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Oral presentations: Perspectives
A new General Medical Council approach to doctors with health concerns—balancing public safety with the needs of ill registrants

Corresponding author
Anthony Omo
General Medical Council
aomo@gmc-uk.org

Co-authors
Anna Rowland

Learning objectives
1. Outline some of the issues that doctors who are unwell may face when they are under investigation by the General Medical Council (GMC).
2. Highlight the challenges for regulators in creating reforms that both reduce distress for doctors who are unwell or at risk and maintain public protection and confidence in the profession.
3. Present a discussion of the GMC’s proposed reforms on the way it handles investigations to reduce stress for doctors.

Context/background
A key challenge facing medical regulators is how to investigate cases where concerns are raised about a doctor’s or practitioner’s fitness to practice safely and the doctor’s health presents a risk to themselves or patients. These cases require regulators to find a balance between supporting ill or vulnerable doctors through an often stressful fitness-to-practice investigation process while carrying out an important regulatory function to protect patients. Finding this balance is not always straightforward: legislative frameworks may limit the flexibility of a regulator to introduce reforms that would allow a different approach to health cases; some health cases also involve serious misconduct or concerns about seriously deficient performance that requires a robust response, and sometimes doctors who are unwell don’t engage with the investigation.

Conclusions/discussion
Following a recent independent review into cases where doctors died by suicide while under the GMC’s fitness-to-practice procedures among other ongoing procedures, the GMC is reviewing and reforming the way it approaches cases where a doctor may be unwell. The GMC has already implemented a number of the report’s recommendations, such as a review of the way the GMC communicates with doctors under investigation. As part of this process, the GMC also appointed Prof. Louis Appleby, one of the United Kingdom’s leading mental health experts, to oversee a review of its approach to health cases between January and March 2016, and identify any further changes that could be made to support unwell and/or vulnerable doctors. The proposals arising from that review were presented for discussion with stakeholders in April 2016.
A recipe for creating and implementing a physician health and wellness strategic plan in a large academic tertiary care hospital

Corresponding author
Caroline Gérin-Lajoie, MD
University of Ottawa/The Ottawa Hospital Physician Health and Wellness
cgerin-lajoie@toh.ca

Co-authors
Kerri Ritchie, PhD, C. Psych.
Virginia Roth, MD
Daniella Sandre, PhD, C. Psych.

Learning objectives
1. Participants will learn about the importance and rationale for developing physician wellness initiatives in a large academic tertiary care hospital.
2. Participants will hear about the steps taken to identify physician wellness priorities and to create/implement a physician wellness strategic plan.
3. Key outcomes and successes based on the physician wellness strategic plan will be presented for years one and two.

Context/background
The issue of physician health is complex and can also have a negative impact on physician recruitment and retention, workplace productivity, efficiency, quality of patient care and patient safety … key priorities in today's health care system.1 In May 2009, one of Canada's largest teaching hospitals, The Ottawa Hospital (TOH), embarked on a quality improvement journey to improve physician engagement, patient satisfaction and outcomes. Physician engagement surveys (in 2009 and 2012) revealed that physician health and wellness ranked within the top five drivers that could improve physician engagement. However, less than one-third of TOH physicians agreed that the hospital was investing enough in this area.

Methods/approach
Based on the physician engagement surveys, TOH created a Physician Health and Wellness Committee in 2013 to identify physician wellness priorities, and develop initiatives to promote resilience and support physician well-being. After a series of presentations to TOH administration and physician leaders, physician wellness surveys and focus groups were organized.

Results and conclusion
In August 2014 the data obtained was used to develop the TOH Physician Health and Wellness Strategic Plan, based on three strategic priorities (advocacy, leadership, support) and linked to specific outcome measures. Successes to date include: creating a robust Physician Health and Wellness Committee, raising awareness and refining methods of communication with front line physicians, adding an Employee and Family Assistance Program and access to family physicians, and improving food quality and in-house exercise facilities. As a key outcome measure, the 2015 physician engagement survey reported a 10 percent improvement on the item related to physician health and well-being. Key steps, lessons learned and generalization to other organizations will be discussed.

A tale of two countries: Innovation and collaboration aimed at changing the culture of medicine in Uruguay

Corresponding author
Juan J. Dapueto, MD, PhD
Universidad de la República
jdapueto@hc.edu.uy

Co-authors
Mercedes Viera, LicPsyc
Charles Samenow, MD, MPH
William H. Swiggart, MS, LPC/MHSP
Jeffrey Steiger

Learning objectives
1. Identify three strategies followed through a collaboration of multinational institutions to enhance physician wellness and professional behavior
2. Discuss the educational activities developed and impact on the culture
3. Discuss the barriers encountered and future strategies to promote change

Context/background
Through a five-year collaboration between the George Washington University; Vanderbilt University; and the Faculty of Medicine of the Universidad de la República, Uruguay, we achieved sustained cultural change. Using traditional didactics, interactive theater and professional development workshops, we were able to address three pillars of physician health—physician wellness/self-care, professional behavior and patient safety.

Methods/approach
The interventions consisted of three rounds of activities between 2010 and 2015: (1) traditional didactics and meetings with key stakeholders (2010), (2) an interactive theatrical presentation to raise awareness and spark dialogue (2013), and (3) skills-based workshops to promote change (2015). Participants included faculty members, doctors in general practices, stakeholders and other health professionals (nurses, psychologists, social workers).

Findings/results
These educational interventions were rated as satisfactory or very satisfactory by participants (n = 359) in the following categories: relevance (89.7 percent), applicability (60.2 percent), quality (82.1 percent) and global quality of activities (83.6 percent). Far more important are the systemic changes and cultural impact made by this collaboration. The initial presentations (1) contributed to elevated consciousness on these issues among faculty members and the medical community, (2) helped identify and empower local champions, (3) promoted the creation of a network between the Faculty of Medicine, medical associations, the Medical College of Uruguay, policy makers and stakeholders, (4) sparked changes in the curriculum with the inclusion of a code of conduct in the first year and the implementation of a workshop on professional health and behavior in the last year of medical school, and (5) launched the Observatory of Professional Behavior, a working group that strives to improve the quality of the relational environment between faculty members and students in different settings and learning environments.

Conclusions/discussion
A multinational collaboration using a variety of creative approaches can help promote sustained changes in physician health, behavior and patient safety.
Changing the face of health care through compassionate physician leadership

Corresponding author
Mark R. Rosenberg, MD
Providence Health & Services
Mark.Rosenberg@providence.org

Co-author
Rebecca A. Hawkins, MSN, ARNP, ACHPCN

Learning objectives
1. Describe compassionate leadership as it applies to physicians
2. Examine the impact of compassionate leadership on the health care system
3. Explore strategies for developing leadership qualities that promote compassion

Context/background
Compassionate leadership provides a fertile approach for physicians to recapture the love of medicine. Physicians appreciate compassion as a critical component of patient relationships. We propose that compassion is equally crucial in relationships among co-workers and is a fundamental requirement of physician leaders. The literature describes benefits of leaders who lead with compassion, yet it is sometimes perceived as a weaker leadership style. Compassionate leadership requires personal courage and sharing of vulnerability, qualities rarely taught or encouraged in leadership development. Physician leaders, utilizing their patient care experience, are in a unique position to bring the energizing quality of compassion into leadership work. We believe that this is key to bringing joy to leadership.

Methods/approach
This presentation will describe compassionate leadership traits, impact on teams, methods for developing compassionate physician leaders, and barriers to compassionate leadership and its expression. It will be illuminated how engaging with leadership can develop a fundamentally shared belief that compassion is essential for quality patient care and inspires organizational governance. Full integration of compassionate leadership is explored by providing intentional development and physician engagement at every level. Further discussed will be the process that Providence Health & Services (a multistate organization with 70,000 plus employees) has undertaken to align culture and create the shared vision needed to achieve the integration of compassion, quality and safety. Also highlighted will be strategies for engaging leaders to consider compassion as a core value, encouraging hard wiring compassion into organizational practice and leadership response throughout the organization. A candid discussion will follow exploring the difficulty of hard wiring compassion, measuring its impact and the challenges of developing processes for dissemination.

Conclusions/discussion
It is our belief that safety, high-quality and reliable patient care can only be achieved by creating a compassionate caring culture, which includes leaders who both value and exemplify compassion.
Decrease physician burnout, improve performance and job satisfaction with coaching

Corresponding author
Lisa Herbert, MD
Just the Right Balance LLC
info@justtherightbalance.com

Learning objectives
1. Understand the field of coaching
2. Define and recognize physician burnout
3. Understand how coaching can eliminate physician burnout and improve joy

Context/background
How and why was the study/perspective developed? It is no secret that the physician burnout rate is at an all-time high. Physicians’ increased work demands and long hours coupled with their intense, goal-driven nature can be a recipe for disaster if not addressed. “Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General U.S. Working Population,” a study by the Mayo Clinic, revealed that “burnout and satisfaction with work-life balance in U.S. physicians worsened from 45.5 percent in 2011 to 54.5 percent in 2014.” In addition to support in the practice setting, the authors recommended other strategies to address this issue, which included helping physicians engage in self-care and develop habits that promote resilience in challenging situations.

Methods/approach
How did this perspective come about? CEOs of organizations are starting to realize the benefit of coaching. Similar to physicians, CEOs are faced with rapidly changing markets, technology advances and increased responsibilities. Paul Michelman, writing in the Harvard Business Review’s “Working Knowledge,” has found that most major companies now make coaching a core part of their executive development programs. These programs lead to increased productivity, improved communication and decreased levels of stress. These companies understand that personal collaboration with an objective third party can provide a value that other forms of organizational support can’t.

Conclusions/discussion
Partnering with a coach can also help physicians in finding solutions to increasing joy in medicine. Coaching helps professionals not only improve their professional performance and work-life balance, but it can also help with career satisfaction and improve relationships.

What if coaching was used by medical schools, residency programs and hospitals to help and support physicians and provide them with a framework for dealing with adversity and improve their capacity to be resilient? This could be a solution.
Development of a novel and sustainable wellness curriculum to combat burnout and promote resident well-being

Corresponding author
Sangita Goel MD, MSc
Mount Sinai St. Luke's/Mount Sinai West Hospital
Sangita.goel@gmail.com

Co-authors
Krishna A. Chokshi, MD
Vani Gandhi, MD
Shelly Latte-Naor, MD
Erica A. Vero, MD

Learning objectives
1. Learning the importance of having a wellness curriculum within medical training programs
2. Building blocks needed to start an effective wellness program with minimal resources
3. Learning how to create a program that is sustainable and responsive to needs of residents

Context/background
National data suggest that nearly half of all physicians in the United States experience burnout and internal medicine residents are among those most affected. Our surveying of 109 residents with the “Maslach Burnout Inventory” established a high prevalence of burnout within our residency. There is an undeniable need for wellness practices that foster the ability to reflect meaningfully on clinical experiences, as well as mindfulness interventions in medical training programs. Prior to our innovation, there was no forum within our residency for exposure of residents to these practices.

Methods/approach
We developed a comprehensive wellness curriculum that encompasses three components: medical humanities, mindfulness training and evidence-based integrative medicine didactics. We conduct these sessions in intimate groups, during protected time to ensure inclusion of the entire house-staff program. In “Reflection Rounds,” we use collaborative writing and discuss literature to explore themes such as, experiencing loss and promoting empathy. In our mindfulness sessions, residents are exposed to relaxation techniques, yoga movement, mindful communication and stress awareness techniques. Each session offers a safe space for introspection and expression in an effort to develop successful habits for coping and growth. Residents or faculty trained in these wellness modalities lead our sessions.

Findings/results
We have successfully reached all of our 149 residents with over 25 wellness sessions. Residents have expressed the positive impact of the wellness sessions both anecdotally and through preliminary surveying. The majority of responders felt the curriculum will positively affect their patient care and expressed interest in having more sessions.

Conclusions/discussions
Our wellness curriculum offers a powerful cognitive resource for providing better medical care by cultivating compassion, communication and quality of life in health care providers. We feel that this curriculum will transform resident well-being. These methods, when integrated into medical education, can inspire residents to derive meaning, achieve fulfillment and find joy as a physician.
Finding joy in medicine by serving the underserved (personal reflections from volunteering in the USA and Haiti)

Corresponding author
Monika Kusuma Pringle, MD
Johnstown Free Medical Clinic
monikak-p@atlanticbb.net

Co-author
Mary Zemyan Polito, CRNP, DNP

Learning objectives
1. Recognize the value and joy that volunteering add to their lives as physicians
2. Identify the positive lasting effect after working on a mission trip
3. Share their own volunteer experiences to inspire others to make the same rewarding choice

Context/background
As an international medical graduate from Indonesia, I had already been exposed to poverty before my training in medical school. My exposures to many difficult circumstances in providing affordable health care combined with educational, cultural, religious and financial challenges have made me very passionate about caring for the underserved. For the last nine years I have lived in the United States and have worked as both a health care volunteer and patient advocate at a free clinic in a small city. Once again I encountered this problem where patients have no health care and minimal resources. We rely solely on volunteer physicians and other health care providers to attend to their needs. Our patients are indeed very grateful that these health care professionals are donating their precious time, serving them in their time of need—but the gratitude doesn't end there. Our volunteer physicians return week after week because of the satisfaction, joy, perspective, camaraderie, grounding to reality, the chance to work creatively and personal pride. This caring quality and passion crosses many barriers to improve the health—and ultimately the lives—of this population and the surrounding community. As a hospital volunteer myself, at the end of my shift, I walk out with a fresh perspective on life. I feel elated knowing that I’ve touched someone’s life today. Additionally, working on a medical mission team in Haiti this past January has inspired me and given me a lifetime experience worth sharing. Such experiences remind us of our gifts and why we really want to be physicians in the first place. Volunteering enables us to dig deep and learn something new about ourselves. With that being said, I would like to take this opportunity to present the positive effects of volunteering in medicine through my media presentations. Volunteering my medical skills has brought joy to my life and my colleagues. It changed my life, and I hope it will change yours too.
Fostering caring organizational cultures: Faculty education fellowship in medical humanism and professionalism

Corresponding author
Elizabeth A. Rider, MSW, MD
Institute for Professionalism & Ethical Practice, and Division of General Pediatrics, Boston Children's Hospital; Department of Pediatrics, Harvard Medical School
elizabeth_rider@hms.harvard.edu

Co-author
William T. Branch Jr., MD, MACP

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

Context/background
Institutional cultures strongly influence the well-being of faculty members, the professional identity formation of trainees and ultimately the care they provide. We describe a multi-institutional faculty development project, “Passing the Torch: Fostering Medical Humanism through Faculty Role-Models,” designed to foster humanistic physicians and faculty role models to promote more humanistic organizational cultures, and its implementation via fellowship at one institution.

Methods/approach
Boston Children's Hospital is the first pediatric site selected to implement this curricula. To achieve acceptance and sustainability, we created a one-year Faculty Education Fellowship in Medical Humanism and Professionalism. Faculty fellows participate in one-and-a-half hour, twice-monthly interactive small-group sessions with curricula including caring attitudes, reflective teaching, narratives, appreciative inquiry, inter-professional teams, skilled communication and values exploration based on the International Charter for Human Values in Healthcare. To increase institutional impact, we identified an advisory board and collaborators/sponsors (Institute for Professionalism and Ethical Practice, Offices of Faculty Development and Graduate Medical Education, Academy for Innovation in Education).

Findings/results
Twice as many faculty applied as positions available. The first cohort included 10 faculty physicians, most in educational leadership roles. Fellows continue to meet quarterly post fellowship, implementing teaching and workshops modeled on program curricula and collaboratively developing an institution-wide project to promote humanistic values. The second cohort of 11 fellows started September 2015.

Conclusions/discussion
Part of a multi-institutional project, we developed a Faculty Education Fellowship in Medical Humanism and Professionalism, including curricula to foster personal and professional resilience and well-being. The fellowship provides opportunities for faculty to enhance reflective capacities, teaching skills and role modeling in humanism/professionalism, to collaboratively promote humanistic values and teaching environments, and to serve as positive influences on institutional culture.

1. Supported in part by a multi-institutional grant from the Josiah Macy, Jr. Foundation (Dr. Branch as PI; Dr. Rider as site PI.)
Making health care a healthy enterprise: A leadership imperative

**Corresponding author**
Les Schwab, MD  
Atrius Health  
Leslie_Schwab@atriushealth.org

**Co-author**
Joe Kimura, MD

**Learning objectives**
1. Learn a systems approach to physician well-being
2. Understand physician resilience as a necessary condition for professionalism and organizational success
3. Understand how individual physicians may gain resilience in an effective manner

**Context/background**
The presenters (the current and previous chief medical officer of a large multispecialty group practice) share a commitment to build the morale of the physician workforce in the service of their colleagues’ own professionalism and active participation in the organization’s progress. They contend that it is both the prerogative and imperative of leadership to promote a healthy and engaging practice environment. The assurance of success requires a systematic understanding of the critical points of professional duress for solution design, as well as customized, helpful approaches for individual physicians.

**Methods/approach**
The presenters will share their developmental approach and the current state of their efforts in an interactive discussion with participants.

**Conclusions/discussion**
A systems approach to building physician resilience founded on an understanding of organizational and individual development can yield a more robust and constructive practice experience.
Physician storytelling forum

Corresponding author
Mert Erogul, MD
SUNY Downstate School of Medicine/Maimonides Hospital Department of Emergency Medicine
erogul1@gmail.com

Co-authors
Josh Schiller, MD
Arlene Chung, MD
Tyler Beals, MD

Learning objectives
1. Justify the value of a physician storytelling forum
2. Organize a storytelling event

Context/background
Physicians from major emergency medicine teaching programs in New York City were invited to share stories about their practice and perform their narratives in front of fellow practitioners.

Methods/approach
Stories were specified to be five to 15 minutes in length and to be recounted without notes in front of an audience. For each session a handful of physicians agreed to participate in advance and participation was open to volunteers inspired to contribute during the event.

Findings/results
Approximately 10–12 participants told stories on each occasion. The audience consisted of 50–70 fellow physicians. The stories spanned the emotional gamut but had in common engagement in reflective practice, processing of challenging experiences and fortification of wholesome values in medical culture.

Conclusions/discussion
The stories we tell about our work convey our attitudes and values and form the common culture of our field. We tell stories to explain and understand what has happened to us, and in listening to stories, we absorb their assumptions and their inherent messages. Stories can reveal and perpetuate the attitudes of cynicism and self-preservation that constitute the hidden curriculum of medicine, or can be a vehicle for inspiration and professional self-renewal. Careful attention to the messages of stories is a valuable opportunity for self-reflection and moral growth. Telling and listening to stories about traumatic events can be potentially therapeutic. Hearing our common experiences reflected in other people’s stories eases the isolation of medical training and the imposter syndrome that is common among residents. All of these proposed benefits theoretically support wellness, increase resilience and improve our ability to cope with the stresses of training and medical practice. Formalized storytelling is a unique opportunity to get practitioners together in a social setting in which they not only enjoy themselves, but engage in reflection and leave with a heightened experience of their practice.
The development of a departmental wellness committee in an academic anesthesiology program

Corresponding author
Susan M. Martinelli, MD
University of North Carolina
smartinelli@aims.unc.edu

Co-authors
Amy Penwarden, MD
Brooke A. Chidgey, MD
Cam Enarson, MD
Lisa G. Johnson, MHA
Monika Nanda, MBBS, MPH
David L. Diritto, MSN
Brittney Paduchowski, CRNA
David A. Zvara, MD

Learning objectives
1. Describe important elements of a departmental wellness program
2. Identify the components of an effective departmental wellness infrastructure
3. Describe important outcome measures relating to departmental wellness

Context/background
Rates of burnout for United States physicians are on the rise,¹ with 50 percent of anesthesiologists demonstrating signs.² Burnout is also prevalent in non-physician workers including certified nurse anesthetists (CRNAs)³ and 28 percent of the general public (representative of our support staff).¹ With a goal of promoting healthy lifestyles, improved work-life balance and positive working environments, our department created a Wellness Committee with group specific subcommittees.

Methods/approach
The parent Wellness Committee focuses on factors affecting the entire department and maintains oversight of the subcommittees. A website was developed to provide links for local resources, pertinent documents and an event calendar. We have embraced research⁴ demonstrating the benefits of positive reflection by hosting a forum within our website where members can post “good things” that are happening in their life. Faculty, residents/fellows and CRNAs attend quarterly Wellness Wednesday Grand Rounds. Each subcommittee focuses on factors specific to their group as identified via needs assessment surveys. The Faculty Subcommittee is working on call equity and reimbursement strategies and hosted a retreat focused on improving resilience. The Resident Subcommittee overhauled the didactic curriculum to decrease non-clinical obligations and increase educational gains of required activities. In recognition of the need for group bonding, time and funding were allocated for each resident class to organize a retreat. The CRNA Subcommittee is working to manage utilization of paid time off and to develop a more efficient system for operating room breaks. The Support Staff Subcommittee focused on improving physical wellness through a healthy lunch and the formulation of a step-tracking program.

Conclusions/discussion
The Wellness Committee and its subcommittees have been well received by the department. We believe that by promoting wellness and community, making resources easily accessible and bringing awareness of these issues to the forefront, we will decrease burnout in our department.

Transform the health care system to increase joy in medicine!

Corresponding author
Steven A. Adelman, MD
University of Massachusetts School of Medicine
sadelman@mms.org

Co-author
Harris Berman, MD

Learning objectives
1. Participants will recognize that some of the integral, high-level features of our complex health care system contribute in significant ways to the joy crisis in medicine.
2. Participants will become acquainted with a number of entry points for systemic interventions that may facilitate meaningful changes that will foster the well-being and joy of health professionals.
3. Participants will begin considering strategies and next steps for engaging leaders and colleagues at the local level in discussions aimed at raising awareness of the need for fundamental system change.

Context/background
The decrease in joy in medical practice may be a by-product of a maladaptive health care system that is inadvertently configured to promote stress, burnout and professional failure to thrive. Meaningful increases in joy are most likely to be achieved by implementing large-scale, systemic changes, some of which we can begin to envision.

Methods/approach
This high-level conceptual discussion of systemic factors is gleaned from Dr. Adelman’s experience as a board member and medical leader in a large multispecialty group practice and from his physician health work providing assessment and remediation services to hundreds of distressed physicians. It is also gleaned from Dr. Berman’s extensive experience as an HMO founder, a health plan CEO, and dean of a large medical school. Rich individual and group discussions with an array of thought leaders across the profession and industry also inform this presentation, as does a survey of leaders, professionals and other stakeholders in the overlapping worlds of the health care industry and medical education. Complex systems theory informs the authors’ presentation of eight system-level approaches that could be aimed at diminishing burnout and enhancing joy in medicine.

Findings/results
System-level approaches in the following eight domains will be discussed:
• Medical school admissions
• Funding of medical education to diminish burdensome debt for early career physicians
• Graduate medical education
• Health maintenance
• Value-based care
• Physician self-care and work-life balance
• Technology
• Team-based care

Conclusions/discussion
Systems thinking and complex systems theory, informed by the experience of leaders and stakeholders in the worlds of physician health, health care delivery and medical education, allow us to identify a number of potential entry points for system-wide interventions that have the potential to diminish distress and enhance joy in practice. The authors will share their perspective regarding the most practical and actionable next steps.
Oral presentations:
Research
A randomized controlled trial evaluating the effect of COMPASS (COlleagues Meeting to Promote And Sustain Satisfaction) small group sessions on physician well-being, meaning and job satisfaction

**Corresponding author**
Colin P. West, MD, PhD
Mayo Clinic
west.colin@mayo.edu

**Co-authors**
Lotte N. Dyrbye, MD, MHPE
Daniel V. Satele
Tait D. Shanafelt, MD

**Learning objectives**
1. Report results of an intervention to promote physician well-being
2. Describe a small group curriculum to promote meaning in work
3. Identify key metrics influenced by well-being promotion strategies

**Context/background**
A recent randomized study of facilitated physician meetings demonstrated improvement in meaning and reduced depersonalization in the intervention arm, but it is unknown whether less intensive and less structured forms of this intervention would also be beneficial for physician well-being.

**Methods/approach**
We conducted a randomized controlled trial of a six-month intervention involving 12 biweekly one-hour meetings of self-formed groups of six to eight academic internal medicine physicians, termed COMPASS groups (COlleagues Meeting to Promote And Sustain Satisfaction). Each intervention session consisted of a brief 15-minute group discussion of an assigned topic relevant to the physician experience and drawn from prior physician well-being literature, followed by 45 minutes for a shared lunch or other group activity as determined by each group itself. Each participant received $20 per session for meal expenses. Quarterly surveys included linear analog self-assessment of overall quality of life (QOL), the Maslach Burnout Inventory, the Empowerment at Work Scale assessing meaning from work, the Social Isolation PROMIS instrument and the Physician Job Satisfaction Scale. The trial groups were compared using generalized estimating equations for repeated measures.

**Findings/results**
Sixty-four and 61 participants were randomized to the intervention and control arms of the study, respectively. At baseline, no statistically significant differences were observed between the study groups for any well-being variable. The intervention group had statistically significantly improved QOL (0.52 points on 0–10 scale), meaning from work (+7.9 percent), and job satisfaction (+7.9 percent), with reduced depersonalization (-6.8 percent) and social isolation (-0.53 points on 1–5 scale). Preliminary data also suggest sustained benefits up to six months after the end of the study intervention period for each outcome.

**Conclusions/discussion**
These results suggest that a relatively non-intensive intervention involving self-selected physician small group meetings can be effective in promoting physician well-being, meaning from work and job satisfaction.
A systematic review of mental health well-being programs for medical students and physicians

Corresponding author
M. P. Forbes, MBBS (MD equivalent)
Royal Melbourne Hospital, University of Melbourne
malcolmpforbes@gmail.com

Learning objectives
1. Appreciate the evidence available for medical student and physician mental health and well-being programs internationally
2. Understand what components are included in effective mental health and well-being programs, to assist in implementation on a local level
3. Understand what tools can be utilized to evaluate mental health and well-being programs implemented on a local level

Context/background
While there are many universities and health services implementing resilience and well-being programs for their medical students/physicians, there has been no systematic evaluation of the programs in existence. This review examines what programs exist and provides some recommendations on effective approaches.

Methods/approach
A search of electronic databases (PubMed, Scopus, PsycINFO and CINAHL) was performed up to September 2015. Criteria for inclusion were that the program was delivered to medical students or doctors, the program's impact upon mental health was evaluated, and a comparison group was included. Further studies were identified through citation searches. Using a data extraction tool developed for this study, key components of the education delivered in each program were identified and documented. A narrative synthesis was performed.

Findings/results
Fourteen studies were included in the review. A diverse range of programs was identified, including individual sessions, group discussions, meditation or breathing techniques, didactic material and homework assignments. Program delivery time varied from one day to nine months. Long-term follow-up was defined as at least six months follow-up and was reported in seven studies. Thirty-seven outcome measures were used across the 14 studies. Statistically significant improvement in at least one outcome measure was documented in 14 studies.

Conclusions/discussion
While many mental health and well-being programs have been implemented internationally, the current evidence demonstrating their effectiveness is limited. Although the majority of the interventions identified in this review showed some benefit, the majority of programs did not have a robust evaluation framework. This study has identified key factors that researchers may wish to consider when designing their program and evaluation. Further research is needed to ensure the development of evidence-based strategies that will effectively improve medical student and doctors' health.
A time banking system to support workplace flexibility

Corresponding author
Magali A. Fassiotto, PhD
Stanford University School of Medicine
magali.fassiotto@stanford.edu

Co-author
Yvonne A. Maldonado, MD

Learning objectives
1. Understand the characteristics of an intervention to reduce work-life conflict among medical faculty
2. Develop strategies to acknowledge employees’ previously unrecognized institutional service activities
3. Engage medical teams to think about work-life flexibility as a team, rather than individually

Context/background
U.S. physicians experience greater burnout and dissatisfaction with work-life balance than other U.S. working adults.1 In academic medicine, physician shortages, an aging workforce and persistent gender gaps in senior roles, have led to calls to adapt workforce practices.2,3 While employers today often embrace flex policies, policies are underused and their presence alone insufficiently addresses ongoing work-life needs of medical faculty. To circumvent flexibility policies deemed at odds with the culture of academic medicine, faculty informally trade favors; however, the absence of formal mechanisms recognizing this trading leads to discomfort in asking for favors in return, compounding work-life challenges. In response, Stanford Medicine developed the Academic Biomedical Career Customization (ABCC) pilot program, including a banking system to recognize behaviors supporting workplace flexibility.

Methods/approach
The time-banking intervention measures unacknowledged teaching, service and clinical activities, and acknowledges them with practical rewards. The general framework requires that participating teams identify tasks that: (1) are uncompensated or not adequately recognized and/or (2) benefit other team members’ flexibility. Examples of credit-earning tasks include: filling a colleague’s clinical service on short notice, mentoring students/trainees, and institutional/national committee service. Credits are redeemed for support services meant to benefit career and personal goals by alleviating time pressure and promoting career success: at home (e.g., housecleaning, laundry, meal delivery) or work (e.g., grant-writing, lab management, PowerPoint design).

Findings/results
Five teams (N=60) participated in ABCC from 2013–2014: 57 percent women (N=34); 75 percent clinical faculty (N=45). Pre- and post-surveys captured multiple dimensions of program impact across six scales: perception of control over time/resources (α=.85); support for a culture of flexibility (α=.85); support from colleagues (α=.82); wellness (α=.86); understanding professional development opportunities (α=.80); and institutional/job satisfaction (α=.88). Four scales showed increases in satisfaction in post-surveys: support for a culture of flexibility (P=.020); wellness (P=.013); understanding professional development opportunities (P=.036); and institutional/job satisfaction (P=.020).

Conclusions/discussion
The ABCC pilot time-banking system addresses work-life challenges in medical school faculty leading to reported benefits to physician health and job satisfaction. Banking credits reduced guilt associated with asking others for help and encouraged biomedical faculty team members to take on shared responsibilities when able or reduce workload when needed, thus increasing flexibility across teams. Making flexibility central to team processes allows for recognition around the type and amount of extracurricular service work performed. At relatively low department cost, recognition can, in turn, increase job satisfaction, wellness and perceptions of work-life flexibility.

A virtual approach to the practice of mindful medicine

**Corresponding author**
Betty Lin, MD
The Permanente Medical Group
Betty.Lin@kp.org

**Co-authors**
Elio Gizzi, MD

**Learning objectives**
1. Identify the benefits of a virtual course offering for physicians
2. Being able to compare virtual vs. in-person offering of mindfulness course offering
3. Identify the practical aspects of course development and implantation

**Context/background**
Studies indicate that dissatisfaction, stress and compassion fatigue among physicians are all on the rise, and that over 50 percent of physicians have at least one symptom of burnout. Fortunately, other studies show that mindfulness can help offset these symptoms and lead to improved personal wellness and professional satisfaction. A mindful physician is fulfilled, present, focused and resilient—which leads to better physician health and wellness, fewer medical errors, and increased satisfaction for the provider and the patient. We believed we had an opportunity—and a responsibility—to offer physicians a program that would help them learn the practice of mindfulness. What was unclear in the beginning was whether physicians would invest in their own wellness, or be interested in taking a virtual mindfulness class as opposed to a traditional in-person class.

**Methods/approach**
In April and July 2014, a virtual 12-week mindfulness pilot program was offered to physicians in our medical group. A total of 145 physicians (105 females, 40 males) representing 27 specialties completed the course. Surveys about various aspects of personal and professional wellness were collected—before the program, immediately following the program, and three and 12 months after—to measure the course's impact. The surveys included the Perceived Stress Scale (PSS), the Pittsburgh Sleep Quality Index (PSQI) and the Work Limitations Questionnaire (WLQ).

