

Abstract book







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Beyond surviving: How organizations are supporting women physicians to thrive and rise

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Learning objectives

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- 1. Review findings from national physician engagement survey data to reveal differences for female and male physicians, including minority female physicians.
- Propose addressing 3 strategic areas of focus (flexibility, respect, advancement) for organizations to pursue to address these differences.
- 3. Share examples of organizational efforts to improve flexibility, respect and advancement for female physicians.

Project objective/background

Women make up more than one-third of physicians in the United States and are the growing majority among medical students. However, a significant proportion of female physicians either no longer work full-time or are cutting back. Healthcare organizations cannot afford to lose their female physicians.

Methods/approach

This presentation reviews two national studies evaluating female and male clinicians' responses to engagement surveys using a 5-point Likert type scale, (1) strongly disagree to (5) strongly agree and provides three critical areas organizations must consider.

Results

In the first study, 200,000 physician engagement surveys responses were analyzed. Female and males reported similar meaning in their work, however, females reported they were less able to leave work behind, less satisfied with leadership relationships, and less likely to remain with the organization in three years, even when controlling for age. In addition, female physicians gave lower ratings for staff support, time for patient care, involvement in decision-making, and job stress. Additional gender gaps were apparent when analyzing decompression among physicians.

The second study evaluated 2,800 physician responses to assess differences in female minority clinicians verses male clinicians of the same background on workplace diversity, equity, and inclusion. Results indicated Black and Hispanic female physicians were less likely to report their organization values diversity and demonstrates commitment to diversity.

- Organization values employees from different backgrounds: Black female physicians scored 0.42 of a point lower than males
- Organization commitment to diversity: Hispanic female physicians scored 0.48 of a point lower than males
- Organization demonstrates a commitment to workplace diversity: Black female physicians scored 0.45; Hispanic female physicians 0.54 of a point lower than males

Conclusion

Based upon these findings, three strategic focus areas for organizations include: flexibility, respect, and advancement.

Organizations providing flexibility of clinical schedules, telehealth, job-sharing, working remotely part-time, parental leave, and childcare support, are critical to retaining female clinicians.

Respect can be increased by including women in decision making and increasing diversity in management and care teams. Leaders must demonstrate their culture is inclusive by intentionally involving those who have not historically been invited to join in conversation.

Advancement can be improved through transparency in the hiring process by publicly posting openings, investing in coaching and in mentorship to support junior female physicians.

Reference

https://hbr.org/2022/01/why-so-many-women-physicians-are-quitting



Burnout among health care workers facing COVID-19 pandemic: Opportunity to study the relative importance of individual, occupational, social and organizational factors over time

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Learning objectives

- 1. Describe the prevalence of burnout and psychopathologies among healthcare workers going through the COVID-19 pandemic
- 2. Differentiate individual, occupational, social and organisational variables
- 3. Integrate the importance of resilience, social satisfaction and perceived organisational support

Project objective/background

The COVID-19 pandemic is a chronic stressor that affects the global population and above all, healthcare workers. While the literature examining the prevalence of burnout and psychopathologies among this population has exploded, the relative role of individual, occupational, organisational and social factors have been mostly studied independently. Examining these factors in the same study is essential to have an integrative view of the problem and generate efficient interventions to mitigate burnout.

Methods/approach

We recruited 467 healthcare workers from Quebec, Canada, who responded to an electronic survey covering various mental health outcomes (burnout, post-traumatic stress, anxiety and depressive symptoms) and factors three and twelve months after the start of the COVID-19 pandemic. We were particularly interested to see the relative role of resilience, workload, social support, access to personal protective equipment, access to mental health support and perceived organisational support. We applied multivariable regression models to examine the association between these variables and burnout and mental health outcomes. We controlled for sex, work type and environment, reassignment, direct COVID care, emergency or intensive care unit car and psychiatric antecedents.

Results

At 3-month 52% of our participant displayed burnout and 36% severe symptoms of at least one psychopathology studied. Among all variables studied, resilience and perceived organisational support were the only two being significantly negatively associated with burnout, post-traumatic stress, anxiety and depressive symptoms. In fact, each jump of 6 points of increase on the resilience scale reduces the likelihood of burnout by 31%; and every 12 point increase in the perceived organizational support scale decreases the likelihood of burnout by 25%. At 12-month, burnout rate remained stable (51%) but overall psychopathology rate decrease to 27% (p=0.04). Perceived organizational support remained significantly associated with burnout at 12-month, as opposed to psychopathologies that were no longer associated with it. Social satisfaction emerged as a new protective factor for burnout at 12-month.

Conclusion

The detailed factor analysis suggest that interventions aimed at preserving or increasing the resilience, organizational and social support of healthcare workers should be implemented to protect their psychological health while facing a stressor.



Clinician practice ownership predicts ability of primary care practices to improve quality without increasing burnout

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Learning objectives

- 1. To identify high-performing practices in the EvidenceNow Initiative who saw improvements in aspirin prescribing, blood pressure control, and smoking cessation counseling quality metrics without increasing burnout.
- 2. To characterize practice factors that predict likelihood of being a high-performing primary care practice.

Project objective/background

Work environments and practice structural features influence burnout and the ability of practices to enhance quality of care.¹⁻⁴ The AHRQ-funded EvidenceNow study focused on increasing implementation of cardiovascular preventive care delivery among >1500 small-to-mediumsize primary care practices across seven regional cooperatives and twelve states from 2015-2019. We sought to characterize the structural factors associated with practices successfully improving quality scores over the intervention study period without increasing staff burnout.

Methods/approach

We studied EvidenceNow practices who returned both baseline and post-intervention follow-up surveys (n=1,053). We defined high-performing practices as those for whom the proportion of staff reporting burnout was stable or improved across the study period and who also had an improvement in aspirin prescribing, blood pressure control, and smoking cessation counseling metrics. We used chisquared tests to characterize differences in practice factors and electronic health record (EHR)/quality reporting factors among high-performing versus other practices. We built multivariable logistic regression models with standard errors clustered by cooperative to identify practice-level factors associated with being a high-performing practice.

Results

Our analysis focused on the 727 (69.0%) of practices with complete burnout and aspirin, blood pressure, and smoking quality metric information at both baseline and follow-up timepoints.18.3% (n=133) of these practices met the criteria to be considered high-performing. Among high-performing practices, the mean decrease in burnout across practice staff over the study period was 10.6% versus a 5.3% increase for other practices (p<0.001).

In bivariate analyses, high-performing practices were more likely to be clinician-owned (55.6% vs. 39.9%; p = 0.04). This difference persisted in multivariable analyses adjusted for practice location, accountable care organization (ACO) and demonstration project participation, and practice specialty composition, with clinician-owned practices having 2.02 (95% Cl: 1.09, 3.77) times higher odds of being considered a high-performing practice than those owned by a hospital or health system. There were no significant differences in odds of being a high-performing practice by practice size, location, ACO or demonstration project participation, or by EHR/quality reporting factors such as ability to produce quality reports or meaningful use participation.

Conclusion

Across 727 small-to-medium primary care practices in the EvidenceNOW study, clinician-owned practices were twice as likely to achieve improvements in cardiovascular quality outcomes without an increase in staff member burnout. This is consistent with prior studies suggesting lower burnout among clinician-owned practices.⁴ In the context of increasing healthcare consolidation, our findings suggest the value of studying the workplace culture features of clinician-owned practices that drive positive quality and experience outcomes.

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Competing pressures of the academic physician and relationship to burnout

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Learning objectives

- 1. Define academic physician "pressure points"
- 2. Describe the relationship between academic pressure points and physician well-being
- 3. Analyze the impact of academic pressure points on workplace culture and climate

Project objective/background

Academic medical faculty are known to be at risk for burnout. To date, this has been attributed to role conflict between clinical and non-clinical duties,¹ and inability to focus on meaningful aspects of work has been associated with higher burnout.² Institutional culture and context are also known to influence academic physician burnout.³ However little is known about the relationship between specific stressors faced by academic physicians and burnout.

Methods/approach

The annual wellness survey of the medical staff of a large academic medical center was conducted November 2018 to January 2019 and included a novel scale of seven "pressure points" faced by academic physicians. The degree of stress associated with each pressure point was assessed via a five-point Likert scale, and stressful was defined as "a lot" or "a great deal." Burnout was assessed by the Professional Fulfillment Index.⁴ Standard descriptive statistics described categorical specialty, academic rank, full-time or part-time, age, race, gender. Chi-square and bivariate logistic regression determined statistical independence and associations between stressors and burnout.

Results

The overall response rate was 36%. 588 academic physicians were included in the study and were proportionally representative of the institution's nineteen academic departments. The sample was majority white (80%), male (62%), average age 46 years old. The adjusted odds ratios of burnout were significantly elevated when five of seven stressors were present: standards for clinical productivity, protecting time for education and mentorship, protecting time for leadership responsibilities, standards for academic promotion, and time for research and innovation. (Table 1). There was a higher prevalence of stressors amongst associate professors, full-time faculty, females, and non-whites.

Conclusion

This study is the first to demonstrate a relationship between burnout and specific stressors faced by academic physicians (patient care, teaching, research, leadership). This is also the first application of a novel "pressure point" scale which can be used to assess individual contributors to academic faculty stress and burnout. These findings expand upon previous data suggesting that academic physicians are at risk for burnout related to conflicting demands raised by their multiple roles (clinician, researcher, educator, etc.).^{2,5} The pressure points described here offer targets for systemic intervention to influence departmental and institutional culture and improve academic physician well-being.

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	Stressor Absent^		Stressor Present*	Burnout		Stressor	Burnout	
	n (%)	Burnout (%)	n (%)	(%)	p value	OR	CI	p value
Standards for clinical productivity	377 (64.4)	31.6	208 (35.6)	63.9	< 0.001	3.80	2.56-5.64	<0.001
Protecting time for education and mentorship	399 (68.1)	35.1	187 (31.9)	59.4	< 0.001	2.74	1.84-4.09	<0.001
Protecting time for leadership responsibilities	388 (66.5)	34.3	195 (33.5)	60.5	< 0.001	2.51	1.69-3.71	<0.001
Standards for academic promotion	434 (74.3)	37.1	150 (25.7)	60	< 0.001	2.04	1.33-3.13	0.001
Protecting time for research and innovation	343 (58.7)	35.0	241 (41.3)	53.9	< 0.001	1.76	1.20-2.57	0.004
Procuring access to data or support for statistical analysis	453 (77.7)	39.5	130 (22.3)	55.4	0.001	1.56	1.00-2.43	0.051
Procuring grants or funding support for scholarly work	408 (70.1)	41.9	174 (29.9)	46.0	0.365	0.92	0.61-1.39	0.70

^ Defined as response of "none at all", "a little", or "a moderate amount"; * Defined as response of "a lot" or "a great deal"

Development of a prediction model of primary care physician burnout

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Learning objectives

- 1. Understand the prevalence and predictors of burnout among primary care physicians
- 2. Learn methods and applicability of prediction modeling to identify risk of burnout
- 3. Identify potential system-level approaches to proactively improve physician well-being

Project objective/background

Primary care physicians comprise over one-third of all US physicians and experience some of the highest rates of burnout. However, identifying work settings to be prioritized for burnout interventions is typically reactive, relying on surveys identifying burnout symptoms after they develop. This study sought to develop a prediction model for primary care physician burnout using real-time measures routinely collected in the electronic health record.

Methods/approach

Longitudinal observational cohort study of primary care physicians. We assessed burnout using the Stanford Professional Fulfillment Index and correlated results with 987 candidate EHR usage and clinical practice metrics at up to two timepoints per physician between January 2019 and October 2020. We compared EHR metrics for physicians with paired response and non-response years, using Wilcoxon signed rank tests. We developed separate prediction models for burnout score using linear regression with LASSO, random forest, and extreme gradient boosted trees, evaluating mean absolute error (MAE) using grouped nested 10-fold cross validation (grouped by clinic, with outer folds for MAE calculations and inner folds for hyperparameter tuning).

Results

We included 411 primary care physicians who provided burnout results from 697 surveys. High levels of burnout (>3.325/10) were reported on 199 (28.6%) of the surveys. Among physicians who responded in one of the two study years, the year in which they provided a survey response

(vs. non-response) was associated with several markers of higher workload, including number of appointments (138 vs 97 per month, p=.001), number of inbasket messages (462 vs 309 per month, p=.002), and time spent in the EHR after work hours (22.3 vs 17.7 minutes per 8 hour shift, p=.04). In univariate analyses of all completed surveys, burnout was associated with increased use of shared Smartphrases (p=.02), caring for a higher number of patients who died during study interval (p=.04), and having a higher proportion of notes with contributions from other team members (p=.049). Among prediction modeling techniques, extreme gradient boosted trees demonstrated the best performance, with average MAE 0.856 for predicting clinic-average burnout score (0-10 scale) across 10 folds. Features selected most frequently in boosted trees (highest importance for predicting burnout) included physician age, number of inpatient admissions, proportion of note characters entered via copy/paste, physician gender, and number of patient appointments.

Conclusion

Burnout is prevalent among primary care physicians and can be predicted with modest accuracy using routinelycollected EHR metrics. Quantifying system-level threats to physician well-being may facilitate burnout prevention rather than mitigation.



Exploration of well-being in Australian general practitioners through a positive psychology lens: Highlighting and disentangling the issues

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Learning objectives

- 1. Present the levels of wellbeing in Australian GPs over time, and what determines it
- 2. Describe wellbeing strategies applied and proposed by GPs in their personal and work lives
- 3. Provide a framework for (organizational and systemic) interventions to support GP wellbeing

Project objective/background

Increased generalist capacity, and doctor wellbeing are two priorities for the Australian health system. Positive psychology offers several frameworks for wellbeing and human flourishing, yet there is a paucity of research on GPs' wellbeing as seen through this lens. We address this gap, and complement research into burnout and mental ill health by investigating how Australian GPs flourish and thrive.

Methods/approach

- 1. Qualitative analysis of an Australian panel survey from 2009-2018 (MABEL data) looking into job satisfaction, and life satisfaction (n > 3,000 / year).
- 2. Quantitative analysis of semi-structured interviews with 20 GPs working across Australia (mean duration 32 minutes) from March to September 2021. We qualitatively explored GPs' perceptions of what determines their wellbeing, and which strategies they apply to maintain, and improve it.
- 3. Systematic review of interventions to improve wellbeing, satisfaction, and related positive constructs in GPs from 2000 to 2020.

Result

- 1. We highlight how life / job satisfaction changed over a decade for GPs in Australia, as measured annually.
- 2. Qualitative analysis of interviews with a diverse mix of GPs showed determinants and strategies to improve

wellbeing. These were mostly applied within their immediate personal and professional lives. Barriers to wellbeing were predominantly seen at the system level, and GPs identified very little that improves their wellbeing from a systems perspective. Financial aspects were distinct drivers of wellbeing across all determinants, with direct and indirect consequences for GPs.

- 3. Our systematic review revealed mostly individual level interventions with low to moderate effectiveness for wellbeing, satisfaction, and related positive outcomes. A vast array of interventions, outcomes, and metrics were applied.
- 4. Based on these results we propose a framework upon which to draw when aiming to improve wellbeing, particularly for designing interventions on organizational and systemic levels.

Conclusion

Australian GPs rely on wellbeing strategies in their immediate personal and work lives. Barriers to wellbeing were mostly seen on a systemic, and organizational level. Hence, research into GP wellbeing needs to prioritize systems and organizational interventions. Consistent definitions, outcomes, and dedicated wellbeing metrics must be used.



Give clinicians a voice: What the COVID-19 pandemic taught organizations about keeping clinicians engaged and resilient

Author

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Learning objectives

- 1. How to work with clinicians to address operational challenges
- 2. How to build trust and psychological safety with clinicians
- 3. How to use data to focus on improvement, not perfection

Project objective/background

While many in healthcare continue to struggle with the impact of COVID-19, with unprecedented turnover, resource challenges, and fatigue, some organizations have not only survived but thrived. This study examines national engagement survey data and focus group findings to provide a roadmap for success.

Methods/approach

This research analyzed over 107,971 clinician responses on engagement surveys from 2020-2022. Items use a 5-point Likert type scale, (1) strongly disagree to (5) strongly agree. Each database includes a two- year lookback i.e., 2022 database contains responses for 2020-2021.

Results

The largest declines from the 2021 to 2022 databases were operations and patient care:

- Patients feel cared for (-.36)
- Satisfied with availability of beds (-.35)
- Ease of scheduling (-.33)
- Appropriately staffed to provide high-quality care (-.25)

Additionally, decompression, which is integral to sustaining individual resilience, is at an all-time low.

- Able to disconnect from work communications during my free time (-.15)
- Enjoy personal time without focusing on work (-.14)
- Free mind from work when away (-.13)

Engagement, a validated composite measure, which assesses an individual's connection to their organization, saw steep declines (4.03 down from 4.11).

While some organizations saw steady declines in engagement, decompression and operations, there were organizations that experienced improvement in scores in 2020 followed by a dramatic decline in 2021. Understanding what drove this trend allows us to address these opportunities.

At the start of COVID-19, leaders made significant communication changes: leveraging clinicians' expertise, focusing on bi-directional dialogue, and increasing support around safety, equity, physical, emotional, and financial wellbeing. Top organizations that remained stable or improved engagement continued to focus on partnership with clinicians, psychological safety, and improvements over perfectionism, rather than reverting to pre-pandemic behaviors.

Conclusion

Organizations must work with clinicians to address operational challenges, creating reliable systems for collaboration and developing new approaches. Suboptimal areas prior to the pandemic have been exacerbated and cannot continue to be ignored.

Psychological safety is vital, especially in times of interdependence and uncertainty. Leaders must show up and listen with empathy. During the pandemic, leaders were present even in the toughest conditions, creating space for clinicians to share improvement opportunities and be involved in decision making.

Leaders need to focus on improvement and not perfection. This may be the toughest challenge, as clinicians strive for perfection and are constantly measured for their performance. Holding clinicians accountable to unachievable targets is counterproductive and results in disengagement.



Measuring associations between electronic health record use metrics and inpatient pediatric provider electronic health record experience and burnout

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Learning objectives

- 1. Identify inpatient electronic health record (EHR) use measures independently associated with provider EHR experience
- 2. Understand relationship between inpatient provider EHR experience and burnout
- 3. Identify inpatient EHR use measures independently associated with provider burnout

Project objective/background

EHRs are associated with improved patient outcomes, including reductions in mortality and medication errors^{1,2} but the inefficiency of time spent on EHR may contribute to healthcare provider stress, exhaustion and burnout.^{3,4,5,6} EHR use associates with higher prevalence of burnout in Neonatal Intensive Care Units (NICUs)⁷, but the relationship between EHR use and burnout in other inpatient settings remains unclear. This study sought to identify subjective and objective markers of EHR use associated with provider burnout in the pediatric inpatient setting.

Methods/approach

Attendings, fellows, hospitalists, and nurse practitioners from a quaternary children's hospital who work primarily in the inpatient setting were included in our study. We collected five months (June-October 2020) of EHR-use and schedule data for these providers from EHR user access logs and scheduling platforms, respectively. This data was then linked to 2020 annual wellness survey (September-October) data which included a 4-item EHR experience score and the Stanford Professional Fulfillment Index. We evaluated associations using Pearson correlation, lasso regression for variable selection, and mixed effect linear regression.

Results

Of 246 eligible providers, 179 (73%) responded to the survey. Average EHR experience score was 2.2 ± 0.8 , range 0-4, and average burnout score was 1.1 ± 0.7 , range 0-4, with burnout prevalence of 32%. Average number of notes/orders placed was independently associated with the EHR experience scores (coefficient - 0.013, p=.04). EHR

experience scores were negatively correlated with provider burnout scores (r -0.18, p=.03), but not independently associated after adjustment for work setting and role. Total time on EHR (r -0.17, p=.02), time actively using EHR (r -0.16, p=.03), time on EHR outside shift (r -0.17, p=.02), time on chart review (r -0.18, p=.01), time on order review (r -0.16, p=.03), and number of metrics accessed per patient (r - 0.21, p=.005) were negatively correlated with burnout. Metric count per patient, division, and role were selected as important predictor variables for burnout via lasso regression. Among these, the Pediatric Intensive Care Unit (PICU) division was independently associated with higher burnout scores (coefficient 0.36, p=.016). None of the EHR use measures were independently associated with burnout.

Conclusion

Burnout is prevalent among inpatient providers and being a PICU provider was independently associated with burnout. Although routinely collected EHR use measures may associate with negative EHR experience, we did not identify independent associations with burnout among this sample of inpatient pediatric providers. Larger studies are needed to investigate this relationship further.

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Organizational predictors of work-related stress in Norwegian physicians: A review of prospective studies 2007–2019

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Learning objectives

- 1. Learn about empirically based work factors of importance for tailoring effective organizational interventions
- 2. The importance of prospective studies in order to identify possible risk factors and causality
- 3. These work-related risks may be even more important in a private health system

Project objective/background

There are few prospective studies on trends and factors of importance for physician wellbeing. This paper reviews unique long-term prospective studies among Norwegians physicians in order to identify independent organizational factors that are amenable for effective interventions.

Methods/approach

We did an extensive literature search in the databases MEDLINE, EMBASE and PsycINFO. Both prospective and longitudinal (cohort) studies on work-related stress and burnout among Norwegian physicians from 2007 to 2019 were included. We excluded studies with other outcomes than work-related stress.

Results

Eleven studies were included. Four studies were from the Longitudinal Study of the Norwegian Medical Students and Doctors (NORDOC), 3 from Villa Sana (burnout intervention), 2 from the Reference Panel Study, and 2 from other sources. The observation periods were from one to 20 years. Five studies were about burnout (or emotional exhaustion); two on general job stress, two about work-home stress, one study about hazardous job stress (Effort-Reward Imbalance), and one about bullying/ harassment. Work-related stress among all Norwegian physicians declined gradually from medical school until 20 years later. Only GPs (general practitioners, family physicians) experienced a significant increase in hazardous work stress during the period 2010-2019. Work-home stress levels increased after graduation until 10 year after leaving medical school, before flattening out thereafter. Physicians in a 6-year younger NORDOC cohort reported lower levels of work-home stress. The review identified the following controlled (independent) predictors of work-related stress: Work-home stress, low colleague support, number of work hours, and larger workload or lower levels of professional autonomy. A counselling intervention for burnout, Villa Sana, reduced work-related stress.

Conclusion

Reduction in work-related stress during the years after leaving medical school may be due to enhanced competency in clinical work and reduction in on-call work. The lower levels of experienced work-home stress in the youngest cohort can be due to social welfare reforms in Norway during this period, such as increased number of kindergartens. The Co-ordination Act (earlier discharge from hospitals) implemented in 2012 can explain the increase in work stress among GPs. Organizational interventions should aim at not only reduction in workload/work hours, but also at lessening the burden of work-home stress and fostering better colleague support. This applies particularly to junior doctors in training.

Physician well-being: Efficient workflow and interdisciplinary teamwork

Author

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Learning objectives

- 1. Learn the effect of workflow on teamwork.
- 2. Learn which aspects of teamwork were most influenced by inefficient and efficient workflow.
- 3. Learn how these findings may be practically applied to engage organizations to achieve cultural change to improve physician well-being.

Project objective/background

Physicians may leave autonomous private practices for larger healthcare organizations seeking administrative simplicity and work-life balance.¹ The healthcare system was said to be "strangling in red tape",^{2,3} the "hassle factor" to blame for a hectic-chaotic work atmosphere.^{4,5} The aim of this study was to determine the prevalence of the inefficient work flow and the associations with professional well-being, and the interplay with optimal teamwork.

Methods/approach

A wellness assessment of medical staff across five regional hospitals ran September-October of 2020. The 1504 attending physicians were included in the study. A 17item scale (scored 1 "strongly disagree" to 5 "strongly agree") was used to assess optimal teamwork.⁶ [Table] Using a novel 5-item workflow efficiency scale to averaged scores across one's ability to 'focus on patient care without excessive interruption', 'carry out treatment plans without interference by excessive approval process', 'power to improve workplace functions⁷ and two metrics adapted from the NASA Task Load index assessing 'hurried and rushed' and 'hard to accomplish things'.8 The cut point for inefficient/efficient workflow =2.9. By workflow category, independent t-tests compared means of teamwork characteristics, followed by calculation of effect sizes. Given the left-skew of some teamwork results (oriented negative to positive), the analysis was also run with nonparametric statistics and transformed data (squared), without meaningful difference in statistical significance or ranked order or effect size for this sample of 1504. Logistic regression was used to determine the association between efficient work flow, teamwork, and professional fulfillment and burnout, and adjusted for practice model, specialty group, age group, race group, and gender.

Results

The 1504 attending physicians were 75% white, 56% male, with an average age 44 years old. Only 29% reported efficient workflow. Efficient workflow was associated with more professional fulfillment (OR 3.70, Cl 2.76-4.95, p<0.001) and less burnout (OR 0.17, Cl 0.13-0.24, p<0.001). Optimal teamwork was associated with higher professional fulfillment (OR 5.69, Cl 4.05-8.00, p<0.001) and lower burnout (OR 0.24, Cl 0.17-0.32, p<0.001) amongst attending physicians after adjusting for practice model, specialty group, age, race group, gender. There was a favorable interplay between efficient workflow and optimal teamwork. [Table]

Conclusion

When there was clarity around operations, roles, goals, and situational awareness for others, there was also a sense that everyone was making work easier for one another, and the conditions were fair. These aspects of teamwork were higher with efficient workflow. Optimal teamwork and efficient workflow were associated with higher professional fulfillment an lower burnout.

Reference

Practice Efficiency Affect Interdisciplinary Teamwork									
		LOW <			HIGH >=			Effect	t size
Teamwork Characteristic (Olson et al. ACPH 2021)	n	mean	sd	n	mean	sd	p-value	Cohen's D	CI
Operations Communicated	591	2.91	1.19	529	3.81	1.01	<0.001	-0.81	0.94-0.69
Recognition, No Favoritism	588	3.09	1.11	529	3.90	0.94	<0.001	-0.78	0.90-0.66
Easier for me	590	3.36	1.12	531	4.10	0.84	<0.001	-0.75	0.87-0.63
Easier for them	593	3.97	0.78	530	4.36	0.68	<0.001	-0.74	0.87-0.63
Goals Aligned	592	3.31	1.11	534	4.04	0.89	<0.001	-0.73	0.85-0.61
Safe to Question	594	3.44	1.12	532	4.16	0.83	<0.001	-0.73	0.85-0.60
Accountability, Clear, Fair	587	3.12	1.12	527	3.88	0.97	<0.001	-0.73	0.85-0.61
Roles Clear	594	3.27	1.10	533	4.01	0.95	<0.001	-0.72	0.84-0.60
Awareness of Others	593	3.34	1.03	531	4.02	1.03	<0.001	-0.72	0.84-0.60
Optimal Teamwork	596	3.27	1.15	536	4.02	0.92	<0.001	-0.72	0.84-0.60
Safe to Disagree	593	3.27	1.13	532	3.98	0.92	<0.001	-0.68	0.80-0.56
Safe to Make Mistakes	593	3.43	1.08	530	4.08	0.83	<0.001	-0.67	0.79-0.55
Support Beyond Self-interest	594	3.60	1.05	532	4.23	0.82	<0.001	-0.67	0.79-0.55
Team Collaborates	595	3.77	3.68	534	4.37	0.76	<0.001	-0.64	0.71-0.47
Conflict direct	592	3.05	1.13	528	3.75	1.10	<0.001	-0.64	0.76-0.52
No holding back	595	3.49	1.10	534	4.10	0.93	<0.001	-0.59	0.71-0.47
Share scorecard	586	3.03	1.08	521	3.65	1.06	<0.001	-0.58	0.70-0.46

The optimal teamwork scale6 (Table) is 17-items scored on 5-pt Likert (1-5) of agreement, retained on one Eigenfactor >1 with factor loadings >0.7 (except "*I do my work in a way to make work easier for others*", 0.51), and Cronbach alpha 0.96. The average composite score's binary cut off (=3.454) is per consensus of 1910 medical staff' who "*somewhat to strongly agree*" they have optimal teamwork (sensitivity 0.87; specificity 0.81; AUC 0.84). Optimal teamwork was found to be associated with medical staff professional fulfillment9 OR 5.97 (Cl 4.53-7.85, p<0.001) and burnout9 (PFI) OR 0.19 (Cl 0.15-0.25, p<0.001) adjusted for practice model, specialty group, age, race group, gender. (Olson et al. ACPH 2021)

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Peers for peers physician well-being support program

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Learning objectives

1. The participant will be able to describe the process of the development and implementation of a peer support program

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- 2. The participants will be able to describe the components of the Wellbeing Program Peers for Peers
- 3. The participant will be able to determine if a similar program is of value for them in changing culture at their institution

Project objective/background

The COVID-19 pandemic has caused a significant increase in physician burnout, highlighting the importance of developing programs to focus on physician wellness. The Peers for Peers Physician Wellbeing Support Program is a one-on-one support program designed by physicians for physicians in Canada at an academic institution.

Methods/approach

Phases of development are as follows:

- 1. Development of a leadership team and program vision.
- 2. Recruitment of Wellbeing Leads to provide psychologically safe peer support.
- 3. Program launch and implementation of training curriculum for Wellbeing Leads.
- 4. Program sustainability.

Results

Results of the first year of the implementation of the Peers for Peers Physician Wellbeing Support Program:

- 1. Leadership was provided by Wellbeing Steering committee for program development including project management
- 2. Recruitment of Wellbeing Leads was accomplished in 2 weeks with leadership engagement representing every clinical department. The number of Wellbeing Leads expanded from 17 to 40 in the first year of the program.
- 3. Program launch and implementation included training curriculum, initially by zoom then revised to an asynchronous learning platform

- 4. Results of Peer support interactions in wave 1 and 2: > 200 peer encounters. 80% did not require additional professional health referral. Mental wellbeing was the top reason for seeking peer support; Each wave provided peer support to about 2/3 female and 1/3 male physicians.
- 5. Program sustainability occurred with a) operationalizing a Wellbeing Executive Committee b) Revised asynchronous Peer support training curriculum development c) Monthly Rounding synchro wellbeing leads were supported and drove innovation and quality improvement.

Conclusion

Keys for success:

- 1. Top-level support and leadership are required with the provision of resources to enable culture change.
- 2. It is important to ensure that professional support, psychologists/psychiatrists are in place (i.e., university and provincial resources).

Lessons learned:

- 1. Importance of training engaged Wellbeing Leads to work as a team with the support of their leaders.
- Development of an synchronous training platform in peer support allowed for efficient onboarding of new peer support leads in continuous quality improvement of the program.



Challenges:

- 1. Having faculty members reach out to Wellbeing Leads, making connections during a pandemic with limited face to face interactions was difficult.
- 2. Under reporting of program utilization which is likely higher than what is reported by data collection.
- 3. As psychological safety culture improves, increased utilization is envisioned.

After 2 plus years the Peers for Peers wellbeing program can certainly attest that utilization followed the various pandemic waves with sustained baseline utilization envisioned in support of physician burnout.

Reference

Faculty Development Peers for Peers training program:

https://www.schulich.uwo.ca/clinicalfacultyaffairs/faculty_wellbeing/schulich_ wellbeing_program/index.html



Physician well-being: Perceived gratitude and interdisciplinary teamwork

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Learning objectives

- 1. Learn the effect of perceived gratitude on teamwork.
- 2. Learn which aspects of teamwork are most influenced by perceived gratitude.
- 3. Learn how these findings may be practically applied to engage organizations to achieve cultural change to improve physician well-being.

Project objective/background

Perceived gratitude has the potential to make individuals feel seen, heard, and valued. Gratitude cultivates positive emotions in the giver and receiver. Giving gratitude can improve ones' well-being more than receiving. The aim of this study is to examine the effects between perceived gratitude and characteristics of optimal teamwork.

Methods/approach

A wellness assessment of medical staff across five regional hospitals was conducted September-October of 2020. The 1504 attending physicians were included in the study. The effect of gratitude on teamwork was assessed a 4-item perceived gratitude scale by Trockel et al.¹ and a 17-item optimal teamwork scale (scored on a 5pt Likert scale 1 "strongly disagree" to 5 "strongly agree").² Scored 1-5, the cut point for low/high gratitude was set at 3.4. By gratitude category, independent t-tests compared means of teamwork characteristics, followed by calculation of effect sizes. Given the left-skew of some teamwork results. (oriented negative to positive), the analysis was also run with nonparametric statistics and transformed data (squared), without meaningful difference in statistical significance or ranked order or degree of effect size for this sample of 1504. Using the Professional Fulfillment Index,³ logistic regression was used to determine the association between gratitude, teamwork, and professional fulfillment and burnout, and adjusted for practice model, specialty group, age group, race group, and gender.

Results

The 1504 attending physicians were 75% white, 56% male, with an average age 44 years old. Of those, 70% perceived higher degrees of gratitude. Amongst attending physicians, perceived gratitude was associated with professional fulfillment (OR 6.02, CI 4.16-8.7, p<0.001) and burnout (OR 0.30, CI 0.22-0.41, p<0.001). Perceived gratitude was favorably associated with all 17 aspects of optimal teamwork. In the presence of gratitude, attending physicians especially registered more support beyond self-interest and psychological safety (learn from mistakes, questioning welcome, disagree without fear of backlash), and recognition and accountability being fair without favoritism. [Table]

Conclusion

A culture of gratitude and teamwork can work synergistically to improve professional well-being (improve professional fulfillment and reduce burnout). The science of both can be taught and practiced. This appears to be one powerful way to engage organizations to achieve culture change and improve well-being.

Reference

	Phys	ician's Perce	ived Gratit	ude and Int	terdisciplina	ry Teamwo	rk		
			PI	ERCIEVED GR	ATITUDE (4-itei	m average 1 [.]	-5)		
		LOW <3.4			HIGH >=3.4			Effec	t size
Teamwork Characteristic	n	mean	sd	n	mean	sd	p-value	Cohen's D	CI
Support Beyond Self-interest	350	3.32	1.07	781	4.14	0.03	<0.001	-0.88	1.01-0.75
Safe to Make Mistakes	349	3.17	780	780	3.98	1.06	<0.001	-0.85	0.98-0.72
Recognition, No Favoritism	346	2.87	1.06	776	3.73	1.02	<0.001	-0.83	0.97-0.70
Safe to Question	349	3.21	1.10	782	4.02	0.95	<0.001	-0.81	0.94-0.68
Safe to Disagree	348	3.03	1.12	782	3.85	1.00	<0.001	-0.79	0.92-0.66
Conflict direct	346	2.80	1.10	779	3.63	1.07	<0.001	-0.78	0.91-0.65
Easier for me	349	3.18	1.09	778	3.96	0.96	<0.001	-0.78	0.91-0.65
Accountability, Clear, Fair	345	2.91	1.08	773	3.73	1.04	<0.001	-0.78	0.91-0.64
Goals Aligned	351	3.11	1.06	780	3.89	1.00	<0.001	-0.77	0.90-0.64
Team Collaborates	352	3.56	1.09	784	4.27	0.86	<0.001	-0.77	0.90-0.64
Operations Communicated	348	2.74	1.16	778	3.59	1.11	<0.001	-0.76	0.89-0.63
Roles Clear	352	3.09	1.11	781	3.86	0.04	<0.001	-0.75	0.88-0.62
Easier for them	350	3.78	0.84	779	4.32	0.66	<0.001	-0.75	0.88-0.62
No holding back	351	3.27	1.12	784	4.00	0.97	<0.001	-0.71	0.84-0.58
Awareness of Others	350	3.19	1.00	780	3.86	0.92	<0.001	-0.71	0.83-0.58
Optimal Teamwork	352	3.12	1.11	787	3.85	1.03	<0.001	-0.69	0.82-0.56
Share scorecard	345	2.87	1.05	768	3.53	1.08	<0.001	-0.61	0.74-0.48

The optimal teamwork scale2 (Table) is 17-items scored on 5-pt Likert (1-5) of agreement, retained on one Eigenfactor >1 with factor loadings >0.7 (except "*I do my work in a way to make work easier for others*", 0.51), and Cronbach alpha 0.96. The average composite score's binary cut off (=3.454) is per consensus of 1910 medical staff 'who "*somewhat to strongly agree*" they have optimal teamwork (sensitivity 0.87; specificity 0.81; AUC 0.84). Optimal teamwork was found to be associated with medical staff professional fulfillment3 OR 5.97 (Cl 4.53-7.85, p<0.001) and burnout3 (PFI) OR 0.19 (Cl 0.15-0.25, p<0.001) adjusted for practice model, specialty group, age, race group, gender. (Olson et al. ACPH 2021)

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Prevalence and psychological burden of racism-related distress in New York City health care workers during the COVID-19 pandemic

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Project objective/background

The COVID-19 pandemic has been called a syndemic characterized by a viral pandemic that magnified health inequities. In America, this has been exemplified by racial disparities observed in COVID-19 mortality. Systemic racism has also been linked to poorer mental and physical health, yet little is known about its impact on frontline healthcare workers (FHCWs). To address this gap, we examined the prevalence and factors related to racism-related distress in a cohort of FHCWs in New York City (NYC) during the COVID-19 pandemic.

Methods/approach

2,001 FHCWs (response rate 43%) at an urban hospital in NYC completed a cross-sectional survey from 11/20-1/21. COVID-19-related occupational exposures, burnout symptoms, and stress-related psychopathology (i.e., major depressive, generalized anxiety, and posttraumatic stress disorders) were assessed. Participants rated the extent to which they were emotionally affected or distressed by: (1) racial disparities in COVID-19 related outcomes; and (2) systemic racism highlighted by recent events (i.e., George Floyd's murder). Bivariate and multivariable logistic regression were conducted to identify factors associated with racism-related distress; and incremental associations between racism-related distress, burnout, and psychological distress.

Results

A total of 66.4% of FHCWs reported distress related to systemic racism (SR) and 56.8% to racial disparities (RD) in COVID-19 outcomes. Prevalence of racism-related distress was highest in FHCWs who identified as Black (83.3% SR, 74.3% RD) and multiracial (75.2% SR, 65.3% RD). Results of a multivariable analysis revealed that Black, non-Hispanic

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race/ethnicity (SR odds ratio (OR) 2.84, P < .001; RD OR 2.34, P < .001), female gender (SR OR 1.35, P = .01; RD OR 1.67, P < .001), and a history of mental illness (SR OR 2.13, P < .001; RD OR 1.66, P < .001) were significantly associated with SR- and RD-related distress, respectively. After adjusting for background characteristics, occupational exposures, and protective psychosocial characteristics, moderate-toextreme COVID-19 RD-related distress was independently associated with stress-related psychopathology (P < .001), while guite a bit-to-extreme SR-related distress was independently associated with burnout (P < .001). Other factors significantly associated with both stress-related psychopathology and burnout included fewer years in practice, history of mental illness, lower feelings of being valued by hospital leadership/supervisor, and lower perceived work pride and meaning.

Conclusion

We found that the majority (57-66%) of FHCWs reported racism-related distress during the pandemic. The prevalence of racism-related distress was especially elevated among Black, non-Hispanic and female FHCWs. Results further suggest that this racism-related distress was independently associated with greater likelihood of screening positive for stress-related psychopathology and burnout in FHCWs. These findings underscore the importance of evaluating institutional strategies to address systemic racism in healthcare and to consider the role of perceived racism in contributing to risk for adverse mental health outcomes in FHCWs. Limitations of this study include a modest response rate with potential sampling bias and cross-sectional design at a single site, which precludes causal inference and may limit generalizability of results.

The role of positive workplace culture in mitigating burnout and turnover: An empirical investigation

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Learning objectives

- 1. Learn how Positive Organizational Scholarship provides an overarching empirical lens for identifying positive workplace practices that mitigate burnout and turnover during crisis periods
- 2. Gain knowledge of the organizational practices that are most useful in building positive workplace cultures
- 3. Learn about the role of these practices in mitigating burnout and turnover within an academic medical center based on findings from survey data and path analysis

Project objectives/background

The objective of this study was to examine whether Positive Organizational Scholarship could provide an overarching framework for identifying strategies to address burnout and turnover among healthcare professionals and staff. Previous research demonstrates the importance of positive organizational culture in driving employee wellbeing and organizational performance, particularly during crisis periods. Positive organizational culture describes workplace norms and expectations of virtuous engagement towards others, such as demonstrating compassion, integrity, respect, and forgiveness. The objective of this study was to determine whether these virtuous organizational practices at the unit level could mitigate burnout and turnover during the ongoing crisis of COVID-19.

Methods/approach

A web-based survey was administered to 97 healthcare professionals and staff in 2021 on a vascular and interventional radiology unit within an academic medical center. Positive culture was measured with the Positive Organizational Practices Assessment that asks about the workplace norms and expectations about virtuous behavior in the work setting (e.g., "We treat each other with respect and dignity,"). Organizational factors examined included adequate staffing, scheduling, workflow, resources, clarity of policies and procedures. Burnout, job satisfaction and intent to leave were measured with single item questions. Multiple regression and path analyses were used to identify the importance of culture in predicting burnout and turnover.

Results

Positive organizational culture, adequate staffing, scheduling, and resources were positively associated with job satisfaction and negatively associated with burnout and turnover. Path analysis revealed inadequate staffing and resources positively predicted burnout, which subsequently predicted intent to leave. However, positive culture provided a stronger mitigating effect on turnover than staffing and resource limitations.

Conclusion

Creating a positive workplace culture at the unit level plays an important role in mitigating the strain of inadequate staffing and resources commonly faced in medical centers. Building shared norms and expectations towards virtuousness provides an often under-utilized strategy for mitigating burnout and turnover. Strategies for reversing this trend are discussed.

The sustained impact of the COVID-19 pandemic on hospital clinicians: More burnout, stress and greater need for mental health support

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Learning objectives

- 1. To measure the wellbeing of clinicians during the ongoing COVID-19 pandemic
- 2. To understand the ongoing impact of the COVID-19 pandemic by clinician demographics
- 3. To explore models of mental health support and culture change to meet the demand for increased mental health resources

Project objective/background

The ongoing COVID-19 pandemic has continued to impact clinicians across the country. Hospitals have had periods during which the intensive care units and emergency departments have been overflowing with an influx of COVID patients in addition to patients needing other types of care. It is critical to understand the sustained impact of the pandemic on hospital clinician wellbeing so we may optimally support them.

Methods/approach

In collaboration with the national survey vendor NRC Health, an online survey was distributed to clinicians in 21 Sutter Health hospitals in northern California during September-October 2020 and 2021. The survey included wellbeing questions about stress, feeling valued, mental health support and burnout. Bivariate analyses and multilevel logistic models were conducted. Results reported are statistically significant at p<0.0001.

Results

2,722 clinicians (54.6%) responded to the survey in fall 2020 and 2,598 clinicians (54.1%) in fall 2021. From fall 2020 to fall 2021, burnout rose 9.5% (23.0% to 32.5%) and the need for mental health support also increased by 8.9% (13.4% to 22.3%). The regression model showed that compared to older adults (65+), those younger than 35 showed higher odds of reporting burnout (2.3x), needing mental support (3.2x), experiencing stress (2.1x), and feeling valued (1.7x). Compared to males, females were more likely to report burnout (1.9x), stress (1.7x) and needing more mental health support (1.3x) and had lower odds of feeling valued (0.7x). Asians had lower odds of reporting burnout (0.6x), but higher odds of needing mental health support (1.7x) as compared to Whites.

Conclusion

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The ongoing pandemic has increased burnout, stress, and the need for mental health support among our hospital clinicians, particularly those who self-identified as female and younger than 35. Interestingly, while Asians were less likely to report burnout, they were more likely to report needing mental health support. Individualized reports detailing survey responses were distributed to each hospital, and the Joy of Work team shared results, discussed challenges and formulated actions with leaders and wellness champions at each hospital. Given the need for increased mental health support, the hospital wellness champions recognized that physicians need a menu of mental health resources to choose from. We increased awareness and access to mental health support, built up peer support networks, decreased stigmatization, and increased program support to physicians and advanced practice clinicians.

Understanding drivers of physician Work-Outside-Work (WOW) through EHR usage

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Learning objectives

- 1. Quantitatively describe physician EHR usage during and outside work with details on time usage, messages, documentation, etc
- 2. Understand patterns of EHR usage and connections to clinical practice
- 3. Use predictive analytics to see what aspects of EHR usage are correlated with increased WOW

Project objective/background

We compiled a comprehensive dataset of EHR usage for over 7500 physicians over a 5-year span, including 2 years during the Covid-19 pandemic, was compiled. It includes a broad range of medical specialties and locations. This was combined with payroll records to determine all EHR usage occurring during working and non-working time, including for specialties with irregular hours. Using this dataset, patterns between elements of clinical practice, EHR usage, and WOW could be analyzed.

Methods/approach

Multiple methods were used to analyze EHR usage both during and outside of work in this observational study. A machine learning model was trained to predict physician WOW using monthly aggregated features of EHR usage. These features included demographic features such as medical specialty, location, age, and gender plus major aspects of EHR usage, such as encounters, messages, and clinical notes. By capturing a wide array of features the model was able to control for wide differences in clinical environment, including specialty and work schedule.

Results

Several features were identified to have high predicative power. Overall, individual physician work habits had the largest impact on WOW. This indicates significant space for education to reduce WOW. Total time spent using the EHR during scheduled work had a negative correlation with WOW. Physicians with shorter shifts had less time during their workday to complete charting tasks leading to increased WOW. We also measured the variation in time spent using EHR per day; larger daily variability had a strong correlation with increased WOW. Overall volume of encounters and most message types, such as results, orders, and medications, showed no correlation with WOW. However, patient message volume did correlate with increased WOW.

Conclusion

The strength of this data lies in the quantity of physicians, time and parameters measured - possibly the largest such study ever completed. Our findings point to interventions to decrease WOW. They should involve individual physician training and efforts to reduce schedule and shift variability and help physicians develop a routine when using EHR. It also highlights the need to distinguish between mundane tasks physicians perform and the more mentally challenging aspects of clinical practice.

Why leadership communication matters most in retaining health care professionals and staff during the COVID-19 crisis

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Learning objectives

- 1. Learn about the role of leadership communication in addressing faculty and staff turnover
- 2. Understand the relative value of leadership communication compared to other strategies used to address turnover, such as increasing compensation, improving work/home flexibility and reducing burnout
- 3. Learn why leadership communication has such a powerful impact on potential turnover (i.e., mediators of the relationship)
- 4. Learn about different approaches executives and managers can use to enhance their communication to healthcare professionals and staff

Project objectives/background

Previous research has demonstrated that leadership plays an important role in employee satisfaction and retention. The objective of this study was to determine whether leadership communication is associated with the likelihood of retention among healthcare professionals and staff during the COVID-19 crisis. We examined the relative importance of leadership communication when contrasted to other retention strategies (compensation, work/home flexibility, reducing burnout) and the mediators of the relationship between leadership communication and retention.

Methods/approach

We conducted a secondary analysis of organizational engagement survey data collected in March of 2021 from a large academic medical center. The sample included 2,336 faculty members, including physicians, and 17,664 staff. Scales were constructed to measure retention, feeling valued, work/home flexibility, and leadership communication. Burnout and satisfaction with compensation were measured with single items. A series of multiple regressions and path analysis were conducted to identify the causal relationships among variables. Analyses were run separately for faculty and staff.

Results

Bivariate correlations indicated that the likelihood of retention had a stronger relationship with leadership communication than it did with satisfaction with pay, work/home flexibility, and lack of burnout symptoms. Path analysis indicated that feeling valued explained why leadership communication increased the likelihood of retention. These relationships were present for both physician faculty and staff.

Conclusion

Leadership communication is an underutilized approach to reducing turnover among physician faculty and staff. The power behind this strategy is that it increases employees' feelings of being valued. Leadership communication and feeling valued were stronger predictors of retention than other commonly considered strategies. Using positive organization scholarship and well-being principles, we provide recommendations on communication strategies executive and local leaders can use to demonstrate that they care about their employees.



Pediatric faculty engagement and Areas of Worklife after the COVID-19 pandemic

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Learning objectives

- 1. Participants will learn about the benefits of focusing on physician engagement rather than burnout.
- 2. Participants will learn about the Areas of Worklife associated with physician engagement.
- 3. Participants will learn about how the COVID19 pandemic may impact faculty engagement.

Project objective/background

Prior studies have examined physician engagement and job fulfillment; however, little is known about organizational factors that may be targeted to improve physician engagement, especially during the COVID19 pandemic. Our objective was to identify demographic, professional, and worklife factors associated with physician engagement in pediatric faculty.

Methods/approach

In September 2020, we conducted a cross-sectional survey of pediatric faculty at an academic, tertiary-care children's hospital. The survey included demographic (e.g., age) and professional information (e.g., academic rank), Maslach Burnout Index-Human Services Survey (MBI-HSS) and Areas of Worklife Survey (AWS). Pediatric faculty were recruited via email and had 1 month to complete the survey. The AWS includes six domains (workload, control, reward, fairness, community, values), measured on a 1-5 scale with lower scores indicating problems in that worklife area. Faculty with low scores on emotional exhaustion and depersonalization and high scores in personal achievement as measured by the MBI-HSS were defined as engaged. Faculty reporting difficulty meeting work commitments "Some of the time" or "A great deal of the time" in response to the question, "Since the COVID-19 pandemic, the demands of my family/personal life have made it difficult to meet my commitments at work," were defined as having difficulty meeting work commitments. We used bivariate analyses to examine relationships

between worklife areas and engagement using Student's t-test or Mann-Whitney test. We used multivariate logistic regression models to examine factors associated with the presence of engagement. We controlled for age, gender, ethnicity, difficulty meeting work commitments due to COVID19, and areas of worklife in our model.

