Abstract Book

Improving well-being
through the power
of connections

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Contents

Oral Presentations

"Personalized medicine": an approach to fostering positive relationships between rotating junior medical officers and their teams

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Learning objectives:

1. Participants will identify the positive effects of improved relationships between team members on work satisfaction and team performance.
2. Participants will recognize how to reduce barriers to integration into a new team for both junior medical officers and existing team members.
3. Participants will identify how to improve team cohesion and create a smoother transition for junior medical officers when joining a new team.

Background

A sense of belonging, in the centre of Maslow's hierarchy of needs, represents a fundamental human need to feel connected to others, with positive relationships impacting significantly on well-being. Almost all large organizations are composed of smaller teams that share common goals and distribute workload. Positive relationships between team members increase cohesiveness, which has been shown to affect team performance. Junior doctors are vulnerable to reduced connections with colleagues owing to frequent term rotations.

Objectives

The aim of this initiative is to promote collegiality between rotating interns and their teams by sharing a piece of personal information at the start of the term. The hope is that creating an earlier connection between team members will facilitate smoother integration and allow a more seamless transition. We aimed to "personalize" relationships between working team members to improve satisfaction, reduce anxiety and improve team performance.

Approach

A voluntary open-ended form was circulated to new interns at orientation, asking them to share something about themselves that could be communicated with their teams. Twenty-five interns submitted responses prior to Term 2, which were collated and shared with term supervisors and department heads prior to each rotation. Department consultants were also requested to provide personal information about themselves to be shared in a reciprocal fashion. A survey questionnaire will be distributed to all participants at the end of Term 4 to assess the objectives of the program and collect feedback on the experience.

Lessons learned

Sharing personal information between team members is likely to increase cohesion although it is important that this is done voluntarily. Interns were given the option of completing the form and sharing any information they felt comfortable with. Interns were more likely to complete the open-ended form when this was requested by a fellow intern. Results of the evaluation survey done in Term 4 will be presented.

Practical implications

Promoting cohesion within a team increases the satisfaction of individual members and improves performance. Known as "the water-cooler effect," personal connection between colleagues also has numerous positive effects, although in recent years, there have been reduced opportunities for interactions in the workplace. This initiative facilitates conversation and connections between colleagues by providing voluntarily shared information that can start a conversation and highlight the individuality of the rotating team member. Junior doctors are more likely to feel valued and integrated into the team if they are recognized as an individual and this may well reduce anxiety associated with term changes. Feedback obtained from participants will further inform lessons learned and will be presented.

"Do they think I'm good enough?": General practitioners' experiences when treating doctor-patients

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Learning objectives:

1. At the end of this presentation, participants will develop an understanding of the impact of professional socialization when the treating doctor cares for a doctor-patient.
2. At the end of this presentation, participants will have explored a model for caring for doctor-patients that enables treating doctors to address the complex dynamics of this therapeutic relationship that recognizes their human connectedness.
3. At the end of this presentation, participants will be able to upskill with a set of pragmatic treatment strategies that enhance the safety and quality of care provided to the doctor-patient.

Purpose/relevance

When doctors seek medical care, there is evidence that the treating doctor can struggle to provide optimal treatment. Guidelines state that doctor-patients should be treated like any other patient, but the limited literature indicates this is challenging for the treating doctor. This study set out to explore the positive experiences general practitioners (GPs) have when caring for doctor-patients and what they find challenging about these consultations, to investigate whether GPs believe they treat doctor-patients differently to other patients and if so, in what ways, for what reasons and how this impacts their provision of care. Using these data, a conceptual model was developed to make sense of GPs' experiences caring for their doctor-patient.

Materials and methods

A grounded theory study was conducted, involving in-depth interviews with GPs. Analysis of deidentified transcripts followed the tenets of pragmatic grounded theory, using constant comparative analysis and theoretical sampling. Emergent concepts were grouped under key themes, with the evolving understandings used to develop a model for presenting these findings.

Results

Twenty-six GPs were interviewed. Their experiences treating fellow doctors revealed the complex interplay within the therapeutic relationship with concepts of respect and collegiality having a dominant role in their engagement. GPs shared that the use of medical language (and assumptions about the doctor-patient's knowledge/behaviours), decisions around testing, exploration of sensitive issues and negotiating shared decision-making were areas in which their treatment could vary when caring for a doctor-patient. Treating doctors were often more anxious about errors and were concerned about scrutiny from their medical peers. Decisions to treat the doctor-patient differently were driven by a desire to maintain the sense of collegiality, to meet their doctor-patient's expectations and to appear competent. These factors could influence the quality of care provided. Indeed, ignoring the complex dynamics of the doctor–doctor consultation is to ignore the elephant in the room.

Professional socialization of doctors impacts the therapeutic consultation. This study helps by naming this elephant in the room and presenting a model for understanding the impact of this issue. In articulating these issues, a series of treatment strategies are presented to assist the treating-doctor to navigate their consultations with doctor-patients, allowing the doctor-patient to be recognized as a colleague while receiving quality care.

Conclusions

Doctor-patients wish to be treated like any other patient to avoid the traps of poor care resulting from special treatment. While current guidelines for treating doctor-patients highlight the need to care for the doctor as a normal patient, these guidelines fail to provide the practical tools for addressing the complex and potentially challenging dynamics when issues of human connectedness impact the therapeutic relationship. Treating doctors need training to ensure they can effectively manage these normative issues of collegiality and respect that emerge from their medical culture and may distort the quality of care they deliver to their doctor-patients.

"GYN for GME": the effect of a weekend clinic on resident wellness

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Learning objectives:

1. Explain the impact the lack of access to health care has on medical trainees.
2. Analyze and explain the potential barriers medical trainees face to access health care.
3. Discuss an innovative solution to gynecologic care for housestaff.

Purpose/relevance

In 2017, as a response to increasing rates of resident burnout, psychiatric disorders and suicide, the Accreditation Council for Graduate Medical Education (ACGME) revised its Common Program Requirements to emphasize and prioritize resident well-being. This included a directive that all residents be given the opportunity to schedule medical appointments during their working hours. Despite institutional adherence to the requirement, most residents reported continued difficulty scheduling personal health appointments. To better support housestaff, faculty in the Department of Obstetrics and Gynecology proposed offering resident-specific access outside regular clinic hours. This study aimed to: 1) better understand the remaining barriers to housestaff gynecologic care during regular clinic hours and 2) evaluate the impact of offering a weekend gynecology clinic for residents on a quarterly basis.

Materials and methods

The "GYN for GME" Clinic was introduced during the 2023–2024 academic year. Clinics were held on Saturday mornings and staffed by volunteers, with three faculty, three medical assistants and one nurse each time. Clinics were advertised by the GME Office to all housestaff via email and posted flyers. With IRB approval, both resident-patients and clinic volunteer staff were asked to complete an anonymous online survey via Qualtrics after participating in the clinic.

Results

Three "GYN for GME" Saturday morning clinics were held between October 2023 and March 2024. Patients included 59 residents and fellows, with 42 (71%) completing the post-clinic survey. For 26/42 respondents (62%), it had been more than two years since their last OBGYN visit (including 11 residents who had never received OBGYN care). When describing barriers to care, 87% of patients reported unavailability during working hours, difficulty taking time off during work duties, and unpredictability of schedule as significant barriers. When asked how this event impacted their personal well-being, 96% of patients reported a significant positive impact, 90% felt it had a significant positive impact on their sense of belonging/connection to the institution and 96% felt it positively impacted their perception that the medical school cares about its physician trainees. Overall, 96% reported they were extremely satisfied with their experience and would recommend the clinic to other residents or fellows. A total of seven physician faculty and three clinical staff also completed a post-clinic survey, with nine responding to all items. Of these, 78% reported a significant (n = 6) or slight (n = 1) positive impact on their well-being, and 89% reported a significant (n = 7) or slight (n = 1) positive impact on sense of belonging.

Conclusions

The "GYN for GME" Clinic initiative increased access to health care for postgraduate medical trainees and demonstrated a positive influence on wellness metrics for both the resident-patients and the physician faculty and other clinical staff who volunteered their time to see patients during the clinics. It also serves as an innovative solution model to address the barriers to care faced by medical trainees.

"Physician, heal thy culture": assessing the role of medical culture in physician burnout

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Learning objectives:

1. At the conclusion of this activity, participants will be able to list three dimensions of the medical culture that are positively related to physician burnout.
2. At the conclusion of this activity, participants will be able to recognize how burnout in their profession could be related to systemic issues unique to their professional culture.
3. At the conclusion of this activity, participants will be able to evaluate the implications of the study's findings on medical culture for physician well-being initiatives within their own practice settings.

Purpose/relevance

Despite extensive research and intervention efforts, physician burnout remains a pressing issue, emphasizing the need for a deeper understanding of its root causes. The role of medical culture in influencing physician burnout is gaining interest. However, empirical studies directly investigating the concept of medical culture or its association to physician burnout are lacking. The current study addresses this gap by examining the harmful dimensions of medical culture and their respective weight in contributing to physician burnout. By exploring this relationship, the study offers insights crucial to fostering a healthier professional culture for physicians.

Materials and methods

This cross-sectional study was conducted from Sept. 5 to Nov. 5, 2023. A convenience sample of 1,002 physicians (74.8%) and physician residents (24.9%) completed an online survey. Measures included the 12-item Burnout Assessment Tool and items measuring harmful dimensions of the medical culture. Exploratory and confirmatory factor analyses were conducted to explore and then confirm the factorial validity of the Harmful Dimensions of the Medical Culture structure, along with correlation and regression analyses to assess their associations with burnout.

Results

Results of the exploratory factor analysis revealed a solid eight-factor structure representing dimensions of the medical culture: (1) work priority strain, (2) physician's profession as source of meaning, (3) sacrificial nature of medical practice, (4) physician's central identity role, (5) physician's discomfort with patient role, (6) physician's moral obligation to patients and colleagues, (7) colleagues' stigma toward burnout in physicians and (8) personal stigma toward burnout in physicians. This structure was then consolidated through confirmatory factor analysis into three distinct but interdependent higher order dimensions representing Harmful Dimensions of the Medical Culture: (A) physician's professional priority commitment ($\alpha = 0.85$), (B) the myth of the invulnerable physician ($\alpha = 0.77$) and (C) physician stigma toward burnout ($\alpha = 0.62$). The three dimensions were interrelated (ρ ranging from 0.25 to 0.42, $p < 0.001$) and independently associated with higher burnout scores at $p < 0.001$. Interestingly, physician's profession as source of meaning was protective of physician burnout (Std B = –0.30, $p < 0.001$). The current research efforts resulted in the development of a valid questionnaire to assess Harmful Dimensions of the Medical Culture.

Conclusions

This is the first study that quantitatively explores Harmful Dimensions of the Medical Culture and quantifies its impact on physicians' professional well-being. Three central Harmful Dimensions of the Medical Culture were found to be interrelated and significantly associated with more burnout in physicians. Our findings underscore the urgency to address cultural factors in both prevention and intervention strategies to mitigate burnout in the medical community. The results of this research open up new clinical, educational and organizational perspectives in medicine.

3-Women in Medicine (3-WIM): a novel approach to a women in medicine mentorship program

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Learning objectives:

1. At the conclusion of this activity participants will be able to define the role of a mentor and distinguish this from that of a counsellor or coach.
2. At the conclusion of this activity participants will be able to identify three benefits of forming a mentoring relationship with other female doctors.
3. At the conclusion of this activity participants will be able to implement a three-tiered mentorship program for females or other groups within their organization.

Background

Published literature demonstrates that female mentorship programs provide significant benefits for women in medicine and other careers, including improved work-related well-being, communication and career progression. Prominent female mentors and role models facilitate opportunities for women to aspire and progress to leadership roles. Mentorship is usually defined by a single mentor and mentee relationship, but there are probably benefits derived from broadening this to include individuals at different stages of training.

Objectives

We defined and implemented a novel mentorship program for female-identifying doctors at an Australian hospital. This program groups a junior medical officer with a trainee and a hospital specialist to form a three-tiered mentoring group. Each member thus benefits from the perspective of two others within the group. We sought to create a mentorship program that appeals to female-identifying doctors at various training levels, in turn fostering human connections and inter-professional relationships in the workplace.

Approach

Expressions of interest were sent to all female-identifying doctors at a tertiary hospital in Sydney, Australia. Sixty female-identifying doctors opted to participate in 2024. Junior medical officers were grouped with a trainee specialist and a medical specialist, with doctors in training given the opportunity to select a specialist on the basis of their career interest. The program was launched with a group dinner coinciding with International Women's Day, and allocated groups were encouraged to meet during the year at their convenience. Information outlining the aims of the program and strategies for successful mentoring relationships were distributed. Questionnaires will be distributed to participants at the mid- and end of the clinical year to assess the program and evaluate outcomes for all participants.

Lessons learned

A pilot mentorship program of 30 women in medicine was initiated in 2023, which expanded to 60 women in 2024. Interviews were conducted with 10 individuals after 12 months of participation. Key benefits identified were access to career advancement and research opportunities, listening to and sharing experiences, and strategies for achieving work–life balance as a female. Junior doctors noted that meeting with a trainee and specialist was beneficial as it provided guidance for both short- and long-term holistic goals. Trainee specialists voiced that the unique program allowed them to both give and receive mentoring, allowing them to hone their leadership skills and network with multiple generations of female doctors.

Practical implications

Feedback from our pilot suggests that mentorship programs for women are met with high satisfaction and can improve the well-being and career progress of female doctors. A three-tiered mentorship structure connecting junior doctors with a trainee specialist and a specialist can broaden the benefits associated with mentoring programs. There is no clear evidence in the literature regarding best practices for a female-focused mentorship program; therefore, institutions should tailor their programs to available resources and goals. Our project demonstrates the importance of implementation of mentorship programs for women to facilitate their professional and personal development, and the potential benefits of a novel structure. Hospitals can improve well-being and satisfaction for women in medicine through the power of mentorship and connections.

A multidimensional framework for supporting student well-being in medical school

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Learning objectives:

1. By the end of this presentation, participants will be able to describe the extent of psychological distress among medical students including the prevalence of stress, burnout and mental health problems.
2. By the end of this presentation, participants will be able to discuss the rationale and steps toward building a multidimensional wellness strategy to support medical students.
3. By the end of this presentation, participants will be able to idedntify the elements of a wellness framework that could be applied in their own setting.

Background

From medical school through postgraduate training and into medical practice, doctors at every stage of professional development experience stress and distress that can have negative effects on personal well-being, academic performance and patient care. As future doctors, medical student well-being has received significant attention worldwide. Studies have reported the worrisome prevalence of psychological distress and its contributing factors and recognized the benefit of early intervention to mitigate potentially unwanted consequences.

Objectives

We sought to: (1) design an evidence-informed multidimensional, student-centred framework to promote and support wellness in the medical school environment and (2) implement a comprehensive, coherent and sustainable wellness initiative that engages students-as-partners on the basis of the proposed framework.

Approach

A framework to support medical student wellness was developed and implemented, informed by research studies conducted on the extent of stress and mental health problems among medical students in the local setting, a student needs survey focused on wellness support and barriers to help-seeking, advice from local and external experts and a literature review to identify good practice from medical schools and universities around the world.

Lessons learned

Our research found that medical students were a high-risk group with unmet needs due to a high prevalence of poor psychological well-being coupled with inadequate or inappropriate health-seeking behaviours. The literature review revealed that principles of quality improvement were useful in formulating the resultant wellness framework structured as concentric circles, each representing a dimension of support widening from the individual to the medical school community to the learning culture. These essential interconnected elements could be operationalized and came to fruition as a student wellness counselling team exclusive to the medical school, a vibrant student–faculty partnership for wellness outreach and a co-created teaching and learning charter that articulated the principles underpinning the wellness culture we are striving for.

Practical implications

A cohesive strategy to implement concrete initiatives to support and promote student wellness in medical school needs an integrated bottom-up, top-down and middle-out approach that draws on the power of connections — among and between students, teachers and faculty senior management — to succeed. Students play an important role in constructing and sustaining wellness initiatives and are a valuable, and often untapped, resource. This wellness framework and its practical elements may be adapted and extrapolated to other health care educational and practice settings.

Addressing the impact of medico-legal events on physician wellness

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Learning objectives:

1. At the conclusion of this activity, participants will recognize how medico-legal events affect physician well-being.
2. At the conclusion of this activity, participants will be able to list the four steps of the CMPA Member Support Program.
3. At the conclusion of this activity, participants will be able to describe the impact of the program on physician wellness.

Background

The Canadian Medical Protective Association (CMPA) launched the Member Support Program in November 2017 to help its physician members to address underlying factors that may be contributing to their medico-legal risk. The target audience is physicians perceived to be at increased risk of, or experiencing, a higher frequency of medico-legal events. Physicians who may benefit from the program are identified using internal processes within the CMPA. Physicians can also self-refer to the program.

Objectives

The CMPA's goal in creating this program was to enhance services to its physician members, by helping physicians to identify strategies to reduce their medico-legal risk, provide safe medical care and practise with greater confidence. The CMPA also wanted to better understand the needs of physicians experiencing more medico-legal events than their peers. The program also addresses physician wellness related to medico-legal events and is attentive to issues of equity, diversity and inclusion.

Approach

There are four steps to the program: identification, assessment, development of an action plan and ongoing support. Physicians participating in the program benefit from a review of their recent medico-legal history, guided reflection about their practice and educational advice. Issues addressed through the program include patient communication, conflict with colleagues and practice management; the physician advisors also explore issues related to wellness, including coping with stress related to medico-legal events, workload and burnout. Participants receive ongoing support from their assigned physician advisor, which includes follow-up calls and reassessments every one to two years. A subset of participants also receive one-to-one coaching; the length of participation is approximately six to eight months, although some physicians have been coached for longer.

Lessons learned

We recently completed a comprehensive evaluation of the program. Seventy percent (70%) of survey respondents stated that wanting to reduce stress related to medico-legal events motivated them to improve their practice. When asked about the program's impact, 29% reported having less practice-related stress and 21% had sought professional help for their well-being. The percentage of participants wanting more frequent contact with the program has increased recently (i.e., 4% in 2021 v. 14% in 2023). In contrast, physicians who received coaching reported that the frequency of coaching sessions was just right. Coaching participants all also agreed/strongly agreed that coaching had a positive impact on their well-being, that they felt supported through coaching and that it improved their confidence and reduced stress.

Practical implications

We hypothesize that the desire for more support expressed by program participants mirrors the increasing levels of stress and burnout reported in other studies of Canadian physicians. Stress related to medico-legal events appears to be unique and physicians appreciate being able to speak to physician advisors who understand their experience. The ability of physician health programs to fully support physicians with stress related to medico-legal events may be limited by constraints such as patient confidentiality and solicitor–client privilege. The Member Support Program is one of several initiatives by the CMPA to better support physician wellness. We hope to be able to expand this program to offer more support to more physicians as they struggle with today's increasingly complex health care challenges.

An organizational approach increases women faculty engagement at an academic medical centre

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Learning objectives:

1. To describe a novel approach to organization-level faculty engagement that promotes three key engagement drivers: meaning in work, culture and values, and social support and community at work.
2. To apply an existing faculty engagement survey to evaluate the outcomes of organization-level engagement approaches.
3. To explain the specific impacts of an engagement approach on women faculty at an academic medical centre.

Background

Engaged physicians are enthusiastic, dedicated and less likely to experience severe burnout. Organizational factors associated with engagement, individual work effort and well-being include: 1) meaning in work, including sense of achievement and professional fulfillment, 2) alignment of culture and values across individuals and workplace and 3) social support and community at work.

Objectives

To describe a novel approach to organization-level faculty engagement that promotes three key engagement drivers: meaning in work, culture and values, and social support and community at work.

Approach

An organization-level faculty development plan was implemented with specific focus on three known drivers of physician engagement across all genders, which also supported needs specific to women faculty. Programs to promote meaning in work provided leadership training and support for scientific research. Programs to promote alignment of culture and values prioritized diversity, equity and inclusion efforts. To promote social support and community at work, cross-departmental networking groups and social gatherings were created. Data were collected by the Association of American Medical Colleges (AAMC) StandPoint Survey during the time period overlapping with program implementation (2018, 2022) and responses were analyzed for associations with gender.

Lessons learned

There was a significant increase in agreement among women that supervisors encourage career development (68% v. 73%, $p = 0.03$), satisfaction with mentoring quality (78% v. 84%, $p < 0.0001$), and in knowledge of promotion requirements in teaching (63% v. 70%, $p = 0.004$), research (61 v. 70%, $p = 0.002$), patient care (63% v. 68%, $p = 0.04$) and administration (47% v. 57%, $p = 0.0001$). Significant increases were also seen in recruitment of women (78% v. 85%, $p = 0.0005$) and racial/ethnic minorities (51% v. 61%, $p = 0.0001$), and collegiality (80% v. 84%, $p = 0.04$). There were also nonsignificant increases in supervisor listening to women (72% v. 76%, $p = 0.08$), satisfaction with professional advancement (52% v. 57%, $p = 0.06$), appreciation by colleagues (71% v. 75%, $p = 0.08$), and colleague respect of work–life balance efforts (70% v. 72%, $p = 0.4$).

Practical implications

The COVID-19 pandemic negatively impacted physician careers across academic medicine, with reports of even greater impact on women. Many interventions are not designed with the specific needs of women in mind. Going forward, academic medical centres developing engagement strategies for all physicians should consider the specific impacts of their interventions that improve engagement among women.

An organizational approach to physician engagement can be designed to incorporate known key drivers of professional fulfillment. Special attention should be paid to the impact on women faculty, which can be measured using an existing engagement survey. Academic medical centres should consider this novel approach to organization-level engagement.

Artificial intelligence assisted radiotherapy quality assurance workflow for radiation oncology clinical staff well-being improvement

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Learning objectives:

1. Characterize the inefficiency of the current quality assurance (QA) workflow for intensity-modulated radiation therapy (IMRT) in radiation oncology.
2. Discuss the impact of inefficient IMRTQA workflow on health care professionals' well-being in radiation oncology.
3. Demonstrate how an artificial intelligence (AI)-assisted hybrid workflow can improve workflow efficiency and the well-being of radiation oncology professionals.

Purpose/relevance

Radiation oncology is a highly technical specialty that requires the concerted efforts of diverse health care professionals for a variety of indications. IMRT is a common, standard-of-care treatment modality that delivers highly conformal radiation to tumours. To ensure the safe administration of radiation, QA procedures are utilized but these time-intensive procedures rarely identify unsafe treatment plans (~1% of all plans). There exists an enormous opportunity to improve radiation oncology professionals' well-being by utilizing AI to identify unsafe plans while not negatively impacting patient safety. In this study, we first quantified the workload associated with current IMRTQA practice and its impact on clinician well-being. We then developed and validated an AI model that triages IMRT plans for selective QA that can potentially eliminate/reduce this workload significantly.

Materials and methods

We quantified the IMRTQA workload as the average number of weekly measurements (or documents) or hours, for radiation oncologists, medical physicists, dosimetrists or radiation therapists by retrieving the past five years' IMRT plans and QA data from two major academic hospital sites. The AI model consisting of a multilayer perceptron with two hidden layers was trained with 402 plans and validated using 534 plans. The IMRTQA workload reduction was estimated retrospectively on the basis of the sensitivity and specificity of the model.

Results

The current IMRTQA practice requires an average of 25.0 ± 3.1 measurements and documents per week. This includes the review and approval of IMRTQA consult documents by radiation oncologists and medical physicists. The preparation of IMRTQA by medical dosimetrists takes approximately 6.2 ± 0.8 hours per week, while medical physicists spend around 12.7 ± 1.6 hours on measurements, data analysis and generating IMRTQA consult documents weekly during evenings and weekends. Additionally, radiation therapists check the approval status of every document before the first patient treatment session.

The AI model has demonstrated a sensitivity ranging from 73.3% to 100% in correctly identifying IMRT plans for QA measurement, while the specificity ranges from 26.5% to 54.1% in correctly identifying the plans not requiring measurement. A specific scenario ensuring a 100% sensitivity for patient safety corresponds to a specificity of 26.6%, resulting in a 25.8% reduction in measurement and saving an average of 4.9 after-hours work and 6.4 documents per week. Consequently, approximately a quarter of plans would no longer require QA measurement and documentation, while still ensuring patient safety.

Conclusions

We have identified and quantified the inefficiency in the current IMRTQA standard that has had a significant negative impact on the well-being of radiation oncology professionals. To address this workflow inefficiency, we have developed an AI-assisted framework that provides actionable triage predictions to reduce the burden of performing IMRTQA measurement and the associated preparation and documentation for every treatment plan. We successfully demonstrate the potential feasibility of this AI-assisted hybrid approach to transform the current resource-driven IMRTQA practice into an efficient workflow for the well-being of health care professionals in radiation oncology.

Association between work control, burnout and career intentions among US physicians — a cross-sectional analysis

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Learning objectives:

1. Identify the association between low control/influence of the clinical environment and physician burnout.
2. Identify the association between low control/influence of the clinical environment and physician intentions to reduce clinical effort and intentions to leave their current practice.
3. Consider organizational strategies that may invest more operational decision authority to the physicians closest to the patients and the potential financial benefits associated with that strategy.

Purpose/relevance

Physician control and influence over their immediate work environment, such as over their workload, patient volume, clinical team, hiring of staff and clinical schedule, is hypothesized to be associated with both burnout and career intentions. The purpose of this study is to investigate those relationships.

Materials and methods

American Medical Association (AMA) Organizational Biopsy is a survey tool and set of services that support organizations in measuring and taking action to improve the well-being of their workforce. The survey comprises 40 core items, including the single item Mini-Z burnout assessment along with subscales related to organizational culture, practice efficiency, and individual and organizational demographic items. Six items investigate physicians' control/influence over their care environment,

Results

Among respondents, 61.4% (1,438 of 2,339) reported moderate or higher control over their patient load, 60.8% (1,422/2,339) reported moderate or higher control over who is on their clinical team, 46.9% (1,099/2,339) reported moderate or higher influence over hiring of staff and 73.1% (1,712/2,339) reported moderate or higher influence over their clinical schedule. Latent class analysis was used to divide the respondents into high and low control/influence categories. On multivariable analyses adjusting for personal and professional characteristics using propensity weighting, burnout (OR 4.22; 95% CI 3.55–5.01), ITR (OR 2.40; 95% CI 1.95–2.96) and ITL (OR 2.40; 95% CI 1.95–2.96) were higher for physicians with lower levels of control/influence over their clinical work environment.

Conclusions

In this large, cross-sectional study, low control/influence over patient volume, workload and clinical team, hiring of staff and clinical schedule was associated with burnout and career intentions. Organizational efforts to optimize physician control and influence over their immediate care environment should be considered as a means to lower burnout and improve retention among physicians.

Authenticity is protective against burnout, depression and suicidal ideation in physicians

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Learning objectives:

1. At the conclusion of this activity, participants will be able to identify authenticity-related protective factors for depression, burnout and suicidal risk.
2. At the conclusion of this activity, participants will be able to assess their own institution's authenticity-related protective factors for depression, burnout and suicidal risk.
3. At the conclusion of this activity, participants will be able to identify risk factors related to the lack of authenticity for depression, burnout and suicidal risk.

Purpose/relevance

Physician burnout, depression and suicidal ideation continue to be faced by physicians at alarming rates. Emerging data indicate a potential role for authenticity in mitigating burnout, depression and suicidal risk. Authenticity is being true to one's core self in all situations, relationships and roles. Authenticity enables meaningful relationships and fosters a sense of belonging. Focusing on faculty physicians and trainees, this study assesses the impact of authenticity on burnout, depression and suicidal risk, offering hope for future interventions.

Materials and methods

Members of the departments of surgery, emergency medicine, pediatrics, obstetrics and gynecology, family medicine and internal medicine at a large, academic level 1 trauma medical centre completed anonymous surveys between May 2023 and March 2024. The survey included the Authenticity Scale to assess authenticity, the Patient Health Questionnaire (PHQ9), the Copenhagen Burnout Inventory (CBI) and the Ask-Suicide Screening Questions (ASQ). The Authenticity Scale scored three domains: authentic living (AL), accepting external influence (AEI) and self-alienation (SA) to characterize the relationships.

Results

Of the 1,216 physicians surveyed, 783 (64.4%) completed the survey. Higher AL scores correlated with reduced burnout (r = –0.13, p = 0.16) and depression (r = –0.40, p = 0.0002). Conversely, higher AEI scores were associated with increased burnout (r = 0.15, p = 0.007) and depression (r = 0.25, p < 0.0001). Higher SA scores were similarly associated with increased burnout (r = 0.40, p < 0.0001) and depression (r = 0.55, p < 0.0001). Higher SA scores were also indicative of an increased suicidal risk (r = 0.15, p = 0.005), while higher AL scores were associated with lower suicidal risk (r = –0.15, p = 0.004). Specific SA questions yielded an elevated odds ratio (p = 0.010, p = 0.008, p = 0.002) of a positive ASQ. ALS increased with advancement in professional rank (p < 0.0001), while AEI (p < 0.0001), ASA (p < 0.0001), depression (p < 0.0001) and burnout (p = 0.041) decreased. Suicidal risk was not impacted by rank (p = 0.211). No significant differences were found between departments for AL, AEI or SA scores.

Conclusions

In this study, higher authenticity was associated with a lower likelihood of burnout, depression and suicidal risk among physicians. This study contributes valuable insights for the development of targeted interventions and support mechanisms utilizing authenticity to enhance interpersonal connection and overall well-being.

Autonomy, competence and belonging: the relationship between burnout and satisfaction of essential human psychological needs in academic medicine faculty

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Learning objectives:

1. Participants will describe the three essential human psychological needs (relatedness/belonging, autonomy and competence) as defined by the self-determination theory of motivation.
2. Participants will evaluate the association between the three essential human psychological needs and burnout.
3. Participants will evaluate the association between the number of essential psychological needs satisfied and burnout.

Purpose/relevance

Self-determination theory (SDT) proposes that all humans have three basic psychological needs (competence, autonomy and relatedness) and satisfaction of these needs is essential to well-being and engagement. Work environments that facilitate employee autonomy, sense of competence and belonging can optimize performance. Between October 2020 and November 2023, the Association of American Medical Colleges (AAMC) administered the StandPoint Faculty Engagement Survey to 27,389 faculty members at 25 US academic medical institutions and assessed measures of belonging, autonomy and competence and their association with burnout. Using de-identified data from the AAMC StandPoint Faculty Engagement Survey, we examined the associations of belonging, autonomy and competence with burnout from the 15,758 faculty survey respondents (response rate 57.5%).

Materials and methods

Faculty rated their satisfaction with their autonomy, sense of belonging and sense of personal accomplishment on a five-point Likert scale. Burnout was assessed with the single-item mini-Z on a five-point scale ranging from "I feel no symptoms of burnout" to "I feel completely burned out." A three-point SDT score was calculated on the basis of the number of psychological needs positively endorsed by respondents. Regression analysis was performed to assess the association between SDT score and burnout and odds ratios were calculated.

Results

Faculty with higher SDT scores had lower burnout scores. In multivariable regression analysis models adjusted for gender, race/ethnicity and rank, every one-point increase in SDT score decreased burnout by 0.471 (95% CI: −0.487 to −0.454, $p < 0.001$). Respondents with one component satisfied had 27.2% lower odds of reporting symptoms of burnout than those with no components satisfied (OR = 0.728, 95% CI: 0.582–0.910, $p < 0.05$). Respondents with two components satisfied had 66.4% lower odds of reporting symptoms of burnout than those with no components satisfied (OR = 0.336, 95% CI: 0.273–0.413, $p < 0.05$). Respondents with three components satisfied had 90.4% lower odds of reporting symptoms of burnout than those with no components satisfied (OR = 0.096, 95% CI: 0.079–0.118, $p < 0.05$). Satisfaction with mastery was associated with the greatest impact on lowering the odds of reporting symptoms of burnout (OR = 0.158, 95% CI: 0.144–0173, $p < 0.05$), compared to autonomy (OR = 0.235, 95% CI: 0.215–0.257, $p < 0.05$) and connectedness (OR = 0.277, 95% CI: 0.256–0.300, $p < 0.05$), although all were significant.

Conclusions

US academic medical institution faculty who feel satisfied with their autonomy, competence and sense of belonging at work are less likely to report feeling burned out. Creating work environments that support autonomy and a personal sense of accomplishment and mastery and create a culture of connectedness can empower faculty to be less burned out and more likely to perform at their best.

Becoming a Best Place to Care: a physician-led strategy to care for caregivers in a growing organization

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Learning objectives:

1. Describe how a physician-led strategy to reduce barriers between physicians and APP/Cs and their patients can improve physician and APP/Cs' well-being and engagement.
2. Identify a multi-faceted framework to engage and involve physicians and APP/Cs to address core issues serving as barriers in their ability to provide care for their patients and enhance joy in medicine across a large, multi-state organization.
3. Identify components of this strategy that can be transferred to attendees' home institutions.

Background

Clinician burnout has remained in the global news for decades. At Advocate Health, we take pride in being early promoters of clinician well-being, even before a transformational event like the COVID-19 pandemic. In 2018, we created the Best Place to Care strategy, with a focus on our clinicians. Starting as a grassroots effort, this is now an enterprise effort for Advocate Health, one of the largest non-profit health systems in the United States.

Objectives

This physician-led strategy has a unique focus on reducing administrative burdens and friction points and optimizing EMR usage and other system factors to enhance the work environment, while offering supportive programming to deepen a culture of well-being among clinicians.

Approach

Our Best Place to Care strategy is a multi-pronged framework to enhance well-being efforts at Advocate Health. Some key areas of success in driving this strategy include our infrastructure of workstreams, an enhanced communication plan and increased access to clinician well-being and support initiatives. One foundational element includes three unique workstreams to drive this work: workflow efficiency (focus areas include removing unnecessary administrative tasks, optimizing the EHR, and in-basket management), recruitment, retention and onboarding (focus areas includes recruiting top talent and enhancing the employment experience upon hire) and culture and well-being (focus areas include enhancing a culture of well-being and professional development). These workstreams are led by physicians and comprised of multi-disciplinary team members across the organization.

Lessons learned

In 2023, we earned the Gold Joy in Medicine award from the AMA in the Southeast (Atrium Health) for our efforts. We deployed the PWAC and the AMA organizational biopsy as survey methods to measure progress. Our Midwest clinicians (Advocate Aurora Health) took the PWAC survey in May 2023 with overall professional fulfillment at 6.41, slightly worse than the cut-point, and burnout at 2.92, slightly better than the cut-point. Data from the AMA from 2022 to 2023 demonstrated progress in areas including job stress, which decreased by 5% (7% lower than national comparisons); burnout, which decreased by 5.3% (8% lower than national comparisons); job satisfaction, which increased by 1% (5% higher than national comparisons); and feeling valued, which increased by 2.5% .

Practical implications

We continue to learn through the voices of our physicians & APP/Cs to deepen our efforts to become a Best Place to Care and achieve the Quadruple Aim. Their ongoing feedback keeps this work focused and relevant. We are committed to the systemic issues and drivers of burnout to improve well-being. Best Place to Care is a key strategic initiative for our organization. With the growing footprint of the organization, actualizing change takes significant strategy and effort. Our CEO, executives and leadership teams are invested in this work and the importance of well-being for our clinicians and teammates. We cannot take the best care of our patients without being the best place to care for clinicians and all teammates.

Beyond burnout: workplace social-cultural factors linked to intention to leave among academic physicians

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Learning objectives:

1. Describe demographic and occupational characteristics associated with physicians' intention to leave their jobs.
2. Identify workplace cultural factors associated with physicians' intention to leave their jobs.
3. Describe the role of workplace culture factors in moderating the effect of burnout on physicians' intention to leave their jobs.

Purpose/relevance

In recent years, especially during and following the COVID-19 pandemic, physicians and other health care professionals have left their jobs and sometimes the health care field altogether. While several studies have examined the association between certain demographic and work stressors associated with physicians' intention to leave their jobs, scarce research has examined how workplace social-cultural factors such as organizational culture, psychological safety and leadership support may relate to this outcome. To address this gap, we examined how a broad range of demographic (e.g., age, sex), occupational (e.g., faculty rank, burnout) and workplace social-cultural factors were linked to intention to leave among physicians in a large academic hospital system. We also evaluated the role of workplace social-contextual factors in moderating the association between burnout and intention to leave.

Materials and methods

An institution-wide survey was distributed to all physician faculty at an urban academic eight-hospital health system between July and September 2022. Intention to leave one's job in the next two years was assessed using a five-point ordinal likelihood scale. Multivariable logistic regression and relative importance analyses were conducted to examine associations between demographic, occupational, workplace social-contextual factors and intention to leave one's job, and the role of workplace social-contextual factors in moderating the association between burnout and this outcome.

Results

A total of 1,534 physicians completed the survey (41.6% response rate), of whom 829 had clinical responsibilities (mean = 65.5%). A total of 112 physicians (13.5%) reported an intention to leave their job in the next two years for reasons other than retirement. Higher scores on measure of positive workplace organizational culture (odds ratio [OR] = 0.69 $p < 0.01$; relative variance explained [RVE] = 35%) and leadership support (OR = 0.93, $p < 0.001$; RVE = 27%) were negatively associated with intention to leave, while lower faculty rank (OR = 1.45, $p < 0.05$; RVE = 21%) and burnout (OR = 2.10, $p < 0.01$; RVE = 17%) were associated with a greater likelihood. Post-hoc analyses on specific cultural and leadership aspects indicated that believing that the organizational culture promotes a caring work environment (OR = 0.56, $p < 0.001$), having a clinical care team that works efficiently together (OR = 0.81, $p < 0.05$) and leaders who provide helpful feedback/coaching on performance (OR = 0.68, $p < 0.001$) and keep faculty informed about organizational changes (OR = 0.77, $p < 0.05$) were associated with a lower likelihood of intention to leave. Furthermore, believing that one's clinical care team works efficiently together moderated the association between burnout and intention to leave (OR = 0.57, $p < 0.01$). Among physicians who screened positive for burnout, those who scored higher on this measure were more than five times less likely to report an intention to leave their job (9.9% v. 53.0%).

Conclusions

Results of this study suggest that fostering a positive workplace culture and enhancing leadership support may play an important role in promoting physician retention in the post-COVID era. While burnout was associated with a greater likelihood of physicians intending to leave their jobs, working in an environment with efficient clinical care teams moderated the impact of burnout, reducing the likelihood to leave. Limitations include a moderate response rate and the cross-sectional design. Nonetheless, organizational initiatives aimed at promoting a caring work environment and efficient clinical care teams, and improving communication between leaders and faculty members could help increase physician retention.

Building a community of "Joy at Work" mini-grant awardees: using the power of connections to promote sustainable well-being initiatives at the local and organizational levels

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Learning objectives:

1. Explain the process of creating a well-being mini-grant program.
2. Describe examples of well-being initiatives that can result from a well-being mini-grant program.
3. Identify how to leverage the power of creating connections between program grantees to benefit local work units and the organization.

Background

Promoting a culture of well-being in health care organizations requires institution-wide and local efforts at the work-unit (department, division, team) levels. Mini-grant programs, where the organization provides funding for work units to develop well-being programs, recognize that members of a work unit are best suited to identify and address their unique well-being needs. Such programs present an opportunity to create and nurture a community of health care professionals who can continue to impact well-being in their work units and organizations.

Objectives

Our Joy at Work mini-grant program aims to foster a culture of well-being through funding well-being projects in local work units and creating a forum where grantees can continue to connect with other grantees and share best practices. As the number of grantees increases with each future yearly grant cycle, we will expand this cohort of health care professionals and help maximize their local and organizational impact through connection, networking and sharing of best practices.

Approach

Our mini-grant program is based in a large academic health institution and completed its inaugural year of funding in academic year 2023–2024. In March 2024, we organized a virtual symposium attended by grantees, their team members and anyone interested in applying for future funding. Each grantee provided a short video describing their project, highlighting lessons learned and plans for sustainability. Over 25 videos were presented with the concluding session of the symposium devoted to engaging grantees specifically in providing suggestions to develop an infrastructure for networking and continued connection. Select suggestions to create a community of grantees included creating a discussion forum through virtual meetings, newsletters, a text-based platform, and to share ways to work with leadership to foster sustainability.

Lessons learned

Obtaining leadership support and having clear goals when announcing the program and well-defined review criteria were important. We will show short video clips to demonstrate the variety of projects that were funded and lessons learned about the creativity and resourcefulness of the projects (examples: affinity/peer support groups, reflection sessions, incorporating gratitude and mindfulness in meetings, celebrating milestones in residency, awakening humanity through volunteering, beautifying a work area through gardening or art, team-building initiatives). We found that organizational leadership was supportive and appreciative that efforts for well-being came from grassroots local projects highlighting the need for bidirectional efforts at well-being. We will share lessons learned from initiatives to develop networking, connection and community between grantees, with an emphasis on fostering sustainability.

Practical implications

Mini-grant programs represent a way for health care organization leadership to engage health care professionals and teams to develop local work-unit well-being interventions. This can complement other leadership-led system-wide changes that support professional well-being. Creating a networking infrastructure for grantees and harnessing the power of connection between grantees and their work units can help maximize the impact of the mini-grant program within the organization through piloting innovative well-being solutions that can be shared between grantees and with other work units. Such an infrastructure can support the important message that health professional well-being should be planned at all organizational levels and that all, including individuals, health care teams and leaders, can participate in creating a culture of well-being in the health care workplace.

Burnout experiences among historically marginalized medical students from 2019 to 2021

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Learning objectives:

1. Explain the prevalence of burnout by sex, race, ethnicity and sexual orientation among US medical students.
2. Outline how the prevalence of burnout has varied from 2019 to 2021 among US medical students.
3. Describe trends in the prevalence of burnout among US medical students by intersectional demographics.

Purpose/relevance

Little remains known about the experiences of medical students with intersectional identities as previous studies have not simultaneously examined relationships between severity of burnout, assessed as a continuous variable, disaggregated racial and ethnic groups, and sexual orientation while controlling for other variables associated with burnout risk (i.e., age, marital status, debt, number of dependents). Additionally, whether work-related stressors and subsequent burnout varied by medical student demographic characteristics during the COVID-19 pandemic is unknown. Therefore, we studied the prevalence of burnout by sex, race, ethnicity and sexual orientation from 2019 to 2021 in a national sample of graduating medical students and explored for trends over time within intersectional demographic groups.

Materials and methods

We obtained medical student responses to the 2019–2021 Association of American Medical Colleges (AAMC) Graduation Questionnaire (GQ) linked to data from other AAMC sources. The data set included year of GQ completion, responses to the Oldenburg Burnout Inventory and demographics (from the GQ: age, marital status, dependents, sexual orientation, premedical school debt, medical school debt, consumer non-education debt, and from other AAMC sources: sex, race, ethnicity). Multiple linear regression analysis was performed to evaluate independent associations between demographics and burnout.

Results

The overall response rate was 80.7%. After controlling for other factors, exhaustion scores were higher among Asian (parameter estimate [PE] 0.38, 95% CI 0.21, 0.54) and bisexual (PE 0.97, 95% CI 0.76, 1.17) or gay or lesbian (PE 0.55, 95% CI 0.35, 0.75) students than those who did not identify with each of those respective groups. Disengagement scores were lower among women than men (PE −0.47, 95% CI −0.52, −0.42) and among Hispanic (PE −0.11, 95% CI −0.22, −0.01) and White (PE −0.10, 95% CI −0.19, 0.00) students and higher among Asian (PE 0.17, 95% CI 0.07, 0.27), Black or African American (PE 0.31, 95% CI 0.18, 0.44), and bisexual (PE 0.54, 95% CI 0.41, 0.66) or gay or lesbian (PE 0.23, 95% CI 0.11, 0.35) students than those who did not identify with each of these respective groups. Scores were stable to improved across nearly all intersectional groups across the three years.

Conclusions

Male, Asian, Black or African American and sexual minority medical students had a higher risk of burnout while female, Hispanic and White medical students had a lower risk of burnout.

Championing gender equity: adjusting outpatient productivity targets for lactating physicians

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Learning objectives:

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

1. Identify challenges that female outpatient attending physicians encounter when breast pumping in an academic medical setting.
2. Identify potential gaps in existing organizational lactation policies regarding time needed to pump, outpatient productivity targets and incentive opportunities (i.e., bonuses).
3. Design an outpatient physician lactation program to adjust clinical productivity targets to accommodate time needed to pump for breastfeeding physicians.