**Findings/results**
A total of 101 physicians completed the survey 12 months after attending the course. All key measures indicated statistically significant results. Scores on the PSS decreased 6.5 points. The PSQI results indicated an 18.9 percent increase in overall sleep quality. The WLQ scores indicated that physicians gained an average of 47 minutes per week from increased productivity.

**Conclusions/discussion**
The virtual mindfulness class increased accessibility and participation, and delivered strong results for physicians from a broad variety of specialties. Those who completed the survey one year after participating reported significant improvements in several measures of wellness. As a result of this initial success, we have expanded our mindfulness program and are offering it to all of our physicians.
Addressing house-staff physician professional fulfillment and burnout

Corresponding author
Mickey Trockel, MD, PhD
Stanford University
trockel@stanford.edu

Co-authors
Stewart Babbott, MD
Bardia Behravesh, MD
Greg Unruh, MD
Brad Poss, MD
Ellen Morrow, MD
Brian Flahery, MD
Mark Linzer, MD
Rosemary Quirk, MD
Caroline Okorie, MD
Sumit Bhargava, MD

Learning objectives
1. Factors correlated with house-staff physician fulfillment and burnout
2. Identify promising strategies for promotion of fulfillment and prevention of burnout
3. Examine the importance of addressing sleep in order to achieve house-staff wellness goals

Context/background
Aims of this study are to (1) compare professional fulfillment (i.e., happiness, satisfaction, worthwhileness and self-efficacy) and burnout at four training programs, (2) identify determinants of professional fulfillment and burnout, and (3) examine changes in professional fulfillment and burnout.

Methods/approach
A longitudinal house-staff physician (residents and fellows) wellness survey was administered at four training programs. The survey measured professional fulfillment ($\alpha=0.91$), burnout ($\alpha=0.93$), perceived appreciation ($\alpha=0.88$), peer support ($\alpha=0.92$), and sleep-related impairment (a PROMIS measure; $\alpha=0.92$). Responses to these measures and answers to open-ended questions guided development of interventions. Interventions such as newsletters to express gratitude, jeopardy coverage, workout facilities, emotional support and tapered transitions to stressful responsibilities were implemented. Year one follow-up data is available from two sites.

Findings/results
From the four programs, 912 house-staff completed the survey (response rates 52–70 percent). Rates of high fulfillment by program ranged from 7 percent to 18 percent. Percent with burnout ranged from 28 percent to 65 percent. Training program accounted for only 3 percent of variance in professional fulfillment and 5 percent of variance in burnout scale scores. Perceived appreciation, peer support and sleep-related impairment accounted for an incremental 53 percent of variance in fulfillment and 50 percent of variance in burnout scale scores. Perceived appreciation, peer support and sleep-related impairment accounted for the majority of program differences in fulfillment and burnout. High perceived appreciation was the most significant regression model predictor of high professional fulfillment ($OR=11.6, 95\% CI=7.4–18.2; p < 0.001$) and sleep-related impairment was the most significant predictor of burnout ($OR=9.9, 95\% CI=7.1–13.6; p <0.001$).

Conclusions/discussion
A house-staff wellness survey is feasible, with high responses rates and results guiding intervention strategies. Training program explained little of the variability in continuous scale scores. House-staff training programs may use this instrument, and may improve fulfillment and burnout by showing appreciation for hard work and minimizing sleep-related impairment.
Aha! ... hahaha: Attending physicians use humor on medical teaching units

Corresponding author
Jane B. Lemaire, MD
University of Calgary
lemaire@ucalgary.ca

Co-authors
Kristen Desjarlais-deKlerk, PhD
Alicia Polachek, MA

Learning objectives
1. Identify how attending physicians use humor in their role
2. Describe how other stakeholders view attending physicians’ use of humor
3. Recognize how humor may impact the work environment

Context/background
The use of humor is recognized as an important coping strategy for physicians. This presentation explores attending physicians’ use of humor during their work within multidisciplinary teams on inpatient medical teaching units.

Methods/approach
We utilize data from 93 hours of ethnographic observations with attending ward physicians and 73 semi-structured interviews with patients, learners and multidisciplinary team members. Observation and interview data were analyzed separately using inductive thematic analysis. Thematic content pertaining to humor was extracted for further analyses.

Findings/results
Attending physicians were frequently observed using humor. They shared jokes with learners, patients, and team members and were often the brunt of good-natured jokes. These tactics appeared to ease tensions amongst team members. Attending physicians appeared to use light-hearted humor to diffuse patient fears. They appeared to step outside difficult situations and note the irony, thereby finding humor even in trying circumstances. These themes emerging from the observational data were supported by the interview data. Attending physicians described humor as a way to offset stressful work situations and buffer clinical work demands. Attending physicians and allied health care providers described humor as promoting productivity, communication and teamwork, as well as contributing to mastery of the attending physician role. Residents expressed that humorous attending physicians who appear to manage their stress well can positively affect the learning environment. Attending physicians noted that work context factors such as having a strong team influenced their ability and likelihood to use humor. Additionally, they reported that stressful work situations reduced their good humor at home.

Conclusions/discussion
Humor may be an important strategy that attending physicians deliberately and successfully use to help support emotional wellness in themselves, their learners, their team and their patients. Furthermore, their use of humor both in the workplace and at home after work may be influenced by the work context.
An innovative program to address barriers to healthful eating in anesthesia residents

Corresponding author
Sandra H. Sacks, MD, MEd
Department of Anesthesiology, Pain and Perioperative Medicine
Stanford University School of Medicine
shsu85@stanford.edu

Co-author
Natalya Hasan-Hill, MD

Learning objectives
1. Recognize the relationship and explain the importance between improved nutrition, physician wellness and patient care
2. List the common challenges that residents face toward optimizing nutrition
3. Discuss possible solutions toward addressing healthful eating habits in residents and increasing overall resident wellness

Context/background
Anesthesiology training is enriching and rewarding but can also be highly demanding and stressful. Increasing rates of mental and physical disorders in residents, including burnout, depression, anxiety and sleep disorders, can result in a decreased sense of professional satisfaction and affect the quality of patient care. Improving physician well-being through programs targeted at their unique obstacles may benefit not only physicians, but also patients and the overall performance of health care systems. While improved workplace nutrition has shown to improve physician cognition, the long hours of residency training can create barriers toward optimizing self-care. Residents attribute poor dietary habits to limited time to plan and prepare healthy meals, short break times that often occur when the cafeteria is closed, financial constraints or a general lack of knowledge about how to prepare and eat well-balanced meals.

Methods/approach
Funding was achieved by a scholarship program offered to promote trainee wellness. The funding has primarily been used to supply healthy snack options in a resident-specific common space. A resource binder containing routinely updated nutritional tips, local farm share resources and healthy easy-to-make recipes was created and shared with residents. In addition, a hands-on cooking workshop was organized for residents where they learned to cook delicious meals from simple ingredients in their pantry.

Conclusions/discussion
The project is resident-centric with multiple survey assessments and modifications throughout the year in order to better serve trainees. Residents have completed surveys periodically on their physical and psychological well-being as well as their overall health and nutrition habits. The surveys have yielded extremely positive overall results; however, time continues to be the main obstacle for trainees pursuing healthful eating behaviors. Residency programs should focus on providing healthful food options in the hospital, as well as educational programming that provides inspiration and solutions to residents' unique time constraints when away from the hospital.
Anatomy of the day: A time-motion study reveals the allocation of physician resources

Corresponding author
Christine Sinsky, MD
American Medical Association
christine.sinsky@ama-assn.org

Co-authors
Lacey Colligan, MD
Ling Li, PhD
Mirela Prgomet, PhD
Sam Reynolds, MBA
Lindsey Goeders, MBA
Johanna Westbrook, PhD
Michael Tutty, PhD
George Blike, MD

Learning objectives
At the conclusion of this research presentation:

1. Participants will learn how much time is allocated to direct clinical patient care compared to administrative tasks and after-hours work.
2. Participants will learn how task distribution in an ambulatory care physician’s typical day can contribute to dissatisfaction or detract from satisfactory patient care.
3. Participants will have a better understanding of the need for further study to identify links between variations in use of physician resources and clinical, financial and professional satisfaction outcomes.

Context/background
Little is known about how physician time is allocated in ambulatory care.

Objective
To describe how physician time is spent in ambulatory practice.

Methods/approach
Quantitative direct observational time and motion study (during office hours) and self-reported diary (after hours).

Setting

Participants
A total of 57 U.S. physicians in family medicine, internal medicine, cardiology and orthopedics who were observed for 430 hours; 21 of these physicians also completed after-hours diaries.

Measurements
Proportions of time spent on four activities [direct clinical face time, electronic health record (EHR) and desk work, administrative tasks and other tasks]; self-reported after-hours work.

Findings/results
During the office day, physicians spent 27 percent of their total time on direct clinical face time with patients and 49.2 percent of their time on EHR and desk work. While in the examination room with patients, physicians spent 52.9 percent of the time on direct clinical face time and 37 percent on EHR and desk work. The 21 physicians who completed after-hours diaries reported one to two hours of after-hours work each night, devoted mostly to EHR tasks.

Conclusion/discussion
Our study quantifies the allocation of physician resources during office hours via direct observation and after office hours via diaries. During office hours, physicians in our sample spent nearly half their time on EHR and desk-work activities and less than one-third on direct clinical face time with patients; in other words, for every hour of direct clinical face time with patients, physicians spent almost two hours on EHR and desk work. In addition, for physicians who completed after-hours diaries, EHR and desk work regularly extended one to two hours beyond office hours into personal time. For every hour physicians provide direct clinical face time to patients, nearly two additional hours is spent on EHR and desk work within the clinic day. Outside office hours, physicians spend another one to two hours of personal time each night doing additional computer and other clerical work.
Association between professional burnout and work identity: Results from a national survey of physicians

Corresponding author
Andrew J. Jager, MA
American Medical Association
andrew.jager@ama-assn.org

Co-authors
Michael A. Tutt, PhD
Audrey C. Kao, MD, PhD

Learning objectives
1. Understand how work identity (WI) was measured and how a WI score was generated.
2. Understand how physician characteristics such as medical specialty were associated with WI score.
3. Understand how professional burnout was associated with WI score.

Context/background
Work is an important source of self-identity, and physicians have traditionally seen their work as more a calling than a job. In this study we examined the relationship between professional burnout and physicians' work identity.

Methods/approach
We conducted a mail-based survey of 3,589 practicing physicians from all specialties, randomly selected from the AMA Masterfile. Physicians' work identity (WI) was assessed using a validated eight-item measure where a higher score (range 0–8) represents greater identification with medicine as a calling, while a lower score represents greater identification with medicine as a job. Burnout was assessed using a validated single-item measure. Differences in WI scores were assessed using the t-test. Associations between physician characteristics, professional burnout and WI score were evaluated using multivariable linear regression.

Findings/results
A total of 2,263 physicians completed surveys (63 percent response rate). The mean WI score was 5.1(SD=2.2). Physicians with no burnout symptoms had a mean WI score of 6.7, compared to 3.8 for those reporting ≥1 symptom (P<.001) and 2.7 for those who reported being “completely burned out” (P<.001). Compared to pediatricians (5.5), lower WI scores were found among physicians in emergency medicine (4.6), family medicine (4.8) and internal medicine (4.9). After including burnout in a multiple regression model, all associations between medical specialty and WI became non-significant (P>.01), but there was a significant association between burnout and WI score. Compared with physicians with no burnout symptoms, those who experienced ≥1 symptom (β=-2.88; 99% CI -3.22 - -2.55; P<.001) or felt “completely burned out” (β=-3.98; 99% CI -4.72 - -3.24; P<.001) had significantly lower WI scores.

Conclusions/discussion
Physicians who experience burnout are less likely to identify with medicine as a calling. Erosion of medicine as a calling may have adverse consequences for physicians as well as those for whom they care.
Attitudes and experiences of early and mid-career pediatricians on division of household responsibilities and strategies to achieve work-life balance

Corresponding author
Amy J. Starmer, MD, MPH
Boston Children's Hospital Harvard Medical School
Amy.Starmer@childrens.harvard.edu

Co-authors
Mary Pat Frintner, MSPH
Kenneth Matos, PhD
Bobbi J Byrne, MD

Learning objectives
1. Describe current patterns of division of household responsibilities according to gender and age
2. Discuss challenges related to the achievement of a balance between work and personal responsibilities for early and mid-career pediatricians
3. Identify multiple strategies to achieve a higher level of work-life balance and career/life satisfaction

Context/background
Physician careers involve multiple professional commitments that must also be balanced with responsibilities at home. Data describing factors associated with work-life balance (WLB) for physicians are limited. We explored: (1) experiences of pediatricians with household responsibilities and WLB; (2) divisions of household work by gender and age, and; (3) themes associated with strategies and challenges in achieving WLB.

Methods/approach
We used national data from two cohorts of pediatricians (graduated residency between 2002–2004 or 2009–2011) participating in the “AAP Pediatrician Life and Career Experience Study” (PLACES), an ongoing longitudinal project of early career pediatricians. Chi-square tests compared experiences by gender and cohort. Comments from two open-ended questions on WLB challenges and strategies were reviewed for common themes.

Findings/results
Seventy-four percent of PLACES participants completed the survey (1328/1803). Women were more likely than men to identify as having primary responsibility for 13 of 16 assessed household responsibilities, such as cleaning, cooking, routine care of children and getting children ready for bed (all p<0.001). Men were more likely to identify as having primary responsibility for outdoor work, household/car repairs and budget management (all p<0.001). Women were less likely to be satisfied with their share of responsibilities relative to others in the home (54 percent vs. 64 percent, p<0.01) and on average, spent fewer hours per week in leisure activities (8.4 vs. 10.3 hours, p < 0.001). Open-ended comments (n=1137) revealed challenges with WLB. Strategies to achieve WLB included reducing work hours, outsourcing household work and utilizing online family calendars. Many expressed interest in hearing tips from those in similar situations.

Conclusions/discussion
Pediatricians who are women spend more time on household responsibilities and less time in leisure activities than men. This discrepancy is especially important in medicine where struggles with WLB and burnout are common and percentages of women entering medicine have increased.
Canadian national medical student health and well-being survey

Corresponding author
Brandon E. Maser, MD
Department of Paediatrics, University of Toronto, The Hospital for Sick Children
bmaser@qmed.ca

Co-authors
Erica Frank, MD, MPH
Marlon Danilewitz, MD
Eva Guerin, PhD
Marie-Pier Bastrash

Learning objectives
1. Become familiar with the current baseline statistics of the mental health of Canadian medical students
2. Recognize some of the risk and protective factors contributing to Canadian medical student mental health and illness
3. Better understand the association between professional burnout and Canadian medical student health and well-being

Context/background
The path to becoming a physician presents medical learners and professionals with a constellation of stressors, culminating in high rates of burnout and psychological morbidity. Burnout rates in medical students, residents and physicians are significantly elevated in comparison to the general population and have been shown to increase with years of study. Increased levels of distress have been linked to other negative outcomes, including poor academic performance, increased dropout rates from medical school, suicidal ideation and substance abuse. While there is a strong body of literature to support the aforementioned findings among U.S. and other international medical students, there is a paucity of literature on the status of Canadian medical student health and well-being.

Methods/approach
An electronic survey was sent to all current Canadian medical students at all 17 Canadian medical schools (a population of 11,617 students). Participation was voluntary, and all responses were anonymous. Individual survey items were taken verbatim, where possible, from previously validated instruments, including the Canadian Community Health Survey Mental Health Questionnaire (Stats Canada, 2011); the Maslach Burnout Inventory 2-item; the Canadian Physician Health Survey (Canadian Medical Association, 2007); among others.

Conclusion/discussion
These results are the first of their kind showing national data on the prevalence of mood disorders, anxiety disorders, burnout and suicidal ideation in Canadian medical students. Preliminary results show that Canadian medical students have higher rates of self-reported anxiety disorders, mood disorders and suicidal ideation compared to their age and education-matched peers. Prevalence of mood disorders, anxiety disorders and burnout varied significantly between genders and years of study. Female medical students showed higher rates of mood and anxiety disorders compared to males. Prevalence of mood and anxiety disorders, burnout and suicidal ideation increased for students in higher years of study (years three and four).
Clinical anxiety ... or just anxious but well. Self-report scales vs. clinical interviews: Do we over pathologise?

Corresponding author
Deborah A. Cohen, OBE, MD
Cardiff University School of Medicine
cohenda@cardiff.ac.uk

Co-authors
Naomi Marfell
Liz Forty

Learning objectives
At the conclusion of this presentation, participants will be able to:
1. Understand how “caseness” as determined by self-report scales for common mental ill health may be dependent on the population being screened
2. Recognize the importance of choosing appropriate methods to assess prevalence of common mental ill health in medical students
3. Identify effective methods to assess well-being and sustain mental well-being in medical students

Context/background
Students are said to become “anxiety driven.” Research suggests medical students often display neurotic perfectionist tendencies. This may influence levels of self-reported and perceived anxiety, but may not necessarily indicate a clinical disorder. Labelling students as “ill” when they may be anxious but clinically well can be detrimental to their well-being. Many studies are based on self-report scales. Clinical interviews can provide more accurate assessment of mental state. This study investigated the suitability of the self-report Hospital Anxiety and Depression Scale (HADS) as a screening tool for medical students and specifically explored optimum cut-off points by making comparison to clinical interview data.

Methods/approach
Comparison of HADS to a structured clinical interview (SCAN) using ICD-10 diagnostic criteria. Students across all year groups with and without mental illness in one medical school were recruited to complete HADS and undertake a SCAN interview in one session. The HADS depression (D) and anxiety (A) subscales were recorded and compared to clinical interview findings. “Caseness” is reported as a HADS score of 8 for both subscales.

Findings/results
Fifty students completed the study. Data suggests revised subscale cut-offs ≥7 for HADS (D) and ≥12 for HADS (A) would give optimal sensitivity and specificity. Patterns in responses to specific items in the HADS scales will be presented to highlight areas where improved support might be targeted.

Conclusions/discussion
Revised anxiety and depression subscale cut-off scores for HADS may be appropriate for medical students and provide a more effective screening tool. Supporting students appropriately in managing emotion and understanding how personal anxiety levels impact on performance is important. Early identification and support also enables students to feel more fulfilled and competent learners. Larger studies are now required to validate these findings so students can be supported to thrive not dive in the training environment.
Development, implementation and outcomes of an interactive model of physician wellness self-assessment

Corresponding author
Dan Cojocaru
University of British Columbia
dancojo4@gmail.com

Co-authors
Erik Skarsgard, MD, MSc
Caron Strahlendorf, MB, BCh
Frederick K. Kozak, MD
Penny Sneddon, PhD
Damian Duffy
Theresa Newlove, PhD, R.Psych.

Learning objectives
1. Develop a working knowledge and framework for implementation of an interactive wellness survey.
2. Describe physician wellness in the context of burnout, resilience and coping strategies in a pediatric quaternary care center compared to national benchmarks.
3. Appreciate the challenges and opportunities of developing wellness initiatives for physicians.

Context/background
Physician burnout and reluctance to seek help are risk factors for compromised personal wellness, delivering quality patient care and poor organizational performance indicators. Physicians at BC Children's Hospital (BCCH) are exposed to organizational risk factors for burnout including increased clinical complexity and demand for patient care, the construction of a new hospital and the implementation of an electronic health record. This self-assessment aimed to generate: (1) immediate individual and peer comparison feedback; (2) access to wellness resources; (3) input towards implementation of wellness initiatives; and (4) a current organizational profile of physician well-being.

Methods/Approach
The Maslach Burnout Inventory (MBI) and the Connor-Davidson Resilience Scale (CD-RISC 25) were administered through a confidential, interactive electronic survey to all medical residents, fellows and active staff at BCCH.

Findings/results
One hundred and thirty physicians participated in the survey (response rate = 39 percent), of which 82 (63 percent) were female. Of the three factors that contribute to burnout, 30 percent reported high levels of emotional exhaustion, while high depersonalization and low personal accomplishment was reported in 20 percent and 21 percent of respondents, respectively. There were no significant differences in burnout among demographic groups. Half of surveyed participants were aware of the provincial physician support program, and 15 percent had used its services.

Conclusions
Physician wellness was directly addressed serving to increase awareness of both burnout and resiliency factors that impact physician's health and patient care. Our response rate, combined with 90 percent of respondents indicating they would be willing to complete a follow up survey, suggest that this online, interactive mode of physician self-assessment may be an ongoing strategy for organizations seeking to support their medical staff. We are developing a stepped action plan to support a shift in culture of physician wellness through awareness of current resources, professional education and training, implementation of requested initiatives, and annual wellness check-ups.
Health care perceptions on burnout

Corresponding author
Ilinca D. Lupea MSc, MD
Henry Ford Health System
ilupea1@hfhs.org

Co-authors
Jessica Love
David Richardson, MD
Lemon Dawn, JD

Learning objectives
1. Review and analyze the perceptions of burnout in medicine by self-identified medical personnel in popular media
2. What is emotional intelligence?
3. Discussion of feasible solutions for burnout in medicine, open the dialogue

Context/background
Burnout in medicine has recently been at the forefront of media discussions as attention is brought to mental health and suicide rates among those working in the medical field. Our objective was to evaluate how health care providers respond to these dialogues and the proposed solutions regarding physician burnout in hopes of obtaining a better understanding on how to address burnout and increase joy in medicine.

Methods/approach
A review of articles on burnout and depression in popular media (NY Times, Washington Post, Globe and Mail, Wall Street Journal and Medscape) in the last four years was conducted. A total of 11 articles were selected using two searches: “physician burnout” and “physician depression.” Comments from self-identified health care providers were included in the analysis. Three individuals read the selected comments separately and, after a group discussion, a list of thematic codes was constructed. The comments were coded once individually and a second time as a group.

Findings/results
A total of 1,413 comments from 11 articles were evaluated and 662 were identified as health care providers. Ten themes were identified. The most prevalent theme was found to be blaming: system 49.6 percent, patients 8.2 percent, other health care providers 8.5 percent and self 7.3 percent. The second most predominant theme was “Medical Culture/Emotional Idiocracy.” The themes of “emotional intelligence” or “self care” were found in 3.7 percent and 8.2 percent, respectively. Also, there was a significantly higher word count in the articles themselves devoted to description of the problem versus possible solutions (9514 - 79% vs 2537 - 21%, p< 0.01).

Conclusions/discussion
The focus of health care provider comments suggests a victim mentality of blame. Rather than continuing to describe the problem, health care providers need to start shifting the focus on providing feasible solutions to ameliorate burnout (i.e., learning strategies for emotional intelligence and better self care).
Integrating personal and clinical health promotion in undergraduate medical education curricula

**Corresponding author**
Erica Frank, MD, MPH
University of British Columbia
erica.frank@ubc.ca

**Co-authors**
Jennifer L. Trilk, PhD
Edward M. Phillips, MD
Rani Polak, MD, MBA

**Learning objectives**
1. Understand the importance of incorporation of personal and clinical lifestyle medicine into undergraduate medical education
2. Learn about the goals and methods of the Lifestyle Medicine Education (LMEd) Collaborative. Participants will be presented with the collaborative website’s first courses in substance use and in public health nutrition
3. Learn about ways in which course participants can use these courses for themselves and their trainees for personal and clinical health promotion, and discuss curricular strategies for promoting the highest aspiration for self-care: going beyond reducing burnout, and moving to actually encouraging joy

**Context/background**
By 2020, WHO predicts that two-thirds of disease worldwide will be the result of poor lifestyle choices. Yet <50 percent of U.S. primary care physicians routinely counsel on nutrition, physical activity or weight control, and few medical students are taught about the demonstrated link between their personal health practices and their patients’ health.

**Methods/approach**
In September 2013 the LMed Collaborative was founded to provide lifestyle medicine (LM) curricula for medical students, physicians and their patients. In 2015 our website lifestylemedicineeducation.org was launched. In 2016 this site is beginning to provide a portal to LM trainings through partner websites including AAMC.org, ACPM.org, ACSM.org, the Institute of Lifestyle Medicine at Harvard Medical School, NextGenU.org, and the University of South Carolina, School of Medicine Greenville.

**Findings/results**
A strategic plan was created through three Macy and Ardmore Foundation-sponsored summits. Principle areas of initial curricular subjects are physical activity, nutrition, medical students’ self-care and behavioral change. We will demonstrate our LM courses, and suggest ways in which participants can use these courses for themselves and their trainees for personal and clinical health promotion. Implementation strategies are currently being acted on, and were determined to be: (1) support deans and key faculty; (2) create federal and state policy commitments; (3) use assessment as a driver of change; (4) provide high-quality evidence-based curricular material on an easily-navigated website; and (5) engage and support student interest.

**Conclusions/discussion**
This innovative, technology-dependent educational initiative is expected to have important physician health and public health implications, by efficiently and effectively promoting the prevention and treatment of non-communicable chronic disease, and a state of well-being, with a scalable and sustainable model to educate physicians in training and practice.
Interventions to reduce physician burnout: A systematic review and meta-analysis

Corresponding author
Colin P. West, MD, PhD
Mayo Clinic
west.colin@mayo.edu

Co-authors
Lotte N. Dyrbye, MD, MHPE
Patricia J. Erwin, MLS
Tait D. Shanafelt, MD

Learning objectives
1. Summarize existing literature on interventions to reduce physician burnout
2. Distinguish between individual-focused and structural/organizational strategies
3. Identify gaps in knowledge of interventions to address physician burnout

Context/background
Physician burnout has reached epidemic levels as documented in national studies of both physicians-in-training and practicing physicians. Consequences include negative effects on patient care, professionalism, physicians’ own care and safety and the viability of health care systems. A more complete understanding of the quality and outcomes of the literature on approaches to prevent and reduce burnout is necessary.

Methods/approach
We conducted a systematic review and meta-analysis to examine the literature to date on interventions to address physician burnout. We searched multiple databases from inception through Jan. 15, 2016. Outcomes included changes in rates of overall burnout, high emotional exhaustion and high depersonalization, as well as changes in emotional exhaustion and depersonalization scores.

Findings/results
We identified 2,617 articles, of which 15 randomized trials and 37 cohort studies met inclusion criteria. The most common interventions were mindfulness and stress management-focused efforts, communication training, small group discussions, local practice modifications and duty-hour changes. For overall burnout, high emotional exhaustion and high depersonalization, respectively, the summary mean differences in absolute rates were reductions of 10 percent (95% CI 5%–14%, p<0·0001, I²=15%, 14 studies), 14 percent (95% CI 11%–18%, p<0·0001, I²=0%, 21 studies), and 4 percent (95% CI 0%–8%, p=0·04, I²=0%, 16 studies). The summary reductions in emotional exhaustion and depersonalization score, respectively, were 2·7 points (95% CI 1·8–3·7, p<0·0001, I²=79%, 40 studies) and 0·7 points (95% CI 0·2–1·2, p=0·003, I²=56%, 36 studies).

Conclusions/discussion
Current literature indicates that both individual-focused and structural or organizational strategies can result in clinically meaningful reductions in burnout among physicians. Further research is needed to determine which interventions may be most effective in specific populations, as well as how individual and organizational solutions may be combined to deliver even greater improvements in physician well-being.
Mindful medical practice: Can modified mindfulness education improve student resiliency, coping and stress management?

Corresponding author
Tatiana M. Rac, MD, MPH, BSc
University of British Columbia
t.rac@alumni.ubc.ca

Co-authors
Anita Chakravarti, MD
Marilyn D.A. Baetz, MD
Marcel F. D’Eon, PhD, MEd
Lloyd D. Balbuena, PhD

Learning objectives
1. Identify relevant research linking mindfulness and physician wellness including resilience, compassion, burnout, quality of care
2. Discuss the benefits of mindful medical practice sessions over a short time period
3. Describe the challenges in implementing and participating in the sessions

Context/background
The evidence-based program Mindfulness Based Stress Reduction (MBSR) is an effective way to help medical students cope in medical school. However, students find it challenging to take the eight-week MBSR (two-hour class/week, daily homework, full-day seminar). We wanted to know if Mindful Medical Practice (MMP), a modified drop-in style six-hour program that has been operating at the U of S since 2012, improved student resiliency and coping and reduced stress.

Methods/approach
In two consecutive years, MMP was delivered to randomly selected volunteer medical students (N=200). MMP consists of six, one-hour sessions with activities such as body scan, mindful breathing, awareness of thoughts, emotions and sensations.

Findings/results
Using qualitative and quantitative methods, we found that those who participated in the MMP drop-in program improved their positive coping skills, reduced their negative coping, reduced their perceived stress levels, improved their resilience and were more likely to be interested in the full MBSR course compared to those who expressed an interest in participating but could not due to an enrollment limit. Those who had not expressed an interest (and subsequently did not participate) reported lower stress and better coping and resilience.

Conclusions/discussion
Since MMP was shown to improve outcomes, we understand the importance of this program being available for all students as an elective within the medical curriculum. These findings reveal a high demand and satisfaction level for the program. Current research reflects the need to consider mindfulness within the physician health curriculum as an opportunity to enhance medical student success, satisfaction and sustainability. Self-care during medical training for both students and residents deserves further study and development.
Opportunities to increase the joy in medicine for LGBT health care professionals

Corresponding author
Carl G. Streed Jr., MD
Brigham & Women's Hospital, Department of Medicine, Division of General Internal Medicine & Primary Care
cjstreed@gmail.com

Co-author
Mickey Eliason, PhD

Learning objectives
1. Identify key barriers to healthy and supportive work environments for LGBT health care professionals
2. Identify opportunities for creating institutional support for LGBT colleagues
3. Advocate for systemic change to support LGBT colleagues

Context/background
Much has been written about the challenges of adopting a minority sexual or gender identity, from the stresses of disclosing to parents and family, to dealing with bullying in schools, and to coming out in the workplace. One area that has been neglected to date is how individuals deal with the stress of being lesbian, gay, bisexual or transgender as a health care professional. This pilot study was the first to study stress and resilience among lesbian, gay, bisexual and transgender (LGBT) health care professionals who must learn and work in environments that are often unfriendly or ignorant about LGBT issues.

Methods/approach
An online survey was distributed among professional networks of LGBT health care professionals.

Findings/results
Among 277 health care providers from diverse disciplines, fewer negative events are occurring in the workplace than previous reported. However, most settings still lack any training on LGBT issues and their nondiscrimination policies do not include gender identity. Approximately one-quarter of respondents had low levels of resilience; they reported more stress, greater frequency of consequences of stress on mental health, physical health, job satisfaction and burnout. However, their work environments were similar to resilient respondents in terms of welcoming and inclusive policies. Despite similar overall levels of support to manage stress, low resilient respondents reported less support from coworkers and bosses/supervisors than resilient respondents.

Conclusions/discussion
Positive events, such as pro-LGBT comments and appropriate treatment of LGBT patients and families, were much more common than negative events. However, we found that there are still unacceptably high levels of discriminatory policies and workplace harassment and differential treatment that can adversely affect LGBT health care professionals. This study identifies opportunities for increasing the joy in medicine and well-being of LGBT health care providers, including support from supervisors, updating institutional policies to include sexual orientation and gender identity and providing support to attend LGBT organizations.
Physician wellness and happiness in the workplace

Corresponding author
Jodie G. Eckleberry-Hunt, PhD, ABPP
Beaumont Health System
jeckleberryhunt@att.net

Co-authors
Heather Kirkpatrick, PhD, ABPP, MSCP
Kanako Taku, PhD
Ronald Hunt, MD
Rashmi Vasappa, DO

Learning objectives
1. Define physician wellness
2. Describe work-related factors that contribute to physician happiness
3. Describe work-related factors that contribute to physician wellness and burnout

Context/background
The purpose of this study was to examine workplace factors related to physician wellness, happiness and burnout.