Results

Response rate was 41% (113/274 participants). In bivariate analysis, engaged faculty had higher mean scores in all areas of worklife (Table 1). In multivariate analysis, positive faculty perceptions of workload, control, and community were associated with higher engagement (Table 2). Faculty reporting increased difficulties meeting work commitments during the COVID19 pandemic reported decreased engagement.

Conclusion

In our sample, we found that workload, control, and community were associated with engagement in pediatric faculty. This work suggests specific areas that may be potentially targeted by organizations to increase faculty engagement and fulfillment, particularly during the COVID19 pandemic.

TABLE 1. Associations between Engaged Faculty and Areas of Worklite Domains									
	Engaged (n=70)	Not Engaged (n=43)	P Value						
Workload*, Mean (SD)	3.1 (0.70)	2.4 (0.74)	<0.01						
Control*, Mean (SD)	3.8 (0.55)	3.0 (0.88)	<0.01						
Reward*, Mean (SD)	3.9 (0.65)	3.3 (0.80)	<0.01						
Community*, Mean (SD)	4.2 (0.53)	3.7 (0.75)	<0.01						
Fairness*, Mean (SD)	3.5 (0.61)	2.9 (0.70)	<0.01						
Values*, Mean (SD)	4.1 (0.55)	3.6 (0.75)	<0.01						

TABLE 1. Associations between Engaged Faculty and Areas of Worklife Domain

*mean scores based on responses to survey questions. Range 1 (low) to 5 (high), with lower scores indicating more problems in that worklife area.

TABLE 2. Multivariate Odds Ratios for Associations with Higher Faculty Engagement^a

Variable	Odds Ratio	95% CI
Workload	2.83	1.2—6.9
Control	3.24	1.4—7.3
Community	6.07	1.9—18.7
Difficulty meeting work commitments due to pandemic ^b	0.13	0.03—0.57
Caregivers of dependents less than 18 years of agec	19.6	3.0—127.5
Age Range Less than 41 years 41-50 years 51-60 years Over 61 years	Reference 0.24 0.57 12.8	0.05—1.2 0.13—2.5 1.5—106.6
Gender ^d	1.1	0.3—4.1

^an=110 ^bReference is "No difficulty or Rarely have difficulty meeting work commitments due to the pandemic." cReference is "No dependents less than 18 years of age" d Reference is self-identified male gender.

Physician wellness: A missing indicator in HHR planning?

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Learning objectives

- 1. Discuss key findings from the Canadian Medical Association (CMA) National Physician Health Survey (NPHS)
- 2. Identify the link between physician wellness and workplace factors
- 3. Build the case for physician wellness as a key pillar of health human resource planning

Project objective/background

The COVID-19 pandemic exacerbated long-standing physician wellness challenges, further straining Canada's health system. Research shows that decreased wellness has a negative impact not only on the individual physician and patient care, but also on health system performance and cost. Indeed, a negative relationship between physician burnout and productivity (e.g., reductions in clinical work hours) has been identified. Considering this, wellness should be a key pillar to incorporate in health human resource (HHR) planning. The purpose of the 2021 CMA National Physician Health Survey (NPHS) was to develop a dataset of wellness indicators, including workplace factors, for use by organizations, researchers, and policymakers.

Methods/approach

The CMA established an Expert Working Group to help guide the survey development. Members included individual experts in physician wellness, with representatives from several national organizations. Prior to data collection, ethics approval was obtained. The online survey link was distributed via multiple channels (e.g., email, social media, e-newsletters, Google Ads) to ensure maximum reach. A total of N= 4121 physicians, residents and medical students from across Canada completed the survey. This presentation will outline key HHR-related findings from the NPHS and make the case for wellness as a pillar of HHR planning.

Results

Findings show that 51% of respondents indicated being dissatisfied or very dissatisfied with work-life integration and 46% reported having poor or marginal control over their workload. As it relates to wellness, 60% indicated that their mental health worsened since the onset of the pandemic, with 57% attributing this to increased workload and lack of work-life integration. 22% disagreed or strongly disagreed that they are satisfied with their career in medicine. Women physicians were more likely to report dissatisfaction with work-life integration, lack of control over workload, and worsened mental health due to the pandemic. Alarmingly, 53% of the total sample reported high levels of burnout, using the 2-item Maslach Burnout Inventory. Finally, 49% indicated that it is likely or very likely that they will reduce their clinical work hours in the next 24 months. Note: advanced statistical analyses examining relationships between psychological and workplace factors will be completed by the conference.

Conclusion

The 2021 NPHS further supports decades of research linking physician wellness to health system performance measures, thus creating a strong case for adding wellness as a pillar in HHR planning. This will be essential in planning for sustainable health system in the postpandemic era and beyond.

Predicting physician departure with machine learning based on EHR use patterns

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Learning objectives

1. How to apply machine learning to predict physician departure in a large ambulatory medical practice

2. Potential role of physician EHR use and productivity data to identify physician at-risk of departure

Project objective/background

Physician turnover affects continuity of care and strains healthcare organizations. Early detection of physicians at risk for departure could allow practice leaders to intervene and retain physicians at risk for departure. Physician EHR use patterns and productivity have been associated with departure using multivariable regression. Here, we apply machine learning methods to identify factors most predictive of physician departure.

Methods/approach

This retrospective cohort study evaluated monthly data on EHR use and patient volume for 319 physicians from a large ambulatory practice in New England between July 2018 to May 2021. To capture time-varying trends in these data, Covid wave and study month were included as well as rolling averages and rates of change for all continuous variables. In total, 51 features (variables) including physician characteristics and metrics of core EHR use metrics,¹ physician productivity metrics,² note quality,³ panel size and complexity, and inbox volume and teamwork were used to train a gradient boosted tree algorithm,⁴ to predict monthly risk of departure within the subsequent 6 months. A training, validation, and testing paradigm was used to prevent overfitting. Feature importance was assessed using Shapley Additive Explanations (SHAP),⁵ an approach that provides interpretability for machine learning classifiers.

Results

Of the 319 unique physicians from 26 medical specialties, 44 (13.79%) departed within the study period. This provided 9928 physician-months of observation with 214 months where departure occurred in the subsequent 6-months. Performance on the unseen testing dataset showed an overall F1 score of 0.97 and Receiver-Operating Characteristic AUC⁶ of 0.80. Using a log-odds threshold of 0.5, sensitivity was 0.997, specificity was 0.860. The PPV and NPV were 0.996 and 0.914 respectively. SHAP results (Figure) shows the contribution of each feature to the model's prediction for an individual physician's monthly risk of departure where physician tenure, exponentially weighted panel complexity, exponentially weighted physician demand, and age group provided the strongest contributions to departure risk with low tenure leading to increased risk of departure.

Conclusion

Predicting physician departure with machine learning based on physician EHR use patterns and productivity is feasible and can identify specific factors contributing to individual departure risk that practice leaders may use to identify and intervene on at-risk physicians.



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Figure. Shapley Additive Explanations (SHAP) analysis Beeswarm Plot showing the 7 top features contributing to physician departure. Each dot represents a physicianmonth. Positive SHAP values (right of 0.0 vertical line) indicate the feature increased the individual physician's monthly risk of departure. Actual feature values are color-coded with high feature values indicated in red, low values in blue and null values in grey.



Suicide and self-harm among physicians in Ontario, Canada

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Learning objectives

We have created a world-class data infrastructure to examine the physician health and wellbeing of physicians using big data. To our knowledge, we have created the largest longitudinal physician cohort globally by linking ~50,000 physicians to their own health records in Ontario, Canada (a province with publicly funded health care). We capture all Ontario physicians' demographics, practice information, health care utilization, and health outcomes through this data linkage.

- 1. Participants will have a comprehensive understanding of physician suicide and self-harm rates, including who is at risk (e.g., physician specialty) and how physician suicide and self-harm compare to the population.
- 2. Participants can use these findings (e.g., physician groups at higher risk for self-harm and suicide) to inform prevention programs

Project objective/background

Studies of occupation-associated suicide suggest physicians may be at a higher risk of suicide than nonphysicians. We set out to assess the risk of suicide and self-harm among physicians and compare it to nonphysicians.

Methods/approach

We conducted a population-based, retrospective cohort study using registration data from the College of Physicians and Surgeons of Ontario from 1990 to 2016 with follow-up to 2017, linked to Ontario health administrative databases. Using age- and sex-standardized rates and inverse probability-weighted, cause-specific hazards regression models, we compared rates of suicide, self-harm, and a composite of either event among all newly registered physicians to nonphysician controls.

Results

Among 35,989 physicians and 6,585,197 nonphysicians, unadjusted suicide events (0.07% v. 0.11%) and rates (9.44 v. 11.55 per 100,000 person-years) were similar. Weighted analyses found a hazard ratio (HR) of 1.05 (95% confidence interval 0.69-1.60). Self-harm requiring health care was

lower among physicians (0.22% v. 0.46%; HR 0.65, 95%Cl 0.52-0.82), as was the composite of suicide or self-harm (HR 0.70, 95% Cl 0.57-0.86). The composite of suicide or self-harm was associated with a history of a mood or anxiety disorder (OR 2.84, 95% Cl 1.17-6.87), an outpatient mental health visit in the past year (OR 3.08, 95%Cl 1.34-7.10) and a psychiatry visit in the preceding year (OR 3.87, 95% Cl 1.67-8.95).

Conclusion

Physicians in Ontario have a similar risk of suicide deaths and a lower risk of self-harm requiring healthcare relative to nonphysicians. Risk factors associated with suicide or selfharm may help inform prevention programs.


Trends in physician health care visits for mental health and substance use during the COVID-19 pandemic in Ontario, Canada

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Learning objectives

We have created a world-class data infrastructure to examine the physician health and wellbeing of physicians using big data. To our knowledge, we have created the largest longitudinal physician cohort globally by linking ~50,000 physicians to their own health records in Ontario, Canada (a province with publicly funded health care). We capture all Ontario physicians' demographics, practice information, health care utilization, and health outcomes through this data linkage.

- 1. Participants will have a comprehensive understanding of the trends of physician mental health and substance use (MHSU) before and during the COVID-19 pandemic
- 2. Participants can use these findings to inform effective interventions (e.g., aim programs to physician groups at higher risk for MHSU).

Project objective/background

Physicians self-report high levels of symptoms of anxiety and depression and surveys suggest this has been exacerbated by the COVID-19 pandemic. However, it is not known whether pandemic-related stressors have led to increases in health care visits related to mental health or substance use among physicians. Therefore, we aimed to evaluate the association between the COVID-19 pandemic and changes in outpatient health care visits by physicians related to mental health and substance use (MHSU) and explore differences across physician subgroups of interest.

Methods/approach

Design: A cohort study from March 1, 2017, to March 10, 2021, using ARIMA models and generalized estimating equations. **Setting**: Population-based study in Ontario, Canada using health administrative data collected from the province's universal health system (OHIP). **Participants**: Physicians, Residents and Fellows who registered with the College of Physicians and Surgeons of Ontario between 1990 and 2018 and were alive and eligible for OHIP during the study period. **Exposure**: The period during the COVID-19 pandemic (March 11, 2020 – March 10, 2021) compared to before COVID-19. **Main Outcome and Measures**: All in-person, telemedicine and virtual care outpatient visits to a psychiatrist or family medicine and general practice providers related to MHSU.

Results

Our analysis included 34,055 practicing physicians (mean age 42 years, 52% male). The annual crude number of visits per 1,000 physicians increased by 27% from 816.8 pre-COVID-19 to 1037.6 during COVID-19 (adjusted incident rate ratio [alRR] per physician of 1.13, 95% CI 1.07-1.19). The absolute proportion of physicians with one or more MHSU visits within a year increased from 12.3% pre-COVID-19 to 13.4% during COVID-19 (adjusted odds ratio 1.08, 95%CI 1.03, 1.14). The relative increase was significantly greater in physicians without a prior MHSU history (alRR 1.72, 95% CI 1.60-1.84) than in physicians with a prior MHSU history.

Conclusion

The pandemic was associated with a substantial increase in physicians' mental health and substance use visits. Physician mental health may have worsened during the pandemic, highlighting a potential greater requirement for access to mental health services and system-level change.





A randomized trial to investigate the impact of professional development coaching for physicians

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Learning objectives

- 1. Participants will be able to understand the general approach of peer-to-peer coaching and its application to address physician well-being and burnout.
- Participants will be able to describe the impact of a novel peer-to-peer coaching program on physician well-being and burnout.
- 3. Participants will be able to explain best practices in implementing a peer-to-peer coaching program in their institution.

Project objective/background

To explore the effect of peer-to-peer individualized professional development coaching on physician wellbeing, workplace satisfaction, engagement, and burnout.

Methods/approach

One hundred thirty-eight physicians were randomized to immediate (0-3 months) versus delayed (3-6 months) individualized coaching from physician peers certified in health and wellness coaching. The intervention consisted of 6 coaching sessions over a 3-month duration beginning in September 2021. Quantitative assessments were measured at enrollment, 3, 6 and 9 months utilizing a modified Maslach Burnout Inventory (mMBI)^{1,2}, Professional Fulfillment Index (PFI)³, Negative Impact of Work on Relationships scale (NIWR), Utrecht Work Engagement scale (UWE)⁴, Clinician Self-Valuation scale (CSV)⁵, Quality of Life scale (QoL)⁶, and assessment of likelihood to make changes to clinical practice.

Results

Fifty-two physicians were randomized to immediate coaching and 71 to delayed. Statistically significant improvements in overall burnout, interpersonal disengagement, professional fulfillment and work engagement were observed after 3 months of coaching when compared to no intervention. Mean scores for interpersonal disengagement decreased by 30% in the coached group and increased by 4% in the control group (relative difference of -34%, p < 0.01) while overall burnout decreased by 22% in the coached group compared to an increase of 3% in the control group (relative difference -25%, p < 0.01). Professional fulfillment mean scores increased by 11% in the coached group compared to no change in the control group (relative difference of 11%, p = 0.046) while mean scores for work engagement increased by 6% in the coached group compared to a reduction of 2% in the control group (relative difference of 8%, p = 0.04).

There were no observed statistically significant differences between the two study groups in work or emotional exhaustion, negative impact of work on relationships, selfvaluation, and quality of life.

Conclusion

A novel, hospital-sponsored physician coaching program involving professionally trained physician peer coaches reduced overall burnout and interpersonal disengagement while improving professional fulfillment and work engagement in a cohort of physicians. The potential for long term impact on hospital culture and physician retention warrants further exploration of additional benefits of this program.

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Creating a kind, compassionate and respectful culture in academic medicine in Canada

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Learning objectives

- 1. Understand the challenges in the current culture in academic medicine in Canada.
- 2. Describe the Canadian project for creating a kind, respectful and compassionate culture in academic medicine.
- 3. Consider opportunities for transferring this approach to other regions.

Purpose/relevance

The Association of Faculties of Medicine of Canada (AFMC), which represents all 17 Canadian medical schools, received a grant from the Physician Wellness+ Initiative supported by the Canadian Medical Association to address the culture of medicine in Canada. This initiative will focus on advancing improvements in all environments where medicine is being practiced and taught. The campaign will model other successful behavioral change campaigns in our sector (e.g., Choosing Wisely).

Materials

A team of researchers, communications and evaluation experts was assembled to support the project. A repository of seminal scholarly work and successful behavioral change campaigns was developed.

Methods

The AFMC engaged with several Canadian national health organizations and established a partnership with the Canadian Federation of Medical Students.

An executive committee of faculty wellness experts and students and an advisory group with broad representation including patients, students, residents, staff, representatives from Indigenous and Black Health organizations, universities, hospitals, rural communities, and all major health education organizations were created to provide guidance on the work. An extensive environmental scan was conducted to identify the dynamics in the current culture with focus on issues and instances that enhance and impede a compassionate, kind and respectful culture.

Results

The consultation confirmed the endemic challenges of the current environment with excessive demands and power imbalance all exacerbated by the pandemic. This led to complete burnout of all within the healthcare system. The need to work on institutional reform and individual behaviors in tandem is clear. With these results the project will enable the development of institutional charters as well as a behavioral change campaign using multiple media sources.

Conclusion

This initiative is clearly focused on mitigating burnout and promoting professional well-being, as well as equity, diversity, inclusion and anti-racism. We will be able to present the final roll out plan for the "Creating a Kind, Compassionate and Respectful Culture in Academic Medicine in Canada" in time for the ICPH2022.

Develop an impactful, longitudinal structure to address wellness for a hospitalist group

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Learning objectives

- 1. Identify a successful structure to address wellness for a group in a longitudinal capacity
- 2. Recognize COVID groups as a highly adaptable wellness intervention
- 3. Coaching clarifies high impact wellness interventions

Project objective/background

Physician burnout has been previously recognized a growing problem affecting the medical community and the COVID pandemic has added increased stresses. We currently have no formalized wellness structure or support within our organization. Our objective was to identify active stressors for a hospitalist group caring for COVID patients and develop and implement real time interventions.

Methods/approach

We created a team of "Wellness Warriors" that consisted of a project leader and 3 Hospitalists that were members of a 65-provider group in the Providence system in Portland, Oregon. A survey that included the Maslach Burnout Inventory, job satisfaction, pandemic effects, and turnover intent as well as prompts to reflect on the largest drivers of burnout was disseminated to the intervention group as well as a comparable control group within the same city and system. We quickly developed bi-weekly COVID groups to address the major stressors of rapidly evolving clinical care as well as workflows. The Warriors then met bi-weekly to identify the tone of the group and any new or active challenges and plan the next COVID group. All members of the group were also offered 1:1 coaching for 9 months of the intervention period.

Results

At the start of the project the two Hospitalist groups were not statistically different. After 1 year the burnout rate dropped from 37 to 32% at the intervention site and increased from 39% to 57% in the control group (Chisquare=6.9, p<.01). 48% of the intervention group reported high levels of wellness support vs. 0% of the control group (Chi-square=33.5, p<.00001). The intervention group attributed 44% of wellness support to Providence alone, while controls attributed 12% to Providence alone (Chisquare=24.3, p<.00001). 95% of survey respondents had participated in COVID groups. 38% of the intervention group accessed 1:1 coaching. There was a significant shift from learned helplessness to individual and group empowerment.

Conclusion

The framework of three "Wellness Warriors", with a small amount of dedicated time (0.3% of the total group FTE) to address group well-being through a proactive and longitudinal process, significantly decreased burnout. Bi-weekly groups that consisted of information communication in addition to timely themes were well attended and effective and are widely adaptable for any group. We also found that at the beginning of our intervention there was a pervasive sense of learned helplessness that significantly impacted our ability to identify high impact interventions. A significant portion of the group accessed 1:1 coaching for individual empowerment, and the Wellness leaders became adept at identifying variables that the group had control over. This further helped to clarify where organizational change was needed for clearer advocacy.



Empowering physician leaders to make organizational change: Qualitative evaluation results from the leading physician well-being program

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Learning objectives

- 1. Employ qualitative methods to describe shared understanding of terms such as burnout, well-being, and thriving.
- 2. Understand pathways to thriving through leadership, well-being practices, and quality improvement.
- 3. Identify key quality improvement strategies for improving physician well-being.

Project objective/background

In 2020, the American Academy of Family Physicians (AAFP) launched a certificate program to equip family physicians to lead change for improving physician well-being within their practices and organizations. The program includes didactic education and an applied project to meet the following objectives: Foster a movement in family medicine that changes the culture, policies, and systems in health care to better support well-being; improve the collective understanding of how to effectively lead change in health care organizations to improve well-being; and create a sustainable program that allows the AAFP to grow and cultivate a community of family physicians leaders for clinician well-being. Experts in physician well-being have called for a shift at both the individual- and organizationallevels in the culture of care and wellness for physicians.¹ Qualitative methods (e.g. content analysis, key-informant interviewing) utilized by the evaluation team for the Leading Physician Well-being Program analyzed openended questions from participants' applications to build a consensus understanding of the terms burnout, wellbeing, and thriving. Semi-structured interviews at the midpoint of the program deepened understanding of factors contributing to burnout and well-being. Analysis of System Wellness Improvement Projects identified novel quality improvement practices for improving physician well-being as well as promoting measurement of outcomes of pilot projects. These findings support improvements to the Leading Physician Well-being Program, and also improve understanding of the levers for changing both system and individual factors for physician well-being.

Methods/approach

Multiple qualitative methods were employed as part of the ongoing evaluation of AAFP's Leading Physician Well-being Program. Applications for candidates (N-=111) accepted into the program were uploaded into ATLAS.ti and two researchers conducted an initial round of coding using the codes "Leadership", "Quality Improvement", and "Wellbeing". ATLAS.ti's Network Analysis tool linked together all of the segments for each code and a thematic analysis of segments was conducted. A trinity diagram was generated from the findings based on the work of John Sadaña to link together themes that support an environment of thriving.² Semi-structured interviews were conducted with program participants (N=10) at the mid-point of the program; interviews were recorded, transcribed, and uploaded into ATLAS.ti. The process of initial coding and utilization of a network diagram was applied to interviews. Lastly, participant charters for the system well-being improvement projects (SWIP) were added to ATLAS.ti and a content analysis of projects was conducted.

Results

The multiple qualitative methods employed for the evaluation of the Leading Physician Well-being Program produced a shared understanding of terms, modelled a trajectory of leadership for participants, and produced a list of novel programs and metrics for improving system capacity for physician well-being. First, a shared understanding of the terms "physician well-being", "burnout", and "leadership" were established through qualitative analysis of applicant essays. This provided a baseline understanding for the LPW program about how scholars defined these constructs and supported a shared language. The semi-structured interviews added a shared understanding of what it would look like for physicians to be "thriving" and articulated what aspects of leadership were needed to make systems change to support physician well-being. Leadership, quality improvement, and physician well-being all contribute to a state of thriving for physicians by illuminating opportunities for both incremental and revolutionary change, as well as promoting organizing for change. The content analysis of SWIP charters produced a list of novel quality improvement projects for advancing physician well-being in the workplace as well as articulated methods for measuring the impacts of those projects including at least nine scholars who implemented gratitude projects paired with resiliency training, SMART Goals, and personal health initiatives.

Conclusion

Both individual interventions and systems interventions are necessary to facilitate physician well-being. Employing a curriculum pairing leadership with quality improvement training promotes small scale changes that promote shared understanding of challenges and opportunities.

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Examining the gendered nature of mental health issues, leaves of absence, and return-to-work experiences of Canadian physicians: Guiding interventions to support physician well-being

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Learning objectives

- 1. To understand physicians' mental health, leaves of absence and return-to-work experiences and how they have been impacted by the COVID-19 pandemic.
- 2. To understand the antecedents, barriers, and facilitators to taking a leave of absence from work and the subsequent return to work.
- 3. To identify interventions that foster physicians' mental wellbeing, ability to take a leave of absence, and successful return to work.

Objectives/background

Mental health challenges are a growing concern among physicians, but research is sparse on how they impact physicians' work and family lives, access to leaves of absence, and return-to-work. The impact of gender on these experiences is also under-researched.

This research explores the gendered experiences of personal, familial, or work-related mental health issues among physicians and identifies the factors that influence decisions to take leaves of absence and return to work. Further, this research explores the impact of the COVID-19 pandemic on physicians' mental health, leave of absence, and return-to-work pathways.

Methods

This paper is based on a subset of data from the national Healthy Professional Worker study, focusing exclusively on physicians and medical trainees (residents and medical students). Our mixed methods approach included semistructured interviews with working physicians across disciplines (n=28) and key stakeholders including leaders, researchers, and experts in the field of physician mental health (n=18). An on-line survey was also deployed to professional workers across Canada (n = 3759 total, including 310 physicians and trainees). An explicit gender perspective was taken in data collection and interpretation. Findings were synthesized and analyzed iteratively to achieve a holistic perspective on the issues.

Results

Of the physicians surveyed, 60% had suffered from a mental health issue and women were more likely than men to have experienced and/or reported poor mental well-being. Of those, 54% made changes to work and 51% considered a leave of absence. Only 18% of physicians took a leave and of those, 79% returned to work. The COVID-19 pandemic contributed to a decline in physicians' mental health and an increase in distress, presenteeism, and burnout.

Stakeholders identified widespread presenteeism and maladaptive coping strategies, with regulatory stress as a key challenge faced by physicians. Physician interviews highlighted concerns such as lack of redundancy in the system to accommodate leaves of absence, genderspecific challenges (including maternity leaves, barriers to pursuing leadership opportunities, and vulnerability to harassment), feelings of guilt, and interrupted leaves of absence. Promising practices included clear and accessible policies, negotiators to assist with organizing leaves, centralized locum databases, disability insurance coverage, graduated return to work processes, and workplace wellness breaks and resources. Participants also emphasized the role of education and training curricula to shift medical culture toward wellness.

Conclusions

These findings have implications for gendered policy and decision-making focused on supporting physicians' mental health, reducing presenteeism and attrition, and mitigating the impact of the COVID-19 pandemic.

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Grieving patients' death in a pediatric intensive care unit

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Learning objectives

- 1. Understand the need to support caregivers who experience high rates of death
- 2. Identify barriers and strategies for cultivating a united front for engagement in support services
- 3. Learn about the value participant report experiencing

Background

An estimated 49,000 children die every year in intensive care units after withdrawal of life sustaining therapies. ICU caregivers who witness the death of a child often have some degree of distress with potentially negative impacts on wellness. The objective of this project was to institute routine, professionally facilitated, adverse event-oriented peer-to-peer support sessions in the pediatric (PICU) and cardiac intensive care units (CICU) to determine the feasibility and potential benefits.

Methods

This was a quality improvement pilot program conducted in a 16-bed CICU and 28 bed PICU in a universityaffiliated pediatric tertiary care children's hospital in the Intermountain West.

Participants included health care team members who cared for children in the CICU and PICU between March 2021 to March 2022. Support sessions were moderated by a psychologist with expertise in peer-to-peer support and caregiver adverse events.

Measurements and main results

Over the past year we had 33 sessions honoring 86 deceased children in a hospital's CICU and PICU (averaging 7 deaths a month). Children had a median age of 2.6 years and a median ICU length of stay of 3 days. The majority of children died after withdrawal of life sustaining therapies (n=56; 67%). Participants (N=221) were comprised mainly of critical care nurses (n= 116, 52%), physicians (n=61, 27%), and critical care nurse practitioners (n=24, 11%). Other attendees included chaplains, social workers, physical therapists, occupational therapists, and respiratory therapists (n=20;10%).

25 participants took a baseline burnout survey with (n=21, 84%) of respondents reporting some level of persistent burnout. Fifteen participants (n=15; 60%) responded that they have a practice that they use to help cope with the death of a patient. Participants indicated the sessions were helpful and provided more value than anticipated. Topics discussed included reactions and recovery surrounding adverse events, being a parent working in pediatric ICU's, balancing patient family and patient needs, loss of patients, COVID related stress, work-life balance, inclusive thinking, and valued living among others. Plan-Do-Study-Act cycles and stake holder assessments have allowed for flexibility and improvement in the group structure and timing. Significant participatory growth was observed, in member attendance, and through growing interest from other departments seeking support for their caregivers.

Conclusions

The sessions had a positive impact on unit culture through multidisciplinary improved consideration of the psychosocial needs of staff and utilization of the services after difficult deaths. We believe these types of professionally facilitated peer-to-peer support sessions can positively impact a culture of wellness, prevent second victims, and improve recovery from adverse events.

Honoring lives lost and processing grief through COVID-19: Remembrance events and gratitude

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Learning objectives

- 1. Participants will be able to identify at least one way to honor those lost to COVID-19
- 2. Participants will be able to suggest one way to show gratitude amidst pain and suffering

Project objective/background

During the SARS-Cov-2 pandemic, health care teams have focused on the grief of family members as their loved ones are hospitalized, placed on ventilators, and die without family by their side. Because the work is never-ending and one surge has followed another, there has been little time for health care workers to process their own losses. Some don't feel "safe" enough to do so as they believe their grief may open feelings that they simply don't have time to address. Others have processed their losses and are moving on. The rest are somewhere in between.

In 2021, we launched a program called "Rise & Renew – Our Journey Towards Recovery", which aims to help our staff and employees support themselves, support their teams, and offer crisis resources. While recognizing that our people were in different places in their Arc of Recovery¹ (Figure 1), we aimed to create a safe space where people could remember and grieve for their patients, friends, family, and colleagues lost to COVID-19.



Figure 1: Arc of Recovery

Methods/approach

As part of our "Rise & Renew" program, deployed in 2021, all 13 areas conducted remembrance events March - June 2021. Programs included tributes to those lost with gestures that included releasing of doves, musical performances, candlelight walks, tree plantings, poetry readings, and more (see Figures 2-5). Many areas invited COVID survivors to speak about their experience within our system and share gratitude for the health care team. A video of gratitude (Dear Kaiser Permanente - https:// kp.qumucloud.com/view/1r2nYG4qTBg#/) was created by words from our patients and their families and sent to our physicians and staff. Many of these programs were live streamed on Yammer (our internal social media site) and Instagram. For those not able to attend a live or live streamed event, events were recorded.





Figures 2-5

Results

All our 13 areas and our regional offices participated by hosting events. They were well received by physicians and staff. The gratitude video has been viewed more than 50,000 times.



Conclusion

Health care workers have experienced heavy losses (both professionally and personally) during the SARS-CoV-2 pandemic. Much of our grief has remained unprocessed. Creating psychologically safe spaces — in this situation, a remembrance event — is one way to help health care teams process their grief and loss. The gratitude video is a way to remind physicians and staff to be mindful of the positive impact they contributed during these formidable times.

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How a peer mentoring program using a "coach approach" can enhance physician engagement ... and more

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Learning objectives

- 1. Describe Peer Mentoring Program participants' perception of the value of employing a "coach approach" to mentorship in a physician peer mentoring program
- 2. Assess Peer Mentoring Program outcomes, including academic productivity and enhanced engagement

Background

Developing support networks allows for a sense of collegiality, camaraderie and peer support that may be lacking for many faculty. A traditional dyadic mentoring relationship can provide connection, though certain limitations exist. We designed a novel peer-mentoring program (PMP), consisting of groups of faculty peer coaches, mentors, and mentees. We sought to help mentees achieve their short-term goals, and enhance engagement through a longitudinal, Department-wide voluntary program.

In 2018, the PMP was launched by the Department of Pediatrics. A core faculty team designed the unique PMP structure and outlined the roles and responsibilities of the coaches, mentors, and mentees. PMP participation was solicited from all 320 Department of Pediatric faculty members. Applications were accepted from those wishing to be coaches, mentors, and mentees. Mentees completed an individual development plan (IDP) outlining their shortterm goals related to academic productivity. Prior to joining the PMP, all program participants completed a 2- hour orientation which included coaching skills training (active listening, asset-based thinking, and use of empowering language) to apply in their group mentoring conversations. Five meeting agendas with coaching-related curriculum were developed to further guide group discussion.

Methods

Peer groups were created based on common mentor domains (e.g., grant writing, educational scholarship). Each group included 3-4 mentees, 1 mentor and 1 coach. Eight peer groups joined the program at three different time periods between 2018 and 2020. Individual peer groups met multiple times throughout the academic year. All participants were asked to complete an IRB-approved survey in July 2020. Survey content included demographic information, Likert-type questions about academic productivity, use of coaching skills, and engagement - as well as free text options.

Results

Total PMP participants surveyed included 30 mentees, 8 mentors, and 6 coaches. 33/44 (75%) participants responded to the survey. Groups met an average of 5.8 times/year. 93% of mentees and 100% of coaches and mentors reported using some degree of coaching skills during their group conversations. A majority of mentees 14/19 (74%) and almost half of coaches/mentors 6/14 (43%) reported that PMP participation positively influenced their overall academic productivity. Mentees attributed 20 published manuscripts, 16 funded grants, 46 lectures, 18 presentations and 31 committee memberships to participating in the PMP. Nearly all respondents reported an enhanced connection to those outside their division. (Table 1) 60% of mentees reported additional PMP benefits, including "networking", "willingness to mentor others", and "use of coaching skills with patients".



N=23

Testimonials and additional benefits

Mentees:

- Networking and meeting other members outside of my division has been the greatest benefit of participating in PMP; it has been lovely getting to know the other members of my group.
- Being connected to colleagues in other divisions and receiving feedback and support from senior colleagues from other divisions has been extremely helpful.
- It has been a rewarding experience to help peer mentor and has given me an opportunity to develop skills in mentorship that I can use elsewhere in my academic role.

Mentors/Coaches:

- *Create a collaborative* and *supportive environment* for junior colleagues.
- Appreciate breadth of interests across disciplines/ among colleagues.
- I have learned a great deal about the department and the medical school, that I wouldn't have known otherwise. I have been able to share this information with others.
- Meeting junior faculty and making myself available to them in the future as a mentor.
- Utilizing coaching skills has been helpful.

Conclusions

These data support our belief that a peer group mentoring program can positively impact academic productivity for pediatric faculty. Using peer groups and incorporating a "coach approach" may be instrumental in goal attainment and facilitating a developmental peer network.

Table 1 - PMP Benefits Mentee Academic Productivity*

Published manuscripts	20
Funded grants	16
Lectures	46
Presentations	18
Committee memberships	31
Use of coaching skills during meetings	%
Mentees	93
Coaches and Mentors	100
Use of coaching skills outside meetings	%
Mentees	88
Coaches and Mentors	100
Enhanced connection to those outside their division	%
Mentees	94
Coaches and Mentors	100

*Mentees were asked to quantify the "number of _____" (e.g., published manuscripts, funded grants) attributed to PMP participation

OUR KP Physician Wellness Academy, a Kaiser Permanente program to help improve physician self-care and well-being

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Learning objectives

- 1. Describe Peer Mentoring Program participants' perception of the value of employing a "coach approach" to 1. Learn how Kaiser Permanente created a 12-week course for physicians to improve well-being
- 2. Understand how PWA has been able to positively impact physician self-care
- 3. Advocate for organizations to create programs supportive of physician well-being

Project objective/background

Even prior to the Covid-19 pandemic, physician rates of burnout have been rising. Physicians often dismiss their own self-care secondary to their practice of medicine. Studies have shown that physician illness, stress, and burnout can negatively affect health care systems and patient care. OUR KP PWA was created to help improve physician well-being with respect to exercise, self-care, nutrition, and stress management.

Methods

Kaiser physicians in all specialties were offered to voluntarily sign up for a 12-week course. The course encompassed lessons on mindfulness, movement, sleep, biofeedback, motivation, self-compassion, meaningful connection, plantbased nutrition, and healthy habits. Four sessions were conducted between March 2018 and November 2019. Preand post- surveys were collected and statistical analyses conducted using paired t-tests, significant at a 10% alpha. Main outcomes evaluated include level of physical activity, self-care habits, nutrition habits, ability to manage stress, and overall level of wellness.

Results

61 of 103 physicians completed pre- and post- surveys. Among these physicians, significant increases in Mean Difference (MD) scores were seen across multiple measures. For exercise, a MD of 0.33 (p < 0.001) was seen in "I get at least 30 minutes of exercise per day," with a MD of 1.27 (p < 0.001) for ranking in terms of overall physical activity. For self-care, a MD of 1.00 (p < 0.001) was seen for "making positive lasting changes to your self-care habits" with a MD of 1.31 (p < 0.001) for ranking in terms of overall self-care. With nutrition, a MD of 0.36 (p< 0.001) was seen for "eating 5+ servings of vegetables per day" with a MD of 1.27 (p< 0.001) for ranking in terms of overall nutrition habits. With stress, MD of 0.34 (p<0.001) and 0.20 (p<0.05) were noted with being "confident in my ability to handle personal problems" and "able to handle circumstances no matter how many difficulties arose" respectively. Overall ability to manage stress had a MD improvement of 1.02 (p< 0.001). Lastly, overall level of wellness had a MD increase of 1.19 (P< 0.001). Results showed a significant improvement in 100% of individual attributes and 85% of summary attributes.

Conclusions

OUR KP Physician Wellness Academy has significantly shown to be a useful program in helping physicians improve overall self-care in terms of exercise, nutrition, and stress management. These results advocate for implementation of support programs to improve physician self-care and well-being.

Physician well-being: Participatory leadership effect on interdisciplinary teamwork

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Learning objectives

- 1. Learn the effect of participatory leadership on teamwork.
- 2. Learn which aspects of teamwork are most influenced by quality participatory leadership.
- 3. Learn how these findings may be practically applied to engage organizations to achieve cultural change to improve physician well-being.

Project objective/background

Many physicians have perceived a loss of autonomy and voice, perhaps given the trend to integrate physicians into large organizations with centralized control.^{1,2} Participatory leadership, similar to transformational-servant leadership, ensures constituents are seen, heard, valued, developed, engaged, empowered, such that they belong and believe in the mission. Shanafelt et al. found that high quality participatory leadership predicted 47% of the variance around physician satisfaction with the organization, and less burnout with increasing leadership guality.³ Similarly, interdisciplinary top-of-license team-based share-the-care with allied health professionals, efficiency and optimal teamwork, predicts higher professional fulfillment and lower burnout.⁴⁻⁷ The aim of this study is to determine how high-quality participatory leadership influences teamwork, how optimal teamwork affects well-being, thus elucidate practical ways healthcare organization can achieve culture change and improve well-being.

Methods/approach

A wellness assessment of medical staff across five regional hospitals was conducted September-October of 2020. The 1504 attending physicians were included in the study. The effect of participatory leadership on teamwork was assessed using the average of a 9-item leadership scale by Shanafelt et al.³ (Likert scoring 1-5, low/high cut off at 3.4) and a 17-item optimal teamwork scale (1-5 Likert scale: *"strongly disagree"*, 1 to *"strongly agree"*, 5).⁶ By leadership group, independent t-tests compared means, followed by calculation of effect sizes. Given the left-skew of some teamwork results (oriented negative to positive), the

analysis was also run with nonparametric statistics and transformed data (squared), without meaningful difference in statistical significance or ranked order or degree of effect size for this sample of 1504.

Results

High quality participatory leadership had a statistically significant moderate to large effect on the majority of teamwork characteristics assessed. It had an especially large effect on the assessment of whether decisions about operations were transparent, explicit, and clearly communicated. Participatory leadership had a favorable influence on the psychological safety to learn from mistakes, to question and respect differing opinions, to disagree without fear of backlash, to resolve conflicts directly without triangulation. The perception that rewards and accountability were fairly distributed without favoritism was better with high quality leadership. [Table] Optimal teamwork was associated with higher professional fulfillment (OR 5.69, CI 4.05-8.00, p<0.001) and lower burnout (OR 0.24, CI 0.17-0.32, p<0.001) amongst attending physicians after adjusting for practice model, specialty group, age, race group, gender.

Conclusion

High quality participatory leadership improves all aspects of optimal teamwork. Participatory leadership and teamwork can be taught to improve trust, quality healthcare, and professional well-being.



Reference

Participatory Leadership and Interdisciplinary Teamwork									
Participatory Leadership Quality, Avg 15 (Shanafelt et al.)									
		LOW <3.4		HIGH >=3.4		Effect size Effect size		t size	
Teamwork Characteristic (Olson et al. ACPH 2021)	n	mean	sd	n	mean	sd	p-value	Cohen's D	CI
Operations Communicated	434	2.83	1.24	687	3.67	1.03	<0.001	-0.75	0.87-0.62
Safe to Disagree	435	3.16	1.17	687	3.89	0.93	<0.001	-0.71	0.83-0.59
Recognition, No Favoritism	431	3.01	1.13	684	3.75	1.13	<0.001	-0.70	0.82-0.57
Conflict direct	432	2.96	1.19	688	3.65	1.02	<0.001	-0.63	0.76-0.51
Safe to Make Mistakes	433	3.34	1.13	687	3.97	0.86	<0.001	-0.64	0.76-0.52
Safe to Question	435	3.40	1.16	688	4.03	0.90	<0.001	-0.62	0.74-0.50
Accountability, Clear, Fair	429	3.08	1.15	683	3.73	1.02	<0.001	-0.61	0.73-0.48
Share scorecard	430	2.96	1.12	680	3.56	1.12	<0.001	-0.57	0.69-0.44
Easier for me	430	3.39	1.16	688	3.93	0.93	<0.001	-0.53	0.65-0.41
Awareness of Others	434	3.38	1.06	688	3.85	0.92	<0.001	-0.48	0.60-0.36
Goals Aligned	436	3.36	1.15	685	3.85	0.98	<0.001	-0.47	0.59-0.35
Support Beyond Self-interest	435	3.62	0.90	688	4.07	0.90	<0.001	-0.46	0.58-0.34
Optimal Teamwork	437	3.33	1.21	691	3.83	1.00	<0.001	-0.46	0.58-0.34
Roles Clear	434	3.34	1.18	690	3.82	0.99	<0.001	-0.45	0.57-0.33
Team Collaborates	436	3.79	1.12	689	4.23	4.16	<0.001	-0.45	0.57-0.33
Easier for them	432	3.97	0.82	689	4.27	0.70	<0.001	-0.40	0.52-0.27
No holding back	435	3.53	1.14	690	3.94	0.98	<0.001	-0.39	0.51-0.27

The optimal teamwork scale⁶ (Table) is 17-items scored on 5-pt Likert (1-5) of agreement, retained on one Eigenfactor >1 with factor loadings >0.7 (except "I do my work in a way to make work easier for others", 0.51), and Cronbach alpha 0.96. The average composite score's binary cut off (=3.454) is per consensus of 1910 medical staff' who "somewhat to strongly agree" they have optimal teamwork (sensitivity 0.87; specificity 0.81; AUC 0.84). Optimal teamwork was found to be associated with medical staff professional fulfillment8 OR 5.97 (Cl 4.53-7.85, p<0.001) and burnout⁸ (PFI) OR 0.19 (Cl 0.15-0.25, p<0.001) adjusted for practice model, specialty group, age, race group, gender. (Olson et al. ACPH 2021)

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Physician wellness support lines: A comparison of six international models

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Learning objectives

- 1. Contextualize the performance of the CMA WSL through insights gained from external programs.
- 2. Learn about comparable physician wellness support lines including their respective histories, design features, level of integration, strengths, and limitations.
- 3. Gain an understanding of what makes a physician wellness support line successful.

Project objective/background

In June 2020, the Canadian Medical Association (CMA) added a new 24/7 Wellness Support Line (WSL) in response to the increased stress placed on the medical profession by the COVID-19 pandemic. The service offered to 58,000 physicians, medical learners, and their immediate families residing in provinces and territories where this service did not previously exist. In year 2 of this initiative a robust evaluation was conducted with support from KPMG to measure the performance of the WSL and to compare results to similar models.

Methods/approach

In the absence of literature comparing wellness line models for physicians, the CMA commissioned a comparative analysis. First, jurisdictional scan was conducted to discover relevant programs to include for comparison. The inclusion criteria for the scan were that the support lines be tailored to physicians, free of cost, and available 24/7 or have extended hours and included both domestic and international comparators. six support lines were selected from Australia, Canada, the United Kingdom, and the United States three primary sources of data collection methods were leveraged to further analyze the programs including a literature review, interviews (N = 6), and a member survey.

Results

Despite a range in utilization rates, all six programs showed a continual increase in utilization rate over time. Identified factors for success include high awareness of the support line, a strong relationship between the funder and service provider, and a positive perception of the program by physicians. Common limitations were length of treatment, appropriate and timely referrals, stigma, program sustainability, survey response rates, tailored support, marketing, and provider concerns. Differences between support lines often lie in the details of their design, which are shaped to their respective physician wellness landscapes. The member survey will be analyzed, and results will be available by the conference date.

Conclusion

The comparison analysis of physician wellness support line was the first to evaluate and compare a set of international models. It proposes design features and offers valuable information on strengths, limitations, and best practices of physician wellness support lines for organizations who may be considering implementing similar programs. It underscores the importance of tailoring the service to the regional needs. Results from this analysis provide insight on the performance of the CMA WSL and will be used to inform the future state of the program.

Practical well-being in hospitals: The #theatretoastie Project

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Background

SARS CoV-2 viral infection presented an unknown and rapidly evolving pandemic to hospitals worldwide. This resulted in a large amount of anxiety and stress amongst healthcare workers. There was a recognition in operating theatres that staff were working longer hours and unable to easily take breaks.

The challenge was to assist with the nutritional wellbeing of theatre staff irrespective of the time of day. Following consultation with frontline staff, the feedback was consistent. Convenient access to comforting nutrition was requested. Over the last ten years there has been a systematic removal of all food provisions from all staff tearooms due to financial constraints, and this needed reconsideration. The most desired option from theatre staff was for a simple toasted sandwich.

Methods

In May 2020, the #theatretoastie initiative was piloted in the main operating theatres of Royal Prince Alfred Hospital, to 200-300 staff. Sandwich press machines, white, brown, multigrain and raisin bread, butter, and low-fat cheese, were delivered to the operating theatres three times per week. This yielded 363 toasted sandwich servings per week at a cost of \$136AUD. After 6 months theatre staff were surveyed regarding their frequency and timing of access to the new provisions, and the self-reported impact of this initiative on their wellbeing, job performance, job satisfaction and quality of patient care (5-point Likert scale, not at all to extreme improvement).

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Results

After 6 months, 8712 #theatretoastie servings at a cost of \$3264AUD were provided to 250 theatre staff. 105 (42%) theatre staff (54% medical, 40% nursing, 6% support staff) completed the survey. 94% had accessed the provisions on average 50 times, most frequently between 0730-1730 (73%). Self-reported large or extreme improvements were reported in physical (84.6%), emotional (81.7%), and overall sense of wellbeing (78.8%), job satisfaction (80.8%), improved relationships with others (72.1%), efficiency and performance (74.0%) and quality of patient care (72.1%).

Conclusion

The #theatretoastie was a simple, cost-effective strategy that improved the working conditions for 250 theatre staff during a period of high stress and uncertainty. The improved working conditions were due to an improved sense of physical and emotional wellbeing at work, job satisfaction, and quality of patient care delivered. During this period there were no adverse outcomes for staff or patients related to COVID infection or transmission in the operating theatres. This initiative has now been approved for ongoing funding and is being rolled out across hospitals in Sydney Local Health District.



Professional coaching and surgeon well-being: A randomized controlled trial

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Learning objectives

- 1. Participants will be able to articulate the impact of professional coaching on burnout and resilience among surgeons.
- 2. Participants will understand that the benefits obtained from professional coaching are likely to be attenuated once coaching ends.

3. The participants will be able to list limitations of a randomized controlled trial.

Background

External professional coaching has been previously shown in a randomized controlled study of general and subspecialty internal medicine, family medicine, and pediatric physicians to reduce burnout and improve quality of life and resilience. Postintervention effect and evidence in support of professional coaching for physicians in other specialties is limited. This study sought to determine if individualized external professional coaching reduces burnout and improves quality of life (QOL) and resilience in surgeons, and if the effects are sustained 6 months after conclusion of the intervention.

Methods

A randomized controlled trial of 80 surgeons evaluating the impact of 6 monthly professional coaching sessions on burnout, QOL, and resilience immediately postintervention and 6 months later. Participants randomized to the control group subsequently received 6 professional coaching sessions during the following 6 months (delayed intervention group).

Results

At the conclusion of professional coaching in the immediate intervention group, the rate of overall burnout decreased by 2.5% in the intervention arm compared to an increase of 2.5% in the control arm (delta -5.0%, 95% Cl -8.6%, -1.4%, p = 0.007). Resilience scores improved by 1.9 points in the intervention arm compared to a decrease of 0.2 points in the control arm (delta 2.2 points, 95% Cl 0.07, 4.30, p = 0.04). Improvements in this group were generally diminished 6 months after completion of the coaching period. The delayed intervention group experienced improvements in burnout during their coaching experience relative to the immediate intervention group during their postintervention period (18.2% decrease vs 2.9% increase, delta -21.1%, 95% Cl -24.9%, -17.3%, p < 0.001).

Conclusions

Professional coaching over 6 months improved burnout and resilience among surgeons, with reductions in improvement over the ensuing 6 months.



Promoting a culture of physician well-being through healthy sleep: Effect of a structured heartfulness meditation program

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Learning objectives

- 1. Explore sleep and its relation to overall physical and mental health and burnout.
- 2. Discuss the current sleep patterns of physicians in training and the effect of a structured meditation program.
- 3. Learn the techniques of Heartfulness meditation to promote sleep.

Project objective/background

Sleep is a fundamental requirement for health. Health care systems need to adopt strategies to facilitate healthy sleep practices to physicians. There is a need for a shift in the culture towards sleep. Medical residents are vulnerable to poor sleep quality due to intense work shifts and academic load. Studies objectively quantified with sleep quantity and quality among resident physicians are limited. Meditation techniques have been shown to improve sleep but are rarely studied in this population. The aim of the present study is to evaluate sleep patterns of internal medicine residents and the effect of a structured Heartfulness meditation program to improve sleep quality.

Methods/approach

A total of 36 residents participated in a pre-post cohort study. Sleep was monitored during a one-week outpatient rotation with two validated assessment tools, namely consensus sleep diary and actigraphy. After four intervening weeks, when the residents returned to the same rotation, Heartfulness meditation was practiced, and the same parameters were measured. At the end of the study period, an anonymous qualitative feedback survey was collected to assess the feasibility of the intervention.

Results

All 36 residents participated in the study (mean age 31.09 years, SD 4.87); 34 residents (94.4%) had complete pre-post data. Consensus sleep diary data showed decreased sleep onset time from 21.03 to 14.84 min (P = .01); sleep quality

and restfulness scores increased from 3.32 to 3.89 and 3.08 to 3.54, respectively (P < .001 for both). Actigraphy showed a change in sleep onset time from 20.9 min to 14.5 min (P = .003). Sleep efficiency improved from 83.5% to 85.6% (P = .019). Wakefulness after initial sleep onset changed from 38.8 to 39.9 min (P = .682). Sleep fragmentation index and the number of awakenings decreased from 6.16 to 5.46 (P = .004) and 41.71 to 36.37 (P = .013), respectively.