Background

Breastfeeding in academic medicine is challenging. Significant obstacles include lack of time to pump, decreased productivity and decreased pay for many physicians who pump. To address this inequity, a few health care organizations implemented lactation programs to protect time and adjust outpatient productivity targets for clinicians to accommodate pumping without penalty. The Children's Hospital of Philadelphia (CHOP) implemented a similar program for general pediatricians, but there was an opportunity to support subspecialists.

Objectives

The aims were to 1) conduct a lactation needs assessment to determine opportunities to further support breastfeeding attending physicians related to protected time needed to pump, productivity targets and incentive opportunities and 2) design a lactation program to address ongoing needs including time and financial disparity, to support gender equity, diversity and inclusion.

Approach

We surveyed division leadership and physician well-being champions across all departments and conducted qualitative interviews; 65% (26/41) reported protected time for lactating physicians to pump (69% protect time as needed, 8% protect time every four hours, 4% protect time every three hours and 19% had no set process). In addition, 82% (22/41) reported that the annual productivity targets and incentive targets were NOT adjusted to account for time needed to pump.

We then designed a lactation program to reduce clinical effort and adjust productivity targets for up to 12 months post-childbirth for CHOP outpatient attending physicians who express breastmilk. Specifically, there is a 30-minute clinical effort reduction per four-hour outpatient clinical session, and the productivity target within the incentive is adjusted.

Lessons learned

Most breastfeeding attending physicians did not have an adjustment in their annual productivity targets or incentive opportunities to account for time needed to pump prior to initiation of the lactation program. This highlights a significant disparity for this group of female physicians. Additionally, the financial inequity primarily applied to physicians in the outpatient setting. Furthermore, many physicians noted during qualitative interviews that they stopped pumping soon after returning to work because of time constraints. Most were not aware of an existing staff policy on lactation that allowed the time to pump but did not address financial equity for physicians.

Practical implications

Supporting breastfeeding is critically important for gender equity and diversity, can increase an organization's retention of physician parents and helps to create a more supportive environment for physicians. Interestingly, CHOP had a pre-existing lactation policy to allow time to pump without financial equity for physicians, and yet 35% of survey respondents reported no protected time for physicians to pump. Either survey respondents were not aware of the existing policy or perceived a lack of policy support from leaders. Engaging senior leaders in this process is critical to ensure leadership approval and help physicians ask for the time. Communicating the program is essential. Ultimately, improved health outcomes for the children receiving human milk is the most important benefit of this program.

Changing the system: how to develop a suicide prevention and depression awareness program for health care workers

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Learning objectives:

1. Identify how to develop, implement and evaluate an anonymous and confidential suicide prevention and depression awareness program aimed to screen, assess and refer health care workers (HCW), including trainees, to additional mental health support.
2. Identify how to navigate the challenges encountered during implementation of the program, including changing the culture of well-being, at a large public/academic level 1 trauma medical centre.
3. Idedntify how to decrease the stigma surrounding depression and suicide and increase use of mental health services by cultivating a culture of safety, trust and connection in a very disconnected large health care system.

Background

Rates of burnout, depression and suicide are rising throughout the health care workforce. Physicians, nurses, health care support workers and technicians face increased risk of suicide compared to the general population. At our large public/academic hospital, there were unmet needs in mental health support provided to hospital staff, worsened during and since the COVID19 pandemic. This program addresses this real, but often hidden, burden of serious depression and suicidal thinking while destigmatizing help seeking among HCW.

Objectives

This program, provided to all clinical and nonclinical staff, faculty, trainees, nursing and health care executives at a large public/academic hospital, addresses systemic and individual factors contributing to burnout, stress and other mental health challenges in health care. We aim to reduce help-seeking barriers, proactively offer personalized support, provide education about stress and mental health and connect HCW to mental health services. Through ongoing outreach, we are cultivating a culture of safety and connection

Approach

With our partnership with the American Foundation for Suicide Prevention, we implemented an anonymous and confidential interactive screening program (ISP) for our entire workforce. Staff, faculty and trainees self-identified and received confidential follow-up and referral while also taking self-screeners assessing for anxiety, depression, suicide, trauma and substance use. By providing access through a confidential online platform, staff were able to utilize support services while maintaining anonymity — overcoming a significant deterrent in accessing mental health resources. We utilized in-person and virtual outreach mechanisms to provide education and promote this interactive screening program. Through these in-person meetings and huddles, we were able to normalize help-seeking behaviours and debunk myths around mental health and treatment, while building trust with our colleagues.

Lessons learned

Through informal and formal feedback (i.e., participant surveys), we learned how to adjust our program to fit the needs of our HCW. We learned that choosing a destigmatized name for the program (e.g., My Well-being) is more likely to increase participation than including mental health terms in the name. Providing education on how the ISP maintains anonymity was essential for buy-in and promoting engagement. To address acute distress and active suicidal ideation, albeit anonymously, we modified the mental health counsellor's dialogue template to include a safety plan. We learned some disciplines needed additional education around suicide prevention and the rationale for using this program. Utilizing virtual and in-person mechanisms for outreach and education made this program more accessible to staff.

Practical implications

As a public/academic hospital, our priority is providing comprehensive services for our multi-ethnic and underserved population in a training environment. Our workforce is burdened by workload and being witness to the difficult lives our patients endure (moral injury). The ability to provide care is greatly influenced by HCWs' levels of stress. This program addresses these concerns and also reduces barriers for seeking help by connecting individuals to a counsellor and providing referrals to mental health services. We are proactively normalizing discussions and education on suicide prevention, depression and other mental health concerns. Bringing this to other public medical centres locally will address well-being needs and gaps in access to care for HCW in additional public sites with limited resources.

Cultivating culture change: a peer support continuum

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Learning objectives:

1. Differentiate the broad range of peer support initiatives offered by Doctors Manitoba.
2. Explain the impact of these peer support initiatives drawn from participant feedback and evaluation measures.
3. Recognize the role peer support can play in cultivating culture change in medicine across the career span.

Background

Physicians face unique stressors and challenges that are often best understood by other physicians because they share similar life experiences. Doctors Manitoba has offered peer support through their Physicians at Risk program since 1986. In recent years, Doctors Manitoba advocated for increased funding to expand and diversify the evidence-based peer support initiatives offered to medical students, residents, and practising and retired physicians to support their well-being and influence culture change.

Objectives

The objectives of Doctors Manitoba's physician peer support program are to provide a range of evidence-based confidential peer supports to medical learners, residents, and practising and retired physicians, to connect members to additional supports when needed, and to cultivate culture change within the medical community that prioritizes help-seeking behaviour and shared organizational responsibility for clinician well-being. The Doctors Manitoba peer support program hopes to influence and increase a culture of compassion and empathy in medicine and contribute to building physician unity.

Approach

Doctors Manitoba uses a comprehensive, wraparound approach to peer support initiatives, focusing on personalized care and influencing culture change. Through educational sessions and skill-building workshops, individual peer support, group-based peer support with a focus on supporting equity-deserving members, and supporting organizations to develop their own peer support teams, members receive tailored support and connection to resources. We view our peer support initiatives as upstream interventions and seek to influence individual- and system-level changes that contribute to improved well-being for Doctors Manitoba members. Additionally, each peer support initiative provides referral pathways to additional support services, ensuring comprehensive care for Doctors Manitoba members.

Lessons learned

(1) Doctors Manitoba has recognized the unique reality of our organization's relationship with its members and how we are well positioned to provide tailored support to members. Adaptability, personal connections and responsive support have been critical components of each peer support initiative within the program. (2) Doctors Manitoba recognized the importance of providing training and education to both peer supporters and physicians seeking support, ensuring that peer supporters are equipped with the necessary skills to provide effective support while empowering members to know how to access support services. (3) Doctors Manitoba realized the value of integrating the peer support programming with existing resources and services within the medical community to provide a comprehensive approach to physician well-being.

Practical implications

The practical implications of Doctors Manitoba's peer support program extend beyond individual physicians to impact the entire health care system: (1) The program directly contributes to the well-being of physicians, reducing feelings of isolation, stress and burnout. (2) The program facilitates early intervention for mental health concerns among physicians, reducing the escalation of issues and promoting timely access to support and resources. (3) Doctors Manitoba's peer support program contributes to a broader cultural shift toward help-seeking behaviour and shared organizational responsibility for clinician well-being. (4) The program fosters a sense of community among physicians, strengthening professional relationships and creating opportunities for collaboration and knowledge-sharing. (5) Doctors Manitoba's peer support program serves as a model for other organizations seeking to implement similar initiatives.

Culture of academic medicine initiative: a national approach to well-being at faculties of medicine in Canada

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Learning objectives:

1. List the factors that led to the development of the Culture of Academic Medicine Initiative.
2. Demonstrate how systemic and individual well-being approaches can be fostered in a complementary manner.
3. Discuss the Culture of Academic Medicine Initiative's progress to date and opportunities for future work and collaboration.

Background

Medical education in Canada has made significant efforts to address learner well-being and there is increasing recognition of the importance of focusing on systems-level interventions in the learning environment. Despite this, systemic efforts have been difficult to initiate and maintain. The Okanagan Charter: An International Charter for Health Promoting Universities and Colleges was developed to apply health-promoting education principles to higher education. To advance well-being efforts, we require a national collaborative evidence-based approach.

Objectives

The Culture of Academic Medicine Initiative (CAMi) encourages Canadian academic medicine institutions to adopt and implement best practices and initiatives that foster respectful, inclusive and health-promoting environments for the well-being of all. This initiative seeks to empower individuals in academic medicine to collectively strive toward embedding respect, safe spaces, empathy, compassion, equity, self-care and kindness into the fabric of our communities through adopting the principles of the Okanagan Charter

Approach

Through a two-pronged approach, we have taken a systemic, scholarly, collaborative approach to advancing well-being using health promotion principles. The Okanagan Charter Collaborative (OCC) includes representation from all faculties of medicine in Canada as well as patient and national equity-deserving group representation. We have developed resources including promotional communication material about the goal of the charter and the OCC, terms of reference documents to ensure strong governance practices, a national educational webinar series and an implementation and audit toolkit for implementing the Okanagan Charter. We focus on co-creation with the faculties and the stakeholders we aim to serve. A rigorous evaluation process is underway, guided by national and international experts to measure individual and systems outcomes.

Lessons learned

By pairing individual and systemic approaches the initiative can further engage more individuals in the well-being movement. To develop a health-promoting medical learning environment, strategic objectives include: 1) embed health in all policies; 2) develop sustainable, supportive spaces; 3) create thriving medical communities and culture; 4) encourage, support and sustain meaningful personal development; and 5) review, develop and strengthen faculty-health services; and we added 6) collaborate and invest in continuous improvement. Faculty and leadership development are critical to developing and sustaining a national collaborative. Flexibility that allows for individuals and faculties to adapt on the basis of their local context, while adhering to the core overarching principles, is key to buy-in and longer term sustainability

Practical implications

CAMi serves as an example of how a national collaborative approach to addressing well-being in academic medicine is possible and productive. The Okanagan Charter provides institutions with a common language, principles and framework to become health- and well-being-promoting campuses. This initiative presents a unique opportunity for our faculties to lead by example in creating environments and spaces that support the health and well-being of all by adopting and translating the Okanagan Charter into action. Future work will involve continuing to build the initiative and further partnering with important stakeholders in the health system (e.g., health authorities) and medical education to sustainably embed the principles and progress into the health system.

Decreased physician burnout and improved well-being in a large health system in California

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Learning objectives:

1. Define physician burnout and additional well-being metrics in a large integrated health care organization from 2019 to 2023.
2. Compare differences in physician burnout and well-being outcomes by age group, gender identity and medical specialty, including year-over-year comparisons through 2023.
3. Identify actions taken by Sutter Health leaders that led to a reduction in physician and advanced practice clinician burnout scores.

Purpose/relevance

Physician burnout is a national epidemic, affecting nearly two-thirds of physicians and costing $4.6 billion annually in the United States. Sutter Health is a large integrated health care not-for-profit organization in Northern California with over 14,000 physicians serving more than 3.3 million patients. Since 2019, Sutter Health conducts annual physician well-being surveys in their 22 hospitals gathered by NRC Health, an independent surveyor. We evaluate changes in physician burnout from 2019 to 2023 and additional well-being metrics from 2022 to 2023 using three survey items: (1) the non-proprietary single-item burnout measure, (2) the statement "I feel highly valued" and (3) the statement "I would like more support for my mental health needs." We then discuss actions taken by Sutter Health leaders to reduce physician burnout.

Materials and methods

Physician responses were dichotomized (yes/no) and then separated by age group, gender identity and medical specialty. Chi-squared tests were used to compare annual changes and group differences. An average of 2,577 physicians participated between 2019 and 2023. In 2023, most were 35–44 years old (31.7%) and 45–54 years old (30.7%); half identified as male (50.6%); by medical specialty, the most common were hospitalist (13.0%), emergency medicine (12.8%) and anesthesia (12.0%).

Results

Overall, burnout was 23.4% in 2019, peaked in 2022 (33.9%) and significantly decreased from 2022 to 2023 (29.3%; $p = 0.0005$). From 2022 to 2023, feeling highly valued increased significantly from 60.0% to 64.1% ($p = 0.003$), and requests for more mental health support decreased modestly from 24.3% to 23.9% (not statistically significant, $p = 0.736$). There were statistically significant differences in 2023 by age group and gender identity in both burnout and requests for more mental health support ($p < 0.0001$). Physicians 35–44 years old (31.8%) and physicians who preferred not to share their gender identity (42.9%) had the highest burnout percentages; both 35–44 year olds (28.7%) and females (29.6%) had the highest percentages requesting more mental health support. For physicians who felt highly valued in 2023, physicians under 35 years old (69.7%, $p = 0.058$) and physicians who self-identified as non-binary/transgender (75.0%, $p < 0.0001$) had the highest percentages. Annual changes in the three survey items may be attributed to the establishment of Sutter Health's system-wide Interdisciplinary Well-Being Committee (IDWC) composed of chief medical executives, chiefs of staff, and medical group and hospital physician, nursing and staff well-being leads.

Conclusions

In response to the increase in physician burnout, Sutter Health's IDWC meets every other month to review survey results, categorize survey comments, conduct listening sessions, engage system resources to address survey comments and results, create formal peer support and "hotspot" high-burnout departments. The IDWC invites its members to share current work to address identified comment categories and create a two-way dialogue between the system-wide IDWC and local hospital IDWCs. Future IDWC actions include making improvements by age, gender and medical specialty. Our study of a large physician population offers insight to reduce burnout and improve well-being.

Determinants of a healthy learner

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Learning objectives:

1. At the conclusion of this activity, participants will be able to recognize components of an innovative program designed to support resident physicians during their intern year of training.
2. At the conclusion of this activity, participants will be able to formulate possible learning improvement projects in their own systems/programs.
3. At the conclusion of this activity, participants will connect concepts of psychological safety, just culture and the interplay of support for learners.

Background

Determinants of a Healthy Learner (DHL) is a system designed to identity areas where incoming resident physicians may need support. This may include learning related to critical thinking, issues, social determinants of health, mental health and burnout. It is an upstream method designed to identity issues before they become problematic during residency. It is designed to integrate academic health psychologists providing connection and support throughout the intern year.

Objectives

If a poster: participants will be provided data from three years of operation of the DHL program in addition to the above objectives. If a 10-minute presentation: participants will be able to understand the program and begin to develop (utilizing design thinking) adaptations of such program in their own systems/programs.

Approach

The DHL program was created using the design thinking model, of which the first step of development is empathy. This necessitates the elimination of duality considerations of resident physicians, such as a "good resident and a bad resident." The program is an upstream one, designed to provide connection and to understand what support is needed at the beginning of residency. Every intern, when matched, receives a number of survey tools that evaluate critical thinking, learning styles, emotional intelligence, perfectionism, burnout and engagement/fulfilment. Upon arrival, each intern is assigned an academic health psychologist for the entire intern year. Together they review the survey tools and develop a learning plan for success. Data from 450 residents will be shared.

Lessons learned

1. Resources must be available to pay for tools and time as well as data entry and analysis. 2. A program such as this must have approval and support from the top levels of graduate medical education (GME) to succeed. 3. At least 10% of residents struggle during residency significantly enough to require some form of remediation. 4. To effect culture change, GME must promote psychological safety and just culture to support the idea that residency is hard for everyone and that everyone needs connection and support. 5. Struggling residents tend to isolate because of shame and this program decreases isolation by providing that connection to support

Practical implications

Developing an upstream method that is providing support for residents is a process that involves culture change and necessitates involvement at all levels of GME. It is not only an intervention for learners; it appears that faculty benefit also. Faculty generally spend an inordinate amount of time and effort with struggling residents and often feel that the other residents, who are not struggling, do not receive their faculty time. The DHL program identifies issues earlier, provides a connection with the health psychologist, who is also faculty and interacts with the residency program director, and mentor, creating a circle of connection and support for the resident and the faculty.

Development of a provincial-wide micro-aggression course for physicians though tripartite collaboration

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Learning objectives:

1. At the conclusion of this activity, participants will be able to identify ways to initiate multi-stakeholder collaboration for improving inclusion within the health system.
2. At the conclusion of this activity, participants will be able to differentiate the barriers and enablers likely to be encountered when implementing a collaborative learning initiative.
3. At the conclusion of this activity, participants will be able to recognize the importance of evaluating learner experience when introducing learning initiatives in the health system.

Background

In 2023, the Alberta Medical Association (AMA), the College of Physicians & Surgeons of Alberta (CPSA) and Alberta Health Services (AHS) partnered to develop an online training course on race-based micro-aggressions. The hosting platform has the potential of reaching almost 100% of Alberta physicians and learners. The training was soft-launched in June 2023 and over 600 regulated members completed the training. The official launch is now scheduled after achieving accreditation by the two national colleges.

Objectives

The aim of the project is to position Alberta's physicians as leaders in addressing racism in health care settings. The course will help with understanding what micro-aggressions are, how to recognize them, why they are harmful and how to respond. This training is an excellent example of partner organizations working collaboratively and pooling resources effectively and efficiently. Developing the training demonstrates how the organizations are working toward becoming anti-racist and anti-discriminatory.

Approach

The project management team, comprised of a representative from each of the three organizations, guided the two-year project through the processes of initiation, planning and development, implementation and evaluation. A unique component that significantly contributed to this project's success was the creation of the Course Content Working Group (CCWG). Members of the CCWG represented a variety of different organizations including the CPSA, AMA, AHS Physician Experience, AHS Diversity & Inclusion, University of Alberta Indigenous Health Program, University of Alberta Black Medical Students' Association, University of Alberta Faculty of Medicine and University of Calgary Cumming School of Medicine. The course scenarios were developed using the CCWG contributors' real-life examples or were taken from examples in the research literature.

Lessons learned

The process to attain accreditation from the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada, which may serve as an important incentive for individuals to complete the course, should be initiated early as it takes months and requires organizational resources to complete. Ongoing evaluation of the course is necessary to determine the impact of this integrative initiative and is currently in progress. Contracting an eLearning provider dedicated to creating an inclusive and accessible learning experience was invaluable and helped address content writers' biases. Given work such as this has the potential to improve physician and learner well-being, remuneration should be considered, thereby indicating value and prioritization to health organizations.

Practical implications

Patients, colleagues and teams look to physicians to create healthy and safe health care environments. Research shows that racism is a common experience in health care settings both between health care providers and patients and within health care teams. Discriminatory behaviour like micro-aggressions can contribute to health care disparities and can lead to physician stress and burnout. This provincially accessible course will equip physician leaders with practical tools and realistic scenarios to identify, support and intervene when seeing race-based micro-aggressions happening. The course is voluntary and qualifies for 4.5 Mainpro+ and MOC credits. It is anticipated that awareness of the course will be by dissemination through a joint tripartite communication strategy and also by word of mouth of satisfied participants.

Efficacy of focused collegiality interventions in improving cross-specialty relationships among front-line physicians

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Learning objectives:

1. At the conclusion of this activity, participants will explain the relationship between collegiality, physician well-being and quality of care.
2. At the conclusion of this activity, participants will make use of relationships between consulting departments within their medical centres.
3. At the conclusion of this activity, participants will be able to plan focused cross-specialty collegiality interventions.

Purpose/relevance

Collegiality has been defined as the collective manifestation of respect, empathy and solidarity within medical teams, driven by a common pursuit of clinical excellence in patient care. Increasing workloads, administrative burdens and the highly specialized nature of medicine can negatively impact our respect, empathy, and ultimately, collegial relationships with one another. These interactions affect teamwork, physician well-being and patient care. System-wide initiatives have been shown to improve collegiality within our organization; however, they may be time and resource intensive. We conducted a pilot with goals of exploring and improving relationships among four hospital-based specialties, with a large portion of interventions being virtual.

Materials and methods

Physicians of emergency medicine, general surgery, hospital medicine and OBGYN received surveys exploring the quality of relationships within and between departments. Responses were rated on a Likert scale of 1–5, with 5 being most favourable. Free responses were also obtained. After data were analyzed, interventions began, which included virtual journal clubs, commensality, shared education and simulation time. Particular focus was given to the departments with the lowest inter- or intra-departmental relationships. Follow-up surveys were sent to all departments.

Results

Response rates on the pre-survey were between 42% and 72% (n = 123) with post-survey response rates ranging from 22% to 52% (n = 64). The intradepartmental relationships remained relatively stable across the board. Pre-intervention data highlighted the most strained relationship between emergency medicine and general surgery; as a result, our interventions focused on these departments primarily. For this group there was a significant improvement on the post-survey, with emergency medicine's rating of general surgery improving from a composite score of 2.6 to 3.4 (p = 0.002). A trend toward improvement was seen in general surgery's composite view of emergency medicine, 3.1 to 3.5 (p = 0.19). Analysis of free responses demonstrated similar improvements in the relationship between general surgery and emergency medicine. There were no interventions undertaken between general surgery and OBGYN, and this was evident in both quantitative and qualitative results showing worsening of the interdepartmental relationship (general surgery rating of OBGYN: 3.9 in pre-survey to 3.5 in post-survey [p = 0.0002]; OBGYN rating of general surgery: 3.6 in pre-survey to 3.1 in post-survey [p = 0.02]).

Conclusions

Our collegiality interventions were feasible and low cost and yielded the most positive results among the most fractured departments (emergency medicine and general surgery). These included two fully virtual combined journal clubs, one in-person engagement at a procedure lab, and engagement between department leadership. While survey participation decreased for the post-survey, we still had meaningful participation, especially emergency medicine where we saw our most positive trend. There were no specific interventions between general surgery and OBGYN, and here we saw the largest reduction in composite scores. Our work demonstrates the importance of collegiality-based interventions in improving cross-specialty relationships.

Enhancing physician well-being by improving the workplace for parents

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Learning objectives:

1. Describe unique workplace challenges of women physicians that can affect their well-being.
2. Recognize some of the specific challenges facing physician parents in the workplace.
3. Identify practical system-level interventions to address challenges facing women physicians and develop tips for partnering with administrators and health care leaders to address and promote healthy work environments throughout a woman physician's career to prevent and reduce their burnout and attrition.

Background

Prioritizing physician well-being and reducing burnout are key components of the American Medical Association (AMA) Recovery Plan for Physicians. Women now make up half of incoming medical students in the United States. Women physicians face well-known unique challenges, including balancing family and work responsibilities, that increase their risk for burnout. Health care systems should address and promote healthy work environments throughout a woman physician's entire career to prevent and reduce their burnout and attrition.

Objectives

The College of Medicine at the University of Florida (UF) in Gainesville, Florida (United States), formed a Women's Task Force, charged with creating an ideal environment for women faculty to work in academic medicine. The committee set out to identify some of the challenges facing women physicians and to develop policies to address these challenges and to enhance the work–life balance of women medical students, residents, fellows and faculty.

Approach

Members of the task force included women faculty (both MD and PhD) from different departments within the College of Medicine and human resources personnel. Committee members provided anecdotal insight into some of the challenges. We also reviewed the results of an earlier institutional survey of 80 physician mothers and their experiences with 152 children. Once the challenges were identified, committee members decided on specific ones to address. We then set out to research existing policies at UF, best practices across all institutions and available local resources. The committee met regularly to review and discuss findings and develop workplace strategies and programs to address these challenges.

Lessons learned

The task force agreed that lactation is one of the areas that significantly affects the work–life balance of both physicians in training and physicians in practice. Our institutional survey found a discrepancy between physician mothers' breastfeeding duration goal and their actual breastfeeding duration. While the maternal goal for the duration of breastfeeding was 12 months or more for 57% of the infants and physician mothers were able to successfully initiate breastfeeding for 97% of the infants, only 34% of the children were actually still breastfeeding at 12 months. In 43% of cases, survey participants stated that breastfeeding cessation was due to demands of work. We also identified and addressed two other areas that affect the work–life balance of both physicians in training and physicians in practice: maternity leave and childcare.

Practical implications

Physicians successfully partnered with UF to advocate for the well-being of women physicians, improve their work–life balance and ultimately enhance their retention. While officially a "women's" task force, the committee at UF is now developing a document that guides clinical and basic science faculty (both women and men) before, during and after pregnancy. Examples of proposed and practical interventions include written paternity leave policy across the institution and development of additional lactation facilities on campus. Our process can be used by other institutions and practices to set standards that promote healthy work environments, enhance physician well-being and support the careers of physicians of all genders.

Ethno-racial trauma experienced by physician trainees and medical students in the United States and its impact on their well-being: a scoping review

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Learning objectives:

1. Identify the most cited forms of ethno-racial trauma experienced by physician trainees and medical students.
2. List sources of ethno-racial trauma.
3. Describe the impact ethno-racial trauma has on the well-being of medical trainees and students.

Purpose/relevance

Racism serves as a source of stress for health care providers. Underrepresented in medicine trainees are disproportionately susceptible to the trauma stemming from systemic bigotry and injustice as they face discrimination, barriers to career advancement and leadership opportunities, and lack mentorship and representation. There is a need to investigate the impact systemic racism has on medical provider well-being and to identify strategies to mitigate the negative effect it has on the flourishing of health care providers. This scoping review aims to map existing literature to determine the impact ethno-racial trauma (defined as the psycho-emotional injury caused by the mistreatment or discrimination of a person on the basis of their race or ethnicity) experienced by physician trainees (i.e., resident or fellow physicians, or medical students) has on their well-being.

Materials and methods

The review was conducted according to Joanna Briggs Institute (JBI) methodology. A comprehensive search strategy was created with an information specialist and underwent peer review. The search was performed in six bibliographic databases and one grey literature source with no timeframe restriction. English language studies conducted in the United States that assessed the impact of ethno-racial trauma on health care providers were included. Study selection involved a title/abstract screening followed by full-text review. Three pairs of reviewers screened results and extracted data.

Results

Out of 3,985 studies identified for initial screening, 435 studies underwent full-text review and 71 studies met inclusion criteria, of which 46 studies focused on physician trainees. Study designs included observational (48%), qualitative (30%), mixed methods (13%), and reviews (9%). The most frequently reported forms of ethno-racial trauma experienced by medical trainees and students included discrimination, microaggressions, isolation or feeling invisible, implicit bias, devaluation of works, disrespectful actions, lack of belonging, and explicit bias. Patients, faculty and preceptors, residents, peers and other practitioners were identified as sources of ethno-racial trauma. Literature cited that ethno-racial trauma sustained by medical trainees and students was often associated with burnout, isolation, stress and frustration. This ethno-racial trauma had negative impact on elements of well-being and human flourishing, most notably their emotions, learning experience, mental health and confidence.

Conclusions

The literature pertaining to ethno-racial trauma experienced by medical trainees and students demonstrates its impact on their personal and professional well-being and flourishing.
The existing literature is limited by the heterogeneity of study populations, study methods, assessment instruments used and domains of well-being assessed. There is need for prospective studies with interventional methodology to assess the influence of ethno-racial trauma and strategically intervene to alleviate its impact on well-being.

Evaluating the impact of targeted EMR intervention on practice efficiency among primary care clinicians

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Learning objectives

1. At the conclusion of this activity, participants will be able to evaluate the impact of sharing individual electronic medical record (EMR) data in a 1-1 setting on clinicians' EMR patterns.
2. At the conclusion of this activity, participants will be able to evaluate the impact of individual clinical informatics specialist (CIS) interventions, including shadowing, coaching on EMR tools and techniques and weekly CIS follow-up, on practice efficiency.
3. At the conclusion of this activity, participants will be able to measure the impact of EMR interventions on clinicians' burnout and satisfaction with work-life.

Purpose/relevance

Nearly 70% of clinicians report health information technology related stress, and they commonly attribute administrative burden to the EMR. In fact, some clinicians report that they spend more time on clerical tasks than they spend with patients. Among national estimates, primary care clinicians spend the most time in their EMR, compared to other specialties. Previous literature suggests that EMR optimization is important for many clinicians, and the utilization of targeted interventions, such as deployment of a CIS, has proven beneficial. This project aims to identify methods of supporting physicians and advanced practitioners to reduce EMR burden as well as understand if, and to what effect, a targeted intervention utilizing a CIS impacts EMR burden, symptoms of burnout and work–life satisfaction among primary care clinicians.

Materials and methods

This study utilizes a modified quasi-experimental interrupted time series design to evaluate the EMR intervention's impact on 48 employed primary care clinicians (29 physicians; 19 advanced practitioners) at seven practices in a large health system. Participating clinicians will complete the NEO Five-Factor Personality Inventory, an EMR usability survey and the Maslach Burnout Toolkit (pre-/post-, with exception of the NEO). EMR data sharing, CIS shadowing, and CIS intervention follow standardized protocols. Pre/post changes in Epic Signal metrics will also be assessed.

Results

To establish baseline time in EMR, data were assessed three months prior to intervention. On average, the sample of primary care clinicians who have enrolled spent 217 minutes in the EMR per day (SD = 58.17) with most of that in Notes (M = 70 minutes, SD = 26.82), Orders (47 minutes, SD = 10.46), and In Basket (M = 45 minutes, SD=18.65). Seventy-six of these Time in System minutes per day were Outside of Scheduled Hours (SD = 17.98) and 62 minutes were Pajama Time (SD = 40.90). EMR utility is a complex topic. Only 50% of participants reported that the EMR made them as efficient as possible and over 80% of respondents indicated that the EMR contributed to their burnout daily or almost daily. Paradoxically, 66.7% believed that the EMR allows them to make purposeful contributions in their work and the same percentage was confident that they could incorporate EMR changes into their workflow. In assessing burnout, clinicians were in the 77th percentile for emotional exhaustion, the 35th percentile for depersonalization and the 88th percentile for personal accomplishment. Regarding areas of work-life, clinicians were in the 15th percentile for workload, 69th percentile for control, 74th percentile for reward, 81st percentile for community, 93rd percentile for fairness and 88th percentile for values.

Conclusions

Baseline EMR data suggest that there are ample opportunities for intervention among primary care clinicians. Current findings point to the EMR as a potential driver of burnout (emotional exhaustion, more specifically) and source of burden for most clinicians. Despite this, a majority of clinicians are confident that they could incorporate positive changes into their EMR workflow if provided intervention. Therefore, improvement in EMR efficiency may contribute to reduced burnout and improved work–life satisfaction. Future opportunities for research include expanding the scope of CIS intervention to more primary care clinicians, to more clinics and to other specialties.

Examination of physician substance use and treatment: uncovering adverse actions against physicians and the urgency for systemic support in the United States

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Learning objectives:

1. At the conclusion of this activity, participants will be able to recognize the prevalence and impact of substance use disorders among physicians.
2. At the conclusion of this activity, participants will be able to interpret data from the National Provider Data Bank to identify trends in adverse actions taken against physicians because of substance use disorders, including types of action taken, distribution across states and demographic characteristics of affected physicians.
3. At the conclusion of this activity, participants will be able to evaluate the importance of existing support services and interventions for physicians with substance use disorders, including physician health programs, medications for addiction treatments and changes in medical licensure and credentialling language to reduce mental health and substance use stigma.

Purpose/relevance

Recent research suggests a nearly 30% increase in physician visits to outpatient mental health and substance use treatment since the beginning of the COVID-19 pandemic. The presence of alcohol or drug dependence among physicians is associated with burnout, depression, decreased professional quality of life and medical errors. However, little literature exists in understanding the prevalence of substance use among physicians, the number seeking treatment and the factors that may lead to a physician having adverse actions taken against them when seeking treatment or accessing resources from their state licensing boards. We aim to understand the prevalence of adverse actions against physicians related to substance use disorders (SUD) over time by utilizing a national database that requires mandated reporting of adverse actions.

Materials and methods

Data were obtained from the National Provider Data Bank, a required United States Department of Health and Human Services database that routinely collects information relating to medical malpractice payments, adverse actions, state licensure, clinical privileges and professional society membership actions. The analytic sample included 1,190 physicians, whose basis for adverse action was "unable to practice safely by reason of substance use" between 2013 and 2023.

Results

Of the 1,190 physicians, 87% were allopathic physicians (medical doctors), 54% were over the age of 50 and nearly 40% graduated medical school after 2000. Physicians from all states, except for Idaho, reported having adverse actions against them because of inability to practice due to reason of substance use, with Ohio (9%), North Carolina (9%) and California (8%) having the most reports. Approximately 77% of reports came from the health care practitioner's licensing board/authority, with an average of 108 reports per year. Additionally, 2% of physicians were unable to practise due to psychological impairment, physical impairment, and due to being an immediate threat to the public, respectively. This resulted in 18% of physicians having their licence placed on probation, 18% having their licence suspended, 12% having an emergency suspension of their licence, nearly 9% voluntarily surrendering their licence and almost 8% surrendering their licence pending a complete investigation. Approximately 80% of physicians received an indefinite penalty length, 8% received a permanent penalty and 12% received a specified penalty length, with an average of 3.7 years.

Conclusions

The mental health of physicians is of paramount importance, and the availability of support services for physicians who live with SUD must be addressed. Utilization of physician health programs, medications for addiction treatment and multi-level interventions have proven to be successful in combatting SUD among physicians. Further, changing language on medical licensure and credentialling applications can decrease physicians' fear of reporting problems and reduce stigma of seeking treatment for SUD/mental health reasons. This could encourage physicians to take early action in seeking effective treatment and achieving recovery before adverse actions are taken against them.

Expansion of a physician parental wellness program at the Massachusetts General Hospital

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Learning objectives:

1. To identify the unique challenges faced by physician parents in early parenthood and the return to work following parental leave.
2. To share the impact of an expanded faculty parental wellness program and reflect on lessons learned through program implementation.
3. To explain the need for a culture of support within health care institutions that acknowledges and accommodates the needs of physician parents.

Background

Physician parents may experience a range of challenges during their transition to parenthood and return to work. We previously developed and implemented a limited pilot parental wellness program that supported new physician parents through 1:1 coaching, financial resources and connections to other parents. The pilot program positively affected wellness, supported lactation efforts and fostered community building. With additional funding, we expanded this program to all Department of Medicine (DOM) faculty physicians.

Objectives

Our goal was to assess the feasibility of scaling the pilot program to the DOM and describe obstacles we encountered during its implementation. To gather feedback for program improvement, we conducted de-identified surveys at baseline, six months and 12 months following the birth of the child. Questions pertained to challenges of returning to work, lactation and helpfulness of the program. At the program's conclusion, we surveyed all participants regarding their experience and suggestions for improvement.

Approach

Participants joined the program between October 2021 and September 2022. The core program consisted of two components that were available to all participants: 1) a feeding/lactation reimbursement of $500 (intended for a wearable breast pump) and 2) a one-on-one pairing with a parental wellness advocate (PWA), who was an experienced parent coach who provided support to the participant over the course of 18 months (expectant phase to one year of child's life). Participants and PWAs were matched on the basis of the number of children, job description (percent clinical/research/administrative time) and special considerations if indicated (such as breastfeeding, dual-physician family, multiple birth, etc.). PWAs were provided with an outline of suggested topics to be discussed over two to five one-hour meetings with each participant.

Lessons learned

A total of 68 participants were supported by the program. Fifty-three participants (85% female) responded to the baseline survey, and 85% self-identified as junior faculty/early career. At baseline, 85% planned to breastfeed; 88% of respondents at 12 months (n = 25) reported having done so. By 12 months, 44% of respondents had at least two meetings with their PWA. Ninety-two percent reported at 12 months that the program improved their well-being on return to work. Respondents unanimously answered in follow-up surveys that the program helped them overall and they would recommend it to their colleagues. Respondent comments demonstrated that pumping, daycare hours, lack of sleep and feelings of stress or anxiety were the major difficulties in their return to work.

Practical implications

We demonstrated the scalability of a novel parental wellness program that primarily supported female junior faculty physicians at a time of major life transitions. At baseline, respondents answered that they hoped to receive connection, support and resources; follow-up survey data confirmed that the program provided these supports. In open-ended feedback obtained following the program's completion, participants voiced that they experienced decreased stress, had improvement in wellness and appreciated the connection to an advocate. Despite these positive aspects, participants still expressed desire for improvement in areas such as compensation, equity for women and clinical coverage during parental leave, suggesting that culture change on an institutional level remains critical to supporting physician parents.

Food insecurity and associations with well-being among graduate medical education trainees in the United States: a multi-site study

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Learning objectives:

1. Define the prevalence of food insecurity in a large sample of graduate medical education trainees from two institutions in the United States.
2. List factors associated with a positive screen for food insecurity among residents and fellows.
3. Describe the relationship between food insecurity and well-being for residents and fellows.

Purpose/relevance

Food insecurity, defined by limited or uncertain access to food within a household, is common in the United States and has previously been found to be prevalent among undergraduate students and postdoctoral fellows. Food insecurity disproportionately affects those who come from lower income communities or communities of colour, leads to a variety of negative physical and mental health consequences and is associated with stigma and self-isolation. Little is known about food insecurity among resident and fellow physicians in graduate medical education (GME). Understanding the prevalence, drivers and factors associated with food insecurity is important to meet basic physical well-being needs for all GME trainees, as well as to identify disproportionate impacts on specific demographic subgroups that may reinforce structural inequities in experience and isolation.

Materials and methods

We conducted a multi-institutional cross-sectional survey study at two institutions with four geographically diverse training sites between April and June 2023. Measures included the Hunger Vital Sign food insecurity screening measure, a validated two-item measure of burnout, intent to stay at the institution, social isolation and demographic information. We used univariable analysis and multivariable logistic and linear regression to determine predictors of food insecurity and whether food insecurity was associated with burnout, desire to stay at the institution and social isolation.

Results

A total of 1,656 residents and fellows participated (response rate 45%–47% across sites). The overall prevalence of a positive food insecurity screen was 15.9%, with key differences by urbanicity of training site (15.6%–21.3% for those at sites in major urban areas v. 4.5% outside of major urban areas, $p < 0.001$) and race/ethnicity, with a prevalence of 22.4% among residents identifying as Black/African American compared to 8.4% among those identifying as White ($p < 0.001$). These associations remained statistically significant in multivariable analysis. The prevalence of overall burnout in the sample was 42.6%. In multivariable analysis, compared to trainees without food insecurity, those screening positive for food insecurity were markedly more likely to screen positive for overall burnout (OR 2.13, 95% CI 1.46–3.11, $p < 0.001$). In addition, residents with food insecurity were less likely to consider remaining at their institution for further training or a faculty position (OR 0.64, 0.95% CI 0.44–0.92, $p = 0.02$) and had higher social isolation scores (T-score increase 2.28, 95% CI 0.80–3.75, $p = 0.003$, 0.23 SD difference).

Conclusions

We report results from the first multi-site study to characterize food insecurity in GME trainees. A substantial proportion of GME trainees are at risk for food insecurity, especially at major urban training sites. Our findings demonstrate strong associations between food insecurity and important well-being outcomes such as burnout and social isolation, and they suggest implications for retention. With food insecurity disproportionately affecting trainees with racial/ethnic identities other than White, addressing food insecurity is critical to support inclusion, well-being and retention of trainees from diverse backgrounds. Further study is needed to explore effective interventions for food insecurity in GME trainees.

Gender differences in the associations of professional fulfillment and burnout with physician task load and electronic health record helpfulness and hassles

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Learning objectives:

1. Participants will be able to define cognitive task load.
2. Participants will be able to list factors that contribute to physician task load in women.
3. Participants will be able to identify efficiencies in practice that may decrease burnout.

Purpose/relevance

Women physicians face unique challenges that can contribute to a higher risk of burnout. Addressing gender-based challenges and promoting supportive and efficient work environments is crucial for the well-being and retention of women physicians. Inefficient practice environments contribute to cognitive load, which has been shown to contribute to medical errors and occupational distress. In this study, we explored the association of physician gender on physician task load (a measure of cognitive load) and electronic health record helpfulness and hassles with professional fulfillment and burnout. Additionally, we explored the degree to which physician gender affects the relationship between health record helpfulness/hassles and occupational well-being metrics changes with differences in physician task load.

Materials and methods

We performed cross-sectional analysis of physician survey data from the eight academic medical centres participating in the Physician Wellness Academic Consortium. Surveys were completed between June 2019 and June 2021. The survey included standardized tools: Professional Fulfillment Index (PFI), Physician Task Load (PTL), Electronic Health Record (EHR) Helpfulness, and Electronic Health Record (HER) Hassles. Other items assessed demographic characteristics and intent to leave (ITL). Descriptive and inferential statistics were performed.

Results

Of 5,600 responders, most were men (males) (55.6%) working in primary care (50%). Significant differences in PTL (range 0–10) were observed by gender, with women (females) reporting significantly higher scores (6.67 [1.82] P < 0.001) than men (males) (6.45 [1.96]). We evaluated differences in hours worked by gender. For those working full-time, women (female) physicians worked 2.31 fewer hours per week than men physicians. For those working part-time, women (female) physicians worked 3.44 (–2.31 + 5.75 = 3.44) hours more per week than men (males). In an adjusted analysis of those working full-time, being a woman (female) physician is associated with 2.77 fewer hours per week than men (males). In an adjusted analysis for those working part-time, being a woman (female) was associated with working 4.43 more hours per week than men (males). Being a woman (female) was associated with having a 0.34 point higher PTL (range 0–10), with each additional work hour associated with a 0.03 point higher PTL. Women (female) physicians had significantly lower odds of experiencing professional fulfillment (OR = 0.68; 95% CI 0.61–0.77, $p < 0.001$) and burnout (OR = 1.47; 95% CI 1.3–1.67, $p < 0.001$). In contrast, women (female) physicians had significantly lower odds of ITL (OR = 0.74; 95% CI 0.62–0.88, $p < 0.001$) compared to men (male) physicians.

Conclusions

This study found significant differences in experiences of PTL (a measure of cognitive load) by gender. Women physicians had significantly higher PTL scores than men physicians after adjusting for other personal (e.g., age) and professional (specialty, work hours) factors. After adjusting for differences in PTL, women had significantly lower odds of experiencing professional fulfillment and higher odds of experiencing burnout than men. These associations underscore the importance of gender-specific analyses as part of interventions to optimize workflows, reduce cognitive burden and improve physician well-being. Further studies are needed to explore the underlying causes of gender differences in PTL.

Guiding lights: well-being navigators as embedded agents of support and culture change

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Learning objectives:

1. Describe the origin of the well-being navigator role in a post-pandemic hospital system.
2. Describe the impact of trust, shared experience and connection on the efficacy of bi-directional communication through these roles.
3. Examine programmatic and support outcomes, and opportunities for future expansion.

Background

In the height of the pandemic, it became clear that while we had a substantial peer support program, our hospital-based teams felt underrepresented in decisions that impacted their well-being and unsure where to go for ongoing support. From this need grew Geisinger's Well-being Navigator Program — a novel approach that employs flex employees with a variety of health care centric backgrounds to serve as embedded supporters and advocates for our front-line caregivers.

Objectives

These navigators have the critical role of fostering trust and authentic connection with hospital teams on all shifts to advocate for their often-unspoken needs. Navigators facilitate access to resources crucial for employee well-being such as mental health services and peer support. Moreover, they work to establish bidirectional communication channels for employees to provide feedback to senior leadership without concerns of identity or hierarchy. By leveraging these strategies, the Well-being Navigator Program not only enhances the overall well-being of front-line staff but also cultivates a culture of support and inclusivity within hospital environments.

Approach

Well-being navigators round on the floors on all shifts and build relationships, hold real-time support and education sessions and bring back critical front-line experience feedback for actionability. Navigators maintain minimal documentation, recording units visited and number of employees connected with for impact, as well as documenting de-identified concerns and escalating individual and team needs directly. Concerns presented by the navigators are escalated to appropriate leadership channels through our chief wellness officer, and actionable feedback is delivered in return through the navigators. Leveraging flex employees with significant hospital experience for this role maintains a low-cost solution with quick ability to create meaningful connection with the front-line staff through shared experience.

