Building a Comprehensive Approach to Wellness in the Residency

Liselotte Dyrbye, MD, MHPE, FACP
Mayo Clinic

The afternoon session will target Faculty, Program Directors, Chief Residents, Residency & Fellowship Coordinators, Medical Education Specialists, and other GME professionals. The session will be held in the Mystic Ballroom.

Session Objectives:
1. Explain the prevalence of burnout and potential contributors
2. Describe the consequences of burnout
3. Give examples of self-care strategies that mitigate risk of burnout
4. Identify organizational strategies/system approaches to enhance well-being and encourage appropriate help-seeking behaviors
5. Describe strategies to reduce risk of resident suicide

11:45-12:30 pm Poster Presentations and Buffet Luncheon
12:30-12:35 pm Welcome, Overview & Introductions
12:35 – 1:40 pm Part 1 – Prevalence, Drivers and Consequences of Burnout
1:40 –1:55 pm Q & A
1:55 - 2:15 pm Break – View Poster Presentations
2:15 – 2:45 pm Part 2 - Personal Strategies to Mitigate Risk
2:45 – 3:45 pm Part 3 - Overview of Evidence-Based Organizational Strategies and Developing System-Level Change
3:45 – 4:15 pm Review, Priority Action Plans, and Final Discussion
4:15 – 4:30 pm Wrap-up & Complete Evaluations
Building a Comprehensive Approach to Wellness in the Residency

Part 1. Prevalence, Drivers, and Consequences

Epidemiology of Burnout\(^1\text{-}^6\)

- \(~54\%\) of physicians have substantial symptoms of burnout, higher than other US workers even after controlling for work hours
- Prevalence of burnout increased 9\% from 2011 to 2014
- Substantial differences in prevalence of burnout by specialty
- Greater burnout: more work hours, younger age, female physicians, pay based entirely on billing, children <22 years old, dual career relationships
- 30-70\% of residents have burnout, unknown if varies by specialty, lower prevalence among IMG
- 27\% of residents have depression, higher than age-similar norms, with 11\% have suicidal ideation
- At matriculation medical students have better mental health profiles than peers who choose other careers

Drivers\(^2\text{-}^3,^7\text{-}^14\)

- Excessive workload
- Inefficient work environment
- Problems with work-life integration
- Loss of autonomy, flexibility and control
- Poor alignment of values
- Reduction of meaning in work
- Lack of social support at work
- Learning climate, relationships with supervisors, lack of timely feedback
- Educational debt
- Personal life events

Consequences\(^10\text{-}15,^30\)

- Decreased quality of care, medical errors
- Career choice regret, career dissatisfaction
- Malpractice litigation
- Lower medical knowledge
- Turnover and decreased productivity
- Poor professionalism, lower empathy
- Suicidal ideation
- Alcohol abuse/dependence
- Motor vehicle incidents
Part 2. Personal strategies to mitigate risk$^{7,31-35}$

“These are the duties of a physician: First...to heal his mind and to give help to himself before giving it to anyone else.” - Epitaph of an Athenian doctor, AD 2

<table>
<thead>
<tr>
<th>Self-Calibration</th>
<th>Exercise</th>
<th>Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Hours</td>
<td>Delayed Gratification</td>
<td>Mindfulness</td>
</tr>
<tr>
<td>Meaning in Work</td>
<td>Work-life Balance</td>
<td>Work-Home Conflict</td>
</tr>
<tr>
<td>Take Vacation</td>
<td>Positive Outlook</td>
<td>Focus on Most Important</td>
</tr>
</tbody>
</table>
Dealing with stress: Rate how important the following strategies are for dealing with stress in your current life/practice:

<table>
<thead>
<tr>
<th></th>
<th>Not important</th>
<th>Minimally important</th>
<th>Moderately important</th>
<th>Essential</th>
</tr>
</thead>
<tbody>
<tr>
<td>I find meaning in my work</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I try to take a positive outlook on things</td>
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<tr>
<td>I incorporate a life philosophy stressing balance in my personal and professional life</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>I focus on what is most important to me in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take vacations</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I look forward to retirement</td>
<td></td>
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<td></td>
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</table>

What one thing could you do (that you are not currently doing) on a regular basis that would have a tremendous positive impact on your personal life?

What one thing could you do in your professional life that would be similar?