Conclusion

Residents obtained nearly 7 h of sleep during outpatient rotation. Findings suggest a structured Heartfulness meditation practice to be a feasible program to improve subjective sleep onset time and several objective measures among resident physicians. There is a need for shift of culture to promote sleep in physicians.

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Thimmapuram J, Pargament R, Tredici SD, et al. Sleep Patterns of Resident Physicians and the Effect of Heartfulness Meditation. *Ann Neurosci.* 2021;28(1-2):47-54.

Randomized trial to improve well-being through gratitude at the departmental level

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Learning objectives

- 1. Participants will learn about a potential large scale/department level positive psychology intervention using three good things to support gratitude.
- 2. Participants will learn about the benefits and limitations of a wellness intervention using text-based platform.
- 3. Participants will consider ways we can extend what we know from physician well-being efforts to our broader community, across roles, especially during this time of sustained and cumulative stress of COVID-19 and the future demand for recovery.

Project objective/background

With widespread recognition of physician burn out, and with nurses facing similar concerns, burn out across roles in the health system is also a concern. Most wellness interventions are aimed at either physicians or nurses. Evidence shows that positive psychology interventions improve resilience and well-being, but these studies are typically not randomized and not delivered across fields. We sought to deliver a wellness intervention, applied across roles within a department.

Methods/approach

We conducted a randomized controlled trial involving all employees in a large academic department. Participants were randomized to an immediate or delayed intervention which involved receiving a "three good things survey" via text on Monday, Wednesday, and Friday evenings for three weeks, asking participants to respond with good things which happened that day. We used surveys at 0, 1, 3, 4 and 6 months to assess PANAS-SF (Positive and Negative Affect Schedule), the 3-item GAC (Gratitude Adjective Checklist), the 5-item Satisfaction with Life Questionnaire, the 9-item PHQ9 (Patient Health Questionnaire) to screen for depression and one question each to assess self-reported physical and mental health. Data was analyzed using a mixed-model with time as the within-subject factor, controlling for age, gender, and department role, both to evaluate differences between control and intervention groups and then to evaluate changes in all participants before and after they completed the intervention.

Results

Of the 468 eligible individuals sent recruitment emails, 223 (48%) enrolled and were randomized to an immediate

intervention (n=116) or a control group—delayed intervention (n=107), with breakdown by job role including 19% administrative staff, 41% clinical staff, and 40% faculty, fellows, or residents. Overall, we observed non-significant improvements in well-being on all measures in the shortterm (1 month) but scores declined toward baseline by the three month follow-up. Older age was consistently associated with improved scores, and we observed small but significant variations by gender and role.

Conclusion

While this was a short study, and the initial improvements in positive affect and gratitude measures are not sustained, it proves the potential for a large scale, department or institutional intervention using text messaging. It shows early promise for implementing Positive Psychology interventions across roles. The results do not show sustained improvement but also do not show decline, despite the overlay of the COVID-19 pandemic. Further studies may clarify if similar interventions support resilience during times of crisis, or improve well-being outside of crisis times.

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Unlocking the potential within: How peer coaching programs foster engagement and retention for physicians

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Learning objectives

- 1. Facilitate a developmental network for physicians and PhDs to enhance engagement and retention.
- 2. Assess additional benefits of a peer-based program.

Background

In 2009, physician leaders in an academic health center created a Center for Excellence in Coaching and Mentoring, whose mission is to facilitate a relationship-centered developmental network for all physicians across their career continuum. The Center trains physicians to use coaching skills and oversees two physician peer-based programs.

The Staff Coaching and Mentoring Program (SCMP) is open to all and requires participants to attend a CME training and practice of coaching and mentoring skills session prior to joining. Coachees are matched with peer coaches who encourage self-reflection, option expansion, and accountability. Some coachees also connect with mentors, who offer content expertise and advisement. To date, 772 physicians and PhDs have attended the peer-training and ~350 are engaged in a coach-coachee relationship at any one time.

In 2015, the Center launched a by-invitation-only Advanced Peer Coaching Program (APCP) to provide advanced coaching for peers approaching the executive level or those at-risk. To date, 117 advanced peer coaches (APCs) have participated in a four-day immersion course. APCs are matched with physician peer-coachees through Center leadership.

Methods

In 2020, we conducted a survey of both SCMP and APCP participants to understand participant practices and to measure self-reported impact of participation on components of engagement, retention, and use of coaching skills. Survey questions were designed using a 1-5 Likert scale. The survey was approved by our organization's Institutional Review Board.

Results

89 (51%) of the 273 coaches and 193 (33%) of the 580 coachees in both programs responded. We defined SCMP Participation as those respondents who completed the CME peer-training and engaged in a coaching relationship.

Percent Impacted by SCMP(S) and APCP(A) Participation							
	SCoachees n=75 (%)	SCoaches n=31 (%)	ACoachees n=58 (%)	ACoaches n=47 (%)	Total n=211 (%)		
Sense of value as a Professional Staff member	71 (95)	30 (97)	54 (93)	47 (100)	202 (96)		
Ability to find meaning at work	69 (92)	29 (94)	54 (93)	46 (98)	198 (94)		
Connection with others across the organization	72 (96)	30 (97)	52 (90)	47 (100)	201 (95)		
Decision to stay at the organization	55 (73)	22 (71)	39 (67)	32 (68)	148 (70)		

Conclusion

Our peer-based coaching programs provide a network of support that enhances engagement and retention. Participants report the ability to use their coaching skills in numerous aspects of their professional and personal lives, not just in their coaching relationships. Further, program participation benefits both coaches and coachees, and potentially saves the organization millions of dollars in turnover costs by driving retention.



Utilizing a "Community of Practice" model to drive system change in physician health and wellness (Manitoba, Canada)

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Learning objectives

- 1. To understand the value of the Community of Practice (CoP) model as a knowledge translation strategy in the context of Physician Health and Wellness (PHW).
- 2. To understand the steps involved in setting up a PHW CoP.

3. To identify the success conditions for and barriers to knowledge-to-practice uptake and application for PHW.

Project objective/background

In response to troubling Canadian physician wellness data and local concerns shared by members, Doctors Manitoba (the medical association representing all physicians and medical learners in Manitoba, Canada) launched the PHW Communities of Practice Project (herein, the project) in 2020 to assess the environments and systems in which physicians work, focusing on three areas of the province.

The purpose of the project is to improve PHW and reduce burnout within each of the three CoP sites by implementing achievable actions aimed at the organizational and system level.

Approach

In each of the three geographic areas, physicians, senior administrators, a Physician Champion, and Doctors Manitoba staff come together regularly to learn about evidence-based interventions, general and local drivers of physician burnout and engagement, and to choose meaningful and achievable local interventions.

A process evaluation was conducted to explore experiences in establishing and implementing the project, including CoP member relations, collaboration, communications, decisionmaking protocols, conflict resolution, CoP member training and professional development.

Results

The findings of the process evaluation indicate several important success conditions and considerations for establishing a PHW CoP including the importance of:

- Collaborative leadership;
- Approaches that honour the physician voice;
- Trusting relationships and psychological safety;
- And the types of supports required.

Conclusions

Results from the process evaluation of the project indicate very positive results, suggesting the CoP model is a good fit in the context of PHW and health system change, and has important implications for physician and senior health leader engagement. An outcome evaluation of the pilot is planned to assess the strength of the CoP approach, with complete findings expected in 2023.

When awareness leads to action: Skills that prepare medical student response to mistreatment by patients

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Learning objectives

- 1. Understand the prevalence and long-reaching impacts of mistreatment of students by patients
- 2. Review the process of collaboratively developing curricula to best prepare students to respond to mistreatment by patients, including feedback from students
- 3. Discuss the goals of an institutional response to mistreatment and ways to support students

Project objective/background

Medical student mistreatment by faculty, residents, and other healthcare staff involved in their education is a recognized concern, one that institutions and governing bodies work diligently to mitigate. Patients remain an overlooked source of mistreatment for medical students and are not yet considered during such efforts. Recent studies confirm patients are a prevalent source of mistreatment for trainees. The next steps include establishing procedures that support students following these experiences and developing curriculum that prepares students to know how to respond to negative patient interactions before they occur.

Methods/approach

A survey investigating medical student mistreatment by patients was administered to all students enrolled at Wayne State University School of Medicine in 2020, with a response rate of 45.6% (n=523). It surveyed the prevalence, types, and effects of mistreatment by patients and assessed the interest in potential development of protective and preparative measures. Based on the needs noted through this survey, students, faculty and administration in the offices of medical education and student affairs collaborated to develop a longitudinal curriculum. The pilot session was presented to 110 students during their residency preparation rotation, 93 (85%) responded to the pre-survey and 96 (87%) responded to the post-survey.

Results

Of all respondents to our survey of mistreatment by patients, 51.1% noted at least one experience of mistreatment by patients and 86.0% believed these experiences should be included in mistreatment policies and procedures. 80.1% of respondents thought they would benefit from training sessions that address how to appropriately respond to situations of personal and observed student mistreatment. After attending the pilot session, students reported an increase in preparedness to respond to mistreatment from both patients and healthcare team members (3.22-3.29 pre-survey to 4.14-4.21 post-survey).

Conclusion

Students both need and support organized mitigation efforts related to mistreatment by patients. Training sessions with scenario-based small group discussions and information about ways to respond integrated into longitudinal curricula alongside continued surveying of mistreatment and session impact may address these needs. Curriculum on this important topic is one integral way an institution fosters a safe learning environment and ensures trainees develop skills to protect themselves and support one another.



A 12-week medical staff coaching initiative as an effective, immediate, well-being intervention in the absence of existing well-being infrastructure

Author

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Learning objectives

- 1. Demonstrate that a coaching program is an effective, evidence-based well-being intervention for providers across specialties and campuses.
- 2. Gain awareness of an immediate, impactful intervention available even in the absence of formal well-being infrastructure.
- 3. Identify potential funding sources.

Project objective/background

Physician burnout has been well described as a growing problem with organizational drivers. Most institutions have not developed a robust well-being infrastructure to address this crisis leaving inadequate resources to address a complex problem. There is a paucity of effective organizational well-being initiatives at many institutions. Coaching has been proven as an effective tool to decrease burnout. Our organization currently lacks well-being infrastructure, but we will describe our success bringing coaching as a successful intervention to 8 Oregon hospitals.

Methods/approach

We partnered with Coaching for Institutions, a firm offering coaching by certified physician coaches, to provide a 12-week coaching initiative at no cost to participants and with 24 hours CME that included recorded teaching, small group sessions, and 1:1 coaching. Funding was obtained through medical staff funds and foundation grants. We extended the application to all medical staff across 8 Providence Oregon hospitals. We received over 150 applications for 60 spots. Participants were selected based on perceived distress and potential to benefit others.

Results

We will review our pre-, mid- and post- program survey data and share impact statements from the participants. The Well-Being index for participants dropped from 3.96 to 1.78. Participants assessed their ability to meet their goals in 8 domains including burnout treatment/ prevention, leadership development, and mental health which all significantly improved upon completion of the intervention. There is also increased empowerment and cohesion within the culture. The success of the initial cohort and interest from additional applicants has led to additional funding for subsequent cohorts. We hope to be in our 4th iteration of this intervention by spring 2023.

Conclusion

We will share executing coaching for a diverse medical staff across multiple hospitals as a high impact wellbeing intervention. We will share our unique strategy for obtaining funding and executing the intervention without having robust well-being infrastructure in our organization.

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A scoping review of terms and measures used to investigate the physician work-life interface

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and data extraction of WLI terms, phrases, definitions, and measurement tools were conducted independently by two researchers and any disagreements were reconciled by a third.

Results

After removing duplicates, 1600 studies were screened and 75 met inclusion criteria. The majority of studies were cross-sectional (n=62, 83%), and most used a survey to measure the WLI (n=64, 85%). Of these, 51 studies provided the survey question(s), and only 10 reported using a validated survey. The five most common WLI terms included: work-life balance (used in 58 studies), work-life integration (14 studies), work-life conflict (10 studies), work-home conflict (12 studies), and work-life imbalance (5 studies). There were ten terms that were defined in any study. Those terms, the definitions and study are listed in Table 1.

Conclusion

While the WLI is a common area for investigation to improve physician well-being, there is a wide variation in terms used, their definitions and measurement. Future studies should focus on establishing consistent terms, definitions and measures of the WLI.

lable 1. WLI terms that in	ncluded a definition in any manuscript	
Term	Definition(s)	Author
Work-life imbalance	A broad term that refers to the lack of time for personal interests due to work demands.	Ayyala 2019
	Physicians' family and community life circumstances as those relate to physicians' work	Cossman 2009
	Defined by your own personal sense of well-being with regard to managing the various challenges of both your professional and your personal life	Menasche 2018
	Three major categories relevant to work-life balance: personal life, professional responsibilities, and impacts on mental health and overall wellness	Raffi 2020
	The perceived sufficiency of time available for work and social life	Streu 2011
	Implies that work and life can be compartmentalized and equally apportioned when in fact the two often overlap and are disproportionate in terms of the time and attention paid to each	Stutzman 2020
	Includes all aspects of flexibility, satisfaction, and family	Tomer 2015

Background

The work-life interface (WLI) is a major contributor to physician well-being. Yet, it is unclear whether there are consensus terms, definitions or measurements in investigations of the physician WLI.

Objective

Describe the terms, definitions and measures used in physician WLI studies.

Methods

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We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) Extension for Scoping Reviews Checklist for our study design and reporting. Eligibility criteria included peer-reviewed articles published in English between January 1990-April 2020 describing qualitative, quantitative, and mixed-methodology studies that (1) investigated the WLI in US practicing physicians and (2) measured the WLI as an outcome. Studies involving trainees and physicians practicing outside the US were excluded. We searched PubMed, CINAHL, Scopus, and Web of Science using a search strategy that included keywords and MeSH terms for physicians, medical faculty, work/career, life, integration/interface, balance, conflict, boundaries, fit and satisfaction. Screening, study selection,



Work-family conflict	A form of inter-role conflict in which the demands of work and family are "at odds."			
	The need to perform both work and personal affiliated tasks	Starmer 2019		
Time-based work interference	The perception that the time demands of work interfere with participation in the family role	Grisso 2017		
Strain-based work interference	The perception that the stress from work has a negative impact on family life	Grisso 2017		
Role strain	Conflict experienced when managing competing life role obligations	Meyer 2019		
Time-based conflict	When the time demands of one role interfere with effective participation in the other role	Westring 2012		
Strain-based conflict	When the stress or strain from one role inhibits effective participation in the other role	Westring 2012		
Role conflict	Frustration with the competing demands of career, marriage, and family	Shanafelt 2016		
	Struggle to balance personal responsibilities with a demanding medical career	Dyrbye 2014		
Work-home conflict	The need to perform both work and personal related tasks/responsibilities simultaneously resulting in conflict between work and home	Dyrbye 2014		

Assessing burnout and professional fulfillment in a regional community hospital

Author

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Learning objectives

- 1. Defining and assessing physician burnout and professional fulfilment
- 2. Determining factors associated with burnout and professional fulfillment
- 3. Implementing strategies to improve physician wellness

Project objective/background

Physicians have a higher rate of burnout and lower satisfaction with work-life balance than the general population, which can ultimately lead to poor quality of care. This study evaluated a regional community hospital's physician burnout and professional fulfillment and assessed the factors affecting psychological distress and coping mechanisms.

Methods/approach

The Standford Professional Fulfillment Index (PFI) Survey was sent out to all physicians in a regional community hospital in October 2021. The questionnaire included demographic, lifestyle and practice patterns questions. Participants also graded the effectiveness of specific wellness strategies and shared some beneficial strategies. Multivariable linear regressions were performed for data analysis.

Results

Out of 120 surveys completed, 69 physicians experienced burnout (57.5%) and only 24 physicians had high professional fulfillment (20%). In multivariable analysis, increased time spent doing paperwork is negatively correlated with professional fulfillment. On the other hand, strategies to promote leadership traits was positively correlated with professional fulfillment and negatively correlated with burnout.

Co-authors

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Conclusion

Approximately 6 of 10 physicians are experiencing burnout and only 2 of 10 physicians have high professional fulfillment. Burnout is present across the entire surveyed population with no single demographic predictive factor. Improving professional fulfillment could be addressed by limiting the time spent with documentation, indicating the need for institutional support and resources. Using suggestions made by study participants, further interventions can be developed to improve physician wellness. Ultimately, physicians in the selected community hospital are experiencing burnout at a higher rate than the Canadian national average of 30% as reported in the 2017 CMA National Physician Health Survey.

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Lifestyle medicine-based virtual program for residents and medical students: PAVING the path to wellness feasibility and acceptability study

Author

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Learning objectives

- 1. Participants will be able to identify the 6 pillars of lifestyle medicine and the effects of their disruption during medical training
- 2. Participants will be become familiar with the PAVING the Path to Wellness intervention and the ways in which this program can be adapted to various stages of medical training
- 3. Participants will learn practical ways to implement well-being strategies into their daily lives as physicians and physicians in training

Project objective/background

Alarming levels of burnout and mental illness continue to affect medical trainees of all levels. Research shows almost 40% of surgical residents report weekly burnout symptoms1 and 27.2% of medical students report depression or depressive symptoms (7.1% in general population)2. This is not so surprising given medical training often disrupts all 6 pillars established by lifestyle medicine as being necessary to overall well-being: nutrition, exercise, sleep, stress management, risky substances, relationships. The PAVING the Path to Wellness program, a researched-based holistic wellness program expanding upon the 6 pillars of lifestyle medicine, was first piloted in stroke survivors in 2012. Since then, it has been successfully adapted to various patient populations, including thyroid and breast cancer survivors3. We hypothesized that this intervention could be successfully adapted to a virtual format for medical trainees.

Methods/approach

The PAVING the Path to Wellness intervention was implemented for surgery residents and for first year medical students. A group of 15 surgery residents met bimonthly for 6 sessions, and a group of 15 medical students met weekly for 12 sessions via Zoom for 1-2 hours. Both groups covered all 12 pillars of the intervention: physical activity, attitude, variety, investigations, nutrition, goals, stress resiliency, time-outs, energy, purpose, sleep, social connection. Each session included a discussion of the day's pillar(s) and free-form discussion amongst participants.

Results

Average attendance was high for both groups, despite training obligations: 10/15 (66%) for surgical residents and 11/15 (73%) for medical students. Attendees actively participated in all sessions. 100% of medical student respondents said they would recommend the group to another medical student. Growth mindset, gratitude, and mindfulness were noted as the 3 most frequently used program themes. One participant remarked, "[This program offers] a community of people who are willing to talk honestly about what motivates us... what our values and boundaries are, and how to think about our lives in medicine as more than just moving from one achievement/milestone to the next."

Conclusion

Given alarmingly high levels of burnout and mental health struggles during medical training^{1,2} it is imperative to give trainees the tools they need to not only survive their training, but to thrive. This case demonstration reveals the feasibility and desirability for a virtual wellness intervention, expanding upon the 6 pillars of lifestyle medicine, at different stages of medical training. Future studies will be aimed at expanding this program to serve a larger number of trainees and better understanding long-term impact.

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Measuring well-being: A scoping review of metrics and studies measuring medical student well-being longitudinally

Author

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Co-authors

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Learning objectives

- 1. Participants will discuss the breadth of studies that measure medical student wellness over multiple timepoints
- 2. Participants will be able to describe gaps in study methodology among studies measuring medical student wellness over multiple timepoints
- 3. Participants will identify which metrics are the most frequently used to measure various constructs relating to medical student wellness

Project objective/background

Numerous studies have demonstrated high rates of burnout, depression, anxiety, and psychological distress in medical students.¹⁻⁶ However, no evidence-based guidelines exist for study design and metric selection, thus resulting in wide methodological variations across studies. This impairs the comparability and consistency of evidence produced. This study aimed to examine the metrics and methods used to measure medical student wellbeing across multiple timepoints and identify areas where further guidance is necessary to guide medical schools and future research.

Methods/approach

Arksey and O'Malley's framework² and Levac et al's recommendations[®] for scoping reviews were followed. A protocol was developed a priori using the PRISMA extension for scoping reviews[®]. Five electronic databases were searched between May and June 2021 for primary research studies that employed validated survey-based metrics in a medical student population at two or more timepoints. Systematic reviews and meta-analysis' reference lists were hand-searched for relevant articles. Screening and data extraction were done independently by two reviewers with conflicts resolved via consensus. The authors extracted data regarding the manuscript, study methodology, and metrics used and cross-analyzed the data points for patterns.

Results

221 studies met the inclusion criteria with 109 longitudinal studies and 112 interventional studies. 75.6% were published from 2010-2021 and only 15.4% focused on the clinical medical student population. 48.0% had less than 100 participants and 61.1% measured wellness at only two timepoints (as opposed to longer term observation,) Only 3.57% of interventional studies followed participants longer than 12 months post-intervention, and 38.4% did not use a control group. Stress management interventions were the most common (40.2%) type of intervention. There were 140 unique metrics measuring 13 different wellness-related constructs. Mood/affect (22.5%), anxiety (21.4%), and stress (15.7%) were the most commonly measured constructs. 52.1% of metrics were only used once among all studies.

Conclusion

Although many studies have explored medical student wellness over time, guidance is needed to address gaps in study design such as the lack of inclusion of clinical students, low sample sizes, short follow-up, and lack of control groups. In addition, although there exists a wide range of metrics that measure wellness-related constructs in medical students, use is highly variable across regions and populations with a significant portion having only been used once among our included studies. Further research is necessary to elucidate the best metrics in each category and provide evidence-based guidance for tracking medical student wellness over time.



Recognizing when we are not OK: The stress continuum as a well-being assessment tool for physicians

Author

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Learning objectives

Participants will be able to:

- 1. Utilize the Stress Continuum as an assessment tool for physician wellbeing
- 2. Describe how the Stress Continuum relates to the Perceived Stress Scale
- 3. Describe one way the Stress Continuum can be implemented in their setting

Project objective/background

A culture of wellbeing should encourage physicians to recognize when they need to seek support and when to encourage help-seeking in a colleague. In our large healthcare system, we are implementing the Stress Continuum (SC; Watson & Westphal 2020) as a simple and intuitive tool to quickly identify negative effects of stress and recognize when help is needed. The purpose of the current study is to understand how the SC correlates with the widely used Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983).

Methods/approach

259 healthcare worker participants in two training cohorts (October 2021; January 2022) about stress management were invited to complete a pre-training survey that included the PSS and the SC. The PSS is a 10-item questionnaire with good psychometric properties. The SC provides four color zones that correlate with level of stress symptoms/impact on functioning (green, yellow, orange, red; green is associated with no negative effects of stress and red with severe effects of stress).

Results

214 (83%) participants completed surveys. Mean age was 45 (S.D. = 13). 87% were female, 44% identified as clinicians, 30% as non-clinical role, 42% as leadership, and 9% in academics (participants could select multiple roles).

The mean PSS score was 16.5 (SD=6.3) with 33% in the low-stress level, 62% in the moderate-stress level and 5% in the high-stress level. On the SC, 16% were in green, 68% in yellow, 14% in orange, and 3% in red.

Spearman rank correlation between the two categorical variables was 0.57, a moderate level of agreement, also confirmed by Gwet's AC statistic (0.57).

Narrative feedback about the tool in training sessions and meeting included that the SC is easily understood and practical.

Conclusion

Co-authors

Mihriye Mete, PhD Dan Marchalik, MD

The SC is a very quick and easy to understand one-item tool for assessing physician distress at work. It has a moderate association with the PSS, an established stress measurement tool. Frequent, widespread self-assessment and the ability to quickly detect high levels of distress in colleagues is a critical part of creating a wellbeing culture that includes pinpointing and addressing sources of stress, identifying physicians in need of support or new strategies, and reduces stigma in asking for help.

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The COVID-19 pandemic's impact on career plans of family physicians: A call for action to support the well-being of our primary care physicians

Author

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Learning objectives

- 1. Describe US family physicians' exposure to COVID-19 related traumatic stressors.
- 2. Describe the impact of these stressors on life priorities, burnout and physician career plans.
- 3. Discuss implications of these findings on the primary care workforce and policies needed to sustain it.

Project objective/background

Pre-pandemic, physicians experienced high burnout, which predicted intent to reduce clinical hours and retirement. Family physicians had high rates of intention to leave practice (about 24%) and reduction of clinical hours (over 28%). Given COVID-19 challenges, we assessed the effect of the pandemic as a traumatic stressor, on family physicians' life priorities, burnout, and intention to withdraw from clinical practice.

Methods

The 4,314 members of the Council of Academic Family Medicine organizations were emailed an electronic survey in September-October 2021. We analyzed data from American physicians >=4 years post medical school. Survey items included 2 burnout questions from the Professional Fulfillment Index, one item from the post-traumatic growth scale regarding changing life priorities since the pandemic, and a single-item encapsulating the Diagnostics and Statistical Manual –V definition of traumatic stress. "R-factors" questions reflected withdrawing from clinical practice. Each was scored on a 5-point Likert scale, then dichotomized. Descriptive statistics included geographic region, academic rank, age, race, and gender. Fisher exact tests and bivariate logistic regression were used on 2x2 contingency tables.

Results

The response rate was 22.0%. The cross-sectional analysis included 683 family physicians (38.3% male, 79.0% white, average age 46.5).

Overall, 35.2% respondents experienced high exposure to or threat of death due to COVID-19. Those were more likely to change their priorities of what is important in life (35.3% vs.16.4 %; OR 2.8; 95% CI, 1.9-4.1), and experience burnout (50.6% vs. 35.5%; OR 1.8; 95% CI, 1.3-2.5). Those with burnout were more likely to have changed their priorities (35.3% vs. 14.3%; OR 3.3; 95% Cl, 2.2-4.8).

Respondents who experienced traumatic stress were more likely to relocate (OR 1.8; 95% Cl, 1.2-2.6), reduce clinical work effort (OR 1.6; 95% Cl, 1.2-2.2), re-route their career away from patient care (OR 1.6; 95% Cl, 1.1-2.3), and restrict scope of practice (OR 1.5; 95% Cl, 1.1-2.1). Retiring (OR 1.3; 95% Cl, 0.8-2.2), re-engaging with colleagues (Reverse-OR 1.1; 95% Cl, 0.6-1.9), and re-designing the clinical practice (Reverse-OR 0.9; 95% Cl, 0.6-1.5) were not statistically associated with exposure to extremes of stress. Family physicians were nearly twice as likely to relocate, reduce, re-route, retire, and restrict clinical practice with burnout or changing priorities.

Conclusion

The COVID-9 pandemic has had significant impact on family physicians including burnout, life priorities and intent to withdraw from practice. This supports the urgent need for organizational policies and interventions to sustain the well-being of our primary care workforce.

Table: R Factors and COVID-19 related Traumatic Stress, Changing Priorities and Burnout in US Family Physicians

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Tracking physician wellness indicators in Canada: Comparing data from the 2017 and 2021 CMA National Physician Health Surveys

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Learning objectives

1. Learn about the current state of physician wellness in Canada

- 2. Compare rates of physician burnout, depression, and suicidal ideation from 2017 to 2021
- 3. Discuss behavioural, workplace, and cultural factors contributing to physician wellness

Project objective/background

The Canadian Medical Association (CMA) aims to distribute a National Physician Health Survey (NPHS) every 3-4 years to maintain an up-to-date dataset, monitor physician wellness overtime, and detect new influencing variables. The 2017 NPHS established how a multitude of factors – behavioural, workplace, cultural – impacted physician wellness (N = 2,947). The next iteration was conducted in the Fall of 2021, two years into the COVID-19 pandemic. It repeated some of the same concepts as its predecessor to allow for comparisons and added new concepts to capture current and emerging challenges. The purpose of this presentation will be to present data from the 2021 NPHS and to make comparisons between the 2017 and 2021 datasets to track changes in wellness over time.

Methods/approach

The CMA established an Expert Working Group to help guide survey development. Prior to data collection, ethics approval was obtained. Data collection began in October 2021 and the survey was open for five weeks. The online survey link was distributed via multiple channels (e.g., email, social media, Google Ads) to ensure maximum reach. Canadian physicians and medical learners were eligible to participate and there was a total of N = 4,121 responses.

Results

Findings from the 2021 NPHS revealed that 53% of the sample were highly burned out (using the 2-item Maslach Burnout Inventory) compared to 31% in 2017. Nearly half (48%) screened positive for depression (34% in 2017). 36% reported having suicidal thoughts at some point in their life (19% in 2017) and 14% experienced these thoughts in the last 12 months (8% in 2017). According to the Professional Fulfillment Index, a new measure added to the 2021 survey, only 21% indicated being professionally fulfilled. Not surprisingly, 60% indicated that their mental health worsened since the onset of the COVID-19 pandemic and the top three contributing factors were: longer time with social restrictions, increased workload/ lack of work-life integration, and rapidly changing policies.

Conclusion

The 2017 and 2021 NPHS comparison provided an updated status of physician wellness, revealed a worsening of mental health over time and confirmed the additional stress brought on by the pandemic. Results offer insight into the impact of cultural and environmental factors which provide focused areas for organizations, stakeholders and policy makers who strive to take action and help to suggest impactful physician wellness solutions throughout the pandemic and beyond. Future iterations of this survey will continue to identify new/changing trends in physician wellness.


A "how-to" workshop for creating peer connections: Cultivating an organizational structure to build peer discussion groups

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Learning objectives

- 1. Explain the purpose and value of peer discussion groups
- 2. Describe the experience of participating in a CIRCLE peer discussion group
- 3. List implementation steps including feasibility and iterative responsiveness required to develop peer discussion groups at their own organization

Project objective/background

Organizations can support a culture of wellness by providing a structure to cultivate peer connections. Physicians who participate in peer discussion groups have shown reduction in burnout and improvement in meaning at work. We developed and implemented a "CIRCLE" (Colleagues Involved in Reaching Colleagues through Listening and Empathy) peer discussion program during the COVID-19 pandemic offered via virtual and text-based platforms. Participants reported a reduction in interpersonal disengagement based on pre and post program surveys and indicated that the program helped reduce isolation and improve peer connections. This interactive workshop will focus on engaging participants in actual CIRCLE discussions and equip participants with the knowledge and tools needed to implement this program within their organizations.

Session plan, description and timeline

15 minutes: Introductions, presentation of CIRCLE program, obtaining leadership buy-in and CME accreditation, developing evidenced-based discussion topics, adapting topics to external circumstances (e.g. COVID-19), implementation steps, rules of engagement (listening, sharing, not attempting to "fix" others' problems and confidentiality).

20 minutes: We will form small groups of 5 to 8 participants. Each group will receive one of 3 handouts used in our CIRCLE program (summarized below) with topic description and question prompts. Every group will participate in an introduction exercise: Sharing names and "one thing you are proud of and that most people don't know about you." They will then discuss their assigned topic.

Topic 1: Meaning and purpose

Integrating passion, mission, profession and vocation to support well-being. *What inspires you to do the work that you do? What parts of your work give you joy?*

Topic 2: Work-life (W/L) integration

W/L Balance implies gaining one side at the expense of the other. Integration creatively considers both sides. What does "good" W/L integration look like or feel like for you? What pearl of wisdom can you give a colleague to help them find W/L integration during COVID-19?

Topic 3: Openness to new possibilities

Post-traumatic growth: "A positive psychological change experienced as a result of a struggle with highly challenging life circumstances". **Consider pandemic-***related consequences and opportunities:*

- How have they inspired innovation and growth in your self-care?
- How have they inspired new possibilities in your work?

10 minutes: Each group reports back on the peer discussion experience and shares key discussion points.

15 minutes: Workshop facilitators share lessons learned and address participant questions with focus on implementation strategies within the workplace culture at their own institutions.

References

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A playbook for saving hours each day: Stop doing unnecessary tasks

Author

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Learning objectives

- 1. Get rid of stupid stuff (GROSS) and recognize several tasks that are unnecessary in your daily work.
- 2. Identify how to assist your teams to find timesaving opportunities and stop overinterpreting rules.
- 3. Save hours each day by implementing simple changes under your control and make the case for cultural change to leadership.

Project objective/background

Almost ¹/₂ a physician's day is spent performing tasks that do not require an MD/DO degree. Addressing burnout, wellbeing, inefficiencies, and cultural change require time. Physicians are familiar with the additional tasks required of them since adopting EHR systems. The urgency to find time to address meaningful and more structured interventions has been magnified by the COVID pandemic. Given current labor shortages the focus must be on removing unnecessary work in order to get back to 'doctoring'. The vast majority tasks are under your local control. The AMA has developed a Saving Time Playbook to guide physicians to identify and reduce these unnecessary tasks, avoid overinterpretation of regulations and implement efficient workflows. The playbook highlights STEPS Forward actionable toolkits, the AMA Deimplementation Checklist, and the debunking regulatory myths resource.

Session plan, description and timeline

The purpose of this workshop is to:

- Stop doing unnecessary tasks and duplicative work that prevent physicians from meaningful work. Reduce EHR burdens, including the inbox and patient portal, by going 'upstream' and eliminate the messages that do not need to be routed to the physician's the EHR inbox.
- 2. Incorporate practice fundamentals such as pre-visit planning, pre-visit lab testing, team documentation, expanded rooming and discharge protocols, and

streamlined prescription, which collectively can save several hours each day.

3. Make the case to leadership by demonstrating the ROI, with improved financial and quality outcomes, patient access and satisfaction and care team well-being. Tailored communication strategies will be shared.

Timeline:

(5	min
	(5

- GROSS (Getting rid of stupid stuff) (10 min)
 - Overview and examples from the AMA De-implementation Checklist
 - Small group breakout to identify unnecessary tasks in their day and report back
- Incorporate Practice Fundamentals
- Small group breakout (Each group (20 min) chooses 1)
 - Annual synchronized prescription renewal
 - Pre-visit labs and planning
 - Team based care and documentation
 - Report back to larger group solutions to implementing 1 fundamental
- Make the business case (10 min)
 - Overview of STEPS Forward calculators
 - Examples of tailoring messages to varied in house audiences (IT, compliance, c suite etc.)
- Panel questions and discussion
 (15 min)

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A strategic approach for GME Programs to identify, implement and assess system-based interventions to improve physician well-being

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Learning objectives

- 1. Approaches to assess specific drivers of burnout within the clinical learning environment.
- 2. Systems-based interventions to mitigate burnout within the clinical learning environment
- 3. Measures of impact of systems-based interventions

Project objective/background

To support the COVID related well-being needs of residents and fellows, a multidisciplinary national monthly virtual meeting of GME Well-being representatives was established in March 2020. Meeting format includes guest speakers, small group breakout discussions, group reportouts and topic-specific external workgroup formation. The content has broadened beyond pandemic-specific issues, with a current focus on implementing effective systems-based well-being interventions that can be shared and applied to meet program specific needs. This group adapted the Plan-Do-Study-Act (PDSA)¹ cycle, creating a guide for GME programs to implement well-being improvement interventions directed at systems-based drivers of burnout. **NOTE:** This guide is currently being developed and has therefore not been evaluated, and a final work product will be available in September 2022. Materials developed will be used in the workshop and distributed to participants.

Session plan, description and timeline

The session will be conducted in three 15-minute working segments focused on 1) assessing needs, 2) implementing systems-oriented interventions and 3) measuring impact. Each topical segment will include a brief overview, specific examples from the GME well-being group, and small group sessions for participants to discuss ongoing or potential applications of this model within their local environment. Sharing examples following the PDSA process, allows for further adaptations, perpetuating the cycle of process improvement.

limeline	
Background	5 min.
Introduction: <i>Assessing Needs</i> • Holistic measures of burnout and well-being • Specific actionable assessments (quantifiable vs. group process assessment)	5 min.
Small Group Discussion	10 min.
Introduction: <i>Implementing Interventions</i> • Targeting interventions to meet systems level needs as identified by assessments (with examples)	5 min.
Small Group Discussion	10 min.
Introduction: <i>Measuring Impact</i> Review of potential measures of impact with focus on existing data sources. Measures of leading indicators of burnout and well-being (with examples). 	5 min.
Small Group Discussion	10 min
Questions & Answers	10 min
TOTAL:	60 min.

References

1. Plan-Do-Study-Act (PDSA) Worksheet | IHI - Institute for Healthcare Improvement

Am I flourishing? Fortifying the domains for clinician well-being

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Learning objectives

- 1. Describe and assess the six domains of individual flourishing and six domains of community flourishing.
- 2. Compare resources aimed at enhancing clinician well-being.
- 3. Develop an action plan to improve individual and workplace flourishing by integrating applicable resources in their personal lives and bringing resources to their institutions respectively.

Project objective/background

Amid societal instability that has dominated the lives of Americans in recent years from civil unrest from racial strains¹ and the novel coronavirus pandemic,^{2,3} the health and well-being of medical providers are in jeopardy. The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."⁴ Declining well-being in clinicians has detrimental clinical and organizational impact via clinician burnout, languishing, and suffering.⁵⁻⁷

As one's well-being is complex and multifaceted, it is important for clinicians and trainees to readily identify which aspects of their well-being are waning and be familiar with resources available to fortify those facets. Our workshop aims to assist participants in assessing their state of personal and professional flourishing (a deeper conception of well-being)⁸ by utilizing the Secure Flourishing Index⁹ and the Workplace Community Wellbeing Measure.¹⁰ Participants will readily identify weaker domains of their personal and professional well-being, and learn of resources, strategies, and best practices to improve their well-being during this workshop. We will use improvisational theater and communication exercises to facilitate collaboration amongst participants to find common ground on the resources most applicable to them and equip them with strategies to bring such resources back to their respective institutions.

Medical improv, which is an application of theater arts improvisation, is emerging as a promising approach in medical education, including among health care students. The improv process – based on active listening, connectedness, and spontaneous collaboration with others – requires empathy and willingness to adjust one's own communication to meet another's needs and foster a clear and accurate exchange of information. Such skills are critical for effective communication among interprofessional healthcare teams. In the last few years, reports have demonstrated the positive effects medical improv training has on confidence in communication, and the ability to effectively deliver messages to colleagues and patients.¹¹⁻¹⁵ Effective team communication among healthcare workers is critical to ensure a thriving resilient workforce and support equitable, culturally competent, and effective healthcare delivery.

This workshop is open to and relevant to all clinicians and trainees, irrespective of level of clinical experience.

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Creating a SAFER workplace culture through trauma-informed leadership

Co-authors

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Learning objectives

- 1. To reframe burnout as chronic complex traumatic stress
- 2. To list the sources of workplace trauma in healthcare
- 3. To reflect on how trauma may show up in ourselves, teams, organizations
- 4. To list the SAFER leadership principles to create trauma informed workplaces
- 5. To reflect on ways you can embed SAFER leadership principles into each interaction, each team and organizational policies, procedures and protocols

Project objective/background

The world has experienced a collective trauma through the COVID pandemic. There is particular concern for the longterm impact to healthcare workers who have been serving on the frontlines through this pandemic. Compared to other professions, physicians already demonstrated disproportionally higher rates of burnout, depression, and suicidal ideation before the pandemic. This was already a workforce impacted by trauma/experiencing traumatic stress. Further mental health impact and workforce shortages are predicted amongst healthcare workers postpandemic. In most healthcare systems, there is a lack of awareness and recognition of the role trauma plays at the individual, team, and system level (patient safety, health equity, quality, cost). This workshop introduces leaders to new trauma-informed leadership skills to foster recovery, build wellness and promote post-traumatic transformation in the healthcare workforce.

This workshop is based on What? So What? Now What? facilitation tool that helps groups reflect on a shared experience in a way that moves participants from shared understanding to action. This will be an interactive session with multiple opportunities for engagement throughout.

About your facilitators

Jodi Ploquin is a certified workplace traumatologist, with additional certifications in adult learning and design thinking. Jennifer Williams is striving to be a traumainformed and compassionate physician leader who has sat on provincial and national panels related to physician wellness, and is a certified physician wellness officer through Stanford. Both are PROSCI certified change management practitioners.

Empowering health care professionals to be local change agents: Implementing a well-being champion program

Author

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Learning objectives

- 1. Understand the role of a well-being champion program in organizational efforts to improve well-being
- 2. Identify common barriers to implementation of a well-being champion program and design strategies to overcome them
- 3. Apply a design thinking approach to problem solving

Project objective/background

Well-being champion programs are a potent tool for raising awareness about clinician well-being, addressing locallevel pain points, and giving clinicians a voice in shaping institutional well-being strategy. When empowered with well-being data and the support of leaders, local well-being champions are ideally positioned to act as change agents, given their familiarity with the front-line experience and the credibility they enjoy among their peers. Well-being champion programs have been successfully implemented at the four institutions represented among the workshop facilitators and have been associated with increased attention to well-being and implementation of local-level well-being improvement projects.

Session description

Participants will have the opportunity to learn from experts who have successfully implemented well-being champion programs, as well as from their fellow workshop participants through participation in small groups. Participants will practice using a design thinking approach to develop strategies for overcoming challenges in the process of implementing a well-being champion program. Participants will leave the session with a clear road-map of how to implement a well-being champion program, how to overcome common challenges, and how to apply a design thinking approach to problem solving.

Торіс	Activity	Time
Introduction to session	 Facilitator introductions Participants use Mentimeter to share their hopes for the workshop and questions they would like the facilitators to address 	
Facilitators present on their well-being champion programs	 Facilitators share narratives of the development of their institution's well-being champion program, focusing on the 3-4 most salient learning points 	
Introduction to design thinking	Brief didactic on the design thinking approach to problem solving	3 mins
Crowdsourcing anticipated challenges	 Participants use Mentimeter to identify the challenges that they anticipate in implementing a well- being champion program at their institution The most common challenges are identified via a Mentimeter word cloud 	5 mins
Small group formation and introductions	 Participants form groups of 5-7 Each group is assigned one of the crowdsourced challenges Group members introduce themselves 	5 mins
Design thinking session	 Small groups brainstorm solutions to their assigned challenge and decide which solution they would most want to prototype 	
Report-out	Groups share the solution they designed to their assigned challenge	10 mins
Q&A and wrap-up	•Return to original Mentimeter question about hopes for the workshop •Workshop facilitators address questions that have not been answered and invite new questions •Participants receive well-being champion job description and well-being champion program best practices handouts	10 mins

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First steps in transforming culture in well-being: Selecting evidence-based interventions to promote an environment of well-being

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Learning objectives

- 1. Identify current organizational activities that support physician well-being
- 2. Identify an existing need (gap) in physician well-being at your institution
- 3. Discuss evidence-based interventions that can promote well-being
- 4. Develop a customized mini change plan to promote cultural change and clinician well-being in your workplace

Project objective/background

Transforming culture to positively impact well-being requires organizational efforts, careful strategies, and appropriate change management planning.¹ A strategic plan is developed by identifying the gap between the current state and the optimal state to understand and evaluate organizational needs. Strategies to meet a gap should focus on specific organizational challenges, opportunities, and goals.

Many frameworks can help engender cultural change to improve workplace well-being, and we have selected Shanafelt's blueprint.1 It includes four components: foundational programs (evidence-based interventions), cultural transformation, rapid iterative experimentation, and sustainability. We have selected the first two for this workshop.

- 1. Cultural transformation is a multifaceted approach that includes leadership behaviors, building coalitions, and building a network of change agents as drivers of cultural change. These drivers must be part of operational decisions and modeled by leaders to make successful change(s) in physician well-being.²
- 2. The authors recommend that feasible and evidencedbased interventions (i.e., foundational programs) be implemented in healthcare organizations to promote well-being. Key dimensions include leadership development,³ deliberate approaches to promote collegiality and community⁴ and identifying workplace factors that "irritate" physicians.

In addition to the blueprint, which outlines organizational well-being components, a consistent approach can help align efforts. We discuss the Quality-of-Life Improvement (QOLI) approach, a novel step-by-step approach to operationalize well-being that incorporates principles of human-centered design, quality improvement, and implementation science.⁵

Methods/approach

This 60-minute workshop focuses on guiding participants to utilize the Shanafelt blueprint to identify a local need related to well-being in their own work environment and the QOLI approach to develop a mini-plan for an intervention to build cultural change to support wellbeing. The handout will include basic principles, tools from workshop activities, and resources.

Results

Participants will generate a mini change plan to improve their own workplace culture with the intent to implement an intervention using a QOLI approach to enhance well-being.

Conclusion

Transforming culture to positively impact well-being requires organizational efforts, careful strategies, and appropriate change management planning. Local well-being efforts can be successful using the Qualityof-Life Improvement (QOLI) approach, a novel stepby-step approach to operationalize well-being that incorporates principles of human-centered design, quality improvement, and implementation science.

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Go to Rome—a journey of physician well-being. A practical toolkit to recognize burnout and enable physicians to not just survive but thrive

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Learning objectives

- 1. Recognize signs of burnout in self and teams
- 2. Learn evidence based practical interventions to prevent burnout and improve joy, meaning and purpose at work at both individual and system levels
- 3. Understand the role of NHS Practitioner Health, a confidential mental health and addiction treatment service in England and Scotland.

Project objective/background

Evidenced based and practical tips and tools to prevent burnout and improve wellbeing focusing on each of the 5 ways to wellbeing identified by the New Economics Foundation that can be applied within the physician's workplace- Connect, take notice, Be active, Learn and Give.

An energetic, positive and fun workshop that utilizes music, humor and audience interaction. The audience will be facilitated to recognize their own signs of burnout and will participate in practical demonstrations of wellbeing interventions from each of the 5 key areas of wellbeing. The research demonstrating a positive effect on health and wellbeing will be considered for interventions such as kindness and civility, strengthening team connections, mindfulness, physical activity, gratitude and cultivating joy and meaning at work and their application into the workplace demonstrated.

Session plan, description and timeline

The overall plan for the session is to recognize signs of burnout in physicians and learn practical wellbeing strategies and tools that can be utilized to prevent burnout, cultivate joy and promote positive wellbeing in the workplace.

The workshop will conclude with a summary of the NHS Practitioner Health Program, a confidential mental health and addiction treatment service for physicians, dentists and other health care staff in England and Scotland. Timeline:

- 0-5 mins Introduction, neuroplasticity experiment to demonstrate how making small behaviour changes in each of the 5 domains of wellbeing can change neural pathways in the brain
- 5-10 mins Recognising signs of burnout in ourselves and others (interactive poll)
- 10-40 mins 5 ways to wellbeing with interactive examples, e.g., civility saves lives movement, mindfulness and impact on physician burnout and patient relationships and goal setting
- 50-60 mins Questions

This workshop has been successfully delivered to over 3000 healthcare professionals at local and national level to consistently excellent qualitative feedback.

'This should be mandatory training for all healthcare staff'

---Consultant paediatrician, Nottingham UK

Harnessing artificial intelligence to assess the climate of institutional wellness

Author

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Learning objectives

- 1. Define artificial intelligence and its potential use within organizational wellness.
- 2. Identify how artificial intelligence can capture metadata to assist in determining overall organizational wellness.
- 3. Share and discuss ways to use artificial intelligence in medical institutions

Project objective

Artificial intelligence tools can leverage daily interactions within a health institution to assess wellness climate. The attendee will be able to demonstrate through interactive learning the creation of an artificial intelligence chatbot that can be applied to enhance the participant's own organizational wellness through a demonstration of Microsoft's Power Virtual Agents.

Background

Over the last year we have seen artificial intelligence (AI) move to the forefront of virtual healthcare, including assisting with operational sustainability for many organizations throughout the pandemic. Healthcare institutions realized the power of AI and information provided through its captured metadata. Through the userfriendly build of AI Chatbots, organizations can evaluate their employees needs through basic conversational interactions during resource support and help desk functions. AI Chatbots can assist users in finding pertinent information while capturing individual sentiment, and a ground level pulse on user well-being during the interaction. By embedding chatbots within daily practice operations and services, pulse assessments of climate can be assessed with changes in operations, policy, or new service roll-out. Al can provide a 24/7 non-biased outlet for employees to safely express their needs and seek out organizational resources while simultaneously providing executive leadership with wellness climate information about the success or challenges of operational, policy, or service changes so that they can be responsive to the wellness needs of their employees.

Approach and results

- 1. **Engage** 10 minutes- Presenter introduction, definition of AI and metadata, and interactive handson demonstration of the seamless use of artificial intelligence one participant available technology (ex, cell phone, tablet, laptop). Divide participants into breakout groups.
- 2. **Plan** 15 mins- Using Plan-Do-Study-Act-Cycle process, breakout groups will discuss potential scenarios where Al can be implemented in their organizations and potential obstacles to deployment.
- 3. **Create** 15 min- To engage all attendees, generate innovative ideas about data capture, and inspire discussion and collaboration, breakout groups will decide on one item they would like their chatbot to capture. The teams will present their structured Al questions, the metadata they want to capture, and the potential use of the information.
- 4. **Analysis and feedback** 15 mins- The audience will re-group to synthesize the captured metadata, discuss what it means and how it can help inform climate and influence programming and planning from a wellness perspective.

Conclusion

Artificial intelligence tools are a potential way to leverage daily interactions to assess changes in wellness climate in real-time.

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Helping leaders address well-being through people-focused strategies

Author

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Learning objectives

- 1. Participants will develop a deeper understanding of how they can support leaders at their organization to cultivate a culture of well-being.
- 2. Participants will identify leadership competencies that support a culture of well-being.
- 3. Participants will discuss how to help leaders use a values framework and an authentic voice to support strategic aims of their organization.