Lessons learned

Our well-being navigators have been an incredible source of support, which we've heard both directly and anecdotally. Referrals to ongoing resources available through our Center for Well-being, EAP, or Division of Behavioral Health have increased significantly and corresponding with the timeline of this program taking flight in some of our major hospitals, we've seen a significant 10% drop in front-line nurse burnout. The feedback gained through these discussions has served as the foundation for ongoing programs to increase overall well-being, such as Paws to Reflect: a peer support and pet therapy program innovated directly from front-line feedback through our navigators.

Practical implications

Moving forward, this program will continue to create better communication and shared understanding across matrixed system structures. The learnings and communication pathways we've generated with these initial roles will also continue to be a critical voice in designing evidence-informed, tailor-made strategies to enhance the overall well-being of the organization. Areas of future opportunity include unique well-being navigator role solutions for community-based sites and remote employees, recognizing that other environments will have unique needs, while maintaining the financial sustainability of the core model.

Impact of a group-based leadership coaching program on professional fulfillment and peer support in mid-career academic physicians

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Learning objectives:

1. Describe a model for group-based leadership coaching for mid-career academic physicians.
2. Review the impact of group leadership coaching on professional fulfillment and peer support in mid-career faculty.
3. Identify factors related to professional fulfillment that are impacted by a group-based leadership coaching program.

Purpose/relevance

While training programs provide physicians with instruction in patient care and research skills, formal training in leadership is often lacking. Mid-career faculty are commonly elevated to roles managing former peers, often assuming responsibility for implementing priorities determined by higher level leaders. There is often little to no leadership training as individuals assume these "middle management" roles. These factors contribute to burnout and lack of professional fulfillment (PF) in leaders and in faculty and staff for whom they are responsible. To address these issues, we developed a group-based executive coaching program focused on leadership and conflict resolution for mid-career faculty at the Dana-Farber Cancer Institute. Here, we report the impact of the program on professional fulfillment and related outcomes in mid-career faculty leaders.

Materials and methods

The leadership coaching program consisted of four, one-hour group sessions with a cohort of eight to 10 mid-career faculty (delivered via Zoom). Participants also underwent assessment with the Hogan Development Survey and had a one-on-one session with an executive coach to review assessment results and leadership challenges. Pre- and post-program surveys included validated measures of professional fulfillment and peer support from the Stanford Professional Fulfillment Index. Differences in responses between pre- and post-program surveys were estimated using linear modelling adjusted for coaching cohort.

Results

Between 10/2021 and 10/2023, 51 mid-career faculty took part in the group-based coaching modules focused on leadership and conflict resolution, and 48 (91.1%) completed the program. Participants included assistant and associate professors who were serving as clinical directors, floor leaders, centre directors and principal investigators of wet and dry labs. Survey response rates were 81.0% at the pre-program timepoint and 74.4% post-program. PF scores increased from a mean of 6.52 (SE 0.29) on the pre-program survey to 7.39 (SE 0.26) post-program (p = 0.02). The proportion of coaching participants who met criteria for professional fulfillment increased by 20.3% (95% CI: –1.5% to 42.1%) from the pre- to post-program survey. In particular, coaching participants reported improvements in satisfaction with their work (pre v. post survey means: 2.76 [SE 0.13] v. 3.15 [SE 0.12], p = 0.03), sense of control at work (1.91 [SE 0.15] v. 2.36 [SE 0.14], p = 0.05) and feeling that they were contributing professionally in the areas most important to them (2.76 [SE 0.14] v. 3.24 [SE 0.14], p = 0.01). Participants also reported a non-significant increase in feelings of peer support between the pre- and post-program surveys (mean 6.45 [SE 0.34] v. 7.32 [SE 0.33], p = 0.11).

Conclusions

A group-based leadership coaching program led to improvements in professional fulfillment in mid-career faculty leaders at an academic medical centre. Coaching participants noted improvements in several factors related to fulfillment, including a heightened sense of contributing in ways that were meaningful to them and increased satisfaction with their roles. Participants also appreciated the opportunity to review leadership issues with peers facing similar challenges. Group-based coaching could provide a scalable tool for introducing leadership skills to emerging leaders at academic health centres.

Impact of an online group-coaching program on ambulatory faculty clinician well-being: a randomized clinical trial

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Learning objectives:

1. Describe implementation of an all-digital group coaching program.
2. Explain the impact and limitations of this coaching program in faculty.
3. List the scalability and benefits of technology, asynchronous curricula delivery and group-based coaching for physician well-being.

Purpose/relevance

Physician burnout contributes to distress, turnover and poor patient outcomes. Evidence suggests individual professional coaching may mitigate burnout but it is costly and time intensive. Group coaching evidence is lacking. Here, we assess a group coaching program in ambulatory-based faculty.

Materials and methods

A randomized clinical trial occurred between Feb. 1, 2023, and May 31, 2023, in five ambulatory and/or primary care-based departments at an academic institution. Participants voluntarily enrolled and were randomly assigned to an intervention (offered a four-month, web-based group coaching program) or to a control group (not offered). Surveys with validated indices measuring dimensions of distress (burnout, impostor syndrome, moral injury, loneliness) and well-being (self-compassion, flourishing) were administered before and after. A linear mixed model analysis was performed on an intent-to-treat basis.

Results

Among 160 participants, the mean (SD) age was 42.0 (8.4), 131 (81.9%) identified as female and 135 (85.4%) as White. Professional coaching improved intervention participants' burnout domain of depersonalization (delta: –1.72 points [CI: –3.26, –0.17]; p = 0.03), impostor syndrome (delta: –0.82 points [95% CI: –1.47, –0.18], p = 0.01) and flourishing (0.35 points [95% CI: 0.03, 0.66], p = 0.03) compared to the control. There were no significant differences in the emotional exhaustion or personal accomplishment domains of burnout, moral injury, loneliness or self-compassion.

Conclusions

An online four-month group coaching program for faculty clinicians delivered by certified physician coaches resulted in significant improvement in professional distress and well-being. Integration of coaching into the health care workforce has already demonstrated effect and feasibility and holds great promise; however, widespread adoption and long-term sustainability will depend on institutional and societal investment in physician well-being.

Improving the transition back to work following parental leave in a busy US academic children's hospital

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Learning objectives:

1. At the conclusion of this activity, participants will be able to recognize the challenges faced by new parent physicians who are returning to work.
2. At the conclusion of this activity, participants will be able to describe a process for moving from understanding and often unseen challenge to implementing solutions.
3. At the conclusion of this activity, participants will be able to identify interventions that address the themes described by new parent physicians.

Background

Faculty at our institution generally return to work 10 to 16 weeks following the birth or adoption of a child, similar to other US medical schools. New parents are at risk for increased stress for several reasons, including fatigue, sleeplessness, postpartum depression and demands of lactation. Early-career faculty are particularly vulnerable to stress related to career development and feeling they are burdening colleagues. The cost and availability of high-quality, reliable childcare create additional challenges.

Objectives

Our goal was to devise a departmental approach to the transition back to work and foster a supportive culture around parental leave with standardized practices aimed at reducing stress, fatigue and guilt while promoting team well-being.

Approach

Faculty members who took parental leave in the past five years were identified by the department and invited to participate. Two focus groups were held in January 2024 and led by the study PIs using guided questions to learn about the participants' experiences. The meetings were recorded and transcribed using Rev software (www.rev.com). Anonymized transcripts were reviewed by the study team to identify themes. A workgroup was formed to create guidelines to address each theme. Guidelines will be presented to the division leadership and interventions will be created by each division to align with the recommended guidelines. Intervention adherence and success will be assessed by focused individual interviews with faculty returning from parental leave following guideline adoption.

Lessons learned

There were a total of 14 participants with an equal representation of men and women. Qualitative analysis identified five major themes: lactation challenges, lack of clarity around HR policies, workplace culture, degree of personal and career support, and preparation and expectations for leave. Guidelines created by the workgroup included creating a checklist for leave preparation, including formal handoff for patient care, creating "out-of-office messages," turning off calendar invites, creating an easy way to access information, development of ramp-up guidelines for clinical work while supporting existing teams, and scheduled time and provision of resources for lactation. The workgroup focused on "low lying fruit," interventions that could be implemented without requiring additional resources, yet would still have a meaningful impact.

Practical implications

Addressing the stresses for new parents returning to work will lead to an improved workplace culture and is focused on a team-based approach for well-being. Reducing the burden on individuals by creating standardized guidelines will help improve the experience and create more support for faculty, particularly those in their early career.

Improving well-being through loop closure: building a tiered support infrastructure for health care providers across a health system's 15 emergency departments

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Learning objectives:

1. At the conclusion of this activity, participants will be able to define moral distress and operationalize the impact that moral distress has on individuals and care teams.
2. At the conclusion of this activity, participants will be able to theorize how a tiered support infrastructure can support provider well-being in their entities and/or health care systems.
3. At the conclusion of this activity, participants will be able to identify at least three inter-professional connections necessary for a tiered support infrastructure to enhance their teammates' well-being.

Background

Health care professionals experience moral distress from systemic barriers of limited resources, high patient acuity and overloaded hospitals. Organizational awareness of morally distressing events is dependent on health care professionals' escalations. While many institutions have developed pathways for reporting adverse events, responses and loop closures are inconsistent. Feedback loops remain open and staff frustrations continue to build, thus creating a cycle of moral distress and potentially unsafe patient care that impedes health care professionals' mental health and well-being.

Objectives

The purpose of this presentation is to share learnings from an innovative well-being intervention that was implemented in 15 emergency departments across a statewide health care system. The authors will explain the differences between burnout and moral distress, which they will use to situate this novel intervention. Through description of the infrastructure, review of escalations and responses, and lessons learned from this study, attendees will be able to theorize how this tiered support design can support clinician well-being in their entities and/or health care systems. Key inter-professional connections that are vital for supporting staff well-being will be explored.

Approach

This arm of a NIOSH-funded grant studying rural and urban clinician well-being addressed clinician well-being at 15 rural and urban emergency departments across North Carolina. Participants (n = 600+ doctors and nurses) were provided structured pathways through which to report work-related incidents that negatively impacted their well-being. Upon submission, clinician champions at each entity responded to submitters with gratitude, acknowledgment of their distress, and plans for issue resolution. Submissions were catalogued and routed to appropriate action owners and resolved at either the entity or system levels. Pre- and post-intervention surveys assessing well-being and burnout were administered to all participants. The intervention lasted 60 days, during which the core project team provided direct support to the champions at each participating entity.

Lessons learned

The authors found that fostering human connections at both the entity and system levels in this innovative well-being intervention allowed submitters to feel heard and validated. Procedures allowing for psychologically safe submission of well-being issues empowered participants to escalate concerns that they may have otherwise disregarded without such a platform. Offering multiple ways for participants to submit issues made the escalation process both easy and psychologically safe for participants. Over the 60-day intervention, participants submitted over 100 instances of moral distress resulting from patient/staff safety concerns, personal struggles, patient care, communication, physical environment, heavy workloads and inefficient workflows. Inter-professional connections at both entity and system levels facilitated issue response and resolution, resulting in improved practice efficiency across the system.

Practical implications

First, tiered support infrastructure allows for escalation, response and resolution of clinician well-being issues by providing processes for increased information sharing and timely loop closure. In addition to improving individual well-being and mental health, as well as organizational and teammate culture, the benefits of tiered support have downstream positive impacts on patient care. Second, this intervention is designed for completion at the entity and system levels. The intervention provides project champions with local quality improvement initiatives for their individual entities; similarly, the core project team determines trends across hospitals, from which they may propose system-wide improvement initiatives. Third, the design of this tiered support model allows for increased inter-professional human connections through the processes required for issue management and resolution.

Integrating conflict management training in medical education: a systematic review for professional growth

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Learning objectives:

1. Participants will be able to explain how conflict management relates to physician well-being.
2. Participants will be able to discuss strategies for successful conflict management.
3. Participants will be able to identify how constructive conflict can empower connections between physicians and their colleagues, co-workers and patients.

Purpose/relevance

Practising medicine requires interdisciplinary teamwork for effective patient care. Sources of conflict can develop between physician colleagues, interdisciplinary team members, patients or families. Skills of conflict management and resolution are integral to patient care and physician well-being as workplace environments fraught with conflict can increase burnout. To successfully lead and manage teams is a necessary physician skill, and a component of British medical leadership frameworks (MLCF), Canadian specialist directives (CanMEDS) and global professionalism constructs integral to American graduate medical education competencies (ACGME). There is no mandate or consensus on implementing conflict management curriculum in medical education. Considering the hierarchical structure of physician training, harmful power disputes are a potential source of conflict; therefore, early training beginning with undergraduate education may be beneficial.

Materials and methods

We performed a literature search of PubMed, CINAHL and APA PsychInfo for articles in the last 10 years according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The initial search resulted in 434 articles, and after duplicates were removed 162 remained. The remaining articles' titles and abstracts were screened for eligibility on the basis of the inclusion criteria and a resultant 34 full-text articles were evaluated. After review, 26 articles were included for qualitative synthesis.

Results

Twenty-six studies conducted conflict management training with the majority for residents/fellows (54%) than medical students (46%). The training occurred with either conflict management as the focus of the curriculum (10/26), or in combination with additional subjects such as leadership (7/26), emotional intelligence (2/26), interprofessional care (4/26), professionalism training (2/26) or others (1/26). Each of the conflict management-focused curricula included role play and/or simulation sessions. Training often discussed conflict management styles and included skills of perspective taking, communication/active listening, shared goal identification and managing emotions, among others. The number of study participants varied greatly between studies, with 10 as the smallest group of participants and 203 as the largest after a 3-year compilation. The study designs included a self-reported evaluation or questionnaire using Likert-type scales delivered pre- and post-training (12/26) or post-training only (10/26) to ascertain effectiveness. One utilized a reflective essay. Many received positive qualitative feedback from participants. Quantitative data suggested conflict management skills were enhanced post-training. Two studies utilized a control group to conduct comparative simulations. In comparison to control groups, conflict management and resolution skills were greater in experimental groups after training. Only two studies conducted long-term follow-up at six months or 12 to 18 months.

Conclusions

Conflict management is an important physician skill; however, consensus is lacking as to whether conflict management training should be a component of the medical education curriculum and if so, at what point in training it should take place. Once consensus has been reached, further research on the most effective course format or study design will be important. Where feasible, quantitative survey measures and comparative studies can provide greater clarity on results. Physician wellness measures could be researched in tandem to ascertain impacts and improvements. Longitudinal curriculum design and long-term follow-up are needed to understand the duration of potential benefits.

Measuring physician wellness within Albertan physician groups: a developmental and outcome evaluation of the Well Doc Alberta process

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Learning objectives:

1. Summarize Well Doc Alberta's Longitudinal Quality Improvement Physician Wellness Measurement Process.
2. Describe the findings from the developmental and outcome evaluation of the measurement process.
3. Relay how the findings are being used to enrich the Longitudinal Quality Improvement Physician Wellness Measurement Process.

Background

Physician wellness impacts patient care/safety, individual physicians and effective system-level functioning/costs. Measurement of physician wellness is key to assessing the problem, pinpointing drivers and identifying strategies to reduce occupational distress and promote professional engagement. Well Doc Alberta has developed and piloted a Longitudinal Quality Improvement Physician Wellness Measurement Process to support physician groups with measurement. Three years after launching the program, we undertook a developmental and outcome evaluation to ascertain its impact, effectiveness and functionality.

Objectives

The primary objective was quality improvement: to evaluate the measurement process and identify what is working, where there are challenges and if any changes should be made. The secondary objective was to understand the impact of the measurement process on the physician groups measured through Well Doc Alberta. In line with our broader vision and theory of change model, this evaluation helps us explore whether the process has helped embed wellness supports at the system level.

Approach

Between January 2020 and April 2024, Well Doc Alberta measured with 24 physician groups across Alberta (e.g., divisions, departments, zones). The process, ideally repeated on an 18- to 24-month cycle, involves consultation with leaders and wellness representatives, distribution of a survey, data analysis, sharing results with group members/leaders and facilitating discussions about leveraging the results to make change. For the evaluation, 17 semi-structured interviews were conducted with 10 group leaders/wellness representatives and seven group members across eight different physician groups that engaged in the measurement process, using a hybrid purposive and convenience sample. Participants varied by specialty, career stage and practice area, as well as the number of measurement cycles completed (one, $n = 2$; two, $n = 5$; three, $n = 1$).

Lessons learned

We identified two concrete areas of potential enhancement for the measurement process: one related to fostering greater engagement/response rates such as protecting time for members to complete the survey and the other related to providing additional support for implementing change following the completion of a measurement cycle. We also identified four key impacts related to the physician wellness measurement process: 1) embedding physician wellness in the system (e.g., workplace changes/interventions), 2) shifting culture and improving understanding of physician wellness (e.g., fostering awareness and decreasing stigma), 3) leadership development (e.g., increasing leaders' wellness literacy) and 4) a desire for success of the measurement process (e.g., wanting to leverage measurement on a broader scale).

Practical implications

Physician groups continue to face challenges in implementing sustainable system-level interventions. This developmental and outcome evaluation has prompted refinements to Well Doc Alberta's measurement process, including the ongoing development and implementation of additional supports for leaders, a network to share successes and strategies to enhance physician wellness among participating groups, alterations to final reporting to enhance access to results for group members, and enhancements to the post-measurement share-back and discussion workshop. We plan to evaluate the impact of these adaptations and further explore the factors that underpin the success of wellness initiatives. Ultimately, this evaluation will improve Well Doc Alberta's offerings, help groups to implement wellness initiatives on the basis of their data, and illuminate successful approaches in measurement and data-oriented action.

Mental health check-ins: value and feasibility

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Learning objectives:

1. Participants will be able to describe the optimal components of mental health check-ins for residents and fellows.
2. Participants will be able to evaluate the benefits and challenges of mandatory versus optional check-ins and the resulting impact on stigma reduction.
3. Participants will be able to evaluate the feasibility of conducting mental health check-ins at their own institutions.

Background

Concerned by high rates of burnout and depression among physicians and trainees and motivated to find meaningful support for residents, there has been increasing interest in offering 1:1 check-ins to residents and fellows during training. Broad goals of the 1:1 check-in initiative have varied, focusing on issues including educating trainees about local resources, facilitating access to mental health care for those in need, providing validation and support and creating opportunities to process challenging experiences

Objectives

We aimed to evaluate the feasibility, acceptability and efficacy of once-yearly 1:1 check-ins with residents and fellows, facilitated by mental health faculty. Further, we aimed to explore if opt-out versus mandatory participation in the check-ins impacted the check-in.

Approach

Here we present preliminary data across two institutions (Montefiore Medical Center [Bronx, NY] and Columbia University Irving Medical Center [New York, NY]) that have piloted 1:1 check-ins. The initiative was a collaboration between program leadership and chief residents and psychiatry faculty. Some programs offered opt-out formats, and others made the check-ins "mandatory." Check-ins were 20–30 minutes in duration, offered one or two times per year, in-person or virtual, and facilitated by psychiatry faculty with expertise in physician and trainee mental health. Three-hundred and sixty residents/fellows representing nine specialties participated. Trainees completed pre- and post-check in surveys assessing program expectations, MH symptoms, MH stigma and general health and wellness.

Lessons learned

Overall, 57% participated in the check-ins. Greater than 90% of residents endorsed the check-ins as "helpful" and "would recommend they become a regular part of the residency curriculum." Approximately 10% requested referrals for MH treatment. There were no significant differences in burnout, depression or anxiety scores between those who completed the check-in or opted out. The percentage endorsing "If I had a MH issue, I would seek treatment" may have increased (55%–>63%, $p = 0.06$). The content of the check-in was not different for those for whom check-ins were mandatory compared to voluntary. The most common reason reported for how the check-ins were helpful was "I received support for what I'm going through." The most common reason trainees opted out was because they were already in therapy.

Practical implications

One-to-one check-ins are feasible and acceptable to residents and fellows across a range of specialties and across institutions, and they can provide meaningful support during training. Further study is necessary to address questions related to optimal frequency, facilitator credentials and format (opt out versus mandatory). Regular check-ins can serve as a platform for addressing issues related to stress management, work–life balance, burnout prevention and access to MH care. Furthermore, making these check-ins "mandatory" as opposed to "opt out" is also feasible and may serve to normalize and destigmatize attitudes toward seeking care. Furthermore, mandatory check-ins may reach residents who are struggling who might otherwise choose not to participate.

National strategies to improve physician well-being by reducing admin burden

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Learning objectives:

1. Describe the process through which the Canadian Medical Association (CMA) created a national Admin Burden Working Group and how they generated their recommendations.
2. Build a case for tackling the reduction of physician admin burden in Canada.
3. Recall the recommendations from the CMA Admin Burden Working Group and the actions taken nationally to reduce physician admin burden.

Background

The 2021 National Physician Health Survey (NPHS) revealed that 75% of doctors have said their administrative workload is an impediment to caring for their patients, getting in the way of important relationships and their satisfaction in work. Admin burden also plays a role in extending the workday and negatively affecting work–life integration. According to the 2021 NPHS, nearly 60% of physicians have said these are issues that directly contribute to worsening mental health.

Objectives

The impetus for reducing unnecessary physician administrative burden is to address the myriad of negative impacts this increasing burden has on physicians, the health system, patients and society. The goal is also to ensure that the time and effort spent on administrative work is proportionate to the value realized by patients and the health system.

Approach

To tackle this challenge, the CMA struck the Admin Burden Working Group (ABWG), which included members of the CMA board of directors and representatives from provincial and territorial medical associations who had relevant expertise. Their mandate was to advise the CMA on the current state of administrative burden, the root causes, the desired future state and the actions the CMA could take to help achieve this future state.

Lessons learned

Despite the promise of new technologies such as EMR, overtime among health care workers is at the highest point in more than a decade. On average, physicians are working more than 10 hours per week outside of the normal workday on administrative tasks. Of these tasks, 38% could either be done by someone else or eliminated entirely. The development and implementation of a national action plan to reduce unnecessary physician administrative burden is necessary to improve physician well-being, job satisfaction and patient care and must involve physician engagement from the beginning.

Practical implications

Over a period of six months, a comprehensive environmental scan and upwards of 74 key stakeholder interviews were conducted. The ABWG underwent a visioning exercise, developed potential solution canvases and held six deliberation sessions. Their final report consists of a robust set of four key recommendations and two foundational activities for the CMA to undertake to improve physician wellness by reducing admin burden. The consultative and collaborative approach was taken to optimize of the ABWG's recommendations. Now national action has begun with a view to address doctors' admin burden by: building the case for admin burden, addressing federal and national forms, championing interoperability though legislation, elimination of unnecessary sick notes, and building a position on AI and admin burden.

Optimizing support for physicians with physician advisors: a two-year pilot project

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Learning objectives:

1. Recognize the need for external supports for physicians.
2. List the breadth of the challenges that physicians are facing in their workplaces.
3. Recognize strategies to apply a role of physician advisor to your workplaces.

Background

Several provinces provide neutral supports to physicians that are available to them. These physician advisors vary from non-physician coaches or leaders to physicians with shared experience. Support is meant to focus on stressors other than clinical and psychosocial issues, which often are supported elsewhere. There has not been the presentation of data regarding the utility of these roles. In times when physician stress is high, creating multi-tiered supports can be a proactive solution.

Objectives

This presentation will outline the advantages of having a highly trained physician available to support physicians, in an external capacity. Data from this pilot have allowed for the evaluation of physician experiences and needs and how they perceived this type of support. This presentation will create an understanding of how a skilled advisor can support physicians to navigate their work environment with a high level of success. The logistics of the position will be described.

Approach

This talk will outline the background of medical association physician advisors in Canada, including what the different provinces are doing in this area. The experience in Alberta with a two-year pilot project will be reviewed. Data from this project include intake surveys, exit surveys and testimonials that outline how this type of support is beneficial for physicians. The audience will learn the benefits of this now-provincial program, which the medical staff associations run across the province. In addition, skills that are recommended for these advisors will be discussed and supported as well as a review of how these positions can be created and supported.

Lessons learned

The physician advisor program, which started in the Edmonton Zone in Alberta (medical staff association) has now expanded to the other zones in the province. This is due to the data collected during the two-year pilot, which has shown efficacy and the importance of this type of support. From the data collected, it is clear in the Edmonton Zone that physicians are currently less satisfied with local organizational supports (47% satisfaction) and are looking for external support. In addition, they are significantly impacted by stress from the situations that they face (75% stress induced by situations). The physicians responding to the survey were 91% satisfied with the advisor support. The current advisor is a certified coach and mediator, which will be discussed.

Practical implications

The audience will evaluate several aspects of physician support. Firstly, the background of physician advisors will be reviewed. How to initiate these roles, what is needed to maintain the roles and how medical associations can replicate such supports will be clear. A summary of topics that cause conflict will be presented in a "physician briefcase" graphic, which leads to a process that the advisor undertakes to provide support. Attendees will acquire the information needed to start this type of program in their own organizations, including the time, promotion and skills required for this role. A clear process to implement this program will be outlined. Challenges for roles such as this will be reviewed and future steps outlined.

Performance measures in primary care: an insidious source of waste and burnout

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Learning objectives:

1. At the conclusion of this session, participants will be able to list examples of how performance measures are negatively impacting ambulatory practice.
2. At the conclusion of this session, participants will be able to recognize scenarios where a goal is being displaced by a measure.
3. At the conclusion of this session, participants will be able to identify how implementation of performance measures inadvertently contributes to wasted time and effort for clinicians and teams.

Purpose/relevance

Performance measures are meant to improve quality, yet their implementation may have unintended negative consequences in practice. We conducted a series of studies to investigate whether well-intended activities sometimes become "check-the-box" tasks. The target becomes meeting a measure as opposed to the true objective of enhancing care, a concept known as surrogation or goal displacement. The result is an increase in administrative burden and clinician burnout without the intended patient benefit. Our studies investigate this phenomenon in outpatient primary care, focusing first on visit-based screening questionnaires and then turning to problem and medication list review in the electronic health record (EHR).

Materials and methods

We will present findings from three studies that entailed retrospective data analysis of EHR data from a national network of federally qualified health centers (FQHCs) in the United States. One study also included qualitative interviews with patients, clinicians and staff to better understand sources of inaccuracy and burden. One study also involved a survey of clinicians to understand their perceptions on list review and cognitive load associated with activities tied to performance metrics.

Results

In this session we present three studies exploring the unintended consequences of performance measures. (1) A multimethod study investigating overuse of intake screening questionnaires tied to performance metrics found over two million excess screenings across 24 organizations in one year. (2) A retrospective analysis found compromised accuracy of two of these screeners, the PHQ-2 for depression and the GAD-2 for anxiety, in a real-world setting. Scores of over 91% of PHQ-2 and GAD-2 tests indicated low likelihood of depression or anxiety, which diverged markedly from published literature on screening outcomes. (3) We also conducted a multimethod study to characterize problem and medication lists in the EHR and to gauge clinician perceptions of review activities and the cognitive burden these activities impose. We found that problem and medication lists are sometimes long, with unnecessary items. Clinician attestation that the list has been reviewed, an activity tied to performance metrics, does not equate to shorter and less duplicative lists.

Conclusions

Visit-based screenings and clinician attestation linked to performance metrics may not be delivering the intended value in practice and risk distracting clinical effort from other high-value activities. Any task that adds to cognitive load reduces clinician or staff ability to do other work. Time, attention and cognitive load are not elastic, but rather precious, nonrenewable resources. Safety hazards may result when time and cognitive capacity are spent on repeating screenings or other excessive tasks to ensure compliance with performance metrics.

Physician incivility — applying observed events of COVID-19 to harassment frameworks

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Learning objectives:

1. Describe the nature of incivility that was faced by public health physicians from physician colleagues and the impacts that this had on those leaders and the overall response.
2. Draw out parallels with harassment frameworks to name the nature of incivility that occurred during COVID-19 and identify mitigating measures.
3. Discuss and outline how such harassment might be occurring more insidiously in other medical settings, the implications of that, and what might be done to address this through individual reflection, community conversations, and contextual and policy changes.

Background

During the COVID-19 pandemic, public health physician leaders were targeted by unprecedented incivility. Most notably, some of this incivility arose from physician colleagues, driven by a diversity of opinion around pandemic measures and arising in an array of public and private settings. A recent CMAJ rapid review raises concerns around the association of physician incivility with impacts to the health and well-being, worse work and team outcomes, and role modelling of problematic behaviour to trainees.

Objectives

Addressing a problem first requires acceptance and understanding to enable the development of effective strategies to address it. Poor collegiality and incivility are also of concern to licensing and certifying bodies as possible misconduct. This presentation will outline observed examples of incivility directed by physicians at public health physicians during the pandemic and then overlay harassment frameworks to name, categorize and propose interventions to better prevent such behaviours and foster greater understanding between colleagues.

Approach

Using harassment frameworks, incivility toward public health physicians from colleagues manifested in both synchronous and online (social media) settings as follows. Grounds-based (discriminatory) harassment: disparaging comments targeting public health physician colleagues' protected statuses, commonly gender, family status or ethnicity. Bullying and targeted harassment: suggesting incompetence or incapability on the part of public health physicians, intended to humiliate or lower their public stature. Threats and physical harassment: overt or veiled threats to the safety of public health physician colleagues, or collaboration with members of the public to do so. Psychological harassment: epistemic trespassing, belittling and dismissiveness, and destructive criticism. Power harassment: threatening public health colleagues' livelihoods through approaching employers or regulatory bodies.

Lessons learned

In Canada, public health physicians found physician incivility uniquely challenging given that it effectively constituted "friendly fire" from colleagues with noted impacts to individual health and well-being amid an already unprecedented, difficult time. Such expressed incivility also had broader impacts beyond the individual in contributing to misinformation and disinformation, ratcheting up division and causing a loss of trust in public health and physician leaders among certain segments of the public. Conversely, examples will show that approaching colleagues respectfully, understanding and respecting each other's training and background, seeking to collaborate rather than to be "right," and private versus public debate between colleagues were best practices with better outcomes for the collaborators as well as the broader community.

Practical implications

The cauldron of crisis provides a glimpse into incivility that might be occurring more covertly and regularly within the medical community. Foremost is the need for honest reflection and healing of division within the medical community, particularly for public health physicians who were most impacted by "friendly fire." There is also an opportunity for all physicians, especially those who engaged in such conduct, to identify areas for development that will ensure future interactions with colleagues are more positive and constructive. Finally, there is a dialogue for regulators, academic and community leaders, and other interest holders around what context and policy changes might be made to foster more positive environments and deter such incivility in the future and in other settings.

Physician suicide postvention in Canada: current landscape and recommendations for the creation of pan-Canadian guidelines

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Learning objectives:

1. Recognize the current literature and existing guidelines on physician suicide postvention.
2. Identify gaps in and barriers to physician suicide postvention strategies.
3. Discuss actionable steps toward creating and implementing effective physician suicide postvention guidelines.

Background

When a physician dies by suicide, it affects and connects individuals from their personal and professional spheres. "Suicide postvention" refers to actions taken by an organization to support those affected by the loss. Studies have identified a lack of external guidance and the need for postvention after a physician suicide, owing to their unique position in a health care team, their relationship with patients and the stigma that still surrounds suicide within the medical profession.

Objectives

In alignment with the recommendations from the Ontario Medical Association Physician Suicide Prevention Taskforce, we: 1) reviewed current peer-reviewed and grey literature on physician suicide postvention, including the development and effectiveness of available guidelines within Canada and internationally, 2) conducted stakeholder interviews examining the existing physician suicide postvention strategies in Canada and internationally and 3) created a roadmap for developing and implementing guidelines on physician suicide postvention for all Canadian medical training and practice settings.

Approach

The Ontario Medical Association Physician Suicide Prevention Taskforce identified suicide postvention as an area of focus, recommending the creation and sharing of postvention guidelines to support impacted individuals and organizations. As a first step, we conducted a literature review of published research on the development and effectiveness of physician suicide postvention. We also examined publicly available toolkits from the UK's National Health Service and the American Foundation for Suicide Prevention. We then consulted with Canadian and international leaders around the development or availability of resources that were not yet publicly available. By combining the available literature with the recommendations and experience shared by these experts, we proposed a roadmap for creating and implementing suicide postvention guidelines at the national level.

Lessons learned

Evidence-based suicide prevention and postvention programs should be introduced during medical school and residency to set a foundation of psychological safety and promote collegiality within and between departments. Postvention guidance must be developed for specific professional groups and subgroups (e.g., trainees, early and later career physicians, allied health), drawing on the lived experience of these groups and from the lens of their specific needs/culture. In addition to engaging the Canadian provincial physician health programs in the response, connecting the medical community to better supports through postvention has a prospective impact on suicide prevention. Consistent scales measuring the effectiveness of suicide postvention guidelines should be identified and used to allow for cross-comparison (e.g., posttraumatic stress symptoms/growth, burnout, mental health).

Practical implications

By identifying the gaps in published research on physician suicide postvention development and effectiveness, as well as the currently available resources and guidelines, this study provides recommendations for the development of national guidelines to support physicians, their teams and patients in the event that a physician or learner dies by suicide. This study also highlights the integral role of physician health program involvement in supporting the ongoing need for greater awareness, research, tracking and education surrounding physician mental health, to better assess rates, identify high-risk groups and reduce the stigma that is often a significant barrier preventing physicians from seeking support.

Physician wellness: exploring mid-career physician experiences

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Learning objectives:

1. Describe the phenomenon of mid-career malaise.
2. Identify some positive and negative mid-career experiences and the contributing factors.
3. Describe how this intervention may inform system-level initiatives to improve wellness for mid-career physicians.

Background

Mid-career physicians, a sizable and productive sector of the physician workforce, may experience a phenomenon called mid-career malaise. Mid-career physicians may experience frustration, loss of direction, low job satisfaction and career dissatisfaction. They may lose their sense of purpose, struggle to know what steps to take next in their careers and feel a lack of engagement at work. Tackling mid-career malaise is important for both individual physicians and the organizations in which they work.

Objectives

The objective of this initiative was to develop a session targeting mid-career physicians to better understand their experiences and needs and to allow reflection and discussion around potential strategies to support their wellness within their unique work environments.

Approach

A blueprint for organizational strategies to promote the well-being of physicians describes the foundational programs needed to support physician wellness at the system level. One foundation program is "Having resources to address the needs of individuals during major life transitions." Well Doc Alberta developed a 2.5-hour interactive workshop that explores the experiences of mid-career physicians where participants 1) reflect on mid-career physicians' positive and difficult work experiences and the contributing factors, 2) suggest ideas for individual-targeted and organization-targeted interventions to improve mid-career physician wellness and 3) prioritize ideas to take to leadership and move forward. Well Doc Alberta facilitated the session. An interactive software tool was used to anonymously gather participants' input, the content of which was sent to leadership post-workshop.

Lessons learned

The workshop was piloted in collaboration with leadership in the departments of medicine at two faculties of medicine in Alberta. At both sessions, attendance by the invited mid-career physicians exceeded expectations, participant engagement was high and the event evaluation was very positive. The interactive software tool enabled participants to candidly share personal experiences and to identify factors in their work environment and culture that both facilitated and impeded their ability to thrive mid-career. Much of what participants shared mirrored known mid-career physician wellness gaps and strategies to address them as reported in the literature. However, participants were able to identify drivers of mid-career malaise specific to their respective work environments and culture, and what it might take to see improvements.

Practical implications

Mid-career malaise negatively impacts physicians and may lead to disengaged physicians who leave the practice of medicine for reasons other than retirement. A 2.5-hour workshop exploring mid-career physicians' experiences at the department level provides an important first step for both mid-career physicians and their leaders. Mid-career physicians can increase their literacy about the mid-career malaise phenomenon, reflect on their own mid-career experiences and move mid-career physician wellness forward within their department by identifying gaps in support and opportunities and by proposing targeted solutions. From a leadership perspective, the workshop provides helpful information about what's working well and how to build on those positives, but also concrete suggestions on how to improve support in the areas most meaningful to their mid-career physicians.

Prioritizing physician mental health: implementing a Critical Incident Stress Management (CISM) program in the workplace

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Learning objectives:

1. Participants will be able to demonstrate knowledge of the current state of mental health and evidence-based practices to support physician mental health in the workplace.
2. Participants will be able to recognize opportunities for support and identify the tools to train, implement and facilitate critical incident stress management in the workplace.
3. Participants will be able to articulate the benefits of providing critical incident stress management and mental health support for our physicians.

Background

COVID-19 amplified mental health challenges. Approximately one in five Americans faces mental health issues. Suicide is a leading cause of death among 19-to-44-year-olds. Roughly 400 physicians die by suicide annually, equivalent to a medical school cohort. Trauma and moral injuries have soared, impacting professional decisions. Health systems can shape organizations' mental health landscape by prioritizing physician well-being and implementing interventions like Critical Incident Stress Management (CISM) programs, which aid physicians by managing acute stress/trauma and fostering wellbeing.

Objectives

This presentation will enhance dialogue on workplace wellness and inspire organizations to proactively address mental health challenges, creating healthier, more resilient work environments. Participants will gain valuable insights into implementing sustainable strategies to develop mental health programs that support psychological safety in work environments. This presentation discusses effective strategies for implementing a CISM program in the workplace. CISM provides a structured approach to addressing acute stress and trauma among employees, allowing them to receive timely support they need and mitigating the long-term effects of chronic stress to continue thriving in their roles.

Approach

Creating an effective CISM team begins by identifying key individuals interested in the supportive care of their colleagues, establishing leadership support, completing the required training and creating a small budget for associated training costs. This interactive discussion will share how our nine-hospital health system in the Chicago area developed a diverse team of 87 certified responders. Our CISM team supports over 2,000 team members and physicians annually and has shown to have a positive impact in the well-being of our physicians. We will share best practices learned through the implementation process so that each participant feels confident in developing and implementing a CISM team at their home institution.

Lessons learned

Lessons learned from implementing a CISM program underscore the need for proactive, empathetic and comprehensive approaches to supporting physician mental health. Prioritizing mental health and investing in supportive initiatives create environments where physicians feel valued, resilient and empowered to thrive. Key takeaways include the value of comprehensive support systems, leadership's pivotal role in setting the tone, the impact of stigma reduction efforts and the power of normalizing help-seeking behaviours. These insights shape a resilient and supportive workplace culture that fosters employee well-being.

Practical implications

Implementing a CISM program in workplaces offers practical benefits: (1) Enhanced employee well-being: CISM provides timely support for employees facing stress/trauma, leading to increased job satisfaction and positive work environments. (2) Reduced absenteeism and turnover: Proactively addressing mental health through CISM interventions can decrease absenteeism and turnover rates, promoting workforce stability. (3) Improved organizational resilience: CISM equips physicians with tools to navigate challenges effectively, enhancing the organization's ability to weather crises and adapt to change. (4) Greater productivity and performance: Supporting mental health directly impacts productivity and performance for physicians and organizations. (5) Positive impact on physician engagement and loyalty: Investing in mental health initiatives fosters a culture of trust and support, resulting in more engagement and loyalty.

Pros4Peers: sleep medicine experts share science with colleagues for optimal sleep

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Learning objectives:

1. Describe how the Pros4Peers program builds an empathetic connected culture by engaging internal expertise for well-being promotion.
2. Describe how health care professionals' behaviours may be inconsistent with their beliefs about the value of sleep.
3. Describe at least three behaviours associated with more optimal sleep.

Purpose/relevance

The high prevalence of sleep impairment among health care professional has known adverse associations with quality and safety, leadership, self-valuation, professional fulfillment and burnout (Trockel et al.), and impairment escalated during the pandemic (Olson et al). The Pros4Peers program engages and empowers internal expertise to impart professional to professional (peer to peer) wisdom to improve colleague and community well-being and foster a more caring and connected culture. Sleep medicine experts were engaged to create education and activities to foster more optimal sleep for colleagues, including a comprehensive assessment of sleep habits and attitudes with the intent to raise awareness of optimal sleep habits. The aim of this study is to describe the sleep habits of health care professionals and determine which are more highly associated with quality sleep.

Materials and methods

The Section of Sleep Medicine developed education and assessment of zeitgebers ("time givers"), process S (adenosine-based sleep pressure), process C (light and darkness), quieting routines, personal beliefs and attitudes, self-valuation (single-item, competition with self-care, Trockel et al.), pandemic health changes and underlying sleep conditions. A modified Insomnia Sleep Severity Index assessed the presence or absence of insomnia. Secondary analysis of the sample of convenience included standard demographic statistics, chi-square tests of independence and unadjusted logistic regression.

Program details: https://medicine.yale.edu/internal-medicine/pulmonary/news/national-sleep-week/#:~:text=Check%20off%20each%20item%20to,March%2012%2D18%2C%202023.

Results

Over the five days of National Sleep Week (March 13–17, 2023), 315 participated in the sleep assessment. The sample was comprised of researchers (41%), medical professionals (25%), administration (24%), allied professionals (5%) and others (5%); 75% were white and 79% were women, with an average age of 39.8; a quarter students/trainees. Two-thirds had insomnia, 21% clinical. Those who rarely or never worked nights were 258% more likely to sleep well compared to the 10.5% who often or always worked nights. Respondents believed sleep impacted their health (94.8%), long-life (92.4%), performance (95.5%) and tendency for mistakes (78.9%). Yet only 61.3% made sleep a top priority; the majority sacrificed sleep to get more done (67.0%). Of the respondents, 69.9% wanted to change their sleep habits, 77.6% felt it was difficult to change habits and 75% felt their own needs were incompatible with the needs of others. Those with regular habits had better sleep ($p < 0.05$): bed times (65.7%, OR = 2.69), meals (60.3%, OR = 2.52), exercise (31.4%, OR = 1.77), social life (31.5%, OR = 3.09), bedtime reading (42.7%, OR = 2.98) and quiet conditions (83.8%, OR = 2.27). The 78.6% using digitally lit devices until bedtime had worse sleep ($p < 0.05$, OR = 2.28).

Conclusions

In collaboration with the Office of the Chief Wellness Officer and Office of Academic Professional Development, Pros4Peers expands the concept of peer support to engage and empower internal talent for health and wellness toward collegiality and care for one another for a more empathetic connected culture (inter-professional, human-connections). Through the expertise of sleep medicine our health care community is able to make informed decisions to optimize their sleep. Those leading well-being at an academic medical centre have a better understanding of the obstacles and sacrifices medical professionals make for the needs of others and to get more done.

Background

The high prevalence of sleep impairment among health care professionals has known adverse associations with quality and safety, leadership, self-valuation, professional fulfillment and burnout (Trockel et al.), and impairment escalated during the pandemic (Olson et al). The Pros4Peers program engages and empowers internal expertise to impart professional to professional (peer to peer) wisdom to improve colleague and community well-being and foster a more caring and connected culture. Sleep medicine experts were engaged to create education and activities to foster more optimal sleep for colleagues, including a comprehensive assessment of sleep habits and attitudes with the intent to raise awareness of optimal sleep habits. The aim of this study was to describe the sleep habits of health care professionals and determine which are more highly associated with quality sleep.

Putting out the fire: a toolkit for physician wellness leaders

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Learning objectives:

1. After participating in this session, attendees should be able to describe the importance of institutional and systems-wide approaches to improving wellness.
2. After participating in this session, attendees should be able to state the core components of a systems-wide toolkit for wellness leaders.
3. After participating in this session, attendees should be able to integrate the principles outlined herein to any systems-wide change initiative.

Background

In response to the rising tide of physician burnout, many hospitals across our health sciences network appointed wellness leaders. However, a lack of coordination and common language resulted in duplication of efforts and inefficient use of resources. To remedy this, we created and shared a toolkit across the network, enabling systemic interconnectedness across the various institutions, more efficient use of time and resources, and a common purpose for individuals and institutions combating physician burnout.

Objectives

Our aim was to create a wellness toolkit available and applicable to all wellness leaders across the health sciences network. The toolkit's purpose was three-fold: (1) to summarize the state of physician burnout before and since the pandemic, (2) to provide practical tips in setting a wellness strategy for new and established wellness leaders and (3) to provide a list of local, national and international resources categorized in themes.

Approach

The toolkit was designed as follows: (1) a working group comprising physician wellness leaders from different institutions and at different stages of wellness leadership was formed, (2) a local, practical lens was applied to existing resources (for example, papers published in the medical literature; whitepapers published by provincial and national medical associations) and (3) a comprehensive list of available resources for physician wellness. The resultant toolkit had three sections: an introduction to physician wellness and burnout; a strategic "blueprint" for wellness, based on previously published guides [e.g., Shanafelt T, Stolz S, Springer S, et al. New Engl J Med Catal Innov Care Deliv 2020;1(6)]; and a resources section categorized by theme.

