Session # E4a

Preventing Physician Burnout, Promoting Wellness and Resiliency through the development of a Wellness Curriculum

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

1. Identify at least two risks to physician burn-out and two barriers to wellness
2. Identify tools to measure or assess burnout
3. List specific strategies to promote wellness

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Background

- The Association of American Colleges (AAMC) published in 2017 their projections in the physician supply and demand from 2015-2030.
- They projected that physician demand will continue to grow faster than supply, leading to a total physician shortfall of between 40,800-104,900 physicians by 2030.
- In Primary care they projected shortfalls between 7,300 to 43,100 by 2030.

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Background

- The American Council on Graduate Medical Education, in their 20th report – Advancing Primary Care, addressed the increasing shortage in the number of Primary Care Physicians.

- This was attributed to the high rates of burnout and poor quality of life experienced by PCP.

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Burnout: Emotional Exhaustion, Depersonalization, & low personal accomplishment

6 key ingredients of burnout:

1. High job demands in conjunction with a lack of control;
2. Disconnect between individual values and that of the organization or system;
3. Insufficient rewards such the one feels taken for granted, undervalued, and/or uncompensated;
4. Work overload;
5. Unfairness; and
6. Breakdown of community.

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Risk Factors

- Women : 17% in residency, 10% in practice
- Foreign graduate: Attrition 18.5%
- Year of training (PGY 1)
- Family Medicine is in the top 3 specialties with high burnout rates

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Burnout:

"Burnout is the problem, the system is the cause, WE are the answer! Well-being is the outcome."

Dr. Clifton Knight MD Senior Vice-President of Education of the AAFP, 2nd National conference in 2017 – Why-WE-Here: The Burnout Impact on Physician Well-being

Burnout affects the young physicians' ability to establish rapport, clearly work through diagnostic dilemmas, and competently deal with complex treatment decision making.

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Our Program

- Southern New Mexico Family Medicine Residency
- Wellness Retreat 2016/2019
- Wellness Policy
- Wellness Curriculum

Southern New Mexico Family Medicine Residency Program Established in 1996

www.snmfmrp.com

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Assessing Resident Wellness

- Retreat—Curriculum Development & Needs Assessment

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Self-report Measures

- Past Measures- Maslach Burnout Inventory & Focus Groups
- Current Measures:
  - Professional Quality of Life Scale (PROQOL): https://proqol.org/ProQol_Test.html
    - Compassion Satisfaction
    - Burnout
    - Secondary Traumatic Stress
  - Oldenburg Burnout Inventory

https://www.sciencedirect.com/science/article/pii/S2213058614000576

- Disengagement **
- Emotional Exhaustion**

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Oldenburg Burn-out Inventory

- Disengagement from work-- 7 of 18 indicated having elevated scores/indicating significant episodes of disengagement from work
- Exhaustion scale-- 11 out of 18 endorsed exhaustion in work setting.
- Subscale significant findings:
  - Residents in program year 1 are significantly more likely to report exhaustion as compared to residents in program year 2 [$F(2,10)=3.875$, $p=.05$].

	Disengagement	Exhaustion
Program Year (n)	Mean (SD)	Mean (SD)
1 (6)	16.3 (2.1)	23.8 (4.4)
2 (3)	15.3 (2.5)	15.7 (2.3)
3 (4)	16.2 (3.2)	20.3 (5.4)

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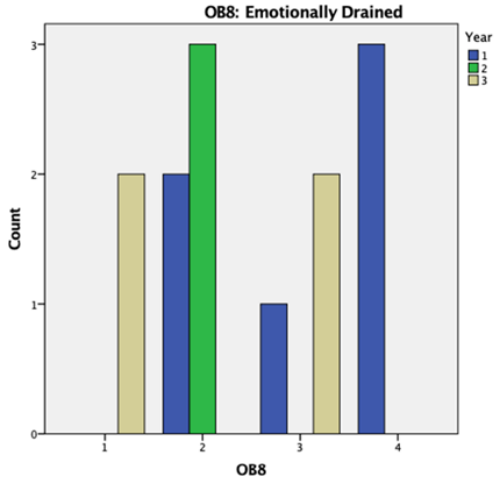
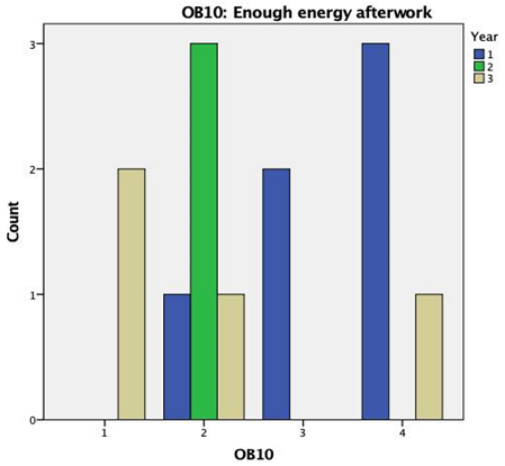
OBI

