovation: “This process by which an innovation is communicated, through certain channels, over time, among the participants in a social system. This process relies heavily on human capital.”
- We, conference attendees, are the innovators and early adopters in the movement toward a kinder, healthier culture.
- Sometimes it feels lonely, as if we are the only ones in our organizations called to restore our profession to its primary purpose and wisdom, which is vital human relationships.
- As we commune here around this common virtue, we recharge and inspire.
- As the conference ends, we carry our new affiliations home. We apply fresh strategies to connect with yet more early adopters, and multiply our supportive networks.
- Slowly and surely, the majority tips, and we change the world.

Catherine Cheng, MD FACP
Northwestern Executive Health, Northwestern University Feinberg School of Medicine, Chicago, Illinois

We Are Elite Athletes

- Specific skill set
- Trained and honed
- Disciplined practice
- Member of a team

How Elite Athletes Care for Themselves:

Fuel & Train
- Our bodies are our vehicles. Elite athletes’ vehicles require premium fuel and meticulous maintenance.
- “Regular people diet and exercise. Athletes fuel and train.” – McLean Orth-Fray
- “Every good lifestyle choice, no matter how small (apple instead of candy, stand rather than sit), is a step of intention toward optimum health.”

Rest & Recover
- Sleep and recovery are integral for sustaining long-term performance and injury prevention—burnout.
- Streamline your methods: 25 minute walk, 20 minute meditation, 5 minutes of journaling—aimed, visual, manage.

Manage your stress
- What do you do when you’re “bombed”? How does stress manifest in your body?
- What is your existing resilience practice? Now quickly do you abandon them when things get busy?
- Exercise enhances your resilience in the moment: better sleep, speak and act intentionally, eat mindfully.

Cultivate positive relationships
- We thrive when we feel seen, heard, understood, accepted, loved, and safe.
- It’s okay if our relationships are strong and we feel connected, that we can truly care for ourselves, our patients, and our teams.
- Who is your support network, and how do they help you up?

From Coping to Thriving: Finding Our Own Agency in a Challenging Cultural Milieu

Melissa Orth-Fray

www.CatherineChengMD.com

See recommended reading list on accompanying poster handout

Be the Change Agent for Culture in Your Tribe

- Get clear on your personal mission and how it manifests most authentically.
- Immense your psyche in the calling, the vocation.
- Invest: Fuel, Train, Rest, Nurture, and Cultivate positive relationship with yourself.
- Take the returns and re-invest in others.
- Take your project mission so everybody can see. Align it with the best in those around you.
- Call out everybody’s personal excellence and aim it in service of the shared mission.
- Stay on the path.
Poster: From Coping to Thriving: Finding Our Own Agency in a Challenging Cultural Milieu

Catherine Cheng, MD FACP
Northwestern Executive Health, Northwestern University Feinberg School of Medicine

Objectives:
1. Recognize physician self-care as analogous to that of elite athletes
2. Understand the importance of physician health in our roles as Tribal Leaders
3. Apply the Law of Diffusion of Innovation to personal and systems change, to move medical culture away from shame and isolation, toward self-efficacy and unification.

Who Are We and Why Are We Here?
• We answered the call to care for people in need, to help them heal.
• We honor the privilege and responsibility of this sacred contract.
• We harbor intrinsic meaning and motivation for the vocation.
  □ Yet, healthcare systems increasingly separate us from our core mission.
  □ We struggle with frustration, cynicism, burnout, and loss of meaning.
  □ Medical culture shames and isolates us, tells us we are weak, for feeling distressed.
  ❖ We attend conferences on physician health seeking connection.
  ❖ We seek strategies to rekindle the fire we felt in our hearts when we started our training.
  ❖ We seek the wisdom and counsel of fellow healers, and the fellowship of the like-hearted

We Are Elite Athletes
➢ Specific and highly developed skill set
➢ Trained and honed over years of practice
➢ Continual discipline to maintain
➢ Goal oriented, always striving to improve
➢ Member of a team (think Olympics: Swimmer, Swim Team, Team USA, Olympic Village)

HOW ELITE ATHLETES CARE FOR THEMSELVES:

Fuel & Train
« "Regular people diet and exercise. Athletes fuel and train." –Melissa Orth-Fray
» Our bodies are our vehicles. Elite athletes’ vehicles require premium fuel and meticulous maintenance.
» We struggle with the same challenges as our patients—time, motivation, discipline.
» We have an opportunity to walk the talk, and practice what we preach. Every good lifestyle choice, no matter how small (apple instead of candy, stand rather than sit), is a step of intention toward health.

Rest & Recover
» Chronic sleep debt increases risks for diabetes, obesity, impaired immune function: GET MORE SLEEP.
» Rest and recovery are integral for sustaining long term performance and injury prevention—ie burnout.
» Take your allotted vacations and really disconnect. The world will still function (temporarily) without you.
» Broaden your methods: 15 minute walk, 10 minute meditation, 5 minutes of journaling—unwind, unload.

Manage your stress
» How do you know when you are ‘stressed?’ How/where does stress manifest in your body?
» What are your existing resilience practices? How quickly do you abandon them when things get busy?
» Exercise mindfulness: Live in the moment; breathe deeply; speak and act intentionally, not incidentally.
» We are no different from toddlers—easily emotionally hijacked when tired, hungry, over-extended.
» Elite athletes use the disciplines above to manage their emotions and stay focused.
Cultivate positive relationships
» Coaches, teammates, trainers, psychologists, equipment managers—no athlete succeeds alone.
» We thrive when we feel seen, heard, understood, accepted, loved, and safe.
» It is only when our relationships are strong and we feel connected, that we can truly care for ourselves, our patients, and our teams.
» Who is your support network, and how do they hold you up?
» Who do you support, and why/how does this fulfill you?

We are the Team Captains—the Tribal Leaders
- Most of us live in what Logan et al describe as a Stage 3 Tribe. Our attention is focused on ourselves—our own performance and success, whether we feel acknowledged for our contributions, and how we are perceived by others. The mantra for people living at this stage is, “I’m great; you’re not.” Tribes at this stage function poorly.
- Recall your experience as a medical student on different rotations, learning from supervisors in each specialty disparaging others, expecting you to play along. You were like a child in a family feud.
- Physicians stand at the intersection of health and leadership. Like it or not, we are the tribal leaders in medicine. As such, our moods and attitudes are contagious, and can infect whole organizations. This why self-care is so crucial—imagine having to work for the tantruming toddler all day, every day!

HOW EXCELLENT CAPTAINS CARE FOR THE TEAM:

Appraise: Prioritize self-care
» Like on an airplane: “Put your own mask on first.” Tribal leaders know that to effectively care for others long term, they first need to be healthy themselves.
» Practice awareness and management of your emotions, and prevent emotional hijacking, so as to be emotionally available to our teammates and tribe members.

Empathize: Speak the team’s language(s)
» Members of a given culture can only comprehend the language of the cultures directly above and below them. We cannot take someone from Stage 2 directly to Stage 5.
» Think of your favorite teachers—they were able to relate to learners at all stages of development—at all stages of tribal culture—and lovingly lift us to the next stage.
» “People don’t care how much you know until they know how much you care.” --T. Roosevelt

Inspire: Lead by example
» Effective leaders reject victim mentality, take responsibility for our actions, and model accountability for fellow tribe members.
» When we captains can take our own mistakes in stride, as learning opportunities rather than shameful horrors, we make it safe for our teammates to do the same.
» Everybody is then free to take more risks, voice more ideas, offer more of their authentic selves as a contribution to the whole,
» Because they see us, their leaders, the ones who set the tone for the group, doing it, too.
» Key here also is leading out loud—excellent captains articulate and coach the methods of self-awareness and self-management that help us all succeed.
» By inspiring individuals to pursue personal excellence, leaders create a supportive milieu for collaboration and collective achievement.
Motivate: Empower team members

» Effective captains (coaches, leaders) recognize team members’ strengths and potential, as well as areas for improvement.
» Rather than shaming teammates for mistakes or deficiencies, good tribal leaders provide feedback and encouragement, and opportunities for practice and development.
» They take into account each team member’s personal goals, and help to align them with those of the collective—excellent captains connect individuals to the whole.

HOW EXCELLENT CAPTAINS ELEVATE TEAM MORALE (TRIBAL CULTURE):

Project the Mission

» Like a Bat Signal! Embodying it with crystal clarity themselves, true captains and leaders project the core mission of the group: illuminating shared purpose and the common path forward in service of the Mission.
» Excellent leaders walk among the group, casting the beacon to the front. Any team member need only look up to affirm the ideal with confidence, passion, and integrity.

Focus on the Endeavor, not the Outcomes

» We can only control what we do—attitudes, protocols, practices—not others’ reactions, not their outcomes. Think smoking cessation, glucose control, blood pressure, patient satisfaction. We cannot control these. But do we do what we say we will do? Do we conduct ourselves according to our own tribal mission and values?
» Exceptional leaders uphold a tribe’s intrinsic drive toward self-defined excellence, rather than allowing external incentives and artificial benchmarks to dictate conduct.
» When we work together to do the right things, aligned with our core values and shared mission, the right outcomes will inevitably result.

Focus on All of Us Together, not any one alone

» Effective leaders forsake “I’m great,” and embrace “We’re great.” It’s not about any one person’s success or failure, least of all the leader’s.
» The health and success of the group depends on the strong connections among its members, each with a unique and acclaimed contribution to make.
» The strongest leaders tend the glue that sustains those connections. They are not the glue themselves; they simply spread it.

Why Tribal Leaders Need to Connect

Law of Diffusion of Innovation: “The process by which an innovation is communicated, through certain channels, over time, among the participants in a social system. This process relies heavily on human capital.”

• We, conference attendees, are the innovators and early adopters in the movement toward a kinder, healthier culture in medicine.
• Sometimes if feels lonely, as if we are the only ones in our organizations called to restore our profession to its primary purpose and wisdom, which is vital human relationships.
• As we commune here around this common virtue, we recharge. We share a common language, cross-pollenate ideas. We inspire one another to stay on the path.
• We amplify our common voice.
• As the conference ends, we carry our new affiliations home. We apply fresh strategies to connect with yet more early adopters, and multiply our supportive networks.
• Slowly and steadily, the majority converts, as one by one they realize the benefits of advanced tribal membership: connection, mission, agency, and fulfillment.
Be the Change Agent for Culture in Your Tribe

• Get clear on your personal mission and how it manifests most authentically.
• Immerse your psyche in the calling, the vocation.
• Articulate it. Model it. Exude it.
• Invest: Fuel, Train, Rest, Nurture, and Cultivate positive relationship with yourself.
• Take the returns and re-invest in others. Mentor, Coach, and Lead by example.
• Project your mission so everybody can see. Align it with the best in those around you.
• Call out everybody’s personal excellence and aim it in service of the shared mission.
• Commune with the Tribe often. Have patience. Change takes time. Stay on the path.

Recommended Reading


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Sleep Health in Medical Students:
A Cross-Sectional Study at Stanford University School of Medicine

Connolly, S., Trockel, M., & Smith-Coggins, R. -- Stanford University School of Medicine

Introduction

Good sleep is known to have many psychological benefits including better mood and improved cognitive function. Unfortunately, many medical professionals struggle with getting quality sleep. Sleep issues may begin in medical school when students are developing career related habits. Understanding sleep health in medical students may allow for informed interventions at this crucial stage and provide a solution for increasing “joy in Medicine”.

Goals

1. Describe sleep health scores, relative to national norms, in a sample of medical students
2. Identify common problems affecting medical student sleep health
3. Recognize associations between common sleep problems reported by medical students and daytime sleep related impairment and depression symptoms

Methods

Stanford medical students of all years were asked to complete an anonymous online survey that included NIH PROMIS Sleep Disturbance, Sleep Related Impairment, and Depression short forms. Students were also asked to report their average number of hours slept per night and to identify specific problems that prevented them from getting better sleep. Demographic information (year, gender) was collected. Averages for sleep and mental health outcomes were calculated and compared to national averages using T-scores. ANOVA was used to measure the effects of different sleep problems and demographic variables on sleep health outcomes.

Findings

470 students were invited to participate. 162 students completed the survey.

Demographics:
- 37% M1, 17% M2, 20% M3, 20% M4, 6% other
- 56% female, 44% male

Students reported an average of 6.77 hours of sleep per night (SD 1.0). Average Sleep Disturbance score was 19.3 (SD 5.8, T-score 49.3), slightly below national average. Sleep Related Impairment and Depression scores were above national average at 20.7 (SD 6.9, T-score 55.8) and 6.6 (SD 2.9, T-score 53.0), respectively. Sleep Disturbance, Sleep Related Impairment, and Depression increased with class year but this trend was not statistically significant.

Two-thirds of students (n=107) identified at least one problem affecting their sleep. Common problems were not having enough time to sleep (53%), being too stressed to sleep (34%), feeling most productive late at night (29%), and enjoying staying up late (28%). Several problems were significantly associated with Sleep Related Impairment: being too stressed to sleep (p<.001), not having enough time to sleep (p<.001), having an irregular sleep schedule (p=.002), and having insomnia (p=.045).

Females had significantly more sleep problems than males (p=.002). Females reported more frequent problems with Sleep Disturbance, Sleep Related Impairment, and Depression scores (p<.001, p<.001, p<.02).

Conclusions

Medical students on average are getting less sleep (6.77 hours/night) than recommended for their age group (7-8 hours). Observed sleep problem correlations with Sleep Related Impairment and Depression suggest sleep problems may be barriers to experiencing “joy in Medicine” beginning in medical school.

Future Steps

Online interventions addressing sleep problems are being developed at Stanford University and will be studied in a multisite trial beginning in Fall 2016. We plan to continue measuring sleep health parameters in future iterations of this survey.

Acknowledgements/References

Contact: sgconnol@stanford.edu -- Visit: wellmd.stanford.edu
Increasing Joy In Residency Training: The University of Alberta’s Innovative Approach to Learner Advocacy & Wellness

Erica Dance and Melanie Lewis
Office of Learner Advocacy & Wellness, Faculty of Medicine & Dentistry, University of Alberta, Edmonton Alberta, Canada

Introduction

Medicine can be a rewarding and joyous career, however, physicians face significant levels of burnout, depression, addiction and suicide (Gundersen, 2001).

Resident physicians often have high levels of stress, compounded by academic challenges, job insecurity and rapidly increasing expectations of them.

Residency training may be the lowest point of personal wellness in the path towards becoming a physician (Lefebvre, 2012).

Office of Learner Advocacy & Wellness

The University of Alberta Faculty of Medicine & Dentistry adopted a unique approach to the struggling learner by creating the Office of Learner Advocacy & Wellness (LAW).

The LAW Office is a safe, inclusive and confidential space designed to ensure that learners are able to achieve their full personal and academic potential. Working with the LAW Office is voluntary.

To avoid conflict of interest, and to better maintain learner privacy, the LAW Office does not report to the Medical Education Offices in the Faculty.

While the LAW office supports both undergraduate and postgraduate learners, this poster focuses on the postgraduate learner population (residents and fellows).

Approximately 10% of residents and fellows are seen for a new issue at the LAW Office each year. Cases range from those requiring brief support to complex issues requiring referrals, coordination and long term follow up. Some individuals access the office for multiple unique issues.

Participation in the LAW Office is voluntary. Referral is from a variety of sources and routes. Correlation cannot be made between the frequency of issues seen in the LAW Office and those in the general learner population.

Number of Cases Seen

Residents and fellows are seen from all training years, typically in proportion to the base population. However, females are seen at a disproportionately larger ratio compared to the population (58% of LAW cases are female, while only 48% of all residents and fellows in the faculty are female).

Type of Cases Seen

The figures below show the primary concern for all new presentations from 2011 to 2016 (excluding 28 cases not specifically affiliated with a residency training program).

Multi-Stakeholder Collaboration

Key to the LAW Office’s success is its ability to advocate for learners in complex and contentious issues while maintaining collaborative relationships with their training programs.

The LAW Office also has a close working relationship with non-university stakeholders including:

- Alberta’s Physician and Family Support Program (Physician Health Program)
- Professional Association of Resident Physicians of Alberta
- Canadian Medical Protective Association
- College of Physician and Surgeons of Alberta

Other Features

Undergraduate and postgraduate resources in the same office allowing for increased presence and continuity of case management from medical school to residency.

In-house psychologist with a special interest in medical learner distress and ability to perform learning assessments.

Close ties with other learner resources allowing for coordinated service.

Initiatives

The LAW Office’s focus is one-on-one learner case management. However, program directors and other educators can also access support and advice relating to learners in difficulty.

Educational sessions are also offered and widely accessed. Topics include physician health, boundary issues and professionalism, all with a focus on learner specific issues in these areas.