Lessons learned

Four factors were pivotal in creating a useful and usable comprehensive toolkit: (1) Shared perspectives across different institutions: It is essential to have a common understanding and shared vision among different institutions to ensure that the toolkit is relevant and useful to all stakeholders. (2) Shared perspectives of leaders at differing stages of the leadership journey: Leaders at different stages have unique insights and experiences, allowing for a more comprehensive and inclusive toolkit. (3) Applying a local lens to existing resources: This is pivotal to operationalize wellness concepts into concrete, local actions. (4) Cataloguing the resources into categories: This allows users efficient access to resources based on need.

Practical implications

Wellness initiatives grounded in common language and purpose across different institutions allow for better use of resources and enable systems-level changes. We created a comprehensive toolkit and made it available across our health sciences network. In doing so, we have aligned knowledge, purpose and resources for wellness leaders at all stages of their leadership journey. The toolkit is available online and gives institutions the best chance at improving physician health and well-being. Future work includes providing guidance and support for implementing the strategies described in the toolkit, monitoring implementation and sharing the toolkit across provincial and national stages.

Reducing administrative burdens — the Manitoba experience

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Learning objectives:

1. At the conclusion of this session, participants will be able to extrapolate or directly measure administrative burdens, using the measurement approach and results in Manitoba as a case study.
2. At the conclusion of this session, participants will be able to apply strategies to reduce administrative burdens within their jurisdiction.
3. At the conclusion of this session, participants will be able to prepare a plan to reduce administrative burdens, including sick notes and other common third-party medical forms.

Background

Administrative burden is a leading cause of physician burnout. Excessive or unnecessary administrative burden is distressing, taking time away from patient care or affecting work–life balance. Doctors Manitoba has been pursuing administrative burden reduction in a number of ways. A Joint Task Force was formed with the Manitoba government, and it has made progress on measuring and reducing burdens. Doctors Manitoba is also pursuing eliminating sick notes and streamlining common medical forms such as return-to-work and accommodation requests.

Objectives

The key objective for our work is to reduce administrative burden for physicians. This presentation will cover our approach to estimating the baseline magnitude of administrative burden, measuring progress to reduce it, strategies for engaging burden owners to make reductions, and recommendations the Task Force has made for further progress. We will also review progress made on sick notes and common third-party forms.

Approach

We have found that collaboration is an essential ingredient to making any progress on reducing administrative burden. Burdens are owned by other groups, including within the health system, other provincial and federal government departments, external agencies such as Worker's Compensation, private insurance companies, employers, educational institutions and others. A collaborative approach with clear evidence and accountabilities is essential to making progress on reducing administrative burdens for physicians.

Lessons learned

Our biggest lesson learned is that burden owners, the organizations responsible for an unnecessary or overly complicated administrative task, need to accept responsibility for the problem and own and sustain the improvement. It can't be done for them. At the same time, some burdens don't have a clear owner as they are initiated by many different organizations. This includes sick notes, or forms from employers or insurance companies. These players have to be engaged, but there needs to be a central "driver" to coordinate and align them on a shared solution.

Practical implications

Every province is at a different place when it comes to progress on reducing administrative burdens for physicians. By sharing our experience in Manitoba, including what has worked and lessons we've learned, we hope to help colleagues across Canada make progress in their jurisdiction.

Short- and long-term sick leave among mid-career Norwegian physicians (NORDOC): health- and work-related predictors

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Learning objectives:

1. Identify the importance work-related factors that may impact physicians' workability also when adjusted for physical and mental health impairment.
2. Recognize the importance for developing empirically based intervention programs to help maintain workability among doctors.
3. Recall the importance of (1) studying representative samples and (2) using multiple regression models to adjust for confounding effects.

Purpose/relevance

Physicians have traditionally low rates of sick leave, but a more challenging work life during the last decades may have changed this. We lack recent nationwide studies on the prevalence and rates of sick leave among physicians. The study's overall purpose is to identify any work-related factors and health problems that may be amenable for prevention or intervention. We aim to answer the following questions: 1) What is the prevalence of short-term and long-term sick leave in mid-career Norwegian physicians, and are there differences between the genders or between general practitioners (GPs) and hospital physicians? 2) What health- and work-related factors are associated with short-term sick leave (STSL) and long-term sick leave (LTSL)?

Materials and methods

Two nationwide cohorts (1993/94 and 1999 classes) were surveyed 20 years after graduation; the mean age was 48 (2.8). Outcome was number of days on sick leave during the last year. Short-term: <15 days; long-term: >15 days. (1) Background factors, (2) general work factors (demands, autonomy), (3) Physician-specific work factors (GP/hospital position, workload (hours, sleep, 24/7 responsibility, fear of complaints, work–home conflict, workplace violence) and (4) weighted physical problems and mental health problems were entered in blocks in multiple logistic regression analyses.

Results

Response rate was 57% (558/972), 56% were women. The prevalence of STSL was 35% (195/558), and that of LTSL was 10% (54/558). There was no significant sex difference in any prevalence. Adjusted predictors of STSL in the final multiple regression model were being a GP (OR = 0.26, $p < 0.001$) and physical health problems (OR = 1.14, $p = 0.007$). Adjusted predictors of LTSL were work–home conflict (OR = 1.39, $p = 0.049$) and mental health problems (OR = 2.10, $p < 0.001$). There were no interactions with gender or cohort in any of the significant predictors, which means that they had the same impact in both genders and cohorts. The weighted physical health problems that predicted STSL were "digestive problems or stomach/intestinal disease," "muscle/skeletal pain" and "migraine/headache." There was a close to significant independent effect of physical health problems on LTSL (OR = 1.14, $p = 0.053$). The weighted predictor of LTSL included the similar three items to those above and in addition "asthma, lung disease or respiratory disease" and "allergy or skin problems."

Conclusions

A substantial proportion of Norwegian physicians take sick leave each year. GPs take short-term sick leave less often than do their hospital colleagues. Norwegian GPs are their own (private) employers and they have no compensation from the social security system for the first two weeks on sick leave, unlike the physicians in public hospitals. Work–home conflict is an important predictor of burnout among doctors and this study shows it may even be a risk for long-term sickness absence among them. The physical health problems associated with short-term sick leave (e.g., migraine, muscular pain) may also be associated with work-related stress.

Should I stay or should I go? Emotional exhaustion's association with intent to leave in a national sample of female physician trainees

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Learning objectives:

1. Describe the current rates of intent to leave in women physician trainees.
2. Recognize the relationship with emotional exhaustion.
3. Explain the implications of measuring and mitigating burnout of the health worker workforce.

Purpose/relevance

Physician burnout disproportionately affects women and contributes to attrition from the workforce, a costly problem that probably begins in training. The association between burnout in training and attrition intent in women residents and physicians is unknown. Here, our objective is to understand the current state of female trainee physicians' intent to leave and explore associations of this with burnout in a national sample.

Materials and methods

Cross-sectional analysis was conducted of a national sample of female physician trainee surveys on burnout and intent to leave, assessed with Likert-scale questions: 1) "Likelihood to leave your current program before graduation?" 2) "Likelihood to leave your current training specialty within two years?" 3) "If offered a job at your training institution after graduation, how likely would you be to take it?" and 4) "Likelihood to recommend your program to a medical student?" Associations were analyzed using chi-square testing and univariable linear regression.

Results

A total of 1,017 trainees responded. The average (SD) age was 30.8 (4.0) years, 959 (94.3%) self-identified as a woman, and 540 (53.1%) as White. One-fifth (207, 20.7%) were in postgraduate year (PGY)-1, 198 (19.8%) in PGY-2 and 595 (59.5%) ≥ PGY-3. Most scored positively for burnout, and 77.5% experienced high emotional exhaustion (EE). One-fifth (20.6%) reported some intent to leave their program before graduation, and 32.7% reported an intent to leave their specialty within two years. There was a strong association between EE scores and intent to leave: trainees reporting a high likelihood to leave before graduation had a 22.27 higher EE point average than those reporting no likelihood (95% CI: 7.80, 36.74, p = 0.003). Said simply: trainees who were more burnt out were more likely to report intent to leave at their program and specialty, and trainees who were less burnt out were more likely to report intent to stay at their institution and to recommend it to others.

Conclusions

Almost three-quarters of women trainee physicians are burnt out, and just over 20% have at least some intent to leave medicine before completing their training. The strong positive association between emotional exhaustion and intent to leave highlights the need and opportunity for training programs and health system leaders to screen for and address burnout early to reduce workforce burnout and support the growth of women physicians. The imperative here is not just to recognize the issue, but to implement targeted interventions and support mechanisms to mitigate burnout and foster the retention of female physicians.

Success starts here: connecting new doctors with leadership teams for impactful onboarding

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Learning objectives:

1. At the conclusion of this activity, participants will be able to create and implement an onboarding program for newly hired physicians that increases retention rates, executes intentional networking and promotes continued learning and wellness throughout the organization.
2. At the conclusion of this activity, participants will be able to establish an interprofessional networking system that produces connections between multi-disciplinary physicians through open and honest communication and relationship building.
3. At the conclusion of this activity, participants will be able to generate psychological safety as new hires are invited into a culture of communication between senior leadership and newly hired physicians to promote joy at work.

Background

Our in-person onboarding program, Shared Success, began 15 years ago through mentor partnerships and didactic courses. It has morphed into an exceptional experience in networking, wellness and education for newly hired physicians. Initially, an emphasis was placed on continued learning, combined with a mentor component that was less structured. In recent years, we have refocused on interprofessional relationship building and reexamined the curriculum to be more inclusive of the ever-changing needs of newly hired physicians.

Objectives

Physicians in Shared Success attend quarterly half-day sessions, with their patient schedules blocked. The Shared Success program has three main objectives: networking, mentor partnership and education. We have maintained these as our focal point of the program over the years but have recently specialized it to the more urgent and impactful needs of our newly hired physicians and how meaningful connections can be made between front-line physicians and senior leaders.

Approach

From the Institute for Healthcare Improvement's Joy in Work framework, we know that happy, healthy and productive physicians need the ability to contribute feedback, acquire proactive learning from defects and successes and see organizational values role modelled in our leaders. We reviewed Shared Success to make a systems approach to making joy in work a sense of responsibility by altering the program to promote psychological safety and bridging the connection gap between leaders and front-line physicians to work through operational inefficiencies. By encouraging diverse perspectives and modelling a speak-up culture, Shared Success provides psychological safety to physicians to ask questions of their leaders and peers, share their thoughts and create innovative techniques in information sharing across the organization.

Lessons learned

Developing psychologically safe spaces with new physicians opens lines of communication that did not previously exist. The connections created in Shared Success continue to thrive between physicians and leaders, even after completion of the program. Partnering newly hired physicians with seasoned physicians, outside of their department, proved to be a tremendous strategy in relationship building and making medicine a more sustainable career choice. Retention rates are two points better than the national average for physicians and data collected from physician exit interviews proved that the onboarding program was a top three experience in their time with TSPMG. Additionally, data from our annual Listening Survey showed a two-point increase in engagement and three-point increase in culture of health from 2022 to 2023.

Practical implications

Our physicians feel happier, healthier and more engaged than they have in previous years through utilizing Shared Success as a critical component of our physician onboarding experience. We have been able to provide psychologically safe spaces to address difficult post-COVID-19 environment topics such as heroism, civil unrest, physician burnout and physician safety between front-line physicians and our senior leadership team, in addition to reducing operational inefficiencies that cause discord among our group by cultivating rich, interprofessional relationships. Connections made between coworkers, mentors and leadership have proven to be a top satisfier and a highlight in one's tenure with TSPMG on the basis of various data collected across the organization.

Supporting physicians: a multi-systems investigation to understand burnout and moral injury

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Learning objectives:

1. Explore how professional fulfillment and psychological safety function as potential buffers against burnout and moral injury among physicians.
2. Examine the associations between various domains of psychological safety and professional fulfillment with different dimensions of moral injury.
3. Identify the need for systemic, multifaceted interventions that promote a supportive work environment.

Purpose/relevance

With health care workforces worldwide facing high rates of burnout and moral injury, understanding the factors that mitigate these risks is crucial. This study explores the mitigating roles professional fulfillment and psychological safety may serve as buffers against burnout and moral injury among physicians.

Materials and methods

We conducted a mixed-methods longitudinal study with physicians in London, Ontario. The current presentation focuses on the baseline survey responses collected from 253 physicians. We used validated measures of the Professional Fulfillment Index, Moral Injury Outcome Scale and Maslach Burnout Inventory, plus other related constructs. Regression analyses identified predictors of burnout and various dimensions of moral injury.

Results

The study revealed that professional fulfillment consistently predicted lower burnout levels among physicians. When assessing moral injury, professional fulfillment was notably linked to reduced shame-related outcomes. Interestingly, in the case of trust violation-related outcomes (e.g., those associated with perceived betrayal), not only did professional fulfillment emerge as a significant predictor, but a combination of all domains of psychological safety proved crucial. These domains encompassed interpersonal risk-taking, mutual trust and respect, organizational support, identity affirmation and supportive leadership.

Conclusions

The study underscores the significance of professional fulfillment and psychological safety as key factors in mitigating burnout and moral injury among physicians. Findings suggest that perceived psychological safety alongside a sense of professional fulfillment plays a pivotal role in mitigating the effects of moral injury, especially in situations of perceived betrayal or violation of trust. A psychologically safe workplace may buffer against or reduce betrayal and trust violations. These insights suggest the need for systemic, multi-faceted interventions aimed at fostering a supportive work environment that emphasizes psychological safety and professional fulfillment.

The (dis)integration of shame: a qualitative study on how medical learners engage with shame in training

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Learning objectives:

1. List pillars of shame resilient internal scaffolding and fixed shame internal scaffolding.
2. Describe key features of constructive, shame disintegrating emotional engagement.
3. Explain how the environment can hinder or support medical learners' constructive engagement with shame and development of emotional resilience.

Purpose/relevance

Shame, an emotion resulting from a negative evaluation of the global self, is salient in medical training. Prior research in medical learners has described the origins, experience and impacts of shame, highlighting both its destructive nature and potential to catalyze meaningful learning, growth and identity formation. What is currently unknown is how medical learners engage with their shame once it occurs, including the actions, coping strategies and resources they employ and how the environment influences this engagement. Addressing this gap will inform development of skills, support mechanisms and environmental conditions to advance learner resilience in medical training. Thus, in this study, we utilized hermeneutic phenomenology to ask: How do medical learners engage with shame experiences once they have developed, and what factors influence this engagement?

Materials and methods

We utilized existing data from a qualitative research program on shame in residents (n = 12) and medical students (n = 16). We previously explored the origins, nature and impacts of medical learners' shame but had not examined how they engaged with shame, once present. From the original 28 interview transcripts, we selected a diverse sample (seven medical students and seven residents) representing various training levels, individual backgrounds and shame impacts. Ajjawi and Higgs' six steps of hermeneutic analysis guided our data analysis.

Results

Individuals' internal scaffolding — which we conceptualize as the thought processes, self-evaluative tendencies and position relative to others that could bolster, undermine or skew self-concept upon engagement with shame — was central to their shame engagement and heavily influenced by the surrounding environment. During acute shame experiences, participants experienced unstable internal scaffolding, marked by perceptions of judgment from others, fixed thinking, assumptions masquerading as facts and seeking external validation. Constructive, shame disintegrating engagement served to strengthen internal scaffolding, facilitate recovery and engender shame resilience. This engagement consisted of examining assumptions, practising self-compassion, detaching worth from performance, reaching out for help and establishing realistic expectations. This transition was facilitated by a supportive, inclusive, psychologically safe environment. Destructive, shame integrating engagement served to internalize shame, entrench fears of judgment and mistrust of others and ingrain fixed mindsets. This engagement consisted of repression of shame feelings, striving for perfection, isolating oneself and harshly comparing against others. This transition was driven by disrespectful, marginalizing, psychologically unsafe and exclusive environments. Internal scaffolding ultimately seemed to confer resilience or susceptibility to future shame depending on its nature.

Conclusions

How medical learners engage with shame — and how the environment supports or hinders this engagement — has significant effects on the internal scaffolding that influences learning, well-being and belonging in medical education. To maximally support learners' emotional well-being, faculty should receive training in shame competence — or the ability to recognize and respond to shame in way that supports stable, resilient, shame disintegrating emotional engagement. Learners should be trained to identify and respond to shame in a similarly constructive manner. This response should centre on instilling growth mindsets, examining assumptions driving self-evaluation, ensuring and utilizing psychological support, engendering self-compassion and promoting authentic belonging and self-expression.

The Co-WRaP Study: co-creating solutions to enhance the well-being of resident physicians and their partners during training and beyond

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Learning objectives:

1. By the end of the session, participants will be able to describe the individual, dyadic and systemic enablers and challenges impacting the mental health and well-being of resident physicians and their partners during training.
2. By the end of the session, participants will be able to assess the diversity of lived experiences of resident physicians and their partners to help inform the design of physician well-being initiatives.
3. By the end of the session, participants will be able to identify potential solutions, co-created by resident physicians, their partners and educational leaders, to better support medical learners and their partners during training and beyond.

Purpose/relevance

Practising as a physician can be gratifying and professionally fulfilling. The years spent in residency training are integral to one's professional and personal identity formation, establishing the foundation for future success. However, residency training is commonly associated with work demands that can negatively impact the mental health and well-being of resident physicians and their intimate relationships. There is limited research on the relationships of resident physicians despite the potential role partners can play in protecting against, or in some cases exacerbating, the stressors associated with training. The Co-WRaP Study aims to better understand the impact of training on the well-being and relationships of resident physicians and their partners and to co-create potential well-being initiatives to better support them at the individual, dyadic and systemic levels.

Materials and methods

This qualitative, interpretive descriptive study was conducted at McMaster University, Hamilton, Ontario, Canada. It consists of two phases: (1) one-on-one, semi-structured interviews with resident physicians and partners and (2) co-design sessions with residents, partners and educational leaders. An invitation to participate was sent to all residents and their partners, and a diverse group of participants was selected. Reflexive thematic analysis was used to analyze the interview data. The co-design sessions are ongoing; results will be available by August 2024.

Results

In the first phase of the study, 23 resident physicians and 15 partners of residents were interviewed. Eight preliminary themes were developed including: (1) the unforgiving practice and culture of medicine, (2) a lack of control over life and future, (3) the mental and emotional toll of training, (4) a battle of identities and responsibilities (Who shoulders the burdens?), (5) the resident–partner relationship as a protective "bubble" or safe haven, (6) threats to the "bubble" and preservation strategies, (7) expanding the "bubble" (family planning and other relationships) and (8) need for advocacy: a call to change the culture of medicine. Thematic analysis of the interview data informed the experience-based co-design sessions. A total of 10 residents, 10 partners and 10 other stakeholders, including educational leaders, were invited to participate in six co-design sessions, which are in progress. The co-design sessions are focused on the co-creation of actionable solutions and initiatives to enhance the mental health and well-being of resident physicians and their partners.

Conclusions

This study has identified salient issues that resident physicians and their partners face during medical training and beyond. The co-design approach will inform the development of actionable individual, dyadic and organizational strategies to cultivate a culture of well-being for physicians in training and their partners. In the future, these strategies can be implemented and evaluated within medical training programs and health care systems, with the goal of better protecting and enhancing physicians' mental health and well-being, as well as preserving their relationships.

The crucial role of national medical associations in artificial intelligence policy development to improve physician wellness: a cross-border perspective

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Learning objectives:

1. Summarize the rapid evolution of AI in health care and its implications for regulatory frameworks, emphasizing the role of national medical associations in shaping policy to ensure the safe and ethical integration of AI technologies.
2. Identify the specific challenges and opportunities associated with implementing AI solutions to improve physician wellness, with a focus on AI scribe technology as a practical example.
3. Discuss strategies employed by national medical associations to navigate the complexities of AI integration in health care, including fostering dialogue, advocating for comprehensive policies and facilitating collaboration across partners for optimized AI utilization and enhanced physician well-being.

Background

Artificial intelligence (AI) can help lighten physicians' administrative load by generating patient-care provider discussion notes, prior authorization, patient discharge and patient scheduling. The adoption of AI applications in health care is outpacing dedicated regulation globally. As representatives of the physician community at the forefront of using AI tools in health care, medical associations are concerned that the rapid adoption of this technology and its power for exponential growth can surpass the knowledge needed to use it safely.

Objectives

The overall objective of the presentation is to provide participants with a comprehensive understanding of the critical role that national medical associations play in shaping policy and navigating the integration of AI in health care by the AMA and the CMA. Drawing on the AMA's extensive engagement in AI policy development and advocacy efforts, as well as the CMA's pioneering role in advocating for health in Canadian AI policy, the presentation aims to highlight the importance of national medical associations in shaping AI policy to enhance physician wellness and improve patient outcomes.

Approach

The AMA actively engages in various endeavours to seize the opportunities presented by AI. These include robust policy development, advocacy efforts, and initiatives aimed at enhancing physician education and collaboration. The AMA focuses on promoting policy changes that uphold AI quality, performance and trustworthiness, while also defining physicians' roles and responsibilities in AI integration. Collaborative platforms for AI facilitate interaction among physicians and industry partners. Similarly, the CMA conducted an environmental scan to understand the role of AI in health care. The scan revealed a significant leadership gap among national health stakeholders in shaping AI policy in Canada. Consequently, the CMA launched an advocacy campaign to address this gap. Collaboration to leverage learnings from medical associations can strengthen AI policy internationally.

Lessons learned

1. Importance of collaborative platforms: Both the AMA and the CMA highlight the significance of collaborative platforms for AI in fostering interaction among health care professionals, patients, policy-makers and industry stakeholders to improve physician wellness. 2. Need for ongoing scanning and evaluation: As AI is growing exponentially in health care, it is critical to be abreast of new developments in the applications of AI and policy development to ensure AI implementation in health care is safe and ethical for physicians and patients. 3. Advocacy for policy changes: The AMA and CMA's advocacy efforts demonstrate the necessity of proactive engagement from medical associations in promoting policy changes to ensure the quality, performance and trustworthiness of AI technologies in health care as a trusted health voice.

Practical implications

This work highlights practical implications for health care partners, emphasizing the critical role of medical associations in navigating the integration of AI technologies. By advocating for policy changes to ensure AI quality, performance and trustworthiness, medical associations like the AMA and the CMA pave the way for safer and more effective AI implementation in health care. Ultimately, with strong AI policy, AI holds promise to reduce administrative burden and ultimately improve physician wellness and strengthen the joy in medicine.

The healing connection: elevating physician well-being through physician health program (PHP) partnerships

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Learning objectives:

1. At the end of this presentation, attendees will be able to distinguish the difference between physician health and physician well-being.
2. At the end of this presentation, attendees will be able to explain the importance of collaborative partnerships between parties that determine physician health and those advancing physician well-being.
3. At the end of this presentation, attendees will be able to integrate individual interventions provided by a physician health program (PHP) with organization-level efforts.

Background

The increasing trend of health care organizations pursuing wellness initiatives is twofold. It is wonderful that workplaces put time and resources into ensuring physicians are at their best. But, duplication of efforts, confusion about where to seek help and/or circumvention of necessary care may occur (i.e., a well-being program will not resolve major depressive disorder). The Colorado Physician Health Program (CPHP) sought to integrate efforts and clarify resources for physician health and well-being throughout Colorado.

Objectives

CPHP leadership defined the differences between physician health and well-being, their importance in delivering safe patient care, and identified the partnerships necessary to ensure both are addressed. With the rise of wellness committees at organizations and chief wellness officers (and other similar positions) on staff, CPHP needed to guarantee physicians' health remained a priority. Health is a necessary baseline of physician well-being, and patients receive the best care when physician health and physician well-being are simultaneously and adequately addressed.

Approach

Physician's health and well-being are often used interchangeably but differ in scope and emphasis. Health refers to a physician's physical and mental state, including disease prevention, treatment of illnesses, management of chronic conditions and addressing mental health concerns like burnout, depression and anxiety. Well-being also considers work–life balance, job satisfaction, sense of purpose, fulfillment, social support networks, personal growth and resilience. The well-being emphasis is on fostering environments and practices that promote overall quality of life and fulfillment. Health and well-being are interlinked and are crucial for the quality of life, care and safety of health care professionals and their patients. CPHP looked to clarify the differences, similarities and importance of the two concepts to the Colorado medical community.

Lessons learned

In 2022, CPHP started discussions with chief wellness officers (CWO) across Colorado. Conversations focused on where health interventions stop and where well-being initiatives begin (i.e., "spectrum of care/support" available) and recognized that communication across systems was nonexistent. In 2023, the Colorado CWO Forum was established; CWO representatives (10) from Colorado's six largest health systems started collaborating. CPHP facilitates the quarterly forums and allows for information exchange and opportunities for combined efforts on statewide initiatives. The forum creates a space where CWOs can candidly share their challenges, successes and unique systemic hurdles in safeguarding the well-being of health care professionals. As part of the conversation, CPHP reinforces the importance of physician health in the well-being equation.

Practical implications

Recent studies emphasize that both individual interventions AND organizational changes are necessary to improve the well-being of health care professionals. The increase in wellness efforts throughout today's health care organizations is promising but will not be beneficial without physician health remaining a vital component. Physician health programs (PHPs) should collaborate with organizations prioritizing well-being (and guide organizations starting efforts). CPHP aims to play a significant role in offering well-being support that complements systemic changes and expert individual health evaluations for physicians of Colorado. With CWOs' and CPHP's combined knowledge and strengths, the well-being of health care professionals will undoubtedly increase. Physician health must remain central to advancing well-being; PHPs can serve as natural facilitators of systemic change across organizations.

The impact of structured stress first aid training for graduate medical education leadership

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Learning objectives:

1. At the end of the presentation, participants will be able to state the rationale for stress first aid training for graduate medical education (GME) leadership to promote a culture of psychological safety for trainee physicians.
2. At the end of the presentation, participants will be able to recognize the unmet need for stress first aid training in GME program leadership.
3. At the end of the presentation, participants will be able to plan for implementation of a stress first aid training program for GME program leadership.

Purpose/relevance

Stress first aid is a recognized intervention to help mitigate emotional distress following adverse patient events in the health care environment. In the physician trainee population, adverse patient events can have a profound impact on the risk for burnout syndrome. However, graduate medical education (GME) leadership is rarely trained in the concepts of stress first aid and peer support. In this study, we describe the use of stress first aid training based on skills of active listening and empathy for GME leadership to intervene at times of adverse patient events involving trainees.

Materials and methods

A robust peer support program supporting attending physicians currently exists at our institution, which was used as a framework for GME leadership training. Both in-person and virtual stress first aid training sessions with supplemental online modules were offered to all program directors (PDs) and associate program directors (APDs) of residency and fellowship programs at our academic medical centre.

Results

Twenty GME program leaders completed training (PD = 11, APD = 8, other = 1). Pre and post surveys were utilized to assess the impact of training (*n* = 10/20 and *n* = 15/20, respectively). One hundred percent reported no prior training in stress first aid, and 70% reported no prior training on burnout syndrome. Ten percent reported offering training on stress first aid to trainee leaders (chief residents or fellows) prior to PD and APD training. One hundred percent reported delivering stress first aid to trainees within the previous 12 months, but 50% felt neutral on their ability to deliver this. Following completion of training, 80% agreed/strongly agreed that they felt confident in delivering stress first aid and 60% stated they would change their current practice as a result of training.

Conclusions

Learning from complications and coping after adverse events are key features of promoting a culture of psychological safety, wellness and continuous learning. PDs and APDs are important leaders in the trainee environment who can encourage these skillsets with appropriate training in stress first aid.

The Recharge Room: a biophilic, multi-sensory space for provider wellness

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Learning objectives:

1. The learner will be able to identify the role of biophilic design implementation in the reduction of stress and anxiety for the health care worker.
2. The learner will be able to identify best practices regarding how to establish similar spaces within any health care system.
3. The learner will be able to identify the mechanisms through which stress and anxiety are reduced through immersion in nature.

Background

UCHealth is Colorado's largest and highest rated health care system, with 14 hospitals, 34,000 employees and 700+ inpatient beds, conducting over 1.3 million outpatient visits annually. Compassion fatigue, moral distress and burnout are significant issues across the health care workforce, with those providing direct patient care facing the highest levels of distress. Provider well-being is a top institutional priority, and the future of health care requires programs for mitigating employee distress. Our Recharge Room provides this respite for providers.

Objectives

UCHealth, like many other major medical institutions, has faced a twofold crisis in recent years: how to provide the highest quality health care while simultaneously sustaining the physical, emotional and mental well-being for providers. Confidential, safe spaces for providers to focus on their well-being have traditionally been nonexistent in health care facilities. A novel approach to addressing provider well-being at UCHealth includes the Recharge Room, an immersive space for employees to rest, recover and recharge.

Approach

Biophilic design research demonstrates stress reduction for health care providers, with as little as 10-15 minutes showing benefit. We addressed caring for our workforce through a novel approach: a nature-inspired experience inside the walls of our hospital with the intention of reducing stress and mitigating burnout. Our Recharge Room offers two large multi-sensory immersive spaces with projected nature scenes and paired nature sounds, aromatherapy and indirect lighting. Additionally, four smaller spaces offer massage chairs, virtual reality headsets and guided meditation for a personalized immersive nature and/or meditative experience. To better understand the impact on provider well-being, we adapted the four-point Navy Stress Continuum as a quantitative means to capture the immediate impact of using this space while at work.

Lessons learned

Effectiveness of the Recharge Room has been measured through survey returns that include a subjective rating of stress level reduction between check-in and check-out using an adapted version of the Navy Stress Continuum. Launching 10/22/2021, the Recharge Room has been visited over 15,000 times with 10,713 surveys being completed upon check-out (as of 3/31/2024). Of those visits, 76.6% of users (8,206 employees) reported acute reduction of stress. Further breakdown of data indicates 59.9% of users reduced stress by one level, 13.9% by two levels and 2.8% by three levels. An overwhelming majority of participants provided positive testimonials about their experiences, such as enhanced well-being, reduced anxiety, increased self-management, bolstered self-esteem and improved preparedness to return to work.

Practical implications

Providing high-quality health care requires organizations to take provider well-being seriously. Data collected from provider use of our Recharge Room have helped clarify the defining characteristics of what actually (not theoretically) leads to acute stress reduction in the health care setting while at work. Given the size of our organization, this information has spurred additional spaces being developed in other facilities throughout Colorado and has led to the formation of Recharge Room committees on a system and regional basis. Further, the information gleaned from this project continues to inform decisions on other well-being initiatives for providers throughout the system. Future research efforts may examine the intersection between general well-being, Recharge Room use, perception of hospital culture, personal resiliency and patient quality.

The well-being/professionalism connection: creating a professionalism peer support program to compassionately address professionalism concerns and increase well-being

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Learning objectives:

1. Describe why a professional environment is needed for positive connections and communication to flourish.
2. Distinguish differences in the types of lapses in professional behavior and where the techniques learned by peer support physicians can influence these behaviours.
3. Recognize the barriers faced by and implement mitigation strategies for integrating peer support initiatives into professionalism.

Background

Communication and community between coworkers are necessary for patient safety, quality care and professional fulfillment. Coworker incivility in the workplace has risen to one of the top three contributors of burnout in physicians. Addressing incivility in most organizations is often approached as a punitive process rather than restorative or an opportunity for understanding and community building. Incivility may also be linked to physician stressors with increased bureaucratic tasks, increased work hours and decrease in pay.

Objectives

Corewell Health East is an eight-hospital system with 5,000 physicians, 1,000 residents/fellows and 33,000 employees. We implemented and evaluated the effectiveness of peer support trained physicians meeting with physician colleagues with professionalism complaints, as opposed to HR/leadership interventions. Owing to differences in implementation across hospitals, we aimed to compare within system differences. The goal of the professionalism peer support model was to demonstrate proof of concept by decreasing incivility and improving satisfaction.

Approach

Professionalism peer support (PPS) was implemented in 2015, based off the Vanderbilt model and common peer support models. A three-hospital unification allowed some programs to be widely used such as traditional peer support. PPS became an extension of the traditional program, with training in active listening, coaching, support and possible referrals. PPS approached with compassion and restoration, not punishment. The addition of five other hospitals and differences in medical staff bylaws and leadership expectations resulted in the management of professionalism issues varying widely – three hospitals involved their PPS regularly to address concerns, while the other hospitals managed professionalism by intervention from higher leadership (e.g., chairs or CMO), allowing for comparison between the hospitals on professionalism and outcomes.

Lessons learned

With health systems that have undergone multiple mergers, the variability in leadership and bylaws governing professionalism issues can impair the ability to implement a system-wide procedure. Starting with early-adopting leaders/physicians and gathering data is necessary. Having those leaders/physicians, as well as those who received the intervention, speak to the benefits "beyond the numbers" is helpful. Anecdotally, most of the unprofessional behaviour was connected to intrapersonal issues — often stress/burnout with limited effective coping strategies, limited self-awareness/insight or a mismatch between the intent and impact of the physician in the workplace. Opportunity to identify, discuss and plan for addressing these issues with the peer supporter may support improved coping and behaviour in the future — creating a better workplace.

Practical implications

As health care struggles with collegial incivility in the workplace and physicians set the example for behaviour in the health care workplace, addressing professionalism in physicians becomes increasingly important. Our approach, based on merging the Vanderbilt model and traditional peer support models, allows for a more compassionate and non-punitive intervention that is more likely to result in sustained behaviour change. Additionally, approaching with compassion and support is likely to impact retention and recruitment, as there are improved relationships across the organization, including with one's leader, and increased identification of and access to resource/support needs. Finally, leaders themselves should be trained in the PPS model, particularly as they continue to address professionalism directly, to allow for compassionate intervention and management of professionalism concerns.

To opt-in or to opt-out?: Connecting with resident physicians to promote well-being

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Learning objectives:

1. At the conclusion of this presentation, participants will be able to explain the rationale for professional check-ins to connect with resident physicians.
2. At the conclusion of this presentation, participants will be able to compare and contrast two different institutions' programs (opt-in and opt-out procedures), including corresponding pros and cons.
3. At the conclusion of this presentation, participants will be able to evaluate barriers and challenges to promoting resident well-being, including stigma about help-seeking behaviours and mental health care access.

Background

A structured approach for resident physicians to develop helping relationships at work is optimal. Opt-in (invitational) and opt-out (universal) check-in programs conducted by mental health clinicians offer individual support. These preventive programs are designed to promote well-being, increase utilization of mental health care resources and mitigate barriers to seeking help when experiencing distress. Both programs are designed to encourage self-assessment and self-monitoring. While focused on the individual, these programs demonstrate the institutions' commitment to well-being.

Objectives

Two US Mid-Atlantic institutions will describe the purpose, goals, components and procedures of an opt-in, personal growth project and an opt-out, wellness check-in program. Utilization data and feedback about each program will be shared to guide development of a program adapted to your needs and institutions.

Approach

The Personal Growth Well-being Project (PGWP) is an opt-in, invitational program designed for first-year residents to learn more about themselves through psychological assessment. Humanistic and psychodynamic principles in psychotherapy and the Therapeutic Assessment model guide the intervention. Participants complete psychological tools and meet for an hour-long consultation to explore strengths and areas of growth. Wellness check-ins are a proactive opt-out program. The primary goal is to identify, support and monitor residents who are struggling with their mental health and to remind them of in-house services that are free of charge. A secondary goal is to encourage residents to reflect on their individual signs and symptoms of burnout and to develop an action plan to cope with burnout during residency.

Lessons learned

1. Institutional engagement and buy-in are critical for the success of a check-in program. 2. A key decision is whether to offer opt-in or opt-out meetings during protected or voluntary time. 3. The best program is tailored to the individual institution and GME culture. 4. Frequency and time of year for meetings are important topics. 5. Offering check-ins to first-year residents is beneficial, and continuing to offer check-ins every year during residency builds engagement and increases help-seeking behaviours. 6. Identifying a system for follow-up care and readily available resources is important to lower barriers to seeking future mental health treatment.

Practical implications

Both system- and individual-focused efforts are needed to promote resident physician well-being. Opt-in and opt-out programs offer practical frameworks for individual support. These programs normalize struggle and the need for help-seeking behaviours. Implementing opt-in and out-out programs can be done with relative ease. By decreasing barriers to accessing support, institutions can increase connection and engagement with their residents. Such institutional efforts demonstrate to resident physicians that their well-being is valued and an important component of their work.

Understanding and addressing primary care administrative workload in Atlantic Canada: a qualitative study

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Learning objectives:

1. To describe the challenges with primary care administrative workload in Atlantic Canada.
2. To describe potential strategies to reduce the volume of low-value administrative work.
3. To identify strategies for local implementation or advocacy at the provincial level.

Purpose/relevance

Many Canadians struggle to access the primary care they need while at the same time primary care providers report record levels of stress and overwork. Administrative activities, including work related to caring for individual patients and clinic administration, may play a substantial role in understanding changes to primary care workload. The objective of the qualitative component of this mixed methods study was to conduct interviews with family physicians, nurse practitioners and administrative team members working in primary care: i) to describe their current experiences of administrative workload, ii) to understand how administrative workload has changed over time and iii) to explore strategies that might be used to streamline processes and reduce the volume of administrative work.

Materials and methods

We used a screening questionnaire to purposively select interview participants. Interviews were approximately one hour in duration. We followed Braun and Clarke's approach to reflective thematic analysis, which fit well with our critical qualitative approach and relativist epistemology. Interviewees represented a range of payment models and a variety of clinic models and were from both urban and rural locations in Nova Scotia and New Brunswick. Thirty-six interviews were conducted. Qualitative interpretation and analysis involved representatives from each stakeholder group.

Results

The increasing demands of administrative work are adversely affecting the health and well-being of primary care providers. The burden of responsibility for this work coupled with a lack of control, as well as difficulty finding coverage for leave or vacation, has caused some family physicians to decrease their weekly clinic hours or consider leaving their comprehensive practices altogether. Information management is central to health care delivery, but often not valued or actively supported. Within primary care most administrative work requires both information management and clinical judgment. Therefore, we developed a typology as part of the analysis and reflected on the practicalities of redistributing different types of administrative work. Participants recommended electronic medical record connectivity with other parts of the health system, pre-population of information on forms from patient charts, changes to insurance and disability forms and processes, redistribution of administrative tasks, assistance with overhead expenses, improved training for administrative staff, development of competencies and guidelines for clinic operations and other actions. Increased opportunities for collaborative team-based and multidisciplinary practices were suggested by participants as a means of supporting redistribution of administrative work, enabling family physicians more time for clinical care activities.

Conclusions

Findings reinforce the substantial adverse effects of administrative work on physician well-being and highlight that the function and impacts of administrative work vary, and tailored solutions are needed. Identifying practical strategies to make information management more efficient can support innovative health care models, improve patient care and improve the well-being of primary care providers.

Understanding distress disparities among underrepresented physicians: implications and recommendations for well-being programs

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Learning objectives:

1. At the conclusion of this activity, participants will be able to evaluate the reported differences in distress experienced by underrepresented physicians, compared to non-Hispanic White physicians.
2. At the conclusion of this activity, participants will be able to interpret the statistically significant differences in high distress levels among physicians based on race/ethnicity, recognizing the varying experiences of distress and work interference among different demographic groups.
3. At the conclusion of this activity, participants will recall the importance of examining changes in well-being among underrepresented physicians to address disparities and gaps in physician well-being, and to contribute to the development of equitable well-being programs in health care settings.

Purpose/relevance

The prevalence and awareness of physician burnout, globally, within the field of medicine has grown; however, understanding the drivers of burnout among underrepresented physicians, more specifically, is inconclusive. Compared to non-Hispanic White physicians, underrepresented physicians experience more social isolation and discrimination by patients and colleagues, and they tend to have more non-clinical tasks associated with the promotion of workplace diversity and inclusion. Physicians who identify as part of an underrepresented race or ethnicity also report being more likely to experience burnout, compared to White physicians. Examining differences in well-being among underrepresented physicians is vital to addressing disparities and gaps in physician well-being and in creating equitable physician well-being programs.

Materials and methods

Data were obtained from a repeated cross-sectional, longitudinal study, conducted from June 2021 to July 2023 among employed physicians of a large US health care system. The Well-Being Index was used to assess well-being among physicians, utilizing a validated cut-off for high distress (scores equal to or greater than 3). A total of 497 physicians completed the survey in July 2023.

Results

In 2023, approximately 37% physicians identified as White, 27% identified as Asian, 20% as Black/African American, 4% as Hispanic/Latino and 2% as more than one race, and 11% preferred not to disclose their race. Fifty-nine percent of respondents had more than 15 years since medical school graduation and 55% identified as male. Mean distress scores and the percentage of physicians in high distress among those who preferred not to identify their race/ethnicity were significantly higher than the overall physician sample ($p = 0.046$ and $p = 0.04$, respectively), though not when compared to White physicians. Those identifying as Asian and those who preferred not to identify their race/ethnicity reported less agreement that the work they do is meaningful to them, compared to White physicians ($p < 0.01$ and $p = 0.01$, respectively). The percentage of physicians in high distress who identified as Hispanic/Latino was significantly lower than White physicians and the overall physician sample (both at $p = 0.02$), though it is important to interpret these results with caution given the small sample size ($n = 21$). There was no significant difference in mean distress score or percentage in high distress for male and female physicians.

Conclusions

Findings from this study underscore the importance of recognizing and addressing disparities in physician well-being, particularly among underrepresented physicians and physicians who do not feel comfortable disclosing their race or ethnicity on a system-wide survey. It is apparent from these results that these groups have different needs and may be disproportionately affected by drivers of distress. By acknowledging and addressing these gaps through utilization of well-being councils, targeted interventions and equitable distribution of resources, health care systems can strive toward creating more inclusive environments that promote the well-being of all physicians.

Unraveling the journey: a longitudinal study of burnout onset and resolution among physician trainees throughout residency

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Learning objectives:

1. Participants will be able to recognize a common pattern of length of burnout symptoms and syndrome throughout residency training.
2. Participants will examine trends in stability/ improvement between the intern year and end of residency.
3. Participants will be able to apply the implications of this prospective cohort study.

Purpose/relevance

Physician trainee burnout is a well-established concern. The ACGME has brought increasing focus to the prevention of burnout in training; however, possible patterns of burnout over time in trainees need to be studied more. Are symptoms of burnout stable over time? Do trainees improve or worsen throughout residency? The authors' previous work demonstrated consistent burnout development across the PGY-1 year when average scores were examined. To explore whether burnout endures over training time, we administered burnout measures yearly until graduation. We followed individuals up to their final year of training, comparing each individual's score to those documented from their PGY-1 year.

Materials and methods

From 2014 to 2024, residents at a Midwestern community hospital were assessed using the Maslach Burnout Inventory (MBI). The MBI has three subscales: Emotional Exhaustion (EE), Depersonalization (DP) and Personal Accomplishment (PA). Burnout symptoms were defined as EE > 27 or DP > 10. Burnout syndrome was defined when EE AND DP were high and PA was low (EE > 27, DP > 10, PA < 31). The MBI was completed twice during the PGY-1 year (July and May) and subsequently once per year (February).

Results

A combined 322 PGY-1 resident physicians completed surveys in the 10 years studied. The overall combined PGY-1 resident years (n = 322) had mean baseline scores that were relatively low (EE = 13.3, DP = 2.6, PA = 36.9) at the beginning of the year. At end of PGY-1 year, there was an average progression to moderate levels of burnout (EE 19.3 [↑46%], DP 19.3 [↑112%] and PA 5.6 [↑ 9%]). Progression to or improvement from burnout was examined by comparing individual scores from the beginning and end of the intern year and then to the final year of training. Comparing the beginning to the end of the intern year (n = 231), 40% of residents remained free of burnout symptoms, while 37% progressed from no burnout to burnout symptoms. When comparing individuals from the end of the intern year to the end of their residency training (February of their final year of training) (n = 124), more than half of the residents had similar scores concluding their training compared with the end of intern year (37% remained well; 28% consistently experienced burnout symptoms). Twenty-two percent of residents improved from symptoms to being symptom-free. This difference was statistically significant, p = 0.01.

Conclusions

Resident physicians in general appear to have stability in burnout scores throughout their training years. For those who were relatively symptom-free at the end of the intern year, they tended to remain that way in their final year of training. Those who experienced the development of burnout symptoms tended to continue to meet that criteria near the end of their training. This may imply that the internship year is a critical time for training in preventing burnout. Implications for support during the intern year will be discussed.

Use of a generative artificial intelligence (G-AI)-assisted documentation tool to reduce clinician burden and associated stress

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Learning objectives:

1. Explain how a generative artificial intelligence (G-AI) tool can automate clinical documentation in the outpatient setting.
2. Describe the feasibility of integrating a G-AI tool into outpatient clinical care.
3. List the potential benefits of using a G-AI tool to assist with clinical documentation.