Methods/approach
A random sample of the American Academy of Family Physicians (n=449) completed questions about workload and health status; the Physician Wellness Inventory; the Maslach Burnout Inventory; the Subjective Happiness Scale; and the Patient Care Scale. Using a hierarchical regression analysis, we utilized the burnout and wellness sub-scales as predictor variables and physician happiness as the outcome. Next, we entered years in practice, hours worked per week, health/mental health status, ability to manage workload, and perceived support as predictor variables in a regression model with burnout and wellness subscales as outcome variables.

Findings/results
Career purpose, personal accomplishment and perception of workload manageability significantly had significant positive correlations with physician happiness. Distress had a significant negative correlation with physician happiness. Self-reported mental health status significantly predicted all of the wellness scales, the burnout scales, and quality of patient care. Ability to manage workload predicted career purpose, distress, emotional exhaustion and quality of patient care.

Conclusions/discussion
A sense of career meaning and accomplishment are important factors in determining physician happiness. It is not the number of hours a physician works but perceived ability to manage workload that is related to happiness. Physicians self-reported mental health status and ability to manage workload are important to understanding wellness and the quality of patient care. (Southern Journal of Medicine, April 2016).
Predictors of life satisfaction among Norwegian medical doctors: A 15-year longitudinal, nationwide study (NORDOC)

Corresponding author
Javed Iqbal Mahmood, MD
Department of Behavioral Sciences in Medicine, Institute of Basic Medical Sciences
j.i.mahmood@medisin.uio.no

Co-authors
Kjersti Steen Grotmol, PhD
Martin Tesli, MD, PhD
Torbjørn Moum, PhD
Reidar Tyssen, MD, PhD

Learning objectives
1. Identify the importance of longitudinal and representative studies in order to identify possible causative risks and beneficial factors
2. Recognize the advantage of using mixed method repeated measures statistics in order to increase statistical power
3. Recognize the role and importance of work-related factors in addition to individual and life-style related predictors of satisfaction with life in Norwegian medical doctors

Context/background
A previous study has shown lower life satisfaction among Norwegian doctors than in the general population. We lack long-term studies of predictors, and, in particular, the role of doctors' working conditions when controlled for other known predictors.

Methods/approach
Two nationwide cohorts of medical students (medical student cohort and young doctor cohort) who graduated six years apart (N=1052) from all four Norwegian universities were surveyed in their final year of medical school training (1993/94 and 1999) (T1), and four (T2), 10 (T3) and 15 (T4) years later. Life satisfaction was measured by three items at T2–T4, and the results were analyzed using mixed models repeated measures. Personality traits were measured at T1; whereas, other known individual and life-style predictors, in addition to several work-related factors, were measured repeatedly at T2–T4.

Findings/results
Ninety percent (947/1052) responded at least once, and 42 percent (450/1052) responded at all four time points. There was no significant change in life satisfaction levels from T2 to T4. Adjusted predictors of higher life satisfaction in the final model were: female gender (p=0.043), low neuroticism trait (p<0.001), low reality weakness trait (p=0.029), being married/cohabitant (p<0.001), perceived social support (p<0.001), physical activity (p<0.001), no use of alcohol to cope with tension (p<0.001), no hazardous drinking (p=0.003), few life events (p<0.001), low work-home stress (p<0.001), low perceived job demands (p<0.001), and high colleague support (p<0.001). The predictors that contributed most were being married/cohabitant, low levels of work-home stress and colleague support.

Conclusions/discussion
Female physicians reported higher life satisfaction than men. The most important predictors related to doctors' work were: work-home stress, colleague support and perceived job demands (interruptions, hurried and fussy at work place, etc.). The beneficial effects of social support, colleague support and life style factors such as working out and cautious drinking behaviors should also be emphasized.
Routinized assessment of physicians’ professional, personal and interpersonal outcomes at a physician health program

Corresponding author
Elizabeth Brooks, PhD
Colorado Physician Health Program and the University of Colorado – School of Public Health, Department of Community & Behavioral Health
elizabeth.brooks@ucdenver.edu

Co-author
Scott A. Humphreys, MD

Learning objectives
1. Describe the need and value of a physician-client exit survey
2. Describe the development process and components of a physician-client exit survey
3. Understand how to request an existing open-access physician-client exit survey

Context/background
The development of physician peer-assistance programs gained momentum in the early 1970s when the American Medical Association highlighted the need to help physicians struggling with substance use disorders, other mental illnesses and physical impairment. Despite the proliferation of programs internationally, we have relatively little published outcome data for physicians involved in these efforts, potentially undermining the promising work that such establishments realize. To address this deficit, the Colorado Physician Health Program (CPHP) recently developed a Client Exit Survey, which aims to collect nuanced information about client outcomes.

Methods/approach
A team of CPHP administrators, clinicians, researchers and staff carefully developed the exit survey over the course of a year. The planning team executed a series of steps to create the survey that included: (1) determining the purpose/intent of exit survey; (2) resolving administration and data collection issues; (3) establishing survey domains; (4) establishing domain categories; and (5) developing, testing, and finalizing survey questions and response options.

Findings/results
The final Client Exit Survey is a brief, 40-item tool that measures the program’s impact on clients’ professional, personal and interpersonal behavior, as well as client satisfaction. Satisfaction questions evaluate internal and external services and specific program practices. The survey is quick to complete and program costs are minimal.

Conclusions/discussion
The exit interview lends itself to prospective data collection and may be a valuable resource for other peer-assistance program interested in carrying out similar evaluation activities. The tool is freely available and assessable through the CPHP.
Strategies for putting the JOY back into practice after complaints

Corresponding author
Dawn K. Martin, MSW, RSW, MEd, PhD
University of Toronto, Ontario
Dawn.martin@utoronto.ca

Learning objectives
1. Label communication challenges commonly identified in a health care setting using the CanMEDS 2015 framework
2. Identify a list of strategies for addressing common problem areas that take the joy out of practice

Context/background
Receiving negative feedback about performance with patients, colleagues or the health care team can be disheartening, embarrassing and frustrating. These feelings can be further compounded when the feedback is unexpected and/or the skills for change are poor. This presentation will highlight lessons learned from over 10 years of coaching physicians who were identified as needing learning support by the College of Physicians and Surgeons, Canadian Medical Practice Association and/or hospitals.

Methods/approach
A document analysis of 100 cases where physicians had been identified as having “communication” problems was retrospectively examined for statistical trends across cases and where a theme analysis by type of problem was done. The Royal College of Physicians and Surgeons of Canada’s 2015 CanMEDS framework was used to identify the intrinsic roles most commonly identified as problem areas. CanMEDS 2015 is a competency framework that forms the basis for all Royal College educational standards. The emergent themes were used to further look for common educational needs and the learning strategies employed.

Findings/results
The intrinsic roles most frequently seen were collaborator, communicator, manager/leader and professional. Collaboration with others, communication with patients, practice management and professionalism lapses were the main areas of difficulty. Knowing personal triggers, strategies for running a patient-friendly office and implementing personal feedback loops were some of the strategies that were found helpful.

Conclusions/discussion
Unexpected negative feedback about competence and identity naturally throw us off balance and removes joy. Affirmation, skill training and making different choices helped physicians regain a sense of efficacy. There are common gaps and pitfalls that are easily remediated and perhaps, more importantly, preventable.
Strengthening compassion in outpatient practice

Corresponding author
Mark R. Rosenberg, MD
Providence Health & Services
Mark.Rosenberg@providence.org

Co-author
Rebecca A. Hawkins, MSN, ARNP, ACHPCN

Learning objectives
1. Explain the need for addressing physician burnout within the context of medical teams
2. Understand the strengths and limitations of previous interventions to improve joy in medicine in the outpatient setting
3. Describe a multifaceted curriculum focused on compassion, mindfulness and reflection as a model for reducing burnout

Context/background
Primary care has become increasingly complex and stressful. Burnout rates for primary care physicians approach 50 percent. Primary care medical homes have been credited with improving patient care and provider satisfaction through the use of multidisciplinary teams. Research has documented increase in physician satisfaction through the practice of mindfulness and meditation.

Methods/approach
A randomized controlled trial utilizing medical home teams. The trial was conducted over six months, utilizing 12, 90-minute sessions, providing teams with mindfulness training, self-reflection and attention to team dynamics. Recruitment for participation came from a large medical group in a single metropolitan area (23 practices). Study intent and design were described and volunteer clinics were solicited. Eleven clinics volunteered and were randomized to intervention and control clinics (approximately 30 physicians/220 staff in each group). All participants completed a 50-item questionnaire compiled from previously validated survey instruments. Key measures include: burnout, compassion, mindfulness, work-life balance, and perceived stress. Each session consisted of mindfulness practice, videotaped lectures and structured exercises led by clinic staff facilitators. Ongoing training and regular debriefs with facilitators were held to ensure quality and success of the curriculum.

Findings/results
The six months of structured curriculum and follow-up survey were completed in June 2016. Current data analysis and evaluation appear favorable as improving team health and encouraging individual practices for resilience. Long-term outcomes of this curriculum will not be ready for dissemination.

Conclusions/discussion
Providing clinics with a multifaceted curriculum provided teams with both positive outcomes and challenges. This method of providing renewal opportunities requires intentional time supported by leadership and attendance by participants, and has outstanding benefits to teams and individuals. Therefore, finding the balance and best practice is still being developed.
Striving for professional fulfillment—physicians’ experiences of engagement

Corresponding author
Fredrik P.G. Baathe, PhD
Institute of Health and Care Sciences, Sahlgrenska Academy at Gothenburg University
Institute of Stress Medicine/Sahlgrenska University Hospital
fredrik.baathe@vgregion.se

Co-authors
Åsa Lindgren, PhD

Learning objectives
1. Understand the connection between physician experiences of engagement and striving for professional fulfillment
2. Relate two central and alternative physician role-tendencies to engagement
3. Appreciate how organizing principles can contribute towards increasing joy in medicine

Context/background
Physicians are engaged in the bio-medical and technical development of health care. In spite of consensus between researchers and practitioners that change initiatives benefit from engaging multiple-care professionals, it is a persistent and well-documented problem that physicians' engagement in developing clinical services and processes often is limited or missing. This study aimed to gain a deeper understanding of physicians' own perspective about physician engagement in improving clinical services and processes.

Methods/approach
Using a grounded theory approach, this study developed a conceptual model of physician engagement, based upon empirical material from semi-structured interviews with 25 physicians working at three clinical departments in a Swedish hospital.

Findings/results
Striving for professional fulfillment was found to be a central motivator for physicians' engagement for both clinical and development work. This conceptual model had two dimensions: being useful and making progress. Engagement was reinforced if the task at hand was experienced as contributing to professional fulfilment. Which tasks contributed was related to how medical practice was understood. Two opposite role-taking tendencies emerged when continuing the analytical process. One was named the traditional doctor role with high autonomy in relation to organization and management with clinical work serving as the main source of fulfillment. The other was named the employeeship role in which also organizational engagement contributed towards increased professional fulfilment. Physicians' experienced that continuity, recognition, task clarity, and role clarity were organizational conditions that facilitated engagement and thus contributed towards an increased sense of professional fulfilment.

Conclusions/discussion
Uncovering what physicians’ themselves consider most important towards finding professional fulfillment, and outlining what organizing principles physicians’ consider facilitated such experiences provides health care leaders with a physician informed roadmap towards increasing professional fulfillment, that is, increasing joy in medicine.
The ideal gas lounge: Boosting resident happiness with empowerment and common space improvements

Corresponding author
Adam Was, MD
Departments of Anesthesiology and Pediatrics, Stanford University School of Medicine
awas@stanford.edu

Co-author
Tara Cornaby, MD

Learning objectives
1. Dedicated common spaces can have a significant effect on resident well-being.
2. The improvement of physician trainee common spaces represent a high-impact, cost-effective and evidence-based means of increasing resident happiness.
3. Resident involvement and empowerment increases the acceptance and success of common space improvements.

Context/background
Residency can be a challenging and stressful period for many physicians. The health, happiness and well-being of physician trainees remains an important focus of residency leadership. However, residency programs often face the challenge of using limited funds to provide wellness improvement interventions that are high-impact, long-lasting and cost-effective. One workplace intervention shown to improve employee happiness is the development of a dedicated and protected common space. We describe the improvement of an anesthesia resident common space at a large academic center, known as the “Gas Lounge,” as an effective way to empower trainees and increase their joy and wellness.

Methods/approach
Seventy-nine anesthesia residents were surveyed to provide ideas for potential improvements to their common space. Interventions were selected based on cost, feasibility and popularity. Residents submitted pre- and post-intervention usage and satisfaction surveys.

Findings/results
Thirty-four residents completed pre-intervention surveys regarding their use of and satisfaction with the Gas Lounge. Thirty-three potential improvements were proposed, of which 13 were chosen and implemented. Twenty-three residents submitted a post-intervention survey. Daily use of the Gas Lounge increased from 21 percent to 70 percent. Satisfaction with the Gas Lounge increased from 3.5 to 7.5 ($p=4.05E-10$). Seventy-four percent of respondents said the improved common space definitely increased their well-being.

Conclusions/discussion
Empowering residents in the improvement of their common spaces is an effective way to increase the well-being and joy of physician trainees.
The relationship between support and surveillance: A qualitative study of peer counseling

Corresponding author
Karin Isaksson Rø, MD, PhD
LEFO – Institute for Studies of the Medical Profession
karin.ro@legeforeningen.no

Co-authors
Frode Veggeland
Olaf G. Aasland

Learning objectives
1. Reflect upon the importance of support and surveillance in peer support
2. See how the balance between formal and informal elements in a peer counselling scheme can be studied by using a qualitative study design
3. Discuss what an optimal balance between support and surveillance can be in relation to different kinds of peer support

Context/background
Promoting doctors’ health is important for doctors and for patient treatment. The medical profession has therefore advocated the need for peer support to members, as well as the necessity of collegial reactions to academic or ethic failure. These considerations can be complementary, but also conflicting. We wanted to study how the peer support programme in Norway addresses these considerations.

Methods/approach
Focus group interviews held with Norwegian peer counsellors from August 2011 to June 2012 were analysed by a stepwise deductive-inductive method.

Findings/results
Based on organisational theory, two ideal types of counsellors were identified from the data, and these were then used to reanalyse the text. We found that the organisational framework is associated with the peer counsellors’ role conception and thereby the relationship between the counsellor and the help-seeking doctor. The relationship between informal frameworks like collegiality, confidence and discretion, and more formalized incentive-driven frameworks, appear to influence the accessibility to peer support, the mandate to provide relevant help and the understanding of what peer support represents.

Conclusions/discussion
The study showed the need for a continuous awareness of a balance between the informal and the more formalized elements in the framework for peer support. This is of importance for how the service can contribute to better health among doctors and to secure quality and safety in the treatment of patients. The analysis can also be used to demonstrate the consequences of how the peer support program is designed—such as the degree of formalisation and the balance between hard and soft ways to regulate the interaction between peer counsellors and doctors—for the ability to achieve the stated objectives of the service.
The relationship of self-compassion to joy and suffering in health care providers

**Corresponding author**
Ilinca D. Lupea, MSc, MD
Henry Ford Health System
ilupea1@hfhs.org

**Co-authors**
Tamika Stewart, MD
Cathy Collins-Fulea, CNM
Roopina Sangha, MD, MPH
Michelle Jesse, PhD
David Richardson, MD

**Learning objectives**
1. To understand the relationship between self-compassion/emotional resilience and joy/suffering within the workplace
2. To recognize that pain and stress is inevitable; to suffer is part of being human, but holding on to suffering is optional
3. How should we promote self-compassion and teach emotional resilience?

**Context/background**
Previous work that we had done in medical students and residents suggested that burnout is a form of suffering and that self-compassion might be an antidote. The objective of our study was to determine how joy and suffering in health care providers related to measures of psychological health.

**Methods/approach**
A survey was sent to 501 mid-level providers in the Henry Ford Health System and completed by 155 individuals. Measures of suffering included: Burnout – BO/Secondary Traumatic Stress – STS (Proqol), the Perceived Stress Scale – PSS and the Workplace Incivility Scale – WIS. Measures of joy included: Compassion Satisfaction – CS (Proqol) and the Satisfaction with Life Scale – SWL. Measures of psychological health included: the Self-Compassion Scale – SCS, Empathy (concern – EC and perspective – EP) from the Interpersonal Reactivity Index, the Resilience Scale – RS, and the Health Provider Shame Scale. Correlations and regression analysis were performed.

**Findings/results**
On univariate analyses, there were significant correlations between the measures of joy and suffering with psychological health. The model predicting Compassion Satisfaction was highly significant (F(5,104)=27.49, p<.001) explaining 55 percent of the variance with greater SCS (β=.294, p=.002) and greater EC (β=.216, p=.005) as predictors. The model predicting Satisfaction with Life was highly significant (F(5,104)=11.27, p<.001), explaining 32 percent of the variance with greater SCS (β=.383, p<.001) and greater ER (β=.384, p<.001) as predictors. The model predicting Burnout was highly significant (F(5,104)=14.53, p<.001) explaining 38 percent of the variance with lower SCS (β=-.396, p<.001) and lower ER (β=-.316, p<.001) as predictors. The model predicting Perceived Stress was highly significant (F(5,104)=14.97, p<.001) explaining 39 percent of the variance with lower SCS (β=-.404, p<.001) and lower ER (β=-.323, p<.001) as predictors.

**Conclusions/discussion**
Both joy and suffering in the workplace are predicted by an individual’s self-compassion and resilience.
To regret the choice of medicine as a student, how will it influence doctors’ later career? A nationwide and long-term longitudinal study

Corresponding author
Tore Gude, MD, PhD
University of Oslo
tore.gude@medisin.uio.no

Learning objectives
1. Inform students about risk symptoms
2. Identify regretting doctors
3. Institute early counselling

Context/background
Some doctors regret choosing medicine during their career, but scientific studies of this issue are lacking. A survey among 24,000 U.S. doctors showed an increase from 31 percent in 2011 to 42 percent in 2014 that would not have chosen medicine again. UK GPs reported an increase from 14 percent (1998) to 22 percent (2001) in intention to leave within the next five years. Therefore, we would investigate:

1. Predictors to be traced in the first part of the curriculum for regretting at the end (student cohort)
2. Consequences from regretting at the end of medical school for distress and satisfaction as doctors 20 years later (doctor-cohort).

Methods/approach
Students starting medical school (student-cohort) at all Norwegian universities in 1993 (N=545) were mailed a questionnaire in their first year, halfway, and at the end of school (six years later, N=365, 67 percent). Graduating students were addressed in 1993/1994 (doctor-cohort, N=567), then 20 years later (2014). Response rates varied (60–70 percent), after 20-year 55 percent responded (N=580).

Findings/results
In the student cohort 26.7 percent had at the end of medical school regretted “often” or “once in a while” their choice. Predictors assessed in the first study year for regretting were: (a) Not being sure to become a doctor (16 percent) and (b) High level of mental distress (Symptom CheckList-5) (together explaining 14 percent of the variance). High scores on the Perceived Medical School Stress inventory (worrying factor) assessed halfway, added another 11 percent explained variance in the regretting score at termination. In the doctor cohort, those who regretted their choice when graduating (29.9 percent) had 20 years later (24.0 percent regretting) significantly lower levels of job satisfaction, higher levels of mental distress and job stress, even when controlled for neuroticism. Respondents with a doctor father regretted less, while female doctors regretted more than males.

Conclusions/discussion
Regrets and doubts about the choice of medicine at the end of medical school can be traced already in the beginning and mid-ways in the curriculum. Further, such regretting may constitute a risk factor for later distress/dissatisfaction as a doctor, even after 20 years. Students reporting mental distress and uncertainty about becoming a physician early in the curriculum should be offered counselling to decide their further career.
Toward preventing physician suicide: Incorporating the insights of those they leave behind

Corresponding author
Michael F. Myers, MD
SUNY Downstate Medical Center
michael.myers@downstate.edu

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

Context/background
Despite much research on personal and workplace stressors, personality traits, psychological vulnerabilities and psychiatric illnesses in physicians, the published literature is sparse on information obtained from intimate others.

Methods/approach
In January 2015 the author began interviewing the family members, medical colleagues, friends and therapists of physicians who have died by suicide. Forty-two interviews have been conducted with a data base of 27 decedents. The interview format is invitational, semi-structured and comprehensive. Thirteen have been conducted in person and 29 by telephone. Duration has ranged from 45 minutes to two hours. All participants have signed a release form.

Findings/results
(1) A significant minority of physicians killed themselves without receiving an assessment or treatment by a health professional; (2) for those in care, stigma was huge and adversely affected the therapeutic alliance and treatment adherence; (3) there are perceived shortcomings of some physician health programs (overemphasis on substance use disorders and the abstinence model, neglect of comorbid mental health conditions, lack of psychiatric consultation); (4) split treatment can fail and contribute to suicide; (5) under diagnosis of suicidal despair is common; (6) physician loved ones are often not interviewed by treating professionals for collaborative information or psychoeducation; (7) in some decedents, there is emergent psychosis with agitation, profound insomnia, delusional and constrictive thinking in the hours or days just prior to death; (8) after the suicide, some loved ones felt the treating professionals were available and empathic; others felt shunned and abandoned; (9) all interviewees are committed to help prevent suicide in physicians.

Conclusions/discussion
These observations have relevance for instituting change in efforts to prevent suicide in physicians. A message from the families was the pressing need for more basic education about warning signs of worsening illness and suicide—for physicians themselves as well as their families.
Uncovering work-related physician stressors: Unintended benefits of a strategic planning exercise at an academic health science center

Corresponding author
Heather A. Lochnan, MD
University of Ottawa, The Ottawa Hospital
hlochnan@toh.ac

Co-authors
Philip S. Wells MD, MSc
Edward G. Spilg, MBchB, MSc

Learning objectives
1. Demonstrate how a strategic planning exercise uncovered high levels of faculty stress.
2. Describe how concept mapping can create a collaborative conceptualization of physician wellness.
3. Discuss whether the findings are generalizable to faculty at their academic health center.

Context/background
Physician burnout is a serious condition linked to diminished quality of care. Physicians likely under report their stress or the pressures they withstand in order to contribute their share of the workload and meet academic expectations. Numerous faculty concerns and indicators of stress were unexpectedly uncovered during a strategic planning exercise.

Methods/approach
Faculty members in the department of medicine at an academic health science center were invited to participate anonymously in an online, brainstorming forum. Faculty were asked to identify the major challenges that should be addressed within the areas of quality and safety, education, research, clinical programs, IT, physician wellness and promotion, communications and others. This was followed by a rate (for priority) and sort (into themes) exercise. Concept Systems Inc. software was used to for data collection and generation of concept maps to create a collaborative conceptualization of the challenges facing the faculty.

Findings/results
Faculty members logged 325 comments—many expressing indicators of stress and burnout: “The pressures of clinical practice have greatly diminished the collegiality and professionalism of department members. Some services appear to resent patient care obligations and communicate this to care team members and trainees.” Unique themes were identified for a sort and rate exercise. Ninety-six faculty members completed the rating exercise and 22 completed the sorting into thematic categories. The theme: “Physicians struggle with balancing workloads” was highly rated for prioritization. Comparative analysis exploring various demographics indicated a significant difference in ratings of statements between genders in themes related to physician wellness and patient issues (p<0.01).
Using Balint groups to restore wonder

Corresponding author
Jonathan “Shake” Seigel, MBChB, DA, MScMedEd
BMA support doctor
shake.seigel@btinternet.com

Learning objectives
1. Describe the distinguishing features of a Balint group. (“What is a Balint group?”)
2. Think about a clinical situation in a Balintian way. (“How to apply Balint”)
3. Consider the impact of this approach on themselves and others. (“What effect does this have?”)

Context/background
My ideas and insights come from my experience with Balint groups over the past 32 years. I have been a member of a group over these 32 years and have also been involved in setting up groups in a variety of medical settings. I have run Balint groups for GP trainees, experienced practitioners in many specialities and medical students. My work has predominantly taken place in the United Kingdom but has included some work in Australia as well.

Methods/approach
The presentation will consist of a mixed methodology, mirroring my journey. There will be some contextual data presented with a description of Balint work: what it is, how to do it and what possible effects it may have on physicians. There will also be an element of interactive and experiential learning during the presentation. The final section will provide space for reflective discussion and questions.

Conclusions/discussion
This presentation was prompted by the following quote by a medical student at the end of an intensive Balint residential weekend of group work in Oxford, UK. “This is the first conference I have been to where every doctor has told me how much they enjoy their work.”
Wellness retreat: An education innovation for Ontario’s medical students

Corresponding author
Soniya Sharma, BSc, MD
Department of Anesthesia, University of Toronto
soniya.sharma@mail.utoronto.ca

Co-authors
Marie Leung
Kayla Berst
Marianne Stroz
Shannon Chun
Christine Prudhoe

Learning objectives
1. Identify the burden of burnout in medical student trainees
2. Identify the importance of creating wellness interventions at this level
3. Discuss tools that can be used to promote trainee wellness

Context/background
Medical student burnout is a well-known phenomenon. Maladaptive habits formed early in training lead to higher than average suicide rates and depression in physicians. To achieve physician health in the long run, we must invest in education, awareness and life-style changes early in training. The Ontario Medical Association is the provincial representative body for medical students. We developed a wellness retreat to educate and motivate students to achieve a healthier lifestyle and reinvigorate their joy for medicine.

Methods/approach
One hundred Ontario medical students gathered at the Briars Resort and Spa in March 2014 and 2015. The weekend included team-building activities, opportunities for self-reflection, mindfulness, exercise and nutrition. Physician guest speakers held panel discussions on their personal experiences. Student experts led mindfulness, meditation and yoga sessions. Ethics approval was achieved. Students completed a Maslach Burnout Scale (MBS), Perceived Stress Scale (PSS) and Brief Resilience Scale (BRS) before, immediately after and 30 days after the retreat. The results were anonymized and statistically analyzed.

Findings/results
Qualitative data from our post-retreat survey showed high student satisfaction. Students appreciated the sessions offered, especially those focused on relationships in medicine, depression and burnout. Students had a renewed sense of balance and relaxed mindset after the retreat. They felt that they had learned concrete skills that could be applied to their medical education. Quantitatively, we had 59 percent response rate in the pre-retreat survey, and 42 percent post-retreat survey. There was a trend towards decrease in MBI, PSS and increase in BRS; however, the only statistically significant decrease was in the MBI: Exhaustion component (p=0.04).

Conclusions/discussion
This student-developed innovation is the first of its kind in Ontario to gather students in a regional setting to encourage the development of healthy habits in medical school. We succeeded in offering educational interventions to supplement curricular teaching to effectively improve student wellness. We plan to continue developing and offering the wellness retreat to Ontario’s medical students to address mindfulness teaching and balance.
What factors in medical school predict later perceived mastery of clinical work among Norwegian doctors?
A 20-year longitudinal NORDOC study

Corresponding author
Anna Sofia Viktoria Belfrage, MS
Department of Behavioral Sciences in Medicine, Institute of Basic Medical Sciences
University of Oslo
Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust
anna.belfrage@medisin.uio.no

Co-authors
Kjersti Steen Grotmol, PhD
Lars Lien, MD, PhD
Reidar Tyssen, MD, PhD

Learning objectives
1. Participants will learn about the importance of studying perceived mastery of clinical work.
2. They will know more about early predictors of later perceived mastery of clinical work.
3. They will learn about strengths and limitations with longitudinal survey studies.

Context/background
Doctors’ perceived mastery of clinical work may influence their career and patient care, in addition to their own health and well-being. We lack knowledge about predictors at medical school of future perceived mastery of clinical work. The aim of this study was to identify such predictors.

Methods/approach
N= 631 doctors have been surveyed at the final year of medical school in 1993/94 (T1), 10 (T2) and 20 (T3) years later (Young Doctor Cohort of NORDOC). Perceived mastery of clinical work (PMCW) was measured at T2 and T3 by four items selected by factor analyses (alphas=0.88 and 0.84). The predictor variables, measured at T1, include personality traits, medical school stress, perceived medical recording skills, identification with the role of doctor, hazardous drinking and drinking to cope with tension, in addition to age and gender. Predictor effects were studied by multiple linear regression models.

Findings/results
Response rates: T1: 83 percent (522/631), T2: 71 percent (371/522), T3: 55 percent (289/522). Mean PMCW scores (range 8–28) at T2 and T3 were 22.2 (SD=4.3) and 24.5 (SD=3.1), (t=8.2, p=<0.001), with no gender difference. Adjusted predictors of PMCW at T2 were: identification with the role of doctor (B=0.13, p=0.001, CI=0.05–0.21), perceived medical recording skills (B=0.13, p=0.03, CI=0.01–0.24) and drinking to cope with tension (B=-2.69, p=<0.001, CI=-4.19 to -1.2). Adjusted predictors of PMCW at T3 were perceived medical recording skills (B=0.13, p=0.009, CI=0.03–0.22) and extraversion (B=0.17, p=0.037, CI=0.01–0.33).

Conclusions/discussion
Perceived medical recording skills predict perceived mastery both 10 and 20 years after graduation. In addition, drinking to cope with tension predicts lower while early role identification predicts higher mastery at the first stage, when most of the doctors are in a training position. Later in their career, when the participants turn into more responsible clinicians and leaders, the personality trait extraversion predicts higher mastery.
Work enjoyment in emergency medicine residents: Association with organizational climate and near misses in patient care

Corresponding author
Bengt B. Arnetz, Md, PhD, MScEpi, MPH
Department of Family Medicine, College of Human Medicine, Michigan State University
bengt.arnetz@hc.msu.edu

Co-authors
Philip Lewalski, MD
Judy Arnetz, PhD
Karin Przyklenk, PhD

Learning objectives
1. Participants will be able to learn about feasible means to study work enjoyment and patient outcomes in a busy emergency department setting.
2. Participants will be able to discuss how specific organizational determinants impact physician work enjoyment.
3. Participants will be able to discuss how work enjoyment and engagement in residents relates to patient outcomes.

Context/background
Human errors have been identified as an important contributor to adverse medical outcomes. Physician stress is commonly reported to be a main culprit. However, to date, there has been no published study relating self-reported or objective measures of stress to individually-linked data on adverse medical outcomes. Moreover, focusing on medical errors tends to promote a culture of blame, rather than one of trust and learning. Even less is known about the possible interaction between the psychosocial learning environment of residents, self-rated stress and adverse outcomes. The current study focuses on near misses. The large urban, Level 1 trauma center that was part of this study defined a near-miss as “Any process variation that did not reach the patient, employee or visitor but for which recurrence carries a significant chance of a serious adverse event.”

Methods/approach
Residents in emergency medicine consented to take part in this study, which was conducted at a large, Level 1 trauma teaching hospital in a mid-Western U.S. city. Participants were asked to rate their work enjoyment and engagement using a paper survey. The supervising physician rated the resident’s skills and performance. Organizational climate was measured using the Quality-Work-Competence (QWC) survey. Both residents and supervising attending physicians rated the occurrence of “near misses” in patient care during the work shift. Residents with the highest possible ratings of their work enjoyment (n = 14) were compared with those with lower ratings (n = 18) on all measures of organizational climate. In addition to self-reported stress, biological markers of stress (cortisol) and inflammation (C-reactive protein, TNF-Alpha and Interleukin) were collected. Statistical significance was set to a p<.05. The study was approved by the pertinent institutional review boards.

Findings/results
Physicians with the highest work enjoyment scored significantly higher on work engagement and social climate, but lower on work intensity. Almost 80 percent of the supervising attending physicians reported that their resident had no “near misses” during the shift, as compared to less than 70 percent among the residents, with no associations between resident’s and supervising attending’s ratings.