- Chi-square & Fisher Exact test analysis- no significant relationships between program year. Except for OB8 & OB10:
- OB8: **2nd year residents where significantly more likely to feeling emotionally overwhelmed, and 1st years were least likely to report feeling emotionally drained** (X2 [6, 13] = 14.6, p = .01).
- OB10: **2nd year residents where significantly more likely to report feeling they have enough energy for leisure activities after work, while 1st years were the least likely to report feeling this way** (X2 [6, 13] = 12.4, p = .04).





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Focus Group Feedback

Most Stressful:

- Admin Duties
- Need more support staff
- Feedback that is critical
- Meetings
- Inpatient rotation
- Lack of family support
- Social Isolation
- Long days & nights
- Limited control over schedule

Most Rewarding:

- Helping my patients
- Positive feedback
- Learning
- Sharing experiences/laughing with colleagues
- Working with refugees

Suggestion for Wellness Curr.:

- Fun
- More support/inclusion of families
- Admin Time

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What did we do about it?

- Administrative Time
- Inclusion of Families
- Use of Wellness in Didactics
- Use of Res-Res meetings to get a pulse of problems
- 5th Fun Free Wednesdays
- Focus Groups giving voice

What we do as a wellness curriculum may always fall short because…

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Barriers to Improving Wellness

- Moving beyond individual responsibility to systems/structure of medicine
- Moral Injury
- Structural Violence in Medicine
- Challenges within Family Medicine Residency Programs

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Barriers – Moral Injury

- Moral injury- term first used for medicine by Talbot and Dean in 2018
- Term derived from work with combat soldiers
- “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.”

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Barriers – Structural Violence

- Structural Violence- harm caused to individuals or groups by social, economic, or political structures
- Cultivate structural competence and humility

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Barriers – Structural Violence

- Structural Competency in Medicine

Components of Structural Competency

1. Recognizing influences of structures on patient health
2. Recognizing influences of structures on the clinical encounter, including implicit frameworks common in healthcare
3. Responding to structures in the clinic
4. Responding to structures beyond the clinic
5. Structural humility

Structural Humility

An orientation emphasizing collaboration with patients and communities in developing responses to structural vulnerability, rather than assuming that health professionals know best. This includes (but is not limited to) awareness of interpersonal privilege and power hierarchies in healthcare.

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Barriers – Program Related

- ACGME rules/language
- Struggles within interprofessional teams
- Faculty staffing/lack of resources

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Combating Barriers

- Activities to re-focus on meaning in medicine
- Engage the group around stories
- Focus on positives

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Combating Barriers

- Engage in interventions against the structural violence that leads to moral injury
- Give residents/learners/providers training and resources to identify and combat structural violence towards patients
- Encourage residents/learners/providers to take action to directly combat or advocate against structures that are harmful

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Combating Barriers

- Levels of intervention for structural competency
  - Individual- educate about implicit bias, language
  - Interpersonal- use support services, understand culture of medicine
  - Clinic/institutional-restructure clinic, integrate behavioral health
  - Community- collaborate with community resources
  - Policy-challenge inequality, involvement in local, state, and national organizations
  - Research- engage patients in research questions

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Discussion

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Learning Assessment

- Identify and describe at least two factors that contribute to physician burn-out.
- Name at least one assessment tool to measure burn-out and well-being.
- What did you take away from this presentation and how might you apply it to your work setting?

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Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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Join us next year in Philadelphia, Pennsylvania! Thank you!