Purpose/relevance

Clinician burnout is a pervasive, worrisome trend negatively impacting patient care. Although a multi-faceted problem, burnout has been linked to the electronic health record (EHR) and specifically to insufficient time for documentation. Owing to changing billing and regulatory requirements, documentation burden has increased for health care professionals. As part of ongoing efforts of the informatics team to improve clinician satisfaction with the EHR, an ambient listening tool was implemented to assist select clinicians with documentation in this large mixed-academic and community health system. Automating documentation through AI tools offers the promise of allowing clinicians to focus more on patient care and less on administrative tasks. These tools utilize natural language processing to transcribe patient–clinician interactions in real time, streamlining documentation and reducing burden.

Materials and methods

A one-month pilot study assessed the feasibility, acceptability and utility of a generative artificial intelligence (G-AI) tool to automate drafting progress notes. All physicians and advanced-practice professionals from targeted clinics were invited to complete a survey regarding the EHR and well-being. The pilot sample included volunteers and clinicians identified as likely to benefit from the tool. After the trial, respondents were asked to complete a one-month follow-up survey, with 18 clinicians in the experimental group and 50 controls completing both surveys.

Results

After the one-month trial, 66% of users agreed that the tool decreased their time spent documenting (e.g., "[The G-AI tool] has increased my efficiency with writing notes so much. I used to spend an additional 20–30 minutes in a patient chart completing documentation after their visit and now I am closing the majority of my notes within five minutes of seeing the patient"), with 94% indicating that it was acceptably accurate at transcribing speech. Feedback was mixed regarding whether the tool improved documentation quality, and 89% of users indicated that they would benefit from additional training on the tool (e.g., "I think additional touch points can certainly enhance my proficiency").

Despite the short length of the pilot study, the AI tool users reported spending significantly less time on the EHR at home ($t = -2.70$, $p = 0.015$) and demonstrated a trend toward lower job-related stress ($t = 2.03$, $p = 0.06$). As one participant noted, "My stresses have reduced significantly... I sincerely hope [the organization] will continue to offer this amazing tool for me and my clinician peers to be able to lessen the level of burnout and stress we experience related to documentation."

Conclusions

Innovative tools using G-AI can be integrated with the EHR to decrease the documentation burden of physicians and advanced-practice professionals. These tools have the potential to significantly decrease clinician time spent in the EHR (particularly "pajama time") and to improve clinician well-being. Potential benefits may be moderated by individual clinician factors (e.g., proficiency with the EHR, use of existing EHR tools such as templates and smart phrases, and willingness to engage in training). However, for some clinicians, the tool may dramatically impact job satisfaction, quality of life and intent to continue practising medicine.

Using real-time data capture during document review to reduce cognitive and administrative burden and increase patient safety

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Learning objectives:

1. At the conclusion of this activity, participants will be able to identify the steps in the workflow of requisitioning to acting on the results of test or referral for consultation.
2. At the conclusion of this activity, participants will be able to determine the time costs associated with this process in their own clinical practice.
3. At the conclusion of this activity, participants will be able to apply the described system to their own clinical practice and estimate the potential savings.

Background

Physicians request investigations and consultations and review and act on the results. A patient missed an appointment for a CT scan investigating a suspected early lung cancer. A year later, an unrelated scan demonstrated progression to late disease. This loss to follow-up (LTFU) led to a terrible outcome and distress for the patient, physician and staff. The process of requesting and acting on a test is complex, time consuming and prone to a risk of LTFU.

Objectives

To develop a system to eliminate LTFU and minimize the effort of reviewing results of investigations and consultation. The system must efficiently provide pertinent patient information necessary to interpret and act on results. It must promptly notify the physician if tests are overdue and provide the information necessary to act. It must integrate into existing workflows across physician specialties and create an audit trail. It must be adaptable and integrate with multiple existing information systems.

Approach

We analyzed the steps in requesting and reviewing the results of a test or referral and acting upon it. At key steps, information was entered by the physician or staff into a custom-designed computerized practice management system (iSBERGDATA). When reviewing results, the physician uses the system to access pertinent clinical information to make decisions. Instructions are communicated to the office staff, which automatically updates a "notice board" of pending tests and their due dates. An audit trail of each step of the process is automatically created. The notice board is directly linked to the individual record and is accessible by the physician and staff with direct messaging capabilities, avoiding disruptive e-mails and the "in-box burden" or multiple logins.

Lessons learned

We reduced the time needed to review results from a median of 52 seconds per document (range of 15–110 seconds) to a median of 15 seconds (range of 9–15 seconds). With an average of 150–200 documents per week, this is a saving of one to two hours per week per physician. Further, the time needed to book a follow-up appointment by a booking clerk was also reduced. The time necessary to track results decreased from two hours per week to 15 minutes. The system also promptly flagged overdue results and referrals, avoiding potential LTFU. For six physician office, this resulted in a savings of 12 hours of physician time and 10.5 hours of administrative time per week and reduced cognitive load.

Practical implications

Requesting and reviewing the results of an investigation or referral and acting on it are fundamental to medical practice. Current processes are time consuming, prone to error and fail entirely when tests or referrals are missed. Continually searching for disparate sources of information to review and act on results is burdensome. LTFU from missed tests or referrals leads to missed pathology and breakdown in care, resulting in significant and avoidable harm to patients and a significant source of anxiety and medicolegal risk. We present a solution where data are captured within an existing physician workflow, which leads to significant time savings while decreasing the cognitive burden for physicians and staff and increasing patient safety by reducing the risk of LTFU.

Vacation days taken, work during vacation and burnout among US physicians

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Learning objectives:

1. Identify current vacation characteristics among US physicians, including number of days of vacation taken per year, minutes spent on patient care on a typical vacation day and the presence or absence of inbox coverage on vacation.
2. Identify the role vacation characteristics (number of days taken, time spent on patient care work while on vacation and inbox coverage while on vacation) have on physician burnout.
3. Apply approaches health systems and institutions can take to increase the amount of time physicians have for strengthening their personal connections with friends and family.

Purpose/relevance

Vacation has been shown to be an important restorative activity in the general population; less is known about physicians' vacation behaviours and their association with burnout and professional fulfillment.

Materials and methods

This cross-sectional survey of US physicians was conducted between November 20, 2020, and March 23, 2021. Burnout was measured using the Maslach Burnout Index, and professional fulfillment was measured using the Stanford Professional Fulfillment Index. Number of vacation days taken in the last year, time spent working on patient care and other professional tasks per typical vacation day (i.e., work on vacation), electronic health record (EHR) inbox coverage while on vacation, barriers to taking vacation, and standard demographics were collected.

Results

Among 3,024 respondents, 59.6% took ≤15 vacation days/year, with 19.9% taking ≤5 days. The majority, 70.4%, performed patient care–related tasks on vacation, with 33.1% working 30 minutes or more on a typical vacation day. Less than one-half of physicians (49.1%) reported having full EHR inbox coverage while on vacation. On multivariable analysis adjusting for personal and professional factors, concern about finding someone to cover clinical responsibilities (odds ratio [OR], 0.48 [95% CI, 0.35–0.65] for quite a bit; OR, 0.30 [95% CI, 0.21–0.43] for very much) and financial concerns (OR, 0.49 [95% CI, 0.36–0.66] for quite a bit; OR, 0.38 [95% CI, 0.27–0.54] for very much) were associated with a decreased likelihood of taking more than three weeks of vacation per year. Taking more than three weeks of vacation per year (OR, 0.66 [95% CI, 0.45–0.98] for 16–20 days; OR, 0.59 [95% CI, 0.40–0.86] for >20 days v. none) and having full EHR inbox coverage while on vacation (OR, 0.74; 95% CI, 0.63–0.88) were associated with lower rates of burnout, whereas spending ≥30 minutes/day on patient-related work (OR, 1.58; 95% CI, 1.22–2.04 for 30–60 minutes; OR, 1.97; 95% CI, 1.41–2.77 for 60–90 minutes; OR, 1.92; 95% CI, 1.36–2.73 for >90 minutes) was associated with higher rates of burnout.

Conclusions

In this cross-sectional study of 3,024 physicians, the number of vacation days taken and performing patient-related work while on vacation were associated with physician burnout. System-level efforts to ensure physicians take adequate vacation and have coverage for clinical responsibilities, including EHR inbox, may reduce physician burnout.

Wellness through safety: creating a thriving workforce through physical, psychological and cultural (PPC) safety

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Learning objectives:

1. Summarize the Canadian Medical Association's journey — including the research, analysis, engagement, quantitative and qualitative data — toward the development of a pan-Canadian approach to embed physical, psychological and cultural safety in health care learning and practice environments.
2. Examine the relationship and interconnectedness of physical, psychological and cultural safety, the current state of health care safety in Canada and the challenges experienced by health care providers.
3. Apply the fundamental elements and building blocks for physical, psychological and cultural safety and evaluate potential options and strategies to build the path forward toward creating a thriving health workforce.

Background

Safety is a constitutional right, but many health care workers in Canada today operate in high-risk environments. The health of Canadians depends on a thriving health workforce but often health care worker well-being and safety are sacrificed for the needs of the patient, organization or system. The CMA's 2021 National Physician Health Survey shows high rates of burnout (53%), depression (48%), low professional fulfillment (79%) and alarmingly high reports of intimidation, bullying or harassment (80%).

Objectives

We aim to: understand the current landscape, realities and challenges and experiences of health care safety in Canada; develop evidence, influence policy, the business case and build national leadership, commitment and accountability in advancing safety in health care; identify and amplify promising practices, levers and actions to embed PPC safety in learning and practice environments; build and implement a pan-Canadian approach that fosters safe spaces in health care, addressing current gaps and creating accountability and leadership.

Approach

Work began with examination of the current state of PPC safety in Canada, analysis of existing safety frameworks, and research on current efforts and management approaches, nationally and internationally. An engagement and partnership phase followed, with key informant interviews and collaborative working sessions with leaders, experts, health care workers and persons with lived experience to test/validate a National PPC Safety approach, explore alignment and strategy with prospective partners and build the vision and action plan.

Lessons learned

There are considerable advancements and work already underway, particularly around cultural safety, and opportunities for harmonization and amplification of efforts exist, harnessing the unique roles and levers of each respective organization. Key themes are: leadership and creating accountability mechanisms as key drivers of change; implementation and measurement of quality improvement initiatives (e.g., implementation of a framework) as the biggest barriers; certain populations are disproportionately affected and require a tailored approach (IMGs, Indigenous health workers) that is distinct and separate (EDI v. anti-Indigenous racism); and we must co-create with diverse, representative voices paired with those with influence and power to effect system-level change and recognize and account for geo-political realities and the impact on health care worker safety.

Practical implications

Safety is inextricably linked to recruitment, retention and IHHR, health care worker joy, fulfillment and well-being, organizational performance, patient experience and outcomes, equity, diversity, inclusion, reconciliation and anti-racism in health care, human connections and inter/intra-professional relationships and the culture of medicine. The sustainability of our health care system relies on the well-being of our health care providers. When health providers lack protection from abuse, where they do not feel welcomed and respected, where they lack support as people as well as professionals, they are fundamentally unsafe. We need to address the systemic, cultural and workplace occupational hazards that are negatively impacting health providers through a holistic, coordinated, comprehensive response that focuses on the interdependent dimensions of PPC safety.

What scales should we use? A psychometric systematic review of common scales used to measure medical student well-being longitudinally

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Learning objectives:

1. Compare and apply the breadth of constructs and scales commonly used to measure medical student well-being.
2. Describe psychometric (validity and reliability) and feasibility properties relevant to medical student well-being scales.
3. Critique evidence of scales to support their use in measuring medical student well-being.

Purpose/relevance

Medical student well-being deteriorates over the course of their training, including higher rates of burnout, depression, anxiety and psychological distress. Methodical, longitudinal measurement of well-being is necessary to capture the impacts of medical training and potential interventions. We previously found that there are a wide variety of scales employed to measure medical student well-being longitudinally. However, there are limited comparisons of the evidence supporting their use in medical students, and a poor understanding of which scales have the best evidence for measuring medical student well-being. We therefore aimed to examine and summarize the validity and reliability evidence of the 52 most common scales employed to measure medical student well-being longitudinally.

Materials and methods

We conducted a systematic review using COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN). Seven databases and grey literature were searched for psychometric studies of the included scales. Screening and data extraction were done independently by two reviewers. Conflicts were resolved via discussion to achieve consensus. Study quality and psychometrics were assessed using COSMIN methodology. Internal consistency and test-retest reliability were analyzed using pooled analysis when there were at least two studies per scale.

Results

Out of 2,374 total abstracts, 326 passed to full-text screening and 133 studies were included. Over a quarter (27%) of study metrics had no evidence to support their validity/reliability in medical students. Out of the included studies, one-fifth (20%) were multi-centred and the majority (53%) were conducted in Asia. Nearly 90% of studies tested internal consistency and over three-quarters (80%) tested construct validity via convergence/divergence. There was sufficient evidence to support the internal consistency of 30 scales and construct validity via convergence/divergence of 34 scales. However, there were much fewer scales with sufficient evidence of inter-rater reliability (n = 6), responsiveness via convergence/divergence (n = 6), structural validity (n = 5), cross-cultural validity/measurement invariance (n = 4), criterion validity (n = 2) and content validity (n = 1). Five scales had an associated cost and nine scales reported to have completion times of less than 10 minutes. Study quality varied widely among the included studies and only 20 reported participant ethno-racial identity. We will highlight our recommendations for scales and best practices when measuring various aspects of medical student well-being based on psychometric evidence and feasibility considerations, such as cost and length.

Conclusions

Many scales used to measure medical student well-being longitudinally lack medical student-specific validity or reliability studies. Among those that do have psychometrics, few have evidence to support their content validity, cross-cultural validity and responsiveness. There is a significant gap in context-specific validity and reliability despite widespread use of numerous well-being scales. On the basis of the available psychometric evidence and feasibility considerations, we recommend which scales are most appropriate for use in measuring medical student well-being. We will also highlight future areas of research to better inform scale selection.

When disaster strikes: connecting with staff when it matters the most

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Learning objectives:

1. At the conclusion of this activity, participants will be able to identify essential well-being components of a hospital's emergency response plan.
2. At the conclusion of this activity, participants will name short-term and long-term staff support interventions following an emergency response activation.
3. At the conclusion of this activity, participants will apply lessons learned from successes and opportunities from a hospital's actual emergency response activation in the well-being and staff support space.

Background

When a Super Bowl parade took a devastating turn to gun violence, local hospitals immediately prepared to execute an emergency response plan. As part of this emergency response activation, the need to support staff cannot be an afterthought. Nine gunshot wounds among other related injuries flooded our ED within minutes of shots being fired near our hospital. Immediately following this event, the Center for Wellbeing team activated the Center for Wellbeing's Emergency Management Plan (EMP).

Objectives

The main objective of this well-being initiative was to create a policy to guide hospital staff support efforts in the event of a disaster, mass casualty or any other emergency response activation. Following the creation of this document, our team was prepared with an overarching plan to guide meaningful interventions for our health care team members to aid in staff coping, connection, recovery and sustainment of well-being following an emergency/disaster response.

Approach

The Center for Wellbeing (CWB), a small multidisciplinary team of health care leaders, quickly mobilized utilizing the EMP to initiate well-being efforts following the traumatic event. First, the CWB team led an in-person debrief for the team working as first responders on the day of the event. Within 24 hours, we set up in-person, virtual and hybrid offerings of individual support focused on secondary trauma support. Department-specific emotional reflections took place by request from a variety of physician and nursing groups. Additional onsite EAP providers were brought in for walk-in visits. Other offerings included walk-in office hours with nourishment, books to share with children explaining the events, additional mental health counselling referrals, art therapy, donor-funded meals and acupuncture.

Lessons learned

Having an emergency management plan dedicated to staff support following any type of disaster, mass casualty or unanticipated emergency event is critical to keep staff support, connection and well-being at the forefront for the sake of our health care workforce. Space allocation, nourishment for staff and individual and team support sessions were essential to the success of the post-disaster recovery plan and truly contributed to human connection and enhanced well-being following tragedy. Short-term and long-term interventions are equally important to consider as the plan flexes with the work environment and identified needs of staff. Prioritization of department-specific offerings and a sound communication plan should be focal points to ensure the right resources are getting to the staff members in highest need.

Practical implications

It's no longer a matter of if, but instead when. Is your organization ready to take care of your hospital's most precious resource — the staff who care for the patients? It is vitally important to invest time, thoughts and funds to support an emergency response staff support operational plan. Creating partnerships with other disciplines can help meet the larger scale needs of an organization-wide emergency response activation and recovery efforts. Keep an emergency response plan on hand and update it as needed, to foster immediate mobilization of staff support efforts following disasters. Well-being needs a seat at the table for Hospital Incident Command briefings to streamline planning and communication to best support staff and enhance meaningful connections.

From distressed to restored: An integrated approach to supporting our team members

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Learning objectives:

1. Discuss impact of distress in our healthcare workforce.
2. Identify key drivers of distress in our healthcare workforce.
3. Develop a systemic approach to proactively provide support after distressing events.

Background

Healthcare organizations are facing ongoing challenges in creating a culture where their healthcare workforce feels supported and that the work they do is valued. Many people that go into healthcare have a superficial understanding of the actual exposure to difficult and distressing events, and often underestimate how repeated exposure to these events make them feel both physically and emotionally.

Objectives

We sought to understand the most frequent types of distressing events that were affecting our team members and in turn developed a strategy to provide a comprehensive, mutli-tiered proactive support structure for those impacted by such events.

Approach

A multidisciplinary organizational assessment to identify key areas causing the greatest amount of distress to our team members was completed by our Center for Wellbeing (CWB) team in collaboration with other leaders throughout the organization. We found that patient care events, such as a death of a patient or a patient code, along with patient safety events, team member safety events (WPV), pending litigation or other risk management events, patient grievances, in addition to community disasters were the areas causing the most distress. Our CWB team then developed a structured notification process and standardized the delivery of support to impacted team members.

Lessons learned

Through programming the CWB provided 593 independent sessions which resulted in 15,702 touch points with our team members from 2/22-12/23. We tracked various modalities of support, as well as themes in the requests for support. Across the different support modalities, events involving direct patient care such as patient death or patient code were cited most often across all departments and disciplines. Team member safety events (WPV) were then the second most prevalent request for support and included both exposure to physical violence by behavioral health patients, verbal aggression from patients, verbal and physical altercations with families and visitors.

Practical implications

While peer support programs have been proven to be very effective at supporting our healthcare team members after a distressing event, developing a more comprehensive, proactive, standardized process for this support fosters a culture of connection and belonging and shifts the responsibility of seeking support away from the impacted individual. Utilizing a standardized technology platforms also hastens outreach efforts all while promoting collection of data for development of future programs and initiatives.

Association between vacation characteristics and career intentions among U.S. physicians – A cross-sectional analysis

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Learning objectives:

1. Identify the association between number of vacation days taken per year and physician intention to reduce clinical effort or leave current practice.
2. Identify the association between performing patient-related work on a typical vacation day and physician intention to reduce clinical effort or leave current practice.
3. Consider the institutional costs of physician reduction in %FTE clinical and physician departure and institutional opportunities to support physician self-care through time away.

Purpose/relevance

Evidence indicates physician vacation characteristics are associated with burnout; less is known about the relationship of vacation characteristics and physician career intentions. The objective of this study is to assess the association between physician vacation characteristics and career intentions.

Materials and methods

This is a cross-sectional survey of a sample of U.S. physicians between November 2022 and September 2023. The number of vacation days taken in the last year, inbox coverage, performance of patient-related work on vacation (WOV), intent to reduce clinical hours (ITR) in the next 12 months, intent to leave the current practice (ITL) in the next 24 months were measured.

Results

Among 5059 respondents, 2163 of 4537 (47.7%), reported less than 3 weeks (~15 days) vacation in the last year, with 443/4537 (9.8%) taking ~5 days. Nearly half (48.6%) reported not having full EHR inbox coverage while on vacation. The majority (72.0%) reported performing patient-care related work on vacation, with 33.6% performing >30 minutes of WOV per day. On multivariable analyses adjusting for personal and professional characteristics, ITR and ITL were higher for physicians taking ~3 weeks of vacation, not having full inbox coverage on vacation and working >30 minutes per vacation day.

Conclusion

In this large, cross-sectional study, the number of vacation days taken, inbox coverage and time spent on patient-related work while on vacation were each independently associated with career intentions. Organizational efforts to optimize these vacation characteristics may foster recruitment and retention of physicians.

Workshops

From COMPASS to Camaraderie: evidence-based interventions involving intentional space making to foster connection and belonging

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Learning objectives:

1. Apply history of COMPASS/Camaraderie group evidence-based interventions to inform your current program or need.
2. Practice the impact of COMPASS/Camaraderie groups on your own stress and sense of belonging.
3. Create goals for what you will take back to your home institution to either enhance or create your own program to promote connection and belonging.

Session details/description

90 minutes:

- (10 min) Introductions and initial ice breaker: who is in the room with hands up, hands down for an informal experience and needs assessment:
  - Who has never heard of these groups or is completely new to this?
  - Who is hoping to build something like this in the near future?
  - Who has a version of COMPASS/Camaraderie groups at their location?
  - Who has been doing groups for 6 months? 1 year? 2 years or more?
  - Do your groups focus on physicians? A mixed audience? Do they include learners?
- (10 min) Brief explanation of the COMPASS groups model and supporting research: An RCT of COMPASS Groups (West et al. 2021) demonstrated reductions in burnout, depressive symptoms and job turnover likelihood.

- (10 min) Brief explanation of the Camaraderie groups model and supporting research: Camaraderie survey data show that the intervention group (*n* = 113) had a significant increase in their sense of belonging and a decrease in stress and depersonalization, whereas the control group (*n* = 80) had no change (unpublished data, manuscript in preparation).
- (10 min) Questions from the audience on models, extensions and research potential, and will also encourage those in the audience running similar programs to offer ideas and share solutions.
- (25 min) Demo a session with audience participation; facilitators will briefly lead group norms and then allow independent small groups to experience prompts.
    i. Large group (5 min): Establish a psychologically safe space by co-creating group norms via a community agreement, with group norms defined as what participants need to be seen and supported in this conversation.
    ii. Small group (20 min): Participants at each table of six to 10 individuals will select a single prompt to illustrate the experience of these models. Possible prompts include: sharing a little bit about your personal journey and its intersection with your clinician role, reflecting on how you connect with purpose and meaningful impact in your work, naming what you are proud of from the last year, pausing to notice the effects of change and transition.
- (20 min) Debrief on demo session and share operational pearls to build/enhance your own models
- (5 min) Session evaluations

Audience interaction

The workshop is interactive and evidence based. The opening is a community-building needs assessment to guide workshop experience. The large-group discussions between audience members and workshop presenters will further understanding of the model and increase operational success. The experiential component allows participants to be in a prompted group demonstration.

Relevance to conference theme and/or sub-theme(s)

This workshop is relevant to the conference theme "Improving well-being through the power of connections" and sub-theme of "human connections." The workshop focus is on the creation of intentional spaces for those in health care to come together and have meaningful conversations that re-centre the importance of human connections and community.

Connection is your superpower — sharing lessons from NHS Practitioner Health, a service built on connection and arguably the happiest place to work in the world!

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Learning objectives:

1. Attendees will leave the session able to describe the evidence base regarding strengthening connections across all domains to improve well-being, health, happiness and quality of care.
2. The audience will be able to define best practice in developing connections across the human, socio-technical, systems, interprofessional and operational domains and extrapolate this to their own practice — learning from the available evidence and shared experiences and success of NHS Practitioner Health.
3. The audience will develop an action plan to enable them to implement changes in their own practices and within systems.

Session details/description

NHS Practitioner Health is a multi-award-winning mental health and addiction treatment service for health care professionals across England and Scotland. We believe we are the largest of our kind in the world and when we began over 15 years ago we adopted the mantra if you build it they will come. We are built on foundations of compassion, care and connection and our staff tell us that they are extremely happy in their work.

We know that happy staff make happy patients.

This workshop shares the ways that we have developed Practitioner Health into the world-leading service it is today by prioritizing connectedness in all that we do.

We will explore the evidence that strengthening human and social connections is one of the most powerful things we can do to ensure high-performing teams and protect mental health. Having a close relationship might even help you live longer! We will demonstrate how conditions to thrive can be created by developing human, social and interprofessional connection. We will share with you the practical, evidenced-based tools and techniques that we have employed to ensure our staff are the happiest and best they can be to deliver the quality care we are known for.

In this interactive session you will experience first-hand how simple changes to foster connections and strengthen social bonds can create an environment in which people develop trust and learn how the letter H can be a powerful tool to allow teams to develop psychological safety. We will also share strategies used by the military that we have adopted to develop strong connections and well-being within our service.

We will introduce our innovative "5 a day" concept of connectivity and the ways we ensure we are not just connected with each other but with our patients, our work, with the world around us and to a higher sense of purpose.

Leave inspired, energized and connected with your colleagues and with an action plan to improve the well-being of yourself, your teams and your organization.

Leave having uncovered your connection superpower.

Audience interaction

This workshop is designed to be fun and interactive. The audience will be facilitated to engage through practical exercises including a trust exercise illustrating how to develop psychological safety and an exercise involving music that demonstrates the effect of connection on brain psychology and physiology.

Relevance to conference theme and/or sub-theme(s)

The workshop is entirely centred around the conference theme. It provides the theory and practical application of connectedness across all the domains to improve staff well-being and patient care.

Creating psychologically healthy and safe health care workplaces and learning environments to enhance well-being, team performance and quality of care

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Learning objectives:

1. At the conclusion of this workshop, participants will be able toexplain the psychosocial factors that can promote or hinder psychological health and safety in their workplace or learning environment and how it affects quality of care.
2. At the conclusion of this workshop, participants will be able to identify behaviours, policies and practices that can affect psychological health and safety.
3. At the conclusion of this workshop, participants will be able to propose actions to enhance psychological health and safety in their workplace or learning environment.

Session details/description

Doctors are people too, and they are experiencing burnout, depression and thoughts of suicide (CMA 2021 National Physician Health Survey). Creating and supporting psychologically healthy and safe health care workplaces is not only the right thing to do, it can also decrease absenteeism and turnover, boost productivity, enhance organizations' reputation, increase patient satisfaction, reduce medical errors and lower health care costs.

The National Standard of Canada for Psychological Health and Safety in the Workplace, recognized as a leading practice by the Health Standards Organization, identifies psychosocial factors that can affect the psychological health and safety (PH&S) of workers. Given the unique psychological risks facing health care organizations, two additional factors relevant to this sector have been identified in subsequent research: (1) protection from moral distress and (2) support for psychological self-care.

Comprehending these psychosocial factors and everyone's role in supporting PH&S will better equip us to identify gaps and enablers in our teams and organizations. After getting a deeper understanding of PH&S in health care, participants will be guided to find suitable evidence-informed resources through online tools like the Physician Wellness Hub (Canadian Medical Association) and the Psychological Health and Safety Toolkit for Primary Care Teams and Training Programs (PH&S Toolkit).

The workshop will be based on the PH&S Toolkit's seven themes: (1) organizational and team culture, (2) workload management and work–life balance, (3) clear leadership and expectations, (4) psychological protection, (5) protection of physical safety, (6) protection from moral distress and (7) support for psychological self-care.

Practical resources on these seven themes will provide concise steps, checklists and examples that will be put into practice through case scenarios, groups discussions and individual activities. The evidence-informed resources, from Canada, the United States and the United Kingdom, will address the most relevant themes to the audience, such as workload management and work–life integration, support for psychological self-care, stigma reduction and organizational and team culture.

This workshop aims to support the creation and promotion of psychologically healthy and safe environments, which lead to improved team learning, team performance and continuous quality improvement environments (Donovan and Mcauliffe 2020).

Audience interaction

Participants will be guided throughout individual activities, group discussions and tailored case scenarios to facilitate comprehension and support implementation in their workplaces. The practical activities will focus on physicians' current interests, such as workload management and work–life integration, support for psychological self-care, stigma reduction and organizational and team culture.

Relevance to conference theme and/or sub-theme(s)

Comprehending PH&S is crucial to improving well-being through the power of connections, given that "PH&S is embedded in the way people interact with one another" (CSA 2013). Health organizations must create a culture that encourages health workers' help-seeking and self-care, because health workers are people, and patients too.

Failing better!! — using improv theatre exercises to improve communication skills, teamwork and self-compassion in clinical teams

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Learning objectives:

1. At the conclusion of this activity, through experiential learning, participants will identify how their personality traits and biases influence their function clinically, in teams and in life.
2. At the conclusion of this activity, participants will use the "Yes And" improv tool and reflect on two or three examples where it would improve interactions in their own lives.
3. At the conclusion of this activity, participants will utilize a community of strangers, sharing many good solid laughs, practising key skills in promoting similar positive experiences in their own day-to-day lives, by "failing better."

Session details/description

There is growing evidence demonstrating the need for improved communication, teamwork skills and overall empathy in medical education and for practising clinicians. Improv theatre has been used for over 20 years in educating medical students and faculty across the United States. Improv helps clinicians and learners be more expressive, collaborative and empathic in their clinical learning and work (Watson 2016; Quinn et al. 2020).

Additionally, improv embraces failure and a self-compassionate approach to our human limitations. In an unforgiving medical culture, perfectionism is identified as one of the greatest contributors to burnout (Wong 2020). Canadian physicians experience high rates of burnout (53%), depression (34%) and suicidal ideation (14% incidence in the last year) (CMA 2022).

Could improv theatre, which is implicitly supportive and embracing of failures, enable us to be more self-compassionate, connected and healthier humans?

Curious? Come for the possibilities and stay for the fun!

Watson K, Fu B. Medical improv: a novel approach to communication and professionalism training. *Ann Intern Med* 2016;165:591-592 Quinn MA, Grant LM, Sampene E, et al. A curriculum to increase empathy and reduce burnout. *WMJ* 2020;119(4):258-262.

Physician wellness: New 2021 National Physician Health Survey findings — burnout, short-staffing and an overburdened system take their toll. Available: https://www.cma.ca/physician-wellness-hub/content/physician-wellness-new-2021-national-physician-health-survey-findings-burnout-short-staffing-and

Audience interaction

Interactive, inclusive and accessible for all; tables are pushed aside at the start and chairs circled up. Whole-group and small-group theatre exercises to experience the lessons of improv first hand (70%); and group discussion about observations made and applications for medical life (20%). Didactic content <10%.

Relevance to conference theme and/or sub-theme(s)

Improv theatre exercises are an innovative and evidence-based way of improving interprofessional teamwork. Improv theatre is routed in self-compassion and human connection, making it an excellent way to improve clinician wellness, while simultaneously promoting more compassionate patient care. Laughter is the universal language and perfect for this international conference.

How might we? Harnessing the power of connections through human-centred design thinking — skills workshop for solving complex drivers of burnout

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Learning objectives:

1. Introduce concepts of human-centred design thinking (HCDT) and prototyping system-level improvements in medicine.
2. Practise human-centred ethnography skills, which informs the brainstorming sessions for health system problem-solving.
3. Identify ways in which human-centred design thinking can be applied to local institutional well-being campaigns, to improve human connections.

Session details/description

Physician burnout, driven by factors including the electronic health record, inefficient system-wide barriers and inadequate resources, has major implications on patient care and the sustainability of the health care workforce. The leadership at the Department of Medicine Wellness Committee completed training in human-centred design thinking at Stanford University to broaden our thinking and creativity and to seek innovative solutions for the workplace of the future.

Design thinking is human-centred (based on user interviews), systems-aware (mindful of influencers, barriers, social structures) and goal-focused (keeping in mind short- and long-term goals). Since our training, we have taught HCDT skills through more than 10 workshops of various sized audiences, resulting in specialty-specific interventions to create a culture of wellness and thriving at work. Design thinking enabled our group to maximize our well-being campaign and outreach to our department of over 2000 faculty, staff and trainees.

In this workshop, we will introduce participants to the tenets of HCDT followed by an active exercise to prototype solutions to the question of "How might we?" Through debriefing this exercise, we will discuss ways these concepts can be applied in various health care settings with limited resources. Participants will be provided a tool kit and references for design thinking to incorporate into their own organizations.

Breakdown of session: 90 min, 15 min questions.

5 min: Introductions of faculty presenting workshop

15 min: Interactive icebreaker: "Yes, and" improvisation exercise — introduce principles underlying design thinking and can be used by participants in their respective organizations to promote a safe environment for brainstorming.

20 min: Introduction of ethnography and skills practice: With a prompt, practice human-centred interviewing skills in small groups — then compile those interview findings to generate "how might we" questions to promote curiosity in brainstorming.

20 min: Ideation and creation expedition skills. Prototype solutions to "how might we" questions with arts and crafts, share the prototype with small groups.

15 min: Debrief/discussion of ways these concepts can be applied in various health care settings with limited resources. Participants will be provided a tool kit and references for design thinking.

15 min: Questions

Audience interaction

Attendees of this workshop will participate in hands-on design-thinking exercises to illustrate these innovative principles, exploring user-centred interviews, hypothesis and insight generation, prototyping using arts and crafts, testing and feedback. Attendees will leave with skills and resources to continue learning and applying design-thinking concepts to their local well-being campaigns.

Relevance to conference theme and/or sub-theme(s)

Human-centred design thinking (HCDT) integrates individual- and system-level factors with problem solving. These skills have been applied to well-being campaigns in medicine and have proven effective in improving human and interprofessional connections. The creative brainstorming environment created by HCDT can promote solutions to system-wide obstacles.

Introduction of the S.A.F.E.R. framework to achieve practice environments that are physically, psychologically and culturally safe

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Learning objectives:

1. Recall the sources of workplace trauma, including institutional betrayal trauma experienced in health care.
2. List the SAFER leadership principles to create trauma-informed and inclusive work environments by enhancing human connections.
3. Apply the SAFER leadership principles to enhance the human experience in our interactions, teams and organizational policies, procedures and protocols.

Session details/description

There is a growing call to action to ensure safe practice environments in health care, recognizing safety to be comprised of physical safety, psychological safety and cultural safety. Eight out of 10 physicians in Canada report experiencing bullying and harassment in the workplace. One-third of female surgeons report being sexually assaulted by a colleague. There is mounting evidence of racism and microaggressions impacting the well-being of physicians and medical learners. Anti-science has introduced new forms of patient-to-worker violence. The experience of moral distress has been amplified because of the post-pandemic backlog of care and workforce shortages present barriers for patients to have timely access to care. These repetitive exposures to workplace trauma have exacerbated burnout, mental health issues and challenges accessing mental health supports.

When impacted by trauma, many will look to their leaders and health care organizations for support. If their experience is dismissed, minimized, shamed in any way, this causes a second harm, known as sanctuary trauma or institutional betrayal.

How might health care leaders respond in a way that leverages the protective power of human connection? How might the principles of trauma-informed care be extended to human interactions between providers?

The authors present the SAFER framework, a leadership framework that, in the last two years, has reached a total of 331 health care leaders across Canada seeking to create healthy workplace culture through trauma-informed leadership.

The SAFER framework is comprised of the following domains:

S: Safety (cultural, psychological and physical)

A: Awareness of sources of workplace trauma and impacts

F: Foster voice and choice

E: Empathetic curiosity (shift from judgment to curiosity)

R: Restorative connections

The SAFER principles explicitly leverage the protective power of human connection, describing the behaviours needed to create safe, inclusive workplaces where health care providers can thrive. This workshop employs the liberating structure What? So What? Now What? to move participants from new understanding to tangible action.

Audience interaction

Participant engagement tools:

- Handout: SAFER placemat outlining five domains and 13 capabilities of SAFER that leaders need to employ to be effective in creating safe, inclusive environments.
- Interactive polls
- Small-group discussion

Relevance to conference theme and/or sub-theme(s)

This workshop is highly relevant to the conference theme. SAFER leaders enhance human connection to enhance the overall experience

Stories beat data. A workshop to tell better stories, improve human connection and lead change

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Learning objectives:

1. Describe the key components of a compelling story.
2. Use these components to write personal and professional stories that speak to motivation, human connection, and behaviour change.
3. Practise writing and telling stories as key leadership skills to capture attention, improve communication and lead change.

Session details/description

Effective communication is a critical skill in all aspects of life. Health care professionals often struggle with disseminating complex medical data to patients and to their peers.

In his Pulitzer-winning book Thinking, Fast and Slow, Daniel Kahneman wrote, "No one ever made a decision because of a number. They need a story."

At work, the ability to share one's story builds connection and improves a sense of community.

With patients, a clear, compelling narrative that explains real outcomes is far more likely to help patients make informed decisions than those that rely only on data and statistics.

With colleagues, communicating an idea in a compelling way helps build consensus within a team. "Ideas that stick" are powerful tools to advance any given project.

In all three cases, a great story serves the purpose. We are drowning in data, and yet humans communicate in stories. How might we use great stories to augment our evidence-based work?

In this workshop, we will share key elements of what makes an effective story (e.g., context, catalyst, complication, change and consequence). Participants will be given time to draft their own stories, after which they will share their stories in pairs and then workshop their stories and lessons from creating these stories in the larger group. Participants will then discuss together ways to incorporate these lessons to improve communication and connections both personally and professionally.

Session timing:

- Large group: (20 min)
  - Introductions of faculty presenting workshop
  - Storytelling: key components to improve communication and connection
- Individual: (20 min)
  - Write your own story
- Pairs: (10 min)
  - Storytellers share their stories in turn and discuss
- Large group: (25 min)
  - Discuss impressions and lessons learned from sharing stories
  - Brainstorm ideas to strengthen participants' stories
  - Brainstorm ideas to incorporate these skills to improve connections and communication both personally and professionally
- Questions: (15 min)

Audience interaction

Participants will draft their own stories. They will share a story with a fellow participant. The larger group will reconvene to discuss reactions and lessons learned. They will brainstorm ways to use this skill to communicate their message more effectively, improve connections or deliver a compelling proposal.

Relevance to conference theme and/or sub-theme(s)

- Human connections: Too often, our messages are buried in "data." A skillful narrative can build connection and change minds.
- Interprofessional: Clear communication facilitates better teamwork.
- Socio-technical: Particularly in the age of electronic health records and generative AI, storytelling skills and effective interpersonal communication are needed more than ever.

Supporting 2SLGBTQIA+ learners and patients in clinical academic settings

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Learning objectives:

1. At the conclusion of this activity, participants will be able to recall the prevalence of 2SLGBTQIA+ identities in Canada and comprehend the unique health needs of gender-diverse people.
2. At the conclusion of this activity, participants will be able to identify strengths or gaps in gender-inclusive practices in their academic and clinical settings.
3. At the conclusion of this activity, participants will be able to implement steps to enhance the clinical and academic environments for 2SLBGTQIA+ medical learners and colleagues.

Session details/description

2SLGBTQIA+ people make up 4.33% of the population in Canada and accordingly, there are gender-diverse and queer medical students and residents in every program. Gender-diverse learners in particular have unique health and learning environment needs related to the intersection of their gender and physician identities. There are concrete steps that clinical and academic medical professionals can take that will make the learning and clinical environments safe and inclusive for gender-diverse trainees and optimize their health and academic and clinical performance. This workshop will review the unique health and learning environment needs for 2SLGBTQIA+ medical students and residents; the differences between micro- and macro-aggressions as related to gender identity; the impact of these on medical resident health and well-being; general best practices for inclusion for teaching faculty, allied health and administrative staff; and specific recommendations for gender-diverse residents. The format will include didactic portions, video and table-focused discussion as well as a discussion period to conclude.

Audience interaction

Solicited Q&A as well as audience participation slides throughout videos with focused discussion to follow: pronouns and name use; microaggressions; learning environment scenarios for table discussion with examples relevant to surgical, office-based clinical and hospital unit settings.

Relevance to conference theme and/or sub-theme(s)

This workshop and its objectives are relevant to the theme of "Improving well-being through the power of connections" and the sub-themes of "Human connections" and "Procedures and operations." Human connections are deepened when clinical team members and teaching staff have an enhanced understanding of and apply gender-inclusive practices.

Two for the price of one: the resident well-being check-in as an opportunity to enhance individual resilience and promote organizational well-being strategies

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Learning objectives:

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

1. Describe the development of a comprehensive well-being check-in (WBCi) initiative for first-year resident physicians that addresses both personal and organizational well-being factors.
2. Demonstrate the utility of WBCi processes, program materials and data for directly enhancing resident resilience and for reinforcing residency programs' support of resident well-being.
3. Outline lessons learned about creating and promoting effective prevention initiatives for resident physicians and stimulating culture change in medicine.

Session details/description

Resident physicians are at risk of experiencing significant mental health difficulties (e.g., depression, burnout, suicide risk). Barriers to care such as poor access to wellness services, stigma, lack of insight and cynicism toward the promotion of individual well-being interventions while systemic stressors remain unresolved should be addressed early in training to enhance residents' wellness.

To proactively address resident wellness concerns and promote resilience, our Faculty Staff Assistance Program (FSAP) has implemented an annual virtual well-being check-in (WBCi) for first-year residents that addresses personal and organizational aspects of well-being. The WBCi includes a confidential, supportive, educational contact with an FSAP clinician and provides the opportunity to collect resident feedback and other data relevant to training programs' efforts to create supportive and healthy learning environments for trainees. FSAP collaborates with our graduate medical education (GME) leaders to facilitate resident engagement with the WBCi.

The main aims of this preventive intervention include: (1) increasing numbers of residents receiving support from FSAP; (2) effective screening for depression and anxiety, and early recognition of stress and burnout levels; (3) providing a destigmatized, one-on-one interaction with an FSAP clinician to educate first-year residents about their mental health status and stress resilience; (4) providing recommendations, resources and follow-up care for growth during and beyond internship; (5) developing residents' trust in the internal counseling resources; and (6) obtaining data on resident preferences for organizational well-being strategies that will support resident well-being . The WBCi has a flexible design that allows FSAP to capture a variety of quantitative and qualitative data useful for intervening with residents, developing additional wellness resources, sustaining resident engagement, assisting GME leaders in their support of residents and enhancing the WBCi process.

This workshop will outline key steps in designing and implementing the WBCi. It will demonstrate how WBCi data and features of the WBCi lend themselves to providing immediate support for residents, developing future effective resources for them and addressing barriers to their wellness. Participants will consider how organizational support variables can be incorporated into an intervention designed for individual care. The versatility of the WBCi for meeting physicians' wellness needs will be discussed.

Audience interaction

The audience will be engaged through small-group discussion and reporting out on flexible ways to use the WBCi (e.g., depending on organizational or residency program needs) and on potential applications of WBCi data for the development of preventive, clinical or organizational wellness strategies. Q&A will also be utilized.

Relevance to conference theme and/or sub-theme(s)

Human connection is leveraged to promote WBCi effectiveness and acceptability, including through FSAP and GME collaboration, soliciting feedback for WBCi improvement, reporting to stakeholders on residents' personal and workplace needs, and one-on-one clinician contact. The WBCi addresses residents' challenges, reinforces strengths, facilitates growth and is responsive to each participating resident.

Panels

GenAI: How could it accelerate professional well-being? What is the role of the CWO?

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Learning objectives:

1. Explain the basics of artificial intelligence (AI) and current applications in health care, particularly in reducing documentation time and administrative burdens.
2. Describe the well-being leader's role around the adoption of AI tools and how to collaborate with other stakeholders, including key elements of the business case and return on investment (ROI).
3. Describe the pilot data and outcomes of AI on clinician experience, including cognitive load, burnout, efficiency and undivided attention.

Session details/description

Generative AI is evolving at a rapid pace, already becoming embedded into the workflows of health care. Therefore, it is critical that clinicians, especially well-being leaders, understand it and recognize generative AI's potential to improve professional well-being. Excessive administrative burden is identified as a key driver of burnout that needs to be addressed at a system level. AI offers novel solutions to mitigate administrative burden for clinicians. Well-being leaders have a unique opportunity to guide the adoption of AI in ways conducive to professional well-being. The panel will consist of two physician executive well-being officers and two physician experts leading nationwide advancements in AI and electronic health record (EHR) technology. The session will begin with an introduction to the basics of AI, providing attendees with essential knowledge and language to understand the technology and the scope of available capabilities. Panellists will share a variety of cases and highlight experience with AI tools at their institution. Aggregate data from multiple institutions using a generative AI documentation tool will be presented. These data will include the impact on clinician satisfaction, symptoms of burnout, cognitive load and intent to leave. The data will also include patient experience metrics. Panellists will discuss development of metrics and balancing the interests of stakeholders.