Residents’ pre-shift stress was related to supervising physicians reporting more near misses. Higher levels of inflammatory marker in residents’ blood were related to residents reporting more near misses.

Conclusions/discussion
This study provides evidence of the feasibility of studying work enjoyment and stress and its impact on physicians’ performance and patient care in a high-intensity emergency medicine department. The study suggest that not only the psychosocial training environment, but also biological processes related to brain function, are related to self-rated and independently-rated occurrence of near misses. Future studies need to more objectively assess the residents learning environment and stress levels and relate such malleable factors to residents’ actual performance.
Workshops
Building a compassionate health care system: Through creativity, communication and connection

**Corresponding author**
Mark R. Rosenberg, MD  
Providence Health & Services  
Mark.Rosenberg@providence.org

**Co-author**
Rebecca A. Hawkins, MSN, ARNP

**Learning objectives**
1. Discover compassion as the antidote to burnout and the pathway to joy in medicine  
2. Explore the power of compassion strengthening activities in the workplace  
3. Brainstorm ways to integrate compassion into the participant’s institutions

**Context/background**
Increasing numbers (greater than 50 percent) of physicians and other front line staff are reporting feeling burnout and exhausted by their work. With burnout reaching national crisis level, there is a huge necessity to find help for the workforce.

**Methods/approach**
In this session we will explore a set of Compassion Activities that have impacted physicians, clinical teams and non-clinical leaders within our health care system. Through lecture, interactive exercises and discussion the presenters will share: (1) Leadership Focused Compassion Conversations—how to safely facilitate sharing of suffering with colleagues; (2) Compassion Affinity Groups—demonstrating the power of bringing motivated employee volunteers together in service to others; and (3) Structured Compassion Curriculum—outline our 12 session curriculum on mindfulness, reflection and attention to team dynamics. The session will include opportunity to share compassion initiatives from participants’ institution and to consider strategies for implementation. The session will begin with a brief review of the literature and research on burnout and its importance in health care. Compassion will be explored as the antidote to burnout, emphasizing the importance of understanding the compassion/suffering relationship. The speakers will facilitate an exercise focused on personal experience of suffering of participants. Structured writing, small group sharing and large group discussion will be utilized. This exercise validates and normalizes the suffering that is intrinsic in the practice of medicine. The presenters have led this exercise in groups of 50–400. It always elicits connection and sharing within the group. Evaluation from more than 1,500 people have described this exercise as “powerful, eye-opening, and transformational.” This exercise will take 35 minutes.

**Conclusions/discussion**
The session will end with group discussion and sharing of participant’s ideas for integrating compassion in medicine at their home sites as a way to reduce burnout and increase the joy of medicine and practice.
Compassion, presence and resilience training (CPR-T™): Revitalizing the hearts of caregivers

Corresponding author
Mary E. Elliott, MD
University of Toronto – Princess Margaret Cancer Centre, University Health Network
mary.elliott@uhn.ca

Co-authors
Rinat Nissim, PhD, C. Psych.
Mark A. Coleman, MA

Learning objectives
1. Understand the key components of Compassion, Presence and Resilience Training (CPR-T) and their contribution to health care provider well-being.
2. Consider the benefits and barriers to implementing and sustaining an integrated workplace intervention for health care providers.
3. Experience a sampling of the workplace micro-practices taught during the CPR-T and reflect on the possibility of utilizing them throughout the workday.

Context/background
CPR-T™ is a novel group intervention for health care providers aimed at promoting workplace mindful awareness, balance and compassion, and through such, cultivate well-being. CPR-T was developed in response to unmet needs of providers working in the fast-paced, complex and emotionally demanding world of oncology. It is unique in that it brings self-care into the workplace with micro-practice tools developed to be integrated and become part of how health care providers do their job.

Methods/approach
In this workshop participants will: (1) review the curriculum, theoretical underpinnings and evolution of CPR-T; (2) learn about the results of the preliminary qualitative research study, and have discussion surrounding the benefits and challenges to implementing an integrated workplace wellness program; and (3) experience several of the micro practices and reflect on their utility.

Findings/results
Using Patton's Utilization-Focused qualitative research methods, CPR-T was found to be feasible to implement in the workplace. The main themes are reported under the headings of benefits and challenges. Among the challenges, fear of vulnerability will be highlighted. Informed by the study, content of sessions were revised such that emotional regulation and resiliency work was included in each session. Ways of working with vulnerability to enhance the sense of safety was added. To promote the adoption of CPR-T, the curriculum was condensed from eight to four, 1.25 hour weekly meetings. Each session incorporates mindfulness meditation, micro-practices, reflective exercises and workplace practice assignments. Originally there was an equal emphasis on home and workplace practice, the results of the initial qualitative study resulted in a shift toward predominantly focusing on workplace integration of skills.

Conclusions/discussion
The pilot studies found it is feasible to use CPR-T as a workplace wellness program. Further studies are underway to look at the impact of CPR-T on workplace engagement and perceived stress.
Energize your time: How to be a better manager of your most important resource

Corresponding author
Minda Miloff, MA
Coach Minda,
minda.miloff@sympatico.ca

Learning objectives
1. Specify the professional and personal benefits of effective time management.
2. Identify energy-depleting and energy-enhancing behaviors (transition from being drained, distracted and unfocused to being confident, engaged and focused).
3. Establish a personal action plan with specific routines and practices designed to energize your time.

Context/background
Feeling chronically overwhelmed and overloaded, late and behind in our work and carrying the burden of self-doubt leads to inaction, poor decisions (or none at all) and strips away the ability to enjoy our professional and personal life. This workshop teaches practical ways to unravel time management tangles by understanding how positive and negative influences of various stimuli—people, tasks, stresses and our own internal dialogue—impact our personal energy levels. Joy is the feeling we have when we engage in energy-enhancing behaviors, bringing more confidence, engagement and focus to our life.

Methods/delivery
The workshop is intended to promote self-assessment, open-mindedness and action. Participants learn how to set goals related to time management and assess the behaviors which deplete or enhance energy, then identify potential roadblocks and develop specific time management strategies. The session will be interactive, including exercises and questions.

Conclusions/discussion
Getting more out of your most important resource—time—is tied directly to the way you harness and manage your mental, emotional and physical energy. This workshop will teach participants to establish routines and practices that energize their time on and off the job. Participants will learn to understand the positive and negative influences of various stimuli—people, tasks, stresses and our own internal dialogue—on their personal energy levels. The underlying thesis: The better you manage your energy, the better you manage your time. The benefits include increased focus, concentration, motivation and engagement—all of which underlie professional and personal effectiveness.
Experiencing joy in medicine

Corresponding author
Chaplain Bruce D. Feldstein, MD
Stanford University, School of Medicine
bfeldstein@stanfordhealthcare.org

Co-authors
Rebecca Smith-Coggins, MD
Art Johnson, PhD

Learning objectives
1. Recognize and understand nature of joy, including the complex relationship between joy and wellness
2. Identify three common barriers to experiencing joy
3. Identify strategies and actions for overcoming barriers and experiencing joy

Context/background
Joy is fundamental to human existence and well-being, yet is too often absent from our lived experience. In this interactive workshop, participants will engage in a discovery learning process to increase one's capacity for experiencing joy in their professional life. This workshop is a combination of didactic, individual reflection and group discussion. Workshop leaders are experienced medical educators: a chaplain who is a physician, an emergency medicine physician who is associate dean for student wellness, and a psychologist.

Methods/delivery
The educational process in this workshop draws from traditional medical education, humanistic psychology, philosophy, anthropology, theology, spiritual care, wellness and clinical pastoral education. Over the past 15 years it has been used by workshop leaders in teaching spirituality and meaning in medicine, physician self-care, The Healer's Art (originated by Rachel Naomi Remen), and, since 2014, the GWish-Templeton Reflection Rounds. As a result over 1,200 medical students as well as practicing physicians have been provided with skills and strategies to incorporate spirituality and meaning, reflection, and self-care into their clinical practice and personal lives. In this workshop we will apply this educational method to the topic of joy and focus on the questions: What is joy? How can we increase our capacity for experiencing joy in our professional lives?

Conclusions/discussion
Through individual reflection and small and large group discussions, we will examine the nature of joy as an emotion, the object of joy, the habit and virtues that allow for joy and the complex relationship of joy to wellness. We will distinguish joy from happiness and discover how joy can be experienced in the midst of suffering. We will map our workshop findings to the “Landscape of Spiritual Experience,” a tool developed by workshop leaders for teaching medical students and physicians. With this as our foundation, we will explore common barriers to experiencing joy in professional life, including emotional/conceptual blindness, busyness, indifference and burnout. Finally we will discuss strategies and actions to avoid or manage these barriers and experience joy. Handouts will provide resources and guidelines for further learning and teaching.
Feeling burned out? Using sciences and wisdom of contemplative practices to manage your stress and reduce burnout

Corresponding author
Sermsak Lolak, MD
Inova Schar Cancer Institute
Sermsak.Lolak@inova.org

Learning objectives
1. Recognize the issue and impact of physician burnout and compassion fatigue
2. Understand the concept and techniques of mindfulness practice and compassion cultivation, and how these practices can help with the issues of physician burnout and compassion fatigue
3. Apply the knowledge and skills from this workshop into real life both in and outside of work

Context/background
Physician wellness, compassion fatigue and burnout are among the top challenges affecting physicians, regardless of level of training or practice setting. Up to one-third of physicians are affected by burnout, which has negative impacts on health, well-being, job satisfaction and productivity, in addition to patient care.

Although there have been efforts to promote humanism, empathy and communication training in medicine, it is notable that little attention is paid to formally teaching physicians to cultivate compassion, a quality so central to our profession’s identity. Over the past several years there has been an explosive growth in multidisciplinary scientific understanding of compassion, defined as the feeling that arises in witnessing another’s suffering and motivates a subsequent desire to help. Compassion training likely works by promoting functional brain plasticity and affects brain regions responsible for empathy, emotions and executive function. Of particular relevance to medicine is that deliberate compassion training offers a new coping strategy that fosters a positive effect even when one is confronted with the distress of others, a potential antidote to burnout.

Delivery
This interactive workshop will explore concepts and tools to help decrease burnout and promote compassion with the emphasis on scientifically-proven contemplative practices, such as mindfulness and compassion cultivation techniques adapted from various eastern traditions, although can be used regardless of practitioners’ religious orientation. The first part of the workshop will offer a summary of the literature regarding issues of burnout, empathy, and compassion fatigue and its impact, as well as neuroscientific evidence of contemplative practices in reducing burnout and promoting compassion. During the second part of the workshop, we will focus on the utility of contemplative practices focusing on mindfulness, compassion and self-compassion techniques as an antidote to burnout, followed by suggestions of adapting these concepts and practices to everyday life.
Finding your bliss as a physician

Corresponding author
Daniel J. Murphy Jr., MD
Stanford University, School of Medicine
murphyd@stanford.edu

Co-author
Artie Wu, MBA

Learning objectives
1. Understand the concept of bliss and its importance in the life of a physician.
2. Identify elements of their bliss and ideal career trajectory using a collaborative exercise with a peer physician.
3. Learn how to increase the percentage of bliss in their professional trajectories over time, without disruption to their career momentum and progress.

Background
Workforce studies show that when professionals are motivated mainly by personal fulfillment as opposed to status and income, they outperform their peers on almost every measure—including performance, tenure, leadership and impact. A special challenge is that physicians are seldom directed to consider their own intrinsic sources of bliss in practicing medicine. The intensive patient- and regulatory-oriented nature of healthcare tends to ignore the elements of joy for any individual practitioner, and this imbalance can lead to physician burnout and frustration, even in the face of strong income and social status.

Approach
This workshop will teach a set of techniques for physicians to develop their own ideal career trajectories, as calibrated by their inner sense of bliss—that which brings them intrinsic joy and enthusiasm, separate from their sense of social expectations, career demands and organizational pressures. Workshop participants will be able to get engaging, hands-on practice with a number of proven tools for identifying their uniquely personal sources of bliss in medicine, as well socially-acceptable techniques for discussing these topics with peer physicians—a critical factor in making physician-fulfillment a more widely accepted concept. The workshop format will be 90 minutes: 60 minutes of training, blended with 30 minutes of hands-on exercises and group discussion. The framework and tools used in this workshop were developed by a private coaching firm that uses mindfulness-related techniques to achieve personal wellness and professional development in an integrated, balanced manner. These tools have been successfully deployed to thousands of students in the past three years and this physician-specific workshop has been successfully presented to physician groups at a major children’s hospital.

Results
Immediate feedback from the participant MDs has been overwhelmingly positive. Based on that feedback we have lengthened and added more real-life examples.
Fostering joy in medicine through art and reflection

Corresponding author
Holly C. Gooding, MD, MSc
Brigham and Women’s Hospital/Harvard Medical School
holly.gooding@childrens.harvard.edu

Co-authors
Brooke DiGiovanni Evans, MFA
Barbara Martin, MFA
Mariah Quinn, MD
Joel T. Katz, MD

Learning objectives
1. Participants will describe the steps of two art-based activities: Visual Thinking Strategies and Meaning and Metaphors.
2. Participants will rank as valuable the role of museums and art for fostering joy in medicine.
3. Participants will create strategies for implementation of arts-based education in their own setting.

Context/background
The goal of this workshop is to introduce participants to the use of arts-based activities for fostering joy in the lives of physicians as demonstrated through hospital-art museum partnerships.

Methods
Since 2010 the Department of Medicine at Brigham and Women’s Hospital has partnered with the Museum of Fine Arts to create an annual evening of reflection and community-building for internal medicine trainees. Residents participate in a Visual Thinking Strategies (VTS) exercise, metaphor-making with contemporary art, group drawing, a discussion of death and dying, and a guided meditation. Residents report that the program has led them to renew commitments to family and friends, to spend time in daily reflection and to connect more with patients.

Delivery
Workshop participants will experience a VTS exercise led by our experienced museum educators. VTS includes viewing an object of art and asking three simple questions: What is going on in this picture? What do you see that makes you say that? and What more can we find? We will debrief the VTS exercise as a large group, noting its role in our local program and brainstorming together about how workshop participants could adapt it for their settings. Participants will also experience a Meaning and Metaphors activity in small groups of three to five people. Our museum educators will supply images of abstract art and ask groups to reflect on what their assigned piece has to say about some aspect of their life currently. We will return to the large group to debrief the exercise and again consider together how workshop participants could adapt it for their settings. We will conclude with an exercise to identify barriers to implementing arts-based education at participants’ home institutions and strategies for overcoming those barriers.

Conclusion
Participants will leave with two concrete arts-based skills to promote physician wellness and a practical plan to implement these new skills.
Got joy? Changing the culture of medical education with emotional resilience and happiness training programs at two medical institutions

Corresponding author
Miko Rose, DO
Michigan State University College of Human Medicine/
College of Osteopathic Medicine
Miko.rose@hc.msu.edu

Co-authors
Kari Hortos, DO
Jed Magen, DO, MS
Alyse Ley, DO

Learning objectives
1. Identify and describe risks of untreated burnout in student and physician populations.
2. Describe basic tenets of positive psychiatry and challenges of shifting from a pathology driven to strengths-based approach designed to promote joy and emotional resilience.
3. Learn how to work with trainees using various techniques, including: life purpose visualizations, mindfulness relaxation exercises and happiness-focused interventions.
4. Receive the basic framework needed to develop such programs within their own training institutions.

Context/background
Every year the United States loses approximately 400 physicians to suicide, the equivalent of an entire medical school. After completion of their formal medical training, physicians continue to have elevated rates of psychiatric disorders in comparison to the general population. Male physicians complete suicide at a rate 70 percent higher than the population at large; female physicians at a startling high rate of 400 percent. To date, suicide is the only cause of death with risks greater for physicians than the general population.

Methods/delivery
The authors of this workshop conducted a pilot research study incorporating elements of strengths-based cognitive behavioral therapy and mindfulness that demonstrated the efficacy of a 10-week happiness intervention for medical students. This study demonstrated efficacy in increasing well-being and decreasing levels of anxiety in medical trainees.

From this study we have developed an easily deployable programmatic intervention to help students and residents discuss and address their own burnout issues. This intervention has helped sensitize physicians to think about how medical training might be affecting their own mental health.

This workshop will outline the challenges medical trainees and physicians currently face in regards to mental health. We will describe our strengths-based, happiness-focused intervention model and the unique role it played in promoting healthy behaviors and moderating symptoms of burnout in medical students. We will also describe the challenges and evolution of this project—from pilot study to incorporation into medical school curriculum.

Conclusions/discussion
Interactive exercises from our training modules will provide participants direct experience of the material and facilitated group discussion will lend guidance on implementation strategies participants can take back to their own institutions. We will then lead an interactive group discussion to identify and outline the greatest challenges within individual training institutions—using this forum for participants to share interventions and ideas amongst institutions.

Graphic medicine: An interactive workshop reflecting on “sparkling moments”

Corresponding author
Linda P. Miller, MBBS, BSc, MSc, MRCGP, PGCEPC
Professional Support Unit, Health Education North West London
NHS London Leadership Academy
Coaching Supervision Academy
lindamiller@doctors.org.uk

Co-author
Niro K. F. Amin

Learning objectives
1. Participants will recognize the benefits of graphic reflection over written reflection.
2. Depict a positive experience in their own work, enjoy appreciation and consider how to implement this model to enhance joy in medicine.
3. Be inspired to read the graphic novels introduced an accessible form of pathography which will enhance their understanding of the patient experience.

The objective of this interactive workshop, led by clinicians who are medical humanities scholars, is to introduce “graphic medicine” as a hands-on tool to reflect on the joy in clinical practice. Examples of graphic novels by clinicians and patients will be used to introduce the metaphorical potential of graphic narratives for reflection. The audience will be actively involved throughout the session, (though no artistic ability is required). Actual graphic novels and power point extracts will be used to demonstrate use of colour, symbol, repetition and structure in this rich narrative genre.¹

Demonstration will be used to model an appreciative enquiry response to a graphic depiction of a sparkling moment from practice. In small groups the audience will then be invited to reflect on a sparkling moment in a graphic form (materials provided). Small group discussion will provide appreciative feedback. It is expected that participants will experience the motivational impact of such reflection and benefit from peer appreciative responses. Feedback on the experience and further development of the workshop will be invited.

This original methodology has developed from a sparkling moments reflective, supervision workshop² and study of narrative medicine particularly graphic form. Pilot workshops with trainees, coaches, nurses and GPs have demonstrated that participants find the play-like experience liberating and enabled participants to reconnect with the core value of their work. Feeling valued and appreciated is motivating, enhances self-compassion and resilience. The method appeals to an International audience and is relevant to a variety of disciplines and allied health professionals. This workshop is strongly aligned to the conference theme and enhancing health and well-being by reflecting on positive experiences and appreciation.

2. Robin Shohet and Eric De Haan

References

1. "The Bad Doctor" Ian Williams, "Moms Cancer" Brian Fine, "Cancer Vixen" Marisa Acocella Marchetto
2. Robin Shohet and Eric De Haan
Joy to the word: Combining emotional and intellectual engagement to build workplace pleasure among physicians

Corresponding author
Lois Leveen, PhD
Kienle Scholar in Medical Humanities, Penn State College of Medicine
lois@humanitiesforhealth.org

Co-author
Lori Wiviott Tishler, MD

Learning objectives
1. Engage the intellectual and emotional capacities of physicians in ways that promote joy
2. Develop a shared culture, improve compassionate communication, and build teamness among physicians
3. Encourage reflection on work-related emotions by exploring significant themes such as love, grief, family, etc.
4. Support an understanding of and comfort with problem-solving in contexts when there isn't a single, quantifiable correct answer
5. Experience the joy of reflecting on literary works (as well as visual art and other humanities content), and explore ways to bring this joy into your workplace

Context/background
Research shows that facilitated peer support can significantly improve physicians' job satisfaction and relieve burnout. But peer support needn't focus narrowly on what are traditionally considered medical workplace issues. Peer sessions centering on uncustomary topics and offering new perspectives can be especially appealing, stimulating and effective.

Methods
This workshop invites participants to increase their emotional and intellectual engagement through peer discussion of literary texts.

Findings/results
The purpose of the humanities is to make meaning of the world and our experiences in it. This should be congruent with, rather than discrete from, the purpose of medicine—yet the two are seldom well integrated. Although individuals are typically drawn to careers in medicine because they want to do meaningful work, physicians' day-to-day responsibilities can leave little time, structure, or support for the kind of reflection that is essential to making meaning. Join us to learn how the humanities can be used to provide opportunities for meaning-making in physicians' personal and professional lives.

Conclusions/discussion
Participants don't need any background in or knowledge of the humanities. Guided by a humanities-trained facilitator and a medical educator-practitioner facilitator, participants will experience the joy of discovering how to explore new approaches/content and use our minds in new ways. Although narrative medicine and medical humanities programs often focus on literary works that represent patients, caregivers and illness, this workshop incorporates discussion of drama, poetry and prose on more varied topics, to open up consideration of broader themes that promote emotional and intellectual engagement—and thus joy—in our personal and professional lives.
Life by design: Realigning our priorities and values—reconnecting to well-being and fulfillment in medicine

**Corresponding author**
Maiysha Clairborne, MD
Morehouse School of Medicine
drmclairborne@docsupportmd.com

**Learning objectives**
1. Identify how physicians of different age, culture and gender deal with stress and burnout (IMQ’s CLC requirement)
2. Understand how their well-being affects the interaction with patient and therefore patient outcomes
3. Experience a contextual shift in the area of self-care such that they are motivated to take action and be accountable for their own well-being, satisfaction and fulfillment
4. Identify and create new tools for bringing balance and fulfillment to their work and life
5. Be empowered to create a structure for fulfillment for their own self-care and an accountability partner

**Context and discussion**
Physician burnout is common in the United States, with half of family physicians feeling physical and psychological burnout. According to a recent survey, there has been a substantial increase in burnout among family physicians younger than 35 years, where 43 percent are now reporting burnout, compared to only 10 percent in 2013. Many aspects of patient care may be compromised by burnout. Burnout has been associated with reduced patient satisfaction and patient adherence to treatment plans. Physicians who have burnout are more likely to report making recent medical errors, score lower on instruments measuring empathy, have higher job dissatisfaction, and are more likely to retire early. Two major contributors to burnout are communication and self-care. This didactic provides a contextual shift in the impact of burnout and leaves providers empowered with new tools they can begin implementing immediately to achieve increased balance, satisfaction and fulfillment in their lives.

*How do we know this is a problem? (C2)*

*Why does this problem exist? (C2)*
- Lack knowledge about the problem(s)
- Lack strategies to apply knowledge to practice (competence)

*What do attendees need? (C2)*
Attendees need education on the importance of self-care, as well as tools for communication, listening and acknowledgement, to decrease physician burnout.

**Methods/delivery**
This workshop is delivered in the form of interactive inquiry that includes guided questioning, paired sharing, group brainstorm combined with given information to promote learning, and practical application of knowledge and potential practice.
Reading patients, reading poetry

Corresponding author
Dean G. Gianakos, MD
Centra
dean.gianakos@centrahealth.com

Learning objectives
1. Demonstrate how poetry can inspire physicians to find joy in medicine
2. Identify the similarities between reading patients and reading poems
3. Show how poetry can help physicians to appreciate the beauty of words, relationships and the world around them

Context/background
After saying a few words about the life of physician poet W.C. Williams, I will divide the audience into small groups to discuss short poems (humorous, serious and inspiring poems by W.C. Williams, John Wright, MD, Wendell Berry and Raymond Carver) that explore medical themes. Brief, large group discussions will provide opportunities for small groups to share insights with the larger group.

The ultimate goal is for participants to have fun doing poetry in this workshop!
Resiliency: Building individuals and culture to keep the joy in the job—a train the trainer workshop

Corresponding author
Charlene M. Dewey, MD, MEd
Center for Professional Health – Vanderbilt University Medical Center
Charlene.dewey@vanderbilt.edu

Co-author
William Swiggart, MS, MHSP

Learning objectives
1. Compare and contrast wellness, stress, burnout and resiliency.
2. Discuss four major elements of resiliency.
3. Utilize workshop training material for a session at their home institution.

Context/background
Resiliency helps individuals deal with the challenges of life. Physicians experience many transitions in their careers—from enrollment as a medical student to retirement and to death. Physicians are especially prone to burnout in all stages of their careers. Building resiliency and self-awareness helps physicians cope during transitions and difficult life experiences. Building resiliency is important in preventing or reducing stress, burnout and risks for impairment. Organizational culture also plays a role in a physician’s risk for stress, burnout, disruptive behaviors and impairment. This workshop was developed as a train the trainer workshop to help teachers promote resiliency at their institution using four individual practices promoting wellness and resiliency. They will also learn to identify organizational approaches to promote a culture of wellness.

Methods/delivery
This workshop will include a review of basic materials used in the past to conduct resiliency training workshops at our institution. During the interactive, train-the-trainer session participants will become familiar with content and materials used for implementing resiliency training programs. They will identify and develop plans for implementation of a resiliency training program at their institution.

Findings/results
Participants who engage in the training will have a game plan for promoting resiliency and wellness in their institutions. Participants will receive materials developed at the author’s institution to use for future workshops at their institution. Learning materials include web-based module access, handouts, session materials, lesson plans and evaluation forms.

Conclusions/discussion
Implementing a resiliency training session at our institution has been helpful for faculty members across a variety of departments. We hope to make implementing a resiliency training program at other institutions easy by providing materials and training so individuals feel comfortable implementing similar sessions at their institution.
Social neuroscience-based strategies to enhance the rewards of practice through compassion and collaboration in complex organizations

Corresponding author
Beth A. Lown, MD
The Schwartz Center for Compassionate Healthcare/Harvard Medical School/Mount Auburn Hospital
balown@theschwartzcenter.org

Co-authors
Michael J. Goldberg, MD
Andrew Shin, JD, MPH

Learning objectives
1. Describe social neuroscience research regarding neural activation and behaviors associated with empathy and compassion, and the impact of training interventions on stress, reward and burnout
2. Describe a framework of intra/interpersonal skills for compassion, collaboration and well-being
3. Explore and reflect upon organizational strategies that enact compassion and collaboration and ameliorate stress and burnout in the context of organizational change

Context/background
Social neuroscience research suggests that compassion is associated with positive emotions, helping behaviors and sense of reward. Unregulated emotional responses to distress and suffering may result in burnout. If we can overcome personal and organizational barriers that impede our ability to experience and provide high-quality compassionate care, we will be better able to sustain positive emotions and foster resilience. Research supports a framework of intra/inter-personal behaviors that we can learn to offer “Compassionate, Collaborative Care” (CCC) while supporting our own well-being. These behaviors exist at three levels of relationship: with patients/families, co-workers and organizational leaders. These behaviors must be supported by structures, processes, policies and leadership so that they become embedded in organizational culture.

Methods/delivery
A workshop leader will present a mini-didactic on the social neuroscience and behaviors of CCC and associated outcomes. Attendees will then participate in a facilitated, simulated clinic meeting based on a case scenario. During the simulation, participants will discuss ongoing systemic changes that impede CCC and will be prompted to suggest changes. In this fishbowl simulation, some attendees will be clinic meeting participants; others will be assigned the task of observing real-time interpersonal behaviors that demonstrate interpersonal compassion and collaboration; the remainder will be assigned the task of documenting suggestions for positive change made during the meeting. Facilitators will debrief the interpersonal behaviors and organizational changes discussed.

Findings/results/outcomes
The workshop will conclude with participants’ reflections on their own roles in supporting CCC and well-being. They will be asked to name one action they will take following the conference.

Conclusions/discussion
Participants will learn about and experience the behaviors of compassionate, collaborative care in the context of organizational change and explore how this approach can foster well-being.
Strengthening resident resiliency for rewarding, sustainable careers

Corresponding author
Christina Nowik, MD
Resident Doctors of Canada
christinanowik@gmail.com

Co-authors
Tom McLaughlin, MD

Learning objectives
1. Understand the impact of distress on mental resiliency and the importance of early intervention
2. Apply practical, evidence-based skills to help manage stress and support resiliency among residents

Context/background
Residency is a particularly dynamic and stressful time for many trainees, who must balance educational and personal responsibilities with providing patient care, often making significantly life-altering decisions in emotionally-charged situations. Resiliency training is the development of skills to effectively identify, cope with and recover from challenging experiences while setting up physicians for rewarding and sustainable careers. Resident Doctors of Canada has developed a skills-based resiliency curriculum to help mitigate stress during residency, with content support from the Mental Health Commission of Canada and the Department of National Defence’s Road to Mental Readiness Program. It highlights the importance of promoting mental resiliency in physicians by fostering supportive and positive learning environments, and advocates for a systematic approach to understanding and addressing anticipated stresses during residency. The training will assist residents in overcoming adversity and provide them with the tools to better support their peers and patients, not only during their medical training, but also over the course of their careers.

Methods/delivery
This workshop will explore and prioritize the development of tools and resources to support those in a position to facilitate or enable residents during their residency training. The workshop will employ a combination of didactic and multimedia presentation methods with interactive small group exercises and discussion.
“The journey”: A workshop using poetry to explore and sustain joy in the challenging work of a 2016 clinician.

Corresponding author
Amy N. Ship, MA, MD
Beth Israel Deaconess Medical Center
aship@bidmc.harvard.edu

Learning objectives
1. Explore the complexity of the dance involved in the demands of caregiving in 2016
2. Explore the opportunities for connection and sustenance we have to claim in our work as caregivers
3. Experience the joy that results from discussing poetry with others

Context/background
Practicing clinicians are overwhelmed by the myriad demands place on them with ever-diminishing time to do so. These issues challenge clinicians to function, much less to thrive and find meaning in their work. In part because of its non-linear, non-reductive nature, poetry can provide a way in to re-considering these challenges. And discussion of poetry can expand our insights and offer sustenance.

Methods/approach
This interactive workshop will be led by a primary care physician with extensive facilitation experience leading workshops using poetry and literature. She will use four poems (by Mary Oliver, Stephen Dunn, Robyn Sarah and an unnamed 18th century Japanese poet) to explore the process of finding and sustaining joy in our day-to-day work as caregivers. None of the poems are by physicians or directly about patient care. The facilitator will use the poems to create a rich discussion about finding and maintaining joy in challenging and sometimes soul-decimating work. In addition to finding deeper meaning in their own experiences, participants will connect with each other and share insights and strategies to sustain themselves as caregivers. The workshop will allow participants to explore the journey caregivers must embark upon and the joy to be found in that process.
The resilient physician: Individual strategies to promote whole physician health

**Corresponding author**
Elizabeth C. Lawrence, MD
University of New Mexico School of Medicine
Elawrence@unm.edu

**Co-authors**
Eileen Barrett, MD, MPH
Catherine C. Cheng, MD

**Learning objectives**
1. Describe the three general strategies of resilient physicians
2. List resiliency tools to use in everyday clinical practice
3. Commit to trying a new resiliency tool of their choice in their practice

**Background and methods**
We all can think of a colleague who still loves the practice of medicine decades into his or her career. What is that person's secret to remaining enthusiastic about being a physician and to finding joy in medicine? The literature defines three general strategies used by resilient physicians: finding meaning in work, knowing personal values and priorities, and being able to set clear boundaries. Using interactive large group discussions and small group work, we will discuss these general strategies, recognize the resiliency tools we already use in our practices, and learn new tools to promote wellness and avoid burnout. Ideally, participants in this workshop will attend a second partner workshop offered by the same facilitators entitled “The resilient physician: Institutional changes to promote wellness and prevent burnout.” Each workshop is free standing, but people who attend both will have tools to work on promoting resiliency at both the individual and the institutional level.
The resilient physician: Institutional changes to promote whole physician health

**Corresponding author**
Eileen Barrett, MD, MPH
University of New Mexico School of Medicine
ebarrett@salud.unm.edu

**Co-authors**
Elizabeth Lawrence, MD
Catherine C. Cheng, MD

**Learning objectives**
1. Describe how personal resilience strategies relate to institutional resiliency strategies
2. Describe at least two institutional changes to promote resilient physicians
3. Develop at least one strategy for making the case for our own institutional changes to promote resilience

**Context/background**
What is the secret to maintaining joy in medicine? Often it is personal attributes that promote resilience in an organization that provides a supportive work environment. Systems change comes slowly and requires a critical mass. When physicians feel empowered and self-efficacious, we work better together to improve our systems.