Summary

The Faculty of Medicine & Dentistry’s Office of Learner Advocacy & Wellness is a unique model which advocates for and supports medical learners, and provides education on related topics.

The LAW Office strives to aid learners who are struggling, and to be a center of excellence promoting health, resilience and success for all medical learners.

References and Acknowledgment

References


Acknowledgements

University of Alberta trainee population data incurred from the Canadian Post M.D. Education Registry (CAPER) Annual Census reports (www.caper.ca).

The figures below show the primary concern for all new presentations from 2011 to 2016 (excluding 28 cases not specifically affiliated with a residency training program).

Number of New LAW Cases Per Academic Year By Gender

Number of New LAW Cases by Postgraduate Year (PGY) of Training

Enrolled Trainees

Female

Male

Type of Cases Seen

Primary Issue in Family Medicine and Medical Specialty Training (n=562)

Primary Issue in Surgical/ Specialty Training (n=100)

Academic: Academic remediation, Appeals, exam concerns, learning disability, academic air circulation
Medical: Medical needs: physical, psychiatric, or mental health, Medical issues of absence, health to work, work independently, work related disability
Work Related: Work stress or issues related specifically to work, conflicts in work, schedule issues
Career: Career counseling, transfer consideration, job and fellowship concerns
Professionalism: Professionalism, boundary issues, substance abuse, academic accommodation
Other: Other issues in these areas

Acknowledgments

Erica Dance and Melanie Lewis
Office of Learner Advocacy & Wellness, Faculty of Medicine & Dentistry, University of Alberta, Edmonton Alberta, Canada
Qualitative assessment of physician perspectives in an emerging primary care system

Paul Di Capua, MD, MBA, MSHPM1,2,3,4; Tatiana Ivan, MD1,2,4; Tomas Villanueva, DO, MBA1,3; Myriam Ampuero-Martinez, MPA1, Khurram Nasir, MD, MPH1,2,3
1. Baptist Health Medical Group; 2. Center for Healthcare Advancement & Outcomes, 3. FIU Herbert Wertheim College of Medicine, 4. Family Medicine Residency Program

Introduction

Many challenges arise when establishing a well-organized primary care system. High functioning systems are set up to improve population health using a team based approach. The Triple Aim framework has become the keystone approach to optimizing health system performance. However, lack of physician support and resources have been repeatedly noted as barriers to achieving meaningful outcomes. The Quadruple Aim adds to this model by recognizing the importance of clinicians’ role in system development and maintenance. This study seeks to identify key drivers of success and key unexploited opportunities in our primary care system directly noted by clinicians within the system.

Methods

Baptist Health South Florida, an urban non-profit health system, recently created a network of primary care practices geared towards facilitating a system shift towards population health management. A semi-structured interview was developed based on a previously validated model examining factors of physician satisfaction. A grounded theory approach identified major themes and sub-themes. Each theme and sub theme was named and then quotes were used to describe the range and salience of each sub-theme.

Findings

• All primary care physicians active within the primary care system at the time of the study were interviewed (n = 28).
• Motives for careers in primary care included job stability and a good work environment, but primarily focused on the opportunity to achieve a sense of purpose, potential for creativity, and alignment with values.
• Many expressed gratitude for leaders that were invested in their perspectives but also voiced desire for more physician-led changes.
• Finally, although all physicians said they enjoyed working with their primary care team, they also voiced concern regarding communication among team members.

Schematic Model of Population Health Management System

Learning objectives

1. Identifying physician motivators in their jobs can help design mechanisms of engagement and improving satisfaction
2. The computer is the primary care team’s “weakest link”; health system leaders should consider how to minimize this burden in care delivery
3. Contextualizing primary care’s role in a larger population health system can help define key avenues of further development.

Conclusions

Focusing on physician well-being and support is key to building a well-functioning primary care system where physicians feel satisfied in their work life, have less burn out and feel like they are making a difference in patients’ lives. They key is to include physicians when identifying problem areas causing stress and individualize solutions in order to support clinicians’ continual efforts towards finding the “Joy in Medicine.”

In this study, physicians’ motivations in their chosen profession included all tiers of Maslow’s pyramid, but were primarily focused on self-actualization. Relationships with other key stakeholders in the health system can be improved, and so can intra-practice team dynamics.
How Does My Doctor Seem Today? A Qualitative Study of Patients’ Perceptions Regarding Physician Wellness and Its Link to Patient Care

Darby Ewashina MD1 Alicia J. Polacheck MA2 Jaya Dixit MA3 Verna Yiu MD4 Jane B. Lemaire MD1,2

1Department of Medicine, Cumming School of Medicine, University of Calgary
2W21C Research and Innovation Centre, Cumming School of Medicine, University of Calgary
3Faculty of Graduate Studies, University of Calgary
4Alberta Health Services

Introduction

• Physician wellness has become an important area of study in recent decades, yet little is known about patients’ views on this topic.
• Physicians’ health may not be easily observable during physician-patient interactions.
• Patients may, however, speculate about physician wellness based on concrete markers (e.g., signs of fatigue, lack of cognitive focus) or surrogate emotional or mental markers (e.g., irritability, lack of empathy and compassion).

Objective

• To explore patients’ perceptions of physician wellness and how it is linked to patient care.

Methods

• Semi structured interviews were conducted with a volunteer sample of 20 patients utilizing outpatient care settings in a single Canadian city.
• Inductive thematic analysis was performed by two researchers.
• The themes and quotes presented here illustrate the opinions and sentiments conveyed by the participants.

Results

Patients Notice

• Patients noticed cues that they interpreted as signs of doctor wellness or unwellness.
  • This included overt indicators such as physical appearance, demeanor, personality, and appearing rushed or stressed.
  • Patients could also “sense” doctor wellness or unwellness.
• Unwellness was more discernable in long-term relationships where patients noticed changes in the doctor over time.
• Patients provided more examples of unwellness and commented that it was easier to discern compared to wellness.

Based on what they noticed, patients formed judgments about the doctor.

These judgments impacted patients in three ways:

1. Their Views of the Care they Receive
   • Patients believe that unwell doctors:
     • have poor relationships and connections within medicine
     • are less competent
       • they make inadequate assessments, are not as thorough, make errors, and may be inappropriate with patients
     • have poor organizational skills
     • put the onus on patients by limiting complaints and asking patients to self-diagnose

2. Their Feelings
   • When patients perceive that the doctor is unwell, patients may:
     • feel uncomfortable and uncared for
     • lack trust in the doctor
     • may not want to continue seeing the doctor
   Patients felt that well doctors took a more holistic and humanistic approach characterized by:
     • better communication and collaboration with patients
     • increased engagement, rapport, and relatability
     • more empathy for patients
     • seeing and treating patients as a whole person

3. Their Actions
   • When doctors were perceived as unwell, patients described:
     • questioning recommendations and being less likely to comply with their advice
     • having compassion and concern for the doctor
     • limiting the number of problems they addressed with the doctor
     • having to advocate more aggressively for their own care

Conclusion

• Patients may judge wellness in physicians based on what they notice about the doctor.
• These judgments impact patients’ perceptions about the care they receive, their feelings, and their subsequent actions.
• Regardless of whether patients’ perceptions match objective measures of physician wellness, this study indicated the need for doctors to be and appear well as this may shape the physician-patients interactions and experiences.
WHO HELPS OUR HELPERS?
REDISCOVERING JOY IN MEDICINE BY ADDRESSING SECONDARY TRAUMA

Donald M. Friedman, M.D., Clinical Associate Professor of Medicine, Sidney Kimmel Medical College, Thomas Jefferson University, Philadelphia, PA, and Vic Compher, M.S., LCSW

SECONDARY TRAUMA; COMPRESSION FATIGUE; KNEECAP TRAUMA

Secondary Trauma is a psychological sequel to the psychological trauma experienced by professionals who are exposed to traumatic events, such as healthcare professionals who work in areas of conflict, violence, or disaster. It is a form of secondary stress response that can develop in individuals who are repeatedly exposed to the trauma of others. Secondary trauma can manifest as feelings of helplessness, anxiety, depression, and post-traumatic stress disorder.

Compassion Fatigue is a term used to describe the emotional exhaustion and burnout that can occur in caregivers due to prolonged exposure to trauma. It is characterized by feelings of emotional numbness, decreased empathy, and a sense of detachment from patients.

Knee Cap Trauma refers to the physical injury that occurs when the kneecap (patella) is dislocated from its groove in the femur. This can result in significant pain and disability. Treatment typically involves surgery and physical therapy.

WHEN THE WHOLE-HEARTEDNESS OF CARE IS NOT ACKNOWLEDGED, RECOGNIZED OR ANCHORED THE CAREGIVERS, WE LOSE THEIR PASSION, THEIR POWER, THEIR PERSPECTIVE, AND THEIR ABILITY TO CARE.

Portraits of Professional Caregivers
A film about the emotional impact of professional caregivers and how they maintain their health.

"If you have high compassion satisfaction, it counterbalances compassion fatigue because it influences the very kind of notions that compassion fatigue is associated with..."

- Daniel P. Pelz, M.D., from the film "Caregivers"

PHYSICIAN BURNOUT GRAPH - 2015

Burnout Symptoms
- Emotional exhaustion
- Depersonalization
- Reduced personal accomplishment

Features:
- Long work hours
- High stress levels
- Insufficient support

Burnout can lead to decreased job satisfaction, increased turnover, and decreased quality of care. It can also have a negative impact on the personal and social lives of healthcare professionals.

BUILDING RESILIENCE

The ability to cope with stressful situations and maintain equilibrium is essential for maintaining resilience. Resilience is built through a combination of personal resources, the ability to adapt to change, and the support of others.

FEEDBACK REQUIRED

Feeling Overwhelmed?
- "It often feels like we are alone when we're experiencing overwhelming emotions."
- "It's hard to know how to address these feelings without feeling like a burden on others."

RESOURCES
- "I don't know where to turn for help."
- "I feel like I'm drowning in a sea of emotions."

ORGANIZATIONAL STRUCTURES THAT PROVIDE FEED SUPPORT

Examples of supportive organizational structures include:
- "Support groups for healthcare professionals can provide a safe space to discuss and address burnout.
- "Leadership support and recognition for the challenges faced by healthcare professionals can help reduce burnout.
- "Encouragement of self-care and mental health resources can help healthcare professionals maintain their well-being.

EXAMPLES OF SUPPORTIVE ORGANIZATIONAL STRUCTURES

- NURSES AID SERVICE - Offers emotional support for nurses at Jefferson Health Care Center in Philadelphia, PA.
- "SAGE - Offers a support group for LGBTQ+ nurses and healthcare professionals.
- "NURSES AID SERVICE - Offers emotional support and counseling for nurses at Jefferson Health Care Center in Philadelphia, PA.

NOTE: PLEASE CHECK OUT ONLINE LINKS TO THESE AND A NUMBER OF ADDITIONAL SUPPORTIVE PROGRAMS WITH FULL BIBLIOGRAPHY OF SOURCES IN OUR HANDOUT

ALL FEATURED IMAGES FROM "PORTRAITS OF PROFESSIONAL CAREGIVERS: THEIR PASSION, THEIR POWER!"

For additional information regarding the documentary film, please visit www.caregiverson.com
The following are considered the core humanistic values which physicians should evince: honesty, integrity, caring, compassion, altruism, empathy, respect for others, trustworthiness². Humanistic values have been recently emphasized in medical education with the advent of professionalism competencies. Few curriculum interventions affect humanistic professional development at the GME level.

Methods
Residents from Duke and UNC’s OB/GYN residencies and UNC Internal Medicine residency were asked to write a narrative about a challenging clinical experience they have had during their residency thus far. The narratives were qualitatively analyzed for themes. Ten residents voluntarily participated in three small group reflective sessions geared toward development at the GME level.

The success of the intervention was measured with satisfaction surveys as well as using baseline and 60 day follow-up questionnaires related to self-reported frequency of ethical missteps³, a self-assessment of burnout and compassion fatigue (PROQOL)⁴; as well as the psychological medicine abilities (PMI)⁵.

Results
To Develop and Assess a Pilot Curriculum to Foster Humanistic Behavior in Graduate Medical Education

### Baseline Questionnaire Data

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of Mentions</th>
<th>Curriculum Group</th>
<th>Control Group</th>
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<td>19</td>
<td>8</td>
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<tr>
<td>Difficult Communication Scenarios</td>
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<td>23.3</td>
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<td>38.3</td>
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<td>23.3</td>
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<tr>
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<td>Duplicity</td>
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<tr>
<td>Loss of Idealism</td>
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</table>

### Demographics

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<th>N= 10 in both groups</th>
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<th>Control group</th>
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<td>100% female</td>
</tr>
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<td>6</td>
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<td># married</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td># with at least one child</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td># of PGY 2 or less</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td># OB/G vs IM residents</td>
<td>8 vs. 2</td>
<td>7 vs. 3</td>
</tr>
</tbody>
</table>

### References


### Conclusion

A Pilot Humanism Curriculum for GME including exercises to foster empathy for patients and peers, as well as assist residents with skills for maintaining a reasonable work-life balance and negotiating difficult communication scenarios was well received by participants. The curriculum met course objectives and was able to be incorporated into the residents’ practice.

There was a trend toward improved burnout and higher compassion scores for the intervention group vs. the control group. There was no difference in PMI or reported ethical missteps.

Development and evaluation of an expanded curriculum would further explore the feasibility and effectiveness of this type of intervention.
From the Ground Up: resident’s perspectives on improving physician wellness in an academic OB/GYN residency program

Martha B. Kole MD, Erica Weston MD, Alexandra Jen MD, Jane Sharp MD

Department of Obstetrics & Gynecology, Alpert Medical School of Brown University, Women & Infants Hospital of Rhode Island

Introduction

- Nationally, stress and burnout are high among young physicians and medical students.
- Rates of physician suicide have been increasing, especially among the youngest physicians.
- Resident wellbeing is important not only for successful residency training but also for creating a culture of wellbeing moving forward as an attending.
- Few residency programs have formal wellness curricula to focus on combating stress and burnout.

Methods

- **Subjects**: Residents at an academic obstetrics and gynecology residency program
- **Study design**: Residents completed self administered survey on stress, burnout, coping mechanisms and resident program support using a Likert scale
- **Survey instruments**:
  - Investigator designed questions on wellness and coping mechanisms
- **Statistics**: Pearson’s correlation coefficient and student’s t-test

Learning Objectives

- Identify risk factors for stress and burnout in young physicians
- Identify activities residents find beneficial for their personal and professional wellness
- Implement change at their home institution to focus on physician well being

Curriculum Development

- Using information from the residency wide survey completed by 31 of 32 residents a Wellness Curriculum was created which includes:
  - Monthly Noon Conferences
    - Mindfulness
    - Arts in Medicine
    - Exercise
    - Healthy Eating
    - Team building
  - Monthly Wellness Challenges
    - Taking the stairs
    - Cooking healthy recipes
    - Mindfulness practice
    - Spending time outdoors
    - Reading a novel
  - Core Curriculum lecture: focused on mindfulness, self awareness and self care
  - Quarterly evening wellness symposium
    - Physician self care
    - Breaking bad news
    - Spirituality in medicine
    - Work-life balance

Conclusions

- Wellness is important to young physicians
- Residents are overall dissatisfied with their level of wellness
- At Women and Infant’s Hospital residents feel that their institution is concerned about trainee wellness
- As training advances there is a trend towards a decreased focus on wellness

Future Directions

- Continued programs aimed on addressing physician stress and burnout.
- Integration of wellness events into daily activities of physicians-in-training.
- Improved discussion on the importance of a formalized focus on wellness.
Persistence of cynicism despite improved quality of life: Wellness measures all improve in the fourth year of medical school except depersonalization

Rachel Kon, Justine Owens, Tabor Flickinger, Walker Redd, Danielle Oliver, Margaret Plews-Ogan, and John Schorling

Introduction

Physician burnout contributes to loss of empathy, poor job performance and ultimately medical errors and reduced patient satisfaction. Burnout often starts in medical school. To better understand burnout among medical students, we conducted a cross-sectional study of wellness measures in medical students during all 4 years.

Learning objectives:
- To learn about rates of burnout, anxiety, and depression during different stages of medical school
- To discuss why the depersonalization domain of burnout is high in fourth year students when other wellness measures are much better in fourth year than third year

Methods

University Of Virginia School Of Medicine students were sent an online anonymous 128 item survey that included demographics, quality of life measures, anxiety and depression screening (PHQ-4), burnout (MBI), resilience (CD-RISC 25), and QOL and fatigue questions used in national surveys. For the MBI, used cut-offs for high burnout consistent with other studies of medical students, we considered high burnout to be a score of 27 or greater for emotional exhaustion (EE) or a score of 10 or greater for depersonalization (DP). We considered combined burnout to be a high score on either the EE or DP scales.