Project objective/background

Part of the work of a well-being champion is to help leaders understand frameworks of professional and personal well-being for health care workers, what interventions are likely to improve that well-being and how the leader's words and actions supports or detracts. While leadership skills predict the well-being of groups, many leaders in healthcare lack formal leadership training. When training occurs, it is often haphazard without clear competencies or measures of success. When language is provided to leaders by well-being experts, it can often fall flat if not delivered with an authentic voice of the leader.

Methods/approach

This workshop is designed for participants to actively consider what leadership competencies best support health care workers, how to help leaders develop an authentic voice when addressing well-being, and to consider how a values-based framework can help organizations move towards creating a culture of wellbeing that embraces a people-focused strategy.

This workshop will briefly review how a well-being leader can support executive leaders in healthcare, such as chief medical officers or department chairs, using specific skills that are most likely to impact professional well-being.

Results

Participants will reflect on when they have seen leaders be highly successful in supporting a culture of well-being. After a brief overview of a values framework, participants will reflect on their own values and the values their current organization espouses vs. what they act on.

Conclusion

Well-being leaders will be most successful when they engage in cultural transformation alongside system design and personal well-being approaches.

How to help physicians get mental health care: Change the system

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Learning objectives

- 1. Understand the six key structural barriers that prevent physicians from seeking the mental health care services they may need and deserve.
- 2. Explore how your institution can address the six structural barriers to mental health in a transparent, measurable way.
- 3. Equip your physician workforce on how to quickly access the resources they may need to navigate a moment of crisis.

Project objective/background

Over 6 in 10 physicians (62%) report experiencing feelings of burnout. When left untreated, burnout can cause more cases of depression, anxiety, post-traumatic stress disorder (PTSD) and substance use, and lead to suicidal thoughts for physicians, directly impacting physician suicide rates. Yet only 19% of physicians report seeking medical attention for their mental health symptoms. Many don't seek mental health care due to fear of negative consequences in the workplace, including retribution, exclusion, loss of license or even their job. This culture must change. Throughout our journey to support physician wellbeing, we identified six structural barriers that play a role in inhibiting physicians from seeking and obtaining mental health care. And they all start with our nation's health care system.

Session plan, description, and timeline

During this workshop, participants will learn about the six key structural barriers that prevent physicians from seeking the mental health care services they deserve—state medical licensure and renewal applications, hospital and health system privileging and credentialing applications, commercial insurance credentialing, malpractice insurance applications, legal discovery process during lawsuits and mental health insurance requiring treatment where the physician works. Through group work, participants will also explore how their own institution can address the six structural barriers to mental health in a transparent, measurable way, including circulating their institution's and state's facts on each of the structural barriers. Participants will additionally learn how to equip their physician workforce on how to quickly access the resources they may need to navigate a moment of crisis. For example, a Personal Crisis Management Plan for Physicians offer physicians a personalized, stepby-step plan to set themselves up for success in the event of a mental health crisis. In one study, nearly 60% of participating residents agreed that the tool would help them manage a crisis; and nearly a third of the participating residents (31.8%) indicated that they had used their personal plan within the first three months of their internship.

Specifically:

- Co-authors present six structural barriers (provide handout overview to participants) and resources to help physicians navigate a moment of crisis (provide handout of personal crisis management plan) – 15 minutes
- Breakout groups discuss experiences with barriers, how to best address barriers via working through the Licensure & Credentialing toolkit of Audit, Change and Communicate (provide toolkit to participants) for their institution and approaches to integrate prevention resources like personal crisis management plan into their institution – 30 minutes
- Report out from breakout groups and discussion with co-authors 15 minutes

One hundred six years of physician health research—our key lessons and some next steps forward together

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Learning objectives

- 1. Learn about senior physician health researchers' experiences with flops, combating resistance, and creating key successful innovations in their work on physician health
- 2. Consider factors that contributed to success versus failure of previous efforts to inform future innovations to maximize impact
- 3. Co-identify teams to pursue these new physician health research areas together after ICPH

Project objective/background

In this workshop, we will discuss learnings from our cumulative 106 years of physician health research – key lessons from successes, pushbacks, and failures – and discuss their applications to identifying next research steps forward together.

These five presenters cumulatively have 106 years of physician health research. In this workshop, they will highlight their most important findings, the techniques/ successes/failures that led to those findings and lead a discussion of next research steps together.

Session plan, description and timeline

90-minute Workshop Plan/Timeline

8-Minute each presentation of key research successes, failures, pushback, techniques, and findings:

- Frank-30-years:
 - Lessons-From-Failure:
 - Persist if that's where the data lead you
 - Individual-level education is rarely maximallyefficiently beneficent – co-founded APTP to reduce addictive disease in physicians and patients
- Lessons-From-Success
 - Scale wherever you can founded NextGenU.org, now used in every country, to improve physician health and democratize education;
 - There's a strong, consistent Healthy Doc = Healthy Patient link

- You can change national/global (WMA) policy with data (including national studies of physicians/physicians-in-training in America, Cambodia, Canada, Colombia, Israel, & Laos)
- Even the addiction pandemic can be addressed with a physician health focus (data from Annenberg Physician Training Program in Addiction Medicine)
- Study/follow Ikigai
- Tyssen-25-years:
 - Lessons-From-Failure:
 - Previous funding and publications don't guarantee more funding – think new/original
 - For grant-writing, allocate enough time, and aim precisely and right-levelled for your situation
 - Funders aren't necessarily familiar with poorwellbeing among physicians
 - se pre-validated instruments
 - ◆ Lessons-From-Success
 - Invest in high response rates
 - Longitudinal research is still needed
 - Use statistical tools knowledgeably
- Shanafelt-22-years/Presenter Four-10-years
 - Lessons-From-Failure
 - Choose a project that is well aligned with interests
 - Avoid work in crowded space (not clearly needed by society), where many others competing for limited grant funding dollars
 - Lessons-From-Success

- Address something clearly needed by one's own institution/others
- Build on a good foundation of previous work, while adding sufficient novelty to constitute meaningful/valued contribution
- Invest time/\$ in validating new measures
- West-19-years:
 - Lessons-From-Failure
 - Lessons from failed trial of online intervention for job satisfaction and well-being
 - Lessons from multiple failed efforts to extend a sustainable organizational well-being infrastructure
 - Lessons-From-Success
 - Use, study, and refine measurement tools
 - Optimally apply methods training to allow complex statistical methods to inform study

design and analyses (from longitudinal study of resident well-being)

- Link well-being to diverse outcomes and compare across disciplines (within and outside of medicine) to demonstrate impact – answering the "so what" question
- Extend partnerships to national organizations and beyond physicians to expand generalizability

20 minutes – Collective discussion about new research areas

30 minutes – Break into small groups to discuss individual research areas and make plans for post-ICPH follow-up (depending on # of collective projects identified, may even do two 15 minute sessions).

Reparative crisis support: An evidence informed model providing practical tools towards a culture of psychological safety and well-being for patients, health care professionals, their families and organizations

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Learning objectives

- 1. First international presentation of trauma informed appreciative inquiry support for colleagues exposed to overwhelming events
- 2. What do we do together when we no longer should debrief: a model with practical tools
- 3. How we, with minimal changes, trauma inform our patient safety and support processes that already exist

Project objective/background

The workshop described below has been interactively developed between clinicians, researchers, leaders, and Swedish national physician federations. It is incorporated into several national educations for residents, senior physicians, and healthcare leaders. It has been one of the most appreciated workshops, both within the national course for modern crises-support and the course for sustainable healthcare.

The workshop offers:

- A short presentation of recommendations and practical tool for individual and clinic wide application: A first international presentation of trauma informed appreciative inquiry support for colleagues exposed to overwhelming events. What we do together when we no longer should debrief. How we, with minimal changes, trauma inform our patient safety and support processes that already exist.
- An interactive simulation exercise aimed at using the specific practical skills presented. The exercise includes a narrative component hoping to wake deeper insight into how a slight change in our immediate care of colleagues could improve the workplace culture towards increased psychological safety, well-being and quality of care.

Preworkshop video in English will be available but not a prerequisite for participation. Several English Language handouts will be provided

Session plan, description and timeline

20 min presentation: The overall project. High points from presentation with main focus on window of tolerance and trauma informed appreciative inquiry questions. Preworkshop link will be provided for anyone interested. Components from acclaimed apology and second victim programs are merged with Window of tolerance, Mindful trauma informed questions and Appreciative inquiry.

20 min narrative exercise where all participants practice using the trauma informed appreciative inquiry questions. Laminated handout provided as exercise support and takehome material. Course instructors go around to support the participants to actually use the new skills, instead of falling back into habitual patterns.

10 minutes reflective dialogue to deepen the learning and cross-learn from each other's experiences doing the exercise.

• A question and answer period.

Staying empowered while advancing an organizational culture of well-being

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Learning objectives

- 1. Describe personal and operational challenges faced by wellness leaders in healthcare organizations
- 2. Describe a "Power Pause" model of strategies for wellness leaders to maintain their own well-being and efficacy as they advocate for culture change
- 3. Discuss this model's practical applications

Background

Leaders in health professional well-being such as Chief Wellness Officers (CWOs) in the US are both relatively new and tasked to advocate for systems approaches to promote cultural change in healthcare organizations. Attempting to change culture especially while crafting a new position and being a member of this culture is daunting. In this workshop, CWOs from 4 US healthcare organizations will candidly discuss their challenges. They will share a model of personal and operational strategies they employ to maintain their own well-being and efficacy as they engage their organization in culture change.

Session plan, description and timeline

10 minutes: Introductions; description of an empowering and goal-oriented model to navigate leadership challenges; moving from stress/reaction to success/response via a "Power Pause" mnemonic: Mindfulness (self-awareness, thoughts and feelings as information, acceptance), Meaning (knowledge of personal mission and purpose), Mindset (cultivating growth and managing unhelpful thoughts, perseverance), Mastery (committing to action, work boundaries, sense of self-efficacy and control through practice), Mattering to others (connecting/communicating/ collaborating with a caring community), Me time (rest, reflection, recharging, and self-care); practical applications of the model in healthcare settings.

20 minutes: Groups of 5-8 participants will discuss one of 3 vignettes (summarized below) of real-life challenges encountered by wellness leaders. Using the "Power Pause" model and mnemonic, participants will reflect on their

reactions and identify approaches and strategies needed to respond to the challenge.

Vignettes:

- 1. You are introduced as such to faculty by a department chair: We have a new CWO. I didn't approve of this position, but let's hear what he/she has to say".
- 2. You notice that the physicians in a work unit are frequently distressed about the work environment. You find out that, at one meeting in which you were not present, a hospital leader indicated that the new "wellness leader" will "take care of all these problems".
- 3. You're starting to feel discouraged and disillusioned about the challenges of work. Some days you don't feel like working at all. Specifically, you're not feeling effective with executive leadership.

15 minutes: Facilitated discussion of group reports on participants' reactions and responses to the challenges using the model.

15 minutes: Panel and questions. Facilitators candidly share their journeys and personal/professional development in context of the challenges of promoting cultural changes in healthcare and enacting the "Power Pause" model, including their own self-talk, thoughts/ feelings, reframing, boundary setting, plan execution, connections, self-care and reflections.





A departmental approach to improve well-being in a large health system

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Learning objectives

- 1. Define the key domains of a workplace well-being framework used at a major academic medical center.
- 2. Describe the process for engaging with departmental leadership to address faculty well-being.
- 3. Detail the organizational responses that align with the key domains of workplace well-being.

Project objective/background

Until recently, there has been no standardized, systematic approach to assessing and addressing faculty workplace well-being at the departmental level at our organization. The goals of this initiative were to (1) create a novel framework for viewing existing engagement survey questions through the lens of workplace well-being, (2) use that framework to organize results at the departmental level, and (3) select a departmental goal and target resources for improvement more effectively.

Methods/approach

The organization's Wellness Office selected six key domains of workplace well-being, derived by reviewing the research literature and analyzing internal survey data. Key domains are work-home flexibility, psychological safety, professional fulfillment, feeling valued, leadership connection, and burnout. We added custom well-being and burnout driver questions to an existing organizational engagement survey conducted in 2021. Questions were rolled up under each domain for analysis. One guestion was selected as a key indicator to represent each domain of well-being. Individual department faculty data were compared against all clinical or all basic science departments within the organization and against national benchmarks where available. The Wellness Office offered to meet with each department Chair using this framework to review the wellbeing data, recommend targeted resources, and guide leaders in selecting a single well-being goal to pursue in the next year.

Results

The response rate for the 2021 faculty engagement survey was 75% (n=2,466). Forty-one percent of all faculty reported feeling balanced between work, family, and personal growth (work-home flexibility); 64% felt there was a climate of trust in the organization (psychological safety); 65% felt treated with respect (feeling valued); and 53% reported one or more symptoms of burnout. Connection to department leaders scored more favorably in comparison: 75% of faculty felt their department chair, division chief, or administrator addressed their concerns. Despite these challenges, 82% of faculty felt they were contributing professionally in the ways they valued most (professional fulfillment). In general, the basic science departments tended to score more favorably compared to the clinical science departments. Burnout ranged from 28 - 75% across departments; overall burnout levels remain higher than pre-pandemic. To date, the Wellness Office has met with 6 of 9 basic science departments and 18 of 20 clinical departments.

Conclusion

Sharing data through the lens of workplace well-being using a standardized language and framework while systematically partnering with departmental leadership has enabled our organization to address faculty well-being in a coordinated, structured format for the first time.

A holistic framework for medical learner well-being: A catalyst for cultural change

Author

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Project objective/background

Medical learners include learners within a range of programs housed within medical schools. These programs include undergraduate health sciences education, graduate sciences education, undergraduate medical education and postgraduate medical education. The notion that medical learner wellbeing can decline during training is prominent in the literature however, most wellbeing interventions focus on individual level strategies and often address intellectual and occupational wellbeing, focusing specifically on skills related to learning and working. Poor wellbeing can affect medical learners across the continuum of learning. An evidence-based holistic framework that could catalyze cultural change through research and scholarship has yet to be established. We sought to develop and validate a framework for medical learner wellbeing in the context of medical education, health sciences and health professions education more broadly based on theory, systems thinking and empirical research.

Methods/approach

We used pragmatism as the theoretical construct for our research approach to explore medical learner wellbeing in their training and practical functioning. We conducted a series of studies including an environmental scan, scoping review, needs assessment surveys and individual interviews to understand the construct of wellbeing in medical learners, to validate the construct and create an evidence base for a holistic framework for medical learner wellbeing research. Exploring how individual, programmatic and systematic impacts of medical learner wellbeing from the context of learning common to all medical learners was the impetus for the framework validation.

Co-authors

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Results

Findings from an environmental scan, scoping review, needs assessment surveys and individual interviews together elicited four main areas for quality improvement in medical learner wellbeing: 1) Medical learner wellbeing is a multifaceted construct; affected by individual, programmatic and systemic influences; 2) A one-sizefits-all approach to medical learner wellbeing may be counterproductive; 3) Intersections exist between mental, physical, social, intellectual and occupational wellbeing; and 4) Ethical principles such as autonomy, respect, beneficence/non-maleficence and justice necessitate consideration. These areas in turn may modulate trainee experience and the culture of the institution.

Conclusion

A holistic framework for medical learner wellbeing based on theory and empirical research may assist in culture change of an institution with upstream, midstream and downstream effects in medical learner wellbeing and public health more broadly. Considerations of the individual, programmatic and systemic impacts across the five domains of wellbeing (physical, mental, social, intellectual, occupational) could assist in evidence-based curriculum development, competency-based assessment, program evaluation, disaster planning, equity, diversity and inclusion initiatives as well as continuous quality improvement initiatives.

A longitudinal study of burnout in health care workers in New York City during the COVID-19 pandemic: The impact of work stressors, perceived support and optimism

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Learning objectives

- 1. To describe the burnout trajectories of frontline healthcare workers during the first year of the COVID pandemic in NYC.
- 2. To delineate demographic, occupational, Covid-related, coping and psychosocial factors that impacted the burnout trajectories of frontline healthcare workers in NYC.
- 3. To demonstrate which factors most correlated with persistent and new-onset burnout symptoms in frontline healthcare workers in NYC during the first year of the COVID pandemic.

Project objective/background

Previous literature demonstrates increasing rates of burnout in Frontline Health Care Workers over the course of the pandemic, but little is known about the factors that influence this rise. We examined longitudinally the prevalence and determinants of burnout in frontline healthcare workers (FHCWs) during the COVID-19 pandemic in New York City (NYC).

Methods/approach

A prospective cohort of FHCWs at a large NYC Hospital were surveyed initially during the first COVID-19 surge in April-May 2020 (T1) and again between 11/2020-01/2021(T2). Burnout (Mini-Z), demographics, occupational stress and support, exposures to COVID-19, coping strategies, and psychosocial characteristics were assessed. Four courses of burnout from T1 to T2 were identified: none, remitted, persistent, and new-onset. Multinomial logistic regression and relative importance analyses were performed to identify factors associated with symptomatic courses of burnout.

Results

Of 2,579 FHCWs analyzed in T1, 786 (30.5%) completed the T2 survey. Burnout increased from 38.9% (T1) to 44.8% (T2) (p=0.002). Among this group, 222 (28.3%) experienced persistent burnout; 129 (16.5%) new-onset burnout 82 (10.5%) remitted burnout; leaving 350 (44.7%) who experienced no burnout at either timepoint. Relative to FHCWs without burnout, those with persistent burnout were more likely to screen positive for pre-pandemic burnout (relative risk ratio [RRR]=6.67), feel less valued by supervisors (RRR=1.79), and have lower optimism (RRR=0.82) at T1. FHCWs with new-onset burnout were more likely to screen positive for pre-pandemic burnout (RRR=1.75) and report caring for patients who died of COVID-19-related complications at T2 (RRR=3.12). Relative to FHCWs with remitted burnout, those with persistent burnout were more likely to report pre-pandemic mental illness (RRR=2.27), have lower optimism (RRR=1.22), and report difficult decision-making in managing COVID-19 patients at T2 (RRR=4.57).

Conclusion

FHCW burnout increased over the course of our study, largely driven by COVID-19-related and morally distressing experiences, pre-pandemic burnout, mental illness, lack of feeling valued by supervisors, and low optimism. These findings contrast with the decline in psychological distress (depression, anxiety, and/or PTSD symptoms) observed in the same cohort. Ongoing research is needed to evaluate the effectiveness of both individual and organizational prevention strategies and treatment efforts to help mitigate the burden and adverse consequences associated with burnout in FHCWs.

A three-year initiative to improve wellness in a large, multidisciplinary behavioral health department across healthcare practice settings

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Learning objectives

- 1. Multimodal and iterative assessments are crucial in ensuring that clinicians' voices are heard, and wellness initiatives target the right priorities for improvement.
- 2. Efforts to change culture need to be both bottom up and top down.
- 3. Attempts to improve the well-being of clinicians need to include all team members.

Project objective/background

The Department of Child and Adolescent Psychiatry and Behavioral Sciences (DCAPBS) at a large pediatric academic quaternary care center is comprised of a large multidisciplinary group of clinicians (n=198), including psychiatrists (MDs; N=39), psychologists (PhD/PsyD; N=128), licensed clinical social workers (LCSW; N=17), nurse practitioners (N=5), licensed professional counselors (LPC; N=5), and applied behavioral analysts (ABA therapists; N=4). Clinicians practice across multiple healthcare settings, including inpatient, outpatient, emergency, specialty care, and primary care. The objective of this wellness initiative was to identify and address challenges to wellness and contributors to burnout in DCAPBS.

Methods/approach

A multidisciplinary wellness committee was convened with representation across practice settings. Multimodal well-being assessments were performed iteratively over the past three years, including surveys, qualitative interviews, and facilitated team-based discussions with and without leadership present. These assessments informed interventions to address priorities for improvement.

Results

In the domain of culture, priorities for improvement included leadership support, communication, recognition, control of schedule, and cultivation of community. In the domain of practice efficiency, priorities included staffing, workflow, and documentation efficiency. Several interventions were then implemented. To improve communication, bi-weekly town halls, a weekly newsletter, and a wellness website were developed. Opportunities for recognition were created at both the team and departmental level, including a "Good News!" agenda item during meetings where accomplishments and positive patient comments are shared. Clinicians have been given more flexibility to tailor their schedules. The Professional Engagement and Development Initiative (PEDI) was initiated, offering clinicians the opportunity to present about their areas of expertise, and peer support groups were launched. Additional clinical support staff were hired and two quality improvement projects were undertaken to improve workflow and documentation templates.

Between 2019 and 2021, wellbeing measures improved among physicians: the average burnout score improved from 3.01 to 2.84, the average professional fulfillment score improved from 5.69 to 6.46, control over schedule improved from 3.68 to 4.49, organizational/personal values alignment improved from 5.02 to 5.50, and self-valuation improved from 5.18 to 4.74. The other department members were surveyed for the first time in 2021 with a plan to reassess these domains in Spring 2023.

Conclusion

For clinicians to feel heard and empowered in the process of wellness improvement, it is crucial to adopt an iterative and multimodal approach to gathering feedback. This participative approach facilitated successful interventions to improve culture and practice efficiency in a large and diverse behavioral health department.



Addressing systems and cultural drivers of well-being through a multi-residency elective

Author

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Learning objectives

- 1. Design interventions to address organizational and cultural drivers of well-being using process improvement techniques
- 2. Learn how to work across disciplines to make collaborative leadership decisions for well-being

Project objective/background

Physicians experience high levels of burnout, particularly resident trainees.^{1,2} Residents have a unique view of the drivers of burnout and well-being, which are similar across medical specialties, yet residents rarely have the opportunity to collaborate across specialties. To address this, a novel multi-residency well-being elective was created in the 2020-2021 academic year.

Methods/approach

Based off a successful pilot in the Internal Medicine (IM) residency, a multi-residency elective with participants from the IM and Anesthesia residencies was created. Residents participated in didactics and completed independent, mentored project work aimed at addressing a particular systems or cultural driver of well-being in their residency program. Residents used a modified A3, a problem-solving technique based on Lean principles, to track project work. In addition, residents joined the Well-being Elective Council (WEC), a novel group comprised of elective participants, chief residents, and faculty champions that met throughout the year to determine priorities for elective work and review completed project work. WEC members used design thinking techniques to generate and select project priorities.

Results

2 Anesthesia and 5 IM residents participated in the elective. The WEC generated the following priorities for project work: 1. How might we foster deliberate connections, no longer relying on spontaneous, informal connections? 2. How might we build micro-connections in the work environment? 3. How can we expand coping and resilience during the pandemic? All residents completed project work that addressed these priorities. For priorities 1 and 2, projects included a peer support needs assessment and virtual peer support sessions, a novel calendar to identify residents with shared days off, and a residency scheduling needs assessment. For priority 3, projects included a compilation of grieving rituals to honor patients, a guide to community mental health resources, and a survey examining debriefing after adverse events and a novel debriefing tool for the Anesthesia program. All residents completed the A3. Project work was presented to the WEC and shared at the institutional committee level.

Three of the projects led to lasting systems change: the days off calendar was funded as a permanent tool; the scheduling needs assessment led to program funding to automate scheduling processes; the Anesthesia debrief tool was presented at a departmental M&M and adopted by the program.

Conclusion

Residents have a unique view of the drivers of well-being in residency. Promoting inter-residency collaboration through a well-being elective is an effective way to generate novel approaches to address resident burnout.

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An internal centralized medical disability review team to address administrative overload and physician burnout at one of the nation's largest not-for-profit health plans

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Learning objectives

- 1. To understand the advantage of a centralized medical review team in decreasing *physician time spent on *disability paperwork
- 2. To understand the advantage of a centralized medical review team in physician job satisfaction and productivity.
- 3. To understand the advantage of a centralized medical review team in applying a systematic evidence-based approach in determining medically appropriate time away from work.
- 4. To understand the advantage of a centralized medical review team in performing medical appropriateness reviews and its impact on monitoring treatment plans, decreased ill time and importance of capturing patient's voice.

*NOTE: "Physician" references treating clinicians and "disability paperwork" references FMLA, ADA, Short Term Disability, Long Term Disability and all COVID related special accommodations and requests.

Project objective/background

Doctors are expected to see patients every 20 minutes throughout a typical 8-10 hour work day. Doctors are also expected to complete complex disability forms, write narratives about a patient's abilities and limitations while simultaneously responding to multiple and ongoing requests for written attestations in support of time away from work. The pandemic added a whole new layer of complexity and time constraints to the disability realm. The impact on the doctor-patient relationship as well as the impact on professional time is significantly adding to physician job dissatisfaction and burnout. In addition, the simultaneous adverse impact of disability on productivity continues to be a major challenge facing employers, patients and physicians. Our evidence based centralized medical review process applies a comprehensive assessment of the patient's medical record in relation to time-off requests with the goal of reducing medically unnecessary ill time while capturing the patient's voice and removing the burden of disability paperwork from frontline physicians. Our emphasis on "medical ability" keeps the patient engaged in work activities when appropriate. The subsequent development of built-in EMR tools streamlines the process adding patient occupation as a necessary vital sign.

Methods/approach (PICO)

- 1. Population: Health Care organization's patient-base utilizing all forms of disability requiring time away from work.
- 2. Intervention: Establish a Centralized Medical Review Team applying medical appropriateness criteria and recommendations on behalf of the treating physician.
- 3. Comparison: No centralized medical review team
- 4. Outcome measures: Physician time saving (reduced burden on frontline physician) and satisfaction, reduction in medically unnecessary ill time and value of time loss savings.

Results/discussion

- 54-62% reduction in medically inappropriate time away from work
- Reduced burden of paperwork translates to physician satisfaction; physician time savings and more physician-to-patient face time
- 96-98% physician acceptance of recommendations by the Centralized Medical review team
- Secondary advantage: Value of time loss savings is multimillion dollars annually

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Conclusion

Results of our data analysis and physician satisfaction survey have provided the necessary evidence in support of a centralized medical review team as a quality improvement best practice across multiple regions throughout the United States. By removing the burden of non-occupational disability determinations and forms completion from the plates of our frontline physicians, we have advanced our goal of improving physician satisfaction while strengthening the patient/physician relationship, and ultimately providing a favorable impact on a physician's work life balance. Simultaneously, we have significantly decreased medically unnecessary time away from work.



Assessment of leadership strategies, barriers and opportunities among frontline physician leaders in a Federally Qualified Health Center network

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Learning objectives

- 1. Understand frontline physician leadership in an FQHC setting.
- 2. Appreciate the role that frontline physician leaders play in mitigating their teams' burnout and increasing their satisfaction.
- 3. Identify opportunities to enhance the functioning and support of those roles to benefit the workforce.

Project objective/background

Provider burnout consists of emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment, and can lead to increased institutional costs, decreased patient satisfaction, and can drive providers to leave medicine. Research has shown that higher direct supervisor leadership scores correlate with decreased provider burnout and increased satisfaction over time. It is important to understand the perspectives of these supervisors to help improve leadership and therefore the wellbeing of the provider workforce.

Methods/approach

We interviewed frontline physician leaders for their leadership strategies and barriers at Denver Health, an integrated safety net health system. We completed inperson 1:1 semi-structured interviews with 18 frontline physician leaders of Internal Medicine, Pediatrics and Family Medicine clinics (100% participation) over 8 months from February to September 2020. We solicited feedback on their approach to leadership, their training and support, opinions related to provider burnout, and ideas for improvement. Qualitative data analysis was completed using the Immersion-Crystallization method, reaching theme saturation.

Results

Frontline leader themes related to the structure of the role, challenges, and the nature of and response to their provider teams' burnout. Frontline leaders found their role mix (primary care provider plus leadership) to be meaningful and necessary, and viewed themselves as a

bridge between higher leadership decisions and frontline primary care delivery. Longer duration in leadership positions, as well as formal and informal mentoring and connection with other leaders, was related to increased confidence. There was variation in the amount and perceived value of initial leadership training as well as ongoing leader development and support. Frontline leaders also related the importance of a high-functioning clinic leadership team (with nursing and clerical leadership) and expressed frustration with a lack of connection to senior leader decision-making. They were mostly highly empathetic to the drivers of burnout among their teams, and while they utilized similar tools to assist individual providers (reducing FTE or diversifying their clinical responsibilities) they faced challenges to making progress related to structural barriers (time, workload, financial and access pressures, and others).

Conclusion

This project highlighted the challenges and opportunities unique to frontline physician leadership. Frontline leaders play a powerful role in the wellbeing and resilience of their provider care teams, and these leaders are highly engaged, with many concrete ideas for improvement. Investing in their development and support will help ensure a resilient workforce, particularly in primary care and safety-net settings.

Assessment of single sign-on technology usability and clinician workplace satisfaction

Author

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Learning objectives

At the conclusion of this presentation, participants will be able to:

- 1. Summarize usability ratings of Single Sign On versus manual log-on processes.
- 2. Describe multiple dimensions of clinician satisfaction related to Single Sign On processes.
- 3. Assess the role of Single Sign On technology to enhance efficiency in their practices.

Project objective/background

Clinicians typically log on to computers multiple times per day requiring frequent pauses to enter credentials. Poor her usability is recognized as a driver of clinician burnout.^{1,2} Single Sign On (SSO) devices allow simplified log-on processes without repetitive password entry or typing and have been recommended to improve practice efficiency.3 This study sought to evaluate usability of a SSO log-on process relative to the default manual log-on process, as well as impact on workplace satisfaction and well-being.

Methods/approach

We conducted a pre-post study of deployment of SSO devices to workstations used by clinicians in a large outpatient general medical division at an academic medical center. Participants completed the System Usability Scale (SUS), an industry standard technology measurement tool,⁴ to evaluate the prior manual log-on and SSO processes on a 0-100 scale. Additional measures included the two-item Maslach Burnout Inventory and questions about impact of SSO on multiple dimensions of workplace satisfaction. We performed descriptive and paired statistical pre-post analyses.

Results

Of 103 eligible clinicians, 59 (57.3%) and 54 (52.4%) completed the pre and post surveys, respectively. Roughly 75% of respondents were physicians, with the remaining 25% comprised of NP, PA, acupuncturist, and massage therapist colleagues. Median SUS was 53.8 for manual log-on (an F grade) and 87.5 for SSO (a B grade; paired p<0.0001). 70.6% preferred SSO, 3.9% preferred manual log-on, and 25.5% reported no preference. Participants reported favorable impacts on workplace satisfaction

Co-authors

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(58.5% positive, 1.9% negative), efficiency (60.4% positive, 1.9% negative), time spent on meaningful work (45.3% positive, 0.0% negative), and well-being (37.7% positive, 1.9% negative). Burnout improved slightly but statistically nonsignificantly from 47.5% to 41.5%.

Conclusion

SSO devices exhibited markedly higher usability scores than manual log-on processes, with concurrent favorable impacts on workplace satisfaction and clinician well-being. SSO devices represent a relatively inexpensive system investment to promote clinician well-being.

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Association of organizational leadership to attending, APP's and trainee burnout: A mixed-methods study

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Learning objectives

- 1. Describe burnout and potential determinants among physicians and APP's
- 2. Evaluate associations between organizational leadership and burnout
- 3. Identify specific leadership behaviors as targets for interventions

Background

Physicians, advanced practice providers (APP), and trainees frequently experience high levels of burnout and low levels of professional fulfillment. Lack of effective organizational leadership may contribute to clinical burnout and reduced professional fulfillment. Our objective was to explore perceptions of organizational leadership and its relation to physicians, APP, and trainee-reported burnout and professional fulfillment at a large academic medical center.

Methods

In June 2021, 754 attending physicians, 483 APPs, and 396 trainees completed a survey that included questions on participant characteristics, burnout screening items, professional fulfillment, perceptions of organizational leadership, and alignment of personal and institutional values. (Free-text responses were coded using thematic analysis.) Multiple linear regression models were created with the composite burnout score and professional fulfillment index as the outcome variables and the composite organizational leadership score as a predictor. Covariates included role (attending, APP, trainee) and gender (male/female). Quotes associated with clinician perception of leadership were selected to enhance quantitative survey results.

Results

The prevalence of burnout was 45% in attending physicians, 43% in APPs, and 54% in trainees. Overall, 29% of attendings, 31% of APPs, and 25% of trainees reported a high level of professional fulfillment. Additionally, 66% of attendings, 64% of APPs, and 67% of trainees reported high levels of satisfaction with their immediate supervisors.

Participants who reported greater satisfaction with organizational leadership had lower levels of burnout (b=-0.26, 95% CI=-0.28 to -0.24, p<0.001) and higher levels of professional satisfaction (b=0.35, 95% CI=0.33 to 0.37, p<0.001) after accounting for covariates. Qualitative analysis was consistent with these findings: from an attending physician, "Hospital administrators make major changes ... without considering ... how it may affect job satisfaction." Similarly, from a trainee "Numerous faculty are leaving due to lack of support from leadership... [leadership] is sacrificing the long-term health and wellness of the department in pursuit of short-term revenue gains." The specific items within the organizational leadership scale that were most strongly associated with professional fulfillment included "My supervisor empowers me to do my job" (b=0.21, 95% CI=0.17 to 0.2, p<0.001) and "My supervisor keeps me informed of changes taking place at our institution" (b=0.07, 95% CI=0.04 to 0.10, p=0.007).

Conclusions

Given that burnout and fulfillment among clinicians may be mediated by improving organizational leadership, future burnout interventions should target aspects of leadership in healthcare settings. Effective interventions may include those which address perceptions of empowerment and those which focus on enhancing communication between leadership and the front line.

Between white coats and someone else's shoes: A fresh look at secondary traumatic stress, compassion fatigue and burnout in physicians

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Learning objectives

- 1. Engage with physicians' narratives of their negative experiences with attention to structural factors
- 2. Critically examine constructs of burnout, compassion fatigue, and secondary traumatic stress
- 3. Locate a systems-conscious, transformative linguistic approach to physician wellbeing

Project objective/background

Adverse work-related experiences have been welldocumented in physicians. Research describes them under a variety of terms, including 'burnout,'secondary traumatic stress' (STS), and 'compassion fatigue' (CF). Though these terms are widely used, limited consensus exists regarding their precise definitions and distinctness. Few studies have critically examined these constructs in relation to physicians' own descriptions of the experiences they attempt to describe. The present qualitative study pursues an in-depth analysis of physicians' narratives of negative work-related experiences, how they reciprocally map onto conceptions of burnout, STS, and CF, and how they relate to systems-level factors.

Methods/approach

Semi-structured interviews were conducted with a purposive sample of 18 Rhode Island physicians from four fields (internal medicine, family medicine, pediatrics, and psychiatry) who met criteria for burnout, STS, and/ or CF based on their responses to quantitative measures. Participants were first asked open-ended questions about overall satisfaction/dissatisfaction, wellbeing, and difficulties related to work, and then prompted to describe what 'burnout', 'CF', and 'STS' meant to them. Interviews were thematically analyzed using a post-structuralist and hermeneutic phenomenological approach.

Results

Four themes were identified across physicians' descriptions of their work-related difficulties: (1) moving against stagnation, (2) extending beyond depletion, (3) interfacing without interconnectedness, and (4) inhabiting fractured identities. Structural and sociocultural context were key components of each. Together, they can be construed as systems-based disruptions in physicians' ability to generate meaningful narratives in relation to patients, colleagues, and themselves. The terms 'burnout' and 'CF' elicited a wide range of definitions, and various semantic and temporal relationships between the two were proposed. While several participants expressed a lack of identification with 'STS', some described distress in reaction to patients' trauma; most of these descriptions ultimately reflected a more central sense of helplessness regarding systemic barriers to providing effective care and processing difficult encounters. Conceptions of 'burnout,''CF,' and 'STS' simultaneously overlapped with and opposed one another, with lapses in clarity, continuity, and contextualization constraining the narrativizability of the experiences they are meant to describe.

Conclusion

Physicians' negative work-related experiences might be understood as disintegration of transformative narratorial potential in the face of systemic burdens/barriers. The terms 'burnout,''CF,' and 'STS' may create further narrative slippage by gesturing away from the multiplicity and structural embeddedness of physicians' work-related difficulties. Framing physicians' negative experiences in constructs rooted in physicians' own narratives may give way to generative dialogue and meaningful initiatives centering wellbeing by facilitating a refined understanding of its antitheses.

Caring for the caregiver: Supporting working faculty parents

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Learning objectives

- 1. Understand the impact of work-life conflict on working faculty parents at an academic medical center.
- 2. Learn how to engage stakeholders to understand their support needs and launch targeted program development by working with stakeholders across the institution.
- 3. Create a way to monitor uptake of programming by working faculty parents.

Project objective/background

In the United States, working parents compared to employees without children are twice as likely to report being worn out at the end of the day, less interested in work, and feel that their work is insignificant.¹ In our academic medical center, working faculty parents compared to faculty without children were more likely to consider leaving our institution, decreasing their professional effort, or turning down leadership opportunities due to work-life conflict.² Medical institutions need to support working parents to prevent turnover, improve professional fulfillment, and enhance the culture of wellness.

Methods/approach

The University of Texas Southwestern Office of Faculty Wellness engaged working faculty parents in discovering common needs, created targeted programming to address these needs, and tracked the uptake of the programs.

Results

After reviewing faculty survey data, focus group and individual interview data, departmental outreach meetings, as well as consultation with experts at the Center for Parental Leave leadership, four key themes were identified: Desire for 1) support of work-life integration, 2) institutional commitment to and support of faculty wellbeing, 3) access and knowledge of childcare benefits, and 3) support and community with other employed parents (Figure 1). Based on these themes and with collaboration with multiple institutional leadership groups, 10 programs were launched with 1492 points of contact with individual faculty members (Table 1).

Conclusion

By engaging our working faculty parents in identifying their stressors and needs, we were able to focus interventions to better support them and their wellness **Co-author** Jaime Harry, LCSW

through creating more supportive environments, creating community at work, and enhancing institutional benefits and grant support to promote a culture of wellness for our working parents.

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Figure 1. Common Needs of Working Faculty Parents and Targeted Interventions



Table 1. Uptake of Programming by Individual Program				
Initiative	Launch Date	Number of Faculty Reached		
Individual Professional Coaching	11/2020	191 sessions		
Interactive Screening Program	12/2020	107 surveys taken		
Individual Counseling	12/2020	25 sessions		
UTSW Faculty Wellness Facebook	1/2021	425 members		
UTSW Working Parents Facebook	1/2021	316 members		
Parenting Webinars	6/2021	18 attendees		
Faculty Group Coaching	9/2021	20 attendees		
Supporting Working Parents webpage	11/2021	353 independent views		
Faculty Parent Transition Back to Work Program	11/2021	26 participants		
UT Focus Program (grant support for "extra hands" for researchers with caregiving responsibilities)	12/2021	15 applicants, 5 selected		

Changes in ambulatory physician workload, work-pattern and electronic health record burden during the COVID-19 pandemic

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Learning objectives

- 1. Identify changes in physician workload and work-pattern during the COVID-19 pandemic
- 2. Identify changes in EHR use (quantitative methods) and areas of increased EHR burden (qualitative methods) during the pandemic
- 3. Identify associations between changes in EHR use with the pandemic and burnout

Project objective/background

Evidence suggests an increase in prevalence of physician burnout since the onset of the COVID-19 pandemic potentially fueled by changes in workload and time pressure^{1,2,3,4}. We sought to quantify changes in ambulatory physician workload, work pattern, and her usage during the pandemic, and investigate its association with burnout.

Methods/approach

Ambulatory physicians from academic and community practice settings were included in our study. We compared EHR use measures for a period of 6 months before and after the onset of the pandemic (March 2020) using interrupted time series analysis. Mixedeffects linear regression modeling were used to regress wellness measures on predictor variables for a period of 3 months before survey administration in April 2019 and September 2020. Ongoing qualitative interviews are now being analyzed using thematic analysis to identify major themes around perceptions of EHR burden in the context of the pandemic.

Results

In terms of workload, although the number of patient appointments decreased by 27/physician/month

(p<0.001), time spent on scheduled patient visits/ physician/month increased by 11 hours in March 2020

(p<0.001). There was an increase in the number of patient messages/physician/month by 6 in March 2020

(p=0.004) and the number of messages increased at a slower rate during April-September 2020 (months after

the onset of pandemic) than during September 2019-February 2020 (pre-pandemic months) (**βbaseline trend**= 4.17, **βtrend change**= -2.56, p<0.001 for both). Work-pattern as measured by orders with team contributions decreased by 6% in March 2020 (p<0.001) and showed an increasing trend in the months after the onset of pandemic as compared to pre-pandemic months (**βbaseline trend**=0, p=0.48; **βtrend change**=0.01, p<0.001). In terms of HER usage, we noted a 4.6 minutes decrease in time spent on in-basket/8 hours scheduled patient time (p<0.001) and a less rapid increase in time spent on in-basket/8 hours patient scheduled patient time (**βbaseline trend**=1.72, p<0.001; **βtrend change**= -0.76, p=0.002) in the months after the onset of pandemic when compared to prepandemic months. Initial results from physician interviews suggest in-basket volume as a source of HER burden among physicians. Additional analysis of associations between changes in workload, work-pattern and EHR usage during the pandemic and independently assessed burnout will be presented at the meeting\$

Conclusion

The pandemic ushered in a fundamental change in the way healthcare is delivered. Our results highlight the need to leverage metrics to understand the impact of such changes on physician workload. This could help optimize new care delivery models and promote physician wellness and professional satisfaction.

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Changing medical culture in Canada: Creating a single source of physician wellness tools and resources

Author

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Learning objectives

- 1. Learn the value of providing a single source of physician wellness related resources
- 2. Understand how organizations can offer timely and relevant resources to audiences
- 3. Discuss the impact of these timely wellness resources on audiences

Project objective/background

In 2019, the CMA set out to start a movement to change the culture of Canadian medicine by creating the Physician Wellness Hub (the Hub), the only national centralized destination for comprehensive and curated physician wellness resources. It aims to promote positive individual/ systemic changes by offering resources for physicians, medical learners, health leaders and medical educators. The website includes over 470 physician resources across 28 topics such as burnout, stress, organizational wellness and reducing stigma. Moreover, the Hub is home to the CMA's peer support program and support line, which is accessible to physicians, medical learners and their families 24/7. During the COVID-19 pandemic, the website has evolved to provide timely and relevant resources, including the Sound Mind podcast, a podcast about physician wellness and medical culture, and the Pandemic Wellness Toolkit, a collection of curated resources to help physicians navigate their wellness throughout the pandemic.

Methods/approach

The Hub was developed through cross enterprise collaboration with the goal of offering an interactive and intuitive user experience for physicians and medical learners navigating wellness resources. Engagement metrics are continually monitored to identify which Hub resources are being accessed. To evaluate Hub user satisfaction, an online survey was developed using the tool "Pendo" and data collection is underway. The survey is embedded on the Hub as a banner, and individuals are asked about their overall satisfaction, how their experience could be enhanced, and how they plan to use resources accessed on the Hub.

Results

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Providing relevant and timely resources to audiences led to significant uptake in website usage. This was especially the case for the top three accessed resources: the Pandemic Wellness Toolkit, Compassion Fatigue and Burnout 101. Website metrics for these pages and others support the case for providing timely and relevant resources to audiences. The total page views for the Hub since launch in September 2020, is 382,498. The top accessed resource, the Pandemic Wellness Toolkit, has received 18,268 page views. The Sound Mind podcast was downloaded over 10,000 times since launching in January 2020. Results from the user satisfaction survey will be analyzed/presented by the conference date.

Conclusion

The Hub has shown that having a single source of curated wellness resources for physicians can offer value in creating change at both the individual and organizational level. Work will continue to provide timely information to audiences and evaluate how this information is used and the impact it can create. User feedback and engagement metrics will be analyzed and used to inform the continuous improvement of the Hub.

COVID debrief sessions: Allowing intentional time to process

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Learning objectives

- 1. Describe system-wide debrief sessions that allow space for clinicians to pause and reflect on the rapid changes that have happened, acknowledge losses, nurture healing, and celebrate the work that has been done
- 2. Create a method to quickly conduct structured debriefing sessions for a large number of employees
- 3. Evaluate the effectiveness of debriefing

Project objective/background

Clinicians have experienced increased fatigue, depersonalization, depression, anxiety, and fear since the onset of the COVID-19 pandemic. Staff have coped with multiple stressors related to the pandemic including PPE shortage, increase caseloads, fear of contracting the virus, isolation from family members, staffing shortages, and loss of social norms. There needs to be an avenue to discuss the impact, challenges, and triumphs and to ensure that memories and lessons learned are not lost.

Methods/approach

Department Chief and departmental wellness leads were trained and provided facilitator guides to conduct 15-minute mini debrief sessions at existing department meetings to begin the emotional release and debrief process. By utilizing in department facilitators to drive the mini sessions, psychological safety is built and allows participants to contribute thoughts more easily. Facilitator guide included question prompts and reactions with training including communication skills and active listening practice. For those who wanted to continue the conversation, 45-minute standalone sessions were led by EAP.

Results

In five months, 75% of departments held mini sessions and eight extended sessions were held. To test the value of the debrief sessions, random participants were sent a post session survey. Of the 827 employees who participated in the sessions, 42% (n. 347) responded to the survey. The sessions received an average of 4.3 (out of 5) star rating with 86% (n. 298) of participants stating emotional processing and release led to a lowered state of worry and anxiety.

Conclusion

These sessions offered a quick and easy avenue for employees to emotionally process the pandemic and other stressors. Even though the pandemic continued to impact lives well after the debrief sessions, operational procedures are now in place to quickly deploy beneficial debrief sessions with minimal required resources.
Creating and reclaiming connection in a large medical group during the COVID-19 pandemic

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Learning objectives

- 1. Share unique strategies on how to remain and reclaim connection during and after the COVD-19 Pandemic.
- 2. Create opportunities to check-in on colleagues during times when isolation and mental health challenges are greater.

3. Bring awareness to the importance of healthy relationships and community building for one's overall wellness and well-being.

Project objective/background

Longer periods of isolation due to the COVID-19 Pandemic have led to greater stress, burnout, and disconnectedness amongst physicians and healthcare workers in the United States. Positive and recurrent social connections have been linked to lower stress levels, illness protection, greater fulfillment, and increased engagement in both personal and professional obligations, and our organization has leveraged creative approaches to remain and reclaim connection.

Methods/approach

Our organization, consisting of nearly 1700 physicians and 300 staff members, made reclaiming connection a strategic priority. The methods employed were:

Colleague connection

Meaningful in-person social interactions in 1:1 capacity between colleagues who share similar geographic locations. Colleagues are reimbursed for meals or activities they partake in with one another.

Leadership connection

Leaders deliver snack bags to team members in a 1:1 capacity, have conversations around how each team member is doing, and refer to appropriate support resources if they notice something is awry. Leadership check-ins in a 1:1 capacity are critical in establishing trust and creating a psychologically safe environment where employees feel comfortable speaking up. The goal for this program was to kickstart future/consistent rounding by leaders.

Interest-based connection

Interest-Based Communities, including Culinary, Fitness/ Sports, Music/Arts, Narrative Medicine, and Parenting, on a digital platform that allow for colleagues to connect with one another who share similar interests. Coordinated interest-based activities including virtual cooking and painting classes, as well as in-person running and golf outings.

Results

Colleague connection

Since June 2021, there have been more than 150 in-person 1:1 reimbursable connections made between colleagues, including the following:

- Delivered lunch to a colleague out on leave
- Celebrated a new baby
- Met up for cocktails and talked about vacation spots

Leadership connection

In 2021, we successfully piloted this offering with a group of 56 of our physician leaders; later expanding it to all 90 primary care physician leaders. We then offered it to every leader in our region and 87% opted into the program. It has now evolved and been offered to all leaders within our organization as part of a companywide appreciation initiative in February 2021.

Interest-based connection and communities

- Music and Arts: 98 members
- Culinary: 183 members
- Fitness & Sports: 80 members
- Permanente Parents: 110 members
- Narrative Medicine: 96 members

Conclusion

By implementing innovative strategies to combat isolation, meaningful social connections can be established thus reclaiming a sense of community and joy at work.

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Creating a culture of well-being through incremental change, innovation and collaboration

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Learning objectives

- 1. Overcoming "resistance to change" through "invitation and collaboration"
- Providing creative ideas for building incremental changes
- 3. Inspiring Institutional change through role modelling

Project objective/background

Our objective is to establish a "Culture of Well-Being" within our large Anesthesiology department of nearly 200 clinicians. In the UK it is advised that every Anesthesiology department has a "Well-Being Lead" and recent national guidance has been published on the nature of this role. We describe our journey over the last 4 years of bringing a cultural shift through incremental changes.

Methods/approach

We have "drip-fed" our department with small well-being initiatives over the last 4 years. Some have been "de novo/ grass-roots", some have involved linking in with established national initiatives. We began with a collaborative "appreciation cards" project and continued with numerous others including: a well-being lending library, noticeboard with clear sign-posting to support resources, departmental art gallery, well-being teaching for Residents, well-being e-newsletters, well-being surveys, a dedicated well-being talk on Resident induction days, a peer-support system and others. Our most recent project is developing a departmental well-being charter.

Results

We have found an approach of gradual introduction of well-being initiatives with a strong emphasis on openness to feedback and collaboration has substantially raised the profile of "well-being" in our department. Although there have been small pockets of resistance to cultural change, these initiatives have been enthusiastically welcomed by our clinical colleagues and whole-heartedly supported by our managers. The need for Well-Being Leads and initiatives has been well-recognized by our Institution during the pandemic. Our already-existing work in this area has enabled us to inspire other departments in our Institution to look responsively at their own well-being needs. We have also been able to dovetail with other Well-Being Leads in our Institution and have regular "crosspollinating" conversations.