**Methods/approach**
In this session, using interactive large group discussions and small group work, we will discuss strategies that can be implemented at the institutional level to promote resilience and wellness and avoid burnout. Ideally, participants in this workshop will attend a partner workshop offered by the same facilitators entitled “The resilient physician: Individual strategies to promote whole physician health.” Each workshop is free standing—as we hope to reach physicians wherever they live on the spectrum of burnout to resilience—and offer strategies for unification and movement toward whole physician health.
The three legs of wellness

Corresponding author
John M. Chuck, MD
The Permanente Medical Group
john.chuck@kp.org

Learning objectives
1. GEAR up for wellness by focusing on gratitude, exercise, adaptation and relationships.
2. Understand that the three legs of their personal wellness journey are INSIGHT about their circumstances; defining their PURPOSE in life; and CHOICE, i.e., choosing the thoughts and actions that will deliver them from where they are now to where they want to be.
3. Identify three role models whose habits they will imitate in order to be more well and joyful.

Context/background
On a daily basis physicians are subjected to multiple simultaneous conflicting imperatives that make it challenging for them to tend to their own self-care and wellness. In 2015 the Mayo Clinic reported that 54 percent of American physicians are burned out. Our medical group has responded to issues of burnout by developing resilience training courses that focus on evidence-based habits associated with wellness and improved performance. This workshop highlights some of the teachings that Dr. Chuck has shared with our group and external physician audiences.

Methods/delivery
Dr. Chuck will review the origins of burnout as well as the adaptive habits of resilient physicians. Participants will have the opportunity to share their experiences and best practices both in dyads and report outs to the larger group. They will also be given a handout that invites them to commit to specific wellness practices.

Conclusions/discussion
Physician burnout is at an all-time high and still rising. This has major negative implications for professional satisfaction and joy, physician retention, the desirability of a medical career to prospective physicians, and most importantly the quality of patient care. Physicians who are unwell themselves are in no position to provide the type of care they would want for themselves or family members. The time has come to call out physician burnout as a public health crisis and to strategically address it. A key element of that strategy is to help physicians become more resilient by focusing on evidence based habits that will help restore balance, sustainability and joy to their lives. Those habits include gratitude journaling, regular exercise, adapting to change by adopting best practices, and investing in the relationships that define the meaning and purpose of a life well lived. A time honored method for personalizing one’s resilience journey is to identify resilient role models and intentionally imitate their habits.
Poster presentations: Perspectives
A happy marriage: How administrative leadership can support joy in physician hospital practice

Corresponding author
Miranda E. Germani
Quinte Health Care
mgermani@qhc.on.ca

Co-author
Dick E. Zoutman, MD

Learning objectives
1. Understand the proposed conceptual framework showing that joy in physician hospital practice triumphs at the intersection of physician engagement, enablement and empowerment for quality improvement and wellness
2. Know best practices to support joy in physician hospital practice
3. Tailor and apply tactics to the work environment to increase joy

Context/background
Like many jurisdictions, Ontario, Canada, is facing rising health care costs, long patient wait times, and issues with access to primary care and some specialists. In addition to this, physician health and burnout is seen as a concern. One of Quinte Health Care’s 300 physicians practicing at the Ontario hospital declared, “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.” This mindset is what in part sparked this project

Methods/approach
The experiences of Quinte Health Care from 2012 to 2016 are used as a case study. It is proposed that joy in physician hospital practice triumphs at the intersection of three key areas: physician engagement, enablement and empowerment for quality improvement, and wellness. Quinte Health Care’s physician engagement strategy was implemented from 2012 to 2016. Over this period, nine physician surveys were done that included consistent measures of physician engagement. In 2015, 66 percent of physicians felt burned out at some point and craved tangible improvements. Strategic medical affairs activities were thus increased to include wellness as well as enablement and empowerment for quality improvement tactics.

Findings/results
Quinte Health Care experienced a prolonged period of change, including the reduction of the hospital budget by a drastic 10 percent. 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 percent positive. Hospitals’ administrative leadership can support joy in physicians’ hospital practice through strategic medical affairs, including efforts in physician communications, continuing professional development, physical space, and human resources (medical affairs team, physician leadership structure and physicians overall).

Conclusions/discussion
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.
Changing medical trainees’ behavior concerning mental health and substance abuse

Corresponding author
Martha E. Brown, MD
University of Florida College of Medicine, Department of Psychiatry
marthabrown@ufl.edu

Co-authors
Jacqueline A. Hobbs, MD, PhD
Penelope Ziegler, MD

Learning objectives
1. Identify the different types of impairments that can occur in medical trainees
2. Understand key components to developing an educational program to help medical trainees recognize substance abuse and other impairment issues
3. Identify key resources that may help medical trainees develop skills that will help prevent burnout and increase their joy in medicine

Context/background
Medical students and residents often experience psychiatric disorders, burnout, substance abuse or other problems that can cause difficulties in their early careers or later. Medical school and hospital environments create unique challenges not normally found in graduate education. Stressors include long working hours, life-or-death crises, access to drugs and “sanctioned” binge drinking. Although potentially impairing substance use and mental health issues could be identified early in the careers of some students, medical schools often do not recognize problems or emphasize/teach healthy coping mechanisms.

Methods/approach
Two events in Florida helped make an impact on student behaviors and their ability to seek help. First, the University of Florida’s Department of Psychiatry has dedicated two weeks—one week inpatient detox and one week at Florida Recovery Center (FRC), which treats a significant number of health care professionals—of its six-week psychiatry clerkship to students learning about substance abuse and other impairment issues than can affect them. The FRC week allows students to help evaluate, attend groups and observe the treatment of professionals and other patients with substance abuse/mental health problems. Additionally, the Professionals Resource Network (PRN), the state’s Physician Health Program, developed a contract between PRN and the University of Florida to monitor students who have difficulties.

Findings/results
The outcome has been that more students received information about impairment issues, physician health, and the benefit of seeking help early in their careers for their own mental health or substance abuse issues.

Conclusions/discussion
Exposing students to a dedicated two-week track for substance abuse and other mental health impairments and emphasizing the need for self-care allows them to have firsthand knowledge of issues that can occur in their patients, themselves and their colleagues. Education and earlier interventions on burnout and impairment issues in medical students will hopefully lead them to have more joy in medicine and less problems during their career.
Assessing the role of joy in physician’s well-being using survey

Corresponding author
Sujit Kumar Kotapati, MD
UAB-Huntsville Family Medicine Residency Program
skotapati@gmail.com

Co-authors
Rajalakshmi Cheerla, MD
Shivani Malhotra, MD
Nancy Blevins, MD
Suman Donepudi, MD
Rashid Ansari, MD
Andrew Smith, MD
Meredith A. Lewis, LCSW
Angela Edwards, BA

Learning objectives
1. Responsibility was shared among the team to prioritize patient continuity in collaboration with care teams like pharmacists, social workers, etc.
2. Strengthening trust and reliance among the team was achieved by improving team communication.
3. Excellent work-flow design and planning improved team functioning, which in turn led to efficiency, productivity, promoting patient safety and providing better care for patients.

Context/background
The objective of our study is to assess the role of joy in physician’s well-being, spiritual, mission and work-life satisfaction to provide better patient care.

Methods/approach
The joy survey was introduced recently to assess its role on residents and faculty. The survey mainly focuses on ways to increase the role of joy in physicians’ well-being and provides specific information about issues like sharing responsibility among the team, improving team communication and team functioning by work-flow design to provide better care for the patients.

Findings/results
The survey was planned to evaluate the role of joy at the end of the academic year in June 2016. The residents and faculty completed the survey twice in an academic year. The scores and ratings of the survey will be compared to assess their increase in joy in their well-being and professional life. A preliminary analysis of the survey received from 30 of 40 residents and faculty who completed the survey in the month of January showed that it was 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.

Conclusions/discussion
The “Role of Joy” survey will play a key role in assessing current and future physicians in increasing joy in their personal, spiritual, mission, professional and work-life satisfaction.
Care for the caregiver: Utilization of a clinician peer-support program at an academic medical center

Corresponding author
Novneet N. Sahu, MD
Christiana Care Health System
NSahu@christianacare.org

Co-authors
Christy L. Pool, RN, BSN
Heather Farley, MD

Learning objectives
1. Illustrate factors that lead to the 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

Context/background
The goal of this study is to analyze peer support encounters after initial program implementation to determine utilization and identify areas for improvement. After an adverse event, clinicians are at risk for becoming the “second victims,” and have been noted to experience predictable stress behaviors. Clinicians report feelings of personal responsibility for the unexpected outcome, a sense of having failed the patient, and may second-guess their clinical skills and knowledge base. Increased rates of depression, substance abuse and suicide have been reported. Decreased job satisfaction and increased burnout are common, leading some clinicians involved to contemplate leaving their profession. While clinicians may access the Employee Assistance Program (EAP) at their institution, rarely do they utilize this service. For these reasons, a true peer-to-peer support program is necessary.

Methods/approach
In June of 2015, a peer support program entitled “Care for the Caregiver” was launched at Christiana Care Health System, a 1,100-bed not-for-profit academic medical center in Newark, Del. The team includes attending and resident physicians, nurses and chaplains trained in providing emotional support to second victims. The 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-PHI aspects of the encounter, level of satisfaction, as well as suggestions for improvement. This data was analyzed using qualitative methods to determine utilization and to identify areas for improvement.

Findings/results
Peer supporters have recorded 99 encounters to date. Encounters were characterized by type of referral, clinician, unit location, event and initial vs. follow-up status. Twenty encounters included free-text comments.

Conclusions/discussion
A peer-support program sends a strong message that an institution cares for its clinicians. Knowledge that staff is 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.
Completing the puzzle: A descriptive framework of physician health services in Canada

Corresponding author
Derek Puddester, BA, BMedSc, MD, MEd
Ontario Medical Association, Physician health program
derek.puddester@oma.org

Co-authors
Andrew Clarke, MD, Med, DOHS
Carolyn Thomson, MD
Patricia Evans, BA, MCE
Michael Kaufmann, MD

Learning objectives
1. Discuss the value of, and the challenges inherent in, developing a standardized framework to describe a set of complex psychosocial interventions generally
2. Describe the approach used to develop a description of physician health services available in Canada
3. Reflect on how this approach might be extended to, or applied in, their local contexts

Project objectives
1. Engage the Physician Health Program (PHP) community in a progressive effort to develop standards for program activity, performance and quality
2. Use a mixed methods framework to test and affirm models of provincial/territorial PHP activity
3. Apply the framework to identify potential gaps and inequities in access and service delivery

Methods/approach
Mixed methods were applied in seven phases: (1) project discovery; (2) design and planning; (3) pilot data collection; (4) revision of descriptors; (5) national data collection; (6) analysis; and (7) elicitation of drivers for, and barriers to, adoption.

Findings/results
The main variable influencing stakeholder perception was the perceived potential use of the resulting descriptive framework. It was possible to arrive at general descriptive terms for services that all participating stakeholders endorsed as accurate. The number of different organizations (and types of organizations) providing services relevant to physician health makes the development of a standard descriptive framework both challenging and worthwhile.

Conclusions/discussion
Work on this project should continue, with incremental improvements accruing as more organizations apply the framework and supply feedback.
Cultivating a culture of self-awareness, compassion and community through development of a novel anesthesia resident wellness program

Corresponding author
Tara Cornaby, MD
Stanford University
tcornaby@stanford.edu

Co-authors
Ravi Prasad, PhD
Natalya Hasan-Hill, MD
Emily Ratner, MD

Learning objectives
1. Understand the rationale for developing a residency wellness program
2. Understand the components of a wellness program designed for anesthesia residents
3. Understand the reported benefits of having a wellness program for residents

Context/background
Burnout, a phenomenon closely linked with depression and characterized by emotional exhaustion, depersonalization and reduced self-efficacy, has increased at a disproportionate rate in physicians compared to the general U.S. working population. While interventions have been developed to address factors that contribute to burnout among practicing physicians, 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, expertise, efficiency and critical thinking by creating a new culture that fosters interdependence, concern for others, self-care and emotional literacy.

Methods/approach
As one of the inaugural Anesthesia Wellness Programs in the nation, PRIME seeks to enhance resident well-being through a combination of experiential and didactic offerings. The concept of wellness is first introduced to residents at the start of their CA-1 year during a 2.5 day retreat based on Jon Kabat-Zinn’s Mindfulness-Based Stress Reduction course. Trained faculty members lead residents in various exercises that teach productive coping mechanisms and allow for sharing of emotions and vulnerabilities in a non-judgmental and confidential setting. The retreat facilitates gaining insight into inter- and intrapersonal factors that contribute to one’s sense of wellness and aids in creation of social support networks. Residents continue to attend wellness sessions every six weeks during protected, non-clinical time throughout the remainder of the residency program. Trained faculty members 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.

Conclusions/discussion
Preliminary findings from assessment devices administered to residents throughout their participation suggest that the program promotes well-being, community building, and stress reduction. It appears to be beneficial to trainees and produces physicians entering the workforce with a stronger appreciation for wellness.
De-stigmatizing mental illness in medical school through the use of peer/mentor messaging

Corresponding author
Ian C. Gallant, BSc, MCISc
Memorial University of Newfoundland
iancgallant@gmail.com

Co-authors
Stephen Darcy, MD
Heather Flynn, MD

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 for overcoming these barriers.
3. Discuss ways in which we can mentor a culture of medicine change in order to become more open and supportive of help-seeking.

Context/background
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. Students at the beginning of their medical training actually have better mental health profiles compared to their peers outside of medicine.1 However, as they progress through their education and training, medical students' mental health profiles deteriorate to become worse than those of their peers.2 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.3 Students experiencing burnout are more likely to behave unprofessionally and less likely to hold altruistic views about responsibility to others.4 We can change this.

Methods/approach
The goals of this project will be accomplished through the delivery of a short video, put to music, showcasing local physicians affiliated with a medical school displaying brief messages on poster cards that exemplify the mental health issues experienced by medical students and physicians along with supportive messages. These supportive messages will acknowledge that we can talk about the problem and help to change the culture to one of support. 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.

Conclusions/discussion
The expected results of this project are that there will be an increased awareness of the mental health issues commonly experienced by medical students, that these issues will be de-stigmatized, and that this will contribute to a more open and supportive culture of help-seeking. A research study is planned to study the effects of the project.

Exercise for mood in residency

Corresponding author
Stella Miller, MEd, MCouns
McGill University Faculty of Medicine
stella.miller@mcgill.ca

Co-author
Louise Lockhart, RN

Learning objectives
1. To raise awareness of the link between aerobic exercise and mood
2. To support learners in their motivation to exercise for the sake of associated improvements to mood
3. To provide learners with practical tools to support their formation and adherence to a realistic exercise program

Context/background
This presentation will provide information on the Exercise for Mood program at McGill University. Exercise for Mood is designed to build awareness of the link between regular exercise and improved mood, and to convey practical advice to learners on the development of realistic plans for exercising for short-to-medium term psychological benefits. Exercise for Mood was developed by a McGill University nurse (Louise Lockhart) and counselor (Stella Miller). The original (and still running) variant is a 10-week program of two-hour weekly sessions, each of which includes (a) guided aerobic exercise in a supportive group setting; (b) psychoeducational presentations on related topics, sequenced in a stepwise way (e.g., sessions on: the link between exercise and affect; exercise as catharsis and contributor to personal resilience; goal-setting and planning); and (c) facilitated group discussion. Offered to all McGill University students, Exercise for Mood quickly became one of McGill’s most popular wellness workshops and has since gained significant media interest (including recent features in the Montreal Gazette and on CTV News). Exercise for Mood has since been adapted to a short-course format for McGill medical residents. In this presentation, the developers of Exercise for Mood will (a) explain the program and its goals; (b) discuss how it has been adapted for medical residents; and (c) present interim results of ongoing research that they are conducting at McGill on the program’s effectiveness in promoting awareness of, and interest in, exercise for the sake of its psychological benefits.
Finding joy in a haystack

Corresponding author
Harise C. Stein, MD
Stanford Medical Center
harise@stanford.edu

Learning objectives
At the conclusion of this presentation, participants will be able to:
1. Understand the general and generational challenges of communicating with physicians
2. List multimedia communication methods.
3. Apply the power and potential of website design to their institution wellness needs

Context/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.

Methods/approach
This presentation will review multiple approaches to providing general support and information beneficial to physician health and wellness, including generational preferences for receiving information. These methods include a top-rated website (http://wellmd.stanford.edu)—presently the No. 1 site returned on Google search for “physician wellness”—monthly newsletters, business cards and various dedicated support programs with phone lines and email contacts. The website, which during the past four years has grown its returning visitor rate from 2 percent to 30 percent, will be explored in detail, including most-viewed topics and future creative options to involve viewers.

Conclusions/discussion
By increasing a sense of community, providing supportive resources available 24/7, and advertising the many worthwhile programs available, a clear and easily-accessed communication system is vitally important to any physician wellness program. Joy in medicine sometimes literally needs to be “found.”
From burnout to joy: Letting go of suffering with self-compassion

Corresponding author
David A. Richardson, MD
Henry Ford Health System
drichar1@hfhs.org

Learning objectives
1. Understanding the difference between pain and suffering in medical practice
2. Recognizing when the stressors of medicine have turned into suffering
3. Learning different techniques to manage suffering with compassion

Project objective
Research conducted at our institution on medical students, residents and mid-level providers consistently demonstrated that self-compassion is associated with increased satisfaction with life and decreased burnout. Self-compassion is associated with decreased burnout, depression, anxiety and stress. Self-compassion is a teachable antidote to physician suffering.

Pain is inevitable. Everyone on a daily basis experiences pain: physical, psychological, social or spiritual. This pain can include the weather, hunger or the electronic medical record. Pain can also be the feelings of fear, sadness and anger. Suffering is a mental construct that everyone experiences. Burnout is a form of suffering. The cause of suffering is the mental process that resists accepting life on life's terms and desires that the pain be other than it is. For many physicians, avoidance or not feeling is part of our culture. Both taught and honored, avoidance leads to a practice of “enduring” suffering. In this culture, the feeling of emotions is considered wrong. The avoidance can lead to additional suffering, such as self-judgement, shame and addictive behaviors.

Suffering is optional. Pain is similar to any disease state. Treatments exist that may or may not fix the problem. Since suffering is a mental construct, it is not fixable with traditional therapies. One antidote for suffering is self-compassion—learning to hold the suffering with nonjudgmental awareness.

Pain/stress requires individuals to recognize, accept and then identify what needs to be done. Suffering requires awareness and the desire to ameliorate the suffering with compassion. Contemplative and non-contemplative options are available for managing suffering.
From coping to thriving: Finding our own agency in a challenging cultural milieu

Corresponding author
Catherine Cheng, MD
Northwestern University Feinberg School of Medicine
Northwestern Executive Health
chenger91@hotmail.com

Learning 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 Innovations to personal and systems change to move medical culture away from shame and isolation and toward self-efficacy and unification

Context/background
Medicine attracts people who put themselves last, always serving others first, to prove themselves worthy of their position in society. We understand, intellectually, the need to care for ourselves. But our professional culture prevents us, on multiple fronts, from addressing our own needs.

Methods/approach
I aim this poster at both the limbic and cognitive sectors of our brains. Seeing ourselves as elite athletes ignites a sense of pride and self-worth. Linking that pride to our cultural role as tribal leaders (David Logan, et. al. at USC) lends additional significance to physician self-care, and validates it as key to sustaining joy in medicine for ourselves, regardless of the systems surrounding us. Having established ourselves as worthy of self-care, and recognizing that we can “lead (the orchestra) from any chair,” (Ben Zander), we can then apply the Law of Diffusion of Innovations (Everett Rogers, 1962). We can identify where we reside on the continuum of systems change in medicine— I imagine conference attendees as mostly innovators and early adopters—and maximize our contribution from there.

Conclusions/discussion
Joy in medicine starts with the awareness and acknowledgement that we ourselves matter just as much as those we serve. Starting from there, we can—each of us—contribute powerfully to the movement toward optimal systems for physician health and health for all.
From the ground up: Residents’ perspectives on improving physician wellness in an academic ob-gyn residency program

Corresponding author
Martha B. Kole, MD
Alpert Medical School of Brown University/Women and Infants Hospital
mkole@wihri.org

Co-authors
Erica Weston, MD
Alexandra Jen, MD
Jane Sharp, MD

Learning objectives
At the conclusion of this presentation/poster participants will be able to:
1. Identify risk factors for stress and burnout in young physicians
2. Identify activities residents find beneficial for their personal and professional wellness
3. Implement change at their home institution to focus on physician well-being

Context/background
With high levels of physician burnout and stress nationwide, it is imperative that medical students and young physicians alike invest in their own personal well-being. Not only has the rate of physician suicide increased, especially among the youngest physicians, but physicians-in-training are exposed to a workplace where more and more physicians are choosing to move away from practicing clinical medicine. With these ideas in mind, residents at an academic ob-gyn residency program developed a curriculum to focus on resident wellness.

Needs assessment
Initial surveys using a Likert scale of 0–5 (0 = strongly disagree, 5 = strongly agree) were completed by 31 of 32 residents. Results demonstrated that although wellness was very important to residents (score of 4.6) overall they felt dissatisfied or neutral about their current level of well-being, with 34 percent of residents scoring a 2 or less. Additionally, residents indicated that their training institution was concerned about their personal wellness (score of 4.5) but did not provide opportunities within the workday for residents to partake in it or have experiences related to wellness (score of 2.8).

Curriculum development
Using information from the residency-wide survey a wellness curriculum was created to allow for wellness activities to be incorporated into the everyday life of residents. This includes monthly noon conferences, monthly wellness challenges and lectures during the residency-wide core curriculum. Curriculum themes include mindfulness, incorporation of the arts into medicine, exercise, healthy eating and art therapy.

Future directions
Improving physician wellness is imperative to increasing the joy in medicine. Our hope is that the creation of our unique Wellness Curriculum not only improves the overall well-being in our individual residency program but additionally brings wellness to the forefront of the discussion on residency education.
Health behavior of physicians in Israel: Practice what we preach

Corresponding author
Malke Borow, JD
Israeli Medical Association
malkeb@ima.org.il

Co-author
Adv. Leah Wapner

Learning objectives
1. Recognize the need to improve physician lifestyle in Israel
2. Understand how physicians' quality of life affects the health care system
3. Discuss how to promote healthy lifestyles within the physician community through varied means

Context/background
Many studies have linked good health to increased happiness. While there have been remarkable advances in our understanding and treatment to improve health, many physicians have neglected to take care of themselves, as per "Physician, heal thyself." Medicine is an increasingly high risk profession for burnout. In Medscape's 2015 Physician Lifestyle Report, 46 percent of physicians reported burnout, a considerable increase from 39.8 percent in 2013. Burned-out physicians were less likely to rate themselves as having good health and were less physically active. In 2015 the Israeli Medical Association (IMA) surveyed Israeli physicians, believing that physicians who practice a healthy lifestyle will be increasingly happy, more satisfied and more likely to promote healthy behavior to their patients.

Methods/approach
The survey was sent to 25,000 physicians and 4,832 responded. It was hoped that this survey would not only provide information about the health status of Israeli physicians, but also encourage healthy behaviors within the physician community.

Findings/results
The survey found that the majority of Israeli physicians do not practice a healthy lifestyle. Over one-third of respondents reported exercising fewer than 150 minutes a week; only half eat breakfast or sit down to lunch; and only one-third eat a Mediterranean diet, drink enough water, and eat five pieces of fruit and vegetables daily. A total of 8.5 percent of respondents were smokers, lower than the Israeli general population but higher than rates of physicians who smoke in America (4 percent) and Canada (3.3 percent).

Conclusions/discussion
The findings are alarming by any measure. Physicians' quality of life is in direct relation to the quality of the Israeli health system. Why do Israeli physicians not practice healthy behavior? The IMA is now working to promote healthy lifestyles within the physician community. In order to succeed we believe that it is important to work with the Ministry of Health, medical institutions and scientific societies.
Hospital-based specialties need joy too: Wellness programming in an anesthesia department

Corresponding author
Vanessa Kurzweil, PhD
Department of Anesthesia, Critical Care and Pain Medicine, Massachusetts General Hospital
vkurzweil@partners.org

Co-authors
Allison Doney, MHA
Aalok Agarwala, MD, MBA

Learning objectives
1. Participants will be able to describe the unique stressors affecting hospital-based specialists such as anesthesiologists.
2. Participants will be able to identify common barriers to incorporating wellness programming into hospital-based practice and learn strategies for addressing them.
3. Participants will learn about the specific steps taken by our institution to promote joy and wellness and consider how such approaches may be tailored for their own practice.

Context/background
Burnout, depression and low job satisfaction are increasingly affecting physicians in all specialties. However, many programs designed to combat these problems, such as Balint groups, stress management training and wellness retreats are the province of family medicine and other ambulatory care practices. There are several reasons for this—from lack of awareness and training to a culture that discourages self-care. This is unfortunate, as hospital-based specialists face a unique set of stressors and could benefit from wider adoption of wellness initiatives. We provide guidelines for successfully implementing wellness programming in a hospital setting and give examples of potential interventions.

Conclusions/discussion
Barriers to incorporating wellness programming in hospital-based specialties:
• Work schedules
• Lack of awareness
• Lack of trained facilitators within department
• Culture of stoicism

Stressors that disproportionately affect hospital-based specialties:
• High acuity patients
• Call schedules/work schedules
• Lack of relationship with patients
• Risk of litigation

General approaches to overcome these barriers:
• Make it a priority: use scheduled didactic time
• Make it compelling: focus on activities of most interest to the staff
• Make it convenient: use non-traditional formats, and provide food or other incentives
• Make it simple: informal social events and group exercise can be planned without special training

Our interventions:
• Social and relaxation events
• Grand Rounds and lectures on burnout, conflict management and financial planning
• “Drop-in” Q&A sessions on child care, elder care and retirement planning
How health care organizations can build a compassionate care anti-burnout toolbox

Corresponding author
Michael J. Goldberg, MD
Seattle Children's Hospital/The Schwartz Center for Compassionate Healthcare
Michael.goldberg@seattlechildrens.org

Co-authors
Beth A. Lown, MD
Andrew Shin, JD, MPH

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

Context/background
Some of the leading organizations and systems, both internationally and in the United States, 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.

Methods/approach
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).

The contents of a compassionate care anti-burnout toolbox includes 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. Examples include: screening for workforce burnout, managing the consequences of adverse events, designing systems and infrastructure with the compassionate caregiver in mind, preserving work-control autonomy of physicians and nurses in a clinical setting, and recognizing and rewarding compassionate collaborative care.

Conclusions/discussion
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.
How to remain human when everyone is trying to turn you into a robot: A pilot curriculum of self-compassion for year three medical students

Corresponding author
Eileen Hug, DO
Henry Ford Health System
ehug1@hfhs.org

Co-authors
David Richardson, MD
Kendra Schwartz, MD
Kathleen Connors
Jessica Love

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

Context/background
Decreased professional and personal joy in medical students and residents is evident by increased burnout and secondary traumatic stress. Research conducted at our institution on medical students, residents and mid-levels consistently detected an association between increased self-compassion and decreased burnout and secondary traumatic stress. To address this phenomenon we developed a longitudinal curriculum to foster self-compassion in year three medical students.

Methods/approach
A culture of caring and compassion requires students to distinguish the difference between pain and suffering in themselves and their patients. All students experience pain and suffering during their clinical training. They make mistakes. Patients have bad outcomes that they could not prevent. Self-compassion starts with noticing the pain/stress and holding it with non-judgment awareness and acceptance. This is not about teaching students what they should be doing and judging them as inadequate if they fail; rather it is about teaching them how to accept their own humanity and avoid identification with their mistakes.

During the 2014-2015 academic year, we introduced a pilot longitudinal curriculum to 105, year three medical students from Wayne State University, School of Medicine based at Henry Ford Health System. The pilot consisted of seven, two-hour sessions based on the GRACE model developed by Joan Halifax.

Findings/results
A survey was conducted at the end of the course. Results showed that the students felt mediation was least helpful; however the overall consistent result was the students felt the course was invaluable during their first clinical year and the skills taught during the course would be beneficial throughout their professional journey.

Conclusions/discussion
Burnout is simply a form of suffering. The antidote to suffering is compassion. Teaching self-compassion and self-compassion practice is a way of not only preventing burnout but alleviating it once it occurs.
Humanizing medicine through attention to values: A framework for implementation

Corresponding author
Elizabeth A. Rider, MD, MSW
Institute for Professionalism & Ethical Practice, and Division of General Pediatrics, Boston Children's Hospital; Department of Pediatrics, Harvard Medical School
elizabeth_rider@hms.harvard.edu

Co-authors
H. Esterbrook Longmaid III, MD
William T. Branch Jr., MD
Suzanne Kurtz, PhD
Diana Slade, PhD
E. Angela Chan, PhD, RN
Dorothy Jones, BMBS
Phillip Della, RN, PhD
Roger Dunston, PhD
Jack Pun Kwok Hung, BSc (Hons), MA
Christian MIM Matthiessen, PhD

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

Context/background
Attention to core values and skilled communication are necessary for safe, compassionate care environments, and they underpin all relationships within health care settings. Initiated in 2011, the “International Charter for Human Values in Healthcare”—the result of a global inter-professional effort to identify core values—provides a framework of core values fundamental to all health care interactions.1

Methods/approach
An international, inter-professional 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, Commitment to Integrity and Ethical Practice, Commitment to Excellence and Justice in Healthcare—that should be present in every health care interaction. The resulting “International Charter for Human Values in Healthcare,” an initiative of the International Research Centre for Communication in Healthcare (IRCCH), has partners in Hong Kong, Australia, Brazil, the Netherlands, New Zealand, United Kingdom, Uganda and the United States. The charter works closely with the Charter for Compassion International. IRCCH recently became the Asia-Pacific Healthcare Hub for Charter for Compassion International.

Findings/results
The charter’s framework has been used to explore, identify and incorporate values into the curricula of a number of courses, including inter-professional, 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 and discussion. We continue to work collaboratively and internationally to translate values into action in health care settings.

Conclusions/discussion
The “International Charter for Human Values in Healthcare,” developed from an inter-professional, global collaboration, provides a strategy and framework to restore the primacy of human values necessary for practicing compassionate, ethical and safe health care. Values articulated in the charter inform ongoing and evolving projects and programs in clinical care, training, research and organizational culture change.