Statistical analysis was conducted using chi-square testing to compare MBI scores between cohorts as discrete variables with score cutoffs as above. ANOVA testing was used to compare CD-RISC, QOL, fatigue, and PHQ-4 scores between cohorts as continuous variables.

Results

630 students were eligible to participate and 343 responded to at least part of the questionnaire (54.4% response rate). Participants had a mean age of 25 years, with 50.6% being female and 49.4% male. 340 students reported their current year in medical school: 27.1% in 1st year, 24.7% in 2nd year, 26.2% in 3rd year, and 22.1% in 4th year.

Maslach Burnout Inventory:
- Prevalence of high emotional exhaustion for first, second, third, and fourth-year medical students was 21.3%, 34.7%, 50.6%, and 9.1% respectively ($\chi^2 = 33.9, p<.001$)
- Prevalence of high depersonalization was 16.0%, 14.7%, 56.6%, and 40.9% respectively ($\chi^2 = 44.4, p<.001$)
- Prevalence of high combined burnout (high score on either the emotional exhaustion or depersonalization scales) was 30.7%, 40.0%, 66.3%, and 42.4% respectively ($\chi^2 = 22.3, p<.001$)

Resilience:
- CD-RISC scores varied by year in medical school with scores highest in fourth-year students ($p<.005$)

QOL:
- Mean overall, mental, emotional, and physical quality of life scores were highest in fourth-year students ($p<.001$ for all four)
- Mean fatigue scores were significantly better in fourth year medical students ($p<.001$)
- Depression and Anxiety Screen:
- Mean PHQ4 scores were significantly lower in the fourth year ($p=.001$)

Conclusions

When the long hours and frequent test-taking of the third year end, the fourth year of medical school is often a time when students are less stressed. We found that fourth year students in our survey had overall improved wellness scores than students in years 1-3, except for depersonalization, which remained elevated. It is alarming that feelings of cynicism and detachment persist even when working conditions and well-being improve. Further study is needed to determine why depersonalization persists and how best to address it. One possibility is that experiences with long-term patient-student relationships, such as longitudinal clerkships, may combat the onset and persistence of depersonalization.

References

Assessing the Role of Joy in Physician’s Well-being Using Survey
Sujit Kumar Kotapati, MD; Rajalakshmi Cheerla, MD; Shivani Malhotra, MD; Nancy Blevins, MD; Suman Donepudi, MD; Andrew Smith, MD; Rashid Ansari, MD; Meredith A Lewis, LCSW; Angela Edwards, BA
UAB Huntsville Family Medicine Residency Program - Huntsville, AL

PURPOSE
• To assess the role of Joy in physicians’ well-being using innovative survey questionnaire.
• The objective of our study is to assess the role of Joy in physician’s well-being, spiritual, missionary and work life satisfaction to provide better patient care.

METHODS
• The Joy survey was introduced to assess the role that Joy plays for residents and faculty and it focuses on strategies for increasing that role in physicians’ well-being.
• The survey includes clinic specific information about issues like sharing responsibility among the team, improving team communication and increasing team functioning through better work flow design to provide better patient care.
• The survey was administered to faculty and residents of the UAB Huntsville Family Medicine Program in January 2016 and again in June 2016.

RESULTS
• Preliminary analysis showed 40 of 45 January respondents found the survey “very useful” to assess their increase in Joy by sharing the responsibility among the team, improving team communication and team functioning by work flow design to provide better care for their patients.
• Responses in January showed an 88% or higher increase in Joy in each of four categories: Well-being (96%), Sharing responsibility (88%), Building relationships (88%) and Improving team communication (96%).
• June results were comparable to those from January.
• Respondents suggested that promoting healthy lifestyles to patients and partnering with patients and their families in making health-care decisions gave them immense Joy thus helping to make their medical practice fulfilling.

DISCUSSION
• The Joy survey can play a key role in assessing current and future physical and emotional self-awareness. physicians in increasing their personal, spiritual, mission, professional and work life satisfaction.
• Our observations showed that personal and professional satisfaction are interlinked with greater Joy in practice and can be improved by:
  1) Strengthening trust and reliance among the team by improving team communication.
  2) Sharing responsibility among the team to prioritize patient continuity in collaboration with care teams like pharmacist, social workers and etc.
  3) Improving team functioning through better workflow design and planning, which in turn increases efficiency, productivity, patient safety, and quality of care.
  4) Physical activity, yoga, and meditation all seem to contribute to heightened overall wellbeing.

RECOMMENDATIONS
• Expand survey to include allied health personnel as a means to help improve team cohesion, the sharing of responsibility, and communication within the team.
• Add a third, survey date at the beginning of the academic year such that the Joy survey is administered three times during the academic year (beginning, midpoint & end) rather than just mid-point and end of the academic year.

REFERENCES
• www.acgme.org/what-we-do/initiatives/physician-well-being/acgme-symposium-on-physician-well-being
• http://www.drchristinahibbert.com/beyond-happiness-10-ways-to-increase-joy/
• http://www.cancercenter.com/treatments/laughter-therapy/

INCREASE IN JOY AS OF JANUARY 2016

JUNE 2016 RESULTS

Our second survey administration sought to assess the same categories and determine if there was a difference in Physicians’ well-being, spiritual, missionary and work life satisfaction.
Preventing Resident Burnout: A longitudinal study of resident burnout and resilience in the Queen’s University Internal Medicine training program

M. Leung, MD | J. Ames, MD | L. Petrie, MD | B. Monteith, MD | M. Joneja, MD, FRCP(C) | D. Taylor, MD, FRCP(C)
Department of Internal Medicine, 76 Stuart Street, Queen’s University, Kingston, Ontario, K7L 2V7

Background

- Burnout is a syndrome encompassing: emotional exhaustion, cynicism/depersonalization & decreased sense of personal accomplishment
  - Ranges from 27-78% in medical professionals
  - Negatively impacts on patient care with correlation to higher perceived clinical errors and increased medication errors
  - Royal College CanMEDS Framework:
    - Post-graduate medical education should develop core competence in ...
    - Development of self-awareness, including managing the influences of personal well-being and professional performance
    - Promotion of a culture that recognizes and supports colleagues in crisis
  - The Queen’s Internal Medicine-Wellness Resident Leadership Team (“Wellness RLT”) was formed to study the level of burnout amongst Queen’s IM trainees, and explore preventative interventions

Study Objectives

- **Causes:** what factors impact resident burnout?
- **Incidence:** what proportion of residents develop burnout during residency?
- **Prevalence:** how many residents exhibit burnout at any given time?
- **Patterns:** are there periods of training that internal medicine residents exhibit higher levels of burnout?
- **Prevention:** what interventions are effective at preventing its occurrence?

A year in the life of a Queen’s Internal Medicine Resident...

January
PGY1: Start of Residency
August to November:
PGY2: CaMEd, Medicine Subspecialty Month
PGY3: MCCQE II Examination

February 2016

May 2016

August 2016

Nov 2016

First Survey Administered (February 2016)
Second Survey Administered (August 2016)
Planned focus group & third survey (Nov 2016)

Methods

- **Study Participants:** Residents of Internal Medicine at Queen’s University
  - n=67 February 2016
  - n=62 August 2016

- **Data Collection:**
  - Resident “Pulse Check” questionnaire consisting of:
    - Malach Burnout Inventory4
    - Cohen Perceived Stress Scale5
    - Brief Resilience Scale11
  - Each participant is de-identified with a unique code, and their responses can be tracked throughout multiple timepoints using this code
  - Focus groups (semi-structured interviews)

- **Timeline of Collection:**
  - Pulse Check surveys: aim is to administer quarterly
  - Focus groups: facilitators annually to gather qualitative data
  - Continued over four years to capture longitudinal trajectory of residents throughout three years of Internal Medicine Residency

Analysis:

- Cross-sectional & longitudinal analysis of burnout, perceived stress and resilience

Results

**FEBRUARY 2016**

<table>
<thead>
<tr>
<th>No. of Respondents</th>
<th>High CY or EE</th>
<th>High CY</th>
<th>High EE</th>
<th>Low PE</th>
<th>High Perceived Stress</th>
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<tbody>
<tr>
<td>All Residents (n=67)</td>
<td>36 (54%)</td>
<td>25 (37%)</td>
<td>18 (27%)</td>
<td>22 (33%)</td>
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<tr>
<td>PGY1</td>
<td>15 (42%)</td>
<td>12 (80%)</td>
<td>8 (53%)</td>
<td>11 (73%)</td>
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<tr>
<td>PGY2</td>
<td>13 (30%)</td>
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<td>7 (54%)</td>
<td>6 (46%)</td>
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<tr>
<td>PGY3</td>
<td>8 (12%)</td>
<td>5 (63%)</td>
<td>3 (38%)</td>
<td>5 (63%)</td>
<td>2 (26%)</td>
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**AUGUST 2016**

<table>
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<td>All Residents (n=62)</td>
<td>31 (50%)</td>
<td>21 (68%)</td>
<td>21 (68%)</td>
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<td>5 (83%)</td>
<td>4 (67%)</td>
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**Burnout High CY or EE:**

- Of the respondents, there was a high rate of burnout (68 vs 69%) and perceived stress (86 vs 61%)
- Average Brief Resilience Scale Score: 3.1±0.71 (February 2016) vs 3.6±0.78 (August 2016)

Narrative Responses:

Do you have any comments regarding resident wellness & burnout that the Queen’s University Department of Internal Medicine should be aware of?

- “This is really valuable. Of us do not show our confidence that we experience in order to project an image of confidence.”
- “There is also a culture in medicine, in my personal opinion, of working through regardless of what personal hardships a physician or trainee is going through.
I don’t think we ask each other enough times if things are ok.”

Summary & Future Directions

- Preliminary data suggests Internal Medicine residents have high rates of burnout (68-69%) and perceived stress (61-86%)
- Limitations:
  - Low response rate (50-54%); possible participation bias in those who complete the survey
- Future Work:
  - **Causes:** Focus groups (scheduled for Nov 2016) to further elucidate what factors impact resident burnout
  - **Patterns:** Further administrations of PulseCheck survey for longitudinal analysis of periods that might be associated with higher burnout
  - **Prevention:** Utilizing the Resident Wellness Leadership Team to implement strategies to prevent occurrence of burnout

References

8. Do you have any comments regarding resident wellness & burnout that the Queen’s University Department of Internal Medicine should be aware of?

Questions? QR Code Access:
Background

Burnout, a phenomenon closely linked with depression and characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, is a major health concern for healthcare providers. There is a strong need to develop programs that focus on prevention. The Peer Support and Resiliency in Medicine Program (PRIME) was developed in 2010 to restore balance to a training environment that has historically focused on independence, self-sacrifice, efficiency, and critical thinking by creating a novel culture that promotes interdependence, success for all, well-being, and emotional literacy.

Program Components: Retreat

The concept of wellness is first introduced to residents at the start of their CA-1 year during a 2.5 day retreat that is based on Jon Kabat-Zinn's Mindfulness-Based Stress Reduction work. Trained faculty members lead residents in various exercises that allow for sharing of emotions and vulnerabilities in a non-judgmental and confidential setting. These exercises include guided imagery and forgiveness meditations, guided non-judgmental feedback with a focus on attentive listening, rather than problem solving. Residents are divided into two groups: those who attended the retreat and those who did not. The retreat is held in an offsite location to create a physical separation from the work environment.

Wellness Sessions are led by trained faculty members who continue to provide a safe space for residents to receive support during challenging times while concurrently teaching them skills to enhance communication, relationships, and health behaviors.

Program Components: Wellness Seminar

Wellness sessions are held every 6-8 weeks for the duration of the residency program during protected didactic time to reinforce and expand on topics covered during the retreat. Wellness sessions receive uniformly positive evaluations. Participant feedback is solicited prior to each session and inhabitants of wellness sessions receive support during challenging times while concurrently teaching them skills to enhance communication, relationships, and health behaviors.

Program Components: Scholarship Program

The scholarship program provides up to $1500 to support proposals that promote resident wellness and resiliency. All applications must have a faculty sponsor and are reviewed by a selection committee comprised of PRIME faculty members, residency program director, associate program director, chief resident representative, and a resident education committee representative.

Program Components: Symposium Series

Special presentations from nationally recognized experts provide the medical center community with additional exposure to wellness-related topics. Special presentations from nationally recognized experts provide the medical center community with additional exposure to wellness-related topics. Information gleaned should be shared with faculty and residents through a formal presentation.

Program Components: Symposium Series

Symposium speakers from nationally recognized experts provide the medical center community with additional exposure to wellness-related topics. Information gleaned should be shared with faculty and residents through a formal presentation.

Conclusion

The authors and all PRIME Program faculty members thank the Stanford Department of Anesthesiology, Perioperative and Pain Medicine and the Any Angst Foundation for the generous support that allows this program to exist and thrive.

References


Acknowledgements

The authors and all PRIME Program faculty members thank the Stanford Department of Anesthesiology, Perioperative and Pain Medicine and the Any Angst Foundation for the generous support that allows this program to exist and thrive.
Exploring the utility of a continuing education workshop to address and manage disruptive behaviour in postgraduate medical education

Christopher Simon, PhD¹, Derek Puddester¹, MD, MEd, & Colla J. MacDonald¹-², PhD
¹Faculty of Medicine, University of Ottawa; ²Distinguished University Professor Emeritus

Introduction
As Professionals, physicians are committed to the health and well-being of patients through high personal standards of behaviour, accountability, and maintenance of personal wellness (CanMEDS, 2015)

Disruptive Behaviour (DB)
Pattern of inappropriate conduct with potential to negatively impact the workplace and patient safety (CMPA, 2013)

Prevalence
☑ All physicians likely to experience DB in career
☑ 77% concerned about DB in colleagues
☑ Defined issue in PGME (MacDonald et al., 2011)

Consequences
☑ Negative impact on well-being + personal/professional relationships
☑ Medical errors + reduced quality of care (Leape & Fromson, 2006)

Addressing DB
☑ Increasing cultural + legislative shifts in behavioural expectations of medical learners
☑ Proactive approaches gaining momentum

Purpose
Evaluate the efficacy of a training workshop as a strategy to teach medical leaders, faculty, residents and staff to prevent and manage DB in PGME

Methods
W(e)Learn Framework (MacDonald et al., 2009)
- Dimensions: Content, Media (Delivery), Service, Structure, Outcomes

Data Collection and Analyses
In-depth interviews (n = 17)
- Program Administrators; Residents; Workshop Facilitators; Program Directors/Faculty
- Analyses → Qualitative content analysis

Archived, post-workshop evaluations (n = 86)
- Quantitative (Likert ratings)
- Analyses → Descriptive statistics

Results

<table>
<thead>
<tr>
<th>W(e)Learn Component (summarized question)</th>
<th>Summary of Key Themes</th>
</tr>
</thead>
</table>
| **Content**                              | • Generally acceptable
• Could be condensed and prioritized |
| **Reliability**                          | • Very applicable to PGME workplace
• Transferrable skill-set (professional and personal life)
• Incorporate additional, PGME-specific examples |
| **Teaching methods**                     | • Balance of theory and practice appreciated
• Catering to different styles enhancing learning experience
• Strategies enhanced learning experience (e.g., sharing with colleagues. Use of videos to contextualized concepts) |
| **Facilitators**                         | • Important in perceptions of overall quality
• Effective qualities:
  - Knowledgeable of content
  - Ability to contextualize content for PGME environment
  - Flexible, adaptable, engaging and passionate
  - Ineffective qualities:
  - Disorganized and inflexible to needs of audience
  - Perceived lack of knowledge
  - Failed to contextualize content |
| **Resources**                            | • Appreciated and derived value from materials provided
- Minority did not find useful, nor accessed post-course |
| **Organization**                         | • Well-organized and professional
• Scheduling difficulties within PGME environment a barrier
• Small, homogeneous groups preferable |
| **Program directors felt armed to help learners in difficulty** |
| **Confidence**                           | • More comfortable initiating difficult conversations
• Notable increase among residents engaging with peers |
| **Interpersonal skills**                 | • Improved among colleagues and supervisors
• Improved self and emotional awareness
• Common language developed |
| **Environment**                          | • Training beneficial for anyone in PGME
• Training most applicable to:
  - Chief and early-year residents; Program directors;
  - Administrators; international medical graduates
  - Useful remediation tool for disruptive behavior
  - Mixed support for mandating training |
| **Follow-up**                            | • Concern regarding attrition of skills over time
• Skill proficiency requires ongoing practice and effort |