Notes:
Part 3. Evidence-Based Organizational Strategies and Developing System-Level Change

1. Acknowledge and assess the problem
   
a. What dimension of well-being do you want to measure?
   
b. What tool could you use to measure this dimension?

2. Develop Local Intervention
   
a. Share aggregate findings with residents
      
i. Do these findings accurately reflect our resident well-being today?
      
ii. What are we doing that we want to keep doing?
      
iii. What do we want to change that is within our sphere of influence?

b. Collaborative Action Planning
   
i. Who else needs to be involved?
   
ii. Effort/impact implications of possible solutions?
   
iii. What are the barriers/bottlenecks?
   
iv. Who controls/decides/has authority?
   
v. How will you manage changing from current state?
   
vi. How will you measure success?

3. Being Proactive
   
a. My role as a leader
   
b. Work & learning environment
   
c. Policies and procedures
   
d. Core curriculum
   
e. What else?

4. Individual Resources
   
a. Self-assessment
   
b. Promote health
   
c. Treatment for mental health concerns
Select References


Resident Well-Being Resources and Playbook

Lotte Dyrbye, MD MHPE
Professor of Medicine and Medical Education
Co-Director, Mayo Clinic Program on Physician Well-Being
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Introduction

Perspective on how to approach resident well-being

The national prevalence of burnout among physicians is > 54%, increasing, and higher than among other US works even after controlling for work hours and a variety of other factors. Similar to physicians, residents are more likely to have to burnout than similarly aged individuals who pursued other careers. Additionally, residents are more likely to experience depression. This is not because individuals who choose medicine are somehow vulnerable. In fact, a large national study suggests at matriculation into medical school, medical students have better mental health (less burnout and depression and better quality of life in multiple domains) than similarly aged college graduates. A short while later this flips with medical students having more depression, more burnout, and worse quality of life across multiple domains.

Burnout threatens organizational health, quality and safety of patient care, and physician health. Studies have found associations between burnout and medical error, medical malpractice litigation, decreased productivity and professional effort, turnover, lower medical knowledge, motor vehicle incidents, suicidal ideation, and alcohol abuse/dependence. Total cost attributed to burnout is greater than $3.4 billion annually to the US health care system.

Burnout, a syndrome characterized by emotional exhaustion and depersonalization (cynicism and detachment toward patients), is driven by work-related stressors. Most of these stressors stem from excessive workload, inefficient work environment, problems with work-life integration, loss of autonomy, control, and flexibility, reduction in meaning in work, lack of social support at work, and conflict between personal and organizational values. Additional factors associated with burnout among residents include lack of timely feedback, stressful relationships with supervisors, feeling uncertain about the future, perception that personal needs are inconsequential, educational debt, and little emotional support from attendings.

Resident well-being is a shared responsibility of individual residents, the residency program, and the sponsoring organization. This perspective is reflected in the organization and focus areas of this book.

How to use the well-being resource and playbook

In this book you will find an over-arching approach to supporting residents and strategies for how to systematically approach customized, local solutions that leverage organizational resources. Within the bibliography you will find publications focused on drivers and consequences of physician well-being and how to mitigate risk.
Commitment to residents’ careers and health and personal well-being requires a multi-pronged organizational approach that includes investing in program director leadership and faculty development, monitoring and responding to resident well-being scores, having supportive policies and procedures, cultivating community, and providing resources to promote resilience and self-care. In addition, sponsoring institutions are encouraged to facilitate and fund organizational science in physician and resident well-being.

**Monitoring Resident Well-being and Understanding Your Data**

Well-being should be a routine program and institutional performance metric. It is ideal to use validated instruments that correlate with outcomes of interest (safety, quality, retention, etc.) and have national benchmarks.

**What tools are available?**

A variety of instruments are available that measure burnout, engagement, job satisfaction, fatigues, stress, and quality of life. Many of these instruments are long, cumbersome to analyze, and only measure one dimension of distress. As distress can present in a variety of ways using only one tool would fail to identify many in distress. Instruments that measure dimensions of burnout are shown in Table 1, along with a composite measure, the Well-Being index, which evaluates dimensions of burnout, stress, fatigue, mental quality of life, and physical quality of life in the 7-item version with additional items exploring professional satisfaction and work-life integration in the 9-item version.
Well-Being Index

Development of the Well-Being index involved a multistep process with expert input, correlation analysis for previously administered assessments, and validation in separate large samples of medical students, residents, physicians, nurses, advanced practice providers, and other US health care workers. The Well-Being index is embedded within the online Well-Being self-assessment tool that provides individuals a way to anonymously assess their level of well-being and receive both immediate feedback on how it compares to other like professionals at their place of work and nationally (residents compared to residents at their own institution and nationally) as well as resources (locally tailored and national) to help promote wellness. Institutions receive real time customized reports (e.g., residency program, year in training, sex) with comparative normative data. Additional information can be found at: https://www.mededwebs.com/well-being-index.