Increasing joy in residency training: The University of Alberta’s innovative approach to learner advocacy and wellness

Corresponding author
Erari Dance, MD
University of Alberta
erdance@ualberta.ca

Co-author
Melanie A. Lewis, MD, MMedEd

Learning objectives
1. Recognize a unique university approach to the provision of support and promotion of wellness in medical learners
2. Acknowledge the importance of unbiased advocacy and stakeholder collaboration especially in complex cases and with sensitive issues
3. Develop strategies to promote resilience and increase joy for physicians in training

Context/background
Medicine can be a rewarding and joyous career; however, physicians face significant levels of burnout, depression, addictions and suicide (Gundersen, 2001). Resident physicians have high levels of stress, compounded by academic challenges, job insecurity and rapidly changing expectations. Unfortunately, residency training may be the lowest point of personal wellness in the path towards becoming a physician (Lefebvre, 2012), making it difficult for resident physicians to appreciate the joys in medicine. Furthermore, we know that learner distress has been linked to unprofessional learner behavior, poor exam performance and medical error (Dyrbye et al., 2010; West et al., 2009; West et al., 2011).

Methods/approach
In order to address this broad range of concerns and to promote wellness and joy, in 2011 the University of Alberta’s Faculty of Medicine & Dentistry envisioned and developed an innovative support system branded as the Learner Advocacy & Wellness (LAW) Office. The LAW Office is a safe, inclusive and confidential space separate from the medical education offices. It has a mandate to ensure that medical learners are able to achieve their full personal and academic potential.

Findings/results
This poster presentation reviews the volume and variety of postgraduate cases that present to the LAW Office. It outlines how resident physicians are assisted and focuses on navigation of complex and contentious issues. The presentation will also highlight collaboration with university and non-university resources and stakeholders, and protection of learner privacy.

Conclusions/discussion
In summary, this poster presentation provides an analysis of the University of Alberta’s unique model for advocating for and addressing concerns in medical learners. The LAW Office strives to be a center for promoting health, resilience and success in all medical trainees with the hope that even while facing the challenges of residency training, these physicians can find the “joy in medicine.”
Increasing primary care physician satisfaction through improved clinical team dynamics

Corresponding author
Lindsay S. Hunt, MEd
Harvard Medical School Center for Primary Care
Lindsay_Hunt@hms.harvard.edu

Co-authors
T’sera M. B. Mirescu, BA
Trudy Bearden, PA-C, MPAS
Jennifer E. Azzara, MM
Sara J. Singer, PhD, MBA
Andrew L. Ellner, MD, MSc

Learning objectives
1. Convey the unique value of structured, collaborative learning communities in the context of current challenges in primary care.
2. Describe the specific benefit to physicians and residents of a team-based primary care approach.
3. Discuss the future state possibilities for increased physician as well as care team and patient satisfaction in primary care through the implementation of team-based, medical home models with imbedded quality improvement methodology.

Context/background
A collaborative learning community of primary care teaching clinics was launched in 2012 with the aim of practice transformation toward a team-based approach to primary care. In 2014 the collaborative was extended for an additional two years to begin applying quality improvement and team-based care strategies to ambulatory patient safety aims.

Methods/approach
The collaborative includes a mix of practices—16 adult primary care, eight family medicine and four pediatric—that participate in monthly learning activities and share insights, successes and challenges. It was structured based on the Breakthrough Series model, with an added practice transformation framework developed by the Safety Net Medical Home Initiative. Clinical teams comprise various patient-facing and administrative staff, each led by a physician principal investigator and a project manager. Participating PCPs are mostly physicians with some nurse practitioners and physician assistants. A planning team based at the affiliated medical school designed the content and structure of the collaborative with guidance from a steering committee of hospital leadership. Overall outcomes are being evaluated by a group housed at the university’s public health school.

Findings/results
All clinical teams have improved in consensus scores on key “change concepts” with the measures for “continuous and team-based healing relationships” improving 36.1 percent from baseline (p<0.001). The evaluation group separately found significant self-reported improvements specific to physicians. For non-trainee PCPs, better team dynamics are associated with high clinical work satisfaction and quality of patient care coordination. Residents also reported improved team dynamics from collaborative years one to two, which appear related to helping them meet their residency learning goals.

Conclusions/discussion
High-functioning teams appear to reduce stress related to the operational complexity of the primary care setting, making a compelling argument for adopting the kind of QI-driven practice transformation that builds and supports strong primary care teams.

Inspiring through the heart: The “Soul on Fire” podcast series

Corresponding author
Anne K. Wong, MD, PhD
McMaster University
wongan@mcmaster.ca

Co-authors
Janette Barrington, PhD
Ilana Bayer, PhD
Colleen McKey, PhD
Arshad Ahmad, PhD
Bruce Wainman, PhD
Zafar Syed, MA

Learning objectives
1. Describe the use of narrative in health care and educational contexts
2. Explore the potential for narrative podcasts to inspire personal and professional engagement
3. Integrate narrative podcasts as a pedagogical modality for faculty development

Context/background
Faculty development programs traditionally take the form of instructional workshops, lectures and seminars. Our innovative podcast series, “Soul on fire: Narratives that inspire” takes a different approach, premised on the notion that the “most powerful weapon on earth is the soul on fire” and that “education is not the filling of a pail, but the lighting of a fire.” We showcase the personal narratives of exemplary McMaster faculty educators in order to inspire listeners to recognize their own passion and academic potential.

Methods/approach
We interviewed seven exemplary faculty members from McMaster University about their personal and professional journeys. Participants were asked about their academic work and interests, what inspires their own passion and lessons learned. Each interview was edited and formatted as a 30-minute podcast. A website was created to house the podcasts. The launch of the podcast series was publicized through the university websites, newsletters, email notifications and social media.

Findings/results:
The “Soul on fire: Narratives that inspire” podcast series has received much interest as expressed by faculty and listener uptake. Its effectiveness in promoting faculty engagement, reflection and practice is being assessed through online uptake, discussions, surveys and post-podcast interviews. This information will help inform the use of narrative podcasts as a pedagogical modality.

Conclusions/discussion
Personal narratives are a compelling way to inspire and motivate. They may stimulate reflective teaching practices and promotion of academic community engagement. It is hoped that the narratives of these dynamic faculty will inspire listeners to embrace joy in their work and to realize their own passion and potential. Our ongoing program evaluation will help inform the use of narrative as a mode of faculty development.
Mindfulness-based stress reduction retreat to reduce compassion fatigue

Corresponding author
Kashyap Patel, MD
Carolina Blood and Cancer Care Associates
kpatel@cbcca.net

Co-authors
Arya Patel
Taylor Lavender
Dhwani Mehta
Grace Wadell
Theresa Younis

Learning objectives
1. Recognize the unique problems, challenges and opportunities of addressing compassion fatigue and burnout prevalent amongst physicians
2. Describe the components of an evidence-based approach to understand and help these physicians identify compassion fatigue and learn how to care for themselves
3. Evaluate role of mindfulness-based stress reduction techniques in helping with compassion fatigue and physician burnout

Context/background
Compassion fatigue is a growing concern amongst physicians providing end of life care (EOLC) to patients. Compassion fatigue arises from interaction between patients and clinicians. EOLC is one of the most difficult and challenging fields in health care and creates vulnerability for physicians. So far little if any attention has been paid to explore intervention to reduce compassion fatigue and to promote physician well-being in the area of EOLC.

Mindfulness-based stress reduction (MBSR) has been reported to mitigate burnout, reduce compassion fatigue and bring more joy to work. We carried out a pilot study combining training for EOLC and MBSR to mitigate compassion fatigue.

Methods/approach
We conducted a live-in retreat also enabling attendees to claim CME (continued medical education). This was an observational study to explore feasibility and receptivity of MBSR for the EOLC. All participants were given a questionnaire at the conclusion of the retreat and follow-up questions at 12 weeks. This study measured feasibility and efficacy of combining EOLC and MBSR to improve communication skills for the EOL discussion and reduce compassion fatigue on the scale of 1–5.

Findings/results
A total of 14 participants took part in this retreat. Eight of them were providers, and others were either support staff or allied health care workers. The overall satisfaction rating for the retreat was 4.98 out of 5. All participants agreed that the training was pertinent to their field of work and that it would enhance their practice goals and improve professional outcomes. All participants expressed that they would be able to enhance their communication skills for end of life care and improve the process of advance care planning. All participants reported that they were able to recognize, learn and practice mindfulness to reduce their burnout and compassion fatigue. There was no negative reporting. Seventy percent of respondents reported continued affirmative reaction at the end of 12 weeks when they were sent follow-up emails and questionnaires.

Conclusions/discussion
Combining MBSR and EOLC in a live-in retreat format is feasible intervention for reducing compassion fatigue with no negative effect. So far the study has reported retention of knowledge and practice over four months. Further follow-up will explore retention of MBSR practice for further improvements.
Moving toward a culture of joy: A medical staff well-being program

Corresponding author
Bradley L. Edgington, PhD
Intermountain Healthcare, Urban South Region
edgington.brad@gmail.com

Co-author
Neil S. Whitaker, MD

Learning objectives
1. Conceptualize a framework for developing a well-being program
2. Identify principles and key players for developing a well-being program
3. Understand the benefits of a health promotion dimension to a medical staff well-being program
4. Understand how an early intervention rehabilitation program can benefit physicians and other health care providers

Context/background
The Intermountain Healthcare Urban South Region (USR) is comprised of three community hospitals located in a population area of approximately 500,000 people with a combined medical staff of over 800 credentialed physicians and other providers. Rapid growth of the hospitals and medical staff has resulted in ever-greater complexity in physician-hospital and interpersonal interactions and a corresponding rise in physician dissatisfaction and lack of cohesiveness and joy in the professional lives of the medical staff. The USR Medical Staff Well Being program was conceived and implemented by physician leaders with support of hospital administrators to develop health promotion activities for medical departments, enable early interventions for physicians with needs and support rehabilitation of physicians in parallel with the medical staff policies and procedures governing personal conduct.

Methods/approach
Several health promotion activities were implemented in an effort to positively impact a culture of health and well-being among the medical staff. These included educational, social and physical fitness activities. The program coordinator provided medical staff leadership presentations helped develop individualized corrective action plans and direct physician consultation for those in need of increased support or intervention. Attitudes of the medical staff were measured via survey on three different occasions in a general medical staff meeting. The survey was designed to assess attitudes regarding the medical staff’s professional competency, collegiality, cohesiveness, adaptability and comfort with colleagues, and ability to “get things done.”

Findings/results
Medical staff survey results suggest improvement in all six areas surveyed initially and stabilization in all areas after eight years. Many medical staff members have found solutions to simple and complex personal and professional challenges in response to support and intervention.

Conclusions/discussion
A medical staff well-being program with the support of hospital administration can provide both individual and cultural improvements to a medical community.
Physicians drinking well

Corresponding author
Kirk J. Brower, MD
University of Michigan Addiction Treatment Services
kbrower@med.umich.edu

Learning objectives
1. Cite the criteria and scientific basis for assessing low-risk (moderate) drinking
2. Acquire a simple approach to screen and educate 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

Context/background
Alcohol is commonly used in Western cultures to socialize with others and to celebrate joyous occasions such as weddings. In the United States, the use of alcohol became a constitutional right with the passage and ratification of Amendment XXI in 1933. Moderate or low-risk drinking has been defined as consuming no more than three drinks in a day and seven drinks in a week for adult women, and consuming no more than four drinks in a day and 14 drinks in a week for men. About 72 percent of Americans either abstain or stay within these limits. Low-risk drinking can have some health benefits and be cardio-protective in physicians (Petrone et al., 2014) as well as in the general population. On the other hand, high-risk drinking has been associated with burnout in physicians (Pedersen et al 2016); and alcohol use disorders—estimated to affect 15.2 percent of American physicians (Oreskovich et al., 2015)—are a well-known cause of physician impairment. Physicians are expected to be knowledgeable about the effects of alcohol on health and to screen our patients for high-risk and problem drinking; however, physicians’ training, confidence and practice in these areas are frequently deficient (Loheswaran et al., 2015). To screen yourself, ask: How many times in the past year have you had x or more drinks in a day (where x = 4 in women and 5 in men)?

Conclusions/discussion
A balanced perspective on the social use of alcohol is needed to enhance joy in the lives of patients as well as that of physicians. Both the 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 patients’ drinking in a non-judgmental manner.
Planning and assessing wellness interventions physicians create for themselves: Results of a promising natural experiment

Corresponding author
Andrea B. Hausel, MPH
Stanford University
ahausel@stanford.edu

Co-authors
Mickey T. Trockel, MD, PhD
Rachel M. Seaman, MD
Bryan D. Bohman, MD

Learning objectives
1. Participants will be able to explain one model of monitoring physician wellness and professional fulfillment.
2. Participants will be able to state how "A3 Thinking" can be used to plan wellness interventions.
3. Participants will understand a participatory physician wellness intervention approach.

Context/background
The Physician Wellness Program was created in 2015 with the recognition that physician wellness is a critical element in the provision of high-quality care. The program strategy focuses on three wellness domains—personal wellness, organizational culture and practice efficiency.

Methods/approach
Physicians and advanced practice providers (APPs) complete an annual, confidential survey that assesses burnout, professional fulfillment and determinants of wellness. Survey participation is incentivized. Longitudinal data is assessed using a matched cohort of providers who completed surveys each year (n = 146 physicians, n = 27 APPs). Survey data are then used by physicians at each practice group to create their Wellness Intervention Plan using a process improvement tool called an A3.

Findings/results
Over 95 percent of providers (n = 189) completed the baseline wellness survey, and 98 percent (n = 289) completed the one-year follow up survey. Burnout among physicians only was 31 percent. The top statistically significant predictors of burnout (p < 0.05) were self-compassion (OR: 0.31; 95% CI: 0.19 -0.50) and sleep-related impairment (OR: 2.87; 95% CI: 1.73-4.76). For each one-point increase in self-compassion, odds of burnout fell by 69 percent. For every one-point increase in sleep-related impairment, the odds of burnout increased by 187 percent. The top drivers of professional fulfillment ($R^2 = 0.50$, $p < 0.05$) were mindfulness ($\beta = 0.26$), mission alignment ($\beta = 0.22$), appreciation ($\beta = 0.21$), peer support ($\beta = 0.14$) and self-compassion ($\beta = 0.10$).

Conclusions/discussion
Involving physician wellness leaders in planning of wellness interventions using longitudinal wellness measures and incorporating performance improvement tools are factors that facilitate effective physician wellness interventions. While burnout rates remained relatively stable in physicians during the first year of intervention development, this is in the context of published data indicating an increased burnout rate nationally. Interventions designed to affect determinants of burnout and professional fulfillment have potential to increase the joy in medicine.
Removing barriers to joy in medicine with technology

Corresponding author
Sharon R. Vorona, MBBS
Figure 1
svorona@figure1.com

Co-author
Joshua S. Landy, MD

Learning objectives
1. The importance of spiral learning in medical education
2. How the instant feedback from social media can provide reinforcement in medical education
3. The significance of network effects in health care

Context/background
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. Every infuriating form, protocol or piece of technology takes physicians away from their mission. We do fascinating work, yet we revert to the most boring means to learn about it—didactic content, long-form technical essays and textbooks are all complicit in the theft of whimsical delight from the curious and earnest learner. Continuing education should be light and engaging, something one voluntarily turns to in free moments. The medical education platform “Figure 1” leverages its design as a social network to engage users in educational activities. Figure 1 reinforces education by drawing on the principle of spiral learning. The other factor sapping joy from 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 one million health care 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 changes and instant results. On Figure 1, physicians share real-time updates with peers, 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.

Conclusions/discussion
Medicine is intensely rewarding, but frustrating interactions and isolation from colleagues are daily barriers to joy. When doctors can access shared knowledge and validation among a community with shared values, we can once again focus on the joy of practicing medicine.
Resilience in doctors, differences at different stages of career

Corresponding author
Vishal Agrawal, MD
Royal College of Psychiatrists/South Essex Partnership NHS Trust
vishalagraw@googlemail.com

Co-author
Usman Mansoor, MD

Learning objectives
1. Participants will be able to see how doctors in the UK generally feel about resilience.
2. They will be able to understand differences based on the career stage of a doctor.
3. It will give the opportunity to understand why some doctors are more resilient and links to happiness.

Context/background
Whether doctors in the UK have different views on resilience depending on stage of career they are in.

Methods/approach
An online anonymous survey of all doctors in psychiatry in Eastern Division of UK. First 100 responses were analyzed looking at views of doctors on resilience. Further analysis based on career stage of a doctor was conducted.

Findings/results
Of 100 doctors, 40 were consultants. Five were middle-grade (staff grade/associate specialists) doctors, and the rest were trainees. There was a range among trainees from Foundation doctors to senior trainees and registrars. Overall, most felt doctors are resilient individuals who require both professional and personal support when they have to be particularly resilient. Doctors felt own and personal support worked better for them rather than professional support. They felt more could be done to develop professional support. When breakdown according to career of a doctor was done, it showed some interesting results. Very few consultants thought doctors were not resilient individuals as opposed to other doctors. Consultants often found themselves to be in situations that particularly required resilience as opposed to other doctors. For consultants, own resilience worked best in these situations as opposed to all other doctors.

Conclusions/discussion
It appears consultants rely most on their own resilience. This may be based on their long years in practice, experience and having had to develop resilience over time; other doctors may still be developing. Ability to be resilient and handle difficult situations leads ultimately to less stress and a happier life. There is great reliance on personal support, and this support will be crucial in a happy personal life. It may also be that consultants have reached a stage where they are happier and more content leading them to have more positive views about their own resilience.
The aging physician, the search for joy and meaning in life

Corresponding author
Gerald J. McKenna, MD
McKenna Recovery Center
gmckenna001@hawaii.rr.com

Learning objectives
1. Discuss the dilemmas facing physicians as they transition from active practice to retirement
2. Appreciate and discuss the ambivalence that older physicians feel looking back on their careers
3. Discuss the mental, emotional and spiritual orientation of physicians who experience true joy in life and in medical practice

Context/background
Physicians are in a unique position to have multiple choices in the retirement spectrum after the age of 65. They can retire, as many do if they work for an organization or institution; they may continue practicing full time if they are in private practice; they can switch to part-time practice; or they may continue to provide service on a volunteer basis in a number of different ways. Many physicians choose to remain in some form of continued medical practice after reaching the usual retirement age of 65 for people in other professions. Some of their reasons are financial; as they reach retirement age, they may be finding it increasingly difficult to fully fund their retirement programs. The reasons for physicians choosing medicine as a career have changed over the decades. The expectations of younger physicians graduating today and the huge increase in the number of women choosing medicine as a career have all changed dramatically over the decades. The dramatic changes in medical practice from the 1990s onward with the advent of managed care have all had a marked impact on the psyche and beliefs of physicians as they approach retirement, including: the dependence on being part of an insurance company’s physicians panel; the need for justification of providing medical treatment on an ongoing basis; the abandonment of private practice in the hopes of a simpler more secure future in employed practice; the trend toward employed practice among younger physicians; the expectation of limited work hours and periods of on-call service.

Methods/Approach
The methods of approaching this subject have involved personal interviews with more than 20 physicians, giving each of the physicians a short survey of questions regarding their experience in practice and their experience of the retirement process. It also asks them to look back on their medical practice and summarize what joy they experience, how did that joy present itself and what are their expectations for the future.

Conclusions/discussion
The mental, emotional and spiritual orientation that appears to be necessary for everyone as they age becomes critical in helping them determine the kind of joy and fulfillment that they experience as they transition from active practice to full-time retirement. The primary conclusion is that there are varied experiences among physicians in their approach to retirement, their experience of their medical careers, and their willingness to do it all over again or to recommend medicine as a career to their children. The experience of joy in retirement or part-time practice was not an easy question for many to answer. It does appear, however, that those physicians who have a strong spiritual life and program transition more positively to this change from full-time practice in a demanding career to that of retirement.
The joy of “seeing” patients

Corresponding author
Lisa M. Todd, MD
The Joy and Healing Practice PC
lisatoddmd@gmail.com

Co-author
Millie K. Dorsey, BSN, RN

Learning objectives
1. Identify ways to increase rapport and connection with patients through “seeing” the core of who they are and how their medical experience clouds over their sense of purpose and joy.
2. Learn the format of a shared medical appointment coupled with self-care skills to enhance empowerment and community.
3. Identify core values that lead to personal job satisfaction; i.e., making a difference, a sense of purpose and effectiveness, personal well-being and meaningful relationships.

Context/background
A new appointment model and content were born out of a desire to connect more effectively with patients and to allow patients to have added time and value with the provider.

Methods/approach
Combine mind-body medicine skills and the shared appointment model.

Conclusions/discussion
Combining self-care skills with shared appointments for increased patient access, patient empowerment and community support. The model further enhanced connection and joy in medical practice for the provider.
The nature-based map of the healer’s psyche: A holistic eco-psychological approach to physician fragmentation and wholeness

**Corresponding author**
Brian Stafford, MD, MPH
Wilderness Is Medicine
info@WildernessIsMedicine.org

**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 burn-out, addictive, disruptive and unethical behavior overlap with the fragments, 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

**Context/background**
Western psychiatry and psychology were born out of a medical approach to the human psyche. Current issues facing the healer’s psyche—burn out, addictive, disruptive and unethical behaviors—are not well-characterized by traditional nosologies. Our pathological and symptom-focused approach has cramped our abilities to grow whole and to fully mature. The agenda of mainstream psychotherapy, likewise, has been, from its beginnings, remarkably limited and, consequently, limiting. Based on the work of the eco-depth psychologist, Bill Plotkin, PhD, 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.

**Methods/approach**
This map and perspective were developed by the eco-depth psychologist, Bill Plotkin, PhD, and adapted by the presenter after training and studying eco-therapy, depth and archetypal psychology, meditation, imagination and creativity, mystic poetry and wilderness rites of passage.

**Findings/results**
The resulting NBMOHP offers a new model of understanding the healer’s psyche, both the “symptomatic,” or sub-personality fragmentation, and the possibility for mature and exceptional human wholeness.

**Conclusions/discussion**
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

Corresponding author
Brian Stafford, MD, MPH
Wilderness Is Medicine
info@WildernessIsMedicine.org

Learning objectives
1. Define the steps toward becoming a visionary physician
2. Describe the necessary steps to awakening from a patho-adolescent way of living 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 development of health care provider
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: (1) wholing the self, (2) healing the subpersonalities, (3) focusing on developmental stage tasks, and (4) addressing unfinished developmental tasks

Context/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. (i.e., how and why was the study/perspective developed?) We must develop a more mature culture. We need a more mature profession. 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 has adapted this map with the educational, training and practice of Western physicians in mind.

Findings/results
Most physicians are trained to stall out in their development and to live a patho-adolescent existence. The wheel helps physicians, physician health programs and administrators identify suitable developmental tasks in order to become eco-centric and, eventually, visionary physicians. Common barriers to a more mature physician include unfinished developmental tasks, lack of wholeness of the self, lack of healing of the self, and lack of guides pointing to the stage of development leading to the visionary physician.

Conclusions/discussion
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.
Who helps our helpers? Rediscovering joy in medicine by addressing the risks of secondary trauma

Corresponding author
Donald M. Friedman, MD
Sidney Kimmel Medical College
dfried55@aol.com

Co-author
Vic Compher, MSS, MA, LCSW
viccompher@comcast.net

Learning objectives
1. Become more aware of what secondary trauma is and its prevalence in health care professionals
2. Recognize the importance of personal wellness and intentional self-care by physicians and other allied professionals
3. Encourage the development of medical systems in the formation of effective peer support structures

Context/background
The documentary filmmaker, Vic Compher, a former administrator, supervisor and social worker in the Department of Human Services in Philadelphia, realized the presence of secondary trauma in professionals who rescue, assist and/or treat injured, traumatized or physically ill patients. His film, “Portraits of Professional Caregivers – Their Passion, Their Pain,” contains narrative interviews with a broad spectrum of professional empathetic caregivers who describe the stressful effects of their work and how those stresses affect them emotionally and functionally. The purpose of these stories is to promote awareness of secondary trauma/compassion fatigue and how it can be toxic and lead to burnout, promote provider self-care and emphasize the need for an organizational structure that provides support and healing for the medical staff.

Method/approach
Our poster will provide a colorful chart with the statistics of physician burnout and a display of the statistics of secondary trauma in allied professions. The poster will also include definitions of secondary trauma/compassion fatigue, burnout and compassion satisfaction. There will be dramatic still shots from the film depicting professional narratives, self-care in action and group peer debriefing/support sessions. Handouts will include a bibliography of current research, definitions and symptoms of secondary trauma and burnout, illustrations of compassion satisfaction, and examples of organizational structures that provide emotional support and healing for medical staff.

Findings/results
Secondary trauma is prevalent among a wide variety of professional caregivers and can lead to poor performance, dissatisfaction with work and burnout. Provider self-care and institutional support of the caregiver are crucial for promoting compassion satisfaction and resiliency.

Conclusions/discussion
Secondary trauma is a recognized occupational hazard of professional caregivers but can be countered by self-awareness, self-care and institutional support.
Poster presentations: Research
Acceptability of difficult emotions in patient care

Corresponding author
Jessica C. Love
Wayne State University School of Medicine
jlove@med.wayne.edu

Co-authors
Ilinca Lupea, MD
Dawn Lemon, JD
Michele Jesse, PhD
David Richardson, MD

Learning objectives
1. Recognize the variability in how physicians are told they should deal with difficult emotions.
2. Recognize that patient needs and physician needs may also vary.
3. To provide compassionate and empathetic care, physicians need to attune to both the patient’s emotions and their own.

Context/background
Medical students and residents often receive conflicting instruction on appropriate emotional management in patient interactions. This complicates the development of skill sets to manage personal emotions that arise during clinical training. The objective of our study is to determine the perspectives of patients and physicians regarding the appropriate display of emotions by physicians in patient care settings.

Methods/approach
Two online articles examining the role of emotions in medical providers and the associated comments were reviewed.1,2 Three authors (JL, DR, DL) independently read the articles and comments, convened to develop thematic coding, then individually re-read the articles/comments and coded comments based upon the thematic codes. The three authors met to review accuracy of overlap and discuss discrepancies in results.

Findings/results
Eight themes were identified. Physicians felt that in the patient care setting either no emotions should be displayed (22.4 percent) or emotions should be controlled (25.4 percent). Significantly fewer patients (26.5 percent) compared to physicians (58.2 percent) commented that it is acceptable for doctors to display emotions in a patient care setting (p<0.001). A large number of both physicians (39 percent) and patients (47 percent) identified the need for compassion and empathy in patient care. An equal number of physicians (23.9 percent) and patients (22.9 percent) commented that authentic feelings are necessary for human connection. A smaller percentage of respondents (physicians – 16.4 percent; patients – 14.5 percent) emphasized the importance of boundaries in a patient care setting.

Conclusions/discussion
In online forums, there was a lack of consensus in both physicians and patients on how physicians should handle emotions around patients. This variability in both physician and patient responses helps explain the mixed messages given to students and residents in their training. There might not be a “right” answer to this quandary. Physicians need to attune to patients’ emotions, as well as their own, in order to provide compassionate and empathetic care.
An evolutionary model of medical student distress

Corresponding author
Jaleh Shahin, PhD, R. Psych
University of Alberta
jaleh@ualberta.ca

Co-author
William Whelton, PhD, R. Psych

Learning objectives
1. Become familiar with a new comprehensive model of medical learner distress
2. Identify personal and environmental risk and protective factors for learner well-being
3. Gain an understanding of various aspects of the training environment that can contribute to enhancing joy and well-being in medical learners

Context/background
The high prevalence of psychological morbidity among medical students has been a source of concern for many years. Recent research that has linked distress in physicians and medical residents to lower quality of care and empathy for patients makes this especially troubling. Distress in physicians often starts during medical school. Distress in medical students can be manifested as psychopathology in the form of clinical depression and anxiety. Previous research has focused on individual characteristics and personality traits of medical students as risk factors to depression and anxiety. However, the medical students’ training environment and social context has been largely ignored. Evolutionary models of psychopathology have deepened our understanding of the etiology of depression and anxiety highlighting the influence of the environment in interaction with individual characteristics.

Methods/approach
This study adopted evolutionary models in order to explore both environmental and personality factors in relation to depression and anxiety in medical students. Two hundred and nineteen medical students at a local university completed online questionnaires. Hierarchical multiple regressions were used to examine personality factors of perceived social rank, submissiveness and perfectionism, as well as environmental factors of perceived social safeness and support, and mistreatment as predictors to depression and anxiety.

Findings/results
The findings provided support for the hypothesis that the environmental factors of mistreatment and social safeness significantly contributed to the prediction of depression even after accounting for all three personality variables. This did not hold true for anxiety, and only the personality variables were significant predictors for anxiety.

Conclusions/discussion
These results suggest that the medical students’ environment plays a significant role in the manifestation of depression. Therefore, intervention and prevention policies should target both the environment and the personality characteristics of medical trainees in order to appropriately address learner distress and enhance learner well-being.
Assessing burnout and professional fulfillment among pediatric subspecialty fellows

Corresponding author
Caroline Okorie, MD, MPH
Stanford University
cokorie@stanford.edu

Co-authors
Mickey Trockel, MD
Sumit Bhargava, MD

Learning objectives
1. Understand that fellows can suffer high rates of burnout.
2. Understand that sleep-related impairment is strongly associated with burnout and that mindfulness is protective against burnout.
3. Determine that interventions to reduce burnout among fellows should focus on increasing mindfulness and reducing sleep-related impairment.

Context/background
Despite extensive data about physician wellness and burnout, there is a paucity of literature evaluating wellness and burnout among fellow physician trainees.

Learning objectives
1. To assess the degree of professional fulfillment and burnout among pediatric fellows at an academic institution
2. To assess determinants of professional fulfillment and burnout

Methods/approach
We adapted a faculty wellness survey already employed at our institution. The survey was administrated electronically to all 95 pediatric subspecialty fellows.

Findings/results
The survey had a 65 percent response rate (n=62) and demonstrated that 80 percent of fellows reported at least moderate levels of professional fulfillment. Also, 60 percent of fellows reported one or more symptoms of burnout using the single-item burnout self-assessment scale. This is significantly higher compared to the 28 percent of faculty at the same institution. Linear regression model predictors of higher professional fulfillment included: sleep-related impairment (p=0.01, β=-0.35), mindfulness (p<0.001, β=0.47), low focus (p=0.003, β=-0.41), perceived appreciation (p<0.001, β=0.62), and peer support (p<0.001, β=0.63). Logistic regression model predictors of burnout included sleep-related impairment (p=0.01, OR=31.3) and low focus (p<0.001, OR=7.3). Mindfulness (p<0.001, OR=0.03), and perceived appreciation (p<0.001, OR=0.27) were protective against burnout.

Conclusions/discussion
This study revealed a high rate of burnout among pediatric fellows. It also demonstrated identifiable predictors of both professional fulfillment and burnout, with the relationship between sleep-related impairment and burnout especially striking. The data identifies clear areas for intervention; specifically, targeting ways to increase mindfulness and reduce sleep-related impairment to reduce burnout and increase professional fulfillment. Studies have shown how mindfulness can have a positive effect on sleep. Interventions and courses on mindfulness should be deliberately initiated for fellows. Participants identified additional potential interventions, including: structured mentorship, appreciation events, and wellness workshops. Next steps would include assessment of fellows at other institutions and in other specialties and a repeat evaluation to assess for intervention effectiveness.
Brief compassion training intervention for physician well-being

Corresponding author
Robert N. Horowitz, MD
Stanford Prevention Research Center, Stanford School of Medicine, Stanford University
roberth4@stanford.edu

Co-authors
Mickey T. Trockel, MD
Tia Rich, PhD
Sue Kim, MD
Marcia L. Stefanick, PhD

Learning objectives
1. To recognize that empathy may be associated with burnout and that compassion training may reduce empathic distress.
2. To recognize that self-compassion training has been shown to improve life satisfaction and decrease anxiety, depression, and stress.
3. To be able to describe key components of a successful brief compassion training program for physician well-being, including barriers to implementation.