Post-Workshop Evaluation Data

<table>
<thead>
<tr>
<th>W(e)Learn Component (summarized question)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content</strong></td>
<td>%</td>
</tr>
<tr>
<td>1. Volume and complexity was appropriate</td>
<td>4.00 ² 0.00 ³ 20.28 ³ 40.40</td>
</tr>
<tr>
<td>2. Content was relevant to PGME environment</td>
<td>0.00 ² 16.40 ³ 40.40</td>
</tr>
<tr>
<td><strong>Delivery</strong></td>
<td>%</td>
</tr>
<tr>
<td>1. Understood the exercises/activities</td>
<td>0.00 ² 0.00 ³ 3.57 ³ 40.40</td>
</tr>
<tr>
<td>2. The instructor:</td>
<td>%</td>
</tr>
<tr>
<td>3. Used engaging stories to illustrate content</td>
<td>0.00 ² 3.50 ³ 49.47</td>
</tr>
<tr>
<td>4. Asked questions that encouraged discussion</td>
<td>0.00 ² 3.49 ³ 49.49</td>
</tr>
<tr>
<td>5. Kept course moving at appropriate pace</td>
<td>0.00 ² 3.48 ³ 49.49</td>
</tr>
<tr>
<td>6. Explained things clearly</td>
<td>0.00 ² 3.53 ³ 54.38</td>
</tr>
<tr>
<td>7. Was knowledgeable about the material</td>
<td>0.00 ² 3.54 ³ 54.38</td>
</tr>
<tr>
<td><strong>Service</strong></td>
<td>%</td>
</tr>
<tr>
<td>1. Feel prepared to apply strategies</td>
<td>2.00 ² 0.13 ³ 55.30</td>
</tr>
<tr>
<td>2. Course will help me in my professional life</td>
<td>2.00 ² 0.38 ³ 60.60</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td>%</td>
</tr>
<tr>
<td>1. Facilities were conducive to learning</td>
<td>0.00 ² 13.49 ³ 38.38</td>
</tr>
<tr>
<td>2. Pre-course information met needs</td>
<td>0.00 ² 3.64 ³ 33.33</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>%</td>
</tr>
<tr>
<td>1. Skills will address DB in PGME environment</td>
<td>2.00 ² 0.07 ³ 53.38</td>
</tr>
<tr>
<td>2. Would recommend course to colleagues</td>
<td>2.00 ² 2.33 ³ 63.63</td>
</tr>
</tbody>
</table>

Findings reinforced utility in providing training through Faculty, supporting ongoing commitment to systemic efforts to reduce DB within PGME

Discussion

Addressing and Managing DB
- Training is relevant and timely
- Enhanced effective communication within PGME environment → providing tangible strategies, building confidence, and enhancing awareness
- Findings align with trend toward more proactive approaches to addressing DB

Improving the Workshop
- Develop and implement more tailored resources to facilitate ongoing skill development
- Further adapt content for PGME audiences
- Encouraging facilitators to contextualize concepts; be adaptable to the needs of the audience

Future Research
- Compare pre and post levels (e.g., complaints) to determine whether DB could be reduced within a PGME setting after training program is introduced

Conclusions
- Interview data corroborated post-workshop evaluation data that training can be effective strategy to address and manage DB in PGME
- Training has potential to improve physician joy and well being by contributing to effective communication and a positive work environment
- Physician leaders play pivotal role in addressing DB → must be committed to creating culture of respect within institutions to minimize negative impact within medical training
- Continuing evaluation and refinement critical for long-term success of initiative
- Findings reinforced utility in providing training through Faculty, supporting ongoing commitment to systemic efforts to reduce DB within PGME

Contact: christopher.r.simon@icloud.com
Finding Joy in a Haystack
Harise Stein, MD
Stanford Medicine, Palo Alto, CA

Background
With busy lives, overflowing email inboxes, and notification fatigue, there are multiple challenges in communicating with doctors about wellness programs and opportunities that do become available.

Goals
1. Understand the general and generational challenges of communicating with physicians.
2. List multi-media communication methods.
3. Apply the power and potential of website design to institutional wellness needs.

Important Concepts
Website information architecture:
- Page, label, and link navigation is:
  - logical
  - clear
  - consistent
  - efficient (no more than 2 clicks)
  Items quick and easy to find

Writing for the web:
- condensed content
- shorter line width
- appropriate fonts
- adaptable to mobile formats
  Items quick and easy to read

Materials
Find multiple ways to connect with physicians
- email, texts
- in print pamphlets, posters, business cards in the doctors' lounge and other gathering places
- mentions in departmental meetings
- informational slides before start of grand rounds
- materials given out at trainee orientation
- one-stop website with mobile formats, and social media links/brief text requested by trainees

Newsletters (one page, also mobile formats)

Website
#1 Website on Google for "physician wellness"
Return visitor rate 2012-2016: 2% → 30%

Navigation
Find multiple ways to connect with physicians
- email, texts
- in print pamphlets, posters, business cards in the doctors' lounge and other gathering places
- mentions in departmental meetings
- informational slides before start of grand rounds
- materials given out at trainee orientation
- one-stop website with mobile formats, and social media links/brief text requested by trainees

Writing for the web:
- condensed content
- shorter line width
- appropriate fonts
- adaptable to mobile formats
  Items quick and easy to read

Conclusions
- Use multiple types of generationally-sensitive media to increase the chance that physicians will be able to "find" wellness programs and services.
- A clear and well-designed website presence provides:
  - 24/7 supportive contacts and resources
  - Advertising about and a registration method for physician wellness programs
  - Information about regional, national and international physician wellness courses
  - A "home" for wellness survey enrollment and dissemination of results
  - An archive for newsletters and other communications
  - A central hub to find other similar department programs to share projects, best practices, etc.
  - An increased sense of community
  - A searchable repository for multi-institution research and networking
- Future goals:
  - Increase interactive components
  - Add gratitude area
  - Add research article database

Acknowledgements
Stanford Medicine WellMD Center
Stanford Physician Wellness Committee
Contact:
Harise Stein, MD
Webmaster and Newsletter Editor
harise@stanford.edu

Visit us at: wellmd.stanford.edu
Burnout in the NICU setting and its relation to healthcare-associated infections

BACKGROUND

• Medical errors are frequently avoidable and self-reported in adult populations
• The demographic variation of NICU populations
• Burnout affects 27-36% of healthcare workers and has been associated with increased healthcare-associated infections (HAIs) and self-reported errors in adult populations
• The demographic variation of NICU provider burnout and the effect of burnout on neonatal quality of care are unknown

OBJECTIVES

• Describe variation of NICU caregiver burnout by provider characteristics
• Analyze the relationship between caregiver burnout and HAI rates among VLBW infants

METHODS

• Safety culture and burnout survey administered to 44 neonatal intensive care units (NICUs) during a quality improvement initiative
• Burnout score calculated for each respondent based on a 4-question subset of the Maslach Burnout Inventory
• Burnout prevalence calculated for each NICU, with burnout score >50 (out of 100) as positive result
• HAI rate calculated for each NICU as any bacterial or fungal infection acquired after 3 days of age, with adjustment for sex, gestational age in weeks, small for gestational age status, birth weight, and APGAR score at 5 minutes
• Logistic and multi-level regression analyses were employed to describe relationship between burnout and HAI, accounting for infant risk factors, NICU variability, and respondent characteristics

NIVC Level (N = 44), n (%)

<table>
<thead>
<tr>
<th>Size</th>
<th>Respondent Level (N= 2073), n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>10 (22.7)</td>
</tr>
<tr>
<td>Community</td>
<td>28 (63.6)</td>
</tr>
<tr>
<td>Intermediate</td>
<td>6 (13.6)</td>
</tr>
</tbody>
</table>

Respondent Level (N=2073), n (%) | Size          | Respondent Level (N= 2073), n (%) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>1697 (48.4)</td>
</tr>
<tr>
<td>Primarily</td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>63 (3.6)</td>
</tr>
<tr>
<td>Peds</td>
<td>1537 (83.3)</td>
</tr>
<tr>
<td>Birth</td>
<td>140 (8.1)</td>
</tr>
<tr>
<td>Typical Shift</td>
<td></td>
</tr>
<tr>
<td>Nights</td>
<td>602 (32.2)</td>
</tr>
<tr>
<td>Variable</td>
<td>293 (15.7)</td>
</tr>
<tr>
<td>Position</td>
<td></td>
</tr>
<tr>
<td>Attending physician</td>
<td>204 (10.0)</td>
</tr>
<tr>
<td>Fellow physician</td>
<td>31 (1.5)</td>
</tr>
<tr>
<td>Neonatal nurse practitioner</td>
<td>35 (1.7)</td>
</tr>
<tr>
<td>Registered nurse</td>
<td>1644 (7.1)</td>
</tr>
<tr>
<td>Respiratory therapist</td>
<td>286 (14.0)</td>
</tr>
<tr>
<td>Other</td>
<td>21 (1.0)</td>
</tr>
<tr>
<td>Years in specialty</td>
<td></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>20 (1.0)</td>
</tr>
<tr>
<td>6 – 11 months</td>
<td>27 (1.4)</td>
</tr>
<tr>
<td>1-2 years</td>
<td>74 (3.8)</td>
</tr>
<tr>
<td>3-4 years</td>
<td>192 (9.7)</td>
</tr>
<tr>
<td>5-10 years</td>
<td>476 (24.2)</td>
</tr>
<tr>
<td>11-20 years</td>
<td>538 (27.3)</td>
</tr>
<tr>
<td>21 years or more</td>
<td>643 (32.6)</td>
</tr>
</tbody>
</table>

VLBW infants (N = 4386), mean ±SD on n (%) |

| Gestational age at birth (weeks) | 28.3±2.9          |
| Birth weight, g                  | 1070±332          |
| Small for gestational age         | 42 (1.9%)         |
| Male sex                         | 2186 (40.8%)      |
| Five minute Appear score g        |                    |
| 0–6                              | 200 (4.4%)        |
| >6                               | 755 (17.2%)       |
| Iahem                            | 3418 (78.2%)      |
| Healthcare associated infection   | 3206 (74.3%)      |

Table 1. Description of survey respondents and clinical sample.

RESULTS

• Burnout prevalence varied significantly among NICUs (mean 25.2±10.1%, range 7.5% to 43.3%, F<0.001)
• Lower burnout prevalence was found among physicians (17.19% vs 28±11%, p<0.001), shift workers (25±4% vs 30.3%, p=0.03), and those with fewer years of service (16±6% in <3 years group vs 30±4% in >20 years group, p<0.001)
• Positive response to “I feel I am working too hard on my job” was associated with increased HAI with odds ratio 1.15 (95% CI 1.04-1.28, p<0.01)
• Overall prevalence of burnout did not correlate with HAI rates (R = -0.133, p=0.40)

METHODS

• Five minute Apgar score
• Small for gestational age
• Respiratory therapist (4d)
• Burnout prevalence varied significantly among NICUs (mean 25.2±10.1%, range 7.5% to 43.3%, F<0.001)
• Lower burnout prevalence was found among physicians (17.19% vs 28±11%, p<0.001), shift workers (25±4% vs 30.3%, p=0.03), and those with fewer years of service (16±6% in <3 years group vs 30±4% in >20 years group, p<0.001)
• Positive response to “I feel I am working too hard on my job” was associated with increased HAI with odds ratio 1.15 (95% CI 1.04-1.28, p<0.01)
• Overall prevalence of burnout did not correlate with HAI rates (R = -0.133, p=0.40)

LIMITATIONS

• Cross-sectional study, not able to determine causality
• Potential response biases at the NICU level and survey respondent level
• Significant association with HAI based on post-hoc analysis

CONCLUSIONS

• Burnout prevalence is variable, but overall high in California NICUs
• Physicians, night shift providers, and those with fewer years of experience report a greater prevalence of burnout in California NICUs
• Overall prevalence of burnout does not explain HAI rates in this cohort of VLBW infants, but feeling fatigued (p=0.09) and perceptions of working too hard (p=0.01) are associated with increased HAI in fixed effects models.

ACKNOWLEDGMENTS/FUNDING

• We would like to thank the NICU providers who participated by sharing their assessments
• Enlace Kennedy Shriver National Institute of Child Health and Human Development (5P01HD066790 Co-PIs: Profit, Sexton)
• Lucile Packard Children’s Hospital at Stanford, Division of Critical Care Medicine Research Fund
“It Sustains Me”: How Physicians Draw Satisfaction and Overcome Barriers in their Practices

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1Division of General Internal Medicine and Epidemiology Department of Medicine, UNC-Chapel Hill. 2Stanford University School of Medicine. 3Boston Children’s Hospital Institute for Professionalism & Ethical Practice, Harvard Medical School. 4Division of General Internal Medicine, Emory School of Medicine

Funding for this project was provided by the Arnold P. Gold Foundation

Objective
To understand motivating factors and barriers to faculty physicians’ humanistic practices.

Background
Major reorganizations in medical practice today influence physicians’ practices and challenge their ability to deliver compassionate care and remain resilient.

Methods
- Faculty graduates of a longitudinal faculty development program designed to encourage humanism wrote reflections in answer to two open-ended questions addressing their personal motivators and barriers to humanistic practice and teaching
- These faculty represented participants from 8 US Medical Schools and included 68 physicians, 55% female, 69% younger than age 45, 85% junior faculty, 71% of whom held leadership roles at their institutions.
- Questions were administered electronically to faculty participants and were analyzed for themes using the constant comparative method.

Results
The 68 study-physicians represented a 73% response rate (68 of 93 faculty enrollees)

Motivators for Humanistic Practice

<table>
<thead>
<tr>
<th>Theme</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification with humanistic values</td>
<td>“I saw myself as the kind of doctor who cared for patients, brought comfort to them, and was contributing to the good of the world.”</td>
</tr>
<tr>
<td>Providing care that they or the family would want</td>
<td>“Lying on a gurney traversing the very halls I had walked for decades was eye-opening… to feel firsthand what it is like to be vulnerable and scared.”</td>
</tr>
<tr>
<td>Connection to patients</td>
<td>“It fills me up instead of emptying me out; it sustains me.”</td>
</tr>
<tr>
<td>Passing on values through role modelling</td>
<td>“I am able to avoid “burn-out”, remain more connected to my patients, and enjoy teaching more when I approach these things from a humanistic place.”</td>
</tr>
<tr>
<td>Being in the moment</td>
<td>“If one believes that clinical care is of the utmost importance, as I do, then external issues go to the background and patients are treated with one’s full attention and the respect that they deserve”</td>
</tr>
</tbody>
</table>

Barriers to Humanistic Practice

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time, logistics, and structural limitations of practice</td>
<td>“The amount of work and pace that we have to function at along with the pressures that a primary care physician put on us creates an environment that fosters cynicism and anger.”</td>
</tr>
<tr>
<td>The hidden curriculum and its resultant culture</td>
<td>“I feel judged by administrators, pressure to accomplish as much as possible, have to hit the marks, others are not humanistic and have different expectations.”</td>
</tr>
<tr>
<td>Feeling drained by patients</td>
<td>“Having a lot of patients can also promote de-humanizing practices such as referring to patients by their diagnoses as a way to remember which patient the team is discussing.”</td>
</tr>
<tr>
<td>Epidemic burnout and discouragement</td>
<td>“Honestly, personal fatigue, feeling drained of my own spirit times and just not feeling like I have anything to give…”</td>
</tr>
</tbody>
</table>

Conclusions
- Respondents almost unanimously found their personal values and professional identities sustained them, whereas logistical, bureaucratic, cultural and resultant emotional stresses impeded them
- Mindfulness programs, relating to being in the moment, have been shown to help reduce physician stress and burnout.
- Administrators, physicians, and other professional caregivers should collaborate in pursuing practice organizations that support professional values and facilitate humanistic practices.

Limitations
Our convenience sample of especially humanistic physicians may not reflect the attitudes of physicians in general

References
Poster presentations

Monday, September 19, 2016

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.
ABSTRACT

Objective
Preventing clinician burnout is one of medicine’s biggest challenges; over half of front-line physicians report burnout, which predicts poor quality care, high turnover, and diminished physician wellbeing. We report on a promising intervention designed both to improve positive experiences at work and to prevent burnout.

Intervention
*Promoting engagement/preventing burnout (PE/PB)* is a small-group-based psychoeducational intervention delivered in six one-hour sessions. Didactic presentations introduce the concept of a range of functioning at work (from peak experiences to the low of burnout), recommend seeking three positive experiences to counterbalance each negative experience, and demonstrate evidence-based strategies to promote positive experiences and reduce negative experiences at work. Didactic presentations are combined with personal goal-setting and follow up, experiential exercises (to increase uptake) and discussion (to increase mutual support). *PE/PB* is appropriate for either intact or ad hoc training groups of physicians, within or across specialties, or for cross-functional clinician groups, and can be adapted in length as needed.