Table 1. Burnout and Composite Well-Being Tools

<table>
<thead>
<tr>
<th>Scale</th>
<th>Notes</th>
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<tbody>
<tr>
<td>2-items from MBI</td>
<td>Two single questions from the MBI have been validated in validated in separate samples of medical students, internal medicine residents, internal medicine faculty, and surgeons. The 2-items correlated strongly with the emotional exhaustion and depersonalization domains of burnout as measured by the full MBI with an area under the receiver operator characteristic curve of 0.94 and 0.93 for emotional exhaustion and depersonalization, respectively, for these single items relative to the full MBI. Concurrent validity for the 2-items established and national benchmarks for physicians and residents available.</td>
</tr>
<tr>
<td>Oldenburg Burnout Inventory</td>
<td>Developed for use in any occupational group. No national benchmarks for residents/physicians. Small studies have shown correlations with relevant outcomes.</td>
</tr>
<tr>
<td>Copenhagen Burnout Inventory</td>
<td>Developed for use in any occupational group. No national benchmarks for residents/physicians. Small studies have shown correlations with relevant outcomes.</td>
</tr>
<tr>
<td>Physician Work-Life Study single item (embedded within “Mini-Z”): “Overall, based on your definition of burnout, how would you you’re your level of burnout?”</td>
<td>Predicts high levels of emotional exhaustion but not low emotional exhaustion or depersonalization. It is not effective at capturing individuals who have evidence of burnout in the depersonalization or personal accomplishment domains. No national benchmarks and not shown to correlate with relevant outcomes.</td>
</tr>
<tr>
<td>Well-Being Index</td>
<td>Specific versions developed for physicians, residents, medical students, nurses, advance practice providers, and other US workers. National benchmark data available and scores correlate with relevant outcomes.</td>
</tr>
</tbody>
</table>
Responding to Your Data

After reviewing your data and discussing it with your leadership team it is important to identify strengths and key areas of opportunity. Scores that are worse than national benchmarks are concerning, and may suggest a local issue. The next step is to share the findings with the residents.

Acknowledge the problem

Recognizing the problem and acknowledging the difficulties should be done during gatherings with residents. Show trends over time and how the results compare to national benchmarks, when available. Open and candid conversations about the data are useful.

Develop and implement targeted interventions

Although the drivers of burnout are well established (excessive workload, inefficient work environment, problems with work-life integration, loss of autonomy, control, and flexibility, reduction in meaning in work, lack of social support at work, and conflict between personal and organizational values) among physicians how they manifest and which dimension is most important varies by specialty and work group. In addition, there are unique issues for residents that likely contribute as well. Engaging residents to develop solutions is vital. The conversation should focus on understanding the scores, discussing the drivers, and identifying specific contributing factors. Effort should be made to differentiate between factors that are within the control of individual residents, immediate leadership (residency program), higher leadership (institutional DIO), the sponsoring institution, and national factors (e.g., Medicare regulations). While factors beyond the control of the immediate leadership can be communicated upwards, the group should prioritize drivers within their control and brainstorm to identify best possible solutions.

Ways to obtain input from residents include using crowd sourcing activities such as 25/10, “What I Need From You,” and 1-2-4-All. These approaches stem from liberating structures and are well described on the website http://www.liberatingstructures.com/.

Action planning and implementation should involve residents as well as the local leadership team. The action team should follow-up with residents to report on ongoing progress and discuss unanticipated barriers. Small tests of change can lead to meaningful difference, and PDSA cycles can provide a useful and familiar framework.

An ideal solution could be one small action that could really have the biggest impact on burnout and thriving. Questions to consider when engaging in action planning:

- Who else needs to be involved?
- Effort required and implications of possible solutions?
- What are the barriers/bottlenecks?
- Who controls/decides/has authority?
- How will you manage changing from current state?
- How will you measure success?
Being Proactive

What is my role as a leader?