Context/background
Compassion training holds promise for improving physician well-being by reducing empathic burnout and increasing self-compassion. However, compassion training programs generally have substantial commitments of time, travel, and formal meditation practice that reduce their appeal to many physicians. We developed a training program for physician well-being based on: compassion training, with emphasis on self-compassion; delivering training to physician practice groups in their clinical settings; and, brief practices (< 3 min) that can be readily performed during the day.

Methods/approach
Pilot study in primary care clinics: physicians were enrolled as pre-existing groups from primary care clinics. A 45-minute orientation was followed by eight weekly 30-minute skill-building sessions. Guided exercises in compassion skills were presented in a 7–10 minute practice and repeated as a condensed 3-minute practice to reduce the time needed to access target effects. Cards designed as visual triggers and online recordings were provided to support practice. Participants completed pre and post-intervention surveys of empathy, compassion, and self-compassion based on items from validated instruments, and of self-efficacy regarding skills targeted by the program. All items used 5-point Likert scales (1=Strongly disagree, 5=Strongly agree).

Findings/results
Preliminary results: physicians (n = 13; 85 percent women) from three clinics completed the pilot. Program (9-session) attendance (in-person or by phone) was 80 percent. Statistically significant increases in median differences (MD) were observed in general self-compassion (MD=1, p=0.008) and in self-efficacy for: mindful breathing (MD=1, p=0.039), evoking self-compassion (MD=1, p=0.007) and recognizing common humanity  (MD=1, p=0.027). Participants particularly valued the focus on self-compassion. The study is still underway with measures of physician well-being yet to be analyzed.

Conclusions/discussion
A brief compassion training program, emphasizing convenience for physicians, is feasible and appears to improve measures and skills of self-compassion, an attractive and potentially powerful target for physician well-being interventions.
Burnout in the neonatal intensive care unit and its relation to health care-associated infections

Corresponding author
Daniel S. Tawfik, MD
Stanford University School of Medicine and Lucile Packard Children's Hospital
dtawfik@stanford.edu

Co-authors
J. Bryan Sexton, PhD
Peiyi Kan, MS
Paul J. Sharek, MD
Courtney C. Nisbet, RN, MS
Joseph Rigdon, PhD
Henry C. Lee, MD
Jochen Profit, MD, MPH

Learning objectives
1. Appreciate the previously published associations between burnout and quality of care.
2. Recognize the prevalence and demographic variation of burnout among NICU health care providers.
3. Understand the associations between burnout and healthcare-associated infections in the NICU setting.

Context/background
Burnout is variable among staff in neonatal intensive care units (NICUs) and is associated with decreased teamwork climate and safety climate. Adult studies have correlated burnout with increased infection rates and self-reported errors. The effect of burnout on the quality of care provided to very low birthweight (VLBW, <1500 gram) infants is unknown. This study sought to examine burnout prevalence within California NICUs and test the relation between burnout and health care-associated infection (HAI) rates in VLBW neonates.

Methods/approach
We obtained 2,073 provider perceptions of burnout (62.9 percent response rate) from nurse practitioners, physicians, registered nurses and respiratory therapists from a survey conducted among 44 NICUs in California, using a validated four-item questionnaire based on the Maslach Burnout Inventory. For each NICU, we calculated a risk-adjusted HAI rate among VLBW infants from the subsequent two years and tested for associations with burnout rates using Pearson's correlation coefficients and multi-level logistic regression analysis with patient-level factors as fixed effects.

Findings/results
Mean burnout prevalence by NICU was 25.2±10.1 percent, with mean HAI rates of 8.3±5.1 percent. Highest burnout prevalence was found among nurses, nurse practitioners, and respiratory therapists (non-physicians, 28±11 percent vs. 17±19 percent physicians), day shift workers (30±3 percent vs. 25±4 percent night shift), and workers with five or more years of service (29±2 percent vs. 16±6 percent in fewer than three years group). Overall burnout prevalence showed no correlation with HAI rates (r = -0.133). Item-level analysis showed positive association between healthcare-associated infections and perceptions of working too hard (odds ratio 1.15, 95 percent confidence interval 1.04-1.28). Sensitivity analysis of high-volume NICUs suggested a moderate positive correlation between burnout prevalence and HAI rates (r = 0.34).

Conclusions/discussion
Burnout is most prevalent among non-physicians, daytime workers and experienced workers. Perceptions of working too hard associate with increased HAI s in this cohort of VLBW infants, but overall burnout prevalence is not predictive.
Burnout risk factors: Results from a resident wellness survey at one institution

Corresponding author
Bardia Behravesh, EdD
University of Kansas Medical Center
bbehravesh@kumc.edu

Co-authors
Stewart F. Babbott, MD
Michael Brimacombe, PhD
Gregory K. Unruh, MD

Learning objectives
1. Identify several risk factors for physician burnout
2. Describe potential mitigating strategies and
3. Utilize the same survey instrument to assess physician wellness at their respective institutions.

Context/background
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 improvement efforts, the KUMC Graduate Medical Education Committee surveyed its residents in the spring of 2015.

Methods/approach
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.

Findings/results
Three hundred and ninety (73.3 percent) residents and fellows completed the questionnaire, including 151 females (39.0 percent) and 236 (61.0 percent) 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. Using a combined score for self-reported burnout, 15.7 percent of respondents reported some level of burnout, and 63.9 percent some level of stress. 19.2 percent of females and 13.0 percent of males reported some level of burnout. Although not quite statistically significant, self-reported burnout was higher among females (p=0.123, chi-square test) and higher among PGY 2 residents, especially females (p=0.076, chi-square test). Additionally, those that “never” find time to work out are more likely to experience burnout (p=0.002, chi-square test) compared to those who work out 4 to 7 times per week.

Conclusions/discussion
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.
Burnout syndrome in interns and residents: Prevalence and risk factors after spring revolution

Corresponding author
Maroua Mrouki, MD
Tunis El Manar University/Ben Arous Regional Hospital, Department of Internal Medicine
Mrouki_maroua@yahoo.fr

Co-authors
Meyad Abdallah, MD
Rim Rafrafi, MD
Ali Harmel, MD
Skander Mrad, MD

Learning objectives
1. Define burnout syndrome and Maslach Burnout Inventory
2. Develop knowledge and understanding related to risk factors of burnout among interns and residents through this study
3. Propose preventive measures against burnout syndrome

Context/background
Burnout syndrome is a response to chronic strain within the workplace characterized by emotional exhaustion, depersonalization and low personal achievement. This study aimed to estimate the prevalence of burnout in interns and residents and to study associated factors in both populations.

Methods/approach
A descriptive cross-sectional study including all Tunisian residents and all interns within the Medical School of Tunis was conducted. An anonymous survey was sent to 1,567 junior doctors. The level of burnout was assessed using the Maslach Burnout Inventory.

Findings/results
The response rate was 69.9 percent (1,091). A high level of burnout was observed in 24.9 percent of all junior doctors, 29.8 percent in interns and 22.3 percent in residents (p=0.004). 59.7 percent of interns and 51.6 percent of residents had a high level of emotional exhaustion. 63.5 percent of interns and 58.1 percent of residents experienced a high level of depersonalization. 55.8 percent of interns and 52.5 percent of residents had a low level of personal achievement. Factors associated with burnout among interns were the lack of time for hobbies, the low number of afternoons off, the psychiatric family history, and the choice not to sit for the residency exam. These factors, among residents, were the lack of free time, the night shifts, the difficulty to be replaced, the important decisions taken at short notice, the difficulty contacting the seniors, the low taking into account of expressed opinions, the number and the direct contact with the patients, the lack of help from the paramedical stuff, the blurring limits of tasks, the lack of security, the lack of social support, the limited income, the distance from the workplace, the low participation in scientific research and the unconvinced choice of specialty.

Conclusions/discussion
A high level of severe burnout was found in our study related to organizational factors and workload.
Common themes in internal medicine resident narrative essays

Corresponding author
Emily A. Gordon, MD
Rutgers New Jersey Medical School
gordonea@njms.rutgers.edu

Co-authors
Dina M. Khateeb, DO
Jeannie Garmon, MPH

Learning objectives
1. Understand how narrative writing exercises can be used to identify common stressors among internal medicine residents.
2. Relate recurring themes to possible deficits in current trainee didactics.
3. Propose instructional tools to assist residents in dealing more effectively with these clinical dilemmas.

Context/background
Burnout is a prevalent problem faced by the medical community. It begins in medical school, continues throughout residency, and is a commonly cited cause for dropout among attending physicians. In order to mitigate burnout and prevent physician loss, we must identify the root causes of dissatisfaction among medical trainees. The investigators currently lead a reflective medicine seminar for internal medicine residents at New Jersey Medical School. The seminar includes a narrative medicine workshop. After reading several resident narratives, it became clear that these essays and poems often centered on stressors and joys unique to internal medicine trainees. To examine this further, the investigators used qualitative analysis to identify common themes across writing samples.

Methods/approach
The team requested consent from previous participants for their writing samples to be included in the analysis. 38 residents gave consent. The investigators identified and coded frequently repeated words and phrases within and across the writing samples. The codes were sorted into broader themes and the frequency with which each theme occurred was calculated.

Findings/results
The most common themes in the writing samples were:
1. Challenges in caring for patients at end of life (15/38 = 39 percent)
2. Difficulty communicating with patients' families (10/38 = 26 percent)
3. Challenges in caring for patients with poor health literacy (8/38 = 21 percent)

Other common themes included time management, caring for non-adherent patients, conflicts with other medical staff, and feeling like an imposter.

Conclusions/discussion
Analysis of resident narrative essays is a powerful tool for revealing sources of stress among internal medicine trainees. This study found commonly cited themes to include end of life care, communication and challenges with poor health literacy. Targeting these problem areas with novel didactics may reduce burnout and improve job satisfaction among trainees.
Early intervention: Identifying and combating stress and depersonalization in resident physicians

Corresponding author
Erica Weston, MD
Alpert Medical School of Brown University/Women and Infants Hospital
eweston@wihri.org

Co-authors
Martha B. Kole, MD
Meena Theva, MD
Caitlin MacGregor, MD
Amy Snyder, MD

Learning objectives
1. Understand the impact of stress and burnout among residents
2. Identify vulnerable populations within a residency
3. Identify possible target areas for intervention

Context/background
Nationally, stress and burnout are high among practicing physicians. However, few studies investigate the progression of stress and burnout among trainees.

Methods/approach
Residents at an academic obstetrics and gynecology residency program completed an anonymous survey which incorporated validated measures of stress and burnout.

Findings/results
Thirty-one of thirty-two residents completed the survey. As a whole, residents scored markedly higher (indicating higher levels of stress) on the PSS compared to the validated norm group. The PSS score decreased with increasing residency year. The PGY1s scored the highest with a mean of 19.8 and the PGY4s scored the lowest with a mean of 13.1. Components of burnout were evaluated using the MBI and include: depersonalization, overall burnout and personal achievement. Depersonalization was universally in the high-level burnout range with a mean of 13.3 (SD 6.5). PGY1s reported the highest levels of depersonalization compared to residents in other levels of training. Across residency years overall burnout was low, with a mean score of 12.9 (SD 8.2) and feelings of personal achievement were high, with a mean score of 40.7 (SD 4.5). High scores on the PSS statistically correlated with high levels of burnout (correlation=0.6, p=0.0004). Additionally, there was a negative correlation between both PSS and burnout and the likelihood of seeking out a peer for support (r=-0.4, p=0.03; r=-0.5, p=0.035).

Conclusions/discussion
First-year trainees may be the most vulnerable to stress and burnout. This group may be less likely to seek out support making them more susceptible to the deleterious impacts of stress and depersonalization. Of particular concern is the level of depersonalization seen among all residents. Programs aimed at reducing depersonalization, stress, and overall burnout are imperative and should be targeted early during residency to help build coping strategies and avenues for support.
Evaluating the effectiveness of a physician wellness literature and medicine program

Corresponding author
Benny Gavi, MD
Stanford School of Medicine
bgavi@stanfordmed.org

Co-authors
Jacqueline M. Genovese
Mickey T. Trockel, MD
Mary Lou Murphy

Learning objectives
1. Understand the structure of a literature and medicine program for faculty and resident physicians, including similarities and differences
2. Understand a variety of validated survey tools that may be useful for measuring the impact of the literature and medicine program
3. Understand the impact of the literature and medicine program on faculty and residents

Methods/approach
In 2015 the Stanford Medical Center launched a “Literature and Medicine Dinner and Discussion” series based on the national Humanities at the Heart of Healthcare program created by the Maine Humanities Council. During 2015 and 2016 a total of approximately 80 physicians enrolled in a seminar series that met monthly for six months. Each month had a different theme—for example, “The Lives of our Patients” and “Literature and Empathy”—along with poems, short stories and essays related to the theme by physician and non-physician writers. We surveyed faculty in the areas of professional fulfillment, empathy for patients, empathy for colleagues, self-compassion, communication, interpersonal interactions and cultural awareness. Surveys were conducted prior to the onset of the series, during every session and subsequent to the completion of the seminar series. For some areas we measured self-perception of improvement in areas of communication, interpersonal interactions and cultural awareness because prior seminar series reported improvement in these areas. However, in the areas of professional fulfillment, empathy for patients, empathy for colleagues and self-compassion, we utilized a novel research approach to measure the impact of the program. Instead of conducting an end-of-course survey that captured retrospective response, we provided surveys that captured “real-time” snapshots of participants’ responses.

Findings/results
In this presentation we will share our survey tools for assessing professional fulfillment, empathy for patients, empathy for colleagues, self-compassion, communication, interpersonal interactions and cultural awareness, highlighting the difference between measuring retrospective participant perception compared with “real-time” snapshots of participants, and present our research findings.
Exploring the utility of a continuing education workshop strategy to address and manage disruptive behavior in postgraduate medical education

**Corresponding author**
Christopher Simon, PhD
University of Ottawa
christopher.r.simon@icloud.com

**Co-authors**
Derek Puddester, MD
Colla MacDonald, PhD

**Learning objectives**
1. Describe the concept of disruptive behavior, and communicate how it can interfere with wellness within the postgraduate medical education workplace.
2. Demonstrate how a continuing education workshop can help address and manage disruptive behavior within the postgraduate medical education workplace.
3. Describe how managing disruptive behavior can contribute to a more collegial and joyful work environment.

**Context/background**
The purpose of this study was to evaluate the efficacy of the faculty of medicine’s use of a training workshop as one strategy to teach/assist medical leaders, faculty, residents, and students to prevent and manage disruptive behaviors.

**Methods/approach**
A mixed methods approach, involved collecting data from 61 post module quantitative surveys and 17 qualitative interviews. Qualitative data was analyzed through a systematic identification and classification of codes and themes. Quantitative data was analyzed by using descriptive statistics and response frequencies. The constructs of the W(e)Learn framework guided data analysis, i.e., how was this study performed, how will this presentation be conducted, or how did this perspective come about?

**Findings/results**
Findings indicate that participants enjoyed the workshops. Nearly all (98 percent) of respondents agreed the workshop would help them in their professional life, and the skills they learned will help them solve issues they face in the postgraduate medical education (PGME) environment. Participants provided examples of new knowledge and skills they attained as well as how they had improved their communications and behavior in the workplace. Participants observed the workshops had a marked influence on the PGME culture, such as the normalization of engaging in difficult conversations, and the emergence of a common language around effective communication. Participants also made suggestions on how to improve the workshops for a PGME audience.

**Conclusions/discussion**
The training workshops can be an effective strategy to address and manage disruptive behavior, and contribute to a more collegial and joyful work environment. This training has the potential to improve physician joy, health and well-being by contributing to effective communication and a positive workplace environment.
Factors influencing physicians' access to health care: A survey

Corresponding author
Jayanth Adusumalli, MBBS, MPH
Mayo Clinic
Adusumalli.jayanth@mayo.edu

Co-authors
Khalid Benkhadra, MD
Tamim I. Rajjo, MD, MPH
Mohammad H. Murad, MD, MPH

Learning objectives
1. List important factors that influence physician access to healthcare.
2. Recognize the gender disparity in the difficulty of access to healthcare.
3. List the most useful services for improving health care access as reported by physicians.

Context/background
Barriers and gender differences in health care access for physicians are not well studied.

Methods/approach
An anonymous voluntary survey of physicians attending a large primary care conference was administered. The study was Institutional Review Board exempt. Responses were analyzed using ANOVA, T-test and linear regression.

Findings/results
Response rate was 46 percent (270/592). Eighty-four percent were family medicine physicians and 54 percent were males. The age category of above 60 years was the most common (39 percent), and about half (47 percent) reported working 40–59 hours weekly.

Physicians who found difficulty accessing health care were more likely to report finding time (p value= <0.001), cost of lost work time (p value= 0.03) and lack of encouragement by employer (p value < 0.001) as barriers. Physicians who worked more than 60 hours a week reported more difficulty accessing health care and reverting to self-diagnosis when compared to physicians working less hours.

Female physicians were more likely to face difficulty with access compared to male physicians (p value < 0.001), and were more likely to revert to self-diagnosis and treatment (p value = 0.02). Female physicians ranked the following barriers higher than male physicians: finding time (p value = 0.004), confidentiality (p value= 0.002), inability to see someone they know (p value = 0.002) and not being encouraged by their employer (p value = 0.006). Respondents ranked substance abuse as the most common illnesses affecting a physician's ability to practice. Comprehensive care within a 1–2 days and rapid referral were ranked as the most useful services to improve access to health care services.

Conclusions/discussion
Physicians reported several barriers when accessing health care services. Female physicians were more likely to have access difficulties and revert to self-diagnosis compared to male physicians. Short comprehensive care visits and rapid referrals were ranked as the most useful services to improve access.
Healthy exercise habits associated with higher quality of life among U.S. medical students

Corresponding author
Liselotte N. Dyrbye, MD, MHPE
Mayo Clinic
dyrbye.liselotte@mayo.edu

Co-authors
Tait D. Shanafelt, MD

Learning objectives
1. Describe prevalence of adherence to exercise guidelines among medical students
2. State the relationship found between adherence to exercise guidelines, burnout, and quality of life
3. Explain an individual approach that may mitigate risk of burnout

Context/background
Although burnout and low quality of life (QOL) are common among medical students, little remains known about personal health habits of medical students that may promote well-being. Understanding the relationship between adherence to national guidelines and medical student well-being could inform strategies intended to promote a healthier culture in medicine.

Methods/approach
In 2012 the authors conducted a cross-sectional study of U.S. medical students to explore relationships between QOL, burnout, and compliance with CDC exercise recommendations. Overall QOL over the past week was measured using a standardized linear analog scale (0= “As bad as it can be”; 10= “As good as it can be”). This scale has documented validity in a variety of medical conditions and populations.1,2 We measured burnout using the Maslach Burnout Inventory (MBI).3 Since high scores on either the emotional exhaustion (≥27) or depersonalization (≥10) scales distinguish between clinically burned out and non-burned out individuals,3 we considered those who scored high on either the emotional exhaustion or depersonalization domain of burnout to have at least one manifestation of professional burnout. Chi-square test and multivariate logistic regression were performed. The Institutional Review Board approved the study.

Findings/results
Among 12,500 medical students invited to participate 4,402 (35.2 percent) completed surveys. Most (2738/4367; 62.7 percent) engaged in aerobic exercise in accordance with CDC recommendations while fewer (1685/4376; 38.5 percent) adhered to muscle strengthening recommendations. Overall QOL scores were higher for medical students adhering to CDC recommendation for aerobic exercise (7.2 vs 6.6, p<0.0001), strength training (7.2 vs 6.8, p<0.0001), or both aerobic and strength training (8.0 vs 7.0, p<0.0001). The prevalence of burnout was lower among students who engaged in aerobic exercise consistent with CDC recommendations compared with those who exercised less than recommended (53.1 vs 60.8 percent, p<0.0001). Similarly, rates of burnout were also lower among students who strength trained consistent with CDC recommendations (51.8 percent vs 58.6 percent, p<0.0001). Compliance with CDC exercise guidelines remained independently associated with higher QOL and lower risk of burnout on multivariate analysis controlling for age, sex, relationship status, parental status and year in school.

Conclusions/discussion
Medical students whose aerobic exercise and/or strength training habits are consistent with CDC guidelines appear to have higher QOL and are less likely to experience burnout. The findings suggest following CDC guidelines for aerobic exercise and strength training may be a tangible way individual medical students can promote QOL and reduce their risk of burnout.

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

Corresponding author
Donna Luff, PhD
Institute for Professionalism and Ethical Practice, Boston Children’s Hospital
donna.luff@childrens.harvard.edu

Co-authors
Kelsey Mills, RN
Elliott B. Martin Jr., MD
Natalia M. Mazzola, Dipl-Kffr.
Elizabeth A. Rider, MD, MSW
Elaine C. Meyer, PhD, RN

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 the session in terms of supporting their own well-being and satisfaction in work during its most stressful moments

Context/background
This study aimed to examine the existing strategies used by interprofessional clinicians to manage their own emotions when holding difficult health care conversations with patients and families.

Methods/approach
Self-reported questionnaires from interprofessional learners from a range of experience levels and specialties were collected during simulation-based Program to Enhance Relational and Communication Skills (PERCS) workshops for health care professionals. The following open-ended prompt asked clinicians to qualitatively describe the strategies they currently employ to manage their emotions during difficult health care conversations: Please share what strategies/approaches/advice you use, if any, to help manage your own emotions when having difficult health care conversations.

Findings/results
A total of 126 participants from six different PERCS workshops completed questionnaires. Respondents included physicians (42 percent), nurses (29 percent), medical interpreters (16 percent), psychosocial professionals (9 percent), and other (4 percent). Professional experience of respondents ranged from 0–36 years. Respondents identified one to four strategies for managing their emotions. Typically, respondents identified two strategies. Five primary types of strategies were identified: self-care, preparatory and relational skills, empathic presence, team approach and professional identity. Self-care strategies were most commonly reported. Half of respondents reported use of self-care strategies such as: deep breathing; reflecting, journaling, exercising and talking with family members. Illustrative, descriptive responses for each strategy will be presented.

Conclusions/discussion
Across disciplines and years of experience, clinicians reported a similar range of strategies for managing emotions when holding difficult health care 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 health care conversations has the potential to enhance their confidence and capability when engaging in these critical conversations with patients and their families.
How does my doctor seem today? A qualitative study of patients’ perceptions regarding physician wellness and its link to patient care

Corresponding author
Darby C. Ewashina, MD
Alberta Health Services (W21C Research and Innovation Centre at the Cumming School of Medicine)
dcewashi@ucalgary.ca

Co-authors
Alicia J. Polachek, MA
Jaya Dixit, MA
Verna Yiu, MD
Jane B. Lemaire, MD

Learning objectives
1. Describe how patients perceive signs of physician wellness
2. Recognize patients’ beliefs surrounding how physician wellness is linked to patient care and the physician-patient relationship
3. Recognize that patients’ assessments of physician wellness shape the physician-patient relationship

Context/background
Although physician wellness is a well researched area, little is known about patients’ viewpoints on this important topic. Our research aimed to explore patients’ perceptions of physician wellness and how it is linked to patient care.

Methods/approach
We conducted semi-structured qualitative interviews with a convenience sample of 20 patients recruited from outpatient care settings in a single Canadian city. Using inductive thematic analysis, interview transcripts were independently coded by two authors and discussed to ensure agreement on the key themes.

Findings/results
Several themes emerged from participants’ descriptions of physician wellness. These included overt indicators of wellness such as physicians’ body language (e.g., eye contact), physical appearance (e.g., hygiene, weight), and organization (e.g., time spent with patient, focus on the patient). Several participants expressed the ability to “sense” a doctor’s degree of wellness. While many signs of wellness were described as immediately observable, several participants stated that physician wellness was more easily discernable in long-term relationships. Most participants believed that physician wellness is linked to patient care and the physician-patient relationship, noting explicitly that unwell physicians may provide inferior care. Participants described having less trust and confidence in doctors they perceived to be unwell. Participants also explained that they may feel concern and compassion for doctors who appear unwell, altering their behaviors and interactions so as not to further overwhelm the doctor.

Conclusions/discussion
Participants’ experiences suggest that patients can recognize wellness in physicians and believe that physician wellness is linked to patient care and the physician-patient relationship. These results further suggest that how patients judge wellness in physicians is important because it influences trust and engagement in the physician-patient relationship. Regardless of whether patients’ perceptions match objective measures of physician wellness, this study indicates the need for doctors to be and appear well, as this may shape physician-patient interactions and experiences.
Identifying housestaff barriers to self-care: Mentorship matters

Corresponding author
Lindsay K. Borg, MD
Stanford University
lkborg@gmail.com

Co-authors
Keri J. S. Brady, MPH
Jie Li, PhD
Nancy Piro, PhD
Ann Dohn, MA
Mickey Trockel, MD

Learning objectives
1. Identify barriers to housestaff self-care in all domains of health
2. Identify differences in problematic barriers to receiving mental health care vs. preventive or physical health care among housestaff
3. Identify training program factors that reduce odds of perceived barriers to health care among housestaff

Context/background
Physicians make a career of promoting patient wellness, yet are well known for neglecting their own health. Previous studies have examined barriers that housestaff face to self-care, citing time, stigma, cost, fear of negative academic standing, lack of privacy, and reluctance to request coverage as reasons medical trainees avoid care. Few studies have employed a mixed methods approach investigating barriers to housestaff wellness.

Methods/approach
Questions addressing barriers to self-care in the domains of preventive, physical, and mental health were added to the 2014–2015 Graduate Medical Education (GME) housestaff survey at Stanford University and sent to all 1,146 residents and fellows across all specialties. Respondents were asked if they faced barriers in any self-care domain and to rate the strength of potential barriers (e.g., time, stigma, etc.) on a 5-point Likert scale. An open-ended question asked respondents about the greatest barrier to self-care they faced in each domain. Logistic regression was used to assess the effect of training program education and faculty mentorship factors on perceiving one or more barriers to self-care. Free-text responses were thematically analyzed using Dedoose software by two separate researchers. This study used completely de-identified data and was granted expedited approval by the IRB at Stanford University.

Findings/results
Over 500 housestaff responded to the survey. Almost one-third of respondents endorsed at least one barrier to self-care. Among those identifying one or more barrier, time and logistics were the most common barriers identified. Privacy, stigma, and cost were more frequently endorsed as moderate or stronger barriers to seeking mental health than seeking preventive or physical health care. Comments indicated that housestaff available time to seek care does not align with available health services. Having a role model for balancing personal and professional life was associated with 76 percent lower odds (p < 0.001) of perceiving a barrier to self-care. Each incremental increase in respondents’ rating of faculty engagement in education was associated with a 39 percent lower odds (p = 0.003) of having a barrier to self-care.

Conclusions/discussion
Barriers to self-care were common among housestaff. Future intervention aimed at improving housestaff access to self-care may be enhanced by bolstering faculty mentorship and facilitating off-hours access to clinical services. Of these, improving faculty mentorship may be a readily actionable intervention target for most training programs.
Improve your resilience!

**Corresponding author**
Hemalee K. Patel, DO
Stanford University Hospital and Medical Center
hemalee.patel@stanford.edu

**Co-author**
Lisa Shieh, MD
Mickey Trockel, MD

**Learning objectives**
1. Understand how the simple exercise of expressing gratitude leads to improved patient pain scores and patient satisfaction
2. Understand the importance of gratitude in preventing physician burnout and improving overall well-being
3. Understand how a shared practice of gratitude between health care providers and patients improves the patient-provider experience

**Context/background**
The shared connection between providers and patients is important in sustaining physicians’ personal meaning in patient care and overall physician resilience.

Burnout among healthcare providers leads to depersonalization and depression and there is a direct association with poor quality of care. Reciprocally high levels of provider resilience lead to better quality of care. By rediscovering meaning and commitment to the job, practitioners can prevent feelings of burnout in a sustainable way. A daily, psychology tool like “Three Good Things” addresses ways to deal with health care-associated burnout. Involving the respective patients of our providers in the same exercise allows providers to connect with their patients in a more meaningful way and allow patients to derive increased satisfaction as a result of their providers improved sense of well-being. We believe this will translate into improved patient satisfaction scores and pain scores. Our study is the first of its kind to use the practice of gratitude from a multidisciplinary standpoint. The effectiveness of a shared gratitude practice will lead to decreased burnout and improved inpatient pain and patient satisfaction scores while simultaneously improving the shared patient-provider experience.

**Methods/approach**
Our project is currently underway, at the conclusion of which we hope to have enrolled (n=300 participants). Two adult inpatient units at Stanford University Hospital were selected for this study and patients were randomized to receive gratitude journals in which they would write three things they were grateful for. Health care providers on these units were also enrolled in the project and completed the same gratitude exercise nightly for a total of 14 days electronically via web-based, secure, HIPAA-compliant software. Each week written statements of gratitude were compiled anonymously and distributed via an email list-serve to all health care providers on these selected hospital units. Pre and post-survey questions for health care providers included questions on validated scales of burnout, professional satisfaction, and anxiety. Pre and post surveys designed for patients include questions regarding patient satisfaction scores, pain scores and anxiety levels.

**Findings/results**
(Pending.)

**Conclusions/discussion**
In conclusion, our aim is to demonstrate how a simple shared positive psychology practice of gratitude between providers and their patients improves providers’ personal sense of meaning in patient care, resulting in improved professional satisfaction, decreased burnout and increased resiliency.
In pursuit of happiness: Creating an academic hospitalists wellness committee

Corresponding author
Christie L. Masters, MD, MBA, MHA
University of California, Los Angeles
cmasters@mednet.ucla.edu

Co-authors
Michael E. Lazarus, MD
Nasim Afsarmanesh, MD
Annie Zhang, MD
Patrick Bui, MD
Rebecca Wilkinson, MSPH
Mina R. Kang, MD

Learning objectives
1. Differentiate the effects of stress and burnout and understand the benefits of managing physician engagement.
2. Identify components contributing to stress and burnout, individual and organizational interventions that increase engagement and resiliency, and the need to obtain objective data on these components and interventions.
3. Learn from the experiences of a large academic hospitalist group that is actively focused on improving physician engagement.

Context/background
Physician burnout poses a critical threat to the delivery of healthcare. Finding a solution is a leadership imperative. Management of the increasing demands on physicians can prevent burnout and foster engagement. Engaged, healthy physicians are best able to deliver compassionate care, leading to increased value for patients, providers and the health system. This study assesses stress and burnout within an academic hospitalist group and identifies areas to focus interventions on both personal and systemic levels.

Methods/approach
A large academic hospitalist group providing care at multiple sites acknowledged increased levels of physician stress in the setting of continued system expansion. In response, it created the Hospitalists Wellness Committee to focus on organizational development with a continuous improvement project addressing the question of how to thrive while being productive in an ever-changing health care environment. The committee developed the Hospitalists Well-being Survey to collect baseline data from the group, identify root causes of sensed discontent, and determine areas to intervene.

Findings/results
Fifty-four hospitalists (77 percent) completed the survey. Seventy-four percent and 52 percent of respondents expressed satisfaction with their current job and work-life balance, respectively. Nonetheless, 43 percent agreed that they felt a great deal of stress because of their job. Opportunities for individual and organizational interventions fell into three broad categories of mentoring, feedback and resilience strategies. The creation of this committee and survey influenced leadership and organizational changes within the group and at higher levels within the department of medicine.