The panel discussion will also define the role of the well-being leader in the adoption of AI tools, recognizing that the approach needs to be collaborative with stakeholders within operations, information services and digital optimization. Strategies for creating an effective business case and defining key performance indicators will be reviewed. The panel will address the importance of strategic influence as a well-being leader when advocating for the adoption of AI tools to support clinician well-being. Consideration will be taken to avoid the promotion of any one commercial AI product and aim to educate broadly and share effective use cases.

Audience interaction

The panel will be facilitated in an engaging format, inviting relevant comments and questions during the panel discussion. There will also be dedicated time at the end of the panel discussion for questions.

Relevance to conference theme and/or sub-theme(s)

The content is relevant to the conference sub-themes of "systems connections" involving technology, "social-technical" reducing administrative burden, "interpersonal" and "human connection" for face-to-face human-centred care. The panel discussion will discuss digital tools to reduce administrative burdens and increase a clinician's ability to be more present with their patients and colleagues.

Herding cats — fighting burnout by building connections across siloed health care systems through interoperability

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Learning objectives:

1. State the key digital health interoperability pain points for physicians.
2. Discuss the state of interoperability in Canada.
3. Interpret the rationale and recommendations of the DHI task force.

Session details/description

The use of technology in health care has been identified as a contributor to physician burnout. The lack of interoperability is one of the most common digital health factors associated with burnout. In its 2021 *Healing the Healers: System-Level Solutions to Physician Burnout*, the Ontario Medical Association Burnout Task Force recommended the promotion of seamless integration of digital health tools into physicians' workflows as a way to reduce physician burnout. In a 2021 Canada Health Infoway (Infoway)/Canadian Medical Association (CMA) survey, many physicians indicated looking forward to better integration of digital health tools into their electronic medical record (EMR).

In January 2024, Infoway, the CMA, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada put together the Digital Health Interoperability Task Force (the task force) to encourage and motivate implementation and use of interoperable digital health solutions through physician champion endorsement.

From its first session in February 2024 to its report in October 2024, the task force will have pondered technology, data standards, policy, the physician digital experience, data governance challenges, systems gaps and innovation gaps and impediments to come up with recommendations to advance interoperability in Canada's many health care systems. Informed in part by a pan-Canadian physician survey to be conducted in April/May 2024 and in part by experts in the domain and by its own deliberations, the task force will produce a report in September/October 2024.

Data from the survey will be shared for the first time as part of this panel discussion, as will the highlights of the task force debates and report through a panel conversation on the state of digital health interoperability in Canada along the themes of obstacles, a vision for the future and practical next steps. The panel will be composed of leaders in the field, physicians from the task force, a policy person from government and possibly a vendor.

Audience interaction

The attendees will be engaged through a Q&A and questions from the panel for the audience. Data from the survey will be shared for the first time as part of this session as will the highlights of the task force debates and report.

Relevance to conference theme and/or sub-theme(s)

This is an initiative focused on improving physicians' ability to work with various health system technologies seamlessly and decreasing administrative burden or duplicative work and documentation when working with digital health tools and systems. The panel will be composed of leaders in the field, including physicians from the task force.

Stress First Aid in action: implementation of a self-care and peer support framework in a large health care system

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Learning objectives:

1. At the conclusion of this activity, participants will be able to identify three key features of the Stress First Aid model.
2. At the conclusion of this activity, participants will be able to recall two actions they can take to implement Stress First Aid in their setting.
3. At the conclusion of this activity, participants will be able to differentiate two challenges to the implementation of Stress First Aaid at an organizational level and how to overcome them.

Session details/description

Panellists will discuss the processes of adaptation and implementation of Stress First Aid (SFA) — a peer support and self-care model implemented in the Northwell Health system during the pandemic and in subsequent years. The panellists will summarize the evidence around SFA and the scope of its implementation in various health care settings. They will focus in on the adaptation and implementation of it within Northwell Health across disciplines — including physicians and nurses — to illuminate some of the challenges and opportunities for generalizing to other settings. An overview of the process for training and integration into the various settings (e.g., hospital units and ambulatory settings) will be provided along with a review of process and outcome data from multiple hospitals and ambulatory practices within the Northwell Health system. Panellists will present about the overall impact of the program in terms of numbers reached (23,000 to date) and program satisfaction as well as specific outcome data regarding self-efficacy, resilience, perceptions of organizational support, stress, burnout and awareness/utilization of well-being resources. A preliminary longitudinal analysis of outcome data from one hospital indicated statistically significant changes over the course

of one year in self-efficacy around ability to support a stress-impacted coworker, an increase in resilience and an increase in knowledge of well-being resources. Qualitative interviews noted that SFA strengthened problem-solving skills, raised awareness about psychological needs, reduced projection of stress on patients and facilitated discussion of concerns with supervisors. Discussion will be focused on lessons learned, including the need for flexible implementation, organizational challenges, a focus on the benefits of incorporating SFA into existing trainings, and consistent communication across settings.

Audience interaction

Panellists will present an overview of their work for a total of 60 minutes and then open to a question and answer period that will include some moderated questions and questions and answers from the audience.

Relevance to conference theme and/or sub-theme(s)

This panel discussion overlaps with the theme of improving well-being through the power of connections as the SFA implementation in Northwell Health is an organizational peer support and self-care model for developing peer support. As such, it speaks to building human connection and doing so in a programmatic manner.

Posters

"Let's Check-in!" Results of a comprehensive well-being program for first-year residents

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Learning objectives:

After reviewing this poster, conference participants will be able to:

1. Describe the development and implementation of a comprehensive well-being check-in (WBCi) initiative for first-year resident physicians that addresses both personal and organizational well-being factors.
2. Characterize the well-being experiences of interns participating in the WBCi by reviewing their mental health questionnaire scores, resilience factors, perceptions of stigma, and rankings of organizational well-being strategies.
3. Recognize the effectiveness of the WBCi as a preventive intervention for residents and ts potential for informing the development of additional services and resources for physician well-being.

Purpose/relevance

Successful preventive well-being visits offered early in medical training can reduce subsequent barriers to seeking emotional and mental health care (e.g., access to care, stigma, cynicism toward well-being initiatives) and enhance wellness. To proactively address resident wellness concerns and promote resident resilience our Faculty Staff Assistance Program (FSAP) implemented an annual well-being check-in (WBCi) for first-year residents targeting personal and organizational well-being factors. Aims of this preventive intervention included (1) increasing numbers of residents receiving supportive contact from FSAP; (2) identifying interns' mental health needs through individual screening for depression and anxiety, recognizing stress and burnout levels, and characterizing barriers to care and resilience factors; (3) developing trust in the internal counseling resources; and (4) obtaining data on resident needs regarding systems-based well-being strategies.

Materials and methods

In the first three years of the WBCi, participants had one-one-one interviews with FSAP clinicians and completed questionnaires including the Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-2 (GAD-2), Perceived Stress Scale (PSS), a Mini Z Burnout survey item; measures of help-seeking willingness, stigma, meaning and purpose; ranking of the importance and feasibility of organizational well-being strategies; and program evaluation. Descriptive analyses were conducted to characterize interns' WBCi engagement, mental health needs, resilience, stigma and ratings of organizational well-being strategies.

Results

WBCi interviews with FSAP clinicians increased each year (N = 38, 105 and 116, respectively). During program evaluation (N = 61) in WBCi years 2 and 3 most interns evaluated WBCi feedback as relevant (77.1%, *n* = 47), expressed willingness to follow WBCI recommendations (82.0%, *n* = 50) and were willing to recommend the WBCi to future interns (95.1%, *n* = 58). The WBCi was highly acceptable to interns (Acceptability of Intervention Measure, M = 4.3, SD = 0.76). Over the three years in which 252 interns opted into research, 9.5% (*n* = 24) of participants were screened as likely to have major depressive disorder, 17.1% (*n* = 43) were screened as likely to have an anxiety disorder, 39.3% (*n* = 99) reported burnout, while 54.4% (*n* = 137) reported moderate or high stress. Organizational well-being strategies ranked as most important by interns included "flexibility to schedule personal and health care appointments during work hours" and "support staff to allow more time for patient care." The Meaning and Purpose mean score was 7.7 (SD = 1.55 in year 2, SD = 1.56 in year 3). Over 20% of interns agreed or strongly agreed with statements endorsing stigma from supervisors and patients and endorsed fears of bias in hiring.

Conclusions

The WBCi is a flexible, feasible, effective, acceptable and pragmatic psychoeducational preventive program for medical resident well-being. Program utilization and evaluation data suggest the WBCi is likely to have an extended effect on interns' wellness and to become normalized as a supportive intervention for interns. The WBCi also demonstrates how positive psychology factors can be leveraged to enhance resident well-being. Plans include expanding the WBCi for additional physician groups, enhancing resident wellness services and organizational well-being strategies based on study findings, and examining additional personal and organizational wellness variables related to physician wellness.

A group coaching program to reduce burnout among mid-career women clinicians at an academic institution

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Learning objectives:

1. State the rationale for a group coaching initiative for women clinicians.
2. Identify key success factors for building a group coaching program in an academic setting.
3. Explain potential pitfalls for group coaching programs and strategies for overcoming them.

Background

Nationally, women physicians have higher burnout rates than their male colleagues. Lack of time to connect with colleagues prevents women physicians from sharing experiences and strategies for addressing challenges. Individual coaching has been found to be effective in increasing professional fulfillment, but the potential benefits of group coaching for mid-career women clinicians are unknown. In an academic institution in New England, annual wellness surveys had identified mid-career women physicians as having the highest burnout rates.

Objectives

The objectives of this intervention were to: (1) Offer a coaching program to address decreased professional fulfillment and rising burnout and turnover rates among midcareer women faculty, (2) reduce the isolation experienced by busy clinicians and provide a safe forum for forging connections, (3) support well-being and retention and (4) test the feasibility, impact and cost-effectiveness of a group coaching program.

Approach

A professional physician coach designed a 12-week blended program covering topics such as time management, effective communication for requests and boundary setting. Notices were sent to clinicians inviting them to apply. To build collegiality, pods of four or five individuals were created; participants were encouraged to communicate with pod members between sessions by whatever means they preferred. While the coach acknowledged the larger system frustrations that clinicians face, participants were encouraged to identify places where they had agency to make changes. For example, mindset and workflow tweaks. To foster connection, specific attention was paid to the program design: an application process requiring approval of the department chair; a disincentive to miss sessions was put in place; and times offered (weekday morning or evening).

Lessons learned

(1) Group coaching demonstrated a measurable impact: all metrics showed positive trends, and there was a significant reduction in anxiety measures. In addition, participants rated the value of the program highly, with an overall rating of 4.1 out of 5.0. Participation in the sessions averaged more than 90%. (2) A combination of in-person and virtual sessions was feasible and well accepted. (3) Creative incentives and an application process can support high participation levels. (4) Inclusion of female department chairs in some sessions was highly valued by participants. (5) Administrative support for scheduling, communication and logistics is essential. (6) The group coaching model is a cost-effective way to offer professional coaching to a group at higher risk of burnout with the added confidentiality of an external coach.

Practical implications

(1) Initiatives focused on professionals at the highest risk of burnout are well received, impactful and appreciated by participants. (2) Group coaching is a cost-effective means for providing well-being support. (3) Careful planning and sufficient financial and personnel resources are essential for successful group coaching programs. (4) Key challenges include time of day for offering sessions, appropriate incentives to enable participation, and finding effective strategies for forging connections between busy clinicians. (5) Provision by an external coach provided participants with a greater sense of confidentiality. (6) A combination of in-person and virtual meetings is feasible and well accepted by participants, as it offers both the added collegiality of in-person events and the convenience of virtual sessions.

A huddle system to enhance patient safety and staff well-being in surgical departments

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Learning objectives:

1. Understand the importance of adverse event reporting and employee well-being reporting and current barriers in reporting systems.
2. Come up with ways to identify problems within departments via implementation of a widespread reporting system focused on a culture of continuous improvement.
3. Once a system is put in place, understand how to make it sustainable and work well for the needs of an individual department.

Background

Significant barriers in health care reporting hinder physicians and other health care workers (HCWs) from participating in safety reporting. These barriers include uncertainty about reporting mechanisms, concerns about time constraints, and not feeling heard. Similarly, reporting of staff well-being among HCWs remains low, hindering the opportunity for improvement efforts focused on the work environment, which can ultimately impact patient safety.

Objectives

Our project implemented a framework for submission, review and action focused on staff well-being and patient safety while addressing the above barriers to reporting. The goal was to design and facilitate a new system that encouraged widespread reporting of concerns and ideas for improvement. The system would rely on department stakeholders, transparency of methods and timely dissemination of information regarding the resolution of reports.

Approach

Initial efforts focused on two surgical departments individually, with weekly huddles set to discuss intradepartmental reports. Reports from all staff were encouraged, and the SaFESS+ (Safety, Flow, Equipment, Supplies, Staffing, +Well-Being) criteria were used as a framework for submission. At weekly meetings, stakeholders from various backgrounds, including physicians, nurses, administrators and other staff, were recruited to champion a culture of improvement and discuss/solve the identified problems. The project was broken into three phases within each department: 1) initiate and encourage reporting efforts, 2) develop an escalation strategy and communication matrix and investigate/solve problems and 3) optimize for longevity.

Lessons learned

Two departments began improvement efforts and are progressing. Even in the early phases, department leaders were able to identify and solve issues related to patient safety, work environment and job satisfaction. Reporting was enhanced with weekly reminders and incentivization. It was found that many issues could be solved with simple email-based communication between/within departments. Unfortunately, larger issues (such as staffing) are still difficult to tackle, but reports may be used to leverage influence toward future institutional action.

Practical implications

Structured efforts may be utilized within surgical departments to improve working conditions and patient safety via a culture of incremental improvement. Smaller efforts within individual departments may be more successful than efforts across entire divisions or hospitals. Such programs are simple to develop and implement so long as they have the support of stakeholders and department leadership.

A novel three-part coaching program for new academic faculty improves alignment of personal and organizational values and improves professional fulfillment

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Learning objectives:

1. At the conclusion of this activity, participants will be able to describe the role that values alignment plays in a culture of well-being.
2. At the conclusion of this activity, participants will be able to describe how a personal development coaching program for new physicians that incorporates human connections can improve physician morale in an AMC.
3. At the conclusion of this activity, participants will be able to describe the relationship between human connections, values alignment, physician morale and professional fulfillment.

Background

Physician burnout is a national crisis, and drivers of burnout can occur at the organization level and at the individual level and may include a lack of a sense of alignment of personal and organizational values. Physician burnout negatively impacts the clinical care environment and may contribute to physician attrition. Professional development coaching, including both one-on-one and group coaching models, has been shown to improve morale, decrease burnout and improve overall physician well-being.

Objectives

We developed a novel three-pronged coaching intervention for new-to-the-organization academic faculty members at an urban academic medical centre with the goal of leveraging the power of human connection as part of a culture of well-being. We anticipate that this program will improve participants' perception of the alignment of their personal values with the values of the hospital organization, as well as improve their self-description of their professional fulfillment.

Approach

We developed a novel three-pronged coaching intervention for new faculty to our hospital organization that includes a six-month series of large-group onboarding talks, small-group coaching around specific topics relevant to academic faculty members, and optional one-on-one coaching with near-peer faculty coaches who have been through a brief training on the "coach approach" to guiding a coaching session. Our goal is for participants to feel connected to the organization and each other, share and normalize their internal struggles that come with being a new attending and part of an academic health system/teaching hospital, and foster agency and personal growth. We anticipate that this six-month coaching program will improve values alignment with the organization and mitigate burnout.

Lessons learned

In implementing this program, we have learned that scheduling of the sessions and faculty members being able to attend the sessions are both challenging. The program is currently in progress, with preliminary evaluation survey results indicating all three components of the program are thus far well received. Participation in the large-group onboarding lectures has been extremely good and they have been very highly rated, with an average of 4.5/5. Attendance in small-group coaching sessions has been very good with excellent active participation during the sessions. Evaluations of the small-group session has been limited, which may be due to delay in timing of the evaluations until all groups have had their monthly session.

Practical implications

The biggest practical implication is the need for adequate time to participate in the program, both from the new faculty participants, the near-peer coaches and the Chief Physician Wellness Officer who has created the program and its curriculum, is coaching all of the small-group coaching sessions and is 1:1 coaching all of the senior faculty participants in the cohort. Participating in the large- and small-group coaching sessions are considered mandatory; however, the scheduling of clinic patients and surgical cases makes regular participation challenging for some physicians. Evaluations for the program are via the Microsoft Teams platform, and to maintain anonymity but be able to compare individuals' responses over time, participants created a pseudonym for these surveys.

A repeated measure protocol for the study of burnout, psychological morbidity, job satisfaction and stress among Canadian hospital-based child and youth protection professionals

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Learning objectives:

1. To measure the prevalence of burnout, psychological morbidity, job satisfaction, job stress and consideration of alternate work among multidisciplinary hospital-based child and youth protection professionals.
2. To understand the reasons for leaving among former program members.
3. To compare these to results from 20 years ago.

Purpose/relevance

Child maltreatment presents challenges and emotional demands on child and youth protection (CYP) professionals, including physicians, who are at risk from vicarious exposure to trauma. Factors like stress and limited training in child maltreatment work can adversely influence health. In 2005, a Canadian study discovered that 33% of CYP professionals exhibited burnout, 13% psychological morbidity, and almost 66% of members indicated they had considered a change in work. This suggested an impending exodus of CYP professionals and a "crisis" in services. Now 20 years later, it's unclear whether stress, burnout and psychological morbidity for CYP professionals continue to rise, and if service was impacted by shifts in career or other practice changes in the field. Was the crisis averted and where are we at now?

Materials and methods

An online survey will be sent to current and former Canadian hospital-based CYP professionals including physicians, social workers, nurse practitioners and psychologists. Surveys will include validated measures of burnout, psychological morbidity and job satisfaction/stress, and questions about consideration of alternate work. Former members will be asked about reasons for leaving the field. Analysis will be through SPSS and will include descriptive statistics on population demographics. Differences in prevalence of burnout, psychological morbidity and job satisfaction/stress will be assessed using Mantel-Haenszel tests.

Results

The results of this research study are currently pending. Results will be ready in time for a poster presentation at the conference in October 2024.

Conclusions

This study will inform current levels of burnout, psychological morbidity, job satisfaction and stress among Canadian pediatricians and CYP workers and highlight solutions to improve the well-being of team members. With comparison to a baseline from 20 years ago, we aim to better understand changes in the field that may have impacted trends in wellness and job satisfaction, and if concern for a resource crisis in CYP services remains. Lastly, this study will provide insight on what can be done now to prevent ongoing burnout and psychological morbidity over the next 20 years.

Academic physician and trainee burnout, professional fulfillment, mental health and intent to leave practice or training by sexual and gender minority status: a multicentre cross-sectional survey study

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Learning objectives:

1. Identify the prevalence of burnout, professional fulfillment, intent to leave practice or training as well as anxiety and depression by sexual and gender minority (SGM) status.
2. Recognize the value of reducing physician and trainee burnout by characterizing disparities in occupational well-being.
3. Discuss interventions to address burnout, professional fulfillment and retention in practice and training.

Purpose/relevance

Sexual and gender minority (SGM; lesbian, gay, bisexual, transgender and queer [LGBTQ]) clinicians experience unique stressors that are associated with their ability to remain in the health care workforce. The focus on the well-being of SGM physicians is warranted as having a diverse physician workforce inclusive of SGM physicians has been shown to be associated with improved patient health outcomes, reduced stigmatization of SGM patients and enhanced workforce development. To better understand how we can address mistreatment, harassment and burnout, we must first accurately describe the experiences of SGM clinicians using a national survey sampling physicians across specialties.

Materials and methods

We conducted a national, cross-sectional survey study of 15 academic medical institutions participating in the Healthcare Professional Well-Being Academic Consortium with data collected from October 2019 to July 2021. The survey was administered to attending physicians and trainees with 8,376 attending and 2,564 trainee respondents. SGM status was determined via self-reported sexual orientation and gender identity. Primary outcomes were the Professional Fulfillment Index, burnout, intent to leave practice or training, and self-reported anxiety and depression using the PROMIS short-form 4-item measure.

Results

Of 10,940 total respondents, 386 (4.6%) attendings and 212 (8.3%) trainees identified as SGM. Among attendings, SGM respondents had a lower prevalence of professional fulfillment (34.5% v. 40.4%) and a higher prevalence of burnout (47.4% v. 35.4%) and intent to leave practice (33.2% v. 30.9%) (all $p < 0.001$). Similar results were found among trainees except there was no difference in intent to leave training by SGM status. When adjusting for age, race and ethnicity, SGM attendings had increased odds of burnout and decreased odds of professional fulfillment. Similarly, SGM trainees had increased odds of burnout.

Conclusions

In a national cohort of academic medical professionals, SGM attendings and trainees have higher levels of burnout and intent to leave practice and lower professional fulfillment than straight, cisgender peers. These disparities warrant further exploration and targeted intervention development to retain a diverse health care workforce.

An examination of the acceptability and feasibility of a virtually delivered facilitator-led and self-directed cognitive behavioural skills intervention in a sample of physicians and medical learners

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Learning objectives:

1. At the conclusion of this activity, participants will be able to compare the feasibility of a self-directed and facilitator-led CBTm program in a sample of physicians and medical learners in Manitoba.
2. At the conclusion of this activity, participants will be able to summarize the perceived strengths, perceived weaknesses and suggested revisions of a self-directed and facilitator-led CBTm program in a sample of physicians and medical learners.
3. At the conclusion of this activity, participants will be able to state the acceptability of virtual mental health services delivered in this population of medical trainees and physicians.

Purpose/relevance

The prevalence of various mental health conditions is higher among physicians and medical learners. One common barrier to receiving adequate care includes a lack of time to see a provider and follow treatment plans. As such, virtual forms of cognitive behaviour therapy with mindfulness (CBTm) were introduced to mitigate these barriers and provide care in an efficient and effective manner. The objective of the study was to determine the acceptability and feasibility of a five-session CBTm program, delivered in two formats within a population of medical learners and physicians.

Materials and methods

A link was circulated and participants chose a preferred format to participate in the CBTm program. One option was a virtual, facilitator-led class that was held once a week for five weeks (CBTm facilitator-led). Option two was a self-directed course that was independently completed using an online platform (CBTm self-directed). Participant feedback forms were collected and analyzed. Thematic analysis was used to qualitatively analyze participant feedback forms. In addition, questionnaire items were used to determine participant satisfaction with the program.

Results

The results indicated a high level of interest in both CBTm facilitator-led and CBTm self-directed, with a greater preference for CBTm self-directed. Of those who registered for the program, 13.8% (n = 15) registered for CBTm facilitator-led and 86.2% (n = 94) chose the self-directed version of CBTm. Quantitative mean scores of participant feedback forms also showed a high level of satisfaction. For example, the Client Satisfaction Questionnaire 8 (CSQ-8) was analyzed, and the results indicated a mean total score of 28.00 and 26.46 for CBTm facilitator-led and CBTm self-directed, respectively. In addition, many themes emerged from the thematic analysis and were subsequently categorized into three major categories. This included perceived strengths, perceived weaknesses and suggested revisions to improve the program.

Conclusions

Overall, virtual CBTm was feasible and acceptable among physicians and medical trainees in Manitoba. There was a high level of satisfaction with both methods of delivery of the program, with a preference for CBTm self-directed. Additional revisions may be needed to improve uptake and retention of participants. While the qualitative data indicated positive outcomes for mental health, further research should determine the effectiveness of the program using standardized mental health measures, both pre- and post-intervention. In addition, further research should determine whether CBTm has long-term benefits for the improvement of mental health in this population.

Association of electronic health record and clerical burden with burnout and career intentions among physician faculty in an urban academic health system

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Learning objectives:

1. Describe the growing burden of the EHR and clerical work on practising physicians.
2. Identify the relationship between the EHR and clerical burden, and burnout and intent to leave one's job.
3. Delineate the duration of daily clerical and EHR time associated with physician burnout and intent to leave.

Purpose/relevance

The growing burden of the electronic health record (EHR) and clerical work on practising physicians is driven by spending considerable time documenting patient notes outside of normal work hours, a large volume of direct patient-to-physician messaging and increasing volumes of chat-based communications between members of the health care delivery team. This burden has also been linked to burnout and frustration with the health care system. The purpose of this study was to examine changes in the EHR and clerical burden, including daily EHR and clerical time between 2018 and 2022 among physician faculty, and examine the relationship between EHR and clerical time, and burnout and intent to leave one's job.

Materials and methods

An institution-wide survey was sent to physician faculty at an urban academic health system from July to September 2022. EHR and clerical time, EHR frustration and practices' effort to unload clerical burden were assessed using ordinal-scale questions. Burnout was assessed using the Maslach Burnout Inventory-2, and intention to leave one's job was assessed using a five-point ordinal likelihood scale. Demographic and occupational characteristics were assessed. Multivariable logistic regression analyses were conducted to determine associations between EHR/clerical burden, and burnout and intention to leave.

Results

A total of 1,534 physician completed the survey (41.6% response); 829 had clinical responsibilities. The percentage of physicians who spent > 90 minutes on daily EHR and clerical time increased from 2018–2019 to 2022 [22.5% to 30.8%, 10.5% to 24.0%, respectively, $p < 0.001$]. Medicine- versus hospital-based department and hours worked/week were associated with greater EHR and clerical time, and female gender with greater EHR time. After adjusting for demographic and occupational characteristics, greater clerical time (odds ratio [OR] = 1.22, $p < 0.01$) and EHR frustration (OR = 1.29, $p < 0.001$) and younger age (<40; OR = 1.73, $p < 0.05$) were associated with greater likelihood of burnout, and greater endorsement of practice making an effort to unload clerical burden (OR = 0.82, $p < 0.01$) with lower odds of burnout. EHR frustration (OR = 1.28, $p < 0.01$) was associated with intention to leave one's job. Faculty rank was linked to both burnout (instructor: OR = 3.20, assistant professor: OR = 2.58, $p < 0.01$) and intention to leave (instructor: OR = 3.68, assistant professor: OR = 4.52, $p < 0.01$). Planned post-hoc analysis revealed that admission processing (OR = 2.22) and responding to InBasket messages from patients (OR = 1.46) were independently associated with burnout, and that completing forms (i.e., work, school, disability etc.) was independently associated with intent to leave one's job (OR = 1.72). Greater EHR frustration was associated most strongly with intention to leave among younger physicians.

Conclusions

EHR and clerical burden are increasing among physician faculty and linked to greater odds of burnout and intention to leave one's job, with EHR frustration additionally associated with intention to leave. Practice efforts to unload these burdens may attenuate the impact of EHR and clerical burden. Younger and more junior physicians, particularly those reporting high levels of EHR frustration, have a greater likelihood of leaving their jobs. The results underscore the importance of system-wide efforts to unload EHR and clerical burden to help mitigate burnout and promote retention at health care institutions.

BINGO! Could this be the winning ticket to improving resident belonging and well-being?

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Learning objectives:

1. Evaluate burnout rates among OBGYN residents in a public hospital setting in California.
2. Identify benefits of wellness BINGO among OBGYN residents.
3. Demonstrate the opportunity for programs to create a wellness BINGO board for implementation at their own institution.

Purpose/relevance

Burnout is highly prevalent among resident physicians. Obstetrics and gynecology (OBGYN) residency programs are putting more emphasis on resident wellness; however, it is still unclear which interventions successfully impact resident physician well-being. At Harbor-UCLA, OBGYN residents are assigned to a "resident family" during their intern year. Each family has four members (one from each PGY year). Resident families provide mentorship and accessibility to senior residents and serve as teams for low-stakes competitions (e.g., submitting duty hours, answering Q-bank questions and completing administrative tasks). To further support resident bonding, we implemented a wellness BINGO board in 2023 that included several group activities for resident families to participate in. The goal of this project was to build a sense of belonging and positively impact the well-being of residents.

Materials and methods

A wellness BINGO board was created and provided for each Harbor-UCLA OBGYN resident family to complete together. The bingo board included activities that were intended to be enjoyed as a group, such as participating in arts and crafts or watching a movie. Participation from three or more family members was required. The BINGO competition began in October 2023 and there was a winning team in March 2024. After completion, participants completed an anonymous survey, using the Likert scale and open-ended questions.

Results

We provided an anonymous survey to 23 OBGYN residents who were invited to participate in wellness BINGO. The survey included questions about experience relating to resident families and wellness BINGO. A total of 20 OBGYN residents (87%) completed the survey. Most residents (65%) reported feeling at least one or more symptoms of burnout. At baseline, 80% of residents felt supported by their resident family and 65% of residents reported that being in a family helped them feel a sense of belonging. After participating in wellness BINGO, 60% of residents felt more connected to their peers and 25% of residents felt less symptoms of burnout; 85% of residents would like to continue participating in wellness bingo, while the remainder were neutral. When prompted regarding different themes and activities for BINGO, 88% of residents prefer more wellness themes and 77% desire more family bonding themed BINGO boards. In open format responses, residents requested more allocated time and funding to participate in wellness BINGO activities and inclusion of more exercise-related options.

Conclusions

This study suggests that wellness BINGO may be used by residency programs to improve the well-being of resident physicians and increase their sense of belonging. Wellness BINGO successfully helped facilitate bonding within resident families and was viewed positively among residents, with most residents requesting ongoing BINGO throughout the year. Wellness BINGO is versatile and low cost, and it can be executed in any medical specialty or occupational setting. Implementation of wellness BINGO may be an opportunity to foster inclusivity, build community and improve the overall well-being of resident physicians.

Bright-spotting: shining the light on well-being best practices

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Learning objectives:

1. Understand how to use data from a validated well-being assessment tool to highlight departments and teams that are thriving.
2. Understand the methodology of "bright-spotting," a process to identify factors driving a culture of well-being
3. Identify tactics and best practices learned through the bright-spotting process and apply in various setting and leadership programs.

Background

Corewell Health West has been using the Well-Being Index since 2020. As part of a robust follow-up plan, we have historically engaged in a process called "hot-spotting" to perform a deeper dive into areas that have high levels of distress. In 2023, new data offered the ability to identify teams that are thriving. In 2023, "bright-spotting" was piloted, which involved focus groups with leaders and front-line colleagues who were identified as thriving.

Objectives

The "Bright-Spotting" Program was developed in efforts to 1) recognize high-functioning teams and leaders, 2) understand key tactics used to improve team dynamics and well-being and 3) share best practices with other leaders and colleagues in the organization.

Approach

Using 2023 Well-Being Index data, three teams were identified as having the highest percentage of physicians and advanced practice providers (APPs) identified as "thriving." Subsequently, two focus groups were set up: one with leaders and one with front-line physicians and APPs. Food was provided at the focus groups as a way to show recognition and celebration for the team. Key themes and best practices were identified from the focus group discussions, which have subsequently been shared in various leadership development forums.

Lessons learned

Through the pilot program of "bright-spotting," we learned that the process itself was effective in promoting well-being for the teams in that it allowed time to reflect back on the positive achievements as well as created space for recognition of one another. The focus groups fostered community and camaraderie through strategic facilitation and questions related to culture of wellness, efficiency of practice and personal resilience. Two of the three teams were concurrently being awarded formal recognition for achievements in quality and safety. This has allowed us to highlight the Quadruple Aim through system-level communications and marketing.

Practical implications

The "Bright-Spotting" Program has proved to be a valuable component of the follow-up plan for the Well-Being Index Assessment at Corewell Health West. The implementation and execution of the program did not demand excessive time or resources, making it a reasonable effort to scale at other systems. The tactics and best practices that were identified through the focus groups have been used to enhance leadership development programming and shared widely in communications and other meeting venues. Changing the narrative to highlight the "thriving" instead of those in "high distress" has been effective in furthering the conversation of the importance of clinician well-being.

Building bridges and removing barriers to promote the psychosocial health of the care team with a robust internal EAP at a pediatric hospital

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Learning objectives:

1. At the conclusion of the poster presentation, visitors will be able to identify the essential elements of a robust and sustainable internal employee assistance program (EAP) in a hospital setting.
2. At the conclusion of the poster presentation, visitors will understand how high-quality confidential EAP services can be used in fostering a supportive and healthy culture within a health care organization.
3. At the conclusion of the poster presentation, visitors will be able to discuss the merits of an internal EAP program in the promotion of equitable access to mental health support for physicians.

Background

At pediatric health care institutions, providers experience high levels of emotional distress affirmed by PHQ-9 depression and GAD-7 anxiety scores. Mental health support is typically provided by external employee assistance programs (EAP). Unfortunately, most external EAP therapists have limited understanding and training related to the unique challenges associated with the pediatric health care environment. Stigma surrounding utilization of mental health services combined with a support system that is ill equipped to address specific needs contributes to physicians feeling isolated and vulnerable.

Objectives

Consistent with the US Surgeon General's recommendations to increase access to high-quality mental health support tailored to the needs of health care workers, the internal Emotional Support Services (ESS) interventions at Children's Hospital Los Angeles (CHLA) are designed to empower team members to effectively navigate personal and professional challenges and to ultimately promote sustainable well-being. There has been a specific focus on building bridges across the hospital and removing barriers to mental health support.

Approach

The ESS team includes seven onsite licensed therapists. They regularly round on units and provide confidential evidence-based interventions: 1:1 counselling, group debriefs, peer support programs, trainings and workshops. ESS services are available to all CHLA employees and to physicians employed by the medical group. To facilitate connection and an understanding of physician-specific needs, one therapist reports to the Chief Medical Officer and has initiated partnerships with the physician support committee and faculty wellness council. In addition, faculty representatives participate in integrated wellness planning meetings led by ESS and two therapists devote most of their time to medical residents and fellows. The ESS structure allows providers to receive timely support by individuals who have intimate knowledge of CHLA systems and practices.

Lessons learned

The CHLA ESS model has been able to overcome low utilization rates frequently reported by pediatric hospitals relying on outsourced EAP. A robust internal EAP sends a message that CHLA cares and values mental health. Mental and emotional health at CHLA have become "we" rather than "you" issues. ESS does not divulge case details to managers, Human Resources, or any other entity at the hospital, which has helped to ease provider fears related to privacy. Because ESS support is available onsite at no cost, providers are not faced with the burden of finding a therapist with a background in pediatric health care or paying high co-pays or out-of-pocket fees for out-of-network providers.

Practical implications

The ESS program at CHLA demonstrates how a health care organization can centre the well-being of all team members. ESS plays an important role in promoting psychological safety, destigmatizing mental health care, preventing cumulative stress and maintaining a resilient health care workforce. Notably, support provided to medical trainees reinforces a collaborative approach to stress management and healing that they will take with them in the next stage of their career. Keys to long-term program sustainability and success include program visibility, inter-program and inter-departmental collaboration, and advocacy by leaders at all levels of the enterprise. Deployment of a multi-pronged assessment plan to determine ESS' direct impact on individual and unit-based team member well-being outcomes is an integral next step.

Can a peer-led, site/system supported PWB program reduce job stress and burnout at community hospitals? North Denver's experience

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Learning objectives:

1. Can investments in PWB resources improve job stress and burnout at community US hospitals?
2. Do peer-led, site/system supported PWB programs move the needle within US community hospitals?
3. Do investments in physician professionalism processes improve physician engagement and culture within US community hospitals?

Background

One of the positive outcomes in our post COVID-19 pandemic world has been the focus on PWB programs and interventions. However, this newfound culture of wellness has mostly populated within academic institutions. Unfortunately, a parallel movement has not occurred at the same pace or intensity within the community hospital world. The purpose of this article was to explore the effectiveness of a peer-led, site/system supported PWB program at a community hospital.

Objectives

Prospective data were obtained from two Denver hospitals. Both are of similar size and footprint within their medical communities: 100+ bed hospitals with 100+ physicians who regularly practise at the facilities. ND1 invested in a PWB program; ND2 did not. The AMA's mini z survey was used to measure institutional burnout and wellness outcomes. The survey was conducted at both hospitals within similar time periods: September 2021 and October/November 2023. The same population of physicians were surveyed at two-year follow-up. Obviously there was expected turnover, thus physicians surveyed in 2023 were slightly different.

Approach

ND1 hospital had a 23% reduction in job stress and a 9% reduction in burnout between September 2021 and October 2023. In 2021, ND1 doctors were approximately 10% above the national average in burnout rates but then approximately 10% below the national average in 2023, thus had a more than 20% improvement in burnout in comparison to national controls. Job stress and burnout rates at ND2 were down 2% and up 2%, respectively, in comparison between September 2021 and October 2023. Also, engagement went way down; 77% of docs responded to the AMA survey at ND2 hospital in 2021 but only 22% did in 2023. Lack of engagement has been linked to burnout and lack of physician voice as well.

Lessons learned

Investment in a peer-led, site/system supported grassroots PWB program can be highly effective. In addition, it does not require a large financial investment. Specifically, empowering and engaging staff doctors within their daily work experience to understand where the inefficiencies lie and then fixing them seems like a no brainer, worthwhile endeavour. However, most community hospitals do not prioritize such a process. Why? As described by Dr. Shanafelt in the wellness 1.0 era1 of the PWB movement, most EOP interventions promoted by hospital administrators have focused on patient experience/quality or nursing education/efficiencies, but doctors have been left out and forgotten. If a doctor is underperforming, then it must be a personal resiliency issue is the PWB 1.0 era assumption.

Practical implications

When a hospital's PWB mantra solely focuses on physician personal resiliency, it misses the mark. The message to doctors is, it's a "you" problem. When all three aspects of the Stanford model are addressed, doctors feel heard, become more engaged, and by the results of this study, feel less job stress and a higher level of professional fulfillment. Our hope is for community hospitals within the US to see the power and effectiveness of local, grassroots PWB programs and their critical importance to keeping the aging population of US physicians engaged and happy within their workplace. I (or the AMA) can provide the data to support the statements in this abstract.

Connection through comradery

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Learning objectives:

1. Demonstrate the value of virtual comradery groups in creating connection among clinicians in a multispecialty medical group.
2. Measure the value of virtual comradery groups in reducing physician burnout and enhancing meaning in work.
3. Leveraging virtual platforms for comradery groups.

Background

With clinician burnout rates at an all-time high, evidence-based comradery groups are an effective means to decrease burnout and promote meaning in work. In 2022, our medical group's Health and Wellness Committee collaborated to present a monthly virtual comradery group for our primary care clinicians. On the basis of the success, we expanded the opportunity to the broader medical group.

Objectives

In 2023 we launched a virtual comradery group open to multiple specialties. The purpose was to create opportunities for engagement and connection among our medical group colleagues. This spanned multiple disciplines, specialties, clinics and islands. To increase engagement, we created a Teams channel for participants to stay connected between sessions.

Approach

We utilized a virtual platform for monthly comradery groups, facilitated by two physicians and an administrative partner to manage breakout groups and technical support. Sixty-six clinicians enrolled in the comradery group representing a variety of disciplines. We conducted a 45-minute-long program, including a 30-minute breakout session with five or six clinicians/group, and lunch provided through a $30 Uber Eats voucher/person. The program ran over the course of six months from November 2023 to May 2024. January's program was cancelled given the New Year's holiday. A modified Stanford Wellness survey with space for qualitative feedback was administered at enrollment and after the six-month program. We are considering repeating the survey at the 12-month mark pending our six-month survey data results.

Lessons learned

Attendance at each program ranged from 78% to 33% over the course of six months. Our average attendance fell over the course of the program following a break in January because of the New Year's holiday. Common reasons cited for missing a program including conflicting meetings and patient care priorities. This may have contributed to attendance drop-off rates. One may consider using an alternate time period to start and run these connection opportunities. Despite the drop-off in attendance, participants' qualitative comments and Likert scale data suggest that it was still a rewarding experience. Out of 66 enrollment Stanford Wellness surveys, 46 were completed, all of which indicated the participants would want to attend a future comradery group.

Practical implications

Virtual comradery groups are a much-appreciated and value-added approach to building connection and reducing burnout across medical groups. This is especially applicable if your clinicians work in disparate locations across separate islands and if resources are limited.

Creating a culture of well-being and connection using mindful practice in medicine in Canadian postgraduate medical education — a pilot programmatic development project

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Learning objectives:

1. To develop a well-being pan-program academic half-day for first-year postgraduate medical learners at a Canadian university.
2. To evaluate the pre-existing level of well-being and mindfulness experience of first-year postgraduate medical learners at a Canadian university to inform well-being curriculum quality improvement.
3. To evaluate postgraduate medical learners' satisfaction with an in-person and virtual Mindful Practice in Medicine workshop as a part of a well-being curriculum.

Background

The Royal College of Physicians and Surgeons of Canada's report "Creating a Culture of Wellness in Medicine" provides recommendations for wellness in medicine through the CanMEDS Framework (1). Mindful Practice in Medicine (MPIM) is an evidence-based approach from Rochester University consistent with such physician well-being recommendations using techniques like mindfulness and narrative medicine (2). It aligns with accreditation standards for Canadian postgraduate medical education programs (3,4), but there are few data about its use for postgraduate learners.

Objectives

The objectives of this project were to: (1) evaluate the well-being needs of first-year postgraduate (PGY1) medical learners at Memorial University in Newfoundland and Labrador, Canada, (2) pilot a pan-program academic half-day of MPIM for learners in line with accreditation standards, (3) practise mindfulness skills with PGY1 learners in an applied way for medical practice, (4) discuss hidden curriculum in the learning environment with respect to well-being using narratives about controversial topics like self-care, and systems versus individual well-being initiatives, (5) evaluate learners' satisfaction with the half-day for ongoing quality improvement and (6) reflect on the experience of the facilitators through autoethnography.

Approach

A half-day session using the MPIM framework (particularly mindfulness and narrative medicine) was offered to all PGY1 learners at Memorial University in 2024. In-person and virtual sessions occurred separately to accommodate distant training sites and availability. Of 85 eligible PGY1 residents, 35 attended in-person, and 23 attended virtually. An anonymous and voluntary pre-survey assessed learners' level of well-being using the Maslach Burnout Inventory, their prior experience with mindfulness using the Five Facet Mindfulness Questionnaire and their prior experience with narrative medicine. The in-person session had an 86% response rate, while the virtual session had a 56% response rate. An anonymous and voluntary post-survey assessed learners' satisfaction with the session. The response rates were 94% and 43%, respectively.

Lessons learned

Pre-surveys showed similar rates of burnout when compared with Canadian physician norms. There was a high familiarity with mindfulness in the in-person and virtual groups (73% and 92% respectively). Most participants felt mindfulness could benefit their medical practice (92% and 100% respectively). Familiarity with narrative medicine was moderate. Overall, the session was well received and felt to increase knowledge in mindfulness and narrative medicine. Post-survey satisfaction varied based on format — 82% of in-person participants found the session useful and only 50% virtually. This correlated with the autoethnography of the facilitators, who struggled with low learner engagement virtually, but found learners were particularly engaged during the in-person narrative medicine discussions around well-being hidden curriculum.

Practical implications

With respect to well-being curriculum, PGY1s at Memorial University have a high level of familiarity with mindfulness, and believe it is a useful skill for their medical practice. Narrative medicine was helpful for discussing hidden curriculum with respect to learner well-being for enhanced transparency and engagement. Virtual platform offerings for well-being may affect engagement and satisfaction in postgraduate learners, supporting the idea that well-being improves through human connection. This has implications for distributed learning sites.

References

1. Creating a culture of wellness in medicine: Recommendations from the Royal College Physician Wellness Task Force. Available : https://www.royalcollege.ca/ca/en/canmeds/physician-wellness.html
2. Mindful practice in medicine. 2022. Available: https://mindfulpracticeinmedicine.com/about/
3. Canadian Excellence in Residency Accreditation Standards. Available: https://www.canrac.ca/canrac/general-standards-e
4. The College of Family Physicians of Canada. Physician Wellness+ Initiative. Available: https://www.cfpc.ca/en/education-professional-development/practice-tools-guidelines/physician-wellness-initiative

Development and dissemination of a peer support program for physician trainees

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Learning objectives:

1. At the end of the presentation, participants will be able to describe the rationale and need for peer support in trainee physicians.
2. At the end of the presentation, participants will be able to understand the scope of developing a peer support program for physician trainees including the importance of formal training in peer support techniques and stress first aid.
3. At the end of the presentation, participants will be able to plan for development of a peer support program for physician trainees.

Background

Stress first aid (SFA) and peer support are recognized interventions to aid in the emotional recovery of health care workers following adverse patient events. Formal peer support programs are an accepted form of unbiased, non-judgmental avenues to deliver this form of support. However, literature to date has focused on attending physicians or the training of trainee leaders rather than dissemination to the entire population of trainees.