Conclusion

We conclude that, as in popular culture at large, medical culture is also changing. The post-World War II mindset of "Keep Calm and Carry On" is an outdated mindset. It must be recognized and acknowledged that doctors are first and foremost human and, as such, are vulnerable to a range of occupational-related stresses that require intentional focus and action in order to maintain good physical and mental health. A large part of our work involves not only education but normalizing these experiences of stress and giving people "permission" to tend to their own well-being, and to prioritize such tending as a cultural norm throughout our department and Institution.

Designing, implementing and evaluating an organizational change initiative: A case study in applying positive organizational scholarship to health care

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Learning objectives

- 1. Learn how Positive Organizational Scholarship provides a foundational system for addressing burnout, turnover, and dissatisfaction among healthcare workers.
- 2. Learn how this model can be used to identify organizational factors that either limit or liberate human potential and well-being in the workplace.
- 3. Learn how to apply positive organizational scholarship to design, implement, and track strategic organizational change at the unit level of hospitals.

Project objectives/background

Positive Organizational Scholarship (POS) is a subfield of Organizational Science that focuses on promoting human thriving within an organization. POS emphasizes virtuous actions with human well-being as a key indicator of success. This case study describes the application of POS principles to design, implement, and track strategic cultural organizational change in a large interventional radiology unit within an academic teaching hospital. The primary focus was on identifying organizational factors that were both limiting or liberating human potential and their associated impact on burnout, turnover, and physician wellbeing.

Methods/approach

A web-based survey was designed with questions that map to principles of POS. Survey questions prompted for both challenges and strengths of the unit. The survey was distributed to all healthcare workers on the unit. Subsequently, targeted focus groups were created, segmented by job role (e.g., leadership, physicians, nurses, technologists). These focus groups participated in unstructured panel interviews conducted by independent observers to identify the strengths and challenges of the unit. In addition, observational visits to the unit were conducted to gather insights of workplace interactions among staff. Data from surveys, focus groups, and unit visits were collated and presented to the entire unit.

Results

97 surveys were completed from a total cohort of 125 individuals (78% response rate). Eleven targeted focus groups were created, consisting of between 6-11 individuals in each group. The data compiled from the surveys, focus groups, and unit visits provided a consistent and compelling message about the major factors limiting and promoting workplace well-being. Key strengths of the unit included a strong commitment of individuals to the overall mission of patient care; shared comradery among staff; and commitment among staff to support one another. Major challenges facing the unit included leadership communication, staffing shortfalls, and scheduling challenges. These organizational factors generated negative deviance from expected behavior and created misunderstanding and conflict among staff, limiting one of the unit's key strengths. Surveys and focus groups indicated organizational factors and unit culture were strong predictors of turnover, burnout, and dissatisfaction. A multiyear strategic plan was implemented to address weaknesses and increase well-being.

Conclusion

Positive Organizational Scholarship provides a foundational model that can be used to improve well-being among healthcare workers in a hospital setting. The approach enables healthcare workers and their leaders to engage in positive actions to draw upon organizational strengths while addressing challenges. Furthermore, it can be used to evaluate, design, and track strategic organizational and cultural change.



Developing a culture of well-being in a family medicine residency

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Learning objectives

- 1. Recognize factors contributing to residency burnout.
- 2. Identify culture changing strategies to enhance resident well-being.
- 3. Develop own ideas for implementation of well-being curriculum.

Project objective/background

The Hippocratic oath instructs that we must first do no harm. It can be difficult to apply that rule to ourselves as physicians, especially during residency. A systematic review of residents between 1963 and 2015 showed that approximately 28% of residents developed depression or depressive symptoms, with the incidence increasing each year¹. Burnout is also becoming an increasing concern, with a 2017-2018 study among 34 programs revealing that 60% of participants met burnout criteria. Factors that play integral roles in burnout include stress, exhaustion, difficulties with work-life balance, and lack of self-compassion, mindfulness, or empathy².

Methods/approach

To help address resident well-being, in July 2016, a longitudinal well-being curriculum was initiated at the University of Minnesota (UMN) Mankato Family Medicine Residency Program. The curriculum centers around increasing residents' understanding of contributors to and costs of burnout, making departmental changes to address burnout drivers, and education on how to incorporate strategies to improve well-being.

A Culture of Wellness Survey (CWS) was created with questions encompassing the multi-faceted aspects of wellbeing in residency. It contains 27 multiple choice questions, which comprise three distinct sections – Faculty Interactions, Resident Experiences, and the Residency Program. The survey was sent to program residents who graduated prior to the initiation of the wellbeing program (2013 – 2016) as well as current residents in the program (comprising post intervention group). Additional data was collected from annual Mini Z surveys assessing resident burnout across the University of Minnesota Family Medicine Residency programs. Responses to the following question "Using your own definition of burnout, please choose

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one of the statements below" were examined. Response choices range from 'I have no symptoms of burnout' to 'I feel completely burned out.

Results

Response rates for the CWS were 60% and 74% respectively. Using an unpaired T-test, survey responses indicate a statistically significant improvement in the overall wellness culture following the initiation of the wellbeing curriculum. The Resident Experiences and Residency Program sections also show statistically significant improvement.

Mini Z survey responses indicate when comparing the Mankato program to the other UMN programs, the percentage of residents who endorsed some level of burnout was significantly less (0% vs 32%; 0% vs 52.4%; 9.1% vs 43.2% and 10% vs 46.6% respectively).

Conclusion

There has been an increasing focus on physician wellbeing in the past decade. Addressing the well-being needs of resident physicians is equally important but can seem daunting as residency programs often function as a system within a system. By developing a multi-faceted well-being curriculum with an identified faculty and resident lead and the support and involvement of the Program Director and faculty, we were able to create significant culture change around well-being.

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Directors of well-being for graduate medical education: What is their role?

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Learning objectives

- 1. Understand the scope of a GME Well-being Director role
- 2. Describe unique well-being challenges for GME trainees
- 3. Describe unique leadership challenges for GME Well-being Directors

Project objective/background

The Graduate Medical Education (GME) Well-being Director (WBD) has emerged as a new institution-level role to provide organizational support for resident and fellow well-being as a core component of physician training and practice. Given the newness of the role and the variable institutional impetus for establishing it, the responsibilities of the GME WBD are currently heterogeneous. We aimed to describe the responsibilities of a sample of current GME WBDs, their perspective on unique well-being challenges for GME trainees, and specific leadership challenges for Directors.

Methods/approach

We surveyed 43 GME WBDs in the Collaborative for Healing and Renewal in Medicine (CHARM) GME Wellbeing Leaders Network regarding their role and unique challenges for GME trainees and leaders. Demographic characteristics and individual responsibilities were analyzed using descriptive statistics. Free responses regarding perceived challenges were grouped into themes.

Results

26 (60%) WBDs responded. The majority are female (81%) and white/Caucasian (81%). 54% of directors have an MD, 27% education degrees, 19% psychology/counseling/ social work degrees; 62% practice medicine and 38% are mental health (MH) professionals. Most receive protected/funded time, but few manage a budget. More than 75% of directors' roles include improving access to MH services, overseeing institution-wide well-being programs, designing, and delivering well-being education, consultation for program directors and meeting with

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trainees. Many also ensure compliance with ACGME wellbeing requirements, serve on an impairment committee, prepare for Clinical Learning Environment Reviews, oversee well-being surveys and/or chair well-being committees. Less common responsibilities include overseeing MH services, conducting group debriefings, leading faculty development, providing direct MH support, and leading diversity or learning climate/mistreatment efforts. Unique GME well-being leadership challenges centered around 4 areas: 1) lack of resources 2) culture/values mismatches 3) organizational structure/institutional barriers and 4) regulatory challenges Many unique challenges for GME trainees were identified; largely these mapped to published driver domains,¹ with specific sub-themes related to the GME trainee's unique position in the medical hierarchy as both worker and learner.

Conclusion

The typical GME WBD has a broad role, faces several unique challenges in addressing well-being in GME, and often has little control over a budget. Reviewing the job responsibilities of this group of WBDs in the context of the perceived challenges their GME trainees face may help leaders better define the ideal scope of work and advocate for resources to target needs. Notably, among the leaders we surveyed there is a lack of racial and ethnic diversity that also requires attention.

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Does providing healthy snacks to hospital-based health care providers improve wellness?

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Learning objectives

- 1. To identify the burnout rate in one Midwestern US academic hospital medicine division
- 2. To identify if providing access to healthy snacks for hospital medicine providers will have an impact on wellness, and self-reported productivity
- 3. To examine qualitative feedback from hospital medicine providers regarding their experience with access to healthy snacks at work

Project objective/background

Hospital Medicine is a busy, sometimes chaotic field. Providers make daily adaptations, having to provide immediate patient care as the situation arises. As a result, providers often miss meals all together during work hours. Our divisional Wellness Committee conducted a baseline nutritional survey in August 2019, where 80% of respondents noted that they often skipped meals at work because either they were too busy, or they just wanted to focus on getting their work completed. From data obtained from the institutional COVID/AMA distributed in May 2020, when asked whether access to healthy food [during work] would "improve your ability to sustain through the COVID-19 crisis", 52% of total respondents, and specifically 54% of Hospital Medicine faculty and staff responded either "moderately" or "to a great extent".

Methods/approach

We received a well-being grant of \$5000 from our medical center's Wellness Office. As part of the initiative, faculty and staff were encouraged (but not required to) complete a 13-question survey which included questions related to burnout from the Mini-Z and demographic information. The snacks were distributed starting July 2021. Data used in this abstract was collected until Feb 2022 at which time available data was analyzed. The institutional IRB approved this study.

Results

We received 56 responses to the survey, 33 came from faculty (58.9%), 22 from NP/PAs (39.2%) and 1 respondent did not identify their position. Thirty-one responses (56.4%) were from females, with 21 respondent (38.15%) were in practice 1-5 years. Most of the respondents worked a combination of day and evening shifts (45.5%) with 9 respondents (16.4%) working midnights only. Of the respondents, 29 (51.8%) had symptoms of burnout defined by their response to the Mini-Z question 3. When asked if having access to healthy snacks in the work rooms improved wellness, 49 (87.5%) chose "somewhat agree" or "strongly agree". Finally, when asked if having access to healthy snacks increases my productivity 46 (82.1%) choose "somewhat agree" or "strongly agree". Examples from qualitative comments are found in Table 1.

Conclusion

Overall, a high percentage (>80%) respondents felt that having access to healthy snacks improved their wellness and self-reported productivity. This data shows that an inexpensive, simple intervention can make an impact on wellness. While this alone cannot help to decrease burnout, it can be used in conjunction with other strategies to make an impact.

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Table 1: Representative quotations regarding access to healthy snacks during work

If you have any other comments about access to healthy snacks, please provide those below: (selected examples)

It's always a challenge to find healthy food when working on weekends at University Hospital

Having easy access to yummy and healthy snacks makes the whole day much better and it's a lifesaver on a stressful day. It's hard to be at your best when you are hurried and hungry.

Snacks are honestly the thing that keeps me going because I don't have time to eat. These snacks were much appreciated. I haven't eaten all day. There hasn't been time.

Eating healthy while working, especially on nights, has in some ways been one of the biggest stressors and most difficult things for me. Having food available, healthy food, would be huge



Driving culture change in a multispecialty physician group by a focus on corporate board support and process improvement to prevent provider burnout

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Learning objectives

- 1. Identify how to value provider well-being at the multispecialty physician group board level and measure it using the Mini-z physician burnout tool
- 2. Understand the importance of moving from well-being 1.0 to 2.0 systematic support for well-being
- 3. Identify an approach to engaging physicians to ask them what systematic process improvements would bring them joy in the workplace

Project objective/background

Spectrum Healthcare Partners (SHCP), a 180-member physician run and owned multispecialty practice in the northeast has actively supported physician resilience and well-being since 2017 with programmatic offerings to individual providers that include coaching, peer mentoring, and annual evaluations of engagement and burnout. The corporate board demonstrates commitment through a sub-committee and annual strategic goals. A key goal in 2021 was to move to well-being 2.0¹ by implementing process improvements to eliminate workplace frustrations and promote joy for providers. Spectrum is participating in the AMA's Practice Transformation Initiative (PTI) through the Maine Medical Association. The PTI's goals are to reduce clinical burnout, examine and build the evidence base for interventions that support provider well-being and facilitate collaboration and sharing of information and resources among practice sites to create a national network.

Methods/approach

The PTI process measures baseline provider wellness using the Mini-Z burnout tool², a validated 10 question Likert scale survey. Provider groups identify and change systematic processes driving burnout and the Mini-Z tool is performed to see if there has been improvement. Results on the Mini-Z survey are expressed as a number from 1-50 with a score of 50 being the Joy Target.

Results

141 SHCP providers (122 physicians, 10 PAs, 6 other advanced providers and 3 NPs) in five disciplines participated. The aggregate initial Mini-Z score was 34.1

(national benchmark 30.6 for 9523 participants) with the following discipline specific scores: anesthesia 32.9, orthopedics 34.1, pathology 30.7, radiology 36.6 and radiation oncology 39.8. Process improvements achieved in a one year period in anesthesia: requesting and receiving increased hospital support for more physician staffing in a major hospital PACU; orthopedics: hiring a new practice director, selecting and installing an improved electronic medical record; pathology: launching protected office hours for uninterrupted patient care and focusrequiring activities; radiology: focus on work atmosphere and workload control through actions to correct specific physician work atmosphere concerns, coaching for new physician onboarding, addressing hospital IT concerns, and increasing and improving work from home options; radiation oncology: scheduling time for social gatherings.

All providers completed the follow up Mini Z survey by February 15, 2022.

Conclusion

Multispecialty groups can combat burnout by demonstrating value for provider well-being at the board level, measuring burnout, and taking steps to improve operational processes that hamper physicians.

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Effects of shared narrative events on health care professionals

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Learning objectives

- 1. What narrative medicine is and its purpose in health care settings
- 2. How impactful story telling can be incorporated into academic and non-academic settings
- 3. How physician's retelling of stories can provide potential empowerment and decreased solitude

Project objective/background

Spoken narratives have power; they convey information, emotion, and wisdom to an audience. This evokes understanding, empathy, and connection. Narrativebased medicine (NBM) is a practice that allows health care professionals to employ thoughtfulness, allowing them to empathize with their patients, understand their conditions, beyond their illness to overall well-being, along with deepening their connection to their colleagues. "Story slams" are events where healthcare professionals and medical students orally present personal stories, reflecting together on moments of triumph, defeat, and compassion. They provide an opportunity for participants to collectively process the complex emotions and identities that come with working as a healthcare provider. Between February 2017 and October 2021, the Lewis Katz School of Medicine at Temple University hosted nine "story slams", with 96 individual presenters sharing spoken-word pieces involving their professional and personal experiences. Stories were then analyzed for thematic patterns (such as patient-centered care, resilience, gratitude, burn-out, advocacy and injustice).

Methods/approach

Presenters were surveyed following the event to investigate how the experience had affected several aspects of their lives: job satisfaction, empathy, stress, and ability to listen. Some presenters volunteered to be interviewed post-survey to provide additional information about the impact of their experience.

Results

For the thematic analysis, patient-centered care, resilience, and the value of learning comprised more than 50% of all themes presented throughout the 93 narratives analyzed. Resilience was second most popular at 16.67%, the Value of Learning represented 10%. Of 52 completed surveys, about 94% experienced neutral or improved connections with their patients, 40% felt connections were positively improved. When the professionals are isolated from student responses, 100% reported feeling neutral or increased in satisfaction with their profession. The dominant themes from the interviews were; participation had a lasting impact, a sense of community was created, improved sense of humanity, and increased appreciation for diversity.

Conclusion

Overall, it was shown that a shared narrative event nourishes those in healthcare, by engendering good will, community, encouragement, enthusiasm, and helps people feel valued. These one-time or annual events are inexpensive, simplistic, short duration, and effective ways of decreasing burnout within the academic medical community therefore benefiting the overall community served.

Empowering leadership to talk openly about mental health during the COVID-19 pandemic and beyond

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Learning objectives

- 1. Participants will be able to describe how an integrated health care system trained its leaders to talk about mental health during a pandemic
- 2. Participants will be able to explain a multi-modal approach to reach large numbers of leaders
- 3. Participants will be able to determine if these methods would work in their organizations

Project objective/background

Mental illness-related stigma, including that which exists in the health care system and among health care providers, has been identified as a major barrier to accessing treatment, seeking recovery, and receiving quality care for mental illnesses.¹⁻⁵

Culturally, the old dictum, "asking for help as a sign of weakness" remains engrained in the medical profession. The SARS-CoV-2 pandemic brings a unique opportunity to openly discuss mental health challenges health care teams are facing and stigma impacting mental health in general. In 2021, as part of an overall program called **"Rise and Renew – Our Journey Towards Recovery"** – a program with the aim to help our staff and employees support themselves, support their teams, and offer crisis resources – we invited leaders to learn strategies to discuss mental health and well-being with those they lead.

Methods/approach

We asked managers to complete an on-line one-hour learning module entitled *"Mental Health Training for Managers"*. This training is part of an organization-wide strategy to address mental health and stigma in the workplace. Through this training, managers learned about overall mental health, common mental health conditions, and why it's important to create a stigma-free workplace. This learning module also contained tailored information to help managers understand how to support their employees by fostering a supportive environment.

For our physician leaders, we created a one-hour CMEaccredited live activity entitled *"Emotional Well Being for Leaders"*. This training emphasized ways to identify physicians who may be experiencing a mental health issue, offered strategies about listening, introduced questions to elicit what might be going on for physicians, and provided examples of statements to avoid. It concluded with a summary of useful resources for leaders to share with their physicians. We met with all 13 service areas to deliver the presentation, answer questions, and describe resources.

Results

In 2021 more than 3,000 managers completed the on-line learning module and all our physician leaders participated in the one-hour CME-accredited live activity.

Conclusion

Preparing and encouraging all health care leaders to talk about mental health needs with their direct reports is one necessary step to help change the culture in medicine around mental health stigma.

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Engaging residency and fellowship programs in culture change: Where are we now?

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Learning objectives

- 1. Identify important wellbeing metrics for graduate medical education (GME) programs
- 2. Develop a plan for assessing the current state of wellbeing in GME programs
- 3. Utilize data from a large healthcare setting to understand current wellbeing concerns in GME

Project objective/background

For residents and fellows to experience true culture change to support wellbeing, their daily experiences in training must address systemic factors in physician burnout and fulfillment. Our system began addressing wellbeing in graduate medical education (GME) with a wellness champions program in 2017 and a systemwide initiative for GME in 2021. We aimed to evaluate the current state of wellbeing programming in our residencies and to inventory current wellbeing initiatives, identify barriers, and assess needs.

Methods/approach

A survey was emailed to all of the residency and fellowship programs in our system. Surveys identified the program and included items assessing ability to meet ACGME wellbeing requirements, current wellbeing programming, barriers, and needs. A link to provide additional anonymous comments was also included.

Results

53 of 101 (52.5%) of GME programs completed the survey; programs completing surveys represented 77.8% (904/1162) of our current residents and fellows. 34/53 (64.1%) of programs report having a faculty member who is responsible for attention to wellbeing, though only 6 of those (17.6%) reported protected time for the role. When asked about ability to meet ACGME wellbeing requirements from 0 to 100%, the mean response was 86% (S.D. = 15.68). 37/53 (69.8%) report that wellbeing is a regular topic in faculty meetings and 47/53 (88.7%) report wellbeing is regularly discussed in house staff meetings. Narrative comments highlighted difficulties associated with the COVID-19 pandemic, identified a need for additional focus on faculty wellbeing, referenced clinical demands as a barrier, and requested support for providing didactics on wellbeing topics. No comments were provided in the additional anonymous form.

Conclusion

In our system where attention has been paid to wellbeing in GME programs for 5 years, the majority of programs responding report having a faculty members tasked with attention to wellbeing as well as discussing wellbeing regularly in program meetings. Additional support for wellbeing in GME programs might include additional attention to faculty wellbeing, protecting time for faculty wellness champions, and providing in-house speakers or canned talks on wellbeing topics. A forum for GME programs to share wellbeing initiatives could help programs learn from each other's successes and help additional implementation of wellbeing strategies. These findings will contribute to the development of additional GME wellbeing initiatives as well as resources and support for GME programs in our system as we work to change the culture of GME towards one in which all of our residents, fellows, and faculty thrive.

Engaging the assistance of professional health monitoring programs to support recovery among health care professionals referred for unprofessional sexual behavior

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Learning objectives

- 1. Recognize the impact of stress on boundary violations, including unprofessional sexual behavior, among healthcare professionals.
- 2. Explain the role of professional health monitoring programs in supporting physicians with potentially-impairing conditions.
- 3. Describe outcomes for healthcare professionals referred to a state PHP due to unprofessional sexual behavior.

Project objective/background

Boundary failures, including unprofessional sexual behavior (USB), tend to increase in times of stress,¹ particularly among those who have limited support and tend toward overextending themselves.^{2,3} Healthcare professionals (HCPs) who display USB often have untreated underlying conditions, and are at high risk of losing their license/ career. Professional health programs (PHPs) assist HCPs with potentially-impairing conditions in returning to clinical practice while ensuring patient safety.⁴ Studies document exceptionally positive outcomes for those recovering from substance use disorders.⁵ About half of PHPs also offer monitoring services for HCPs with USB, though less is known about their disposition and outcomes.

Methods/approach

The study was IRB approved, and involved review of all records related to USB documented between 1983 and 2018 for one state PHP. The medical director reviewed each chart and extracted anonymous data into REDCap, then exported to SPSSv.26 for analysis.

Results

Records (N = 572) indicated most referrals were middleaged, heterosexual, Caucasian male physicians from the United States, and involved USB toward at least one patient. Monitoring was initiated for 231 cases (40.4%). The PHP did not offer monitoring when: individuals were ineligible for PHP services (e.g., unlicensed or insufficient justification to recommend evaluation/monitoring; n = 222); the licensing board handled the referral (n = 76); the individual relinquished his/her license (n = 41); or the individual became incarcerated (n = 1) or died (n = 3; 2 by)suicide) prior to fully engaging with the PHP. Civil/criminal legal involvement, and licensure restriction/suspension/ revocation or other disciplinary action by the licensing board were present in most cases. The modal length of monitoring was 5 years (range = <1 to >11). Outcomes varied, with 114 cases (49.4%) deemed "very successful," 59 (25.5%) "successful," 27 (11.7%) "neutral," 20 (8.7%) "unsuccessful," and 11 (4.8%) "very unsuccessful." A total of 128 (55.5%) graduated from monitoring at the end of their initial (n = 105) or extended (n = 23) agreement, and 3 (1.3%) graduated but relapsed and returned to monitoring. 28 (12.1%) relinquished their license and 21 (9.1%) were turned over to the Board. The remaining cases were still under monitoring (n =27), taken over by the Board (n = 10) or had other outcomes (e.g., moved out of state, died).

Conclusion

PHP referral may be an important part of risk mitigation for both patients and practitioners, identifying HCPs with USB who are amenable to intervention, and helping them resume working under safer conditions.

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Evaluating the leading physician well-being program: Triangulating pre-/post-test results to identify training needs

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Learning objectives

- 1. Understand rationale for selecting tools to evaluate leadership and physician well-being.
- 2. Evaluate interventions to improve physician well-being using tools tailored to objectives.
- 3. Generate new insights for program evaluation by deriving relevant results across multiple survey tools.

Project objective/background

In recent years job satisfaction and burnout among physicians has increased when compared to all US working adults, and prior to the Covid-19 pandemic, at least half of US physicians reported on symptom of burnout.¹ Experts in physician wellness have called for a shift in the culture of care and wellness for physicians including both individual and organizational interventions.² In 2020, the American Academy of Family Physicians (AAFP) launched a certificate program to equip family physicians to lead change for improving physician well-being within their practices and organizations. The program includes didactic education and an applied project to meet the following objectives: Foster a movement in family medicine that changes the culture, policies, and systems in health care to better support well-being; improve the collective understanding of how to effectively lead change in health care organizations to improve well-being; and create a sustainable program that allows the AAFP to grow and cultivate a community of family physicians leaders for clinician well-being. Rigorous evaluation was implemented to inform program improvements and identify best practices including progress, process, and outcomes evaluation utilizing both gualitative and guantitative methodologies. Data triangulation of results was employed by the evaluation team to develop a comprehensive understanding of the phenomena contributing to physician wellbeing.³ The AAFP's Leading Physician Wellbeing program evaluation results demonstrate significant improvements in measures of physician wellness and raise new questions about the importance of leadership and guality improvement skills for improving wellness at the individual and organizational levels.

Methods/approach

The guantitative component of the evaluation included baseline, mid-, and end-program surveys including items from the "Physician Wellbeing Index", the "Adaptive Leadership Questionnaire", the "Nine Pillars of Quality Improvement", and "The Beliefs, Attitudes, Skills, and Confidence in Quality Improvement" (BASiC-QI) Scale. Based on early qualitative results, a single instance of, "The Everyday Discrimination Survey" was also launched. Survey results were compared between demographic groups such as gender, race/ethnicity, years since residency, and practice setting. Comparisons across survey iterations were also made using mixed ANOVA and mixed effect regressions. Significant results were discussed by the evaluation team and data triangulation was utilized to draw conclusions about factors influencing wellness and burnout among physician participants.

Results

In terms of evaluating the Leading Physician Well-being Program, several significant results were observed in the quality improvement (QI) domains including overall knowledge about QI and participants' ability to measure impacts of a change. Fewer significant changes were observed over time in the adaptive leadership domains and the physician wellbeing inventory scores. Overall cohort one results showed positive change from baseline to the endpoint. Participants improved in their ability to control distress caused by administrative demands, the ability of positive patient interactions to outweigh negative patient interactions, the ability to step back and assess dynamics, the ability of participants to handle conflict, the ability of participants to bring conflicts into the open, the ability to read the room, and the ability to handle uncertainty and to shift perspectives. Results indicate that non-White physicians are better at handling conflict, raising concerns, and having an open ear than White physicians.

The results produced by the single instance of the Everyday Discrimination Survey build on these results by highlighting specific experiences of discrimination and stratifying them based on demographic characteristics such as age, gender, race/ethnicity, and year in practice. Experiences of discrimination included being exposed to pejorative terms, slurs, or jokes; feeling the need to work twice as hard; not being taken seriously; not having one's opinion sought; or the need to be careful about one's appearance and what one says at work. Work setting also has a significant impact on physician's experiences of discrimination such that physicians employed by Federally Qualified Health Centers are less likely to be exposed to pejorative terms, slurs, or jokes than physicians who work in multiple settings; differences in feeling like they are not being taken seriously were also observed between those in academic settings when compared to multiple practice settings.

Taken together, these results point to gaps in knowledge and skills such as the ability to manage uncertainty and the experiences of discrimination as they relate to well-being and leadership.

Conclusion

When it comes to well-being, one's gender, age, race, and workplace all come to bear. Non-white physicians bring different skillsets to their workplaces which may augment their experiences of wellness and burnout, and their experiences of discrimination may also have an impact on their wellness.

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Relation to Conference Theme "Engaging organizations to achieve cultural change" (Subtheme: Building a united front for cultural change while activating systems to improve physician well-being)

The present findings of the Leading Physician Wellbeing program evaluation demonstrate effective use of multiple surveys to allow organizations to identify gaps in knowledge and skills which may contribute to burnout. Differences between groups highlight skills gaps which can inform educational interventions for physicians and promote opportunities for cultural change in medicine. Survey results which indicate that some groups are better than others about speaking up about problems can be compared to findings about experiences of discrimination to develop programming to support allyship among clinical staff and to reduce discrimination which may augment a physician's ability to maintain wellness when facing the chronic and interpersonal stressors that accompany the practice of medicine.

Experiences with discrimination described by northeastern American practicing surgeons

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Learning objectives

- 1. Describe experiences of discrimination among practicing surgeons in New England
- 2. Assess the inequality of discrimination experiences among surgeons
- 3. Gain insight into the effects of discrimination on burnout among New England surgeons

Project objective/background

The recent pandemic heightened awareness of disparities in healthcare delivery and outcomes, raising concerns for structural bias in medicine. Evidence suggests that racial and gender concordance may improve patient outcomes, highlighting the importance of a medical workforce reflective of the population it serves. The aim of this study was to examine the perception of structural bias within healthcare amongst traditionally under-represented or marginalized groups. We also aimed to examine details on sources and bystanders of discrimination and how discrimination relates to physicians' risk of burnout and reduced clinical work-effort.

Methods/approach

The New England Surgical Society (NESS) is a professional society of surgeons in the northeast area of the United States. NESS launched the "The Surgeons' Wellbeing Project" electronic survey in May 2021, prompting member participation by email weekly for six weeks and again at the annual meeting in September. The survey included validated wellness metrics (Professional Fulfillment Index) and both previously published and novel scales to assess the work-life well-being of surgeons, including metrics to assess sources, locations, and triggers for discrimination, and bystander response. Descriptive statistics, Chi-square, and logistic regression was used to determine proportions, statistical independence, and associations between categorical groups. Grounded theory qualitative analysis was used to solicit themes from narrative responses.

Results [Table 1]

This cross-sectional sample of 138 actively practicing surgeons across 11 subspecialties in the northeast region of the United States. The sample is 82% white, 69% male, with a mean age of 50 years. We found that a third of surgeons experienced discrimination. Female surgeons reported significantly more discrimination compared with males (69% v. 21.4%, p<0.001). Non-whites experienced more discrimination than white (62% v. 31%, p=0.054). Surgeons were less likely to witness discrimination at work than outside of work (43% v. 52%) "probably-definitely". Female surgeons were five times more likely to experience gender discrimination than males (61% v 11%, p=0.000). The presence of discrimination ("agree-strongly agree") predicted burnout (20% v 43.8%, p=0.004; OR 3.0, Cl 1.34-6.5). It was not significantly related to the intent to reduce clinical work-effort (49% v 54%, p=0.554).

Conclusion

While surgeons witness less discrimination in the workplace than elsewhere, still a third of surgeons experience burnout. Experiencing discrimination predicts some burnout. Females are three times more likely to experience discrimination compared to males. Non-whites reported a higher proportion of discrimination compared to whites, though statistical significance was not reached. Encouragingly, both females and non-white respondents reported bystanders speaking up approximately half the time. Table 1

Practicing Surgeons Experience with Discrimination												
	TOTAL			GENDER				RACE				
Type of discrimination:	overall		Male	Male (ref)		female		White (ref)		Non-white		р
	n	%	n	%	n	%		n	%	n	%	
Experience discrimination	45	35.7	18	21.4	25	69.4	0.000	30	30.6	13	61.9	0.054
Witness discrimination at work	54	42.9	27	32.1	24	66.7	0.000	38	38.8	13	61.9	0.148
Witness discrimination outside of work	65	52.0	36	42.9	27	77.1	0.001	47	48.0	15	75.0	0.068
Discriminated for												
Race/ethnicity	16	7.3	10	12.2	4	11.1	0.954	5	5.2	9	45.0	0.122
gender	31	25.2	9	11.0	22	61.1	0.005	28	28.9	3	15.0	0.609
religion	2	1.6	2	2.4	-	-	-	2	2.1	-	-	
ability	4	3.3	2	2.4	2	5.56	0.872	3	3.1	1	5.0	0.929
other	other	0.8	8	9.8	-	-	-	8	8.3	-	-	
not experienced	65	52.9	51	62.2	8	22.2	0.034	51	52.6	7	35.0	0.383
Discriminator												
boss or authority figure	9	7.3	7	8.5	2	5.6	0.893	9	9.3	-	-	
colleague	13	10.6	9	11.0	4	11.1	0.996	11	11.3	2	10.0	0.957
nurse	6	4.9	2	2.4	4	11.1	0.714	3	3.1	3	15.0	0.612
other allied health person (not nurse)	1	0.8	1	1.2	-	-		1	1.0	-	-	
patient or patient's family	18	14.6	4	4.9	14	38.9	0.196	13	13.4	5	25.0	0.554
the public	11	8.9	б	7.3	4	11.1	0.055	7	7.2	3	15.0	0.700
I have NOT experienced discrimination	65	52.9	53	64.6	8	22.2	0.023	53	54.6	7	35.0	0.329
Bystanders, you witnessed			_		_	-				-		
Another spoke up for you	23	39.0	8	26.7	14	53.9	0.038	14	31.8	8	61.5	0.175
You spoke up for the other	35	50.7	18	47.4	17	58.6	0.361	28	51.9	7	53.9	0.924
Others spoke up for another	135	97.8	81	96.4	36	100	0.251	96	97.2	20	95.2	0.641
	Experienced Discrimination: "agree" or "probably-definitely yes"											

Mix methods: Qualitative Analysis of responses to Q65 (please enter your ideas to ensure diversity, equity, and inclusion) to be included in the final ICPH presentation.

Exploring associations between stressors and burnout in trainee physicians during the COVID-19 pandemic in the United Kingdom

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Learning objectives

1. Which stressors have been identified in trainee physicians from the previous literature

2. Which stressors are important to trainee physicians during the pandemic

3. Which stressors have been found to be associated with burnout in trainee physicians

Project objective/background

Trainee physicians are qualified doctors engaging in postgraduate training, and previous research suggests trainee physicians experience a range of different stressors in their working lives¹. Although prevalence of burnout is high in doctors as a profession², previous evidence has suggested doctors in the early stages of their career may be at a higher risk of burnout³.

The COVID-19 pandemic has posed unprecedented challenges to healthcare systems, and has not only exacerbated the pre-existing stressors impacting on trainee physicians such as clinical demands, training and career development, but also introduced pandemic-related stressors such as personal protective equipment shortages, transmission risk and uncertainty around the pandemic.

As the COVID-19 pandemic continues to put pressure on healthcare systems, it is important to identify which stressors are important and are associated with burnout in trainee physicians, which can provide guidance on which stressors to prioritise and address.

Methods/approach

An anonymous online questionnaire was sent to a representative sample of 1000 randomly selected trainee physicians in North-West England, including 42 questions on general and pandemic-specific stressors and the Maslach Burnout Inventory. We report trainee physicians' ratings of stressors and burnout sub-scale scores (Emotional Exhaustion (EE), Depersonalisation (DP) and reduced Personal Accomplishment (PA)). Associations between stressors and burnout were assessed using stepwise regression analysis.

Results

A total of 362 responses were received (response rate=37%). Mean scores for EE, DP and PA were 27.7, 9.8 and 34.3 respectively, with 52.3%, 40.1%, 44.2% of the scores meeting the "high" burnout criteria4 for EE, DP and PA respectively. The top 3 stressors rated by participating trainee physicians included "Duration of the COVID-19 pandemic", "COVID-19 disrupting work-life balance" and "Financial remuneration does not reflect workload". Out of the top 10 stressors rated by participating trainee physicians, 5 were work-related, 4 were pandemic-related and 1 was non-work related.

Many stressors found to be associated with burnout dimensions were not necessarily those that were most frequently reported. "Increase in workload and hours due to COVID-19", "Poor leadership and management in the National Health Service" and "Not feeling valued" were found to have strong associations with burnout dimensions. Only "Not confident in own abilities" was found to be associated with all burnout dimensions.

Conclusion

Trainee physicians report several work, pandemic and non-work stressors and report high levels of burnout. Specific stressors ranging across all three categories are associated with burnout, supporting the need for multilevel interventions to mitigate burnout.



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Exploring self-esteem and empathy during clerkship in medical students

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Learning objectives

- 1. Increase knowledge on self-esteem of medical students after they experience clerkship
- 2. Appraise the relationship between self-esteem and empathy when medical students experience clerkship
- 3. Identify the relationship between demographics and self-esteem in medical students during clerkship

Project objective/background

In clerkship, students are susceptible to receiving difficult feedback and having poorer social relationships, which have been linked to low self-esteem.^{1,2} High self-esteem has a positive correlation with greater critical thinking capabilities and higher levels of empathy.³⁻⁶ Empathic physicians have been linked to better health outcomes in patients; the evidence for changes in empathy after medical students start clinical training is mixed.⁷⁻⁹

Objectives

- 1. To discover if the self-esteem of medical students changes after clerkship.
- 2. To understand the relationship between self-esteem and empathy and how they may change after clerkship.

Methods/approach

We conducted a prospective cohort study. All 208 medical students from the Class of 2022 at the Michael G. DeGroote School of Medicine were recruited and asked to complete a survey that included demographic data, the Rosenberg Self-Esteem Scale (RSES), and the Jefferson Scale of Empathy (JSE).8,9 Data collection occurred at the onset and end of clerkship.

The relationship between the independent identity variables (age, gender, ethnicity, sexual orientation) and the dependent variables (RSES score, JSE score) was explored using independent linear regression models at each time period. This involved a stepwise design with forward selection, wherein only significant (p<0.05) independent variables were retained.

Independent t-tests on each dependent variable were conducted to determine if significant differences (p<0.05) existed between the beginning and end of clerkship. Association between RSES and JSE scores was assessed using Pearson's correlation coefficient (PCC).

Results

82 students and 57 students responded in the early and later clerkship surveys respectively. In early clerkship, visible minority status was the only independent variable that was included in the linear regression model, producing a r-squared of 0.07. In later clerkship, no independent variables met the threshold.

The JSE scores decreased marginally from the beginning to the end of clerkship and the t-test was not statistically significant. The RSES scores decreased from the beginning [mean (SD): 18.9 (5.8)] to the end of clerkship [mean (SD): 16.7 (2.3)] and the t-test was statistically significant (p=0.0022).

There was a low correlation between the RSES and JSE scores both at the beginning (PCC of 0.035) and end (PCC of 0.35) of clerkship.

Conclusion

Age, gender, ethnicity and sexual orientation minimally affect empathy and self-esteem in clerkship students. Selfesteem appears to decrease from the beginning to end of clerkship and have low correlation with empathy. Future directions include replicating the study post-pandemic and investigating other factors that may affect self-esteem.

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Factors associated with burnout among minimally invasive gynecologic surgery fellows

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Learning objectives

1. Understand the significance and impact of physician burnout

2. Explore factors associated with burnout among minimally invasive gynecologic surgery (MIGS) fellows

3. Consider interventions to reduce or prevent physician burnout

Objective

To assess factors associated with burnout among minimally invasive gynecologic surgery (MIGS) fellows

Design

Cross-sectional survey including the validated Copenhagen Burnout Inventory (CBI)

Setting

Online survey

Participants

One hundred MIGS fellows in the United States, classes of 2021 and 2022. Out of the 100 fellows invited, 60 fellows completed the CBI survey.

Results

Of the 60 fellows with complete CBI survey data, 73% were female, 50% were first year, and 50% were second year fellows. The mean CBI score was 39.2 (SD=14.4), indicating moderate burnout. 21.7% of fellows had scores over 50, indicating high burnout. Personal and work-related burnout were highest, with CBI scores of 47.9 (SD=16.8) and 45.1 (SD=17.6), respectively. Patient-related burnout scores were the lowest at 23.5 (SD=16.5).

Factors associated with overall burnout included career choice dissatisfaction (Beta=5.6, 95% CI [0.9–10.3], p=.02) and absence of a positive and respectful work environment (Beta=5.9, 95% CI [1.0-10.9], p=.02). Fellows who were somewhat satisfied with their career choice scored 11.2 points higher than those who were highly satisfied. Fellows whose work environment was almost never positive and respectful scored 17.8 points higher than those whose work environment was always positive and respectful.

Only one third of fellows reported regular individual wellness behaviors: mindfulness (23%), exercise (35%), 7-8 hours of sleep (37%), recreation (27%); however, these factors were not associated with lower burnout scores.

Conclusion

Fellows had moderate to high personal- and work-related burnout, while patient-related burnout was low. Factors associated with burnout were negative work culture, lack of control over work schedule, and decreased career satisfaction. Individual wellness behaviors were not associated with burnout, highlighting the need to look beyond individual behavior in the fight against physician burnout.

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Factors contributing to burnout among acute and trauma care clinicians: Survey results from a systems-analysis approach

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Learning objectives

- 1. To understand how to identify factors contributing to burnout among acute and trauma care clinicians.
- 2. To learn how to apply a participatory, data-driven, systems analysis approach to generate a prioritized list of targeted improvement efforts to mitigate burnout.

Project objective/background

While the prevalence of burnout and potential contributing factors has been studied among physicians and surgeons, there is limited understanding of the factors contributing to acute and trauma care clinicians' burnout. Therefore, this study aims to i) explore factors associated with burnout among acute and trauma care clinicians using a systems-analysis approach, and ii) identify and prioritize key improvement efforts.

Methods/approach

A survey was administered to 17 acute and trauma care clinicians, including attending faculty, advanced practice providers (APPs), and nurses, at a US academic medical institution's division between February 14, 2022, and March 2, 2022. The survey included a 2-item Connor-Davidson Resilience Scale, a 2- item abbreviated Maslach Burnout Inventory (MBI) measuring emotional exhaustion (EE) and depersonalization (DP), and 21 general workplace stressors based on the National Academy of Medicine's systems approach to clinicians' burnout. Participants rated the severity of workplace stressors on a 5-item Likert scale and rated the priorities for improvements on a 4-item Likert scale. Burnout was categorized using a 2-Question Summative Score totaling >3 for EE and DP.

Results

Of the 17 acute and trauma care clinicians that received the survey, 16 individuals completed the survey (8 attending faculty, 6 APPs, 2 nurses; 12 [75%] women; 94% response rate). The mean resilience score was 4.25, with a standard deviation (SD) of 0.51. Using the 2-Question Summative Score, 75% (12) clinicians were identified as burned out. The five general workplace stressors contributing most to acute and trauma care clinicians' burnout were inadequate staffing (mean [SD] 3.56 [0.96]), inefficient workflows (3.56 [1.09]), excessive workload (3.13 [1.15]), interruptions & distractions (3.13 [0.89]), and organizational culture (3.00 [1.31]). Participants provided the highest priority scores for improvement efforts and qualitative responses for recommendations targeting the following four workplace stressors: inadequate staffing (2.44 [0.81]; example: additional nurses, clinic, and administration staff), excessive workload (2.31 [0.75]; evaluation of appropriate job descriptions and equity), inefficient workflows (2.20 [0.86]; implement Epic checkout workflows), and organizational culture (2.17 [0.72]; leadership transparency and training).

Conclusion

Survey data demonstrated moderate resilience but high levels of burnout among acute and trauma care clinicians. Results indicate inadequate staffing and inefficient workflows as the most severe workplace stressors and two of the four highest priorities for improvement efforts, with an initial list of targeted improvement efforts. These preliminary results warrant further studies assessing factors contributing to burnout among acute and trauma care clinicians and evidence-based, systems-focused interventions.

Fostering a culture of health and wellness through professional development meetings

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Learning objectives

- 1. Present an example of a Professional Development program that promotes physician health and well-being across a multispecialty organization.
- 2. Learn how Professional Development Days can effectively contribute to a professional culture of wellness.
- 3. Demonstrate the value of investment in SELF CARE practices by medical group leadership.

Project objective/background

In 2015, national thought-leaders updated the Institute for Healthcare Improvement's "Triple Aim" to a "Quadruple Aim," emphasizing care of the physician¹. As part of our mission to be "The Best Place to Work, Deliver, and Receive Care," we hosted our first Professional Development Day (PDD) dedicated to clinician health and wellness (H&W) in 2015. The response was so enthusiastic that we have continued to put this event on annually, with over 400 providers attending. Due to evolving pandemic restrictions, the 2020 PDD was virtual with over 600 providers attending; and the 2021 PDD was a hybrid with both virtual and in-person small-group, breakout sessions.

Methods/approach

Robust PDD educational program was developed:

- Welcome: Executive Medical Director highlighted the necessity of clinician wellness in meeting the challenges of health care delivery today, affirming a commitment to invest in supporting a culture of wellness
- Inspirational testimonial of resiliency: Physician colleague facing career, personal, and/or health challenges
- Keynote speaker: Provided context and scientific support for concepts of physician well-ness and wellbeing
- Breakout sessions (virtual and physical): Activities and classes based on recommendations from the medical group, designed to support SELF CARE, with instructors recruited from the medical group. Attendees selected their sessions and enjoyed time with colleagues

A SELF CARE photo contest held immediately after the 2020 PDD resulted in 282 entries from our physicians and clinicians, who engaged in various H&W activities.

Results

- When surveyed, 98% of attendees stated they were Very Satisfied/Satisfied with the PDD program.
- For the 2020 virtual PDD, 646 clinicians attended (82% of the medical group), and 91% rated the H&W portions of the training as Very Good or Excellent on a CME survey.
- For the 2021 virtual hybrid PDD, 413 clinicians attended (69% of the medical group), and 93% of attendees participated in at least one SELF CARE activity.
- 44% of attendees participated in the SELF CARE photo contest after the PDD, and prizes were awarded to the top 8 entries, one for each SELF CARE category (Sleep, Exercise, Love & Laughter, Food, Compassion, Awe, Resilience, Engagement).

Conclusion

Group-wide Professional Development Days dedicated to H&W are effective engagement tools to promote a culture of wellness and encourage adoption of individual SELF CARE practices within a large, multidisciplinary medical group.

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Fostering connection through tailored communication during the COVID-19 pandemic

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Learning objectives

- 1. Share our medical group's new platform for physician communication during the COVID- 19 pandemic.
- 2. Demonstrate how frequent, timely, systemwide communication with a focus on physician wellness can foster a culture of connection and provide a lifeline during a time of rapid organizational change.
- 3. Learn how such coordinated communication can encourage physician wellness and resilience in times of crisis.

Project objective/background

The American Red Cross Manual on Disaster Services shares a framework of how physicians adapt during a crisis. The COVID-19 pandemic has created uncertainty leading to increased physician anxiety and fear. During times of crisis, physicians need to be able to voice their concerns, receive timely information with direction, and garner resources for themselves and their families. Effective communication during a crisis can reduce stress and improve physician well-being.

Our medical group leadership created a regularly scheduled, live, hour-long audio program called "COVID-19 Airwaves," commencing on March 20, 2020, to inform colleagues on operational changes, provide clinical infectious disease updates on COVID-19, open Q&A opportunities, and offer health and wellness resources to support physicians and clinicians during the pandemic. Following each Airwaves, an email summary digest was shared and included links to earn CME, articles pertinent to the week's program, and a health and wellness topic. Starting in 2021, a segment was added to "Airwaves" entitled "Pandemic Survival Tips," featuring a different physician sharing helpful ways to cope and stay well during the pandemic.

Methods/approach

Development and delivery of a weekly live audio program "Airwaves" for medical group physicians, clinicians, and administrative specialists. The hour-long program includes operational updates, specialty CME related to COVID-19, and a "Pandemic Survival Tip" segment with guest speakers. Creation of a weekly email digest with important operational updates and a link to a Health and Wellness segment. The segments cover a wide range of wellness topics shared by members of the Health & Wellness Committee and other medical group physicians, and touch on SELF CARE (Sleep, Engagement, Love & Laughter, Food, Compassion, Awe, Resilience, Exercise), and helpful videos highlighting useful COVID-19 clinician-patient communication skills.

Results

Starting on March 20, 2020, our medical group created a live audio program and invited 821 participants. At the start of our program, 54.6% of the medical group attended and increased two months later to 70% of the medical group. Participation remains high at 60% on average through 2021.

A February 2022 survey found that 100% of listeners agreed that the program made them feel more connected to their colleagues. And 96% believed it helped to build their resilience.

Conclusion

During the COVID-19 pandemic, delivering a timely, efficient monthly audio program with pertinent information and a health and wellness focus helps clinicians to feel connected to their colleagues, improving their individual resilience.

Fostering professional fulfillment among pediatric hospitalist physicians in an academic setting

Author

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Learning objectives

- 1. Identify strategies that support professional fulfillment for hospitalist physicians
- 2. Understand the importance of professional development opportunities outside of patient care
- 3. Design structures that support autonomy, flexibility, and a diversity of career pathways

Project objective/background

For hospitalist physicians in academic medical centers, there is a tension between clinical demand and the desire to develop professional interests and establish an academic identity outside of patient care. Among pediatric hospital medicine (PHM) physicians, this challenge has been magnified by the introduction of fellowship training programs and board certification. At our institution, an imbalance between clinical and academic priorities was contributing to poor professional fulfillment among PHM physicians, prompting a systematic improvement initiative.

Methods/approach

Members of the PHM section (n=105) at a large academic children's hospital were surveyed using the Professional Fulfillment Index. Qualitative data on priorities for improvement were gathered via iterative open-ended surveys and leaderless forums. A driver diagram and

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strategic plan were developed to inform interventions targeting improved professional fulfillment.

Results

Three themes were identified as vital to professional fulfillment: Sustainable Career, Personal and Professional Development, and Value and Respect. Within each theme, goals were identified and interventions designed to target each goal.

Conclusion

Given constant and ever-changing clinical demands on hospitalist physicians in academic settings, it is necessary to establish systems and structures to ensure that professional development is prioritized. These systems and structures need to be iteratively assessed and refined over time in response to ongoing feedback, with an emphasis on bidirectional communication, flexibility, and a commitment to supporting diverse career pathways.

Theme	Goals	Interventions					
Sustainable Career	Reduce hazard hours	•Strategic hiring of nocturnists and weekend-ists • Scheduling advisory group developed					
	Individual autonomy to choose among a variety of clinical models	 Hospitalists can choose between service lines with different features (i.e shift times, consecutive days of service, front-line vs supervisory work) 					
	Improve work-life balance	Individual scheduling preferences incorporated into the scheduling process					
Personal and Professional Development	Increase access to academic promotion	 Promotion criteria standardized and section members educated on criteria, resulting in 33% of the section being promoted 					
	Increase junior faculty mentorship	Early career mentorship program developed					
	Promote faculty development	Faculty development lecture series launched					
	Promote opportunities to develop professional interests	 Increased opportunities to participate in research, education, quality improvement, and operations Secured funding to support protected time for scholarly projects 					
Value and respect	Redefine and rebrand hospital medicine	 Developed criteria for patients admitted to hospital medicine Worked with enterprise marketing and communications team to define PHM brand 					
	Compensation adjustment	 Benchmarking performed to assess competitive salary range, starting salary was increased by 20% 					



Gender difference in burnout and fulfillment: Can leadership close the gap?