Conclusions/discussion
Awareness of provider stress at group and individual levels leads to opportunities for intervention. Objectively identifying a group's culture, needs, stressors, and values can balance demands of the job by elucidating supportive measures and areas requiring further organizational development. Reassessment of the group and adjustments of interventions are required to meet the continually changing demands on providers.
Increasing joy and cooling off burnout with heartfulness meditation

Corresponding author
Jayaram Thimmapuram, MD
Wellspan York Hospital
drthimmapuram@yahoo.com

Co-authors
Robert Pargament, MD
Kedesha Sibliss, MD
Ronald Benenson, MD
Rodney Grim, PhD

Learning objectives
1. Understand the effects of heartfulness meditation on burnout.
2. Understand the effects of heartfulness meditation on emotional wellness.
3. Appreciate the ease of integration of heartfulness meditation program in a teaching hospital.

Context/background
Burnout is a state of mental and physical exhaustion related to work or care-giving activities posing significant challenges. Meditation is a technique used by some to treat stress and promote general health; however, 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.

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. Meditators received simple instructions in heartfulness meditation and were asked to attend group meditation sessions once a week, along with a daily practice involving a morning meditation, a refreshing session after work and a brief meditation before sleep. Participants were encouraged to practice to the best of their ability. At week 12, all subjects completed follow up MBI and EWA surveys.

Findings/results
At 12 weeks, the meditators had statistically significant decrease of mean scores in emotional exhaustion from 26.7 to 17.9, and depersonalization from 11 to 7.3 (p-value <0.05). An increase in personal accomplishment score from 37.1 to 39.0 was also noted (p-value <0.05). There were no significant changes in these parameters in the control group. Meditators also showed statistically significant improvement in 19 of 22 parameters of the EWA (p-value <0.05), whereas controls showed no statistically significant changes.

Conclusions/discussion
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.
Increasing joy in academic medicine: Identifying challenges and planning support for academic faculty

Corresponding author
Chantal Brazeau, MD
Rutgers New Jersey Medical School
chantal.brazeau@rutgers.edu

Co-authors
Ping-Hsin Chen, PhD
Steven Keller, PhD

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

Context/background
The objective of this ongoing project is to guide a school-wide strategy to support medical school faculty well-being.

Methods/approach
We developed a school specific survey to evaluate faculty perception of work challenges and workplace support strategies. This survey included the Maslach Burnout Inventory. It was administered to 534 faculty beginning November 2015, to guide development of programs to improve faculty well-being.

Findings/results
The response rate was 39 percent. Most respondents were clinicians (63.9 percent), full-time faculty (85.5 percent), working 50 or more hours per week (71 percent). The prevalence of respondents seriously considering leaving the institution in the past year was 55.7 percent, representing at least 22 percent of the faculty body. Overall, 39.8 percent of respondents met criteria for burnout (45.7 percent for clinicians and 29.2 percent for non-clinicians), with more burnout noted in faculty in the 40–59 y.o. age group. Over 90 percent of respondents rated as very or extremely important having sufficient time “to do what is really important,” and having a chair that advocates for faculty, is “fair” and listen to concerns. Also very or extremely important: alignment of faculty goals and vision with the department and school (>80 percent), good communication (>90 percent) and transparency (> 90 percent) by chairs and school administration; with more importance given to the role of the chair.

Conclusions/discussion
This survey points to the importance of chair engagement in the planning of school support for faculty. Hence, we will hold meetings with 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. We will report on the progress of these proceedings. We will repeat the survey in one year.
It sustains me: How physicians draw satisfaction and overcome barriers in their practices

Corresponding author
Amy B. Weil, MD
UNC School of Medicine at Chapel Hill
amy_weil@med.unc.edu

Co-authors
Lars G. Osterberg, MD
Elizabeth A. Rider, MSW, MD
William T. Branch Jr, MD

Learning objectives
1. Understand what motivates and prevents humanism in a cohort of particularly humanistic physicians and see how this resonates with their experience.
2. Reflect on solutions to increase joy and reduce stress and burnout in their practice of medicine.
3. Be galvanized to move their practice towards joy.

Context/background
Burnout is an enormous problem with failures in professionalism as end manifestations. Humanistic practice has been linked to fewer lapses in professionalism. We mined narratives written by faculty graduates of a longitudinal faculty development program designed to encourage humanism to see if we could learn about facilitators and barriers to humanistic practice and find keys to prevent burnout.

Methods/approach
Faculty graduates of a longitudinal faculty development program designed to encourage humanism wrote reflections in answer to two open-ended questions addressing their personal motivations and barriers to humanistic practice and teaching. These faculty represented participants from eight U.S. medical schools and included 68 physicians, 58 percent female, 69 percent younger than age 45, 85 percent junior faculty, 71 percent 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 employing grounded theory.

Findings/results
The 68 study-physicians represented a 73 percent response rate (68/93 faculty enrollees). Motivating themes for humanistic care included (1) identification with humanistic values, (2) providing care they or family would want, (3) connection to patients, (4) passing on values through role modeling, and (5) being in the moment. Barriers to humanism included (1) time, logistics and structural limitations of practice; (2) the hidden curriculum and its resultant culture; (3) feeling drained by patients; and (4) episodic burnout and discouragement.

Conclusions/discussion
Respondents almost unanimously found their personal values and professional identities sustained them, whereas logistical, bureaucratic, cultural and resultant emotional stresses impeded them. “Being in the moment,” described as a form of mindful practice, was a solution that individuals discovered could help them in moments of stress. Interestingly, mindfulness programs 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.
Knowing what you know today, would you still choose to be a doctor? Factors affecting resident and fellow satisfaction with their choice of a career in medicine

Corresponding author
Nicholas A. Yaghmour, MPP
Accreditation Council for Graduate Medical Education
nyaghmour@acgme.org

Co-author
DeWitt C. Baldwin Jr., MD, ScD(hc)

Learning objectives
1. Report the prevalence of residents and fellows who would and would not choose medicine as a career again by specialty, training level, gender and category of undergraduate medical education (allopathic, osteopathic and international medical graduates).
2. Relate enthusiasm for the field of medicine and future career prospects to individual resident characteristics, such as general health and mood.
3. Discuss the difference in perceptions of clinical learning environments across programs and how these perceptions influence the attitudes residents and fellows hold about medicine as a field.

Context/background
Graduate medical education provides a foundation for practicing physicians. Given the importance of this period of training, what proportion of GME trainees would choose medicine as a career again if given the option?

Methods/approach
Residents and fellows were presented with an optional, anonymous survey querying general health and well-being as well as whether they would choose medicine as a career again given what they have learned about the field.

Findings/results
Over 14,000 residents and fellows responded: 25 percent were PGY1’s, 24 percent PGY2’s, 23 percent PGY3’s, 19 percent PGY4-PGY7’s, and 9 percent were fellows. Thirty-six percent of respondents reported that they would definitely choose medicine as a career again, 34 percent reported that they would probably do so, 16 percent were not sure, 10 percent would probably not choose medicine as a career again, and 4 percent would definitely not do so. Respondents reporting that they would “definitely not” choose medicine as a career again reported feeling down, depressed or hopeless nearly half of the time (seven out of the past 14 days) while respondents reporting that they would definitely choose medicine as a career again only reported feeling down, depressed or hopeless on one out of the past 14 days. Similar response patterns were found for general health, sleep disturbance and feeling overwhelmed with one's workload. Mean reports of being belittled or humiliated ranged from 2.4 such events over the past two weeks for respondents that would definitely not choose medicine again to less than one half of one occurrence of belittlement and humiliation for those who would definitely choose medicine again.

Conclusions/discussion
Residents and fellows who reported experiencing poor health, depressed mood, sleep disturbances, overwhelming workload and being treated unprofessionally are struggling to find joy in medicine. Future work must improve the health and mood of trainees and foster humanistic learning environments.
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

Corresponding author
Christopher Simon, PhD
University of Ottawa
christopher.r.simon@icloud.com

Co-authors
Derek Puddester, MD
Alan Chaput, MD
Lorne Wiesenfeld, MD
Larry Harmon, PhD
Paul Gregory, PhD

Learning objectives
1. Define multisource assessments and their role as a feedback tool for resident physicians.
2. Describe how multisource assessment tools can aid in the development of non-medical competencies.
3. Discuss potential nuances respect to the utility of multisource assessment tools with a diverse and international audience.

Context/background
The aim of this presentation is to share how multi-source assessment (MSA) can be a useful tool to provide feedback to residents on non-medical competencies in postgraduate medical education (PGME). Using insights from a recent program evaluation we will discuss how a positive psychology approach—focusing on strengths as well as areas to improve—from multiple perspectives reflects a shift towards a culture of feedback, and presents opportunities to enhance wellness.

Methods/approach
Insights on adaptive expertise and development demonstrate that feedback is an essential component of learning for resident physicians (Bransford et al., 2000). Recently, MSA tools have been implemented in PGME, which provide feedback to learners from several sources (e.g., colleagues, supervisors, self) (Bergman, 2014), adding incremental validity to the assessment, as well as enhancing trust in the authenticity and accuracy of feedback, and receptiveness to alternative perspectives (Malling et al., 2009). Such outcomes demonstrate opportunities for fostering a culture of feedback, collegiality and positive communication, reducing issues such as disruptive behavior, and enhancing self-awareness of behaviors and how these affect others. Our program evaluation data support the utility of an MSA tool. Although the majority of users agreed it contributes to the effective development of non-medical competencies (e.g., professionalism, communication, leadership and collaboration) several aspects could be improved. For instance, while feedback from multiple sources was appreciated, they struggled with self-ratings. Also, less than half felt they were able to effectively incorporate feedback to improve performance. Potential solutions will be discussed.

Conclusions/discussion
Our presentation will provide some theoretical and practical lessons learned, as well as present and discuss implications for resident wellness, and promoting a culture of feedback. Finally, we are interested in discussing potential nuances that may exist with respect to the utility of MSAs, with a diverse and international audience.
Persistence of cynicism despite improved quality of life: Wellness measures all improve in the fourth year of medical school except depersonalization

Corresponding author
Rachel H. Kon, MD
University of Virginia School of Medicine
rhk5c@virginia.edu

Co-authors
Justine E. Owens, PhD
Tabor Flickinger, MD
Walker Redd
Danielle Oliver
Margaret L. Plews-Ogan, MD
John Schorling, MD

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

Context/background
Physician burnout contributes to loss of empathy, poor job performance and ultimately to 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 four years.

Methods/approach
University of Virginia School of Medicine students were sent an online anonymous survey in 2014–2015 that contained 128 items including demographic information, quality-of-life measures, and questionnaires for anxiety and depression (PHQ-4), burnout (Maslach Burnout Inventory), and resilience (Connor-Davidson Resilience Scale). Statistical analyses were conducted using chi-square to compare discrete variables and ANOVA to compare continuous variables between years.

Findings/results
Of 630 students eligible to participate, 343 responded to at least part of the questionnaire (54.4 percent response rate). Mean scores for fourth-year students (22.1 percent of respondents) were compared with cohorts in their first, second and third years.

Burnout: The prevalence of high emotional exhaustion for first-, second-, third-, and fourth-year medical students was 21.3, 34.7, 50.6, and 9.1 percent, respectively ($\chi^2 = 33.9, p<.001$). The prevalence of high depersonalization was 16.0, 14.7, 56.6, and 40.9 percent, respectively ($\chi^2 = 44.4, p<.001$). The 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 percent, respectively ($\chi^2 = 22.3, p<.001$). Resilience: CD-RISC scores varied by year in medical school with scores highest in fourth-year students ($p=.005$). 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 ($p<.001$). Mean PHQ4 scores were significantly lower in the fourth year ($p=.001$).

Conclusions/discussion
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 the fourth-year students in our survey had overall higher wellness scores than students in years one through three, 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 is so common in this situation 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.
Preventing resident burnout: A longitudinal study of resident burnout and resilience in the Queen’s University internal medicine training program

Corresponding author
Marie Leung, MD
Department of Internal Medicine, Queen’s University
mleung@qmed.ca

Co-authors
Bethany Monteith, MD
Jeff Ames, MD
Larissa Petriw, MD
Anas Makhzoum, MD
Mala Joneja, MD
David Taylor, MD

Learning objectives
1. The participant will understand the impact of residency training in internal medicine on trainee burnout, perceived stress and resilience.
2. The participant will identify key points during residency training in internal medicine leading to high levels of burnout and stress.
3. The participant will understand the importance of resident-driven interventions in improving well-being, reducing burnout and reducing risk of depression during residency training.

Context/background
Burnout—a syndrome of emotional exhaustion, depersonalization and decreased sense of personal accomplishment—affects medical trainees at alarming rates, ranging from 27–78 percent. Resident burnout has been shown to negatively impact on patient care with correlation to perceived clinical errors and increased medication errors. Understanding the factors influencing resident burnout is a focus of the Core Internal Medicine training program at Queen’s University. As such, a resident-driven leadership team engaged in resident wellness was formed in 2015. It aims to investigate the level of burnout within Queen’s University internal medicine trainees, as well as to explore potential interventions to prevent its occurrence.

Methods/approach
Internal medicine residents in the Core Internal Medicine program at Queen’s University (n=80) participated in a de-identified survey monitoring the level of resident burnout, perceived stress and resilience throughout their training. Study participants answered a composite questionnaire of validated scales measuring burnout (Maslach Burnout Inventory), perceived stress (Perceived Stress Scale) and resiliency (Brief Resilience Scale) at three-month intervals during their training.

Findings/results
The information gathered by these surveys will be analyzed on a cross-sectional and longitudinal basis to assess key periods of high stress and burnout during internal medicine training. Data collection began in February 2016 and is ongoing. On preliminary data, 86 percent of residents reported high levels of perceived stress; the average score was 25.42±6.78. Sixty-nine percent of residents met clinical criteria for burnout; 50 percent exhibited high levels of cynicism, and 61 percent exhibited high levels of emotional exhaustion.

Conclusions/discussion
The high rates of burnout and perceived stress highlights more investigation into factors causing its occurrence. Further data points will be helpful in elucidating time periods of high stress and burnout.

Promoting engagement/preventing burnout: A six-session experiential skills development group

Corresponding author
Diana L. Dill, EdD
Massachusetts General Hospital, Division of Palliative Care
drdianadill@gmail.com

Co-authors
Vicki A. Jackson, MD
Kathleen P. Doyle, MD
Mihir M. Kamdar, MD

Learning objectives
1. Learn a working model for the range of functioning clinician experience at work
2. Be exposed to several evidence-based, teachable personal strategies for increasing positive experiences and reducing negative experiences at work
3. Be exposed to a potent evaluation strategy for guiding interventions

Context/background
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.

Methods/approach
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.

Findings/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.”
Qualitative assessment of physician perspectives in an emerging primary care system

Corresponding author
Paul Di Capua, MD, MBA, MSHPM
Baptist Health Medical Group
dr.dicapua@gmail.com

Co-authors
Tatiana Ivan, MD
Tomas Villanueva, DO, MBA
Myriam Ampuero-Martinez, MPA
Khurram Nasir, MD, MPH

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

Context/background
To understand if physicians are finding “joy in medicine,” you have to ask them, listen to their answers, and use that data to drive system improvement. This qualitative evaluation sought primary care physician perspectives to understand key barriers and drivers of physician professional satisfaction.

Methods/approach
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/results
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. Physicians reported poor levels of communication with most other stakeholders within the health system, though a few said communications about admitted patients had improved. Many expressed gratitude for leaders that were invested in their perspectives but also voiced desire for more physician-led changes. Physicians were grateful to have behavioral health integrated into the practices though they also identified opportunities for stronger mental health support. The role of the computer was consistently identified as a barrier to professional satisfaction. Finally, although all physicians said they enjoyed working with their primary care team, they also voiced concern regarding communication among team members. This data was used to create a conceptual modeling the role of primary care within a larger population health management system.

Conclusions/discussion
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.

Physicians were grateful for the leadership’s vision and responsiveness in creating the system but seek to have a greater role. Some of the biggest improvements they identified were the implementation of care coaches to facilitate transitions of care and the integration of licensed social workers into the primary care practices.
Resident wellness and burnout: A comparison of central and distributed sites

Corresponding author
Sarah A Smith, MD
University of Toronto
sa.smith@mail.utoronto.ca

Co-authors
Angela M. McGibbon, MD, PhD
Heather C. F. Moffatt, BA

Learning objectives
1. Understanding how resident burnout is defined in the medical education literature
2. Identify many positive and negative factors that contribute to residents' perceptions of burnout
3. Understand how these factors affect residents' perceptions of burnout differently at central and distributed medical education sites

Context/background
The topics of resident wellness and burnout have received considerable attention in the last decade. Research has identified numerous factors that affect resident burnout including gender, year of training, workload, financial burden, perceived stress and relationship status. The objective of this study was to explore potential differences of burnout between residents completing their training at central (urban) versus distributed (primarily rural) sites.

Methods/approach
First- and second-year residents in the family medicine, emergency medicine and internal medicine programs at Dalhousie University were invited via email to participate in this study. Participants completed an online survey consisting of demographic variables, the Maslach Burnout Inventory (MBI) and open-ended questions about their perceptions of burnout.

Findings/results
Twenty-seven percent (N=47) of eligible residents completed the online survey. Analysis of the data showed 89 percent of these residents met the criteria for burnout established by prior research. Although residents' scores on the MBI showed no significant difference between central and distributed sites, residents' reports of the factors affecting their feelings of burnout were site dependent.

Conclusions/discussion
Our results showed a very high level of resident burnout at both central and distributed sites. The contributing burnout factors reported by our residents are consistent with prior research but this study suggests that the salience of these factors differs between central and distributed sites. As more medical education programs expand to the distributed site model these findings have implications for future resident wellness planning.
Sleep health in medical students: A cross-sectional study at Stanford University School of Medicine

Corresponding author
Sara G. Connolly
Stanford University School of Medicine
sgconnol@stanford.edu

Co-authors
Mickey T. Trockel, MD, PhD
Rebecca Smith-Coggins, MD

Learning objectives
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

Context/background
Good sleep is known to have many benefits including better mood and improved cognitive function. Unfortunately, many medical professionals struggle with getting quality sleep. Sleep issues likely begin in medical school when students are forming habits. Understanding sleep health in medical students may allow for intervention at this crucial time and provide a solution for increasing “joy in medicine.”

Methods/approach
Stanford medical students were asked to complete an anonymous online survey that included NIH PROMIS Sleep Disturbance, Sleep Related Impairment, and Depression short forms. Students were asked to report the average number of hours slept per night and to identify specific problems that prevented better sleep. Demographic information (year, gender) was collected.

Findings/results
Four hundred and seventy students were invited to participate; 162 students completed the survey. Students reported an average of 6.77 hours of sleep per night (SD 1.0). Average Sleep Disturbance was 19.3 (SD 5.8, T-score 49.3), slightly below national average. Sleep Related Impairment and Depression 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. Scores increased with class year but this trend was not statistically significant. Two-thirds of students (n=107) identified at least one problem affecting sleep. Common problems were not having enough time (53 percent), being too stressed (34 percent), feeling most productive late at night (29 percent), and enjoying staying up late (28 percent). Several problems were significantly associated with Sleep Related Impairment: being too stressed (p<.001), not having enough time (p <.001), having an irregular sleep schedule (p=.002), and having insomnia (p=.045). Females had significantly more sleep problems than males (1.1 vs 0.8, p=.006). Number of sleep problems positively correlated with Sleep Disturbance, Sleep Related Impairment, and Depression scores (p <.001, <.001, .022).

Conclusions/discussion
Medical students are sleeping less than recommended for their age group (7–9 hours/night). Sleep problem correlations with Sleep Related Impairment and Depression suggest sleep problems may be barriers to “joy in medicine.” Interventions addressing sleep problems are being developed at Stanford University and will be studied in a multisite trial beginning in 2016.
The future of medicine: Understanding the determinants of satisfaction and well-being for resident and fellow physicians

Corresponding author
Tina Shah, MD, MPH
American Medical Association Resident and Fellow Section
tinarashmishah@gmail.com

Co-authors
Benjamin Galper, MD, MPH
Ricardo Correa, MD
Semyon Faynboym, MD
Jessica Deslauriers, MD
Olutoyin Okanlawon, MD, MPH
Shady Henien, MD
Alik Widge, MD, PhD

Learning objectives
1. Describe factors influencing professional satisfaction for physicians-in-training.
2. Compare and contrast factors influencing trainees’ satisfaction to those influencing established physicians.
3. Identify gaps in our understanding of determinants of young physician satisfaction.

Context/background
Health policy changes are being made to address factors driving dissatisfaction for senior physicians, however, it is unknown whether these factors are integral for residents and fellows (RF). We conducted a study to determine factors correlating with joy in medicine for RF.

Methods/approach
Between July–August 2015, we conducted a survey of RF, invited via email from the American Medical Association Resident and Fellow Section listserv and solicited colleague participation. The study was exempt by the Indiana University IRB, and assessed satisfaction in: (1) practice environment; (2) quality of life; and (3) preparation for future medical practice.

Findings/results
Of 46,574 surveys sent and 20,710 opened, 7.2 percent (3,376) responded. Respondents were predominantly PGY1s (42 percent), ages 25–34 (87 percent), female (50 percent), and had $100,000–$300,000 of debt (46 percent). Eighty-three percent were satisfied in their current practice and 92 percent believed that they would be very or somewhat satisfied in their future practice. Most reported no concerns with work autonomy (83 percent). Satisfaction with electronic health records (EHR) was high (87 percent), however 45 percent believed that EHRs interfered with the patient-provider relationship. Interpersonal relationships with family and friends were the most stable aspects of quality of life, while time for sleep and exercise were least stable. Personal health and time with family and friends were high priorities while managing work-related issues such as call frequency and work hours were lower. High stability of mental health was correlated with improved satisfaction ($\beta=-0.297$, p<1.9e-15 by Wald test).

Conclusions/discussion
This national sample of U.S. physicians is the largest study to date on RF satisfaction. RF are satisfied with their current and planned future practice environments. Interpersonal relationships, duty hours, call frequency and EHR use did not substantially correlate with satisfaction; however, factors related to personal wellness did. Our preliminary results suggest that RF have different drivers of satisfaction than physicians in established practice.
Time spent in direct patient care among Norwegian doctors from 1994 to 2014: A panel study

Corresponding author
Judith Rosta, PhD
LEFO – Institute for Studies of the Medical Profession
judith.rosta@legeforeningen.no

Co-author
Olaf G. Aasland, MD

Learning objectives
At the conclusion of this presentation, participants will be able to:
1. Assess the total weekly working hours of Norwegian doctors from 1994 to 2012
2. Describe the hours spent in direct patient care of Norwegian doctors from 1994 to 2014
3. Compare the changes in total weekly working hours and hours spent in patient care for doctors in different type of work and for hospital doctors in different specialties

Context/background
A high level of doctor care hours is associated with better treatment outcomes and satisfied patients and doctors. In Norway, discussions in the media and within the profession itself suggest that the number of doctor hours with direct patient care is declining. This study analyses how this decline differs between doctors in different positions and specialties.

Methods/approach
The study population is an unbalanced panel of 1,300–1,800 doctors in Norway with postal surveys performed in 1994, 1995, 1996, 1997, 2000, 2002, 2004, 2006, 2008, 2010, 2012 and 2014. Response rates range from 65 to 95 percent. Outcome measures are self-reported total weekly working hours and hours spent in direct patient care. Statistical significance is assessed with 95 percent confidence intervals (CI) where non overlapping CIs for proportions or interval variables indicate statistically significant differences.

Findings/results
From 1994 to 2014, weekly working hours remained stable for all specialty and position groups, except for full time researchers, who reported a significant decline. Time in direct patient care did not change significantly for GPs (34.8h vs 33.7h), private practice specialists (33.6h vs 34.4h) or researchers (9.7h vs 5.8h), while it significantly declined for unit leaders (24.1h to 13.7h), senior and junior hospital doctors (27.8h to 20.9h). Among hospital doctors the largest reduction in patient time was among laboratory doctors (unit leaders 24h to 11.9h; seniors/juniors 28.8h to 18.9h), followed by doctors in internal medicine (unit leaders 24.9h to 15.1h, seniors/juniors 27.9h to 19.5h) and surgeons (unit leaders 27h to 20.3h, seniors/juniors 32.4h to 24.6h). A not-significant decline was found among unit leaders (15.1h to 8.9h) and seniors/juniors (19.3h to 17.7h) in psychiatry.

Conclusions/discussion
Health care reforms, increasing demands for documentation, changes in clinical productivity, increasing task-shifts between health care professionals and a growing number of doctors may account for the observed decline in doctor care hours.
Use of primary medical care by resident physicians: A cross-sectional study of University of Toronto trainees

Corresponding author
Savithiri Ratnapalan, MBBS, Med, MRCP
University of Toronto, Hospital for Sick Children
savithiri.ratnapalan@sickkids.ca

Co-authors
Elizabeth Yeboah, MD

Learning objectives
1. To describe the use of formal and informal primary medical care by resident physicians
2. To describe resident views on obtaining informal medical care from peers and faculty
3. To discuss the usefulness of a resource for locating primary care practitioners

Context/background
Interaction between physicians and the health care system as patients is complex. Finding a general practitioner for primary medical care is time-consuming. Obtaining informal "corridor consultations" from peers is convenient behavior learned in training. The objective of our study was to determine how residents obtain primary care. Our secondary objective was to determine whether a resource could help residents find a general practitioner.

Methods/approach
We conducted a cross-sectional study of University of Toronto second-year residents using two online questionnaires. During recruitment, we disseminated a resource listing general practitioners accepting patients. Questionnaire 1 explored how residents obtain primary care and 31/121(25.6 percent) invited residents responded. Three months later, 18 (14.9 percent) responded to Questionnaire 2 that explored usefulness of our resource. Results were expressed as percentages. Odds ratios were calculated for subgroup comparisons.

Findings/results
Of 31 Questionnaire 1 respondents, 80.6 percent had a general practitioner. Though 64 percent found their physician during residency, 19.4 percent reported residency programs had resources to help find physicians. A total of 41.9 percent and 32.3 percent sought medical care (e.g., prescriptions) from other residents and faculty, respectively. The majority of respondents (58.1 percent) felt this was acceptable or very acceptable behavior, with significantly more males agreeing with this practice (12/15 male vs. 6/16 female, OR 6.7, 95% CI 1.3–34, P=0.029). There were no significant differences in these practices between those with a general practitioner and those without. Of 18 Questionnaire 2 respondents, only two used the resource and one successfully found a physician.

Conclusions/discussion
The majority of residents had a general practitioner and found them independently. Despite this, seeking medical care from peers and faculty was prevalent, and the majority agreed with this practice. Our resource for locating a physician was not readily used. Our small study sheds light on personal health practices of residents and their interactions with formal and informal primary care.
What do we mean by physician wellness?
A systematic review of its definition and measurement

Corresponding author
Keri J. S. Brady, MPH
Health Law, Policy & Management
Boston University School of Public Health
kjbrady@bu.edu

Co-authors
Mickey T. Trockel, MD, PhD
Christina T. Khan, MD, PhD
Kristin Raj, MD
Mary Lou Murphy, RN, MS
Bryan Bohman, MD
Erica Frank, MD, MPH
Alan K. Louie, MD
Laura W. Roberts, MD, MA

Learning objectives
1. Identify how physician wellness is conceptualized and measured in the literature
2. Identify gaps in the scope of the literature’s (a) conceptualization and (b) measurement of physician wellness
3. Learn an integrated conceptual definition of physician wellness

Context/background
The rising prevalence of physician burnout has increased concern for physician wellness and its impact on health care quality, calling for concerted intervention. Yet systematic improvement of physician wellness requires conceptual clarity and consistency in how the construct is defined.

Objectives
We conducted a systematic literature review of physician wellness and well-being (physician wellness). We systematically characterized the measurement of physician wellness, using this characterization along with authors’ explicit definitions to elucidate the meaning of physician wellness in published literature.

Methods/approach
We performed a PubMed search, a forward citation search in “Web of Science,” and a manual reference check. Of the 3,057 records identified, 78 papers that quantitatively assessed “wellness” or “well-being” within a physician population were included. From these papers, we extracted and classified a dataset of 171 unduplicated physician wellness measures based on each measure’s dimensional (mental, social, physical or integrative well-being), valence (positive or negative), and contextual (work or general-life) attributes and assessed changes in measurement of physician wellness over time (1989–2015). Explicit definitions of physician wellness were compared against researchers’ measurement of the construct.

Findings/results
Only 14 percent (n=11) of included articles provided an explicit definition of physician wellness. At least one measure of mental, social, physical and integrative well-being was present in 89 percent, 50 percent, 49 percent, and 37 percent of included papers, respectively. We found a significant increase in the number of articles that operationalized physician wellness using measures of integrated well-being in general-life (e.g., balance in life, overall quality of life) in recent versus early years (X²=5.08 df=1, p=0.02). Measurement of other physician wellness domains has remained relatively stable over time.

Conclusions/discussion
There is wide variability in definitions of physician wellness, with greatest emphasis on negative moods/emotions (e.g., burnout). We propose a holistic definition of physician wellness to inform design and assessment of future physician wellness interventions.
Wisdom and burnout in medical students

Corresponding author
Margaret Plews-Ogan, MD
University of Virginia
mp5k@virginia.edu

Co-authors
Justine Owens, PhD
Sudheer Vemuru
Walker Redd
Danielle Oliver
Rachel Kon, MD
Tabor Flickinger, MD
Natalie May, PhD
John Schorling, MD

Learning objectives
1. Discuss wisdom and how it applies to medical students
2. Discuss burnout and how it applies to medical students
3. Discuss the relationship between burnout and wisdom and how it applies to medical students

Context/background
Characteristics of wisdom include understanding the deeper meaning of things, knowing the limits of knowledge, tolerating ambiguity, engaging in reflective and self-reflective thinking, showing compassion and sympathy toward others, and the capacity to be other-centered. These capacities may be protective of burnout. Wisdom has never been measured in medical students. This study sought to measure wisdom and burnout in medical students, in order to better understand the relationship between these factors.

Methods/approach
All medical students at the University of Virginia were sent an online 128 item anonymous survey (demographics, wellbeing measures, and validated questionnaires for anxiety, depression, burnout, resilience and wisdom). Results on Ardelt’s 3-Dimensional Wisdom Scale (3D-WS) (subscales compassion, reflection and cognitive) and the relationship between scores on the 3D-WS and the Maslach Burnout Inventory (MBI), with subscales on emotional exhaustion (EE), depersonalization (DP) and personal accomplishment (PA) are reported here.

Findings/results
Six hundred and thirty students were eligible to participate, and 343 responded to at least part of the questionnaire (54.4 percent response rate) and 265 to the entire questionnaire (42 percent response rate). Mean age 25 with 50.6 percent female and 49.4 percent male respondents. High wisdom students (N=64) vs less wisdom students (N=201) scored as follows on the MBI: 16.8 (SD=8.9) vs. 23.2 (SD=11.0) on emotional exhaustion (EE) (F= 17.9, p<0.001); 4.9 (SD=4.6) vs. 8.3 (SD=6.5) on depersonalization (DP) (F=14.8 p<0.001); and 36.1 (SD=6.5) on personal accomplishment (PA) (F= 11.7, p=0.001). On multivariate analysis (N=265), using standard cutoffs for categories of low and high EE and DP, and separating out the three dimensions of the 3D-WS, there was a significant association between level of EE and scores on the reflective dimension of the 3D WS (p<0.001), and between level of DP and scores on both cognitive (p=0.003) and compassion dimension (p<0.001) of the 3D-WS.

Conclusions/discussion
To our knowledge this is the first measure of wisdom in medical students, and the first to examine the relationship between wisdom and burnout. High-wisdom students had significantly lower scores on emotional exhaustion, and depersonalization, and significantly higher scores on personal accomplishment on the MBI. There was a significant association between levels of EE and scores on the reflective dimension of the 3D-WS, and between levels of DP and scores on both cognitive and compassion dimension of the 3D-WS. Influencing these wisdom capacities may be protective of the various components of burnout in physicians.