In this case, the program was integrated into a multi-step intervention in the Division of Palliative Care at Massachusetts General Hospital, who are committed to building sustainable work practices through structural adaptations and individual resiliency training.
Evaluation results
In a pre-post design, all eligible clinicians responded anonymously to psychometrically sound questionnaires regarding work engagement, stress, burnout, control, and other workplace demands and resources.

Self-reported control—i.e. sufficient autonomy and power to influence one’s experience at work—increased significantly over the intervention period.

Debriefing showed what resiliency training format participants found most helpful: skills-based training in the context of structured and positively focused collegial discussion. Resiliency tools participants found most helpful were those used for reflection and planning of personal change, for focusing on “things that energize me”/ “restorative pursuits”, and for “stepping away from the negative”.

LEARNING OBJECTIVES

In this poster you will learn:

1. FUNDAMENTAL CONCEPTS: what do clinicians need to know to understand their functioning at work and how to set effective targets for improved resiliency
2. RESILIENCY STRATEGIES: several evidence-based, teachable resiliency strategies
3. TRAINING PROCESS: use your group process to fully engage participants and promote skills adoption
4. OUR RESULTS: even in a very small group perceived control improved over the study period
5. ACTION RESEARCH: how to maximize buy-in and results by engaging a practice in evaluating their resiliency and planning interventions based on results
METHODS

Intervention:

*PE/PB* was one of 3 consecutive 6-hour training groups delivered in 1-hour sessions:

- **PE/PB**: CBT-based fundamentals for managing work environment and oneself plus specific resiliency strategies.
- **Balint group** (1): review of case experiences
- **Vicarious Trauma group** (2): vicarious trauma and self-care.

**PE/PB Fundamental Concepts:**

- We are capable of a wide range of functioning at work, from the high of *Flow* (3) or extreme *Engagement* (4) to the low of *Burnout* (5)
- Daily life is typically a mix of positive and negative experiences
- A minimum 3:1 ratio of positive: negative experiences will keep us well-functioning (6)
- Less than a 3:1 ratio puts us over the tipping point into chronic emergency functioning, and can:
  - damage our ability to connect to our patients and colleagues (7)
  - fatigue our ability to apply good clinical judgment (8)
  - diminish our physical and emotional health (9)
- We can improve our ratio by increasing positive experiences AND by decreasing negative experiences. Different strategies are used for each.
- We can improve our ratio most substantially by changing our work environments to match our motivations and stamina.
- Ultimately, it falls to the individual to manage their work experience so it is sustainable.
**PE/PB resiliency strategies:**

**INCREASE POSITIVE EXPERIENCES:**

- Planning experiences that naturally inspire positive emotions (10)  
  See e.g. [PositivityRatio.com](http://PositivityRatio.com)
- Practicing appreciative reflection, both solo (11) and in conversation (12)
- Mindfulness in various forms (13)  see e.g. [Buddhify2 app](http://Buddhify2.com)

**KEEP STRESS FROM ACCUMULATING:**

1. **Recognize your stress signals** *(when are you over your TIPPING POINT?)*  
   and embrace them *(they let you know it’s time to change course)*
2. **Set sustainable goals for your challenge level** over the course of the day:  
   Ideal: moderate challenge punctuated by recovery breaks
3. **Choose effective recovery strategies:**  
   stop using executive functioning and recover, with a mindful and/or physical activity
4. **Maintain a sustainable daily baseline**

**PE/PB group process:**

Didactic pedagogy results in limited practical uptake of the learning material. We aimed to improve learning using the group process in the following ways. Participants:

- discuss how they relate to fundamental concepts in their personal experience
- announce personal goals for increasing positive/reducing negative experiences
- Follow up on goal accomplishment to group
- Experience and practice resiliency strategies in group, with reflection

**Evaluation:**

Participants: All eligible clinicians with the MGH Division of Palliative Care (excluding the investigators) participated, in 3 cross-disciplinary groups of 5-7 clinicians. Each cycled through the 3 training group formats mentioned above (PE/PB, Balint group, Vicarious Trauma group).
Measures: Well-validated self-report questionnaires assessed: experiences of the workplace (Areas of Worklife Scale: AWS, 14) and personal experiences, both positive (Engagement: UWES-9, 15) and negative (Stress: PSS-10, 16, and Burnout: MBI-HSS, 17).

Design and analyses: All participants (N = 13) still with the Division at the conclusion of the intervention participated anonymously in a single-arm pre-test post-test study. Change in self-reports was assessed with matched-pair t-tests (statistical summary available on request).

Limits of the study:

We cannot reliably conclude that the intervention caused the changes we saw, because it was a single-arm design, participants were not blind to the intervention, and 3 interventions were evaluated simultaneously.

We cannot reliably generalize results, because this was a small group of specialized clinicians, working in unusually satisfying circumstances.

RESULTS

There was a significant improvement over the study period in AWS: Control, from average to superior, indicating greater participant satisfaction with being able to impact one’s working conditions. Anonymous debriefing sheds light on this finding. What participants found most helpful in the intervention were skills that improved their personal control:

- Reflection/understanding personal experience and planning change
- What is a sustainable level of arousal/need for recovery during the work day
- More focus on the things that energize me/step away from the negative
- Hearing stories from my colleagues

On other measures, participants reported without change over the study period an unusual combination of superior Engagement and satisfaction with working conditions (AWS) and worse than average Stress, Burnout: Emotional exhaustion, and satisfaction.

Statistical summary is available on request.
TAKE-AWAYs:

- PARTICIPANTS’ PERCEIVED CONTROL IMPROVED SIGNIFICANTLY, AS WE HOPED
- HIGH ENGAGEMENT and positive working conditions ALONE DON’T MITIGATE BURNOUT
- PE/PB SUPPORTED THE PRACTICE’S CHANGE PROCESS

In *Action research* (18) participants are not “blind” to the intervention, but are instead engaged in processing their experience of the intervention while it is ongoing. Participants also work together to analyze quantitative results, plan and implement next steps, and re-evaluate results.

The MGH Division of Palliative Care has a tradition of action research. Here, quantitative results (high stress and burnout and burdensome workload) validated the division’s anecdotal impressions which were already being addressed.

With the awareness that *Burnout: Emotional Exhaustion* is driven primarily by workload (19), changes were underway to improve volume and predictability of clinicians’ work hours.

It is worth noting that subsequent to these changes, problematic scores (*Burnout: Emotional Exhaustion, Stress*, and *AWS: Workload*) had normalized by 5 months after post-test, and maintained in the normal range at 15 months after post-test.

*PE/PB* concepts were incorporated into the ongoing change process, and provided a common framework and language (with concepts like “tipping point” and “3:1 ratio”).

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(2) Vicarious traumatization group: psychoeducational group developed and delivered by Mary Susan Convery MSW: [mconvery@partners.org](mailto:mconvery@partners.org)


(6) Fredrickson B: *Positivity: top notch research reveals the 3 to 1 ratio that will change your life*, 2009. [http://www.unc.edu/peplab/home.html](http://www.unc.edu/peplab/home.html)


(10) Fredrickson B: *Positivity: top notch research reveals the 3 to 1 ratio that will change your life*, 2009. See e.g. PositivityRatio.com


### Abstract

In 2005, we initiated a program to improve medical staff culture in a regional community healthcare system. In compliance with JCAHO standards, we created a Medical Staff Well-Being Program. The program has seen a primary goal of improving physician and patient satisfaction, reducing levels of dissatisfaction and medical staff turnover since the inception of the program. By crafting activities and practices that would facilitate a cultural transformation, tangible changes have occurred as we evaluate evidence of medical staff engagement. With the assistance of the Medical Staff Exchange Board, physicians and other health care providers.

### Health Promotion Activities Include:

- **Medical Staff Exchange Board in the Physician’s Lounge at Utah Valley Hospital**
- **Consult Physician**
- **Evaluate**
- **Medical Staff Well-Being Director**
- **Medical Staff Well-Being Program**
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De-stigmatizing Mental Illness in Medical School Through the Use of Peer/Mentor Messaging

Ian Gallant, MD Candidate 2018, Stephen Darcy, MD, Heather Flynn, MD
Faculty of Medicine, Memorial University of Newfoundland, Canada

Learning Objectives
1. Appreciate an overview of burnout and mental health issues in medical trainees and practicing physicians.
2. Discuss the barriers that limit help-seeking by medical trainees and practicing physicians and illustrate one novel method to potentially overcome these barriers.
3. Discuss ways in which we can help to mentor a change in the culture of medicine to become more open and supportive of help-seeking.

Context
Medical education can be a stressful experience for medical students as they must alter their lifestyle and make many changes throughout the course of their education. Stressful transitional points throughout medical school, along with a heavy burden of academic material and less time for leisure activities can lead to burnout, distress, and/or mental health issues.

Medical students have been found to experience higher levels of mental health issues than the general population and peers their own age, with as many as 40% of medical students experiencing depression or anxiety [1]. High levels of emotional exhaustion [2] and burnout [3] have also been observed in over half of the medical student population. Students at the beginning of their medical training actually have better mental health profiles compared to their peers outside of medicine [4]. However, as they progress through their education and training, medical students’ mental health profiles deteriorate to become worse than their peers. The final year of medical school has shown to have the greatest prevalence of both depression and anxiety [5].

Mental health issues and distress in medical students results in a range of symptoms, including insomnia, fatigue, loss of appetite, physical pain, and increased conflict with family and friends [6]. Accompanying the high rate of mental health issues is a markedly elevated suicide risk, with 11.2% of medical students in a single study reporting suicide ideation over a one year period [3].

Various interventions have been implemented in a number of medical schools and their curricula to address academic related issues of distress. However, a profound stigma of mental health issues remains in the culture of medicine. For medical students experiencing burnout, the primary barrier for not seeking help is perceived stigma [7].

Purpose
The purpose of this project is to increase awareness of the mental health issues commonly experienced by medical students, to de-stigmatize these issues and to encourage an open and supportive culture of help-seeking. These goals will be accomplished through the delivery of short video, showcasing local faculty, physicians, and students at a medical school displaying brief messages on poster cards that exemplify the mental health issues experienced by medical students along with supportive messages.

Project Design

Literature Review
A review of relevant literature was conducted by searching the online databases PubMed and Google Scholar with the following search terms: (medical student), (medical resident), (physician), (doctor), (mental illness), (depression), (anxiety), (suicide), and (burnout). Articles included were those that generated quantitative data by studying a research question, were published in a peer reviewed journal, and were written in English.

Selected articles were reviewed for salient content that pertained to the purpose of this project (increasing awareness, de-stigmatizing, and encouraging an open and supportive culture of help-seeking).

Messages
Content generated from the literature review was discussed and selected by the authors as relating to the purpose of this project. Additional narrative style messages were created by the authors and incorporated with the content from the literature review. The end result was a script composed of peer-reviewed literature and personal narrative that the authors agreed supported the purpose of this project.

Recruitment of Physicians and Peers
In total, approximately 70 individual messages were created. Multiple approaches were used to recruit local faculty, physicians, and peers (medical trainees) to be filmed holding these message cards. Approaches included attending various specialty hospital rounds, faculty meetings, and individual scheduling. All participants signed a release consenting to the use of their content for the video.

Filming and Production
A professional videographer was hired to film participants in various locations holding a card with one of the messages written. No audio of the participants was recorded. A local singer/songwriter was hired to write lyrics, compose and professionally record music to support the theme of this project. The final project will be professionally edited and produced.

Outcomes
All 70 message cards were filmed with a faculty member, physician, and/or medical trainee participating. We were able to obtain a diverse representation of physicians from family medicine and various specialties. Having the individuals responsible for teaching and mentoring students deliver the messages will hopefully empower students to reach out to them if/when they feel the need to talk about their own mental health. Our best effort was made to film the participants in their respective areas of practice in order to make the themes from the video identifiable and relatable to any viewer.

All participants were provided with the full script of messages to read through and select a message they felt comfortable holding for the film. Anecdotal comments made by participants to the authors during filming were generally supportive to the purpose of the project. Comments were made in relation to having personally struggled with issues of work-life balance, acknowledging the stress of medical training and practice, recognizing the importance of spreading information about the occurrence of burnout and mental illness, and advocating for those that could benefit from help to access services.

Conclusion
The next phase of this project will assess the level of self-stigma to mental health issues among medical students before and after a viewing of the video.

“REACH OUT: REDucing stigma Can Help OUT stress in medical students” has already received funding from an internal competition at Memorial University of Newfoundland. The study will seek to answer two questions:

1. What is the current level of stigma towards mental illness among peers within the medical school environment?
2. Is the video an effective tool that can measurably decrease the amount of stigma that medical students have towards mental illness among peers within medical school?

Two previously validated scales will be used to measure levels of stigma. These are the Self-Stigma of Seeking Help Scale (SSOSH) and Perceptions of Stigmatization by Others of Seeking Help (PSSOH) [8,9]. These scales will be administered to a class of medical students followed by a viewing of the video. Repeat measurement of stigma using the same scales will be done at 30 and 120 days after viewing the video to look for the presence and duration of an effect.

References
A Happy ‘Marriage’: How Administrative Leadership Can Support Joy in Physician Hospital Practice

Miranda Germani^1,2 and Dick Zoutman, MD, FRCPC^1,3
^1Quinte Health Care  ^2London School of Economics  ^3Queen’s University

CONTEXT
Like many jurisdictions, Ontario, Canada is facing rising health care costs, long wait times, and issues with access to primary care and some specialists: alongside this, physician health and burnout is seen as a concern. 300 physicians practice at Quinte Health Care’s (QHC) 4 hospitals in Ontario.

LEARNING OBJECTIVES
Participants will be able to:
• Understand the proposed conceptual framework for joy in physician hospital practice
• Know best practices to support joy in physician hospital practice
• Tailor and apply tactics to their work environment to increase joy

METHODS
The experiences of Quinte Health Care from 2012 to 2016 are used as a case study. Over this period, six physician surveys were done that included consistent measures of physician engagement components.

APPROACH USED TO TRY TO SUPPORT JOY IN PRACTICE
Quinte Health Care has increased strategic medical affairs and tried to support joy in practice through:
• New Chief of Staff and new role of Medical Affairs Coordinator
• Increased physician communications, including over 60 editions of well-received newsletter
• Physician portal including online privileges renewals and schedules
• Physician recruitment successes
• Increased continuing professional development, including twice yearly leadership development and wellness weekend
• Education on disruptive behaviour and new Code of Conduct
• Quality improvement coach, education, and events
• New medical leadership model, combining Department Chief and Program Medical Director roles for clarity and depth (in progress)

RESULTS
Quinte Health Care experienced a prolonged period of change, including year on year funding gaps of up to $12 million annually (about 10% of the hospital budget) over the study period. Nevertheless, findings indicate that physician engagement can be maintained and even increased during a challenging period, with physician engagement in September 2015 scored as 87% positive.

CONCLUSION
The results confirm that despite the current context of challenges with scarce financial resources, hospitals’ administrative leadership can support joy in physicians’ hospital practice through strategic medical affairs.

“Working on physician engagement with only physicians at the table is like marriage counseling with just one partner attending - physicians and administration must work together.” - QHC physician

ACKNOWLEDGEMENTS
With thanks to the physicians who make Quinte Health Care an inspiring place to work; Susan Rowe; and the London School of Economics’ Health Economics, Policy and Management MSc program.

CONTACT
Miranda Germani, Medical Affairs Coordinator mgermani@qhc.on.ca
Dr. Dick Zoutman, Chief of Staff stoutman@dickzoutman.com
Abstract:
Some of the leading organizations and systems, both internationally and in the USA, are prioritizing compassion as a core tenet of care delivery and also as a mechanism to mitigate employee burnout. A successful program addressing workforce well-being must be comprehensive and system/organization-wide, similar to successful patient safety, CPI and LEAN initiatives. We propose a practical paradigm that health care leaders can implement in their organizations; a model designed to address the interrelationships between building provider resilience (the individual); nourishing caregiver-to-caregiver compassion (the team); and embedding organization-wide initiatives that support workforce well-being (organizational leadership).

Learning Objectives:
1. Appreciate why health care organizations are prioritizing compassion as a core tenet of care delivery and as a mechanism to mitigate workforce burnout.
2. Understand the interrelationships between building individual resilience, nourishing caregiver-to-caregiver compassion, and embedding organization-wide initiatives that support workforce well-being.
3. Have knowledge of the portfolio of programs contained in a compassionate care anti-burnout toolbox.

Methods:
The contents of a Compassionate Care Anti-Burnout Toolbox include tools for:
1. The Individual:
   - Develop individual resilience with programs that, while easy to teach, are insufficient to withstand an unsupportive organizational milieu; teach communication skills and behaviors that promote caregiver-to-patient compassion.
2. The Team:
   - Nourish caregiver-to-caregiver compassion by scheduling time for open and honest discussion of social and emotional issues that arise in caring for patients.
3. Organizational Leadership:
   - Driving change through organizational leadership begins with making compassion a core value, articulating it, and establishing metrics. A culture of compassion requires programs and policies implemented by the organization itself.