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Learning objectives

- 1. Describe how leadership quality affects the association between gender and burnout.
- 2. Describe how leadership quality affects the association between gender and professional fulfillment.
- 3. Describe how the specific domains of respect and recognition impact gender, burnout, and fulfillment.

Project objective/background

Gender differences in burnout and fulfillment are well documented in physician wellness literature.^{1,2,3} Research is lacking, however, about what to target to improve this gender gap among physicians. We hypothesized that leadership quality moderates gender differences in physician burnout and fulfillment. We further hypothesized that leadership respect and recognition independently moderated gender differences in burnout.

Methods/approach

We analyzed the results of the Physician Wellness Academic Consortium (PWAC) survey of physicians at one large academic health system in 2020. Respondents answered the Stanford Professional Fulfillment Index to assess individual burnout (0-10 scale) and professional fulfillment (0-10 scale). Survey respondents also rated their leadership overall quality and individual leadership characteristics using the Mayo Clinic Leader Index (0-4 scale). We modeled the association of mean leadership quality and self-identified physician gender with burnout and fulfillment in regression models adjusted for provider demographics. Next, we repeated these regressions using models that included an interaction between gender and leadership quality.

Results

We analyzed 2,457 responses from 4,763 physicians to whom the survey was distributed. Respondents selfidentified as 41.2% female, 74% white, and 90% employed full-time. They reported a mean burnout score of 2.78 (SD 1.96) and mean professional fulfillment score of 6.57 (SD 2.13). Higher mean leadership quality was related to lower burnout and higher fulfillment scores (p<0.001). Self-identified female physicians scored 0.41 higher on burnout scales (p<0.001), and 0.47 lower on fulfillment scales (p<0.001) than male physicians. Higher mean leadership quality scores attenuated gender differences in burnout and fulfillment but did not moderate the effect in interaction models. Leadership quality subdomains of respect and recognition did not independently moderate gender differences.

Conclusion

At a large academic medical center, leadership quality and self-identified gender were independently associated with burnout and fulfillment scores (p<0.001). We found that leadership quality attenuates but does not moderate gender differences in burnout and fulfillment. This suggests that while leadership is related to burnout and fulfillment for both male and female physicians, it is not the primary driver of gender differences.

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Graphic medicine: A vehicle to explore humanism and reflection during medical training

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Learning objectives

- 1. Review the role of graphic medicine in medical education
- 2. Explore the utility of a graphic medicine session in students reflecting on clinical experiences and planning their next training year
- 3. Understand how student feedback of this pilot may inform future initiatives to foster humanism in medicine

Project objective/background

The successful retention of medical knowledge is understandably the focus of medical schools. Equally important is the cultivation of humanism in medicine. Art is an underutilized tool in medicine that can foster humanism more effectively than any textbook; it is outside the bounds of board exams; yet more medical schools are incorporating it in their curricula. Specifically, a graphic medicine session was organized for third year medical students to facilitate student clinical experience discussions.

Methods/approach

All 3rd-year medical students were offered an optional 1-hour online session during their Clinical Reasoning Integration Skills Practice course and 12 students elected to attend. The session began with a faculty facilitated PowerPoint discussion about the utility of graphic medicine in education with examples. Students created medical comics illustrating their expectations before 3rdyear, experiences during 3rd-year, and hopes for 4th-year. The session ended with students discussing their work and completing an optional, anonymous feedback survey.

Results

All students (100%, n=12) completed the survey, which consisted of 4 questions rated on a 5-point Likert scale. Most students were not familiar with medical comics (2.17/5; 1 is very unfamiliar, 5 is very familiar). Most students thought drawing a personal comic was valuable in reflecting on their clerkship experience (4/5; 1 is very valueless, 5 is very valuable), and in planning for success during 4th-year (3.8/5). Students rated the session well overall (4.42/5; 1 is poor, 5 is excellent).

Conclusion

This session introduced graphic medicine to medical students and showcased their utility in introspection and formulating plans for success. Participation in the session was perceived by students to be valuable in reflecting on past experiences in medical training and developing clear steps in training and career planning. This deserves further study with a larger group as well as longitudinal follow-up to explore the impact of this session and results of this pilot can inform such studies. The use of graphic medicine has great potential in allowing the expression of complex experiences while evoking humanism in medicine.

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Health care expenditures attributable to primary care physician overall and burnout-related turnover: A cross-sectional analysis

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Learning objectives

- 1. Articulate the excess healthcare expenditures related to burnout-associated turnover in primary care physician.
- 2. Understand how these excess healthcare expenditures costs associated with burnout are in addition to previously identified institutional costs associated with physician burnout due to reduced productivity, and recruitment and replacement costs.
- 3. Consider related areas for future study to advance our understanding of the economic costs of physician burnout.

Objective

To estimate the excess healthcare expenditures due to US primary care physician (PCP) turnover, both overall and specific to burnout.

Methods

We estimated the excess healthcare expenditures attributable to PCP turnover using published data for Medicare patients, calculated estimates for non-Medicare patients and the American Medical Association (AMA) Masterfile. We used published data from a cross-sectional survey of US physicians (conducted between October 12, 2017 and March 15, 2018) evaluating burnout and intent to leave one's current practice within two years to estimate excess expenditures attributable to PCP turnover due to burnout. Published data was used to create a conservative estimate of actual turnover based on self-reported intent to leave. Additional publicly available data was also used to estimate the average PCP panel size and the composition of Medicare and non-Medicare patients within a PCP's panel.

Results

The excess health care expenditures per PCP in the first year after leaving a practice was estimated at \$86,336. PCP turnover was estimated to result in approximately \$979 million in excess healthcare expenditures for public and private payers annually due to effects on continuity of care, independent of recruitment, replacement and lost productivity costs. Of the 316,471 total PCPs, 152,205 are expected to experience burnout at any given point in time. Based on public data, the departure rate over two years was estimated at 9.22% (14,028/152,205) for PCPs with burnout and 5.27% (8,651/164,266) for PCPs without burnout. The difference between these two percentages (3.95%) is the risk of physician turnover over 2 years attributable to burnout. Applying this attributable risk to the number of PCPs with burnout yields 6,012 PCP turnovers in two years or 3,006 PCP turnovers each year attributable to burnout. This turnover results in an estimated \$260 million in excess health care expenditure due to effects on continuity of care attributable to burnout-related turnover in PCPs. Findings from sensitivity analysis suggest annual costs associated with excess healthcare expenditures due to effects on continuity of care attributable to burnout-related turnover range from \$178 million to \$444 million. These costs are in addition to turnover related recruitment, replacement and lost productivity costs.

Conclusion

PCP turnover and its effects on continuity of care, including turnover due to burnout, is costly to public and private payers. Efforts to reduce physician burnout may be considered as one approach to decrease US healthcare expenditures.



Hot-spotting: A methodological approach to identifying and mitigating drivers of burnout

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Learning objectives

- 1. Understand the phases of the Hot-Spotting Intervention
- 2. Identify drivers of burnout within a specific unit
- 3. Align drivers of burnout to mitigation strategies

Project objective/background

The Office of Physician and APP Fulfillment (OPAF) at Spectrum Health in Grand Rapids, MI was established in 2019 as a call to action to address physician and APP well-being. OPAF launched the Well-Being Index (WBI) assessment in 2020 to obtain a baseline measurement of organizational well-being. The WBI is a validated tool that measures six dimensions of well-being: meaning in work, likelihood of burnout, severe fatigue, work-life integration, risk for medical error and risk for suicidal ideation. With the results of the WBI, the OPAF team selects certain high-distress areas to go through an intervention called Hot-Spotting. This intervention is an eight-step process, beginning with leadership commitment, consisting of prework and focus group sessions that result in a co-developed strategic wellness plan aimed at improving the work-place well-being of physicians and APPs within the unit.

Methods/approach

After the 2021 WBI assessment at Spectrum Health, certain high-distress units within the organization were selected for the Hot-Spotting Intervention. In addition to the WBI score, the department's employee satisfaction score, turnover ratio, and patient experience scores were considered as selection criteria. The Hot-Spotting Intervention follows the Nine Organizational Strategies to Promote Physician Well-Being approach (Shanafelt & Noseworthy, 2016).

Results

Department X scored at an 80% rate of high distress on the 2021 WBI assessment. Five physicians and five APPs participated in the pre-work and focus group sessions.

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Leadership participation included representation from the Department Chief, Division Chief, Director of APP Services, Director of Operations, and APP Lead. Results from the prework and focus group sessions found representation in six out of the seven drivers of burnout categories (Shanafelt & Noseworthy, 2016). The strategic intervention plan recommended solutions to mitigate burnout in three areas of the Mayo Clinic Action Sets Triad: Agency, Camaraderie, and Coherence (Swensen & Shanafelt, 2020). Immediately following the focus group sessions, the APP team saw a 20-point increase in employee satisfaction and a 20-point increase in organizational belonging. At the end of the hotspotting process, a post-intervention survey showed that 25% of participants agrees that the hot-spotting initiative impacted their decision to stay employed with Spectrum Health. Upon reassessment of this team as part of the 2021 Well-Being Index Assessment, the team's high distress rate decreased from 80% to 16%.

Conclusion

The OPAF Hot-Spotting Intervention is an effective process that identifies drivers of burnout to mitigated solutions and has been shown to increase employee satisfaction and reduce distress rates within a unit.

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How psychologists contribute to organizational culture change in health care systems: Emerging themes within a burgeoning field

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Learning objectives

- 1. Understand the strengths and training psychologists have in well-being intervention.
- 2. Identify how psychologists contribute to well-being intervention at the organizational level.
- 3. Describe ways healthcare leaders can further support this burgeoning role.

Project objective/background

Psychologists are uniquely suited to guide well-being intervention efforts at the organizational level within healthcare systems and academic medical centers. Psychologists serve in a variety of roles including directing graduate medical education wellness programs, managing peers support programs, providing brief counseling to individuals and teams, assisting with engagement surveys and other types of assessment, and leading well-being strategy. Many of these positions did not exist a decade ago, which means that psychologists are often required to define and create their own role. To better understand the current experiences of psychologists who address healthcare worker well-being at the organizational level, we conducted a national survey.

Methods/approach

Our sample was comprised psychologists and other licensed mental health professionals (n = 22) who work in a hospital setting or academic medical center and have over one quarter of their time dedicated to healthcare worker well-being intervention. Study participants completed a survey to collect information about specific aspects of their role, job duties, population served, mentorship and support resources. Based on their responses, a select group (n =10) completed a 2-hour follow-up interview with a member of our research team to gather more information about their work-related experiences, background and training, lessons learned, facilitators and barriers to success, and recommendations to future psychologists. Frequencies were generated from the quantitative survey results. Grounded theory was employed to identify emerging themes among participants who were interviewed.

Results

Participants well-being roles varied in terms of time allotted for their position, job responsibilities, and population served. Most participants reported engaging in similar well-being programming, including peer support, psychoeducation, brief psychological support, and facilitating system level intervention. Qualitative themes related to establishing parameters within their job responsibilities, navigating ethical dilemmas, identifying mentors, obtaining further training for their role, enhancing their leadership skills, and determining how to better engage in work-life integration.

Conclusion

Psychologists are a valuable resource in addressing culture change within healthcare systems. Our results suggest that psychologists would benefit from further defining their role in organizational change, establishing trainings to enhance their current skill sets, learning from one another, and receiving more support from healthcare leaders.

How rest is defined and fostered among health care providers: A qualitative study of pediatric integrative medicine physicians' perspectives

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Learning objectives

1. Create a definition for rest among pediatric providers

2. Understand how rest is nurtured among physicians who practice integrative medicine

Project objective/background

Rest is a commonly understood basic human necessity. Rest is considered to be synonymous with sleep or inactivity; however, there has been little research conducted on the concept of rest, especially among physicians. Integrative Medicine (IM) is an ideal lens through which the concept of rest can be examined. One of the defining tenets of IM is for practitioners to demonstrate its principles and to engage in selfimprovement, which includes fostering rest in and outside the workplace. We will use this qualitative study to generate a definition of rest and to understand how rest is nurtured among physicians who practice integrative medicine.

Methods/approach

Using qualitative thematic analysis, authors at Stanford University will conduct three semi-structured virtual focus groups (goal of 25 participants) with a diverse group of physicians who practice IM in the US from January to February 2022, using questions developed by investigator consensus. The focus groups will be led by the principal investigator of the study and use qualitative research methods for analysis of categories and themes.

Results

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The focus groups will include open-ended questions on perception, personal attitudes, and antecedents to rest, and allow for open discussion. A pilot focus group conducted in October 2021 was used to create the focus group structure. Preliminary analysis indicates strong interest in this concept, that rest was viewed as a reward and there was a group lack of awareness of the need for rest. This study is ongoing, and results are anticipated in May 2022, which will be presented in full at the conference.

Conclusion

Emerging themes based on this study will be a foundation of creating a definition of rest among physicians. Through these themes, tangible actions can be taken to foster provider rest on an individual, group and organizational basis and treat provider burnout.

How to build momentum in creating a well-being program: A case study

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Learning objectives

- 1. Identify at least 3 elements from this case study that propelled the Wellbeing efforts from Projects to a Program.
- 2. Describe the challenges that were encountered in this journey of creating a Wellbeing Program.
- 3. Examine the relationships and alliances that will benefit your work as you build momentum toward a Wellbeing Program.

Project objective/background

To learn how a Physician Leader from WellSpan Medical Group went from leading sporadic Wellbeing projects as Chair of the Wellbeing Council to building a Wellbeing Program supported by Senior Leadership.

Methods/approach

Physician Leaders wanting to make a difference in improving the Burnout and Wellbeing of their colleagues can struggle gaining momentum within their healthcare system on such efforts. This Leader started with a diverse Wellbeing Council to deliver "Quick Wins" from programming around Wellbeing Speakers and internal Wellbeing Conferences. These successes provided great feedback from the participants, the soil for expansion of wellbeing efforts. This led to this Leader's development as the "Wellbeing Lead" through education, conferences (like ACPH), networking (joining CHARM Network), and mentoring. Subsequently, this Leader established regular meetings with the CMO for updates on Wellbeing projects, created a Wellbeing Budget, expanded the Operational Wellbeing Team, and, ultimately, lead discussion in regular meetings with senior leaders to prioritize wellbeing initiatives mutually beneficial to System Strategic Priorities. The CEO and CHRO ultimately identified this Physician Leader and the Director of EAP to collaborate as dyad leaders for System Wellbeing Strategy Development.

Results

Positive comments and survey results from colleagues attending programming. Improvement in Employee Engagement (EE) Core Measure score for all employees from June 2021 to April 2022 (+3). Maintaining EE Core Measure score for Physicians/APPs (July 2020-June 2021) until pandemic effect April 2022 (-3).

Improving annual Physician and APP Total Turnover metrics from FY18 through FY21 (-2.98%), until pandemic effect FY22 (+3.59%).

Conclusion

This case study can serve as a model for Health Systems that are early in their Wellbeing journey by starting with "quick wins" from Wellbeing projects to growing the Wellbeing Team into a Wellbeing Program while showing the benefit of improving performance metrics on important Strategic Priorities like Employee Engagement and Total Physician and APP Turnover.

Identifying and prioritizing workplace stressors in plastic and reconstructive surgery division of a large academic medical hospital

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Learning objectives

1. Learn how to identify and rank the severity of workplace stressors in a healthcare setting.

2. Learn how to conduct a survey based on a theoretical model of clinician burnout.

3. Learn how to prioritize work system factors for targeted improvement efforts.

Methods

Attending faculty, advance practice providers, nurses, and staff working in the division of plastic surgery at an academic medical institution were recruited to complete a 25-item survey between January 31st and February 10th, 2022. The survey included demographics, a twoitem measure of burnout (emotional exhaustion (EE) and depersonalization (DP); rated from 1 to 6), a twoitem Connor-Davidson resilience scale (rated from 0 to 4), and severity ratings of workplace stressors and their improvement priority based on the National Academy of Medicine's theoretical model of burnout. Workplace stressors were rated for severity using a 5-item Likert scale (0 [not at all] to 4 [extremely high] and priorities for improvements using a 4-item Likert scale (1 [not an issue] to 4 [high priority])

Results

13 out of 14 participants (attending faculty [n=5, 100%], nurses [n=3, 100%], and staff [n=7, 100%]) completed the surveys (92% response rate). Most respondents were female (77%) and white (62%). 92% of respondents indicated high levels of burnout (summative score of EE and DP> 3) with an EE mean (SD) score of 3.8 (1.9) and DP 2.4 (1.6). The mean resilience score was 6.38 (1.14). The five workplace stressors contributing most to burnout were inadequate staffing (mean [SD]) rating of 2.31[1.84]), inefficient workflows (2.23[1.59]), excessive workload (2.15[1.57]), organizational culture (2.15 [1.52]), and time pressure (2.00 [1.58]). Participants provided the

highest priority scores to improvement efforts targeting inadequate staffing (e.g., consistent and dedicated operation room (OR) staff and nurses; 2.00 [1.29]), excessive workload (e.g., provide protected time for quality improvement lead and associate residency program director; 2.00 [1.15]), organizational culture (e.g., improve OR turnover time and reduce delays due to poor hand-offs communication between OR staff; 1.77 [1.01]), extrinsic motivations (provide incentives to retain skilled nurses and OR staff; 1.69[1.18]), inefficient workflows (e.g. modify clinic template to meet requirements of surgeon's office, reduce long clinic wait times; 1.62 [1.26]).

Conclusions

Survey data indicate that plastic surgeons and their support team are experiencing high levels of burnout and resilience and their well-being is being adversely affected by a complex set of interrelated sociotechnical factors such as inadequate staffing, problems related to workflows, increased workload, and organizational culture. There is an urgent need to engage the healthcare system to target improvement efforts and implement the prioritized key improvements.

Implementation of organizational system assessments to promote physician workforce equity

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Learning objectives

Co-authors

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- 1. Introduce organizational system assessments as a tool for promoting equity and transparency within a physician partnership.
- 2. Share the process for chartering work for organizational system assessments.
- 3. Learn a five-step methodology for implementing organizational system assessments.

Project objective/background

Following a series of Listening Sessions held with our physician and employee workforce in 2020, our organization developed a robust strategy for advancing our commitment to equity, inclusion, and diversity. Organizational leaders determined to validate and further explore the concerns raised by physicians during the Listening Sessions via a series of seven "current state" organizational system assessments. Such areas of inquiry included diversity within the physician and physician leader workforce, benefits programs and offerings, and psychological safety and discrimination. A list of all seven assessments and their phased launch timeline is available in Figure 1.

Methods/approach

Charters were drafted for each area of inquiry, outlining the purpose of the assessments, scope, accountable leaders, key deliverables, and other project benchmarks. Charters were reviewed and approved by the Executive Sponsor. Leaders from various organizational departments and stakeholder groups participated in the assessments, including those of Clinician Experience, Human Resources, the Board of Directors and Physician Wellness. Each assessment followed a performance improvement methodology that included: 1) The review of organizational data and information, 2) Process mapping, 3) Compilation of opportunity lists, 4) Prioritization of opportunities, and 5) Summarizing findings and recommendations within a "System Assessment Report."

Results

Findings from the seven system assessments validated the voices of physicians during the 2020 Listening Sessions, while at times also highlighting new challenges or areas of inquiry. Identified opportunities include the need for bias mitigation in the nomination and selection of physicians for leadership development programs, the development of new organizational systems to oversee the filling of open physician leader positions, and the development of tailored benefits programs to meet the unique individual and family needs of physicians. All recommendations were presented to the Executive Medical Director in the form of System Assessment Reports.

Conclusion

System Assessments are a vital step toward promoting equity and transparency within a physician partnership. Findings highlight the myriad ways that inequities can become embedded within organizational structures and systems, and the methodology applied serves as a tool for setting organizational priorities around workforce equity and driving strategy for sustainable systems changes.

Implementation of outpatient Schwartz Rounds in pediatric primary care

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Learning objectives

- 1. Know that burnout is a significant problem in outpatient pediatric practice
- 2. Learn that Schwartz Rounds has been found to improve wellbeing among clinicians
- 3. Understand our experience in creating and implementing Schwartz Rounds in the outpatient setting

Project objective/background

Fifty percent of pediatricians report burnout in 2022, an increase from 40% in 2021¹. Other medical disciplines also report burnout². Participation in Schwartz Rounds, a multidisciplinary venue designed to explore the humanistic aspects of patient care, has been proven to improve clinician wellbeing³. Schwartz Rounds has been successfully conducted at our hospital for several years, however, due to distance and time constraints, outpatient primary care staff rarely participate. Furthermore, few studies examine Schwartz Rounds application in the outpatient setting. In this study, we describe the creation and implementation of outpatient Schwartz Rounds at our academic institution.

Methods/approach

Stony Brook Children's ambulatory pediatric practice is comprised of eight offices throughout Suffolk County, New York. We created a program to conduct Schwartz Rounds at these individual outpatient sites. The sessions are multidisciplinary, including physicians, nurses, and support staff. The sessions occur bi-monthly during a break in patient hours (12:15-1PM). Site selection is rotated to ensure all offices have the opportunity to participate. Topics for discussion are selected in consultation with leadership at each location. To encourage participation, staff are provided assistance in completing their clinical responsibilities before the session begins. Trained leaders from our inpatient Schwartz Rounds assist in facilitating these sessions.

Results

We have conducted outpatient Schwartz rounds at four of our sites. Participants who responded to the survey included attending and resident physicians (36%), nurses (27%), clerical staff (23%), and medical assistants (18%). Feedback from participants using the standardized evaluation form provided by the Schwartz Center⁴ has been positive, with 95% of participants rating the sessions overall as good or excellent. Comments provided by participants include, "I'll be more open and ask others how they are feeling," and "It's nice to hear from my coworkers and to know they feel the same way I do and we are all just doing our best."

Conclusion

Implementation of outpatient Schwartz Rounds is a feasible and acceptable means of improving wellbeing among physicians and staff at our outpatient primary care sites. Next steps include further assessment of outpatient Schwartz' Rounds impact on the wellbeing of participants utilizing focus groups and the Maslach Burnout Inventory⁵.

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Implementing suicide-risk screening to support physicians engaged in physician health program monitoring

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Learning objectives

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- 1. Describe common risks for suicidality experienced by physicians referred to physician health programs.
- 2. List the prevalence of suicide risk among new referrals to one state physician health program.
- 3. Explain why suicide risk screening by physician health program staff is an important component of ongoing efforts to prevent physician suicide.

Project objective/background

Physician health programs (PHPs) are organizations dedicated to the dual missions of: 1) supporting and advocating for physicians with potentially-impairing conditions (e.g., substance use or psychiatric disorders), and 2) working to protect patients from harm.¹ Many participants are referred to their state PHP following occupational, interpersonal, legal, and/or health-related consequences of their disorder. Thus, the initial phase of PHP involvement may represent a high risk period. Specifically, those who experience significant shame or fear loss of their reputation, career, ability to practice, and/ or financial stability may be at increased risk for suicidal ideation/attempts. However, no currently available data document rates of suicidality among physicians participating in PHPs.

As organizations dedicated to physician health and well-being, PHPs have an obligation to understand and minimize the risk of physician suicide. One approach to address both needs is conducting careful, consistent screening. This presentation describes the implementation of a structured suicide risk screening protocol for physicians undergoing PHP monitoring, and presents results obtained from the first year of the program.

Methods/approach

Following staff training, all new referrals were evaluated with the screening version of the Columbia-Suicide Severity Rating Scale (C-SSRS)² at PHP intake, after signing their monitoring agreement, following high-risk events (e.g., job loss, relapse, divorce), and annually throughout monitoring. Chart reviews were conducted to assess the results of screening for new physician referrals in their first year of monitoring.

Results

The 235 referrals included 188 physicians (76.1% male), 30 residents (76.7% male), and 17 medical students (76.5% male). At intake, the majority reported "Very Low" (n = 228, 97.0%) or "Low" (n = 3, 1.3%) risk on the C-SSRS. However, 2 individuals (0.9%) reported "Moderate" risk, and 2 (0.9%) reported "High" risk. PHP staff took appropriate actions to ensure their safety. With regard to lifetime risk, 6 individuals (2.6%) reported "Moderate" risk history, and 5 (2.2%) reported "High" risk history. No screens during ongoing monitoring resulted in greater than "Low" risk, including those conducted after sentinel events. There were no suicide attempts or completions.

Conclusion

PHP staff often interact with physicians during a time of increased psychosocial vulnerability. Although the modal suicide risk rating among physicians referred for PHP services was low, a minority of individuals reported high risk and likely benefitted from timely identification and intervention. Implementing a structured suicide risk screening protocol as part of PHP monitoring is an efficient and effective way to potentially save physician lives.

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Introduction of a universal well-being check-in program for clinical faculty in the department of medicine: A pilot project

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Learning objectives

- 1. To provide faculty with an opportunity to discuss their wellbeing with a peer
- 2. To provide faculty with information re. wellbeing resources at their institution and beyond
- 3. To help normalize discussions about wellbeing, foster a supportive work environment, and contribute to culture change

Background

Physician wellbeing is paramount to the successful operation of healthcare systems, yet innovative programs that support and prioritize wellbeing are lacking. With this in mind, we sought to introduce a novel initiative at our academic institution: a Universal Wellbeing Check-in (WCI) Program, whereby each faculty member would have the opportunity to meet with a trained peer supporter (a wellbeing lead from our established Peers-for-Peers program) for a one-on-one confidential conversation about their wellness. We conducted a pilot project in the Department of Medicine (DOM) to assess the feasibility of implementing this wellbeing check-in program, and to evaluate its impact on faculty.

Methods

DOM faculty received a series of emails introducing them to the WCI Program, and inviting them to schedule a WCI with a wellbeing lead from their division. They also had the option to meet with a lead from another division. WCI's were voluntary, and set to run over a 3-month period. A self-assessment tool was created to help people reflect on their personal wellness. A training video that incorporated a simulated WCI was developed to prepare wellbeing leads to conduct check-ins. Leads were also provided with a "WCI Guide" and a comprehensive list of wellbeing resources to review with peers during check-ins. Faculty members were invited to complete 2 anonymous surveys, one before and one after the WCI period; they could complete the surveys even if they declined a WCI.

Results

78 (52%) of the 150 eligible faculty members participated in a WCI. Uptake varied greatly among the 13 subspecialty divisions (0-91%). Most WCI's were conducted in-person, and lasted an average of 40 minutes. Surveys 1 and 2 were completed by 67 and 46 people, respectively. Most respondents who underwent a check-in perceived it as a positive, comfortable experience, and were willing to have one annually. Awareness of and willingness to access resources increased post-WCI. The primary reason reported for non-participation was reluctance to discuss personal matters with peers. Frustration related to workload and systems issues were widely cited as negatively impacting wellbeing.

Conclusion

Implementing a universal wellbeing check-in program is feasible with the support of leadership and dedicated peer supporters. This pilot project had reasonable uptake, and some inevitable push-back. Next steps include refining the program using lessons learned (e.g., permitting crossdepartmental WCI's), expanding it to other departments, and offering WCI's annually. WCI programs can be an important step on the slow road to cultural change.

Investing in physician leadership development to foster a culture of wellness

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Learning objectives

- 1. Identify ways to invest in professional development and well-being opportunities
- 2. Create cultural change through leadership courses that emphasize the importance of well-being
- 3. Consider ways to build a united front of physician and administrative leaders through educational programming

Project objective/background

Physician leadership development can improve the well-being of both the leaders and those they lead by fostering a culture of transparency, psychological safety, and wellness. This large physician-led medical group offers leadership training, the Physician Leadership Series (PLS), to its several thousand physician leaders.

The philosophy behind PLS is that ongoing leadership development has broad impact on our culture. It motivates physician leaders as they improve their mastery of the skills. It develops a system-wide culture of continuous learning as well as appreciation for diverse perspectives. PLS and other leadership development opportunities encourage "supportive, available, empathic, fair, respectful, compassionate and empowering leadership" (Kings Fund p.4) that supports physician wellness, resilience, and satisfaction, which impacts patient outcomes and satisfaction.

Methods/approach

Our traditional topics had included high performing teams, relationship versatility, implicit bias, and more. As our medical group pivoted to meet the many challenges facing leaders during a pandemic, we added to our leadership development programming to specifically address the emotional needs of physicians.

One program guides participants through the latest science and practice of leading through times of crisis. It focuses on leadership and power, crisis and thriving, and fostering a culture of collaborative leadership.

In addition to this program, we also equipped physician leaders with curricula explicitly focused on how to check in on the wellbeing of their teams, as well as tips and resources to offer to physicians who may be struggling.

Results

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In 2021, 834 physician leaders attended 34 PLS sessions offered as live virtual webinars. Evaluation surveys showed:

- 98% of respondents found the sessions extremely or very valuable for enhancing their leadership skills
- 97% agreed or strongly agreed they would recommend PLS to other leaders
- 82% expressed the intent to adopt the new skills provided through the sessions

Some quotes from participants include

- "I appreciate the fact that (our medical group) is still investing in our professional and leadership development, despite the hardships we have faced."
- "One of the best conferences I've been to. Participating in this remotely rather than driving back and forth was also a huge benefit!"

Conclusion

Ongoing, comprehensive leadership training for physicians is a powerful tool for engagement and culture change. Equipping leaders with skills to lead in a transparent, collaborative way, along with tools to address the wellbeing of their teams is helping our medical group foster a supportive practice environment.

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Is there a home-field advantage in sports medicine clinic? Comparing well-being outcomes of two staffing models

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Learning objectives

- 1. Define differences between integrated versus rotating team-based models of care
- 2. Identify tools to assess professional fulfillment, burnout, and clinical efficiency
- 3. Understand the impact of integrated versus rotating team-based care models on care team members well-being

Project objective/background

Team-based healthcare improves patient access, billable services, and recruitment/retention¹. The staff roles and tasks impacts working to top of license² which likely contribute to professional fulfillment and well-being at work. However, well-being measures comparing teamstaffing models have not been described. We compare well-being measures of an Integrated Consistent Care-Team Model (ICCM) with Rotating Care-Team Model (RTM) in pediatric sports medicine clinics. Our hypothesis is that ICCM providers and staff would consistently demonstrate greater professional fulfillment, less burnout, greater clinical efficiency and more advanced team development compared to RTM providers and staff.

Methods/approach

We identified an ICCM and RTM model within one healthcare system. The ICCM group includes one core team of pediatric sports medicine providers and staff, consistently located in the same outpatient practice setting. The RTM includes varying provider and staff team members at varying locations. All care team members from both models will complete two assessments (0 and 6 months) of professional fulfillment, burnout, and perception of team development. Data collection also includes EMR efficiency metrics.

Results

Time 1 data analysis revealed that ICCM members versus RTM members reported higher professional fulfillment (M = 3.31, SD = .33; M = 2.62, SD = .50), lower work exhaustion (M = .46, SD = .01; M = 1.14, SD = .30), and less disengagement (M = .08, SD = .08; M = .45, SD = .10). ICCM members reported less burnout with a higher supportive work environment (M = 21.92, SD = 2.01; M = 17.64, SD = 2.21) and better overall work environment (M = 43.25, SD = .29; M = 33.78, SD = .75). ICCM members also trended higher in team development.

Furthermore, ICCM providers yielded better EMR efficiency metrics than their RTM colleagues, including less in basket management (M = 3.66, SD = 2.22; M = 5.60, SD = 1.90), PJ time (M = 2.15, SD = 2.12; M = 7.93, SD = 11.97), clinical review (M = 1.06, SD = .25; M = 2.60, SD = 1.34), and EMR time on unscheduled days (M = 11.68, SD = 11.75; M = 44.66, SD = 38.14).

Conclusion

This study describes differences in well-being measures for providers and staff within a pediatric sports medicine ambulatory clinic setting when comparing two different care team models, suggesting that consistent care-team with core providers and less variability has advantages to provider and staff well-being.

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Licensure policy for physicians with medical conditions: A critical analysis of Canadian policy

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Learning objectives

- 1. Understand current best practices for disclosure of physician personal health information in medical licensing applications
- 2. Recognize barriers to disclosure and help seeking for physicians with medical conditions
- 3. Identify the impact of regulatory practices on discourses of personal management of health among physicians

Project objective/background

Medical licensing applications (MLAs) may pose barriers to disclosure and help-seeking among physicians with medical conditions.^{1–5} Recent guidelines outline best practices for identifying and evaluating potentially impaired physicians; however it is unclear whether Canadian MLAs align with these recommendations.^{3,6,7} A series of consensus guidelines in Canada and the United States have provided recommendations for the language and implementation of policies for licensing, evaluating, and supporting physicians. These guidelines recommend that licensure questions should focus on current functional impairment, not the mere presence of a diagnosis or treatment-seeking episode,^{3,6-9} should not distinguish between mental and physical health⁶, should elicit objective information about functional status,⁶ and should include information about confidentiality and safeguarding of personal health information.³ This study aimed to evaluate Canadian medical licensure applications' alignment with best practices, and to understand potential barriers to disclosing illness and seeking treatment.

Methods/approach

We collected medical licensure application forms from all 13 Medical Regulatory Authorities across Canada. We coded applications as "aligned" if they inquired only about current functional impairment, and did not ask about health history, or specific mental health diagnoses. Using methods of critical policy analysis, we analyzed language, framing, and implicit and explicit definitions of impairment and competence to practice within MLAs.

Results

In Canada,¹⁰ (76.9%) licensure applications were not aligned with current recommendations due to questions about historical rather than current impairment. Of these,⁵ (38.5%) included questions about history of mental illness or addictions, irrespective of impairment. Across Canada, physician health and impairment were framed as a "fitness" and "professional conduct" issue, and frequently appeared alongside questions about criminal charges and professional lapses, creating potential stigma around health conditions, particularly mental illness and addictions. Regulatory practices framed impairment vs non-impairment as a binary; yet functional impact of illness exists on a spectrum which is not captured in current licensure policy.

Conclusion

The majority of Canadian jurisdictions do not follow current recommendations for medical licensure policy, which poses potential barriers to disclosure and helpseeking for physicians, and can lead to negative impacts on both physician health and patient care.

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Lifestyle medicine providers report positive effects on burnout and professional satisfaction from lifestyle medicine practice

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Learning objectives

- 1. Describe reasons for LM practitioner burnout
- 2. Discuss reasons for LM practitioners' reduction in burnout levels
- 3. Describe impact of LM practice on professional satisfaction

Project objective/background

Physician burnout is characterized by feelings of depersonalization, exhaustion, and reduced sense of personal accomplishment. Lifestyle medicine (LM) uses health behavior change to treat patients with chronic disease, often yielding positive health outcomes. Objectives included: (1) identify components of medical practice perceived by LM practitioners to contribute to burnout, (2) describe reasons for reductions in burnout levels reported by LM practitioners, and (3) describe the impact of LM on respondents' professional satisfaction.

Methods

In 2019, the American College of Lifestyle Medicine (ACLM) conducted a closed, cross-sectional survey of members. Respondents answered the question: Have you ever experienced a feeling of being 'burned out'? followed by free response questions on burnout experiences, reasons for burnout, and impact of LM on professional satisfaction. Descriptive statistics were generated using SAS software, v9.4. Free-text data were coded into response categories with at least 5% of responses per category. This study was approved by the University of New England IRB.

Results

This analysis included n=482 participants; median (IQR) age 53 (45, 61), and years in practice 18 (9, 26). 64% of respondents held credentials of MD/DO and 87% reported practicing LM. Participants reported feelings of burnout

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all the time (11%), some of the time (21%), occasionally (26%), or never (9%). 28% reported that they used to feel burnout but no longer do. Top three reported reasons for burnout included burden of documentation (33%); barriers to practicing LM (31%); and overwork/work-life balance (29%). Among those who reported they no longer feel burned out, the majority attributed the change to starting to practice LM (67%); having greater work satisfaction because of practicing LM (33%); and self-care improvement (26%). 90% reported that LM had positively impacted their professional satisfaction. Top reported reasons included feelings of accomplishment regarding patient improvement (37%); increased patient satisfaction due to improved outcomes (31%); and enjoyment of teaching/coaching or deeper patient and colleague relationships (21%).

Conclusion

Results suggest that practicing LM can potentially reduce burnout by promoting increased feelings of accomplishment due to improved patient outcomes and reduced depersonalization through positive social connection. Future research should prospectively evaluate changes in burnout among physicians who begin practicing LM and explore how LM may support physicians and other practitioners to counter systemic, organizational causes of burnout.

Mental health of medical trainees at the peak of the COVID-19 Omicron variant pandemic

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Learning objectives

- 1. Investigate the ongoing mental health risks among clinical trainees during the COVID-19 pandemic.
- 2. Explore the relationship between the trainees' perception of COVID-19 and their risk of mental health illnesses.
- 3. Evaluate a potential screening tool for predicting mental health risks in the trainees.

Project objective/background

The Omicron variant of the COVID-19 virus, originally discovered in South Africa1, was detected in the United States in November 20212. Since the first year of the COVID-19 pandemic, New York City has been one of the most affected areas in the country3. Clinical trainees, including residents and fellows of different medical specialties, faced poor perceived institutional support, loss, and imperiled health. Our study assessed the mental well-being of the residents/fellows from November 2021 to February 2022.

Methods/approach

We invited clinical trainees to answer an anonymous survey from November 2021 to February 2022. The survey encompassed COVID-related personal experience questions, burnout (the Oldenburg burnout inventory), anxiety (Generalized Anxiety Disorder 7-items), and depression (Patient Health Questionnaire-2). We used SPSS 27 to analyze the data.

Results

Among those who answered (N=56), 39.3% of trainees endorsed having a COVID-related traumatic experience. Regarding attitude-towards-COVID questions, using bivariate Pearson correlation, a higher score in trouble coping was associated with higher burnout score (r=.450, p=.008, N=34), disengagement subscore of burnout (r=.483, p=.003, N=35), exhaustion subscore of burnout (r=.375, p=.029, N=34), sleep dissatisfaction (r=.485, p=.035, N=19), anxiety (r=.474, p=.005, N=34), and depressive symptoms scores (r=.399, p=.020, N=34). The *insufficient PPE* question was positively associated with the higher burnout score (r=.441, p=.010, N=33), exhaustion subscore of burnout (r=.509, p=.003, N=33), and anxiety (r=.408, p=.018, N=33). Using linear regression, the higher sum of the two screening questions consistently predicted the higher burnout score (β =0.510, p=.007, N=33), sleep dissatisfaction (β =0.554, p=.019, N=19), anxiety (β =0.424, p=.017, N=33), and depressive symptoms (β =0.404, p=.039, N=33). Our results showed consistency after controlling for the trainee's personal loss during COVID, gender, and years in training.

Conclusion

Although our study had a small sample size, our results indicate a high association between certain COVID-19 perception questions (*trouble coping and insufficient PPE*) and increased risk for burnout, anxiety, and depression in trainees during the Omicron variant pandemic. Given the heightened risk for such conditions in our sample, we recommend repeating our study in a larger sample.

Mindful self-compassion training for frontline physicians: A well-being pilot program

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Learning objectives

- 1. It is feasible to recruit physicians for a self-compassion course.
- 2. Mindful Self-Compassion training improves self-compassion among frontline physicians.
- 3. Skills learned in Mindful Self-Compassion training are applicable to patient care.

Project objective/background

Compassion in Action (CIA) is a six-session healthcare adaptation of Mindful Self-Compassion that aims to improve wellbeing and personal resilience in healthcare professionals¹. A pilot program of this course was offered to frontline physicians during the COVID-19 pandemic at an academic medical institution to determine its feasibility.

Methods/approach

The CIA course was offered to physicians of the Department of Medicine Pre and post surveys were conducted using RedCAP. The following were measured: demographics, Short Self-Compassion Scale (SCS), Compassion for Others (CTO), Short Resilience Scale (SRS), ProQOL-Burnout subscale (PBS), as well as qualitative feedback on the course^{2,3,4,5,6,7}

Results

Among 26 physicians who expressed interest in the course, 16 enrolled and provided survey data. Participants were 67% female, 47% were ages 31-50 years, 40% 51-70 years, and 13% were over 70 years. Twenty-seven percent had been in practice for 15 years or less, 40% 16-30 years, and 33% for over 30 years. Baseline to post course, SCS scores improved (mean scores 3.1 to 3.2 on a scale of 1-5), PBS scores were improved (mean scores 25.5 to 23.8 on a scale of 0-50), and SRS scores improved (mean scores from 28.6 to 30.5 on a scale of 8-40). Eighty-eight percent of

the participants found the course helpful while 100% of participants felt that the course was applicable to patient care. At the conclusion of the program many participants stated that they were able to offer themselves compassion when needed.

Conclusion

It is feasible to offer a self-compassion program to busy clinicians during the COVID-19 pandemic. Physicians expressed that the program was helpful and found the lessons to be applicable to their professional settings.

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Mitigating physician burnout and promoting professional well-being: A multidisciplinary team approach in building and implementing a practice transformation program

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Learning objectives

- 1. Understand the American Medical Association's (AMA) Mini-Z survey, an online, evidence-based survey tool designed to capture the joyfulness of a workplace through the lenses of how supportive the workplace is, work pace, and EHR stress.
- 2. Learn a practical practice transformation process and the importance of developing a multidisciplinary practice transformation team.
- 3. Identify potential interventions and outcomes to measure your success with the help of our process and results in reducing physician burnout.

Project objective/background

Physician burnout is a growing problem escalated by the COVID-19 pandemic. In 2019, 80% of physicians reported burnout, and in 2020, 20% of physicians and 33% of advanced practice providers were planning to leave their current practice within two years.

In our rural community, burnout was impacting patient care, morale, staff turnover, and the overall joy of practicing medicine. In 2020, we seized the opportunity to participate in the American Medical Associations' (AMA) Practice Transformation Initiative – an effort dedicated to developing strategies to optimize practice efficiencies, reduce burnout, improve professional well-being.

Methods/approach

Physician burnout is not a reflection of the physician, but rather a fundamental need for system and culture change. To drive organizational change, we recruited a six-member, multidisciplinary team to support a united vision. Our organization-wide initiative included surveying medical and non-medical employees, assessing the viability of interventions and evaluating outcomes.

Utilizing the AMA's Mini-Z survey, an evidence-based tool, we obtained pre-intervention physician burnout results in November 2020. Recognizing the impact of burnout across clinical teams, we expanded the AMA's scope by surveying all levels of staff in workplace atmosphere, care team efficiencies, EMR frustrations, and job-related stressors. Over the course of a year, the team prioritized interventions in these areas based on level of difficulty and degree of impact. In October 2021, we administered our postintervention survey to gauge the success of our efforts.

Results

Our strong pre and post intervention response rates, 86% and 83% respectively, were compared to the AMA National Benchmark data (N = 10,581). Scores for individual questions improved in 9 of 10 categories (job satisfaction, burnout symptoms, team efficiencies, job stress, time spent outside of work, documentation time, work atmosphere, control of workload, and EMR stress). Our overall score improved from 29.9 to 33.2 (national benchmark of 31.1) with improvements in each of the subscales; supportive work environment improving from 17.0 to 18.7 (national benchmark 17.6) and reasonable work pace and manageable EHR stress improving from 12.9 to 14.5 (national benchmark 13.5).

Conclusion

Our team-based approach to identifying and implementing strategies to optimize practice efficiencies, reduce burnout, and improve professional well-being, resulted in a 12% increase in medical providers reporting job satisfaction, 18% fewer medical providers reporting a great deal of job stress, and 26% fewer medical providers reporting burnout. With this approach, we were able to propel our results from trailing behind to surpassing the overall national benchmarks.

Mini-Z Definitions and Targets

Mini-Z Definitions and Targets

Measure and Definition Calculation		Success Criteria				
Joyful Workplace (Min+2 Scores)	Sum of questions 1-10 Range = 10-50	A joyful workplace ≥ 80% (40/50)	80% Burnout Workplace			
Supportive Work Environment (Subscale 1)	Sum of questions 1-5. Range = 5-25	A highly supportive practice ≥ 80% (20/25)	80%			
Work Pace and EMR stress (Subscale 2)	Sum of questions 6-10. Range = 5-25	An office with reasonable pace and manageable EMR stress ≥ 80% (20/25)	80%			

Key questions

	Торіс	Question	Answer Options	Subscale*		Торіс	Question	Answer Options	Subscale*
1	Satisfied with current job	Overall, I am satisfied with my current job	5 = Agree strongly 4 = Agree 3 = Neither agree nor disagree 2 = Disagree 1 = Strongly disagree	Subscale 1	5	Not stressed because of job	I feel a great deal of stress because of my job	5 = Strongly disagree 4 = Disagree 3 = Neither agree nor disagree 2 = Agree 1 = Agree strongly	Subscale 2
2	No symptoms of burnout	Using your own definition of "burnout", please choose one of the numbers below:	5 = I enjoy my work. I have no symptoms of burnout 4 = 3 = I am beginning to burn out and have one or more symptoms of burnout 2 =	Subscale 1	6	Little time spent on EMR at home	The amount of time I spend on the electronic medical record (EMR) at home is:	5 = Minimal/none 4 = Modest 3 = Satisfactory 2 = Moderately high 1 = Excessive	Subscale 2
			1 = I feel completely burned out. I am at the point where I may need to seek help		7	Good documentation	Sufficiency of time for documentation is:	5 = Optimal 4 = Good	Subscale 2
3	Aligned with clinical leaders	My professional values are well	5 = Agree strongly 4 = Agree	Subscale 1		time		3 = Satisfactory 2 = Marginal 1 = Poor	
		aligned with those	3 = Neither agree nor disagree						
		of my clinical	2 = Disagree						
		leaders:	1 = Strongly disagree		8	Calmer work	Which number best	5 = Calm	Subscale 2
4	Care team	The degree to	5 = Optimal	Subscale 1		atmosphere	describes the	4	
	works	which my care	4 = Good				atmosphere in your	3 = Busy, but reasonable	
	efficiently	team works	3 = Satisfactory				primary work area? 2	2 1 - Upstie sheatie	
	together	efficiently together	2 = Marginal					1 – Hetut, thaout	
		is:	1 = Poor		10	No Exustration	The EMP adds to the	E = Strongly disagroo	Subscale 2
9	Workload Control	My control over my workload is:	5 = Optimal 4 = Good 3 = Satisfactory 2 = Marginal	Subscale 1	10	with EMR *	frustration of my day.	5 = Strongly unsagree 4 = Disagree 3 = Neither agree nor disagree 2 = Agree 1 = Agree strongly	Subscale 2
			1 = Poor					1 = Agree strongly	

*No Frustration with EMR is part of Mini-Z v2 questions, but not asked in the national benchmark study

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Mixed methods research exploring the relationship between well-being and burnout in doctors

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Learning objectives

- 1. Understand the current methods used to measure wellbeing.
- Gain an understanding of the relationship between burnout and wellbeing.
- 3. Discuss the importance of salutogenic measures in measuring wellbeing.

Project objective/background

Doctors' wellbeing is of national concern: the GMC, BMA and HEE name it as priority. Wellbeing has no common definition, instead pathogenic measures such as burnout are published as a demonstration of doctors' wellbeing. Yet, the relationship between burnout and wellbeing has not been explored.

Methods/approach

An online cross-sectional national survey was distributed to doctors of all grades and specialties via the Royal Colleges and doctor organisations. The Oldenburg Burnout Inventory (OLBI) measured burnout, and the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) measured wellbeing. Correlation coefficients between total scores of these measures estimated the relationship. Additionally, semi-structured interviews explored personal definitions of wellbeing and its relationship with burnout. Thematic analysis was carried out.

Results

Sixty-four doctors completed the OLBI and WEMWBS. Comparing the total scores for the questionnaires with Spearman's rho indicates a moderate negative correlation (rs= -.658, p=.00, n=64). Total scores were made into binary variables, a Chi-square test showed that a low WEMWBS score (<40) and a very high risk OLBI score (≥2.85 exhaustion and ≥2.6 disengagement) were statistically significantly associated (X 2 (1, n=64)= 4.232, p=.04). Three themes emerged from the 10 interviews conducted: the importance of networks/relationships outside work; skepticism towards the proposal of an NHS wellbeing check-in; and how participants do not strive to improve their wellbeing until its decline.

Conclusion

This research demonstrates that wellbeing and burnout have only a moderate negative correlation when using commonly employed measurement tools. Therefore, measures of burnout are not a surrogate for wellbeing. Further research could adopt a salutogenic approach by using the WEMWBS to monitor doctors' wellbeing and could explore interventions to increase wellbeing, rather than waiting for its decline.

Mobilizing legislation that protects physicians and health care workers in Canada from bullying, harassment and violence

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Learning objectives

- 1. Understand the impact of bullying, harassment, and violence on the healthcare workforce
- 2. Build the case for legislation that can help protect the health and wellness of the healthcare workforce
- 3. Understand the value of advocacy in creating impactful change in healthcare

Background

Throughout the pandemic, there has been a rise in bullying, harassment, and violence against healthcare workers negatively impacting their health and safety threatening the sustainability of Canada's health workforce. Results of Canadian Medical Association's (CMA) 2021 National Physician Health Survey found that more than 75% of physicians have experienced intimidation, bullying and/ or harassment in the workplace, with more than onethird reporting experiencing these issues at least a few times a month. In the face of the urgent issue of safety for healthcare workers, CMA leveraged this data and its advocacy role to urge the Canadian federal government to take swift, legislative action. Bill C-3, an act to amend the Criminal Code and the Canada Labour Code was tabled in fall 2021, and as of January 2022, it is now an offence in Canada to harass and intimidate healthcare workers in their work or intimidate others from obtaining health services.