Objectives

Here we describe the development of a peer-based stress first aid program for trainees across a large single-center academic institution, including both resident and fellow groups.

Approach

Our institution launched a formal peer support program supporting attending physicians after adverse events in 2019. More recently, a stress first aid (SFA) training program was developed and implemented for graduate medical education leadership to create a framework of support for trainees within their programs. Leadership was surveyed and showed a high need for and acceptance of a trainee peer support program. Nominations for trainee peer supporters were sought via meetings with chief residents, program directors, existing peer support physicians and resident email listservs. Over an eight-week period, 40 nominations were received and eligibility was confirmed with relevant program directors.

Lessons learned

Nominations represented a diversity of PGY level and program background (PGY1 = 4, PGY2 = 15, PGY3 = 4, PGY4 = 11, PGY5 = 2, PGY6 = 2, unknown = 2; programs represented = 17). To date, 22 trainees (55%) have confirmed interest and 9 (22.5%) have completed formal peer supporter training. Implementation of annual peer supporter training will be undertaken each summer to ensure adequate numbers of peer supporters after recently graduated supporters move on from training. Ongoing monitoring of post-training survey data, number of referrals to the program and utilization of the peer support program will be performed on a regular basis. Administrative support and feedback at GME forums have been crucial to this process.

Practical implications

Creating a safe learning environment and incorporating programming for trainee well-being are required by the ACGME Common Program requirements in graduate medical education. Peer support programs are feasible and scalable for the trainee environment and can aid in creating a culture of safety and wellness in training programs.

Effectiveness of interventions to improve physician wellness: a systematic review

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Learning objectives:

1. At the conclusion of this activity, participants will be able to identify obstacles to physician wellness and factors leading to burnout.
2. At the conclusion of this activity, participants will have identified effective interventions or programs improving physician wellness.
3. At the conclusion of this activity, participants will understand limitations regarding studies on physician wellness.

Purpose/relevance

An increase in burnout invokes a subsequent decrease in wellness. Mounting evidence suggests that physicians are experiencing increased burnout, presenting a significant concern for the health of physicians and their ability to provide competent care. As a result, multiple agencies have invested in physician wellness programs. However, it remains unclear which interventions are effective and in whom. We conducted a systematic review to identify effective interventions proven to improve physician health and wellness.

Materials and methods

This is a PRISMA-P 2015-compliant systematic review that searched PubMed, Scopus and Medline from May 2006 to July 2023. Searches included MeSH terms as well as keywords including "Physician Wellness Program," "Burnout" and "Mental Health" combined with "AND" and "OR" for more focused searches. Articles published in English that both qualitatively and quantitively measured outcomes of wellness interventions for practising physicians were included.

Results

This review included 36 studies involving 6,708 total participants published from May 2006 to July 2023. Study designs included randomized controlled trials (7), quasi-experimental studies (1) and cross-sectional studies (28). Interventions were diverse and included group therapy, stress reduction strategies, time off/workload reductions, education and peer support. All outcomes were self-reported and outcome evaluation varied greatly, such as 5-point Likert scale surveys in qualitative studies and standardized, validated measures such as the Maslach Burnout Inventory and the Connor Davidson Resiliency Scale in quantitative studies. The efficacy of wellness programs also varied, ranging from no significant difference in physicians' wellness following implementation to significant improvements ($p < 0.05$) in multiple metrics. There are no consistent wellness program interventions that demonstrated effectiveness. Few studies ($n = 3$) demonstrated improvements by physician sex, where interventions were generally more effective for females compared to males. Even fewer studies ($n = 2$) reported differences by age, career stage or medical specialty.

Conclusions

Studies examining physician wellness interventions are highly diverse and indicate no consistent intervention demonstrating improvement. There is considerable heterogeneity in study designs and measurement methods, limiting definitive conclusions about their general effectiveness. Larger multicentre studies with standardized interventions and outcome assessment with the inclusion of specific subpopulations are required for identifying effective strategies for improving physician wellness.

Enhance resident physician well-being: how and why to implement opt-out wellness check-Ins

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Learning objectives:

1. At the conclusion of this activity, participants will be able to recognize the importance of early intervention and connecting resident physicians to mental health care through opt-out wellness check-ins.
2. At the conclusion of this activity, participants will be able to examine how an opt-out wellness program increases help-seeking behaviour for resident physicians.
3. At the conclusion of this activity, participants will be able to formulate strategies to implement an opt-out wellness program at their institution.

Background

The stress of the transition to residency can lead to new or worsening depression, anxiety and burnout among house staff. Providing low-barrier access to mental health services and emphasizing preventive mental health care can improve the mental well-being of residents. Universal well-being assessments, or opt-out well-being assessments, have been used at some institutions to target resident physicians and medical students, to increase help-seeking and provide low-barrier access to mental health care and other supports.

Objectives

A primary goal with proactive wellness check-ins is to identify, support and monitor residents who may be struggling with their mental health and remind them of available mental health services. A secondary goal is to encourage residents to reflect on their individual signs of burnout and develop an action plan to enhance well-being throughout residency. Feedback solicited through surveys is meant to help the program grow and serve residents in the most meaningful way possible.

Approach

Residents were scheduled for a virtual, 30-minute wellness check-in during time off in the workday or evening. They had the choice to opt out or attend. Before the check-in, they were asked to complete a consent form and PHQ-9. The counselling team developed the visit format and conducted the visits. During the visit, residents were asked to reflect on signs of burnout, coping skills and when to seek out professional help. They were encouraged to ask questions about accessing care and any perceived barriers to getting help. During the check-in, intake appointments were scheduled for in-house, long-term psychotherapy and/or medication management. Afterward, all residents received a voluntary survey and details on accessing available in-house and outside wellness resources.

Lessons learned

AY2021–2022 included residents from internal medicine and neurology, of whom 61% (46/76) opted in. Of those, 24% (11/46) scheduled an intake. Eight residents responded to the survey. Five strongly agreed and two agreed that the check-in was helpful. Seven said they would recommend it to peers. AY2022–2023 included residents from psychiatry, internal medicine, neurology, general surgery, emergency medicine, family medicine and pediatrics, of whom 32% (118/369) opted in. Of those, 34% (40/118) scheduled an intake. Show rate and intake conversion rates were tracked individually for each group. Forty-three residents responded to the survey. Twenty-six strongly agreed and nine agreed that the check-in was helpful. Thirty-eight said they would recommend it to peers. Comments encouraged expanding the program as it lowered barriers to accessing care.

Practical implications

After the first year of the free pilot, the internal medicine, neurology and pediatrics departments elected to fund the program for their residents. In the second year of the pilot, new departments were included at no charge. Feedback from residents and programs was positive. Anecdotally, residents appreciated the opportunity to check in about their wellness in an appointment that was free and scheduled for them. Many residents chose to engage in mental health treatment and scheduled intake appointments with the in-house counselling centre. The authors plan to continue to expand the proactive wellness check-in program to all residency programs. The authors anticipate other institutions will see the feasibility and importance of enhancing resident well-being through connection to mental health care.

Freedom from medical education debt improves job-crafting and well-being

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Learning objectives:

1. Understand how educational debt affects physicians' personal and professional well-being.
2. Understand how educational debt affects physicians' freedom to allocate time toward meaningful pursuits.
3. Understand how educational debt disproportionally affects physicians from traditionally under-represented groups in medicine.

Purpose/relevance

American medical students graduate with an average of nearly a quarter million dollars in educational debt. However, little is known about how medical education debt burden is distributed across demographic groups and over time, whether educational debt affects physicians' ability to job-craft (e.g., make decisions about how one's time is spent) and whether medical education debt is associated with well-being measures (e.g., perceptions of work–life balance, professional life being as expected, job satisfaction, professional fulfillment, burnout and commitment to work). This is the aim of this study.

Materials and methods

The 2020 work–life well-being survey included academic, employed and private-practice medical staff across five hospital-based delivery networks. Using aggregated deidentified data of physicians and physicians-in-training, we conducted secondary analysis of "Are you currently paying off student loans for your education?" (yes/no). After standard descriptive statistics, chi-squared tests and unadjusted logistic regressions were used to determine associations between categorical variables with dichotomous outcomes (presence or absence of debt by demographic group and associations with dichotomous well-being outcomes).

Results

Of 1,898 respondents (33% response rate), 79% were attending physicians (21% residents/fellows), including specialties in academic (60.5%), employment (22.8%), private (11.2%) and other (5.6%) practice models. Most worked full-time (91.2%), at least 81% time clinically (54.1%); 16.4% identified as primary care physicians. The sample was 73% white, 53% male, average age of 43 years. Overall, 32.8% of physicians reported servicing educational debt. The lowest proportion of debtors were attendings compared to residents/fellows (26.7% v. 58.6%, $p < 0.001$), private practice compared to academia, employed or other models (21% v. 35.0%, 32%, 42.3%, respectively, $p = 0.004$), part-time compared to full-time (10.9% v. 35.3%, $p < 0.001$), Asian compared to white or black race (26.8% v. 33.7% and 52.2%, respectively, $p = 0.007$), males compared to females (30.1% v. 37.3%, $p = 0.012$) and the odds of debt 63% lower for each decade older. Compared to physicians in general internal medicine, procedural and cognitive specialists in internal medicine had significantly lower odds of servicing educational debt. Associations between primary care and debt were not significant ($p = 0.31$). Freedom from educational debt was positively associated with professional fulfillment (OR = 1.49, CI: 1.17–1.91), job satisfaction (OR = 1.33, CI: 1.02–1.73), work–life balance (OR = 1.36 CI: 1.07–1.72) and absence of burnout (OR = 1.54 CI: 1.21–-1.95). Associations between debt and retention did not reach statistical significance ($p = 0.09$).

Conclusions

Educational debt is prevalent and persistent for decades into physicians' careers. Asian, male, private-practice and specialist physicians were less likely to be paying educational debt. Those who were black, female, young, non-specialists and working full-time were more likely to be paying educational debt. Debt may necessitate more full-time clinical work and less work–life balance, limiting opportunities to allocate time toward other meaningful pursuits that expedite upward mobility and well-being. Freedom from educational debt is associated with multiple aspects of physician well-being. Further investigation is needed to ensure financial security and well-being across a diverse physician workforce.

Identification of resources and support services for physicians after witnessing trauma

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Learning objectives:

1. Participants will identify a stepwise approach to resources in response to PsySTART scores.
2. Participants will identify specific resources for individuals' support after witnessing trauma.
3. Participants will recognize future studies to determine what resources should be recommended after witnessing specific traumas.

Purpose/relevance

Our study aims to identify a stepwise list of available resources to recommend for physicians after witnessing traumatic events. The Psychological Simple Triage and Rapid Treatment (PsySTART) mental health triage system tracks exposure to traumatic events and can alert individuals when they are at higher risk for developing clinical pathologies. Indeed, previous research has shown valid prediction of clinical pathologies (e.g., PTSD, depression). One of the merits of PsySTART is its focus on objective events and not an individual's pathological symptoms, which may carry a negative stigma. Little research has assessed how to connect employees to resources based on PsySTART responses. To avoid the negative stigma around mental health symptoms, we built a framework of stepwise resources that are available to physicians who witness trauma.

Materials and methods

Previous literature was used to identify resources for individuals with mental health disorders linked to experiencing or witnessing trauma. We identified available resources at the national, community, organizational and personal action levels. We categorized these resources into five broad groups: personal resilience intervention, further assessment, education/training, group support services and trained professional support services. This created a guide of stepwise resources with the capability of supporting physicians who witness objective events linked to mental health pathologies according to PsySTART.

Results

Our results show a progressive stepwise list of resources that physicians could access after witnessing traumas. Each step includes resources at multiple levels (e.g., national, local, personal action). The first step on the resource list is personal resilience interventions. Personal resilience interventions include psychological first aid, skills for psychological recovery, yoga/mindfulness programs, structured meditation, journaling programs and exercise programs. The second step is seeking further assessment of the physician's mental health. These include Internet secondary screenings, Healthy KC and the Center for Wellbeing at Children's Mercy Hospital. The third step is education/training, which includes care provider support programs, The Schwartz Center, and Kansas City Public Library mental health resources. The fourth step is group support services. These include health support teams, retreats, Balint groups and National Alliance on Mental Illness Greater Kansas City. The highest intervention is seeking help from trained professionals. These services include crisis text lines, acute connection therapy/crisis support, mental health therapy (e.g., trauma-based CBT, EMDR, etc.) and acute inpatient therapy. Not every PsySTART score should start at the first level, but this stepwise approach provides physicians with actionable steps in response to their PsySTART score.

Conclusions

PsySTART is an effective tool for identifying at-risk individuals who have been exposed to or witnessed trauma in the workplace. However, more work is needed to connect employees with the best resources on the basis of their PsySTART responses. Our taxonomy is a first step toward a more prescriptive response to PsySTART. With the development of this stratification of resources and support services, in a future study we will conduct a cross-sectional survey with physicians and ask them to rate resources or services on the basis of helpfulness after experiencing each trauma within PsySTART.

Implementation of a nursing pool intervention to enhance well-being among pediatric primary care clinicians

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Learning objectives:

1. Explain a novel nursing pool intervention ("the Remote Care Team") to decrease burnout among pediatric primary care clinicians through reductions in clinician-directed electronic patient messages.
2. Demonstrate the importance of the Remote Care Team in supporting pediatric clinicians and their patients.
3. Identify future expansions of the Remote Care Team intervention into other domains of pediatric primary care.

Background

Children's Primary Care Medical Group (CPCMG) is a 164-clinician, physician-owned pediatric practice serving 272,000 patients at 28 sites throughout San Diego and Riverside counties. From 2019 to 2023, the prevalence of clinician burnout increased from 29% to 45%, respectively. We identified an increased volume of clinician-directed InBasket patient messages contributing to burnout, highlighting an opportunity to enhance wellness by reducing the number of electronic messages initially directed to clinicians.

Objectives

1. Create a structure in which remote care nurses may triage My Chart Patient Advice Requests in the InBasket.
2. Decrease "Work outside of Work" and "Time on Inbox" for clinicians.
3. Enhance clinician wellness by decreasing message volume going directly to the clinician.
4. Establish a mechanism by which clinicians may refer complex patients to care coordination, providing support for integration of medical services.

Approach

The Population Health Team at CPCMG initiated a pilot project in which Patient Advice Requests were directed to a "pool" of registered nurses working remotely ("the Remote Care Team"). Care Team nurses responded to the patient directly by triaging symptoms, reinforcing treatment plans and answering medication questions. Nurses then forwarded these messages to the clinician, as appropriate, directed them to administrative or education pools (i.e., appointment management or immunization information) or directly scheduled an appointment using a link for self-scheduling. This pilot included a "refer-in" option in which the clinician could refer complex patients for additional care coordination. During the first year of implementation, the intervention expanded to include 25 offices at CPCMG.

Lessons learned

The percentage of Patient Medical Advice Request messages going directly to the clinician changed from an average of 75% at pilot implementation (January 2023) to 11.1% (January 2024). Efficacy was measured by looking at EPIC Signal data using Time on EHR outside of scheduled patient hours (WOW8) and Time in InBox (IB-Time8) per eight hours of patient scheduled time. From January 2023 (four offices live) the WOW8 and IB-Time8 were 98 and 48 minutes/day/clinician, respectively. As of January 2024 (25 offices live), one year after implementation, the measures were 98.4 and 44 minutes/day/clinician, respectively. During this time referrals for care coordination increased from 50 to 70 patients.

Practical implications

Within one year, our novel Remote Care Team model substantially reduced InBox time and the volume of Patient Advice Requests directed to clinicians, and increased the number of patients referred for care coordination. Future efforts will focus on expansion of the Remote Care Team to other patient care domains — including medication refills, standing orders and mental health — as well as optimization of nurse education, and EMR generated protocol development. As well, efforts to increase referrals for care coordination of highly complex patients will enhance integration of services for additional patients. Future efficacy metrics will include tracking "Work outside of Work" perceptions and burnout through survey deployment.

Implementing an inpatient pathway to manage disruptive behaviours and mitigate workplace violence

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Learning objectives:

1. Identify key elements to a successful interdisciplinary huddle.
2. Outline how to proactively implement an interdisciplinary huddle to mitigate workplace violence.
3. Evaluate the impact of an interdisciplinary huddle in mitigating workplace violence.

Background

Seventy-three percent of all nonfatal injuries and illnesses faced by US health care workers were due to workplace violence, steadily increasing since 2011. Interprofessional collaboration before or around the time of behavioural escalation has the potential to create a more trauma-informed approach to patient engagement that focuses on prevention. This may, in turn, reduce resource-intensive reactionary resources such as security teams and improve physician and nursing morale.

Objectives

Our objective was to mitigate violence and burnout on inpatient medical units by proactively managing escalating patient behaviours by 1) early identification of patients at risk for escalation using tools embedded in the electronic health record (EHR), 2) completing an interdisciplinary huddle to discuss triggers and management of disruptive behaviours to optimize patient care and workforce safety and 3) early disposition planning.

Approach

This pilot initiative occurred on acute care inpatient units in a 690-bed tertiary academic hospital in Aurora, Colorado. Providers, nurses, behavioural health (BH), clinical quality specialists created a "Managing Disruptive Behaviors Pathway" centred on "Stay Safe Huddles." These are in-person, trauma-informed, interdisciplinary huddles activated by a charting alert, Broset Violence Checklist assessments, or any manifestation of concerning patient or visitor behaviours. A charge nurse sends a secure message to the primary provider, bedside nurse, BH clinical nurse specialist (CNS) and care management personnel to conduct a huddle. The CNS facilitates the interdisciplinary huddle, outlining the patient's underlying etiology of disruptive behaviours with collaborative creation of mitigating interventions to address these behaviours. This is communicated to patients and documented in the chart.

Lessons learned

A total of 47 "Stay Safe Huddles" (huddles) were conducted from 11/1/2023 to 3/31/24; 27 of these were for patients with escalating verbal and physically aggressive behaviours. Nursing, BH and providers were present at all huddles, with intermittent involvement from psychiatry. Security alerts decreased from 58 to 13 pre- and post-implementation of huddles. A total of 44 surveys were received from huddle participants: 91% would recommend huddles for patients with disruptive behaviours. Huddles resulted in a variety of care plan changes: increasing patient autonomy, adjusting interactions in settings of dementia, medication adjustments for addiction, pain and mental health, and patient and family participation in defining goals for hospitalization. Huddles were considered efficient, with 30% reporting huddles taking less than 15 minutes and 52% between 15 to 30 minutes.

Practical implications

Proactive interprofessional collaboration, at the time patient disruptive behaviours are recognized and escalating, has the potential to decrease continuation of disruptive behaviours and workplace violence events while creating a more trauma-informed approach. The collaborative huddles successfully decreased professional silos, decreased the need for security intervention, and emphasized patient engagement to address behaviours. Overnight and weekend resources were a limitation for the pilot initiative, and considering workplace violence occurs 24/7, needed to be addressed. The creation of a secondary process for after-hours and weekends was developed and supported by the interdisciplinary team during the weekdays. While the program took place in the inpatient setting, this model can be quickly deployed for ambulatory settings as well.

Lead well, thrive together: a wellness-centred leadership curriculum

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Learning objectives:

1. Implement a Wellbeing 2.0 leadership training course to cultivate wellness at work.
2. Recognize the wellness-centred leadership model as a framework to drive forward team wellness.
3. Identify the central role of leaders to foster professional fulfillment.

Background

Clinician well-being is critical to achieve the organization's mission and vision and deliver best patient care outcomes. It is critical to intentionally advance strategies that restore joy and meaning in medicine. The time for action is now for shared accountability of caring for our clinicians while delivering the best quality outcomes for our patients. Research connects the value of our well-being on our work, and as health care leaders, that means on our team and patients.

Objectives

Leaders can use their influence to embed well-being into organizational and operational decisions to support a healthy workforce. Leaders may also drive peer and team discussions to prioritize wellness-centred leadership and drive professional fulfillment. Modelling the Well-being 2.0 roadmap, our Clinician Well-being Council set as a goal to train leaders on the mindset and behaviours that positively influence team wellness. The program aligned with the strategic objective to thrive as a supportive community.

Approach

In June 2023 our Clinician Well-being Council launched an ongoing leadership development campaign to effectively drive forward our values of teamwork. Our three pillars of focus included meaningful work as a community with leadership embedding a culture of wellness into every decision made, eliminating systemic barriers to drive practice efficiency and to encourage self-care for effective work–life integration. Initiatives of the Well-being 2.0 Leadership Training were: June 2023: Wellness Centred Leadership (synchronous) four-hour forum with Dr. Tait Shanafelt (world expert in physician wellness), quarterly Well-being Council meetings: topics included self-care and resources, optimizing the EHR use, Lorna Breen Foundation and mental health advocacy February 2024: Well-being 2.0 CME Course (asynchronous myLearning platform) with synchronous Wellness Leader Facilitated Skills sessions.

Lessons learned

The curriculum was successfully designed to integrate a storyboard with the latest science and research in the field and offered factual data with a cutting-edge framework that empowered leaders. The Well-being 2.0 Leaders Model the Way enrolled 71 participant leaders with 43 completions of the entire course (live session and online); 36 provided feedback and gave an "excellent" review with a Net Promoter Score at 61%. Leader-facilitated discussions were engaging and created opportunity to foster camaraderie with their peers. Testimonials described it as: "critical topic," "engaging" and as an "opportunity to connect and share stories." The workshops and training offered a variety of options for leaders to engage with the curriculum (live workshop, leader-led sessions, online learning platform).

Practical implications

Training leaders to prioritize and support team well-being is essential for enhancing the effectiveness and success of fostering a culture of collaborative and connected teams. By equipping health care leaders with the skills and mindset to promote team wellness, the mission is strengthened and teams are empowered to achieve their collective goals. Leaders may serve as ambassadors, model best practices and be the change catalyst for team-driven well-being. Connecting with their peers is supportive of camaraderie that positively impacts the shared accountability for meaningful interpersonal connections at work.

Leveraging motivational theory in the design and implementation of a sustainable physician well-being program

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Learning objectives:

1. At the conclusion of this presentation, participants will possess the capability of identifying and leveraging c-suite stakeholder interests (CEO, COO, CFO, CMO) to build a multi-motivational case that garners the budgetary and operational infrastructure needed to deliver on key explicit and implicit programmatic aims.
2. At the conclusion of this presentation, participants will possess knowledge of three core principles of motivational theory and the ability to extrapolate such concepts in the curation of a cross-functional physician well-being team that delivers cross-cutting outcomes (e.g., the business case, moral case, tragic case, regulatory case).
3. At the conclusion of this presentation, participants will enhance efficacy in executing strategic aims by identifying opportunities to create programmatic interdependencies via improved understanding of stakeholder interests, priorities and expectations within a fluid and everchanging health care environment.

Background

In 2019, Shanafelt et al. articulated four motivational themes underlying the development of physician well-being programs: moral-ethical, business, tragic and regulatory cases, respectively. Articulated before COVID-19, the pandemic accelerated the promotion of such programs nationally in relation to all four motives. Accordingly, in 2023, the American Medical Association recognized 72 health systems nationally for work adhering to tenants of the Joy in Medicine Health System Recognition Program — a 64% increase compared to 2021.

Objectives

While health systems evaluate infrastructure to support physician well-being, many programs lack the institutional investment required to ensure that the intended aims are realistic — leaving some susceptible to financial headwinds, shifting organizational priorities, and sustained support from leadership. Recognizing these vulnerabilities, one system designed a novel physician well-being program organized around a "multi-motivational case" and aligned with the Stanford WellMD Model of Professional Fulfillment, AMA Joy in Medicine domains and the health system's strategic pillars.

Approach

From 2021 to 2023, a health system in the southeastern United States garnered annual budgetary resources to support clinician well-being at >$2.5M annually. Resources were allocated for innovative technologies, design/deployment of clinician well-being care pathways and several dedicated positions: director of operations, program manager, analyst, statistician, lean consultant, psychologist and well-being informaticist(s). Whereas initial support for resources was tethered to the organization's moral obligation and "tragic" case associated with COVID-19, programmatic design was conceptualized with motivational fluidity and an upstream focus on post-pandemic opportunities. An Office of Clinician Well-being was established as a consulting entity. Budgetary asks were crosswalked with the system's strategic themes and mapped to the Stanford WellMD and Joy in Medicine frameworks, creating broad appeal and mitigating future sustainability risks.

Lessons learned

Whereas continued support for physician well-being programs persists with respect to various cases, some of the motivations enlisted to support these efforts could contribute to future deprioritization. Given that decisions to invest/scale/sustain vary across institutions, well-being leaders must understand the underlying motivations to support programs now and maintain awareness of how systemic changes, leadership attrition and other factors might erode future support. Ultimately, the authors suggest that programmatic support and sustainability require the following: (1) a multi-lingual understanding to appreciate driving motivations and their fluidity, (2) a multi-motivational and resilient strategy that can weather systemic changes and (3) a multi-dependency delivery model that augments the effectiveness of complementary system initiatives, and inasmuch creates a risk of deprioritizing physician well-being programs.

Practical implications

Physician well-being is essential to the sustainability of the health care system. Problematically, many well-being leaders lack exposure to psychological constructs and motivational theories that can enlist support for well-being programs and position them for success. One health system leveraged well-established psychological concepts and created a novel and cross-functional team that simultaneously leverages the moral-ethical, business, tragic and regulatory cases outlined by Shanafelt et al. (2019). Since inception, findings within this system suggest statistically significant reductions in physician distress from 2021-2021 ($p < 0.001$) and overall burnout prevalence that is significantly below the national prevalence rate ($p < 0.001$). These outcomes build a case that a strategy emanating from psychological science is pragmatic and can drive meaningful outcomes that support sustainability.

Mental health services for physician trainees: results of a national survey

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Learning objectives:

1. Describe institutional approaches to support mental health and well-being of physicians in training.
2. Consider best practices for providing mental health services to physicians in training.
3. Identify opportunities for next steps at participants' home institutions to best support the mental health and well-being needs of their trainees.

Background

The high rates of burnout, depression and suicide among trainees are well documented. ACGME requires that programs/institutions "provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care..." Data collected through this study provide benchmarks on how this requirement is currently being met nationally. Elucidating trends in mental health service provision may inform best practices for meeting ACGME requirements and adequately serving the needs of physicians in training.

Objectives

Identify current practices for the provision of mental health and well-being services to trainee physicians. Information was gathered on the following variables: models of leadership and staffing, services offered, utilization rates, fees for services, assessments and perceived satisfaction. The findings can help inform the national conversation on best practices for supporting the mental health and well-being of trainee physicians.

Approach

A survey was developed in collaboration with well-being leaders from four participating institutions. Individual emails with the survey request were sent to DIOs from 817 institutions nationally between 11/1/2023 and 1/8/2024, including three email reminders. Recipients were asked to forward the survey if needed to individuals with best access to counseling services information. A total of 273/815 (33.5%) institutions fully completed the survey, and 342 (42%) responded partially. The survey included questions about approach to counselling (internal v. external), services offered, reporting structure, hours of availability, fees for services, documentation, number and qualifications of counsellors, utilization rates and satisfaction with services.

Lessons learned

Most programs have an employee assistance program (EAP) and many also offer internal counselling services, community or telemedicine counsellors. Eleven percent have no EAP, 43.5% of those offer internal counselling services and 10% offer no specific resource. Among 199 programs with internal counselling services and/or internal EAP with dedicated GME counsellors, 88.7% offer brief screening and referral, and/or individual counselling (95.7%), 32.2% offer couples counselling and 34.8% process groups; 25.6% of programs have a session limit, 53.2% offer free services, 66.2% refer to their onsite ED for emergencies, 61% offer after-hours appointments and 16% offer GME-dedicated psychiatric services. Only 15.3% of respondents with internal counselling had access to utilization data. Only 17.5% were highly satisfied with their mental health offerings.

Practical implications

This is the first study examining how counselling services are offered to physician trainees and may help institutions identify potential models for providing services to trainees. Data suggest there is wide variability across institutions, which may allow institutions to tailor services to fit their needs. Data on utilization and satisfaction are lacking in most programs and would inform necessary program enhancements. Systematic collection and sharing of data may facilitate collective learning and inform: adequate ratio of counselling staff to population served, whether internal services offer greater flexibility and range of services, effective reporting structures, access to psychiatry and/or emergency services, flexibility in scheduling sessions, utility of assessments, and need for a confidential electronic medical record.

Optimizing the potential of artificial intelligence to reduce administrative burden for physicians in Canada: innovations by national and provincial medical associations

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Learning objectives:

1. Identify three ways in which artificial intelligence can mitigate administrative burden for physicians.
2. Recall strategies for ensuring the safe and effective implementation of AI technologies in health care settings, including frameworks and ethical guidance.
3. Summarize the critical role of collaboration at the national and provincial levels in fostering a cohesive approach to AI integration, promoting knowledge sharing and best practices.

Background

The integration of artificial intelligence (AI) into Canada's health care system signals transformative potential, offering solutions to alleviate physician administrative burden and enhance patient care. However, ensuring patient and physician safety amidst this disruptive innovation is critical. Striking balance between optimizing the potential of AI while ensuring it is safe necessitates collaboration at the national and provincial levels. This abstract explores the promise of AI in health care to mitigate administrative burden through innovations from the Canadian Medical Association and OntarioMD.

Objectives

The objective of the following presentation is to illustrate the pivotal role of collaborative efforts between national and provincial medical associations in optimizing the potential of AI to mitigate administrative burden on physicians and enhance patient health outcomes within the Canadian health care context. The presentation will identify key challenges and opportunities associated with the integration of AI in health care, emphasizing the importance of safety measures for both patients and physicians through the lens of national policy and advocacy by the Canadian Medical Association and through a clinical case study by OntarioMD.

Approach

This presentation discusses two environmental scans and their implementation at the provincial and national levels by medical associations to optimize AI's potential in reducing administrative burden for Canadian physicians. The Canadian Medical Association conducted a two-phase environmental scan to understand AI's role in health care, revealing a leadership gap in shaping AI policy at the national level, and explores their work on national AI policy and advocacy. OntarioMD's environmental scan focused on aligning community technological challenges with digital solutions, with a strong emphasis on AI technology. Amidst primary care crises, AI scribes emerged as a promising option to ease burdensome documentation by physicians, with a mini-pilot conducted by the OMA to assess effectiveness and potential impact.

Lessons learned

Lessons learned from this exploration underscore the indispensability of collaborative partnerships between national and provincial medical associations in navigating the integration of AI within Canadian health care. The importance of establishing robust frameworks, encompassing both policy development and clinical application, becomes evident in mitigating challenges and maximizing the benefits of AI technology. Emphasis on safety measures highlights the imperative of prioritizing patient and physician well-being throughout AI implementation processes. Moreover, the multifaceted nature of AI's impact, spanning administrative streamlining to enhanced patient care, necessitates a holistic approach to its integration. These insights illuminate the significance of fostering collaborative endeavours that transcend organizational boundaries, facilitating a unified and informed approach toward optimizing AI's potential to revolutionize health care delivery in Canada.

Practical implications

Efforts among national and provincial medical associations are essential for implementing AI solutions in Canadian health care. Stakeholders must prioritize developing comprehensive frameworks addressing policy formulation and clinical application to ensure safe integration. Emphasizing safety measures and aligning objectives can optimize AI's potential, alleviating administrative burden on physicians and improving patient outcomes. Ongoing dialogue, knowledge sharing and coordinated action are necessary for a cohesive approach. Attendees will gain insight into AI's benefits through policy and clinical examples, alongside an examination of associated risks and challenges. This session aims to provide a nuanced understanding while fostering discussion on realizing AI's transformative promise in Canadian health care.

Perceived social support declines after entering medical school: a study utilizing 10 years of national-level AAMC data

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Learning objectives:

1. At the conclusion of this poster presentation, participants will be able to identify the various national-level questionnaires used to collect data from medical students in the United States.
2. At the conclusion of this poster presentation, participants will be able to interpret various trends relating to quality of life among medical students.
3. At the conclusion of this poster presentation, participants will be able to generate ideas for an intervention that improves social support for medical students.

Purpose/relevance

The aim of this project is to utilize AAMC data from two different stages of medical education (matriculation, second year) to evaluate for any difference in perceived level of social support. We hypothesize that perceived levels of social support will rise in medical school — compared to the summer before beginning medical school — as students will gain access to a community of fellow students embarking on a similar path of education and training. We also suspect that perceived levels of social support in both cohorts (matriculating students and second-year students) will decrease during the COVID-19 pandemic. The ultimate goal of this study is to identify the trend of perceived social support among medical students, which will be helpful in designing interventions that promote student well-being.

Materials and methods

The design of this study involves the analysis and interpretation of selected AAMC data from the following questionnaires: 1) the Matriculating Student Questionnaire and 2) the Year Two Questionnaire. Respondent rates vary for each of these surveys and also vary by the year (2014–2023), ranging from 8,000 to 16,000 participants. We conducted a standard comparison of means analysis, whereby we compared social support scores across time and group using t-tests (MedCalc Software 2024).

Results

We obtained data from the Matriculating Student Questionnaire and the Year Two Questionnaire, spanning from 2014 to present day. The perceived social support scale is embedded within the quality of life section, which also asks students to report scores for their overall quality of life, fatigue and financial concern. Our analysis demonstrates the following findings. (1) Between 2014 and 2023, social support scores are significantly lower among second-year medical students compared to students who are beginning medical school ($P < 0.0001$). (2) Overall, social support scores in both groups (matriculating students and second-year students) have remained relatively constant over the time period of 10 years, while other scores (fatigue, overall quality of life) have decreased significantly during that same time period. (3) During the time surrounding the peak of the COVID-19 pandemic (2019 through 2021), perceived social support scores remained unchanged among matriculating medical students; however, perceived social support scores among second-year medical students decreased significantly ($P < 0.0001$).

Conclusions

Our findings suggest that perceived levels of social support decrease significantly after beginning medical school, on the basis of 10 years of data from matriculating and second-year students. The findings refute our initial hypothesis, as we anticipated that medical students would report higher levels of social support in second year as they acclimate to the school community. Further, our findings support the notion that second-year students were more affected by the isolation of the COVID-19 pandemic than matriculating students. These findings indicate the necessity for medical schools to increase social support for their students, perhaps by implementing peer support initiatives.

Performance coaching for struggling physicians

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Learning objectives:

1. Recognize the importance of targeted coaching intervention as a pathway to help a struggling physician improve.
2. Apply the framework outlined to your organization to create a program for identifying, screening and determining the appropriate support for struggling physicians.
3. Appreciate the importance of including your local Physician Health Services (PHS) in your coaching support program.

Background

Physicians who are struggling with job performance (e.g., interpersonal communication, executive functioning skills) are traditionally placed on a performance improvement plan by their supervisor and Human Resources (HR). Though such measures can be helpful to solve simple performance issues, they fail to screen for underlying issues that might be contributing to the struggling physician's performance. Working with PHS to screen physicians and offer targeted coaching interventions is a more effective form of remediation.

Objectives

The objective is to create a robust performance improvement framework to support struggling physicians. This framework includes touchpoints from key leaders in the physician's department, HR and PHS, as well as check-ins after the physician has been triaged to a coach to ensure that the coaching intervention is successful. The inclusion of PHS ensured that the physician had an outside, neutral assessment and utilize the resources that PHS provides to all physicians in the state.

Approach

Physicians enter the program through an intake assessment tool that is completed by the physician's leader. This assessment asks the leader about the physician's issues and the interventions already deployed to try to address the issue. This tool is reviewed by senior leadership and HR, and if approved, the physician would be referred to PHS for an assessment. On the basis of PHS's recommendations, the physician is referred into a targeted coaching intervention to address the issues identified in the assessment. An agreement would be drafted and signed by the physician, his/her leader and HR, where the physician commits to completing the recommended coaching. The coach periodically checks in with the physician's leader on coaching program milestones.

Lessons learned

This program had valuable lessons. First, we needed to create a clear process on the steps that we would follow to refer a physician to PHS. As most referrals in the past had been around substance use rather than performance issues, we needed a different process to share information before the referral, post assessment and pre-/post-intervention. Second, we needed to create expectations for physicians engaging in the process that they must be committed to the help offered and attend the coaching sessions offered, and what happens if they do not uphold their commitment. If the physician did not uphold their commitment to coaching and did not improve, we could pivot back to the traditional performance improvement plan through HR.

Practical implications

The focus of the program is to identify struggling physicians and help them improve. The framework allows key leaders both at the organization and PHS to be in the loop. This is key because we find that performance management sometimes happens in silos, so having all parties involved is best for both the physician and the organization. The PHS screening allows for a neutral party to assess the physician, as well as screen for substance use, and recommend a course of action. This helps the physician feel like their employer is trying to help them, rather than judge them for their issues. The focus of this approach is not to blame the physicians, rather it is focused on helping them improve.

Physician leadership development: implementation of a successful co-learning model

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Learning objectives:

1. At the conclusion of the session, participants will be able to describe the benefits of a physician leadership development program that involves physicians and health services administrators in a co-learning approach.
2. At the conclusion of the session, participants will be able to describe the elements of an effective combined leadership development program for physicians and the health services administrators who work with them.
3. At the conclusion of this session, participants will be able to evaluate their own organization's readiness for implementing a physicians/health services administrators joint leadership development program.

Purpose/relevance

The Medical Society of PEI (MSPEI) completed a third leadership development program (LDP) for physicians in 2024. For the first time, the LDP provided a leadership co-learning opportunity for physicians and the health services administrators they work with daily. The purpose of the LDP was to: (1) build foundational leadership skills to drive culture change and solve health care challenges in PEI, (2) create space for collaboration, peer-to-peer learning, and strengthening of intra-professional relationships and (3) provide an opportunity for learners to apply the learning to their work context.

Materials and methods

MSPEI partnered with the Physician Leadership Institute (PLI) of the CMA to design an accredited learning pathway tailored to the PEI context. On the basis of insights from the literature that identifies benefits of physicians and administrators engaging in co-learning about leadership, early in the LDP design process, MSPEI suggested and PLI supported reaching out to Health PEI to invite a cohort of administrators to join the learning pathway for a co-learning experience. Health PEI was an enthusiastic partner for this approach.

Results

An application process for physicians and administrators was launched in March 2023. Nineteen physicians and 13 administrators applied, which was more than the original number of seats in the program; however, in the spirit of wanting to support those stepping forward, additional resources were identified to enable all to participate. Learners participated in six two-day learning modules and worked in groups to explore case studies aimed at problem-solving real and current health care challenges in PEI. All learners had access to five sessions with an executive leadership coach as part of their learning journey. Topics covered in learning modules were as follows: Leadership Begins with Self Awareness, Leading Change, Crucial Conversations, Trauma Informed Leadership, Dollars and Sense, and Social Systems Complexity. Key to ensuring the relevance of each module was a faculty pre-meeting with Health PEI and MSPEI to understand the PEI context. Learners were asked to identify potential topics for case study projects, and MSPEI and Health PEI collaboratively selected seven projects that addressed current system challenges and had readiness for change. Learners worked in groups of physicians and administrators throughout the course to complete these projects. Each module was evaluated and a pre-post impact assessment was conducted for the overall program.

Conclusions

The words of one of the learners sum up the impact of this learning pathway: "Eight months and personal growth later, I would say unequivocally that if you could recreate this course on grand scales — it could be the secret to the success of our system. The learning was phenomenal, but I believe it was the connections and relationships built that brought it to the next level." Every learner valued the co-learning model. At least two of the seven groups have moved beyond their case study to implementing real system change, which they attributed to the co-learning model.

Post-COVID moral injury in a sample of health care providers

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Learning objectives:

1. Review the concepts of moral distress and moral injury in health care settings.
2. Understand the prevalence of moral injury symptoms in a sample of health care providers following the COVID-19 pandemic.
3. Identify system and individual interventions to support health care workers experiencing moral distress or injury.

Purpose/relevance

Moral injury was first introduced as a way to describe the emotional impact of military service, which can require behaviour discrepant from one's values (Shay 1994). The concepts of moral injury and moral distress have more recently been applied to the health care workforce, particularly as a means to understand the toll of the COVID-19 pandemic. We sought to understand the prevalence of moral injury in our workforce and its relationship to other variables, to identify potential targets for future well-being interventions.

Materials and methods

We assessed moral injury in a sample of health care providers (N = 1260) as part of a larger study examining post-COVID recovery in our health care system. We used the 10-item Moral Injury Symptom Scale: Healthcare Professionals Version (MISS-HP), which is a valid and reliable scale for measurement of the symptoms of moral injury and corresponding levels of impairment in social or occupational functioning (Mantri et al. 2020).

Results

All 1,260 participants were employed in our health care system and had participated in a 2020 study examining behavioural health symptoms and work experiences during the pandemic. Of the respondents, 64% were female and 70% identified as white. Twenty-three percent were nurses, 21% represented other clinical roles, 14% were support staff, 10% were leaders and 8% were physicians. Seventy-four percent of our sample responded to at least eight of the 10 questions comprising the MISS-HP, with a mean MISS-HP of 34.7 (SD = 13.2). Using a Spearman rank correlation coefficient (rho, R), moral injury showed significant direct correlation ($p < 0.001$) with depression (R = 0.369), anxiety (R = 0.347) and insomnia (R = 0.282), while all six of the elements of work culture, which were framed positively, showed significant inverse correlation ($p < 0.001$). There was a significantly higher ($p < 0.001$) moral injury score for those with PTSD symptoms.

Conclusions

While the mean MISS-HP score of our sample was lower than the suggested cut-off for identifying significant functional impairment, we found relationships between moral injury and several key factors including those related to the individual (depression, anxiety, insomnia, PTSD) and those related to the work environment (ability to say no to demands, trust in leadership, level of control/autonomy). These results position us to develop interventions at both the individual and system levels and provide a baseline from which to assess our progress.

Prevalence and correlates of post-traumatic stress disorder symptoms in graduate medical education trainees: a multi-site study

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Learning objectives:

1. Understand the prevalence of COVID-19-related post-traumatic stress disorder symptoms among residents and clinical fellows in graduate medical education programs.
2. Determine factors that are associated with an increased likelihood of screening positive for COVID-19-related post-traumatic stress disorder among trainees
3. List demographic factors correlated with COVID-19-specific post-traumatic stress symptoms among trainees in the graduate medical education community.

Purpose/relevance

Many physicians in training are exposed to violence, trauma and death as part of their roles as first responders to medical emergencies. Studies have demonstrated that graduate medical education (GME) trainees suffer from clinically significant post-traumatic stress disorder (PTSD) symptoms at rates as high as 22%, over twice that of the general United States working population. Although prior studies have examined the prevalence of and associated factors for PTSD during the COVID-19 pandemic among front-line health care workers, including GME trainees, very few studies have looked at COVID-19-specific post-traumatic stress symptoms. This study aimed to quantify the prevalence of COVID-19-related PTSD symptoms in GME trainees across three institutions and identify factors associated with COVID-19-related PTSD symptoms.

Materials and methods

We conducted a multi-institutional cross-sectional survey study from 4/2022 to 5/2022 at three academic institutions. Demographic data, social isolation and intention to stay for further training or as faculty were assessed. Symptoms of COVID-19-related PTSD were assessed using PC-PTSD-5, a five-item screen, which was modified to ascertain symptoms related to the COVID-19 pandemic. Univariable and multivariable logistic regression analyses were conducted to identify factors that predicted trainee COVID-19-related PTSD symptoms. A score of 4 or more resulted in a positive screen.

Results

A total of 3,109 eligible residents and fellows participated in the survey, with response rates of 41.0% to 67.5% across sites. The most common demographic groups were age 26 to 30 years (44.8%), female (48.3%), white (42.8%), heterosexual (81.1%) and a resident or fellow in one of the ACGME-accredited specialty or subspecialty programs (96.1%). A total of 190 (6.1%) residents and fellows screened positive for PTSD symptoms. Mean PROMIS social isolation T-score was 45.5 (SD 9.05), and 596 (19.2%) reported that they would not consider remaining at their site for additional training or in a faculty position. In multivariable analysis, trainees identifying as female were more likely than males to screen positive for PTSD symptoms (OR 1.45, 95% CI 1.03–2.04, $p = 0.03$). In addition, each one-point increase in PROMIS T-score for social isolation was associated with an odds ratio of 1.09 for having a positive PTSD screen (95% CI 1.07–1.11, $p < 0.0001$). Respondents who had no intention to stay at their institution for additional training or to serve as faculty were also markedly more likely to have a positive screen for PTSD (OR 1.74, 95% CI 1.17–2.58, $p = 0.01$).