Results:
Examples of Compassionate Care Anti-Burnout Tools:
1. For The Individual:
   - A. Building resilience with Mindfulness; Meditation; Gratitude Journal; Three Good Things (Duke University Health System); Yoga; attention to work-life balance
2. For The Team:
   - A. Schwartz Center Rounds; Tea for the Soul; RISE: Resiliency in Stressful Events (Johns Hopkins University & Health System)
3. For Organizational Leadership:
   - A. Screening the workforce for burnout
   - B. Managing the consequences of adverse events
   - C. Designing systems and infrastructure with the compassionate caregiver in mind
   - D. Preserving work control autonomy of physicians and nurses in clinical settings
   - E. Recognizing and rewarding compassionate, collaborative care

Conclusions:
For every caregiver-patient interaction to be compassionate, the organization must provide the programs and resources that support a culture of compassionate care. The well-being of the workforce drives both patient experience and patient outcomes.
Abstract

- Burnout is widespread among physicians and appears to be increasing in recent years.
- While contemplative practices, such as mindfulness meditation, are beneficial, available programs are inaccessible or unattractive to many physicians because of the lengthy time, travel, and formal meditation practice involved.
- Compassion training holds promise for improving physicians well-being by reducing empathic burnout and increasing self-compassion.
- We developed a program for physician well-being centered on:
  - compassion training, emphasizing self-compassion, and
  - convenience for physicians.

Goals/Objectives

- To recognize that self-compassion training has been shown to improve life satisfaction and decrease anxiety, depression, and stress.
- To be able to describe key components of a successful brief compassion training program for physician well-being, including obstacles to implementation.

Methods

Participants: Physicians (n = 26, 81% women) were enrolled as pre-existing group from 5 primary care clinics in Santa Clara County, CA.

Program:
- A 45-minute orientation was followed by 8 weekly 30-minute sessions.
- Weekly sessions taught 6 compassion skills. Each skill was presented as a 7-10 minute guided exercise and then repeated as a condensed 3-minute exercise to reduce the time needed to access the target effects.
- Exercises were distilled into “Compassion Cards” designed as visual triggers. Online recordings of the sessions were also available.
- 2 sessions were devoted to feedback from participants as research partners to suggest modifications and improvements to the program.

Findings/Results

- 23 of 26 physicians completed the program and post-training survey.
  - Overall attendance was 75% (in person or by phone).
  - Statistically significant increases were observed in medium difference (MD) before and after training for:
    - Self-compassion (self-kindness) (MD = 1, p = 0.002)
    - Self-efficacy for mindful breathing (MD = 1, p = 0.005); recognizing common humanity (MD = 1, p = 0.005); and evoking self-compassion (MD = 1, p = 0.002)
  - Participants liked the convenience and brevity of the training, and particularly valued self-compassion as a way to improve their well-being.
- Challenges encountered included:
  - Participants liked the convenience and brevity of the training, and particularly valued self-compassion as a way to improve their well-being.
- Challenges encountered included:
  - Limited time for review and discussion within training sessions.
  - Study Analyses: Included: small sample size; single trainer; variations in the delivery schedule; modifications to the program during the study.

Conclusions

- While contemplative practices, such as mindfulness meditation, are beneficial, available programs are inaccessible or unattractive to many physicians because of the lengthy time, travel, and formal meditation practice involved.
- Compassion training holds promise for improving physicians well-being by reducing empathic burnout and increasing self-compassion.
- While contemplative practices, such as mindfulness meditation, are beneficial, available programs are inaccessible or unattractive to many physicians because of the lengthy time, travel, and formal meditation practice involved.
- Compassion training holds promise for improving physicians well-being by reducing empathic burnout and increasing self-compassion.
Introduction

Decreased professional and personal joy in medical students and residents is evident by increased burnout and secondary traumatic stress (1). Research conducted at our institution on medical students, residents, and advanced practice providers consistently detected an association between increased self-compassion and decreased burnout and secondary traumatic stress (2). To address this phenomenon we developed a longitudinal curriculum to foster self-compassion in third-year medical students.

Approach

During the 2014-2015 academic year, we introduced a pilot longitudinal curriculum to 105 third-year Wayne State University, School of Medicine medical students based at Henry Ford Health System. The pilot consisted of seven 2-hour sessions based on the grounding-recall-attune-consider-engage (GRACE) model developed by Joan Halifax (4). The introductory session on “Fear and Intimidation in Medicine” introduced the conceptual model. The themes of the subsequent sessions were: G: Grounding to the present moment; R: Recall values, intention, motivation and expectations; A: Attune to self, how and what am I feeling at this time and Attune to others, how and what are others feeling at this time; C: Consider, utilizing wisdom and insight for what actions might be needed and; E: Engage.

Findings

Of 105 participants, 75 (71%) completed the post-course survey (Table 1). Of questions pertaining to treatment for burnout, the majority of respondents perceived meditation to be the least helpful. The overall consistent result was that the students perceived the course as invaluable during their first clinical year and that skills taught during the course would be beneficial throughout their professional journey.

Learning Objectives

• Understand the need for teaching self-compassion to medical students, residents, and physicians.
• Recognize the relationship between low self-compassion and burnout.
• Recognize that self-compassion, compassion, and empathy are teachable.

Pilot Curriculum

Table 1: Post-Course Survey Results

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<th>Question</th>
<th>Yes</th>
<th>Ambivalent</th>
<th>No</th>
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<tr>
<td>Were you satisfied with the course content?</td>
<td>96%</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>Would you recommend continuing these sessions next year?</td>
<td>93%</td>
<td>7%</td>
<td>0</td>
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<td>Were you able to integrate any of the practices into your life?</td>
<td>85%</td>
<td>15%</td>
<td>0</td>
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Conclusion

Burnout is simply a form of suffering. The antidote to suffering is compassion. Teaching self-compassion and practice of self-compassion is a way not only to prevent burnout but also to alleviate it once it occurs.

References

METHODS

BACKGROUND

We defined Data Synthesis & Analysis:

• Using the World Health Organization’s (WHO) (1948) definition of health as our

examine the extent to which existing definitions and measures address the

1.

relating to (a) physicians’ sense of purpose, meaning, calling, balance, and/or

order” constructs representing degree of wellness achieved across multiple

domains (mental, social, physical, work, general-life). Includes constructs relating to (a) physicians’ sense of purpose, meaning, calling, balance, and/or spirituality in life/work and/or (b) a sense of overall well-being (quality of life).

RESEARCH AIMS

Using the World Health Organization’s (WHO) (1948) definition of health as our overarching framework, we aimed to:

1. characterize the conceptualization and measurement of physician wellness in the literature;

2. examine the extent to which existing definitions and measures address the multidimensional nature of the construct;

3. explore inferred changes in the conceptualization of physician wellness over time.

METHODS

• Search Strategy & Inclusion Criteria: We systematically reviewed literature (from 1989 to 2015) for articles focused on quantitatively assessing “wellness” or “well-being” in a physician population (including residents, fellows, or interns).

• Data Extraction: We extracted (1) and how the authors defined physician wellness; and (2) related scale domains, sub-domains, and instruments used to assess physician wellness.

• Data Synthesis & Analysis: we (1) thematically synthesized physician wellness definitions; (2) classified extracted measures by their primary measurement attributes: (a) the primary wellness dimension the measure aimed to assess (4 categories: mental, physical, social, or “integrated” well-being); (b) the number of the measure (3 categories: positive, negative, or other); and (c) the primary context to which the measure related (2 categories: work-specific or general-life specific); and (2) performed Pearson’s chi-squared and 2-sided Fisher’s exact tests of independence to test for significant changes in the proportion of papers that operationalized physician wellness using >1 measure(s) classified within each of the 24 binary measurement attributes across papers published in early (1989-2009) vs recent years (2010-2015) (p<0.05).

• We defined “integrated well-being” as comprising hypothesized “higher-order” constructs representing degree of wellness achieved across multiple domains (mental, social, physical, work, general-life). Includes constructs relating to (a) physicians’ sense of purpose, meaning, calling, balance, and/or spirituality in life/work and/or (b) a sense of overall well-being (quality of life).

RESULTS

Figure 1. PRISMA Flow Diagram

Figure 2. Proportion of included studies with wellness definitions

Figure 3. Proportion of included papers (n=78) operationalizing physician wellness with >1 measure within each well-being dimension

CONCLUSIONS

Elevating physician wellness research to a matter of health policy and requiring systematic measurements and interventions at institutional, national, and global levels depends on a strong base of high quality research. The quality of empirical research on physician wellness depends on the conceptual clarity with which the construct of physician well-being is defined. Without conceptual differentiation of the component constructs, future physician wellness research compromises the interpretability, content validity, and comparability of findings.

Explicit definitions of physician wellness reveal a multifaceted conceptualization of the construct. Yet, despite a significant increase in the proportion of papers that have used integrated well-being measures in recent (2010-2015) versus early (1989-2009) years, the characterization of physician wellness through measurements of negative effects has remained a dominant trend over time.

Our findings emphasize the need for a single, holistic conceptualization of physician wellness to guide future measurement and intervention. Failure to develop and apply a multifaceted conceptually defined measure of physician well-being will continue to undermine the assessment of physician wellness, a limited assessment focused on measurements of burnout inaccurately implies the absence of burnout equals to wellness.

Based on our review, we propose the following integrative definition as a starting point: Physician wellness is defined by quality of life, which includes the absence of illness (physical/psychological) and the presence of a positive physical, mental (subjective, emotional, and psychological), social, and work environment (broadly defined).

The conceptualization of physician wellness is a complex construct with potentially far-reaching implications for the physical, mental, and social well-being of physicians and patients, including those patients who experience physicians’ own distress.

Acknowledgements

The authors would like to thank Davis L. Simon for his assistance with data management.

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How do clinicians manage emotions during difficult healthcare conversations? Implications for training

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Abstract
This study aimed to examine the existing strategies used by interprofessional clinicians to manage their own emotions when holding difficult healthcare conversations with patients and families.

Learning Objectives
1. Understand more about the strategies that clinicians currently employ to manage their emotions before, during, and after difficult conversations.
2. Reflect on ways that this understanding can inform educational interventions to enhance emotion management.
3. Reflect on the resonance our findings have for clinicians in terms of supporting their own well-being and satisfaction in work during its most stressful moments.

Methods
- 126 interprofessional participants (83 females, 40 males) were recruited from six PERCS workshops from fall 2013 to spring 2014. Participants’ self-reported race/ethnicities were as follows: 87 (69%) White, 19 (15%) Hispanic, 9 (7%) Asian, 1 (1%) African American, and 7 (6%) other*. Participants’ professions and work experiences are described in Table 1.
- Participants completed pre-questionnaires that included the following open-ended question: Please share what strategies/approaches/advice you use, if any, to help manage your own emotions when having difficult healthcare conversations.
- Qualitative content analysis was used to determine primary types of strategies.

*3 (2%) respondents did not indicate their race or sex

Table 1: Professions and Work Experience (n = 126)

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<td>Physicians</td>
<td>53</td>
<td>42%</td>
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<tr>
<td>Nurses</td>
<td>36</td>
<td>29%</td>
</tr>
<tr>
<td>Medical Interpreters</td>
<td>20</td>
<td>16%</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>12</td>
<td>9%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Experience</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 6 years</td>
<td>54</td>
<td>43%</td>
</tr>
<tr>
<td>6-10 years</td>
<td>30</td>
<td>24%</td>
</tr>
<tr>
<td>11-20 years</td>
<td>21</td>
<td>17%</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>20</td>
<td>16%</td>
</tr>
</tbody>
</table>

Results

Table 2: Primary Strategies Identified
The strategies are presented in order from most commonly reported to least.

<table>
<thead>
<tr>
<th>Primary Strategies</th>
<th>Illustrative Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Care</td>
<td>• Deep breaths, lipstick and courage! (nurse)</td>
</tr>
<tr>
<td>• Practical techniques</td>
<td>• Find an outlet to vent with others. Find destressors afterwards: exercise, writing, yaga. (social worker)</td>
</tr>
<tr>
<td>• Activities</td>
<td>• I try to first acknowledge my feelings about the situation. (physician)</td>
</tr>
<tr>
<td>• Recognize the importance of one’s own emotions</td>
<td></td>
</tr>
<tr>
<td>Preparatory and Relational Skills</td>
<td>• Anticipate and plan thoughts ahead of discussion. (physician)</td>
</tr>
<tr>
<td>• Consider and rehearse conversations, anticipate the family’s needs</td>
<td>• Speaking as slowly and calmly as possible; gauging the situation to see what the best approach would be. (medical interpreter)</td>
</tr>
<tr>
<td>• Review of conversational approaches</td>
<td>• Listening to the families closely rather than always filling the quiet pauses. (nurse)</td>
</tr>
<tr>
<td>Empathetic Presence</td>
<td>• Try to have a good understanding of the family’s experience thus far in their healthcare journey. (nurse)</td>
</tr>
<tr>
<td>• Keep focus on the family and their needs</td>
<td>• Put yourself in their shoes. Empathy. (physician)</td>
</tr>
<tr>
<td>Team Approach</td>
<td>• Give news with team of people available to answer questions. (physician)</td>
</tr>
<tr>
<td>• Engage in conversations as a team</td>
<td>• Talking to other staff members who understand what you are going through. (nurse)</td>
</tr>
<tr>
<td>• Utilize colleagues as a support network</td>
<td>• Talk with other health care professionals/mentors. (physician)</td>
</tr>
<tr>
<td>• Seek advice from more experienced peers/mentors</td>
<td></td>
</tr>
<tr>
<td>Professional Identity</td>
<td>• Being true to who I am as a nurse. (nurse)</td>
</tr>
<tr>
<td>• Remain mindful of professional role, as well as the values and limitations of the profession</td>
<td>• Remind myself of my role; separate emotion from responsibility. (physician)</td>
</tr>
<tr>
<td>• Separate one’s professional-self from one’s personal-self</td>
<td>• Leave my work problems at work. (nurse)</td>
</tr>
</tbody>
</table>

Conclusion
• Across disciplines and years of experience, clinicians reported a similar range of strategies for managing emotions when holding difficult healthcare conversations. The findings from this study can inform the development and refinement of educational initiatives to support clinicians’ awareness of and skills for effective emotional management.
• Improvement of how clinicians manage their emotions when holding difficult healthcare conversations has the potential to enhance their confidence and capability when engaging in these critical conversations with patients and their families.

References

For more information, please visit: www.ipepweb.org
INTRODUCTION

• Increased demands on physicians without additional physician support and control can
  • Lead to burnout thus negatively affecting work performance and culture
  • Decrease system value by increasing costs: increased turnover, increased patient errors, and decreased patient satisfaction.
• In the setting of rapid growth, UCLA Hospitalists are facing increased demands; informal conversations suggest increased stress, possible burnout, and decrease in well-being within the group thus necessitating formal assessment and interventions.

CURRENT SITUATION 2014

• Expansion of hospitalist group: Valley, Bay, SNFs
• Drive to increase RVUs within the group
• No formal, centralized mechanism for leadership to assess group well-being, burnout
• No national survey for Hospitalist Well-being
• No attending-level Balint groups at UCLA
• Finding Meaning in Medicine groups at SM–UCLA

ANALYSIS & TIMELINE 2014

• Spring: Study physician well-being
  • Connected with experts in the field
  • Researched various surveys on well-being
• Summer: Development of UCLA Hospitalists Wellness Committee
• Fall: Introduction of Well-being Survey
  • To assess baseline data
  • Identify root causes of any discontent
  • Identify areas of intervention
• Winter: Sharing of results with group
  • Mentoring
  • Feedback
  • Coping

PLAN, TIMING, COSTS: Interventions Winter 2015–Now

• Monthly Hospitalists Wellness Committee meetings
  • Better Know A Hospitalist
  • Recognition of service, milestones, achievements
• Restructuring of weekly Hospitalist meetings
  • Creation of Support the Doc series
  • Encourage attendance at Schwartz Centre Rounds
  • Balint Group pilot
• Initiating Exit interviews, surveys
• Change in terminology: Non–teaching to Direct Care
• Promotion of available resources
• Engagement tab on UCLA Hospitalist website
• Continue to work with Medical Staff Health Committee

BENEFITS/EXPECTED OUTCOME

• Improved, enhanced relationships within the group: increased morale, resilience, engagement, efficiency & productivity
• Decreased burnout, Increased well-being
• Decreased turnover
• Hospitalists become leaders in coping with change within the system
• Decreased costs
• Increased patient satisfaction

OPEN ISSUES

• Changes in health care affect all providers
• On–boarding, incorporation of culture change
• Change, even positive, takes time
• Resources: funding, space
• Balancing Demands with Support & Control
• Further assessment of schedule enhancement
• Institutional support
• Transition to SHM Engagement Survey
• Creation of webinar with SHM
Burnout Syndrome in interns and residents: prevalence and risk factors after spring revolution

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(2)Ben Arous Regional Hospital, Internal Medicine Department, 2096, Ben Arous, Tunisia
(3) Mongi Slim Hospital, Psychiatry department, 2046, La Marsa, Tunisia
(4) Mongi Slim Hospital, Internal Medicine department, 2046, La Marsa, Tunisia

Abstract
Burnout syndrome is a response to a chronic stress within workplace characterized by emotional exhaustion, depersonalisation and low personal achievement. This study aimed to estimate the prevalence of burnout in interns and residents and study associated factors in both populations. A survey was sent to all residents and all interns within the medical school of Tunis. An anonymous survey was sent to 1,567 junior doctors. The level of burnout was assessed using the “Maslach Burnout Inventory”. The response ratio was 89%. A high level of burnout was observed in 24.6% of all junior doctors, 58.7% of interns and 54.4% of residents had a high level of emotional exhaustion, 45.9% of interns and 54.9% of residents experienced high level of depersonalisation, 36.2% of interns and 25.4% of residents had a low level of personal achievement. Risk factors in our study were related to organizational factors and workload.