Approach

As a national healthcare organization, CMA plays a strong advocacy role, a function that has become even more crucial since the onset of the pandemic. In the face of the urgent issue of safety for healthcare workers, CMA urged the federal government to take swift, legislative action, in-part by leveraging current state data from the NPHS. The CMA continued its advocacy as the Bill made its way through the parliamentary process. Now that Bill C-3 has passed, CMA is implementing a multipronged approached to ensure this new legislation is optimized to protect physicians. Recognizing legislation alone does not protect physicians the CMA undertook a follow-up strategy to mobilize this legislation, promoting uptake at the local levels, and building awareness amongst both physicians and the public. This strategy also included working with Provincial/Territorial Justice Ministers and Public Safety Ministers and the Canadian Association of Chiefs of Police, and the development of online resources to educate physicians on the legislative change.

Conclusion

Research on physician and healthcare worker health and safety has a key role in advocacy and legislative change. The incidence and impact of threats against healthcare workers will require ongoing monitoring to promote not only the health and safety, but also the sustainability of the health workforce and health systems. The CMA will continue advocate for the health and wellness of healthcare professionals by working with policy makers and local authorities on enforcing the legislation.

New England surgeons' intent to withdraw from clinical practice as related to burnout

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Learning objectives

- 1. Identify how practicing surgeons intend to limit their clinical practice.
- Assess how burnout relates to surgeons' willingness to recommend medicine and surgery to the younger generation as career choices.
- 3. Recognize the association of burnout with surgeon's intention to withdraw from clinical practice.

Project objective/background

Burnout has been associated with the intent to leave practice, amidst a projected shortfall of 37,00-124,000 physicians by 2034¹. We were interested to know if surgeons intended to withdraw from clinical work, if they would recommend their career, and how these responses related to burnout.

Methods/approach

The New England Surgical Society (NESS) is one of four regional societies representing surgeons in the United States. NESS ran "The Physician Wellbeing Project" survey for six weeks through June 2021, prompted once more at the annual conference in September 2021. Of the 860 members invited by email, 195 opened and 185 completed the survey (22% response rate, 95% completion rate). Standard descriptive statistics described the proportions of "Retreat factors" and promotor scores, chi-square determined statistical independence between dichotomous groups, and adjusted logistic regression to determine the association between burnout and the "Retreat factors".

Results

This was a cross-sectional sample of 138 actively practicing surgeons in the northeast region of the United States representing 11 surgical specialties. The sample is 82% white, 69% male, with a mean age of 50 years old. Based on their work-experience over the past two years, a third to half of respondents planned to withdraw from clinical work. [Table 1] Burnout predicted the likelihood of restricting scope of practice (OR 5.0, Cl 2.1-12.29), rerouting one's career away from clinical work (OR 4.5, Cl 1.79-11.0), and reducing clinical work-effort (OR 3.91, Cl 1.59-

9.57). [Table 2] Respondents were less likely to promote specialization in surgery than going to medical school (mean 4.3 +/-1.8 vs. 6.7 +/-3.1 on scale 1-10). One third would not recommend medical school or surgery. [Table 3] Passive or active promoters of surgery had less burnout compared to detractors (OR 0.17, CI 0.08-0.34, p<0.01 for each level of promotion). Promoters of medical school also had less burnout compared to detractors (OR 0.17, CI 0.08-0.34, p<0.01, CI 0.07-0.32). [Table 4]

Conclusion

This study suggests that projected physician shortfalls will be further exacerbated by burnout. One third of sampled surgeons report an intention to withdraw from some aspect of clinical practice, and they are less likely to recommend the profession to the younger generation. To the best of our knowledge, this is the first study to show the proportion of practicing surgeons who are less likely to recommend medicine and surgery as a profession. Physician burnout has been made a priority in healthcare by the National Academy of Medicine². This study supports the urgency of that recommendation.

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^{2.} Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being, National Academy of Medicine Consensus Report, October 2019

Table 1: Retreat Factors

R-factors:	n	%
Reduce clinical effort	69	50.4
Restrict Scope of practice	59	43.1
Reroute Career	40	29.4
Relocate	32	23.5
Reengage (disagree)	60	44.1
Redesign (disagree)	49	36.0
Retire	68	50.0

Table 2: Retreat Factors Associated with Burnout

Burnout amongst those intending to withdraw from clinical practice: R-factors (chi2)							n with burnout	(adjusted)
	No	t B0	E	30				
	n	%	n	%	р	OR	CI	р
Reduced clinical effort	11	16.2	30	43.5	0.000	3.91	1.59-9.57	0.003
Restrict Scope of practice	13	16.7	28	47.5	0.000	5.03	2.06-12.29	0.000
Reroute Career	20	20.8	21	52.5	0.000	4.46	1.79-11.10	0.001
Relocate	27	26.0	13	40.6	0.111	2.15	0.86-5.35	0.100
Reengage (disagree)	18	23.7	22	36.7	0.099	1.34	0.58-3.10	0.497
Redesign (disagree)	27	31.0	13	26.5	0.580	0.78	0.32-1.90	0.588
Retire	23	33.8	17	25.0	0.259	0.91	0.40-2.06	0.815

Regressions adjusted for practice model, full-time equivalent, race, age, gender

Table 3: Promotor Scores

Net Promotor Scores For Medicine And Surgery Amongst Actively Practicing Surgeons

On a scale from 0-10, how likely is it that you would recommend medical school to your college-aged child if you had one. (scale 0 "not at all" to 10 "extremely likely")

variable	Ν	mean	sd
----------	---	------	----

Recommend medical school (scale 0-10) 136 6.742647 3.110309

 |
 Freq.
 Percent
 Cum.

 -----+
 ----+
 ----+

 detractor
 49
 36.03
 36.03

 passives
 37
 27.21
 63.24

 promotors
 50
 36.76
 100.00

 -----+
 Total
 136
 100.00

"On a scale from 0-10, how likely is it that you would recommend surgery or surgical or sub-specialties to your child in medical school if you had one." (scale 0 "not at all" to 10 "extremely likely")

variable	N	mean	sd		
	-+				
Recommend surger	y (scale 0	-10)	137 4.328467 1.79914		
	Freq. Pe	rcent	Cum.		
	+				
detractors	46	33.82	33.82		
passives	32	23.53	57.35		
promotors	5 58	42.65	100.00		
	+				
Total	136	100.00			

On a scale from 0-10, how likely is it that you would recommend medical school to your college-aged child if you had one.

BURNOUT (bo) d	etractors passives promotors Total
+	
not B0 20	29 47 96
40.82	78.38 94.00 70.59
+	
B0 29	8 3 40
59.18	21.62 6.00 29.41
+	
Total 49	37 50 136
100.00	100.00 100.00 100.00
Pearson chi2(2	= 35.2016 Pr = 0.000
Logistic regression	Number of obs $=$ 118
	LR chi2(5) = 41.12
	Prob > chi2 = 0.0000
Log likelihood = -51	178155 Pseudo R2 = 0.2866
burnout Odds Ra	tio Std. Err. z P> z [95% Conf. Interval]
+	

Rec medicine .1549056 .0592263 -4.88 0.000 .0732184 .3277282
fte .2394844 .296407 -1.15 0.248 .0211717 2.70894
age .9229269 .3060661 -0.24 0.809 .4818226 1.767858
nonwhite 1.555665 1.11367 0.62 0.537 .3824352 6.328118
malevfemale .9013081 .4940241 -0.19 0.850 .3078319 2.638961
_cons 50.17951 118.0535 1.66 0.096 .4988501 5047.575

"On a scale from 0-10, how likely is it that you would recommend surgery or surgical or sub-specialties to your child in medical school if you had one."

Q66_NPS_GROUP
BURNOUT(bo) detractors passives promotors Total
+++
not B0 17 24 55 96
36.96 75.00 94.83 70.59
+
B0 29 8 3 40
63.04 25.00 5.17 29.41
+
Total 46 32 58 136
100.00 100.00 100.00
Pearson chi2(2) = 41.7753 Pr = 0.000
Logistic regression Number of obs = 118
LR chi2(5) = 42.86
Prob > chi2 = 0.0000
Log likelihood = -50.311054 Pseudo R2 = 0.2987
BURNOUT Odds Ratio Std. Err. z P> z [95% Conf. Interval]
Rec surgery .1672146 .0595427 -5.02 0.000 .0832097 .3360274
fte .3774885 .4842241 -0.76 0.448 .0305508 4.664275
age .8872165 .2887487 -0.37 0.713 .4688157 1.679025
nonwhite 1.371589 .9589729 0.45 0.651 .3484095 5.399555
malevfemale 1.26435 .7190435 0.41 0.680 .4147472 3.854347
_cons 25.08885 58.20235 1.39 0.165 .2659633 2366.682

On being a rat, an ant and a physician: The loneliness of the whistleblower in health care—an Egyptian experience

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Learning objectives

- 1. Highlight need for organizational structures to address physician concerns
- 2. Emphasize the humanity of physicians, bringing experiences of loneliness and moral distress to the spotlight.
- 3. Demonstrate risks of whistleblowing both on a personal and professional

Project objective/background

The road leading to the moment of whistleblowing is rife with a range of emotions including anger, grief, loneliness and self doubt. Healthcare organizations that do not address physician concerns related to patient harm places the concerned physician at a crossroad. The choice to blow the whistle with all its consequences at a financial, family, career and personal cost may become inevitable for some physicians. Constructs that ensure that physician concerns are addressed in a timely, fair and comprehensive manner are a mandatory component of a healthcare organization. This project set out to explore worldwide constructs in healthcare organizations that emphasize the fiduciary relation between patients and doctors.

Methods/approach

This is a tripartite work that includes 1- A Subjective experience 2- Two literature reviews of a-worldwide trend in addressing harm to patients, including that in the Arab World and b- A literature review of constructs in place to protect physicians from being forced to whistleblow 3- Discussion with three colleagues: two of the same specialty and one who brought the Speakup guardians construct to the attention of the author.

Results

Worldwide, attention is building toward patient safety. Two concrete constructs exist, one in NHS known as the Speakup guardians and the other is the ombudsperson. All other constructs address concerns through patient safety constructs.

Conclusion

Harm incurred unto patients is underreported worldwide, but especially in parts of the world where the "culture of silence" still reigns. Some countries have taken strides in creating the required environment to report concerns safely for everyone, others not so much. Euphemizing the process into "raising concerns", pats the shoulder of the institution and puts those who report a bit at ease but fails to set the alarm to the presence of two main issues in the blind spot: being torn between loyalties, which invariably leads to burnout and moral distress, and that the very nature of the patient doctor relationship is fiduciary making the reporting of error and harm mandatory, not through a top bottom mandate but rather from a personal obligation toward patients who entrust us with their bodies, minds and souls. A work environment that forces a physician to choose between loyalty to the patient, and loyalty to the institution is one that tears at the soul of the profession.

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Perioperative team relationships are associated with the burnout and professional fulfillment of surgeons in the northeastern United States

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Learning objectives

- 1. Ascertain which relationships in the perioperative space can affect burnout among surgeons
- 2. Identify resources that are most associated with surgeon burnout
- 3. Characterize relationships in the perioperative arena would most benefit from careful cultivation.

Project objective/background

Safe, high-quality surgical care for patients is perhaps one of the most resource-intense multi-disciplinary undertakings in healthcare, involving available resources and skilled professionals across disciplines and multiple phases of care. Effective collaboration of this team requires skillful administrative and managerial support. We hypothesize that a poor grade on aspects of perioperative teamwork and available resources would be associated with high burnout and low professional fulfillment.

Methods/approach

The New England Surgical Society (NESS) ran "The Physician Wellbeing Project" survey for six weeks in May through June 2021, once more at the annual conference in September 2021. Of the 860 members invited by email, 195 opened the survey, 185 completed the survey (representing a 22% response rate, 95% completion rate). Grades (A-B vs. C-F) were calculated for the relationship amongst surgical teammates and the availability of resources. Statistical independence and association of dichotomous predictors with the presence/absence of burnout or professional fulfillment was determined by chi-square analysis and logistic regression adjusted for covariates (practice model, FTE, age, white/nonwhite identification, gender).

Results

This is a cross-sectional sample of 138 actively practicing surgeons in the northeast region of the United States, representing 11 surgical specialties. Non-practicing surgeons were excluded. The sample is 82% white, 69% male, with a mean age of 50 years old. Amongst these surgeons, the relationships with scrub nurses and fellow surgeons in the same discipline were most strongly associated with burnout, followed by the relationship with surgical advance practice providers (APPs), anesthesiologists, and non-surgical MDs. The availability of almost all listed resources was associated with burnout, especially the availability of anesthesia, pathology, and diagnostic imaging. Professional fulfillment was statistically associated with good relationships with surgical APPs and fellow surgeons in the same discipline. [Table]

Conclusion

For practicing surgeons, team complexity and reliance on other disciplines increases the potential factors influencing burnout. Those relationships most associated with burnout were scrub technicians and same-specialty surgeons, therefore those who might most closely share a surgeon's work and operative space. This may make these relationships least tolerant of competing priorities, highlighting the importance of value alignment and shared mission across these groups. Almost all resources showed association with burnout if graded by surgeons negatively, indicating the importance of all components in perioperative care. Improvement in the relationship with almost all other perioperative professions may be a worthy target for mitigation of surgeon burnout.

Reference

Q45 - Over the past year....Based on your observations of the culture in your workplace, how would you grade your team's relationship with ... dichotomous [A + B] or [C D F (fail)]

		Bu	rnout	Professional Fulfillment		
		OR	CI	OR	CI	
1	Fellow Surgeons - in YOUR same discipline	6.22	2.11-18.39	0.24	0.07-0.87	
2	Fellow Surgeons - in OTHER disciplines	2.02	0.67-6.02	0.26	0.06-1.04	
3	Fellow Physicians - non-surgical disciplines	2.79	1.01-7.71	0.38	0.10-1.42	
4	APPs - Surgical Team	3.96	1.14-13.74	0.10	0.02-0.58	
5	Anesthesiologists	3.21	1.08-9.57	0.57	0.14-2.36	
6	Nurse Anesthetists	2.89	0.82-10.19	0.81	0.16-4.00	
7	Nursing — Scrub	13.43	2.10-85.83	0.28	0.05-1.49	
8	Nursing – PACU	2.55	0.88-7.38	0.65	0.16-2.70	
9	Nursing - Floor	2.82	0.85-9.38	0.50	0.10-2.53	
10	OR Management*	1.79	0.73-4.38	0.91	0.27-2.99	
11	Administration	2.35	0.96-5.73	0.39	0.11-1.36	

All achieve chi-square of independence burnout (present v. absent) across dichotomous predictor (A-B v. C-F) with p<0.05 (except OR management). Multivariable regression correlating dichotomous predictor with the outcome of burnout (ref absent) adjusted by practice model, fte, age white/nonwhite, gender

Q47 - Over the past year....Based on your observations of the culture in your workplace, how would you grade these functions....

dichotomous [A + B] or [C D F (fail)]

		Bu	rnout	Professional Fulfillment		
		OR	CI	OR	CI	
1	OR Rooms are available when I need them.	3.07	1.17-8.11	0.39	0.10-1.52	
2	Anesthesiologists are available when I need them.	5.94	2.36-14.96	0.21	0.06-0.75	
3	Scrub nurses and OR support staff is available when I need them.	4.03	1.61-10.09	0.59	0.18-1.96	
4	Other surgeons are available when I need them.	3.77	1.12-12.75	0.30	0.07-1.32	
5	PACU staff is available when I need them.	1.91	0.74-4.90	1.06	0.30-3.82	
6	Diagnostic imaging is available when I need them.	5.58	1.98-15.77	0.44	0.11-1.73	
7	Pathology is available when I need them.	7.31	1.94-27.58	0.23	0.05-1.16	

All achieve chi-square of independence burnout (present v. absent) across dichotomous predictor (A-B v. C-F) with p<0.05. Multivariable regression correlating dichotomous predictor with the outcome of burnout (ref absent) adjusted by practice model, fte, age white/nonwhite, gender

Qualitative analysis of responses: What would most improve teamwork in the OR and Peri-operative arena? (Qualitative analysis to be included at ICPH.)

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Physician burnout in Canada: A scoping review

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Learning objectives

- 1. Quantify literature published between 2010 and 2021 pertaining to physician burnout in Canada.
- Map the literature based on context of each study year of publication; rates of burnout; burnout measures employed; terminology used to describe burnout; specialty/discipline studied; risk factors; treatment/remediation; patient outcomes; economic implications.
- 3. Outline the impact of COVID-19 on published research pertaining to physician burnout in Canada.

Project objective/background

Canada's National Physician Health Survey reported that 30% of Canadian physicians were experiencing high levels of burnout in 2018¹. Yet, our understanding of any burnout framework is often confounded by its underlying complexity. System factors, individual factors, and competency factors can all interact at varying degrees to either promote or challenge physician performance. With an increasing need to understand burnout in Canada in light of the COVID-19 pandemic, exploring the literature is becoming increasingly important to highlight target areas for future research, programming and supports.

Methods/approach

A scoping review was conducted using the search terms physician, burnout and Canada, including subject equivalences, across major databases (e.g., CINAHL, Embase, PsycINFO, PubMed). The search was limited to all articles published between January 2010 and December 2021. Two researchers independently screened each abstract for inclusion and remediated any discrepancies through formal discussion. All articles were tracked using the JBI Inclusion and Exclusion flowchart² and screened using reference exports from each database in excel format. Furthermore, once the second review/full-text screening is completed, all papers will be organized thematically according to: geographic location, date of publication, type of article, specialty(ies) studied, burnout terminology, burnout inventories, prevalence rates, economic implications, risk factors, patient outcomes, and interventions (currently ongoing).

Results

A total of 876 articles were identified through the initial database searches. After the removal of duplicates and the abstract screening process, we included 249 articles for the full-text screening/review (second review is ongoing as of time of abstract submission, March 9, 2022).

Conclusion

Mapping literature from the past decade can hopefully provide clarity as to what areas of burnout have been studied, possible factors that contribute burnout, its impacts on physicians' well-being and performance, and gaps in literature. The COVID-19 pandemic has created large shifts in the provision of care across the world, and it is imperative to understand how the global pandemic has affected already prominent rates of burnout. The results from this scoping review can help guide future research pertaining to burnout in Canada, as well as provide insight into areas where programming and supports may be best suited. Medical regulators and other health care institutions may use this review to inform regulatory bestpractices, as well as provide evidence for physician health monitoring programs.

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S.P.A.C.E.: A novel online curriculum of the core elements of human flourishing and leadership in a large, multi-state health care system—impact on measures of physician and health care team member burnout, well-being and engagement

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Learning objectives

- 1. Learn the framework of a holistic program that supports physician fulfillment
- 2. Understand how qualitative and quantitative analysis demonstrate the impact of this initiative
- 3. Define program elements identified through data analysis that enhance well-being and life satisfaction

Project objective/background

As the pendulum rightly swings towards focusing on organizational and systemic drivers of burnout among physicians and other healthcare team members, there is a risk. Initiatives that support physician and team member self-efficacy and fulfillment are labelled as "missing the point" and "blaming the victim." However physicians and team members receive limited training in core competencies of self-mastery, emotional intelligence, or effective communication required for optimal team-based patient care and effective leadership.

The yearlong SPACE Program for Stress Mastery and Peak Performance was created to strengthen the emotional health, life satisfaction and purpose, and core competencies for leading through change at Novant Health – a multi-state healthcare system with 38,000 team members including 1,500 physicians. The intention is for physicians and team members to develop the core skills to optimize mindset, behavior, and leadership while cultivating a culture of care and connection. The impact will be tracked through check-ins before, during, and after the intervention.

Methods/approach

Many frameworks for human flourishing exist and few have been applied to the healthcare setting. Limited data exists on the impact of such programs on measures of well-being, engagement and experience among physicians. We have designed and will implement a system-wide interactive psycho-educational program based on the science of positive psychology and self-determination theory that empowers participants with the skills of stress mastery, joyful living, effective communication, and leadership. The course content was built around top needs as expressed by team members, and integrated with a culture of coaching. The content will serve as reference for emotional health support, team-building, and leadership development programs. The framework is based on evidence-based principles and practices of mindfulness, emotional intelligence, positive psychology, and self-determination theory.

Modules will include multi-media elements and be delivered with a weekly cadence over the course of one year. 40+ modules are based on 5 pillars of total well-being: Self-regulation, Positivity, Alignment, Connection, and Enthusiasm. Each includes a section on the Why, What, and How of the weekly domain. Rollout strategy will be co-designed with the corporate communications team through various channels including webpage/intranet, community forum, and mobile app.

Conclusion

We will collect data across domains of physician burnout and well-being including self-efficacy, enjoyment of patient care, and sense of meaning, purpose and ability to thrive. Commitment to self-care, work-life balance and connection/belonging will also be assessed and reported. Impact on retention and engagement will also be examined. We will summarize core lessons learned from this novel intervention and describe planned refinements for subsequent cohorts.

Positively energizing leadership training: Developing and implementing a program to address burnout in health care providers

Author

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Learning objectives

- 1. Learn about the science and practice of positive leadership and its impact on organizational culture and employee wellbeing
- 2. Learn how to use this body of research to create and implement a leadership training program within pre-existing meeting structures using short 5 minute "snippets" within a hospital setting
- 3. Gain an in-depth insight into 15 practices taught in the program that can be used to address wellbeing at an organizational level

Project objectives/background

Positive Energizing Leadership (PEL) is a research based approach to building positive organizations and supporting employee wellbeing (Cameron, 2021). It is based on a body of research demonstrating that virtuous interactions with employees is a source of positive emotions, energy, and physical wellbeing. The objective of this project was to develop a PEL program specifically tailored to address the unique challenges facing hospital settings. The program provides tangible practices hospital leaders can use to promote wellbeing on their units that take into account the challenges associated with high workloads, personnel shortages, limited flexibility, and scheduling conflicts.

Methods/approach

A systematic review was conducted of the research based positive organizational practices that are compiled at the <u>Center for Positive Organizations</u>. A three-person panel of scholars familiar with Positive Organizational Scholarship and healthcare reviewed practices for relevance within academic hospital settings. Factors considered included leadership and organizational factors unique to healthcare settings (e.g., job design, complex matrix organizational structures and reporting lines) and unique to healthcare worker wellbeing.

Conclusion

Positive Energizing Leadership (PEL) provides an approach to addressing burnout among healthcare workers at an organizational level. It offers research-based strategies to improving workplace interactions among employees that have been shown to increase energy, positive emotions, and physical wellbeing. These strategies can be compiled and adapted and taught to hospital leaders at all levels throughout the organization.

Practicing well: Integrating physician wellness and continuing medical education

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Learning objectives

- 1. To list barriers to delivering high quality care for patients with mental health problems, substance use and chronic pain.
- 2. To outline a novel education program integrating physician wellness and continuing medical education.
- 3. To describe program outcomes with respect to clinician wellness and improved patient care.

Project objective/background

The concept of the "Quadruple aim" – that the wellbeing of healthcare workers be considered a pillar of good care along with patient experience, improved population health, and health system sustainability has been acknowledged for some time now. Yet, high levels of burnout in the healthcare work force persist, impairing health system efforts to meet the needs of patients and populations.

Methods/approach

In 2020, the Ontario College of Family Physicians (OCFP) began to design a new educational offering on the topics of mental health, substance use and chronic pain, informed by member focus groups. Members articulated a specific need for ongoing development of clinical competence to be integrated with interventions to improve clinician wellness. They also emphasized that their own wellness was linked to practice sustainability and key to ongoing quality improvement in clinical care.

The OCFP designed the Practising Well program to include an online community of practice supported via live monthly webinars focusing on clinical as well as wellness topics. Sessions included a centering meditative arrival exercise, and a brief didactic presentation followed by a longer a facilitated discussion. A group of peer facilitators was deliberately selected focussing on diversity with respect to levels of clinical expertise (from novice to expert), length in practice (from junior to well-established) and practice setting (geographical, practice models). Faculty were trained to model and support clinician vulnerability to normalize wellness issues.

Results

From March 2021 to February 2022, the program attracted a total attendance of 1282 with 478 unique attendees, of the approximately 15 000 OCFP members. 96.59% reported their experience in the sessions being positive and 93.75% felt the sessions increased their clinical confidence. 85.77% felt the sessions helped them manage burnout and supported practice sustainability.

Conclusion

This unique educational offering integrating physician wellness and continuing education had a positive effect on management of patients and physician wellness/practice sustainability.

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Pre-visit lab testing workflow enhances the patient and provider experience

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Learning objectives

- 1. Understand how to implement a pre-visit laboratory testing workflow
- 2. Learn how to accurately measure practice efficiency and patient satisfaction
- 3. Learn tactics, process mapping, and workflow redesign that are patient and provider centered

Project objective/background

As part of the AMA Practice Transformation Initiative, Northwell Health Physician Partners Medicine for Women recognizing a case for change, implemented pre-visit lab testing for well visits. Drawing labs is large burden in ambulatory primary care sites. Reviewing results after a patient visit necessitates significant post visit work. Providers must re-familiarize themselves with the visit, document the plan, and contact the patient with the results. Many lab draws are performed with patients fasting, limiting appointments to the morning.

Methods/approach

Well physical labs were offered in advance of scheduled appointment. In this pilot, we reached out to existing patients two weeks prior to their appointment and offered pre-visit lab draws at a local PSC or office. Utilizing standing protocols, medical staff placed lab orders. Patients had blood draws one week prior to exam, then had their labs reviewed at the time of their visit and were provided a printed copy. Satisfied patients had future lab orders placed for subsequent visits. Project was launched over a 3-month timeframe and is sustainable by ordering future labs at the time of the patient visit.

Results

- High patient engagement in pre-visit lab testing 57.8% of patients chose pre-visit testing
- Practice Test Result Call Volume Reduced by 59.9% (3332 before to 1418 after outgoing test result calls)
 - Patients who experienced pre-visit lab (101 Survey Respondents):
 - 95% of patients would like to continue pre-visit labs
 - 90% said it was easy to visit a local laboratory before their office visit
 - Patients who did not experience pre-visit lab (66 Survey Respondents):
 - 75% would be interested in having blood work prior to next visit
 - Number of well exams performed in the afternoon went from 3.2/week to 4.75/week when comparing the 60 days prior to the intervention to after.

Conclusion

Pre-visit lab workflows drove down post-visit follow up phone calls, decreased staff tasks, additional EMR documentation time, outgoing phone calls by nurses and providers, and improved patient access to their test results. This can be implemented, scaled and continued by offering patients pre-visit labs at the time when their lab work is reviewed and next set of labs are defined.

Primary care physician use and frequency of visit among physicians in Ontario, Canada: A population-based cohort study

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Learning objectives

We have created a world-class data infrastructure to examine the physician health and wellbeing of physicians using big data. To our knowledge, we have created the largest longitudinal physician cohort globally by linking ~50,000 physicians to their own health records in Ontario, Canada (a province with publicly funded health care). We capture all Ontario physicians' demographics, practice information, health care utilization, and health outcomes through this data linkage.

- 1. Participants will have a comprehensive understanding of physician use of primary care, including who is less likely to access primary care (e.g., physician specialty) and how they compare to the population.
- 2. Participants can use these findings to investigate the individual, system and medical culture factors associated with primary care-seeking behaviours.

Project objective/background

Maintaining a healthy physician workforce includes routine primary care physician services. However, physicians face many barriers to attaining formal care. This study aimed to determine access to and frequency of physicians' visits to primary care physicians compared to non-physicians.

Methods/approach

We conducted a population-based, cross-sectional, retrospective cohort study using registration data from the College of Physicians and Surgeons of Ontario. We linked data for all practicing physicians as of March 31, 2018, to Ontario health administrative databases. We used generalized estimating equations to compare primary care between physicians and non-physician, matched 1:5 on age, sex, neighbourhood income guintile and health region. Our main outcomes were enrollment in primary care physician practice and a visit(s) with a primary care physician

Results

Among 19,581 physicians (mean age 44 years, 47% female) matched to 97 905 non-physicians, physicians were less likely to be enrolled with a primary care physician than non-physicians (81.8% vs. 86.4%, absolute difference 4.6%, adjusted odds ratio OR 0.75 95%CI 0.72-0.77), and had fewer primary care visits over the preceding two years (median 2.8) vs. 5.3, adjusted relative rate ratio RRR 0.59 95%Cl 0.58-0.60). In addition, enrollment in a primary care physician practice

and frequency of visits of physicians differed by sex (lower for men), by physician specialty (higher for anesthesia and psychiatry, lower for surgeons) and was greater for those with a history of a mental health disorder.

Conclusion

Enrollment with a primary care physician practice and frequency of visits is lower in physicians relative to the general population. Individual, system and medical culture factors driving this trend need to be better understood so that physicians can better care for themselves and their patients.

Professional mental health programming for physician trainees: Evaluation, innovation and implementation

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Learning objectives

- 1. Learn how a single medical school developed an assessment to evaluate student burnout, well-being, and access to mental health care
- 2. Identify common barriers to accessing mental health care for trainees
- 3. Be inspired to implement changes at your home institution

Project objective/background

Medical trainees demonstrate levels of burnout and depression disproportionately higher than their nonmedical peers, and fewer than 13% access professional mental health services.¹⁻⁴ Our institution conducted a survey on medical student mental health, treatment acquisition, and barriers to care. The results demonstrated areas for improvement, including lack of time, fear of negative career repercussions, and cost of care. Using this student-driven feedback, a new medical student mental health program was proposed and adopted at our institution over the course of one year.

Methods/approach

A work group was assembled, comprised of the Chief Wellness Officer, Student Services Dean, student leaders from each class, a psychiatrist, an academic counselor, and a representation from the Office of Health Equity and Inclusion. The work group conducted an extensive analysis, along with an internal review, evaluation of opportunities and current best practices, and visioning of ideal solutions. A 44-page proposal was presented to and accepted by the Dean, endorsing a set of recommendations with commensurate resources. To best serve our medical students, an annual universal, opt-out mental health screening and a robust two-phase expansion of mental health services was endorsed. Implementation has included gaining broad input from curricular and support team stakeholders, allowing us to best understand how to improve access and timing for appointments and opt-out check-ins. Extensive onboarding materials were created for new therapists, and the roles and responsibilities of academic counselors versus mental health therapists have been detailed.

Results

Institution's students can now access psychological care and psychiatric services at no cost as part of their enrollment. The program provides students with confidential psychiatric evaluations, evidence-based treatment, and referrals to both internal and community-based therapists if needed. All evaluations are done by faculty psychiatrists. One FTE faculty psychiatry effort is funded and is split between 3 faculty psychiatrists. Three therapists have been hired, have started seeing students, and are working to implement the opt-out mental health screenings.

Conclusion

This work imagines a more comprehensive system of care that holistically protects those at all levels of professional medical training by designing barrier-free professional mental health programming that connects trainees with care early and often. We hope that the progress we have made promoting structural and cultural change at our institution can serve as a model for other institutions.

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Professional values and self-care: A qualitative study of how a peer support service helps distressed physicians to cope

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Learning objectives

- 1. Learning objective: Cultural change can be facilitated by conversation in a supportive, safe environment such as a peer support service
- 2. Learning objective: Peer support can be a powerful tool to improve physician well-being
- 3. Learning objective: A shift in professional espoused values makes it possible to evolve the professional identity of being a doctor

Project objective/background

Studies have pointed to cultural values that can make it difficult to voice, accept and deal with situations that can threaten health and well-being among doctors¹. This study investigates if a peer support service for doctors facilitates awareness of and necessary change in professional cultural values to promote self-care.

Methods/approach

Twelve doctors, purposefully sampled in relation to demographics and medical specialty, were interviewed shortly after attending a peer support service in 2018 and re-interviewed a year later to capture what impact attending such a service had. The semi-structured interviews were audiotaped and analyzed with systematic text condensation and interpreted with the help of a theoretical framework including Schein's theory on organizational culture and conceptions of the hidden curriculum in medicine.

Setting – a peer support service accessible to all doctors in Norway.

Results

Each pair of interviews (one at baseline and one at follow-up) provided a glimpse into a highly personal story and thus the material provided great variation both regarding the situation they sought peer support for and the development a year later. However, a common theme at baseline was a difficulty to accept the individual situation due to explicit espoused values of what a good doctor ought to be. One-year follow-up also found a common theme, which gravitated around questioning these espoused values. This seemed to make it possible to accept and adjust their situation.

Conclusion

The paper studies doctors who have sought peer support in a difficult situation. Their situation demonstrates some of the phenomena in the professional culture of medicine that can be unhealthy. We believe these phenomena represent problematic components in the professional culture of medicine that need to be discussed. Peer support offers an arena to legitimizes and facilitate these important conversations. By providing a safe environment the intervention can assist the progress for doctors to broaden their scope of appropriate actions thus making it easier to develop and heal. A shift of values and beliefs in the individual professional can also contribute to the questioning of problematic cultural "truths" more generally within the medical profession of what a good doctor should be.

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Promoting a culture of wellness by reducing email burden and improving email etiquette

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Learning objectives

- 1. Understand the role of email burden in making it difficult for healthcare professionals to disconnect from work
- 2. Name best practices that institutions, teams, and individuals can use to reduce email volume
- 3. Understand the importance of leader role-modeling in changing email etiquette

Project objective/background

The inability to disconnect from work during off-hours was identified as a top pain point for clinicians at our institution. On an organization-wide survey, 53% of clinicians reported difficulty disconnecting from work communications during their free time.

Methods/approach

A clinician workgroup was convened in June of 2021 with the goal of reducing email volume and improving email culture. A quality improvement framework was used to define the problem, develop a driver diagram, and identify interventions to test and implement.

Results

The following institutional drivers of email burden were identified and interventions were implemented to address each driver:

Institutional Drivers

Pressure to respond to emails after hours, especially emails from leaders

Interventions

- Organization-wide CEO message socializing the idea that email responses are not expected after hours
- Leaders encouraged to add email signature indicating that responses are not expected during off-hours
- Leaders encouraged to use delay send feature

Institutional Drivers

Use of email for patient related communication

High volume of institutional mass emails

Interventions

 Communication council formed with representation from across the organization, with the goal of reducing email burden, including shifting away from single-item emails and replacing them with newsletters, shared documents, and websites for communication. Team and individual email practices were also identified as contributing to inefficient and redundant communication. National bestselling author, Cal Newport, was invited to speak about strategies to reduce reliance on email in team workflows. A slide deck was developed to educate teams and individuals on strategies to reduce the negative impacts of email on work-life integration, including turning off notifications during off-shift hours, using away messages while on service or on vacation, and limiting emails to five sentences, among many others. This deck is being presented to local teams by well-being champions and 5 out of the 6 departments within our organization have presented the slide deck in a faculty meeting or disseminated the deck to their colleagues. Within the 18 divisions in the department of pediatrics, 13 have presented the deck at a faculty meeting.

Repeat assessment of clinicians' perceptions of their ability to disconnect from work is planned in the fall of 2022. In addition, we saw a 19% reduction in organization-wide emails in FY22 compared to FY21.

Conclusion

- 1. Leader role modeling and messaging is crucial in changing the 24/7 email culture.
- 2. Practices and workflows need to be modified at an institutional, team, and individual level to achieve meaningful improvement.
- 3. Organizational policies and governance focused on reducing email burden are needed to drive reduction in mass emails.
- 4. Local level champions are best positioned to tailor interventions in a way that will change behavior and encourage adoption of email best practices at the local level.

Proposal of new EHR documentation burden metric (DocLag) for characterization of preferred working hours and EHR usage in clinicians

Author

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Learning objectives

- 1. Learning objective: How can heterogeneity of preferred working hours be incorporated in characterization of EHR usage by clinicians?
- 2. Learning objective: Can the novel metric DocLag be used as an outcome measure for interventions that aim to reduce clinician burnout and increase wellbeing?
- 3. Learning objective: How do existing EHR usage metrics approximate clinician work practices and associated burnout?

Project objective/background

Electronic health records (EHRs) improve health care efficiency, but also contribute to clinician stress and burnout.

For every eight hours of scheduled patient time, ambulatory physicians spend more than five hours on the EHR performing tasks that are perceived as a clerical burden that interferes with the time spent with patients. Existing EHR metrics standardize the measurement of usability in terms of the time burdens imposed by EHR use. However, solely quantifying the amount of time spent on EHR outside of work does not consider the heterogeneity in preferred working hours and may not fully capture clinician preferences regarding when to dedicate time to documentation tasks. Thus, the concept of documentation burden remains inadequately defined.

The purpose of this study is to correlate existing EHR metrics with validated clinician well-being metrics and to define and test the predictive validity of a new EHR metric: the time from the point that EHR documentation is initiated to the time it is completed (DocLag).

Methods/approach

DocLag is calculated from encounter-specific data. Information on check-in time and time waiting after check-in will be used to identify the point at which the clinician begins the process of EHR documentation. Encounter closure time will be used to determine the time elapsed from the first point of contact with the patient to the completion of documentation requirements. The aforementioned encounter-specific times are found in Clarity, a database of Epic variables. Mean DocLag values will be reported for three groups of clinicians: attending physicians, resident physicians, and nurse practitioners. We hypothesized that EHR usage practice, as characterized by DocLag, will vary because of differing practice patterns of different clinicians.

Results

We present a preliminary exploratory analysis from a sampled cohort of 196 clinicians – comprised of 92 resident physicians, 83 physicians and 21 nurse practitioners from the general internal medicine department. DocLag was characterized as the mean documentation lag across all encounters for a given provider between April 1st 2019 to June 28th 2019 (N = 18,280). Across this sample, mean DocLag was 149 hours (SD 132 hours). When broken down by clinician type, mean DocLag for each group was: 190 hours (SD 127 hours) for residents, 120 hours (SD 133 hours) for attending physicians, and 84 hours (SD 93 hours) for nurse practitioners, a significant difference (p = 3.9 x 10-7 by Kruskal-Wallis test).

Conclusion

Current measures of EHR usage may not fully reflect the burden of EHR on the clinician. In defining a new metric of EHR burden that better reflects documentation burden, we can establish a new outcome measure to assess the impact of interventions designed to address the impact of the EHR on clinicians.



Providing education in safe settings: A framework for postgraduate programs to promote resident clinical care, safety and wellness

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Learning objectives

1. Describe a framework to support clinical care safety and wellness in residency training

2. Review the literature on resident clinical care safety in postgraduate training

Project objective/background

There is a lack of formal guidance for postgraduate education to address trainee clinical care safety and risk management. We identified this fundamental need in psychiatry residency and are committed to ensure resident training and learning to occur in safe clinical settings.

Methods/approach

Involving residents in developing our clinical care safety and wellness framework could support reporting of resident assault and safety concerns. We collaborated with residents and created a Resident Safety Sub-Committee (RSS) and a Safety Training Framework at a Canadian psychiatry department. Our goal is to provide residency training with an approach to building resident safety culture.

Results

The RSS developed and disseminated safety guidelines and safety checklists to residents and supervisors at each training site. If a safety incident was reported, the RSS would conduct an incident review and provide suggestions to the site for safety improvements. In 2016-2020, four reviews were performed. Recommended safety improvements included having monthly testing/audit of panic/safety alarms for residents; developing a system to flag high-risk inpatients on patient charts; and modifying physical layout of inpatient units to ensure safety. The RSS also conducted site safety assessments regularly. The RSS created a site safety review template with predetermined safety criteria. A training site is deemed to be adherent (green-coded), mostly adherent (yellow-coded), or not adherent (red-coded) to the safety guidelines. In 2016-2020, the RSS conducted 26 site safety assessments, with 17 green, 9 yellow, and none being red. The RSS offered site recommendations, such as, extending safety procedures to outpatient and day-hospital service; relocating weighted furniture to dedicated patient interview rooms; and including wellness resources/offerings available in resident/site orientation.

Conclusion

The RSS and Safety Training Framework provide a novel approach that proactively and retrospectively addresses resident safety training. Involving residents in the RSS can provide a forum for residents to address attitudinal and institutional barriers to reporting safety incidents and promote social and emotional wellness.

Take-home messages

Engaging residents in developing a Safety Training Framework can promote resident clinical care safety and wellness. Safety guidelines and safety checklists in addition to a transparent process for retrospective incident reviews and proactive site safety assessments should be considered.

Screening and engagement: How to reach there?

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Learning objectives

- 1. To understand the rising rates of physician burnout
- 2. Evidence-based techniques to mitigate burnout
- 3. Novel ways to improve physician engagement in screening and treatment of depression and suicide

Background

The Physicians Foundation's 2021 Survey of America's Physicians: COVID-19's Impact on Physician Wellbeing finds that the majority (61%) express feelings of burnout as compared to 40% in 2018. More than half (55%) of physicians know of a physician who has either considered, attempted, or died by suicide in their career.¹

The American Hospital Association (AHA) estimates that 400 physicians commit suicide each year, and hundreds more have suicidal thoughts.²

Burnout is not a problem of people, but of the social environment in which they work.³ Stress management and resilience-building at the individual level are insufficient to prevent burnout in medical trainees.⁴ That is why institutional or organizational efforts are must. Physician well-being committees play a valuable role in the screening and monitoring the health of physicians in the institutions they serve.⁵

Approach/methods

In 2011, wellbeing committee at an academic center started using a web-based interactive screening program developed by the American Foundation of Suicide Prevention.⁶ The survey was accessed by respondents (residents, fellows and faculty) once a year through a link included an email invitation which emphasized confidentiality. Survey counselor reviewed the survey results and provided feedback regarding risk level to all respondents through the system's messaging feature. High and moderate risk respondents were provided emergency contact information and list of therapist and psychiatrists. Respondents were asked to message anonymously with the counselor through the website or break their anonymity by speaking with the counselor in person, by phone or by email. The summary of results from responses and outcomes of this survey over 6 years (February 2013 to March 2019) are described.⁷

Results

The survey was sent to 1800 residents, fellows, and faculty. Response rate was approximately 14%. Most respondents were at moderate (62%) or high (36%) risk for depression or suicide. Eighty-three respondents were referred for mental health care.

Conclusion

Although 98% of the survey respondents fall into moderate and high-risk category, 60% of them did not engage with the study counselor. This represents the lack of engagement of healthcare workforce in depression and suicide screening. This obstacle could be overcome by healthcare organizations' initiatives to educate, enhance resilience, combat stigma, and increase accessibility to mental health services.

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SELF CARE model

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Conference theme: "Engaging organizations to achieve cultural change" Subtheme: Building a united front for cultural change while activating systems to improve physician well-being

Relation to conference theme

During this current pandemic, physician and clinician wellness has become especially at risk. Our SELF CARE model serves as a strategy and framework to both optimize physician and clinician wellness, and the wellness culture of our organization. In keeping with the Quadruple Aim and Stanford WellMD Models, we see SELF CARE as being foundational in helping physicians (and organizations) sustain through these pandemic times and beyond.

Learning objectives

- 1. Introduction of our evidence-based SELF CARE model.
- 2. Demonstrate the ways that the SELF CARE model was implemented in our organization.
- 3. Learn how intentional incorporation of SELF CARE initiatives improves both the wellness culture of an organization and individual wellness.

Project objective/background

The Stanford WellMD Model identifies three key domains contributing to professional fulfillment, with Personal Resilience and Culture of Wellness being two out of the three. Our medical group recognizes the foundational importance of physician and clinician wellness to personal and organizational success, and promotes a wellness culture through widespread incorporation of the SELF CARE Model: Sleep, Exercise, Laughter & Love, Food, Compassion, Awe, Resilience, Engagement.

Methods/approach

- Development of the evidence-based "CARE" acronym, used with the "SELF" model, by one of our partnering medical groups.
- SELF CARE model presentation to organizational leadership to promote organizational endorsement.
- SELF CARE promotion through Professional Development Days and other events.

- SELF CARE incorporation into publications, marketing, website, recruitment, grand rounds, mentoring programs, and regional incentive goals.
- During the pandemic, our leadership had weekly medical group-wide calls to update the participants on COVID-19 activity in our hospital, clinics, and community. This call was widely attended and always included a SELF CARE message of clinician wellness.
- Weekly "COVID-19 Digests" were published by our leadership, with a summary of COVID-19-related updates for our medical group; each digest ended with a Health & Wellness section, incorporating aspects of SELF CARE for physicians and clinicians.
- Measure results of SELF CARE initiatives, through analysis of Quality of Work Life Survey (QWL) and participation rates in SELF CARE Regional Incentive Goals.

Results

Our medical group's SELF CARE Regional Incentive Goal encourages our physicians, providers and administrative staff to close their personal care gap (colorectal cancer screening, hemoglobin A1c < 8%, BP control, breast cancer screening, cervical cancer screening, statin use, statin adherence). Each year we have exceed the target goal.

Year	Target	Actual
2018	76%	79.6%
2019	79.6%	80%
2020	82%	83%
2021	82%	83%

Conclusion

We found by creating a comprehensive SELF CARE model, and prioritizing its intentional incorporation into our organization, we achieved increased personal wellness for our physicians and clinicians and improved wellness for our organization and our patients.



Shattering stereotypes: An analysis of personality traits and career satisfaction across different specialties in medicine

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Learning objectives

- 1. Identify predominant personality type traits and overall career satisfaction across different medical specialties.
- 2. Evaluate any relationship between personality type and demographics.
- 3. Understand the role our data has in the validation or disproval of specialty-specific stereotypes.

Project objective/background

Specialty-specific stereotypes exist in medicine and lead to prejudices against the personality traits and demographic factors of physicians. Persistence of these stereotypes creates a harmful environment that deters medical students from choosing certain paths. Career satisfaction also plays a major role in medical student specialty decisions. Few studies have evaluated personality traits and career satisfaction across specialties in medicine in an attempt to re-examine pervasive stereotypes. Our aim was to better understand the role of personality on specialty choice and career satisfaction amongst physicians, as well the influence of race, ethnicity, gender, and age.

Methods/approach

To measure personality types, we created an IRB-approved questionnaire based on the mini-IPIP, a 20-question survey that measures the five-factor model (Openness, Conscientiousness, Extraversion, Agreeableness, Neuroticism) of personality traits. To measure quality of life, we adapted the Satisfaction with Life Scale, a five-question validated exam, to ask about career satisfaction. The questionnaire was sent to attendings, fellows, and residents at a large academic health center in central Pennsylvania.

Results

Of the 1502 eligible attendings, fellows, and residents surveyed, 467 people completed our survey (31.1% completion rate). There were 276 attendings, 37 fellows, and 137 residents who completed the modified mini-IPIP and modified Satisfaction with Life Scale. Participants represented 14 different specialties. There were 244 primary care physicians and 223 non-primary care physicians that responded. We found that there was no statistically significant difference in personality type nor were there any statistically significant differences in career satisfaction between any specialties. No differences were found when comparing personality types across demographic factors of race, ethnicity, gender, and age.

Conclusions

Our results indicate that there are minimal differences in overall personality of physicians in different specialties or career satisfaction. This counters the perception that there are stereotypes of personality traits associated across different fields and indicates that career satisfaction may be less of concern when picking specialties. This also may be an indicator that there is an increase in the diversity of personalities in different specialties. Our study can serve to empower aspiring physicians who do not feel that they "fit the mold" of certain specialties despite interest and passion to continue pursuing those fields.

Social distancing at the end of life and its effects on hospice and palliative care providers

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Learning objectives

- 1. Explain the effects that social distancing has had on the hospice experience from an individual and systems-based level
- 2. Identify the way that limited visitation and loss of social support during the COVID-19 pandemic have affected hospice providers
- 3. Discuss the long term consequences of these policy changes and how they might be improved

Project objective/background

Hospice and Palliative care has always put great emphasis on social support and advocating for patients' spiritual and emotional needs. The necessary implementation of policy changes involving social distancing, limited visitation and limiting staff interaction has affected the type of social support available to Hospice patients and their families. The effect that these changes have had on the hospice experience has not yet been systematically studied. We hypothesize that during the pandemic, hospice providers have experienced high levels of burnout and secondary traumatic stress as well as low compassion satisfaction in their work.

Methods/approach

This study includes an ongoing survey of 28 hospice and palliative care providers from across the United States who have worked in a clinical capacity during the period of the COVID-19 pandemic. Subjects were recruited through dissemination at VITAS hospice in Connecticut and advertised in closed social media groups for hospice providers (Facebook, reddit). Burnout (BO), secondary traumatic stress (STS) and compassion satisfaction (CS) were measured using the Professional Quality of Life-5 (ProQOL-5) scale and were compared to demographic variables as well as the impression of pandemic impact.

Results

BO and STS scores were significantly higher in our sample of hospice providers than a large sample (Buselli, 2020) of frontline HCWs during the pandemic (one-sample t (28) =4.73, p<.001; t (28) =5.86, p<.001). CS was not statistically different between groups. All respondents reported that visitation restrictions negatively impacted their patients sometimes or greater, with 84.84% reporting that it affected them Often or Very Often. Higher CS scores were positively correlated with the perception that the pandemic had a greater negative impact on their patients (r = .40, p<0.05). High scores in STS were negatively correlated with respondent age (r = -.41, p<0.05).

Conclusions

Hospice and palliative care workers demonstrated high levels of burnout and secondary traumatic stress during the COVID-19 pandemic as compared to other healthcare workers. Younger providers were disproportionately affected. Visitation restrictions and other policy changes were reported to have a negative impact on patients, especially for providers who reported high compassion satisfaction in their work. The pandemic represents a challenge in how we may better support HCWs and patients in hospice, while still maintaining a safe environment.