Conclusions

The COVID-19 pandemic exposed many trainees to potential trauma. Our study is the first multi-site study of GME trainees to identify correlates of COVID-19-specific post-traumatic stress disorder symptoms among this population. We present new evidence identifying female gender, social isolation and intention to stay as factors correlated with COVID-19-specific post-traumatic stress symptoms in residents and clinical fellows within the GME community. Understanding these relationships can inform health care leaders and educators in developing best practices to identify and reduce the risk and impact of PTSD among GME trainees when facing other traumatic events.

Provider perspectives on organizational strategies to reduce provider burnout and improve satisfaction in safety-net primary care clinics in the United States

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Learning objectives:

1. To explain the unique challenges and opportunities to address provider burnout in safety-net settings.
2. To understand the drivers of burnout and satisfaction for primary care providers working in safety-net, federally qualified health centres throughout the United States.
3. To collate recommendations for action for leaders who wish to reduce provider burnout and improve their satisfaction, thereby retaining a stable workforce.

Purpose/relevance

There has been an increase in levels of burnout among US health care providers over the last decade, often affecting primary care providers (PCPs) with greater severity. In the US, safety-net clinics, also known as federally qualified health centres (FQHCs), provide primary care to over 30 million patients regardless of their ability to pay. Addressing provider burnout at these centres is important to ensure health care access and equity. Organizational interventions can improve burnout but data on this topic from resource-limited safety-net systems is lacking. This project solicited feedback from PCPs working in FQHCs on the organizational strategies they believe would reduce burnout and improve satisfaction.

Materials and methods

Qualitative interviews were conducted with 28 FQHC PCPs and three non-PCP FQHC leaders in nine states. Interviews were then recorded and transcribed and analyzed by a group of providers with expertise in qualitative methods. Qualitative data analysis was completed using the immersion-crystallization method.

Results

FQHC PCPs eloquently described their experience of burnout as it related to three major themes: a mismatch between job demands and resources, a sense of impossibility of the job of primary care, and a concern for health care's — as well as their organization's — deviation from its mission. Despite challenges, PCPs also reported satisfaction with their work, achieved with diversity of their roles, support from leaders and teams, and their relationships with patients and mission of the work. Over 200 ideas for future organizational strategies to reduce burnout and improve satisfaction were identified by the providers interviewed. To address job demands, expanded patient visits, electronic medical record enhancements and enhanced team-based care were identified as important interventions. To tackle a sense of impossibility of the job, increased diversification of job roles, expanded mentorship and improved coverage while on vacation were recommended. To deal with deviation from organizational mission, increasing accessible leadership, placing patients at the centre of major decisions and celebrating achievements and milestones were flagged as important.

Conclusions

In the US, many safety-net institutions have lagged behind other practice settings when it comes to creating structured organizational responses to address provider burnout. This is possibly due to resource limitations, as well as concerns about which changes are likely to truly make a difference. However, after interviewing a large, geographically diverse group of providers in this setting, many solutions were identified that are attainable and practical. Interventions in safety-net systems are essential to ensure access and equity. PCPs can be leveraged to support leaders in the design, implementation and evaluation of solutions to retain the workforce.

Provider time and burden in primary care: an analysis on non-face-to-face time and electronic health record system monitoring

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Learning objectives:

1. Assess how time metrics provided by electronic health records impact both physician and patient wellness and satisfaction.
2. Compare physician time through Epic and Epic-Signal standard metrics and clinic schedules via self-reported time.
3. Analyze intraclass correlations of time-burden measures over a one-month period.

Purpose/relevance

Physicians face professional burnout, partly because of increasingly ubiquitous electronic health record (EHR) utilization. Despite health care systems adopting technology to improve patient care and communication, physicians often expend uncompensated time to enhance the patient experience and improve health care quality via asynchronous means.

Materials and methods

Time-burden measures were assessed in an internal medicine practice using electronic record footprints, including total time and metrics per Epic Systems and Epic-Signal standards over one month in 2023. Four different measures were collected in parallel: uncorrected Signal time by total month, corrected Signal time by day, scheduled administrative time by day and self-reported time by day. Self-reported data were obtained via Clockify. Physicians' weekday clinic schedules were audited. Data analysis was conducted using SAS statistical software (version 9.4).

Results

Female physicians represented 50% of the participants, and 25% of physicians had practised for over 20 years post-residency (M = 12.13 years; SD = 8.79 years). The average clinical full-time equivalent (cFTE) was 0.58 (SD = 0.28), which did not differ statistically by gender (Males [M = 0.68; SD = 0.32]; Females [M = 0.47; SD = 0.23]; p = 0.31). Intraclass correlation coefficients of the different time measures were poorly related, with an agreement estimate of 0.04 (95% CI -0.038-0.31; p = 0.21). Controlling for cFTE, Pearson correlation coefficients of self-reported time via Clockify were most strongly correlated with uncorrected Signal time (r = 0.94), followed by corrected Signal time (r = 0.89) and distantly by scheduled administrative time (r = 0.54).

Conclusions

The heterogeneity of different time-burden methods is notably large; the raw Signal data represent the electronic footprint closest to physicians' self-reported time burden. Accurate electronic tracking of time is important not only to understand its interface with patient care but also to support physician wellness.

Psychological Health & Safety (PH&S) Toolkit: interprofessional primary care team and physician relevant resources

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Learning objectives:

1. At the conclusion of this poster, audience members will be able to identify and describe some interprofessional primary care team and physician-specific resources related to psychological health and safety (PH&S).
2. At the conclusion of this poster, audience members will be able to identify some key PH&S intervention gaps related to interprofessional primary care teams including physicians.
3. At the conclusion of this poster, audience members will be able to understand the importance of leadership in creating and promoting psychologically healthy and safe learning environments and workplaces.

Background

Psychological health and safety (PH&S) plays a significant role in the well-being of physicians and other interprofessional primary care team members, enabling them to feel safe, suggest new ideas, offer feedback and seek assistance. The 2021 National Physician Health Survey data indicate that close to 80% of respondents have experienced bullying, harassment and other forms of violence in their workplace or training environment. Physicians are in need of resources that would support their PH&S at work.

Objectives

To facilitate the PH&S of interprofessional primary care practitioners and teams including physicians, we developed and curated the bilingual Psychological Health and Safety Toolkit for Primary Care Teams and Training Programs, containing 122 resources. This toolkit comprises a multi-level categorization addressing team (e.g., peer support and leadership), system (e.g., policies), organization (e.g., training opportunities) and individual (e.g., interface of individual practitioners and teams) level interventions. This poster aims to reflect on the lessons learned through the process of the toolkit development and implementation.

Approach

We conducted a systematic environmental scan targeting academic and grey literature focusing on 15 PH&S factors to identify relevant open-access resources. The framework that guided the development of the toolkit was based on psychosocial factors identified by Canada's National Standard for Psychological Health and Safety in the Workplace and the Mental Health Commission of Canada. To guide the process of search and selection, we created a list of inclusion/exclusion criteria including language, intervention target and other important factors. The toolkit was implemented and refined by co-working with interprofessional primary care teams (e.g., physicians) and training programs (e.g., nurse practitioners and paramedics) across Canada.

Lessons learned

Our toolkit offers a variety of resources in different formats geared toward improving the PH&S of physicians and other primary health care professionals. During the toolkit curation process, we identified several intervention gaps. There is a relative lack of bilingual resources or resources published in French. Many resources do not focus explicitly on primary care settings and training programs, though many are nonetheless relevant. Few resources focus on interprofessional teamwork or on preparing future professionals for interprofessional collaboration. Team and training resources targeting individuals are more prominent than those targeting the team or system levels, and few focus on the interface of individuals within teams. System-level interventions do not focus on the primary care team and training relevant circumstances.

Practical implications

There are some practical implications emanating from the process of toolkit development and our collaboration with interprofessional primary care teams. In particular, organizations and team leaders play a key role in creating and promoting PH&S learning environments and workplaces. They can foster a culture of respect, support, engagement and recognition; effectively manage workloads and resources; and encourage work–life balance. In addition, the readiness of organizations to adopt resources and implement changes is one important factor to consider before conducting any interventions geared toward PH&S in primary health care settings.

Psychological safety & challenging conversations: workshops to enhance well-being focused leadership skills

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Learning objectives:

1. Identify key findings from engaging with health care workers in leadership trainings.
2. Identify the engagement of hospital leaders in mental health and advocacy work.
3. Describe training program sustainability on the basis of our assessment findings.

Background

Health care workers often report that their work culture is not psychologically safe. Results from a large urban single-institution survey show that 35% of staff do not feel encouraged to share improvement ideas and 33% felt supervisors do not transparently communicate information. Only 56% of faculty felt they could bring up tough problems and 60% felt that their leaders provided helpful feedback/coaching.

Objectives

We aimed to address these perceived gaps in leadership behaviour (creating a safe space, providing feedback and managing difficult conversations) by delivering two workshops, titled Cultivating Psychological Safety in Teams and Navigating Challenging Conversations, and then assessing the impact of these trainings on leaders' knowledge and intended skill use.

Approach

A team of trainers developed two, hour-long workshops. The Psychological Safety session included topics such as humble inquiry, recognizing unconscious biases, modelling fallibility and thanking the messenger. The Challenging Conversations session included topics such as Ask First Feedback and STATE (Share facts, Tell story, Ask others, Talk tentatively, Encourage testing) models. Workshops included brief didactics, group discussions and role-playing activities. Leadership (physicians, nurses, social workers) of high-acuity units (ICUs and EDs) were invited to participate. Evaluation methods included pre-post workshop surveys, which assessed content knowledge and likely use of learned skills on a 1–5 (strongly disagree to agree) scale. Basic demographic data were also collected. Pre-post surveys were compared using two-sided t-tests.

Lessons learned

Of the 306 invited leaders, 240 and 136 leaders completed the Psychological Safety and Challenging Conversations workshops, respectively. Most participants were 30–39 (57%) years old, women (53%), and identified as White (54%), Asian (22%), Hispanic/Latinx (11%) and Black/African American (8%). Roles included physicians (80%), administrative staff (11%) and nurses(12%). Following the Psychological Safety workshop, participants had a clearer understanding of humble inquiry (d = –1; $p < 0.001$) and active listening (d = –0.3; $p = 0.008$), and would probably use the skills of unconscious bias awareness (d = –0.7; $p < 0.001$), active listening (d = –0.6; $p < 0.001$), framing work as learning (d = –1.2; $p < 0.001$), modelling fallibility (d =–1.1; $p < 0.001$) and thanking the messenger (d =–0.9; $p < 0.001$). Following the Challenging Conversations workshop, participants had a better understanding of preparing for feedback conversations (d = –1; $p < 0.001$), the Ask First model (d =–1.3; p <0.001) and the STATE model (d = –1.7; $p < 0.001$).

Practical implications

A diverse group of hospital leaders were successfully recruited to participate in two novel workshops. Most attendees reported that the sessions increased their knowledge and skills and that they would be likely to use these skills in future work. Limitations included a moderate number of participants, not yet measuring behavioural change in practice and uncertain future impact. Next steps in sustaining and developing the program further will include delivering these workshops to more institutional leaders, measuring changes in demonstrable leadership behaviours and assessing the impact of these trainings on the well-being of those who are led by the participating leaders.

Psychological safety, burnout and professional fulfillment among clinicians: the role of organizational and leadership well-being factors

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Learning objectives:

1. At the conclusion of this activity, participants will be able to evaluate the relationships among WorkLife well-being survey items.
2. At the conclusion of this activity, participants will be able to analyze the association of psychological safety with both burnout and professional fulfillment in physicians and APCs.
3. At the conclusion of this activity, participants will be able to determine the role of organizational and leadership well-being factors in the association of psychological safety with burnout and professional fulfillment.

Purpose/relevance

Psychological safety, the belief that the group is safe for interpersonal risk-taking, sharing ideas, raising questions or admitting mistakes, is recognized as an essential factor for work teams, such as health care professionals, and is associated with performance, knowledge sharing, continuous quality improvement and patient-centred care. Psychological safety may contribute to burnout and professional fulfillment, but less is known about how well these relationships are influenced by other components of well-being such as leadership and organizational factors. This study 1) examined the relationships among well-being survey items to define common factors, 2) analyzed the association of psychological safety with both burnout and professional fulfillment and 3) determined the relative association of psychological safety with burnout and professional fulfillment once accounting for organizational and leadership well-being factors.

Materials and methods

A cross-sectional survey was distributed in the spring of 2023 to all physicians and APCs within a medium-sized non-profit health care organization. The survey assessed psychological safety, work–life well-being (e.g., work–life balance, employee voice, having sufficient resources, being supported in seeking help when in distress, development, and expectation setting) and burnout and professional fulfillment with the Stanford Professional Fulfillment Index. Factor analyses with varimax rotation and regression analyses were performed.

Results

A total of 608 clinicians (54% physicians; 26% advanced practice nurses; 15% physician assistants; 4% residents) completed the survey. The response rate was 37% for employed clinicians. Two factors emerged from the work–-life well-being survey items: organizational factors (factor loadings 0.53–0.84) and leadership factors (factor loadings 0.75–0.88). Psychological safety was negatively associated with burnout (B = –0.78, $p < 0.001$, F (1, 582) = 119.61, $p < 0.001$, $R^2 = 0.17$). When including organizational and leadership factors into the model, psychological safety was no longer significantly associated with burnout (B = 0.11, $p = 0.19$, partial $r^2 < 0.01$) whereas organizational factors (B = –1.49, $p < 0.001$, partial $r^2 = 0.31$) and leadership factors (B = –0.43, $p < 0.001$, partial $r^2 = 0.05$) factors were significant, F (3, 575) = 144.67, $p < 0.001$, $R^2 = 0.43$. Psychological safety was also positively associated with professional fulfillment (B = 1.07, $p < 0.001$, F (1, 588) = 249.56, $p < 0.001$, $R^2 = 0.30$). When including organizational and leadership factors into the model, psychological safety's association was reduced, but it was still significantly associated with burnout (B = 0.20, $p = 0.01$, partial $r^2 < 0.01$). Organizational (B = 1.24, $p < 0.001$, partial $r^2 = 0.24$) and leadership (B = 0.72, $p < 0.001$, partial $r^2 = 0.13$) factors were significant, F (3, 581) = 189.21, $p < 0.001$, $R^2 = 0.49$.

Conclusions

Well-being survey items captured two distinct well-being constructs, organizational and leadership factors. Lower psychological safety was associated with higher levels of burnout, yet neither psychological safety nor leadership were not as important as organizational well-being factors in the experience of burnout among clinicians. Higher psychological safety was related to more professional fulfillment and remained a significant factor, even when accounting for leadership and organizational factors. Psychological safety might have unique relationships with burnout and professional fulfillment, and organizational factors appear to have the biggest impact on clinician well-being. Understanding the relationships among well-being constructs may inform future intervention development.

Re-validation of the Stanford Professional Fulfillment Index in an Alberta, Canada, physician population

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Learning objectives:

1. Recall the importance of validation studies in diverse contexts for commonly used physician wellness measurement tools, such as the Stanford Professional Fulfillment Index.
2. Describe the results from exploratory and confirmatory factor analyses and model fit tests of the Stanford Professional Fulfillment Index in an Alberta, Canada, physician population.
3. Consider the statistical and theoretical implications of items cross-loading between multiple factors in the context of measuring physician burnout in our Albertan setting.

Purpose/relevance

Physician burnout is an occupational distress syndrome that affects health care systems, patients and physicians. The Stanford Professional Fulfillment Index (PFI) is among several validated scales that have been developed to measure burnout. Re-validation of such scales in different populations supports generalization across diverse contexts, thereby enhancing external validity. Originally developed and validated in the United States, the PFI has been re-validated in other languages and health care professions. Our study aimed to re-validate the PFI among a population of Albertan physicians to assess if results can be interpreted and compared in accordance with the literature. Societal norms, financing and delivery of health care in Canada can influence how burnout is experienced. Re-validating the PFI in our local context enables us to assess the cross-cultural applicability of the instrument.

Materials and methods

We analyzed PFI scores from 1,243 de-identified physician respondents, collected between January 2020 and March 2024 from a voluntary sample of physicians participating in Well Doc Alberta's Longitudinal Quality Improvement Physician Wellness Measurement Process. Exploratory analyses included histogram plots and item correlation heatmaps. Psychometric evaluation included principal component analyses (PCA) and confirmatory factor analyses (CFA). Validation involved various goodness of fit tests, modification indices and expected parameter changes, along with preliminary exploration of alternate models to assess impact on fit.

Results

We had complete professional fulfillment scale scores from 1,227 physicians and complete burnout scales from 1,232. The majority of respondents were men (55.4%) and did not identify as part of a visible minority (65.2%). Respondents were mostly early-career (35.6%) or mid-career (35.3%) at the time of data collection. Histogram results revealed response distributions in line with expectations. The item correlation heatmap illustrated distinct positive correlations among all burnout items (range: 0.41 to 0.85) and among professional fulfillment items (range: 0.43 to 0.74), with negative correlations observed between burnout and professional fulfillment items (range: −0.30 to −0.67). The PCA confirmed the retention of the three PFI subscales: professional fulfillment, work exhaustion and interpersonal disengagement. However, the PCA showed noteworthy cross-loading of two interpersonal disengagement subscale items onto the work exhaustion subscale, with work exhaustion bearing slightly higher factor loadings. The CFA goodness-of-fit statistics indicated a moderately good model fit for our sample; however, from a statistical standpoint, model modifications related to the two cross-loaded items such as shifting them into the work exhaustion subscale, creating a third subscale containing those two items or removing the items entirely enhanced the fit for improved accuracy within our context.

Conclusions

While our findings provide valuable statistical insights into the application of the PFI in an Alberta, Canada, context, we must also consider theoretical significance. Adjustments to the model may enhance fit in our population, but whether they make theoretical sense, allow for more appropriate assessment of relevant constructs or impact burnout prevalence requires further exploration. Additionally, comparing our results with other validation studies across diverse temporal and cultural contexts could offer insights into the specificity of our findings, understanding of why the instrument performs differently in our population, and what adjustments, if any, would be merited for our population.

Revolutionizing health care: AI scribe technology alleviating physician burnout

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Learning objectives:

1. Recognize the potential of artificial intelligence (AI) scribe platforms to enhance the documentation process for health care providers and patients.
2. Demonstrate the scalable application of AI scribe technology for physicians in multiple practice locations.
3. Assess the impact of AI scribe technology on reducing burnout and improving physician–patient connection.

Background

Clinical documentation demands often lead to burnout and decreased work satisfaction among physicians. The high documentation burden in the United States is associated with burnout and dissatisfaction, negatively affecting physician well-being and patient care quality. Artificial Intelligence (AI) scribe technology processes and analyzes data accurately and efficiently, maintaining the confidentiality of physician–patient interactions.

Objectives

During our pilot of AI scribe technology, we aimed to assess its impact on reducing documentation time, easing documentation processes, reducing physician burnout and enhancing professional fulfillment. We also aimed to evaluate the feasibility and scalability of integrating AI technologies into existing workflows.

Approach

We engaged 31 physicians from various settings, ensuring gender and career stage diversity. Pre- and post-pilot surveys assessed burnout using Stanford PFI and work-related factors using task loading questionnaire. Implementation involved training sessions and ongoing support through a dedicated communication channel and office hours. Real-time troubleshooting support was available during patient encounters.

Lessons learned

The burnout scores, indicated an improvement from mild burnout to likely no longer experiencing burnout, supported by a 57% reduction in the average burnout score. Additionally, the AI scribe allowed physicians to focus directly on patients with 60% of physicians reporting feeling more connected to their patients. We also observed a 7% increase in the average percentage of notes signed on the same day, contributing to reduced mental fatigue and improved note completion efficiency. However, we faced challenges in integrating Nabla Copilot into existing clinical and documentation workflows, especially because it is not currently integrated with Cerner, our EMR system. Some physicians had specific preferences for note formatting, necessitating additional time for the AI to adapt to these specifications.

Practical implications

AI scribe technology like Nabla Copilot reduces documentation time, alleviates burnout and enhances the physician–patient connection. These technologies are working on greater integration into the EMR to assist with workflows and improvement in understanding when two languages are spoken within the same sentence. Standard training programs supplemented with tailored sessions can optimize AI technology utilization in clinical workflows. Nabla Copilot is working on improved integration into the EMR.

Should managers and colleagues really be making referrals?: The utility and effectiveness of supervisors making referrals to peer support programs

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Learning objectives:

1. At the conclusion of this activity, participants will learn how diversifying referral sources impacts peer support utilization.
2. At the conclusion of this activity, participants will be able to explain how leveraging supervisor and colleague referrals can increase usage of peer support services.
3. At the conclusion of this activity, participants will be able to provide examples of how to increase awareness/promotion of peer support programs among supervisors and colleagues.

Purpose/relevance

Health care professional peer support programs have become popular in health care settings as an effective way of providing support to colleagues who experience stressful events. Many of these programs utilize only self-referral requests for peer support; however, are these programs limiting themselves by only allowing self-referrals? Using peer support intake and encounter data collected over four years (Feb 2020 – Jan 2024) from a highly utilized peer support program in a non-profit health system, this study examined the differences in acceptance rates of peer support between individuals referred to the program through various referral sources: self-referral, supervisor referral or colleague referral. Our analysis looked at two measures: decline rates (i.e., declining peer support after it was requested) and multiple encounters (i.e., multiple peer support encounters for one intake request).

Materials and methods

Every peer support referral creates an intake form and encounter form, documenting the reason for the request, who made the referral and if the intended recipient declined or accepted peer support. Using four years of intake and encounter data, a Pearson's $\chi 2$ test of independence was conducted to determine if different referral sources resulted in different rates of decline. Additionally, a one-way analysis of variance (ANOVA) was performed to compare the effects of referral sources on the number of multiple encounters.

Results

Following the removal of incomplete intake request and encounter forms, there were a total of 1,276 intake forms requesting peer support; those intakes resulted in 1,812 peer support encounters. Among those encounters, 372 (21.7%) recipients declined peer support and 1,346 (78.3%) accepted peer support. Among the 1,346 who accepted peer support, 442 (32.8%) had multiple encounters for the same intake event. When comparing decline rates between self-referral, supervisor referral or colleague referral, a Pearson's χ^2 test of independence showed a significant association between referral source and whether or not someone declined peer support (Pearson's $\chi^2(2) = 23.86$, $p = 0.000$). Self-referrals were less likely to result in declining peer support service (14.1%) compared to supervisor referrals (24.7%) and colleague referrals (25.6%), but there was no significant difference in decline rates between supervisor referrals and colleague referrals. A one-way ANOVA revealed that there was a statistically significant difference in the number of encounters by referral sources between at least two groups ($F = 3.72$, $p = 0.025$). A Scheffé test for multiple comparisons found that the mean number of encounters per referral source was significantly different between self-referrals ($M = 1.34$) and supervisor referrals ($M = 1.55$), ($p = 0.028$). There was not a statistically significant difference between both self-referrals ($M = 1.34$) and colleague referrals ($M=1.49$) nor supervisor referrals ($M = 1.55$) and colleague referrals ($M = 1.49$).

Conclusions

Peer support programs that allow referrals to be made by supervisors and colleagues can be an effective way to increase usage of peer support. Referrals made by others showed a high rate of utilization, while referrals made by supervisors were more likely to result in multiple encounters per intake when compared to self-referrals. This suggests that supervisors and colleagues may be an essential source for health care professionals in need of support. Discovering strategies to optimize and enhance the utilization of these programs may prove to be highly beneficial in ensuring health care professionals receive timely and efficient support following stressful events.

Stigma-free help-seeking and work buddies predicted more favourable appraisal of stressors and work–life well-being

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Learning objectives:

1. Recognize the proportion of physicians who are comfortable seeking mental health care without any fear of stigma or ramifications in their career.
2. Recognize the proportion of physicians who have a best buddy at work in whom they can confide..
3. Describe how these factors (work buddy in whom you confide, stigma-free help-seeking) influence the appraisal of stressors and well-being.

Purpose/relevance

Improving well-being through interpersonal connections is central to well-being programs (e.g., buddies, peer supporters, wellness checks, coaching, commensality groups, decompression huddles, etc.). It is important to support distressed colleagues while addressing the drivers of their distress. For physicians, peer support is often preferred, believed to be partially due to fear of stigma or ramifications to one's career for seeking mental health care. Yet, the prevalence of this sentiment is unknown, as are the associations between peer support and well-being. The aim of this study is to determine the prevalence of the sentiment "I feel comfortable seeking mental health care without any fear of stigma or ramifications on my career" and associations between "I have a best buddy at work in whom I can confide" and well-being.

Materials and methods

In the fall of 2020, a well-being survey was conducted across the health system, which included assessment of stigma-free help-seeking and buddy-based peer support (as above, five-point Likert, dichotomized "no/maybe or yes"). Stress load was assessed as COVID-related stressors (acute traumatic stress, second-wave readiness, job security, income security), work-related (adverse events, educational debt, discrimination), life-related (major life stressor) and mood (depression, anxiety). Seven well-being metrics were assessed (outlined below). Following descriptive statistics, dichotomous categorical variables were assessed using chi-square tests and 2x2 contingency tables (unadjusted).

Results

Representing a 34% response rate, the sample is comprised of 1,505 attending physicians (academic [60.9%], employed [21.8%], private practice [13.8%]) across four hospital-based delivery networks. Respondents represent all specialties found at an academic medical centre, with 16.0% identifying as a primary care physician. Of those, 84.0% worked full time and 50.9% spent >81% of their time clinically. The sample identifies as 74.9% white, 55.6% male, with an average age of 40.6 years. Of attending physicians, 55.8% felt comfortable seeking help for mental health conditions without fear of stigma or ramifications on their career, and 52.5% had a buddy at work with whom they could confide. Stigma-free help-seeking was associated with more favourable appraisal of stressors ($p < 0.05$): second COVID wave (OR = 0.57), job security (OR = 0.44), secure income (OR = 0.49), discrimination (OR = 0.68), depression (OR = 0.48) and anxiety (OR = 0.66). Work buddies were associated with favourable appraisal ($p < 0.05$) of job and income security, OR = 0.60 and OR = 0.69, respectively. Both stigma-free help-seeking and a work buddy could predict well-being ($p < 0.05$): professional fulfillment (OR = 2.16 and OR = 1.50), professional life being as expected (OR = 2.21 and OR = 1.63), job satisfaction (OR = 2.52 and OR = 1.81), practice promotion (OR = 2.04 and OR = 1.42), retention (OR = 1.73 and 1.19), freedom from burnout (OR = 2.31 and OR = 1.33), respectively, and work–life balance (OR = 1.73 for stigma-free only).

Conclusions

A majority of physicians had a work buddy in whom they could confide and stigma-free help-seeking; both predicted less stress and more well-being. Of the two predictors, "I feel comfortable seeking mental health care without any fear of stigma or ramifications on my career" more strongly and universally predicted desirable appraisals of stressors and work–life well-being. Potentially, this metric is more indicative of a strong organizational culture of psychological safety and support. These findings support the value of improving well-being through connection and comfort seeking help.

The case for training physicians to coach: an opportunity to enhance well-being

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Learning objectives:

1. At the conclusion of this activity, participants will be able to briefly describe the current state of coaching in health care.
2. At the conclusion of this activity, participants will be able to provide evidence-based outcomes from a large health care organization with 15 years of experience in coach training.
3. At the conclusion of this activity, participants will be able to make the case for training physicians to learn and use coaching skills.

Background

Amid the burnout crisis in health care, organizations are exploring how coaching can support physicians and drive well-being. Although the benefits of coaching are well described, some are discovering the tremendous value of training physicians to use coaching skills. In 2008, physician leaders at a large health care organization created a unique coaching framework and curriculum designed to train physicians to coach. Physicians learn and practise the relationship-centred coaching fundamentals of listening, empathy, asset-based thinking and language.

Objectives

The objectives were to (1) examine physicians' self-reported benefits of participating in a one-day coaching skills training and (2) consider key components of a coaching skills training that can enhance physicians' well-being.

Approach

From 2020 to 2023, 237 participants completed a virtual one-day coaching skills course that was offered 15 times. After each course, participants completed a retrospective pre-post survey. IRB exemption status was obtained. The survey assessed the perceived value of the course and change in confidence in: (1) using coaching skills and (2) measures of resilience and engagement using Press Ganey survey question language. A five-point Likert scale was used asking "how confident are you in…" a variety of variables with the scale ranging from "not at all" to "substantially." Survey responses were managed using SurveyMonkey. The Wilcoxon signed rank test compared the pre-post paired samples at a 95% confidence interval.

Lessons learned

Of 154 survey respondents, 77% were physicians who were mostly females (65%), aged 30–39 years (40%), white (56%) and in practice ~ 13 years; 14% were surgeons. In total, 95% (n = 112) of physicians agreed the training taught skills that were feasible to implement and replicate. Comparing pre- and post- survey assessments, physicians reported a significant increase across all factors measured, including building rapport, demonstrating empathy and asking powerful questions to reframe and elicit new awareness ($p < 0.0001$). Additionally, physicians reported a significant increase in engagement (ability to find meaning at work, expanded relationships and sense of value) ($p < 0.0001$) and resilience (dealing with conflict, sense of empowerment and asset-based thinking) ($p < 0.0001$). Nearly all physicians would recommend the training to a colleague.

Practical implications

We believe physicians are uniquely primed to learn and apply coaching fundamentals. Physicians already have relational skills with patients and understand the importance of confidentiality. They are comfortable experiencing a shared vulnerability and know how to maintain focus on those seeking their support. A one-day coaching skills training can bolster physicians' confidence in using these skills in daily interactions across contexts, regardless of specialty and years of experience. Coaching skills training also impacts physicians' engagement and resilience. Training builds confidence in empathy, expanding relationships, finding meaning at work and dealing with conflict. We postulate that these outcomes of coaching training foster connectedness and make the case for training physicians to coach as a way to cultivate well-being.

The power of an integrated behavioural health response in supporting communities during disaster

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Learning objectives:

1. How to build an integrative, trauma-informed behavioural health care model that is accessible to all, by identifying the unique needs of specific populations including children, parents, elders and culturally diverse groups.
2. Creating a central triage intake system and helpline to address the unique needs of specific populations and connect survivors to available resources.
3. Discuss how technological advances assisted in the delivery of therapeutic services and identify wellness interventions that buffer providers from vicarious trauma.

Background

On August 8, 2023, the culturally diverse community of Lahaina, Maui, was ravaged by one of the deadliest fires in modern US history. Within hours, 101 people perished, the fire destroying a historic town rich in Hawaiian culture and state history. Over five thousand people lost their homes, jobs, medical facilities, schools and spiritual centres. We are sharing our experience in how to stand up a comprehensive behavioural health system in the face of disaster.

Objectives

The objectives are to (1) determine principles and strategies connecting community, resources between federal/state agencies, large medical systems, community clinics and grassroots organizations to stand up an integrative, trauma-informed behavioural health care model that is accessible to all, (2) identify the unique demands/needs of specific populations such as children, parents, elders and culturally diverse groups, (3) discuss how technological advances assisted in the delivery of therapeutic services and (4) identify wellness interventions that buffer providers from vicarious trauma.

Approach

Clinician education: Train professionals in trauma care (e.g., psychological first aid) to address long-term needs like suicidality. Culturally sensitive care is vital, requiring diverse teams and training. Survivor support: Validate survivors' reactions as normal. Offer resources to employers, parents and displaced individuals. Flexible care: Adapt services as survivors move from shelters to housing. Provide outreach and standalone care facilities. Technology: Utilize platforms like Zoom, Teams and Jotform to create a virtual hub for communication and triage. Provider wellness: Implement interventions like debriefing spaces and cultural wellness practices.

Lessons learned

With the creation of a centralized behavioural health virtual platform, providers were able to work collaboratively in alignment and share with survivors how to access services and connect them with various health opportunities. These conversations were rooted in the cultural values of Hawaii, and remained respectful, reflective, humble and action oriented. The "Maui Strong" Zoom held space for providers to network and included leaders from larger medical systems throughout the state including front-line clinicians, community clinics, private organizations and the Department of Health. It also was a place to orient new providers to their roles and familiarize them with available resources.

Practical implications

Centralized leadership and community trust is crucial to disaster response. Behavioural health providers can benefit from a centralized communication space like an emergency operations centre. Owing to the rural and geographic nature of Hawaii, virtual platforms were essential once communication was restored. Despite the strength of virtual platforms, communication shutdown accompanies natural disasters, requiring a boots-on-the-ground approach. States would benefit from having a predetermined, local mental health response team trained and vetted in disaster management and community mental health principles. Principles include accessibility to care for all, breaking down of insurance barriers, non-pathologizing care of acute distress, and understanding cultural needs.

Understanding physician burnout: variability, gender disparities and key contributors

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Learning objectives:

1. Identify factors influencing varying rates of physician burnout across specialties.
2. Recognize gender differences in physician burnout and their implications.
3. Propose interventions to address physician burnout and target top contributors such as bureaucratic tasks and workload control.

Purpose/relevance

Over the past decade, physician burnout has surged as a critical issue in health care. Factors like heavy workloads, administrative burdens and a lack of work–life balance contribute to emotional exhaustion and decreased job satisfaction among physicians. This not only impacts their well-being but also compromises patient care. Efforts to address burnout include wellness programs and changes in organizational culture, but it remains a persistent challenge requiring ongoing attention.

Materials and methods

The KLAS ARCH Collaborative is a group of hospital organizations that work together to measure and improve the electronic health record (EHR) user experience. KLAS Research designed an EHR Experience Survey, which was administered at Michigan Medicine between September 28, 2023, and December 1, 2023, with a total sample size of 2,449 respondents including 1,088 nurses, 563 physicians, 530 allied health professionals, and 268 advanced practice providers (APPs). Customized addended Mini Z well-being questions and gender-specific questions were added to the standard survey.

Results

The Michigan Medicine KLAS Collaborative physician survey found burnout rates ranging from 27% to 70% across different medical specialties. Gender disparities were evident, with 59% of men (n = 184) reporting no burnout symptoms, compared to 50% of women (n = 316). An independent T test was performed that showed there was a significant difference between the percentage of men and women reporting no burnout symptoms, with men reporting a higher percentage of no symptoms of burnout (t = –2.0, p = 0.0459). The top five contributors to physician burnout were identified as excessive bureaucratic tasks (72%), staffing concerns (67%), after-hours workload (59%), lack of control over workload (52%) and inefficiencies associated with EHRs (39%). These findings underscore the multifaceted nature of burnout within the medical profession and highlight the urgent need for targeted interventions to address its root causes and mitigate its impact on health care providers.

Conclusions

The findings reveal a complex landscape of physician burnout, marked by significant variations across medical specialties and notable gender disparities. Gender differences in burnout prevalence, with a higher proportion of women reporting symptoms compared to men, underscore the importance of considering gender-specific factors in burnout prevention efforts. The identification of excessive bureaucratic tasks, staffing issues and after-hours workload as the top contributors to burnout emphasizes the critical role of organizational factors in shaping physician well-being. Addressing these key stressors through targeted interventions and systemic changes holds promise for reducing burnout risk and enhancing overall physician satisfaction and patient care quality.

Understanding provider well-being barriers and facilitators at a large, free-standing children's hospital: using well-being grants to empower local initiatives

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Learning objectives:

1. Develop a plan for offering grants for well-being initiatives.
2. Illustrate effective use of funding for well-being.
3. Hypothesize the effects of a locally owned well-being initiative.

Background

Members of the Children's Wisconsin medical staff reported high levels of burnout, which were worsened by the COVID-19 pandemic. Owing to pandemic-related financial headwinds, many sources of funding for well-being, engagement, recognition, appreciation and team building were no longer available. Also, literature demonstrates that engaging workers in local well-being initiatives can reduce burnout and engage workers in the mission of an organization. On the basis of this, the Medical Staff Professional Health Committee (PHC) sought creative solutions.

Objectives

Well-being grants were created to understand the needs of the medical staff and empower medical staff members to design and implement custom well-being initiatives at a local level. The PHC sought to identify successful projects that would have the potential to scale to a larger organizational initiative.

Approach

The PHC developed an application requiring details on team composition, project description, budget, anticipated well-being impact and direct supervisor support. The funding allocated for 2023 was $5,000, which was doubled to $10,000 for 2024 owing to the extensive application volume. Over two years, 44 applications, totalling over $150,000, were received. PHC members scored proposals on the basis of project merit, group burnout risks, anticipated impact and feasibility. Final funding allocations were determined by consensus, on the basis of scores. The PHC chose to partially fund components of 18 grants, totaling $13,555, rather than fully funding a few. Awardees assessed grant impact on their groups and project feasibility without the grant's support.

Lessons learned

The PHC received 44 applications from 68 individuals representing 40 different clinics, sections and practice locations and nine different provider roles. The most common grants requested were outings (12), meals (11), retreats (10) and exercise equipment (five). Some requests were better suited for institutional support (e.g., mattresses in call rooms), and the PHC successfully advocated for institutional support. Grants that were funded included mind–body skills training and facilitation, meals, a wellness wagon, a retreat to address low engagement scores, and workspace enhancements. Organizational barriers included inability to provide protected time to implement projects and hospital policies precluding exercise equipment. Grant application details were shared with medical staff leadership to foster ongoing support for provider well-being.

Practical implications

Well-being grants were well received, as evidenced by the number of applicants and direct feedback to the team. Though funding was modest compared to typical budgets, grants helped improve well-being at the local level. Grants allowed teams to develop a well-being initiative that would be meaningful to their group, and allowed the institution to show recognition and appreciation for all that providers do. Data collection is underway regarding ongoing impact. Initial feedback from providers who received grants noted that the grants were appreciated by their teams, made an impact on well-being and would largely have not been feasible without funding. Additionally, grants identified broader institutional issues that were brought to the attention of institutional leadership for consideration.

Utilizing a narrative medicine workshop series to promote belonging and connection among medical students: a pilot study

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Learning objectives:

1. Identify well-being challenges among medical students.
2. Recognize the value of narrative medicine in fostering human connection.
3. Understand how to implement and evaluate narrative medicine interventions for health care worker trainees.

Background

Medical students face well-being challenges, including imposter syndrome, burnout, work–life imbalance and lack of meaning-making in their studies. These are often linked to a lack of community, belonging and connection to their own purpose. It is thus crucial to allow students a space to build thoughtful communities, to separate from didactics, to reflect together on personal experiences, to process complex emotions and to increase their sense of belonging and community.

Objectives

Narrative medicine is a field that prioritizes action toward justice, giving voice to the suffering and honouring the lived experiences of patients, caregivers and providers. Implementation of narrative medicine programming among health care workers has been limited, though previous work has shown potential to positively impact relationship building, reflection, burnout mitigation, confidence in personal accomplishments and work satisfaction. This project piloted a longitudinal narrative medicine workshop series to promote belonging and connection among medical students.

Approach

We implemented a six-week workshop series that included a weekly one-hour session focusing on one of these themes: (1) making and finding meaning, (2) identity, (3) building community within medicine, (4) isolation from others, (5) confronting the frailty of life and mortality and (6) practising excitement and curiosity. Each session involved a facilitated discussion of a piece relating to the session theme; these pieces included written and slam poetry, a painting, memoir passages and an illustrated short story. The second half of each session entailed individual writing time for a shared prompt, followed by participants sharing and reflecting on their writing. A post-survey was implemented to capture participants' experiences of and growth from the program.

Lessons learned

All workshop series participants indicated that they would recommend the program to other medical students and rated the program's quality as very high. Survey results also demonstrated an increased likelihood of participants incorporating practices of reflection about themselves and others into both their personal and professional lives, utilizing active listening skills in patient interactions and engaging in future narrative medicine opportunities. Furthermore, participants endorsed feelings of improvement in several Accreditation Council for Graduate Medical Education (ACGME) competencies, including interpersonal and communication skills, patient care, practice-based learning environment and improvement, and professionalism. Qualitative survey feedback from participants exhibited the program's effectiveness in fostering deeper human connection, decreasing feelings of isolation and facilitating curiosity and creativity.

Practical implications

This project demonstrated the feasibility of utilizing a narrative medicine workshop series to promote human connection and decrease feelings of isolation among medical students. This program emphasized truth-telling, active listening and emotional processing, skills that are paramount for both personal development and effective patient–provider relationships. Our results indicate that narrative medicine interventions can successfully provide medical students with a safe space to reflect on who they are, what they care most about, and how to hold onto these values as they become physicians. Future work is needed to assess long-term outcomes and behaviour change following narrative medicine programming, evaluate its effectiveness in other disciplines of health care worker trainees and assess its potential to reduce burnout in these populations meaningfully.

WellDOM at the Table: peer-support groups to improve well-being and resilience

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Learning objectives:

1. As a result of this presentation, participants will understand the value of peer-support groups to address well-being and resilience while combating burnout.
2. As a result of this presentation, participants will learn the logistics of the WellDOM at the Table program.
3. As a result of this presentation, participants will be able to think creatively about ways to pilot similar programs within their own institutions.

Background

Employees of our Department of Medicine consistently report high levels of burnout and disconnection from their co-workers, worsened by the COVID-19 pandemic.

Objectives

Inspired by Mayo Clinic's COMPASS groups, the WellDOM@theTable pilot program was launched to provide peer support around well-being and resilience.

Approach

The WellDOM@theTable program is open to all roles and all divisions within our department. Self-created groups of six to 10 participants agree to meet for at least one hour for six meetings over the academic year to discuss wellness and resilience topics from a pre-populated curriculum. These groups typically meet over meals, which are reimbursed up to $20 per person per meal by WellDOM. Survey results for groups at the close of the 2021–2022 academic year are described below. Survey results for 2023–24 will be available to discuss by the 2024 ICPH meeting.

Lessons learned

During the 2021–2022 academic year, there were 15 WellDOM@theTable groups involving 95 participants. Forty participants responded to the end-of-year survey. Thirty-eight percent of the groups were able to meet five or more times, and 40% met three or four times. As a result of WellDOM@theTable, participants expressed an increase in connection with their colleagues (98%) and feeling less isolated (95%). Eighty-five percent felt this program helped address burnout, and 100% felt this program should continue. Select quotes from respondents illustrate the value of this program: "I enjoy the validation of stressors and the comradery. I enjoy hearing my colleagues' creative solutions to the similar problems that we face." Another wrote: "We are more understanding as a result of [these] conversations...We are also more compassionate with each other."

Practical implications

The WellDOM@theTable program has been well accepted by participants, resulting in increased connection and decreased isolation, and it has been helpful in combating burnout. We encourage other institutions to explore similar pilot programs.

Workplace violence in health care: enhancing student preparation for the clinical learning environment

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Learning objectives:

1. Explain why it is important to prepare medical students for threats or violence they may encounter during education and patient care.
2. Identify key stakeholder groups at your institution to include when designing and implementing workplace violence prevention and response efforts.
3. Describe an approach for data collection, monitoring and feedback to stakeholders for continuous quality improvement.

Purpose/relevance

National data in the wake of the COVID-19 pandemic demonstrate an increase in threats and violence against health care workers. This alarming trend has broad potential downstream consequences for all health care workers' well-being, including physical and psychological harm, which in turn has a negative impact on patient care and increased chance of medical error. Medical students' clinical experience and learning occur in the health care workplace in academic and academic-affiliated institutions. Thus, violence in the workplace for health care professionals equates to violence in the clinical learning environment for students. Little is known about how medical schools educate and prepare students for threats and/or violence they may encounter in the learning environment.

Materials and methods

We will present institution-specific data related to workplace violence for local context, as our institution has multiple regional campus sites across three health systems in two states. We will describe the initial approach to broad efforts to address and prepare students for possible violence in the learning environment and workplace. These efforts include curricular content, co-curricular initiatives, and policies. We will present planned next steps including linking support for students to institutional preparation and support.

Results

We will share our approach to identifying our diverse stakeholder group and engaging in cross-departmental collaboration across our medical school and partner health systems. Medical school stakeholder groups include students, Division of Student Affairs, Department of Medical Education, Student Health Services, Student Psychological Services and Information Technology. Emergency Management, Security, Workplace Violence Committee, Clinical Leadership Council and Center for Professionalism and Well-being are health system stakeholders. In addition to stakeholder identification and engagement, we will share our phased approach to prioritizing initiatives, embedding and expanding our work, accomplishments to date and opportunities for continuous quality improvement based on lessons learned.

Conclusions

Medical schools should systematically prepare students for possible threats and violence they may encounter in the clinical learning environment. Stakeholder identification and cross-departmental engagement is critical to ensuring students are prepared to enter the clinical environment and for future work as residents and physicians. Our work may inspire educators, serve as a call to action to expand student preparation for clinical practice and encourage research and scholarship related to preparation for and the impact of workplace violence on medical students' well-being and professional development.