Results
Burnout percentage in interns and residents: prevalence and risk factors after spring revolution

M.Rmouri1,2, M.Abdallah1,2, R.Rafrafi1,3, A.Harmel4, S.Mrad1,4

Figure 1: Response rate

Figure 2: Response rate

Figure 3: Demographic characteristics

Figure 4: Heatmap

Table 1: Mean scores in interns and residents

Table 2: Mean scores in interns and residents

Figure 5: Frequency of burnout in all of the population of interns and residents

Figure 6: Comparison of burnout between interns and residents

Table 3: Factors associated with severe burnout in interns and residents

Conclusions
Burnout syndrome is an emerging social and public health problem in general population and in physicians.
If it is more pronounced when it comes to doctors since it can affect the patient's safety and the quality of health care.
The definition of burnout is still controversial.
The EBI is the most common scale, yet, the cut-offs are different from study to study depending on the country of the study.
This study is the first in Tunisia with a large number of junior doctors (interns and residents) and covering all specialties available in Tunisia.
Among the limits of this study is the fact that it was performed after 2011 while there were social and political issues that may have influenced the findings.
This cross-sectional study is a pilot study in Tunisia to a prospective one for better knowledge of risk factors of burnout and its causes and evaluate preventive measures.
Conclusions

1. Understand the strong association between sleep-related impairment and burnout.
2. Determine that interventions to reduce burnout among fellows should focus on:
   - Increasing mindfulness, increasing a sense of support and appreciation and reducing sleep-related impairment.

Learning Objectives

1. Understand the high prevalence of burnout among fellows.
2. Understand the strong association between sleep-related impairment and burnout and that mindfulness is protective against burnout.
3. Determine that interventions to reduce burnout among fellows should focus on increasing mindfulness, increasing support and appreciation and reducing sleep-related impairment.

Methods

A Faculty Wellness survey was adapted and administered electronically to all Pediatric Subspecialty Fellows at Stanford Children’s Health (n=95). A Faculty Wellness survey was adapted and administered electronically to all Pediatric Subspecialty Fellows at Stanford Children’s Health (n=95). A Faculty Wellness survey was adapted and administered electronically to all Pediatric Subspecialty Fellows at Stanford Children’s Health (n=95). A Faculty Wellness survey was adapted and administered electronically to all Pediatric Subspecialty Fellows at Stanford Children’s Health (n=95).

Data was collected via Qualtrics and de-identified for statistical analysis.

Linear and Logistic regression analysis were used to determine predictors of:
- Professional Fulfillment
- Burnout

Predictors of Professional Fulfillment

- Predictors of Burnout

Survey Scale:
- Sleep Impairment
- Perceived Appreciation
- Meaningfulness
- Mindfulness
- Low focus
- Depersonalization

Project approved by the Stanford Institutional Review Board.

Next Steps – Multifaceted Approach

Performing an educational intervention that addresses sleep related impairment specifically.

The intervention will be to an “opt in” program open to all pediatric subspecialty fellows at Stanford.

The intervention will address sleep and nutritional knowledge and practices as they related to sleep related impairment.

Evaluating of fellows knowledge and behaviors before and after the intervention.

Selected References

5. E. S., Morf, M., Krista, JN., Cho, D., Girard, DD. “If you build it, they will come”: attitudes of medical residents and fellows about seeking services in a resident wellness program. J Grad Med Educ; 2013;5:488-92.

Acknowledgement

Thank you to the Stanford Physician Wellness Committee for its commitment to training physicians.

Project supported by small grant provided by Will’s Way Foundation.
Humanizing Medicine through Attention to Values: A Framework for Implementation

Elizabeth A. Rider, MSW, MD1,2; Suzanne Kurtz, PhD3,4; Diana Slade, PhD5; William T. Branch, Jr., MD6; E. Angela Chan, PhD, RN7; H. Esterbroot Longmaid III, MD8; Dorothy Jones, BMBS, Dip RACOG9; Phillip Della, RN, PhD, FACC8

Roger Dunston PhD, Jack Pun Kwok Hung, BSc (Hons), MA10; Christian MIM Mattheissen, PhD

1- Harvard Medical School, Boston, MA, USA; 2 - Boston Children’s Hospital, Boston, MA, USA; 3 - College of Veterinary Medicine, Washington State University, Pullman, WA, USA; 4- University of Calgary (Emerita), AB Canada; 5- University of Technology Sydney, New South Wales, Australia; 6- Emory University School of Medicine, Atlanta, GA, USA; 7- The Hong Kong Polytechnic University, Kowloon, Hong Kong; 8- Beth Israel Deaconess Hospital-Milton, Milton, MA, USA; 9- Curtin University, Western Australia; 10- Oxford University, United Kingdom. All authors are founding members of the International Research Centre for Communication in Healthcare (IRCCH).

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Context / Background

Attention to core values and skilled communication are necessary for safe, compassionate care environments, and they underpin all relationships within healthcare settings. Initiated in 2011 by the International Charter for Human Values in Healthcare (the Charter) — the result of a global interprofessional effort to identify core values — provides a framework of core values fundamental to all healthcare interactions.

Learning Objectives

1. Explore the importance of attention to core values and effective communication in all healthcare relationships
2. Become familiar with a new framework, the International Charter for Human Values in Healthcare that can be used to inform practice, training, research, and organizational change efforts
3. Identify strategies to embed core values in healthcare education and practice and consider ways these may promote well-being, professional satisfaction and joy.

Description of Innovation / Approach

An international, interprofessional collaborative of clinicians, researchers, educators, communication specialists and linguists collected and analyzed data from multiple groups and used combined qualitative research methods to identify five categories of core values — Compassion, Respect for Persons, Commitment to Integrity and Ethical Practice, Commitment to Excellence, and Justice in Healthcare — that should be present in every healthcare interaction.1 The resulting International Charter for Human Values in Healthcare,2 an initiative of the International Research Centre for Communication in Healthcare (IRCCH)3, has partners in Hong Kong, Australia, Brazil, the Netherlands, New Zealand, United Kingdom, Uganda, and the United States. The Charter works closely with Charter for Compassion International. IRCCH recently became the Asia-Pacific Healthcare Hub of Charter for Compassion International.

Results / Impact

The Charter’s framework has been used to explore, identify and incorporate values into the curricula of a number of courses, including interprofessional, faculty development, specialty, and clinical training programs. Training and curricular modules have been developed. Strategies for explicitly teaching values have included: appreciative inquiry, use of narrative, reflective exercises, small group work, discussion and others. We continue to work collaboratively and internationally to translate values into action in healthcare settings.

Conclusion

The International Charter for Human Values in Healthcare, developed from an interprofessional, global collaboration, provides a strategy and framework to restore the primacy of human values necessary for practicing compassionate, ethical, and safe healthcare. Values articulated in the Charter inform ongoing and evolving projects and programs in clinical care, training, research, and organizational culture change.

References

3. The International Research Centre for Communication in Healthcare (IRCCH). The Hong Kong Polytechnic University and University of Technology Sydney, Australia. 2013. Available at http://irchc.org

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Care for the Caregiver: Utilization of a Clinician Peer Support Program at an Academic Medical Center

Novneet N. Sahu MD, Christy L. Pool RN BSN, Heather Farley MD
Christiana Care Health System, Newark, DE

RESULTS

Characteristics of 99 Peer Support Encounters:

<table>
<thead>
<tr>
<th>Clinician Involved</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Physician</td>
<td>24</td>
</tr>
<tr>
<td>Resident Physician</td>
<td>12</td>
</tr>
<tr>
<td>Nurse, Practitioner or Physician Assistant</td>
<td>3</td>
</tr>
<tr>
<td>Nurse</td>
<td>50</td>
</tr>
<tr>
<td>Patient Care Technician</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
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<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Count</th>
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<tr>
<td>Self</td>
<td>34</td>
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<tr>
<td>Colleague</td>
<td>29</td>
</tr>
<tr>
<td>Supervisor</td>
<td>20</td>
</tr>
<tr>
<td>Risk Management</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
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</table>

<table>
<thead>
<tr>
<th>Location of Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>38</td>
</tr>
<tr>
<td>Inpatient Floor</td>
<td>20</td>
</tr>
<tr>
<td>Obstetrical Unit</td>
<td>16</td>
</tr>
<tr>
<td>Operating Room</td>
<td>9</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Harm or Death</td>
<td>66</td>
</tr>
<tr>
<td>Litigation</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
</tr>
</tbody>
</table>

BACKGROUND

- After an adverse event, clinicians are at risk for becoming the "second victims"
- Clinicians report feelings of personal responsibility for the unexpected outcome, sense of having failed the patient, second-guess their clinical skills and knowledge base.
- Leads to depression, substance abuse, and suicide.
- Decreased job satisfaction and increased burnout are common.
- A true peer to peer support program is necessary.

GOAL

Analyze peer support encounters after initial program implementation to determine utilization and identify areas for improvement.

LEARNING OBJECTIVES

1) Discuss background of second victim phenomenon and understand its manifestations.
2) Characterize referral sources and event types in a peer support program.
3) Plan improvements to a peer support program.

METHODS

- Peer support program entitled “Care for the Caregiver” launched at Christiana Care Health System in June 2015.
- 1,100 bed not-for-profit academic medical center in Newark, Delaware.
- Team includes attending and resident physicians, nurses, and chaplains trained in providing emotional support to second victims.
- Program is available to any hospital system employee or medical-dental staff member.
- Peer supporters were asked to complete a data collection form after each encounter to document non-protected health information aspects of the encounter as well as suggestions for improvement.
- Data was analyzed using qualitative methods to determine utilization and identify areas for improvement.

CONCLUSION

A peer support program sends a strong message that an institution cares for its clinicians. Knowledge that staff are supported by the institution as well as by their peers may lead to more clinicians "surviving and thriving" after adverse events. Collecting and reviewing characteristics of peer support encounters and suggestions for improvement can lead to a robust, responsive team able to promote healing during a vulnerable time in clinicians' professional careers.

IMPROVING THE PROCESS

Representative quotations from peer supporters:

"The nurse was already aware she was referred. I think this really helped the conversation get started because she was not caught off guard."

"We spoke several times over email. I would have preferred to be able to talk on the phone or in person but RN declined."

"No way to know if other peer supporters have already been involved, do not want to intrude if another relationship established."

"Will be arranging a second meeting, giving her some space to process. Deeper grief from past personal event, this event opens old wounds."

"Was not a planned contact, nurse came up to me and told me about what a bad delivery it was, and unexpected."

"Says she is fine, unsure whether we should automatically follow up folks who say they are fine."

"Initial meeting felt a bit rushed to me because clinician was in between cases. I should try to find a more convenient time next time."

Referral Source

- Self: 34
- Colleague: 29
- Supervisor: 20
- Risk Management: 5
- Other: 11

Location of Event

- Emergency Department: 38
- Inpatient Floor: 20
- Obstetrical Unit: 16
- Operating Room: 9
- Intensive Care Unit: 4
- Other: 12

Type of Event

- Patient Harm or Death: 66
- Litigation: 9
- Other: 24
Multi-source assessments as a method to provide feedback to resident physicians in postgraduate medical education: Insights and implications for promoting a culture of feedback and enhancing wellness

Christopher Simon, PhD1, Derek Puddester, MD, MEd1, Alan Chaput, MD1, Lorne Wiesenfeld, MD1, Larry Harmon, PhD2, & Paul Gregory, PhD2
1Faculty of Medicine, University of Ottawa; 2PULSE 360, Physician Development Program

Feedback
- Essential component of learning and development (Bransford et al., 2012)
- Linked to adaptive expertise and development (Barr, 2001)
- Increases awareness of behaviors and how such behaviors affect others/environment around them (Van Velko et al., 2010)

Multi-Source Assessment (MSA)
- Tool providing feedback from multiple sources (e.g., colleagues/supervisors/self) (Bergman et al., 2014)
  - Spectrum of data from all sources presented to ratee (Conway & Huffcutt, 1997)
  - Skills, behaviors, personal attributes, goal progress (Broughton, 2012)
  - Usage increasingly common (Barr, 2001)
- Different evaluation perspectives:
  - Provide unique information, beyond 'supervisor' (Grujich et al., 2012)
  - Add incremental validity to overall assessment (Good & Coonbe, 2009)
- Feedback derived from multiple sources more likely to be:
  - Perceived as fair (Smither et al., 2005)
  - Utilized for improvement efforts (Broughton, 2012)
- Linked to important affective factors:
  - User self-awareness
  - User trust that raters are providing accurate feedback
  - User receptiveness to alternative perspectives (Broughton, 2012)
- Multiple raters more likely to provide truthful feedback (Good & Coonbe, 2009)

Application in Postgraduate Medical Education (PGME)
- MSA increasingly used + valued tool (Sharma et al., 2012)
- Shown to improve performance (Grujich et al., 2012)
- Common application → Assess medical expertise, communication skills, collegiality, and psychosocial and administrative skills (Mailing et al., 2009)
- Endorsed by Royal College of Physicians and Surgeons of Canada as preferred assessment method for competencies in CanMEDS roles (Bandiera et al., 2006)
- Concerns over resource costs (time + effort + process) (Grujich et al., 2012)

uOttawa Context
- Online MSA tool utilized to provide quality improvement feedback to resident learners
- Required participation once per year → complete self-rating + one for each fellow trainee + faculty supervisor + others (e.g., allied health staff)
- Multiple data points cross-tabulated + presented to each resident as opportunity to:
  1. Reinforce areas of strength
  2. Identify areas which could benefit from improvement

Sample MSA Feedback Output:
- Electronic data collection + presentation can streamline process, reducing time and effort required (Grujich et al., 2012)

Key Outcomes from MSA Program Evaluation (n = 159):

Positive Outcomes
- General support (60%) for utility of MSA tool in PGME
- Majority (75.5%) of users agreed MSA contributes to effective development of non-medical competencies
- Majority (80%) agreed that the utility of survey in identifying residents who have opportunities for improvement
- Nearly all (96.2%) reported positive experience in process of completing MSA feedback

Areas for Improvement
- Residents struggled with utility of self-rating (8.1%) relative to ratings from supervisor (31.5%), peer (29.8%), and healthcare staff (24.2%)
- Nearly half (47.7%) of residents felt they were able to effectively incorporate feedback to improve performance
- Concerns raised over time + effort required

Insights and Implications for MSA in PGME

Promoting Culture of Feedback
- MSA useful if properly implemented and effectively adapted for context (Brutus et al., 2006)
- Increase emphasis on resident perspectives in feedback process → Incorporate ‘self’ and ‘peer’ to traditional sources (e.g., supervisor) (Kraut et al., 2015)
- Residents interact differently with supervisors than they do with colleagues
- Offer opportunities for learners to confirm competencies in which they excel + identify areas which could benefit from improvement
- Promotes pattern of ‘feedback-seeking behaviour’
- Motivates to consistently self-assess and improve
- Emphasize importance of being proficient at both giving as well as receiving feedback
- Focus on formative, not summative, feedback

uOttawa Context: Addressing Areas for Improvement
- Better articulate value and utility of MSA assessment to all raters/ratees – particularly ‘self-assessment’
- Increase efficiency of MSA process (time/effort)
- Implement strategies to assist residents in integrating/incorporating feedback from MSAs

Promoting Wellness
- Useful tool for evaluating CanMEDS roles – including “Professional” → Includes ‘attuning to ones own wellness, and that of colleagues’ as key competencies (Frank et al., 2014)
- Given inherent challenges and stressors within medical training environment, feelings of inferiority and low-confidence are common among residents
- Link to positive psychology and enhancing ‘joy’:
  - Focuses on optimal functioning, not only deficiencies (Haworth & Hart, 2007)
  - Receiving favourable feedback highlights qualities of relative strengths others appreciate and value
  - Positive feedback effective for motivating goal pursuit
  - Increases outcome expectancy + self-efficacy
  - Complements role of negative feedback → encourages goal pursuit

Summary
Multi-source assessment can be a useful tool to provide feedback to residents in PGME. Experiences from uOttawa context revealed and reinforced both advantages and challenges to an MSA program. Overall, focusing on strengths as well as areas to improve, from multiple perspectives, reflects a shift in PGME towards a culture of feedback, and presents opportunities to enhance wellness

Contact: christopher.rsimon@icloud.com
Abstract: Western medicine, psychiatry, and psychology has struggled to create a coherent description of the human psyche and has also crimped our understanding of what it means to be fully human. A model that identifies our human capacities and gives us both a method and a map for growing whole is long overdue. The focus on symptoms as a problem rather than symptoms as an indicator of a problem continues to hold us back. Bill Plotkin’s Nature-Based Map of the Human Psyche offers a model highlighting our positive, life-enhancing resource and emphasizes wholeness and potential magnificence, and a method for cultivating wholeness, and healing our own selves. The NBMOHP is nature-based, holistic and integral, wholeness oriented, and contextual. Without such a map, we might not know what we are missing, leading to a life seeking healing, safety, or inauthenticity rather than a life of wholeness, visionary service and joy.