SOS: A "System of Support" for second victims of serious anesthesia-related adverse events

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Learning objectives

- 1. Describe the definition and effect of the "second victim" in serious anesthesia related adverse events.
- 2. Describe the support needed by second victims following adverse events.
- Describe the operationalization of a support system for second victims using present resources in an existing hospital system.

Project objective/background

Despite advances in patient safety, adverse events occur in anesthesia, affecting 1.45-2.11% of surgical patients. Following these events, involved clinicians may experience the "second victim" phenomena, a constellation of reactions, including sleep disruption, guilt, anxiety, and intrusive thoughts, which may persist for months or years. The effect on the clinician's emotional and physical health can be significant, but also impacts medical decision making and patient safety. Recovery from adverse events is enhanced when operationalized support systems are available.

Methods/approach

To operationalize a system to support clinicians involved in adverse events, informal interviews were held with anesthesia care teams involved in adverse events as well as departmental leaders. Second victims universally expressed a desire to have time to reflect following an adverse event. Departmental leaders requested a standardized process and identified sources of available personnel to facilitate clinical relief. A literature review was performed to identify aspects of support which should ideally be present in the system and identify gaps in our current practice. Important elements included immediate relief from clinical duties, peer support, access to patient safety or risk mitigation experts, and additional crisis support. The systematic response should not rely on victim self-report, as those involved may not readily come forward nor be aware of the impact the event is having on their current ability to provide clinical care.

Results

We developed a structured, standardized, automatically triggered organizational system incorporating the following elements:

- 1. The charge anesthesiologist immediately removes the clinical team from service for the remainder of the day, regardless of input from the involved clinicians or prior call responsibilities.
- 2. Senior leadership is notified within 12 hours. Leadership, in discussion with the second victim, determines the provider's fitness to return to work and acts as liaison to access additional crisis resources.
- 3. A departmental member of the hospital peer support system is notified to facilitate organizing a debriefing session with the entire perioperative team.

Following implementation, this system was utilized repeatedly in the first few months. The affected clinicians expressed appreciation for the degree and variety of support offered. Similarly, OR leadership expressed recognition for the clear standardized approach to event response.

Conclusion

A standardized process for the support of clinicians involved in serious anesthesia related adverse events can significantly streamline access to support. This system is straightforward to operationalize and can be designed by reorganizing present resources in one's hospital system.

Supporting the people who support the mission: The interactive screening program launch at University of Texas Southwestern

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Learning objectives

- 1. Acknowledge the mental health effects of working health care and the difficulty with accessing help.
- 2. Describe the launch of the interactive screening program.
- 3. Understand how the interactive screening program can provide data about distress levels to leaders as well as provide access to available personalized resources.

Project objective/background

The stress of the pandemic has impacted the mental health of health care providers. In order to support the mental health of our workforce and connect them to appropriate resources, the University of Texas Southwestern (UTSW) launched the Interactive Screening Program1, an anonymous and confidential, validated wellness screening tool that allows asynchronous, personalized outreach from program counselors to connect faculty and staff to available mental health resources.

Methods/approach

Through partnership with the American Foundation for Suicide Prevention, UTSW created a customized website (utsw.caresforyou.org) where faculty and staff can:

- Take a brief stress and depression questionnaire
- Receive a personalized response from a trained counselor
- Exchange messages with the counselor and ask about available local and national resources
- Get feedback and encouragement
- Get referral to psychology or psychiatry services

Through staff announcements, QR codes in staff areas, endorsement and advertisement by leadership through newsletters and forums, directed individual outreach, and social media, faculty and staff were made aware of the platform. Distress levels, engagement with the platform, and number of surveys submitted were tracked.

Results

Between 12/2020 and 12/2021, 388 individuals submitted a questionnaire, 309 of whom reviewed the counselor's response, 103 of whom continued dialogue with a counselor, and 63 of whom requested an appointment or referral to psychological services. The majority or respondents expressed a high level of distress (56% high distress, 27% with high level of distress and suicidal ideation or behavior: Figure 1).

Conclusion

Distress levels are high among our faculty and staff, illustrating the importance of supporting their well-being.

The Interactive Screening Program provides:

- A confidential and low-cost method to connect faculty and staff to available mental health resources
- A way to engage leaders in supporting the mental well-being of their faculty and staff as well as themselves
- An easier way for leaders to initiate conversations with faculty and staff about mental stress and connect them to personalized resources.

Reference

Info about the American Foundation for Suicide Prevention Interactive Screening tool: https://afsp.org/interactivescreening-program

Figure 1: Levels of Distress in Questionnaire Respondents




Supporting wellness, resilience and community with forest therapy

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Learning objectives

- 1. Establish the feasibility of Forest Therapy as a valuable component of a Wellbeing Program for frontline physicians.
- 2. Appreciate feedback from frontline physicians about the value of Forest Therapy and its potential to help with overall wellbeing, lessening burnout, resilience, and recovery after a stressful event.
- 3. Explore the possible ways that Forest Therapy can be integrated into Wellness programs as well as the questions that warrant further exploration.

Project objective/background

Inspired by the Japanese practice of shinrin-yoku, forest bathing/forest therapy (FT) is an immersion practice in nature that supports healing and wellbeing. Trained guides invite people to become aware of all their senses and to experience partnership with the forest. This pilot consists of guided FT experiences for frontline physicians in the Department of Medicine, with the aim to establish the basis for further development.

Methods/approach

The FT experience was advertised as a free wellbeing initiative for frontline physicians. Participants were invited to complete the FT experience at the Arnold Arboretum in Boston, MA. One week prior to the experience, participants were emailed a link to complete a pre-course survey. Post-course surveys were sent out immediately after the course and participants were given two weeks to complete it. Pre and post surveys measured burnout, resilience, and qualitative feedback on the experience.

Results

Twenty-two faculty completed the baseline survey, twenty faculty participated, with 16 survey respondents. At baseline, 86% (19/22) reported feeling burned out more than a few times a year and 50% (11/22) reported feeling burned out more than once a month. 17% (3/18) agreed they have a hard time making it through stress events. Post intervention, 100% (15/15) of participants rated the experience as very or extremely valuable. 100% of participants (15/15) reported they were interested in more frequent forest therapy sessions. 100% (15/15) of participants would recommend this practice to other Faculty. 80% (12/15) of respondents reported the program could help them with burnout. Despite self-report of high baseline resilience, participants reported that forest therapy could help them with stressful events and setbacks. Post-intervention, participants reported feeling relaxed, at peace, and calm.

Conclusion

This pilot program demonstrates the feasibility and acceptability for frontline physicians. Participants stated that they would consider recommending FT to their colleagues, and that they believed that FT can help with wellbeing, burnout and with responding to adversity. This program may also be successfully incorporated into programs for leadership, teambuilding, and peer support after adverse events.

Sustainable system-level change needs to be championed from the top: How hospital top managers reason about the central leadership task of balancing quality of patient care, economy and professionals' fulfillment—preliminary findings from an interview study

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Learning objectives

- 1. Gain insights into how top managers reason about handling the dynamic imbalances between quality of patient care, economy and professionals' fulfillment
- Learn how individually ignite cultural change by acting with "sophisticated resistance"
- 3. Bring home a foundational research-based solution towards more joy in medicine

Project objective/background

To create a more sustainable healthcare the task of balancing quality of patient care, economy, and professionals' fulfillment need to be addressed.¹⁻³ Managers have the formal role and responsibility to balance these dynamic tensions and this is a central leadership task at all levels.^{4-67,8}

While managers most likely aspire to balance these dynamic tensions, it seems from the prevailing health delivery research that something is amiss. In 2017 the National Academy of Medicine launched an initiative to reverse trends in clinician burnout in the USA⁹. In 2019 the UK created a similar initiative to tackle clinical burnout.¹⁰ Also in Norway research has shown a reduced satisfaction among doctors since 2010.¹¹

Although this is a central task for managers at all levels, there is limited knowledge about how top managers reason about balancing the tensions between quality of patient care, economy, and professionals' fulfilment.^{12,13} This study is contributing with knowledge to fill that gap.

Methods/approach

Individual in-depth interviews with all members of the executive management team at a mid-sized emergency hospital were analysed using reflexive thematic method.

Results

Top managers clearly had the intention to balance between quality of patient care, economy, and professionals' fulfillment. This became increasingly difficult in times of high internal or external pressures. In these more conflicted situations then top management acted as if economy was the most important focus. The findings show that the act of balancing is a dynamic and energy consuming leadership task that requires continuous attention by management. It is not a stable relationship that is either achieved or not.

Conclusion

To create a sustainable healthcare, it is crucial for top managers to acknowledge there is no end point of stability to expect when balancing quality of care, economy, and professional fulfillment. This research about top managers reasoning provides critical insights into how leaders can meet these seemingly conflicting needs and endlessly changing demands. This enables top managers to pursuit a cultural change towards more joy in medicine, without exhausting themselves.

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Tackling physician stress and stigma through a collaborative multi-institutional peer support program

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Learning objectives

1.Participants will be equipped with strategies to create a collaborative peer support system

- 2. Participants will have strategies to decrease stigma in help seeking by increasing anonymity in support interactions
- 3. Participants will be able to institute collaborative relationships that accelerate well-being efforts in home organizations
- 4. Participants will recognize how collaborative relationships allow for easily expanded support structures

Abstract

We discuss a wellbeing consortium established among multiple Central New York State healthcare organizations, and the efficacy of that relationship in accelerating wellbeing intervention development in each collaborating organization.

Objectives/background

Safe, high-quality, accessible healthcare is a core tenet of our missions, a goal threatened by increased healthcare worker burnout. Peer support is one intervention to increase staff support and mitigate burnout. Through collaborative efforts of six different institutions, we created, then expanded a multi-institutional multi-disciplinary peer support program (PSP) in Central NYS. Clinicians facing high stress and vulnerability are provided with easily accessible and confidential emotional support from fellow clinicians. The multi-institutional structure enhances anonymity, decreasing barriers to help-seeking, by connecting clinicians to trained supporters outside of their home institutions.

Approach

Concerned that familiarity within small rural organizations would increase help-seeking barriers in times of distress, the lead organization began collaboration discussions with other regional organizations sharing similar highhealthcare-disparity patient population types, graduate medical education programs, and interests in developing a peer support program (PSP). With grant funding secured on March 13, 2020, the combined resources of participating organizations allowed the rapid development and deployment of a multi-institutional multi-disciplinary peer support program by May 4, 2020. Through monthly discussions supplemented by program and local data, including shared wellbeing surveys, there was rapid expansion and promotion of the peer support program, collective learning, and broadly applicable innovation.

Results

- Clinician surveys demonstrated that most clinicians (~69% of practitioners, ~57% of nurses) believe the multi-institutional PSP structure decreases helpseeking stigma. 45% of individual referrals to the PSP (including physicians) are self-referrals.
- Shared well-being survey efforts facilitate well-being discussions among each institution's respective administrations and improve peer support programming.
- The collaborative promoted development and honing of proactive outreaches to distressed clinicians.
 Volunteer peer supporters are also employed in novel roles that improve crisis response systems and wellbeing championship. A shared multi-institutional "Wellbeing Grand Rounds" features engaging topics from addressing mental health stigma and psychological safety, to human factors engineering and process change, geared toward accelerating culture change toward improved clinician well-being.

Conclusions

The multi-institutional peer support collaborative accelerated well-being efforts in participating organizations. The synergy permitted expansion of wellbeing efforts beyond the original partnership. Peer support program structure helped create psychological safety, increasing help-seeking accessibility. The model easily expands and is adoptable by larger systems, including

The development of an internal coaching program to improve physician and APP fulfillment

Author

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Learning objectives

- 1. Describe the elements of an internal coaching program that targets front-line physicians and Advanced Practice Providers (APPs)
- 2. Identify key metrics of success for a physician and APP coaching program
- 3. Discuss outcomes from a 6-month initial pilot program

Project objective/background

Developing an internal coaching program was identified as a key tactic to improve personal well-being and foster a culture of wellness. Coaching has been noted to have a positive impact on physician well-being, including the reduction of emotional exhaustion¹. Another randomized trial showed that coaching alleviated burnout and improved well-being for primary care physicians². Coaching methodology offers a process of inquiry, accountability, and support to develop a roadmap and strategies for improved professional fulfillment. The objective of this pilot was to design an effective coaching program, offer coaching as a benefit, and study the effects on professional fulfillment.

Methods/approach

In 2020, exploratory work began to build an internal coaching program. Best practices from other leading organizations were reviewed and ultimately, three team members completed a rigorous 6-month-long program accredited by the International Coaching Federation (ICF). In January 2022, the program launched with capacity for 28 participants. The program includes five phases: Enrollment, Discovery, Collaborative Goal Setting, Implementation Coaching, and Milestone Review. There was extensive interest in the program. Acceptance into the program was based on availability and alignment with the goal of achieving diversity of gender, race/ethnicity, specialty, employment status, and career stage.

Results

Of the 28 participants, there were 10 advanced practice providers, and 18 physicians. Other demographics included 22 female and 6 male participants, 9 of which are in the early stages, 15 in the mid-stage and 4 in the late stages of **Co-author** Kara Pettinger, LMSW

their career. Of the participants, 19 identified as Caucasian, 4 as African American, 4 as Asian (not Hispanic or Latino) and one as other, not listed. There was attrition of one physician and one APP over the course of the program.

After completing the program, 40 % of the participants agreed or strongly agreed that the Coaching Program impacted their decision to stay employed with the organization. In the pre-intervention assessment, 36% of participants noted to be satisfied in their role most of the time, while 36% noted to be satisfied sometimes. At the end of the program, 80% of participants agreed that the Coaching Program improved their overall job satisfaction.

Conclusion

Vetted coaching tactics and strategy were used to build a novel internal coaching program. There has been initial great interest in enrolling in the program from physicians and APPs signifying that the goals of coaching to improve professional fulfillment are desirable. Evaluation metrics suggest that coaching is an effective intervention to improve job satisfaction and improve retention.

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The impact of Schwartz Rounds attendance on the flourishing of pediatric health care professionals: A qualitative study

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Learning objectives

By the end of this presentation, participants will be able to:

- 1. Summarize the benefits of Schwartz Rounds (SR) as delineated in current medical literature.
- 2. Describe the five PERMA elements that maintain human flourishing.
- 3. List the eight themes identified among frequent and non-frequent SR attendees that pertain to clinician flourishing.

Project objective/background

Clinicians' wellbeing has been jeopardized by the coronavirus pandemic.¹ Interventions that aim to improve staff wellbeing such as Schwartz Rounds (SR) are critically needed. SR is a forum for clinicians to openly share social and emotional issues that arise in patient care.^{2,3} SR has been shown to normalize emotional experiences⁴, increase understanding between staff⁵, and reduce psychological distress endured by the provider⁶. However, the research has yet to investigate its impact on human flourishing, a concept of well-being founded by Martin Seligman. Flourishing is maintained by the five elements of PERMA (positive emotion, engagement, relationships, meaning, and accomplishment).^{7,8} This study postulates that frequent attendance at SR is associated with greater contributions to the five PERMA elements, and aims to evaluate this relationship.

Methods/approach

Clinicians from or associated with the Department of Pediatrics participated in focus group (FG) interviews. Questions were developed from the Secure Flourishing Index⁹ and Community Workplace Flourishing¹⁰ tools. The authors SI, WL, and UO independently transcribed, coded, and analyzed the FG data using a direct content analysis based on the conceptual framework of PERMA. A consensus was reached among the themes and identified quotations.

Results

FG participants included 16 SR attendees (7 frequent, >2 sessions since 2019; 9 non-frequent, ≤2 sessions since 2019), who were pediatric clinicians of multiple disciplines as shown in Table 1. Data saturation was determined after these sessions. Table 2 lists the FG questions, direct

quotations, and themes in alignment with PERMA. Seven themes were identified among frequent SR attendees: SR 1) serves as a safe and trusted space, 2) promotes validation and support, 3) facilitates introspective thinking, 4) stimulates perspective shifts, 5) augments compassion, 6) reaffirms purpose, and 7) positively impacts one's professional identity. In comparison, non-frequent SR attendees recognized themes 3 and 5-7, and found that SR 8) humanizes medicine. All eight themes were categorized under \geq 1 PERMA elements (Figure 1). In addition, SR had no reported impact on resilience for either group.

Conclusion

While considerable thematic overlap between groups was observed, themes found in the frequent attendance at SR coincided with greater overlap with the five PERMA elements. Given these findings, frequent SR attendance may contribute to a greater flourishing.

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The impact of the physical clinic environment on physician well-being and job satisfaction

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Learning objectives

- 1. Create a novel instrument for measuring physician satisfaction with their physical clinical environment.
- 2. Use this instrument to evaluate physicians' satisfaction with their workspaces before and after a move from a traditional closed-office clinic to an open-concept clinical environment.
- 3. Assess the impact of an open-concept clinic layout on various physician responsibilities; including in-person clinical care, telemedicine, teaching, research, staff communication, and administrative work.
- 4. Determine if the transition from a traditional closed-office workspace to an open-concept clinic layout is correlated with changes in rates of physician burnout.

Background

Chaotic work environments are correlated with higher physician burnout.^{1,2} Half of primary care physicians report such environments². Literature in managerial fields show that an open-office design is associated with poorer privacy, job-satisfaction, and inter-personal relationships as well as increased cognitive loads.^{3,4}

Methods

A survey was designed that combined validated wellness (AMA Mini-Z) and built environment survey instruments with additional questions relevant to an academic primary care practice. This instrument was disseminated to primary care physicians at a large academic health system before and after the transition from a closed-office workspace to an open-concept clinic.

Results

Twenty-two physicians were surveyed 7 weeks before the move, and nineteen physicians were surveyed 11 weeks after the move. Burnout (measured by the one item Mini-Z) before the move was 5/7 (71%) for the 'non-move cohort', and 7/15 (47%) for the 'move cohort' (0.381). Burnout after the move was 4/8 (50%) for the 'non-move cohort', and 4/11 (36%) for the 'move cohort' (0.658). Comparing burnout within the 'move cohort' before and after the transition also did not yield a significant difference (0.701).

After the move, there was a decrease in the proportion of physicians who described their work environment as "free of distractions" [10/15 (67%) to 1/9 (11%) (0.013)] and adequately private for patient communications [11/15

(73%) to 2/9 (22%) (0.033)] and personal matters (eating, phone calls, etc) [8/15 (53%) to 1/9 (11%) (0.191)]. In the open layout, there was a trend toward improved physician collaboration [5/15 (33%) to 5/9 (56% (0.403)] and care team efficiency [(4/15 (27%) to 6/11 (55%) (0.228)]. And a trend away from support for teaching [8/15 (53%) to 2/9 (22%) (0.210)], and telemedicine [7/15 (47%) to 2/9 (22%) (0.389)]

Conclusion

In an academic primary care practice, moving to an open office design was not correlated with changes in physician burnout. The open-concept clinic significantly worsened distractions and decreased privacy for patient communications. There was a trend toward improved physician collaboration and care team efficiency but worsened support for teaching and telemedicine. Further investigation of these trends in a larger cohort is needed to inform the design of clinical environments that optimize workplace efficiency and physician well-being.

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The measure matters: A core outcome set for physician well-being

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Learning objectives

- 1. Raise awareness of the need for conceptual clarity when discussing physician wellbeing
- 2. Raise awareness of the Core Outcome Set for physician wellbeing, developed with input from last years' conference

Project objective/background

Doctor wellbeing should be a concern for everyone. We are missing at least 8,333 doctors in the National Health Service (NHS) in the UK, and 50-80% of doctors internationally are at high risk of burnout. Unfortunately, doctor wellbeing has not been measured well, and there have been repeated international calls to measure it properly. A positive development in health care is that groups of outcomes that are agreed on by experts and patients are being used ever more frequently, so that we can measure and compare the same things: Core Outcome Sets.

Methods/approach

A critical review was undertaken to create an operational definition of wellbeing, which informed a systematic review of how doctor wellbeing has been measured. The acceptability and design of a Core Outcome Set was evidenced through Patient and Public Involvement (PPI), expert surveys and regional, and national, cross-sectional surveys and interviews among doctors. A Delphi Study of doctors, and national stakeholders in the UK was undertaken to agree a Core Outcome Set, following Core Outcome Measurement in Effectiveness Trials (COMET) guidelines.

Results

Systematic review identified 218 studies where wellbeing was an explicit outcome. Fifty-seven unique outcomes were identified, and the Maslach Burnout Inventory (n=18) was the most commonly used measurement tool. Cross sectional surveys (n=348 doctors, n=40 experts) and interviews (n=11) confirmed that doctors felt a salutogenic Core Outcome Set was appropriate. The Delphi study led to an agreed minimum set of 7 outcomes: General wellbeing, Health, Personal safety, Job satisfaction, Life work balance, Morale and Good clinical practice.

Conclusion

Use of a Core Outcome Set for wellbeing, alongside reporting standards and open access publishing by researchers, will ensure that when doctors take time to complete wellbeing surveys, they are evidence-based and make the data collected comparable. This will provide evidence for the system level changes that could really improve doctor wellbeing.

The Michigan Action Progress System (MAPS): Enhancing a culture of professionalism, accountability and psychological safety

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Learning objectives

- 1. Identify current experiences of trainee wellbeing
- 2. Share innovative process to promote professionalism, accountability, and psychological safety
- 3. Establish engagement among stakeholders

Project objective/background

Well-being is a priority among medical training programs.¹⁻² One strategy for supporting well-being is creating infrastructure where individuals may raise concerns without fear of retribution.³ One critical component is promoting psychological safety– the belief that there will not be punishment or humiliation for speaking up—which influences intent to report adverse events.⁴ Attending to the vulnerability of learners requires careful consideration of the hierarchical nature of medical training. We employed a sustainable, community inclusive communication mechanism that allowed concerns to be raised in a safe manner.

Methods/approach

The Michigan Action Progress System (MAPS) was implemented in February of 2021. Key tenants of MAPS include focus on needs of the person using the system (the petitioner), consolidated handling of concerns (statements), transparency and documentation, and emphasis on education and improvement. Engagement of stakeholders, selecting MAPS representatives, and partnering with human resources during implementation are described. Workflow is also detailed, including how statements are entered, representative statement management and engagement with petitioner, potential responses, and closing the loop and eliciting feedback.

Results

Since implementation, a small number of statements addressing acts of incivility have been submitted.

Our early experience reemphasized the benefit of a partnering system, as representatives could discuss various management strategies, obtain feedback, and provide support. These conversations allowed for clarification regarding the importance of capturing events as a means to intervene early and identify trends. Members of our community have discussed the utility of MAPS as an accountability mechanism, highlighting that implementation has further solidified generalized commitment to promoting a culture of professionalism and accountability.

Conclusion

Everyone should be able to raise concerns without fear of retribution. MAPS is one innovative strategy that allows for safe reporting of concerns and fosters professionalism, accountability, and civility. Other programs may take steps to establish similar programs elsewhere.

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The state of wellness education in medical schools across North America: A scoping review

Author

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Learning objectives

- 1. What is the current state of wellness curriculums across North American medical schools?
- 2. From schools that do have a wellness curriculum in place, which common themes are identified?
- 3. How can we use this knowledge to build a national evidence-based wellness curriculum framework?

Project objective/background

Medical students experience increased rates of burnout, depression, and suicide compared to the general population. Yet, it is unclear to what extent North American medical schools have adopted formal wellness curricula. Further, the content and delivery methods vary widely. We sought to establish prevailing themes of existing wellness curriculum across medical schools and aimed to identify opportunities for further curricular development.

Methods/approach

We conducted a scoping review of the literature searching for wellness education programs implemented for undergraduate medical students across North America. Four comprehensive databases and grey literature were searched. Only published original research was included. All papers were screened by two independent screeners with disagreements resolved by a third coder.

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Results

The initial search identified 3996 articles of which 30 met our inclusion criteria and were included for further analysis. Of these studies, three are from Canadian institutions. The most common type of intervention across studies was mindfulness and meditation practices which were included in 18 studies. Importantly, 27 of the studies found their interventions were significantly effective at improving reported mental well-being in some scope.

Discussion

Our review identified a low number of published mental wellness curricular initiatives and many of those identified are of poorer methodological rigor. The themes of existing literature suggest that the adoption of a wellness curriculum has the potential to improve mental health outcomes for medical students. As such, these findings can be used to assist in the development of a validated mental wellness curricular framework to be used across institutions.



Thematic analysis and natural language processing of jobrelated problems prior to physician suicide in 2003–2018

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Learning objectives

- 1. To examine the specific nature of job-related problems prior to physician suicide
- 2. To consider systemic interventions to reduce job-related problems prior to physician suicide
- 3. To learn about the utility of a mixed methods approach combining thematic analysis and natural language processing for analyzing qualitative data

Project objective/background

Although previous studies have consistently demonstrated that physicians are more likely than non-physicians to experience work-related stressors prior to suicide, the specific nature of these job-related problems remains unknown. The objective of this study is to examine the specific nature of job-related problems prior to physician suicide. The present study analyzed data from the United States Center for Disease Control (CDC) National Violent Death Reporting System (NVDRS) in attempt to contextualize the job-related risk factors for physician suicide.

Methods/approach

This mixed methods study used inductive and deductive thematic analyses and natural language processing (NLP) to analyze death investigation narratives of physician suicides with implicated job problems in the National Violent Death Reporting System database between 2003-2018. The National Violent Death Reporting System integrates information from certified medical examiner reports, toxicology data, law enforcement investigation narratives, and death certificates, making it the most comprehensive database of violent deaths in the United States available to date. The study sample included 200 physician deaths by suicide.

Results

Representative themes contextualizing job-related problems preceding physician suicide were determined. Through thematic analysis, six overarching themes were identified: incapacity to work due to deterioration of physical health, substance use jeopardizing employment, interaction between mental health and work-related issues, relationship conflict affecting work, legal problems leading to work-related stress, and increased financial stress. NLP analysis identified themes congruent with those determined through thematic analysis and elucidated important subthemes.

Conclusion

This is the first known study that utilized an integrated approach combining thematic analysis and NLP to characterize work-related stressors preceding physician suicide. These findings highlight the importance of bolstering systemic support for physicians undergoing job problems associated with their physical and mental health, substance use, relationships, legal matters, and finances in suicide prevention efforts.

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Understanding sources of distress among resident physicians

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Learning objectives

- 1. Describe unique contributors to distress among resident physicians.
- 2. Identify potential local interventions to reduce distress among resident physicians.
- 3. Identify specific topics to investigate at your institution to better understand distress among resident physicians.

Project objective/background

Occupational distress among physicians threatens wellbeing but is usually multi-faceted. Medical residents are unique as they are simultaneously learners and providers. These competing responsibilities make them especially vulnerable to distress. Many contributors to distress are unique to local healthcare systems. Describing local systems and factors that contribute to residents' distress may guide intervention efforts. Therefore, the purpose of this study was to describe the contributors to distress among residents at our institution from different specialties at different times in training.

Methods/approach

The study was conducted with resident physicians at the teaching hospitals affiliated with Washington University School of Medicine. Utilizing semi-structured interviews, we explored specific sources of distress, changes to residents' experience from year-to-year, resources for support, and perceived interventions to reduce distress. We recruited a purposeful sample of residents, sampling for diversity across years and types of residency (hospital-based, medical-based, and surgical-based). Interviews were transcribed and inductively analyzed to identify themes and relationships between themes.

Results

20 residents participated (7 hospital-based, 5 medicalbased, 8 surgical-based; 4 PGY1, 5 PGY2, 6 PGY3, 5 PGY4). We identified 7 thematic groups as contributors to distress: workload, work resources, work-life balance, support, culture, resident mindsets, and COVID. Support and culture were the most frequently identified. Workload, resources, and work-life balance included systems barriers, lack of resources to help manage the load, patient-related stressors, resources to support coping, and resident control over schedules. Workload due to complex schedules, volume of responsibilities, and documentation demands contributed to exhaustion and distress. *Resident mindsets* included distress associated with complexity of patient illnesses, related psychosocial issues, and limited time to process patient interactions. *COVID* added to pre-pandemic levels of distress and increased exhaustion, isolation, uncertainty, load of responsibilities, and changes in day-to-day schedules at work and home.

Culture, including tone set by leadership and relationships in the workplace, often exacerbated residents' distress. Prominent in this theme were psychological safety, negative interactions, clinical autonomy, and responses to mistakes. Residents described the presence or absence of support (social: relationships, people listening, appreciation, group activities; professional: career growth, teaching, high quality training) as promoting or undermining well-being and ability to cope with demands of residency.

Conclusion

Themes identified by residents align with prior publications about areas of challenge, but they also offer unique vulnerabilities. Our data highlight key areas for intervention, particularly around the culture of leadership and teamwork. Additionally, we identified specific resources that might reduce distress among residents.

Using a Hospitalist Morale Index (HMI) to measure well-being during the COVID-19 pandemic

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Learning objectives

- 1. To describe how to monitor system-wide hospitalist well-being using the Hospitalist Morale Index (HMI)
- 2. To understand how the HMI relates to measures of morale, quality of life, and burnout
- 3. To understand the potential impact of demographic or clinical factors on well-being

Project objective/background

Measuring, monitoring, and enhancing provider well-being during the COVID-19 pandemic is essential. This study evaluates a Hospitalist Morale Index (HMI) as a measure of well-being compared to other morale, quality of life, and burnout measures.

Methods/approach

HMI is a scale comprising 5 domains: clinical, workload, leadership, appreciation & acknowledgement, and material rewards. Overall and domain scores are weighted means of items based on importance and satisfaction ratings, ranging from 0 (low) to 5 (high). We surveyed hospitalists in 5 programs on quality of life, morale, burnout, depression, and thoughts of leaving medicine or the group. Demographic factors included age, sex, race/ethnicity, and having children. Clinical factors included academic role, position, years as a hospitalist and with current group, number of groups worked for, and percent clinical. We used ANOVA and logistic regression to determine the association of HMI between groups and outcomes, accounting for site clustering.

Results

Of the 183 hospitalists, 141 (77%) responded; 54% were women, 42% Caucasian, 39% Asian, 5% African-American and 1% Latino. The majority of physicians were 35-44 years old (44%), with 28% <35 years old. By position, median 90% clinical time [IQR: 65%, 100%], 46% were Clinical Associates, 42% Faculty Physicians, 12% PA/NPs; 45% identified as academic. By experience, 51% worked as a hospitalist for >7 years, 12% <1 year, and 37% 1-7 years; for 62%, this was their first group.

Average HMI score was 3.00 (SD \pm 0.77). For HMI and its domains, there was no significant association between measured demographic and clinical variables except for position, where NP/Pas had a lower overall HMI compared with Clinical Associates and Faculty Physicians (2.5, 3.1, 3.1, respectively; p=0.04) and those with children reported higher HMI, workload, and leadership scores (all p<0.02). An increase of 1 HMI point significantly increased good guality of life (OR 5.24; 95% CI 2.56, 10.74) and decreased emotional exhaustion (OR 0.51; CI 0.27, 0.98), depersonalization (OR 0.13; Cl 0.04, 0.43), feeling depressed (OR 0.43; CI 0.21, 0.87), poor ratings of personal (OR 0.22; CI 0.10, 0.45) and group (OR 0.40; CI 0.21, 0.75) morale, and thoughts of leaving within 3 months (OR 0.27; CI 0.13, 0.53), from the group (OR 0.27; CI 0.14, 0.54) and hospital medicine (OR 0.34; CI 0.17, 0.69).

Conclusion

Higher HMI was associated with positive well-being measures. There was no significant association between HMI and most demographic and clinical variables, suggesting its robustness across groups to monitor hospitalist well-being during and after the pandemic.

Using rapid qualitative analysis to address markers of distress and burnout among faculty at an academic medical center: The experience of advanced practice providers during the first year of the COVID-19 pandemic

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Learning objectives

- 1. Explain the value of using Focus Groups and Rapid Qualitative Analysis to convey signals of distress among healthcare providers
- 2. Explore the unique drivers of burnout and wellbeing among Advanced Practice Providers (APPs)
- 3. Recognize that APP experiences can differ from physicians in the same environment

Project objective/background

Advanced Practice Providers (APPs) play a key role in the COVID-19 pandemic response providing frontline patient care in partnership with their physician colleagues. However, the experience of APPs is often understudied when assessing burnout and wellbeing among healthcare providers. In response to the first phase of the COVID-19 pandemic, our Department of Medicine (DOM) distributed a wellbeing survey in the summer of 2020. Although most subpopulations demonstrated high levels of burnout, stress, and mental health concerns, these were disproportionately higher among APPs. To better understand the survey results and the factors affecting APP wellbeing both prior to and as impacted by the COVID-19 pandemic, we conducted a series of focus groups through a quality improvement project in the fall of 2020.

Methods/approach

Over the course of 3 months, we conducted 14 semistructured focus groups with APPs across specialty divisions within our DOM to address these questions. We utilized rapid qualitative analysis to identify themes and subthemes; findings were verified through optional member-checking events with focus group participants.

Results

Thirty-four APPs representing 11 of 16 divisions within the DOM participated in our focus groups. The vast majority (97%) of participants were female. Work settings included inpatient (40%), ambulatory (37%), hybrid (12%), and unclear (6%). The following themes were identified: (1) the

Importance of Being Valued (subthemes: role ambiguity, representation, recognition, and workload and salary transparency); (2) the Need for Career Development Opportunities (subthemes: promotion, mentoring, and on-boarding); and (3) the Significance of Professional Fulfillment (subthemes: relationships with patients and colleagues, intellectual stimulation, making a difference, value of autonomy, and contribution to a greater mission). Each of these themes existed prior to, and were exacerbated by, the ongoing COVID-19 pandemic.

Conclusion

The specific manifestations of these stressors is unique to the APP experience. Utilizing the methods of Rapid Qualitative Analysis allowed our team to quickly address signals of distress in our APP population, which has resulted in department-level interventions to address many of these concerns.

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Using rapid qualitative analysis to identify distress and burnout among research faculty at an academic medical center during the first 18 months of the COVID-19 pandemic

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Learning objectives

- 1. Explain the value of using focus groups and rapid qualitative analysis to identify distress and burnout
- 2. Explore the unique drivers of distress and burnout among researchers in a clinical department
- 3. Recognize that researcher experiences differ from clinicians in the same environment

Project objective/background

Research is an integral part of the mission and function of academic medical centers. Yet the experiences of researchers are understudied when assessing burnout and wellbeing within health systems. This oversight presents an opportunity to foster cross-organizational relationships and collaborations when designing wellbeing programs. In response to the first phase of the COVID-19 pandemic, our Department of Medicine (DOM) distributed a series of wellbeing surveys in the summer and fall of 2020. Researchers in our DOM demonstrated high levels of burnout, distress, and mental health concerns, often disproportionate to that expressed by clinician colleagues. To better understand these survey results and the factors affecting researcher wellbeing, we conducted a series of focus groups through a quality improvement project in the spring and summer of 2021.

Methods/approach

Over the course of 3 months, we conducted 18 semistructured focus groups with DOM researchers. Focus groups were organized by tenure track, non-tenure track, and clinically-practicing researchers. Demographics, wellbeing, and burnout metrics were assessed in an entry survey. We utilized rapid qualitative and matrix analysis to identify themes. Findings were verified through optional member-checking events with focus group participants.

Results

Forty-two DOM researchers participated in our focus groups. Sixty-four percent were female, 33% male, 2% preferred not to answer. The vast majority (81%) spent at least 75% of their time in research activities. Forty-three percent were tenure track, 33% non-tenure track, and 14% clinically-practicing researchers. Participant age ranges included 31-40yo (29%), 41-50yo (43%), and >50yo (29%). Seventy-one percent declared caregiving responsibilities (child and/or adult). Fifty-two percent indicated burnout. Sources of researcher distress included: (1) Feeling undervalued; (2) Isolation and lack of connectivity; (3) Need for career development and opportunities; and (4) Funding disparities and insecurities. Each of these themes existed prior to, and were exacerbated by, the ongoing COVID-19 pandemic.

Conclusion

Although the impact of the COVID-19 pandemic is felt by all members of clinical departments, researchers experience unique stressors relative to their clinician peers. Utilizing rapid qualitative analysis allowed our team to quickly delineate signals of distress in our researcher population, which has resulted in ongoing department-level discussions regarding interventions to address these concerns.

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Values alignment between clinical leaders and clinicians: Impact on career plans of clinicians during the COVID-19 pandemic

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Learning objectives

- 1. Explore the predictive impact of value alignment between clinicians and clinical leaders on clinician career plans during a global health crisis.
- 2. Review changes in clinician value alignment with clinical leaders during a health crisis across four-time intervals and four demographics.

Project objective/background

The American Medical Association (AMA) has collaborated with more than 140 health systems since 2018 to measure and respond to system drivers of clinician burnout. The research for this abstract aimed to illuminate predictive workplace factors and their impact on clinician career plans throughout the COVID-19 pandemic (2020-2021). Authors were specifically interested in understanding how value alignment between clinicians and their clinical leaders impacts career plans of those clinicians.

Methods/approach

Authors analyzed the single-item values alignment question from the validated Mini-Z 2.0 instrument (respondents were asked to rate how well their professional values align with the values of their clinical leaders) and its correlation to clinician responses to a single-item guestion related to career plans (respondents were asked to rate their likelihood of leaving their practice in the next two years). Electronic surveys and response data were collected and housed within the existing AMA Data Lab platform. For research purposes a sub-set of the full data set was delineated into 4 six-month intervals from April 2020 to December 2021. Authors utilized descriptive statistics to characterize the population, Chi square analysis to assess the association between variables, and logistic regression to determine the correlations while controlling for demographic variables.

Results

This final data set comprised 13,000 responses from April 2020 - December 2021. 64% of respondents were Physicians, 16% were Nurse Practitioners, and 7 % were Physician Assistants. Throughout the COVID-19 pandemic the single-item values question score saw an overall decrease from 3.7 in April 2020 to 3.5 in December 2021. Alignment with clinical leaders was lowest in those that preferred not to answer for race/ethnicity (OR 1.7, Cl 1.4-2.1), non-binary/ third gender respondents (OR 3.2, Cl 1.4-5.1) and those that preferred not to answer for gender (OR 2, Cl 1.6-2.6).

During the study period, the likelihood to leave practice increased by 15%. Likelihood of leaving was highest in non-binary/third gender respondents (OR 2.0, Cl 1.5-2.6) and Nurse Practitioners (OR 1.6, Cl 1.4-1.8).

Overall, respondents who disagree that there was alignment with their clinical leaders were 4.6 times more likely to note intentions to leave their practice within the next two years (OR 4.6, Cl 4.3-5.1) while controlling for demographic variables.

Conclusion

Amidst the ongoing COVID-pandemic, values alignment between clinical leaders and clinicians played a key role in keeping clinicians at their current practice. With a workforce in peril, it is important for health systems to provide visible, authentic leadership within supportive work environments to further motivate clinicians to stay on staff—a critical finding amid ongoing retention issues in the health care workforce.

WellDOM sound bites: Delivering wellness information in a steady drip to health care workers

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Learning objectives

- 1. Describe the purpose of brief delivery of information about wellbeing and mental health resources.
- 2. Explain the contents of a WellDOM soundbite
- 3. Link to an example of a WellDOM soundbite

Project objective/background

One of the few positive things about the Covid-19 pandemic is the spotlight that it shines on healthcare worker distress. Information about mental health resources and wellbeing services has been frequently highlighted in employee communications during this time. Unfortunately, this information is often lost in the onslaught of other COVID-19 communications. While acknowledging the importance of mental health support, feedback from health care workers indicated that the additional email communications around mental health resources and wellbeing supports can feel overwhelming and like "one more thing to do".

Methods/approach

To make information accessible to our 2000+ members in a large academic medical center, WellDOM (Wellness in the Department of Medicine) champions across 16 divisions developed brief 2–3-minute presentations which were pulled from their monthly WellDOM champions informational meetings and called them WellDOM Sound Bites. Division chiefs were then asked to have their WellDOM champions present the material at monthly division meetings. In this pilot quality improvement project, we describe the responses of one clinical division in our department of medicine to the presentation of a WellDOM Sound Bite on sleep.

Results

Twenty-one faculty members of a clinical division (including physicians, researchers, and

advanced practice providers) completed brief survey questions following the presentation of the WellDOM Sound Bite on sleep. Seventy-five percent of respondents strongly agreed that wellness was an important topic for themselves. Similarly, 80% strongly agreed that wellness was an important topic for their clinical division. Regarding the particular WellDOM Sound Bite to which they were exposed, 55% somewhat agreed or strongly agreed that the information presented would improve their sleep.

Conclusion

Our results indicate that delivering brief wellness information during department business meetings may help improve health care worker wellbeing. Further study and follow-up are needed to optimize this intervention.

What you can do with 15 minutes: Wellness and how it impacts and improves resident burnout

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Learning objectives

- 1. Understand the different classifications of burnout and how they affect resident wellbeing
- 2. Understand the correlation between mindfulness Interventions as they impact burnout
- 3. Effectively implement a curriculum to both address and prevent burnout within a complex resident schedule

Project objective/background

Front line health care professionals experience high degrees of burnout, and residents are no exception. Recent studies have shown that 27%-75% of physicians, dependent on specialty, experience burnout during residency training. Burnout can be experienced through depersonalization, lack of personal accomplishment, and emotional exhaustion. The purpose of this study is to evaluate the impact of a mindfulness toolkit on stress management skills and burnout in resident physicians at a single institution.

Methods/approach

A longitudinal survey study was performed utilizing two optional questionnaires within a Family Medicine Residency Program, the Abbreviated Maslach Burnout Inventory (MBI-9) and a second survey assessing resident wellness through the domains of relationships, exercise, stress management, and diet. After initial completion of the surveys, sessions entitled PoP (Piece of Peace) were integrated during weekly didactic sessions at 15-minute intervals once every 2 weeks. 9 months later the surveys were repeated to assess the impact of the activities on overall well-being and to determine the evolution of stress management skills. All investigators were blinded utilizing survey monkeys anonymous survey software.

Results

Out of the 24 residents surveyed, approximately 80-83% of participants had responded to the initial surveys and 80-92% had responded to the final questionnaires. While a range was observed in burnout scoring across the MBI-9, residents after participating in the interventions were noted to consistently demonstrate increased involvement in wellness domains over the course of 9 months.

Residents exhibited a positive response to the initiatives reporting learning new skills with each session and an improvement in stress management abilities.

Conclusion

The data in this study suggests implementation of 15-minute initiatives into a didactic curriculum at regular intervals correlates to an overall positive effect on resident engagement in wellness in addition to their overall wellbeing and management of burnout as displayed through both quantitative and qualitative measures. If improvement can be appreciated in under a year, implementation across multiple specialties and institutions has the potential to result in a dramatic shift in the muchneglected field of physician wellness.

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Working minds: Mental health awareness and suicide prevention in a large medical group

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Learning objectives

- 1. Create a dialogue for critical thinking about workplace mental health challenges.
- 2. Educate on suicide prevention strategies.
- Describe tactical approaches for creating a help-seeking and help-giving environment while recognizing the importance of connecting with resources.

Project objective/background

Physician rates of depression are 39% and one physician dies by suicide every day. Suicide rates for physicians are 1.41x higher in males and 2.27x higher in females than the general public, and the working age is amongst the highest risk with 1 of 5 Americans in the workplace struggling with a diagnosable mental disorder. The COVID-19 Pandemic has further exacerbated mental health challenges amongst physicians.

Methods/approach

Our organization partnered with University of Colorado's Helen & Arthur E. Johnson Depression Center in 2019 to offer a train-the-trainer course for their "Working Minds" program which is on the National Best Practice Registry for Suicide Prevention. We trained 23 physician/staff trainers and internally customized the Working Minds program and gained support to offer the 2-hour training to all leadership in 2019; 286 physician leaders were trained on how to recognize warning signs/risk factors, where to find support resources, and postvention procedures. Due to the COVID-19 Pandemic, we revamped the training to be effective virtually and with the heightened awareness of mental health challenges, it is now a mandatory training for all new physician leaders. In 2020 and 2021 we trained an additional 50 physician leaders and 20 staff managers. With the success and value of this training, the goal in 2022 is to train more front-line physicians and non-manager staff members, with the eventual goal of all employees receiving this training and offering it as an ongoing annual refresher course.

Results

Post-training feedback in 2019, 2020, and 2021 showed that 100% of participants feel more knowledgeable about our organization's resources available for suicide

prevention and know how to get help for a colleague having suicide ideation. Qualitative results from the training are included below:

- 2019: "Fully applaud getting this information out and the organization showing real care about the health and well-being of its providers."
- 2020 (Virtual): "Wanted to say how much I appreciated the suicide prevention training that was provided last summer. Used what I learned to check-in with friends and a family member. Every single person thanked me for caring and were emotional about my observations."
- 2021 (Virtual): "Very well conducted and organized session that was clear, informative, and motivational. thank you for conducting this training!"

Conclusion

It is necessary and more important now, more than ever, for all healthcare organizations to create and build on a culture where physicians and staff feel comfortable seeking help for these mental health challenges.

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Working towards inclusivity, psychological safety, and accountability through the implementation of a challenging interactions reporting tool

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Learning objectives

- 1. Understand the implications of mistreatment and bullying on trainees
- Understand how the Challenging Interactions Reporting Tool (CIRT) facilitates organizational culture change as well as real-time support for residents experiencing mistreatment
- 3. Identify the resources and processes that are needed to successfully implement a CIRT

Project background/objectives

Mistreatment of physicians and trainees has been associated with burnout. Few interventions have been studied to prevent or mitigate the impact of mistreatment. On ACGME and internal program surveys, our pediatric residents reported frequently experiencing or witnessing bullying. These findings prompted development of a Challenging Interactions Reporting Tool (CIRT). We created the CIRT in 2020 with the following goals: 1) to capture challenging interactions events in real time; 2) to ensure timely and consistent responses from program leadership; 3) to identify recurrent themes and "hot spots"; and 4) to inform future interventions.

Methods/approach

The CIRT was developed, pilot-tested, and deployed via RedCap in August 2020 to our pediatric residency program (n=163 residents). The survey asks respondents to categorize the report as one or more of: harassment or threat, microaggression, vulnerable patient/family with high emotions, unprofessional behavior, other, or unsure. Respondents are also asked whether they believe the event was an instance of racism. Subsequent questions include details about the interaction, any in-the-moment response by participants or bystanders, and the reporter's desired outcome of the CIRT process. CIRT submissions are reviewed by program leaders and chief residents who determine what follow up is appropriate.

Results

162 reports were filed from August 2020 to February 2022. 130 reporters provided demographics (80%), with 72% of reports made by females (n=94), 28% by males (n=36), and 21% by URiM residents (n=26). The most common category reported was unprofessional behavior (71%, n=110), with 23% microaggressions (n=36), 21% other or unsure (n=32), 10% vulnerable patient/family with high emotions (n=15), and 3% harassment or threats (n=4). Racism was identified in 20% of reports (n=30). Responses to reports included: meeting with rotation or division leaders (38%, n=61), identifying themes and increasing awareness (30%, n=48), direct feedback to supervisor (16%, n=26), direct feedback to individual (14%, n=22), and development of educational resources (2%, n=4). In followup surveys, 91% of residents who filed a report expressed satisfaction with their experience of using the tool. Themes associated with use of the tool included appreciation of the opportunity to feel heard, observing change occur in response to their reports, ease of access to the tool, and rapidity onse to reports.

Conclusion

The use of a tool to identify and track responses to challenging interactions has led to a centralized repository of events, identification of themes, and standardization of responses. Future work will incorporate education, including microaggression and de-escalation training.

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You've got gratitude! A multi-specialty and multi-institution program encouraging expressions of gratitude

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Learning objectives

- 1. Describe the role of gratitude in physician well-being
- 2. Design an intra-departmental program for expressions of gratitude
- 3. Discuss viability for system-wide implementation

Project objective/background

Gratitude has long been understood to be a key pillar of social cohesion, health, and well-being¹. Habitually acting on feelings of gratitude has been shown to be a strong predictor of self-reported good health, happiness, and optimism in daily life²⁻⁴. The recent push to improve physician well-being has identified gratitude as a key means to this end, but despite the many reported benefits, expressions of gratitude in the healthcare setting can be infrequent. Exhaustion, lack of time, lack of resources, and burdensome administrative requirements are often to blame^{5–7}. Furthermore, many gratitude exercises such as journaling and resiliency training, implemented to boost morale, can paradoxically be an additional stressor for participants. Here, we describe "Gratitude-Grams", an intervention that strives to alleviate barriers and facilitate expressions of gratitude in a systemic and manageable way.

Methods/approach

We implemented a gratitude program, piloted in the University of Michigan Department of Surgery, and adopted at an additional institution and across several specialties, which employs a web-based platform (Qualtrics) and is accessible to residents, faculty, advanced practice practitioners, and staff. The program interface includes instructions, a staff email directory, and a free text box with anonymity as the sender default. Anecdotal comments about the efficacy of Gratitude-Grams were solicited from residents and faculty during teaching conferences.

Results

Gratitude-Grams streamlines expressions of gratitude while mitigating administrative maintenance, financial costs, and time and energy expenditure. The platform has been highly utilized by members of each participating community. Across institutions and specialties, it was used approximately 1000 times between December 2020 and February 2022. Qualitative feedback indicated that users found the program to be user-friendly and required minimal time and energy. Additionally, users commented on the positive feelings associated with both sending and receiving Gratitude-Grams.

Conclusion

Expressing and receiving gratitude is critical for well-being. In a culture of burnout, skewed work-life balance, and waning job satisfaction, we present an attainable system for cultivating and proliferating generosity, altruism, and joy^{8,9}. To support the expression of gratitude across healthcare teams, departments, and institutionally, the Gratitude-Gram program provides a system-wide viable option ready for rapid implementation.

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