Methods: This map and perspective were developed by the eco-depth psychologist Bill Plotkin, Ph.D. and adapted by the presenter after a review of the literature on the “dis-ease” of the modern physician, and training and studying eco-therapy, depth and archetypal psychology, meditation, imagination and creativity, mystical poetry, and wilderness rites of passage. Based on the work of the Eco-Depth Psychologist Bill Plotkin, the Nature Based Map of the Healer’s Psyche provides a comprehensive, holistic map and an approach that focuses on what is possible rather than what is pathological.

Learning Objectives: 1) describe an ecological and holistic look at the human psyche based on the seven directions of nature, 2) explain the four facets of the healer’s wholeness, the archetypes associated with each facet, and the way of “knowing” for each facet, 3) identify where the concepts of healer burnout, addictive, disruptive, and unethical behavior overlap with the fragments, protectors, or sub-personalities of the healer’s psyche, 4) describe how the fragmented psyche shows up as symptoms in need of cultivating further wholeness, 5) compare the benefits of a non-pathological and holistic model of the human psyche compared to the current pathology and symptom-focused model of Western psychiatry and psychology.

Background: Western psychiatry and psychology were born out of a medical approach to the human psyche which focuses on symptom and pathology. Current approaches to physician “dis-ease” likewise have been pathology or problem-oriented. Current issues facing the healer’s psyche—burnout, addictive, disruptive, and unethical behaviors—are not well-characterized or modeled by traditional nosologies.

Our pathological and symptom-focused approach has cramped our ability to grow whole and fully mature. The agenda of mainstream psychotherapy, likewise, has been, from its beginnings, remarkably limited and, consequently, limiting.

Findings: 1) The NBMOHP offers a model that better describes how and why symptomatic behaviors occur and how to address it. 2) Cultivating wholeness is consistent with other non-pathology focused leading approaches: Mindfulness for the East Facet of the Self, Emotion-Focused Therapy for wounded-disruptive behavior, loyal soldier work for the inner critics, and adds the missing piece of most approaches, cultivating the deeply imaginal Self. 3) Physicians are suppressed in their ability to be present, emotion-centered, and deeply imaginative. 4) Our medical, continuing medical, and Physician-support institutions need to take this wholeness into account.

Conclusions: The Nature-Based Map of the Healer’s Psyche highlights the positive, life-enhancing resources and perspectives and extols them as foundational to our humanity. The accent is not on our fragmented parts or wound stories, or how our psyches stall out in neurotic patterns, or how we might merely recover from trauma, pathology, or addiction; rather, the accent is on our wholeness and potential magnificence, how we can enhance our personal fulfillment and participation in our more-than-human world, and how we can become fully human and visionary artisans of cultural renaissance.
The Path to the Initiated Ego and The Visionary Physician

Brian Stafford, MD, MPH  Wilderness Guide, Eco-Therapist, Depth Psychiatrist, Pediatrician, Founder, Wilderness ls Medicine

Abstract: Western culture has no design tool to describe optimal human development. All healthy indigenous cultures have rites of passage that includes a wander, pilgrimage, vision quest, or walkabout in nature whereby the adolescent finds a vision to live into the world for his culture. In these cultures an “adult” is one who primarily experiences their Self as a member of the earth community, has a mystical understanding of the Self, and is living that understanding into the world. Physicians, because of cultural failure and the nature of their training, rarely complete the development tasks of adolescence. The Eco-Centric Wheel provides a guide, in developmental stages, to become, first a wanderer, then a visionary artist, and potentially maturing into a true elder. The path of the initiated ego and the steps to becoming a visionary healer are a possibility, even in this time of burn-out, cultural deterioration, and global warming.

Learning Objectives:
1) define and describe the current state of affairs using the “ego-Centric” developmental wheel and the difference between ego-centric and eco-centric.
2) describe the necessary steps toward “awakening” from a patho-adolescent way of living and practicing in the world
3) describe a revolutionary new model of human development, the Eco-Centric Developmental Wheel and its application to understanding the life-course pattern lived by the majority of physicians, and the Eco-centric Developmental Wheel.
4) discuss the differences between the Ego-Centric Developmental Wheel, the life cycle pattern lived by the majority of physicians, and the Eco-centric Developmental Wheel.
5) identify the educational, professional and cultural barriers for further development of the physician’s psyche.
6) describe the cultural tasks and the nature-based tasks for the salient developmental stages
7) determine that physician development goes far beyond education, training, and CME, and includes the following broad tasks: Whirling the Self, Healing the Subpersonalities, Focusing on Developmental Stage Tasks, Addressing Unfinished Developmental Tasks, and wandering deeper into one’s true life.

Conclusions:
Like most Westerners, physicians find themselves living an ego-centric existence, even in the midst of being in the “sacred helping profession.” The Eco-centric developmental wheel identifies the possibility of movement toward the visionary physician as well as the tasks toward that place of visionary service and joy.

Background: Professionals are “burning out,” physicians perhaps more than any other profession. Our techno-industrial growth culture is shutting down the major life systems of the planet. Our self-autonomy decreases every day, even as we learn more and more of our inter-dependence. We must develop a more mature culture. We need a more mature profession. We need more mature physicians. A more mature society and profession requires more mature individuals. This call to maturity requires a re-visioning of an individual’s life beyond “to do no harm” and “to love and to work.” A novel and profound model, called the Eco-Centric Developmental Wheel, has been developed by Bill Plotkin, PhD. and is the best map of optimal human development, as well as a design tool for creating healthy human communities. The presenter describes the implications of this map with the education, training, and medical system of the Western physician in mind.

Findings: Based on the wheel, most physicians are indoctrinated into a life of either “healthy adolescence” or “patho-adolescence.” The lack of a deeper understanding of the world, the nature of the Self, and the visionary capacity of every human individual keeps physicians from their deeper visionary potential. The wheel helps physicians, physician health programs, and administrators identify suitable developmental tasks in order to become eco-centric adolescents, and, eventually, visionary physicians. Common identified barriers to a more mature physician include the following:
1) unfinished developmental tasks,
2) lack of Wholeness of the Self,
3) lack of healing of the Self,
4) and lack of guides pointing to the Stage of development leading to the visionary physician.
5) Desire for change or a return to the way things used to be, but not for transformation or uncertainty

Findings:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Nature Task</th>
<th>Cultural Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy: The Nest</td>
<td>A) Acquiring and using soulcraft skills</td>
<td>1) Leaving Home / (A) Having the skills of physical, psychological, and social self-reliance (C) Relinquishing attachment to the adolescent personality</td>
</tr>
<tr>
<td>1)Infancy: The Nest</td>
<td>B) Cultivating a soulful relationship to life</td>
<td></td>
</tr>
<tr>
<td>2) The Garden: Learning the givens of the world and our place in it</td>
<td>Sub-tasks: (1) Discovering the enchantment of the natural world = - 1) Wild nature - 2) The human body</td>
<td>Sub-tasks: (1) Value exploration and social authenticity</td>
</tr>
<tr>
<td>3) The Oasis: Early Adolescence Creating a secure and authentic social self</td>
<td>Sub-tasks: (2) Studying human-nature reciprocity and ecological responsibility</td>
<td></td>
</tr>
<tr>
<td>4) Second Adolescence: The Cocoon</td>
<td>Sub-tasks: (3) Emotional skills: emotional access, insight, action, and illumination</td>
<td>3) Emotional skills: emotional access, insight, action, and illumination</td>
</tr>
<tr>
<td>5) The Present: The Adult Life Stage</td>
<td>Sub-tasks: (4) Status-assigning skills</td>
<td>4) Status-assigning skills</td>
</tr>
<tr>
<td>6) Emotional skills: emotional access, insight, action, and illumination</td>
<td>Sub-tasks: (5) Skills with sex and sexual relationships</td>
<td>5) Skills with sex and sexual relationships</td>
</tr>
<tr>
<td>7) Wild nature</td>
<td>Sub-tasks: (6) Sustenance skills</td>
<td>6) Sustenance skills</td>
</tr>
<tr>
<td>8) The human body</td>
<td>Sub-tasks: (7) Studying human-nature reciprocity and ecological responsibility</td>
<td>7) Studying human-nature reciprocity and ecological responsibility</td>
</tr>
<tr>
<td>9) Creating a secure and authentic social self</td>
<td>Sub-tasks: (8) Welcoming home the Loyal Soldier</td>
<td></td>
</tr>
<tr>
<td>10) Emotional skills: emotional access, insight, action, and illumination</td>
<td>Sub-tasks: (9) Wild nature</td>
<td>9) Emotional skills: emotional access, insight, action, and illumination</td>
</tr>
<tr>
<td>12) Status-assigning skills</td>
<td>Sub-tasks: (11) Emotional skills: emotional access, insight, action, and illumination</td>
<td>11) Emotional skills: emotional access, insight, action, and illumination</td>
</tr>
<tr>
<td>13) Status-assigning skills</td>
<td>Sub-tasks: (12) Sustenance skills</td>
<td>12) Sustenance skills</td>
</tr>
<tr>
<td>14) The human body</td>
<td>Sub-tasks: (13) Emotional skills: emotional access, insight, action, and illumination</td>
<td>13) Emotional skills: emotional access, insight, action, and illumination</td>
</tr>
<tr>
<td>15) Emotional skills: emotional access, insight, action, and illumination</td>
<td>Sub-tasks: (14) Sustenance skills</td>
<td>14) Sustenance skills</td>
</tr>
<tr>
<td>16) Emotional skills: emotional access, insight, action, and illumination</td>
<td>Sub-tasks: (15) Welcoming home the Loyal Soldier</td>
<td>15) Welcoming home the Loyal Soldier</td>
</tr>
</tbody>
</table>
Increasing Joy and Cooling off Burnout with Heartfulness Meditation

Jayaram Thimmapuram, MD; Robert Pargament, MD; Kedesha Sibliss, MD; Ronald Benenson, MD; Rodney Grim, PhD
Wellspan York Hospital, York, Pennsylvania

**CONTEXT/BACKGROUND:**

- Burnout is a state of mental and physical exhaustion related to work or caregiving activities posing significant challenges.
- Meditation is a technique used by some to treat stress and promote wellness.
- The benefits of meditation have not been commonly demonstrated in residents, academic faculty, and nurses.
- In our study, we assessed the effects of a 12-week "Heartfulness Meditation" program on burnout and emotional wellness in health care professionals at a teaching hospital.

**LEARNING OBJECTIVES:**

- Understand the effects of Heartfulness meditation on burnout.
- Understand the effects of Heartfulness meditation on emotional wellness.
- Appreciate the ease of integration of Heartfulness meditation program in a teaching hospital.

**METHODS/APPROACH:**

- Thirty-five subjects were enrolled as "meditators"; 12 subjects were enrolled as "controls."
- All subjects completed a baseline Maslach Burnout Inventory (MBI) and Emotional Wellness Assessment (EWA) at the beginning of the study and at 12 weeks.
- Meditators received simple instructions in Heartfulness Meditation for daily practice at home and were asked to attend group meditation sessions once a week.

**FINDINGS/RESULTS:**

- At 12 weeks, the meditators had statistically significant decrease of mean scores in emotional exhaustion (EE) from 26.7 to 17.9, and depersonalization (DP) from 11 to 7.3 (p-value <0.05). An increase in personal accomplishment (PA) score from 37.1 to 39.0 was also noted (p-value <0.05).
- Meditators also showed statistically significant improvement in 19 of 22 parameters of the EWA (p-value <0.05).
- Controls showed no statistically significant changes in the scores of either MBI or EWA.

**CONCLUSIONS:**

- Our results indicate statistically significant improvement in all measures of burnout and most measures of wellness among health care professionals engaged in a Heartfulness meditation program.
- Our results also indicate that meditation offers an accessible method by which physician and nurse wellness can be enhanced.

**REFERENCES:**


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**Maslach Burnout Scores:**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Baseline</th>
<th>Week 12</th>
<th>Sig.</th>
<th>Baseline</th>
<th>Week 12</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cynicism</td>
<td>5.8</td>
<td>4.6</td>
<td>0.05</td>
<td>4.5</td>
<td>3.7</td>
<td>0.05</td>
</tr>
<tr>
<td>Emotional Exhaustion</td>
<td>26.7</td>
<td>17.9</td>
<td>0.05</td>
<td>11.0</td>
<td>7.3</td>
<td>0.05</td>
</tr>
<tr>
<td>Emotional Wellness Assessment Scores</td>
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<td></td>
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</tr>
</tbody>
</table>

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**Emotional Wellness Assessment Scores:**

- **Addiction:** 2.91 2.09 0.046
- **Anxiety:** 3.89 2.80 0.006
- **Anger:** 5.91 3.51 0.000
- **Helplessness:** 3.66 2.13 0.000
- **Hopelessness:** 3.88 2.77 0.002
- **Mistrust:** 3.89 2.39 0.007
- **Mistrust:** 4.40 3.23 0.000
- **Mistrust:** 2.29 1.71 0.013
- **Mistrust:** 3.46 2.86 0.000
- **Mistrust:** 6.63 4.40 0.000

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*Note: Sig. indicates significance level.*
We all have the capacity to experience joy in medicine, but two things get in our way: We lose sight of the goal and we lose contact with the team. We lose sight of the goal and we lose contact with the team.

Every intimidating form, protocol, or piece of technology takes physicians away from their mission. We do teaching work, yet we revert to the most boring means to learn about B–realistic content, long form technical essays, and textbooks are all complicit in the theft of intellectual delight from the curious and anxious learner.

Continuing education should not be a form of punishment, something we voluntarily turn to in free moments. The medical education platform Figure 1 leverages its design as a social network to engage users in case-based discussion, while also reinforcing education by drawing on the principle of spiral learning. The other factor spoiling medicine is losing contact with our team. High-level collaboration happens daily in a hospital, but a family physician in a rural clinic may rarely experience it. Everyone has a smartphone in their pocket. With it, they can connect with over 1 million healthcare professionals around the world on Figure 1.

Research shows that it takes 17 years for evidence-based findings to be integrated into clinical practice. Today’s physicians are often digital natives, accustomed to quick change and instant results. On Figure 1, physicians can read updates as they come in, connect with specialists quicker than they can at the hospital, and speak openly about the challenges of their work. It provides an instant feedback loop in a world that can feel painfully slow.

**Goals & Learning Objectives**
- The importance of spiral learning in medical education
- How social media can improve medical education
- The significance of distributed knowledge accessible by a centralized platform

**Findings**
- The practice of medicine should be challenging, life-affirming, and fulfilling.
- Removing barriers to joy in medicine with technology.

**Conclusion**
- The advent of mobile technology has changed the world, and medicine is no exception. Healthcare professionals can and do engage with one another on social platforms, and these interactions have the potential to be professional, clinically useful, and ultimately to save lives. Figure 1 enables these interactions by removing traditional barriers to communication — and, by extension, the barriers to joy. When healthcare can move at the speed of modern life, and when healthcare’s best can use intuitive modern technology to become even better, the joy of medicine will be a universal value.