Leaders have critical role in well-being of staff. In a 2013 study of >2800 Mayo Clinic physicians composite leadership scores of immediate physician supervisor strongly correlated with burnout and satisfaction scores of individual physicians. On multivariate analysis, each 1 point increase in leadership score was associated with 3.3% decrease in burnout and 9% increase in satisfaction. Reflect on the below leadership qualities. How often and how well do you display these behaviors with residents?

<table>
<thead>
<tr>
<th>Leadership Qualities for Program Directors</th>
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</thead>
<tbody>
<tr>
<td>Holds career development conversations with residents</td>
</tr>
<tr>
<td>Inspires residents to do their best</td>
</tr>
<tr>
<td>Empowers residents to do their job</td>
</tr>
<tr>
<td>Interested in resident’s opinion</td>
</tr>
<tr>
<td>Encourages residents to suggest ideas for improvement</td>
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<tr>
<td>Treats residents with respect and dignity</td>
</tr>
<tr>
<td>Keeps residents informed about changes taking place at work</td>
</tr>
<tr>
<td>Encourages residents to develop their talents and skills</td>
</tr>
</tbody>
</table>

Which aspects of the work and learning environment should be addressed?

Burnout is driven by work-related stressors. Studies of residents and medical students suggest the work and learning environment are major contributors to their distress. Improving the work and learning environment is a key part of the shared responsibility. Providing opportunities for meaningful work (e.g., minimize non-physician obligations, provide administrative support, promote progressive autonomy & flexibility, etc.), address schedules, work intensity and work compression, and evaluate and address workplace safety data (including injuries, vehicle collisions, well-being after adverse events) are good places to start and are also required by the ACGME Common Program Requirements. As reciprocal relationships, timely feedback, and emotional support from attendings have also been shown to be important for resident well-being faculty development should target these areas in addition to fitness for duty, recognizing and responding to impairment, psychological distress, and substance abuse in themselves and others. Lastly, efforts should be made to cultivate community and build social support among the residents and between residents and attendings.
What procedures and policies should be considered to support resident well-being?

Several procedures and policies related to resident well-being are now part of the ACGME Common Program Requirements. These include:

- Unprofessional behavior and process for reporting, investigating, and addressing
- Policies and programs that encourage resident and faculty well-being
  - Time away for family, personal needs, and own health
  - Adequate rest, healthy diet, regular exercise
- Time away for medical/psychological/dental care
- Policy to ensure coverage of patient care if resident cannot perform their usual duties (fatigue, illness, family emergencies, etc.)

What should we consider adding to our curriculum to support resident well-being?

There are a variety of individual strategies that lower the risk of burnout and may facilitate high quality of life (Table 2). Mindfulness has also been shown to reduce burnout, but only with volunteer participants. A behavior change framework can be used to provide residents with experience with the process of behavioral change and help translate new knowledge into action.

Table 2. Individual Strategies

| Adequate sleep | Avoid mentality of delayed gratification |
| Build relationships & social support | Seek advice about debt reduction |
| Maintain personal health | Maximize work-life balance |
| Manage stress | Compliant with national exercise guidelines |
| Find meaning in work | Up-to-date with prev. health care screening |
| Engage in recreation/hobbies | Exercise |
| Maintain positive outlook | Maintain personal health |

Additionally, the core curriculum provides an opportunity to educate residents about:

- their personal responsibility to be fit for duty
- how to recognize impairment from illness, fatigue, substance use in themselves and others
- how to recognize fatigue and sleep deprivation and depression, burnout, and substance abuse in themselves and others
- how to assist those who experience such conditions and seek care.

These topics are required as part of the Common Program Requirements. Residency programs may also want to show the American Foundation of Suicide Prevention and Mayo Clinic video “Make the Difference: Preventing Medical Trainee Suicide.” The video can be used as an educational tool to educate residents on signs to watch for in colleagues and provide them with words to use when they are concerned about the wellness of a colleague. Effectiveness of wellness curriculum should be subject to rigorous evaluation to ensure optimal resource allocation. Residencies should consider adding well-being as a core competency. Doing so would facilitate development of curricula and thoughtful assessment strategies.
What else should be considered?

Sponsoring institutions and residencies should have procedures in place in case of a resident death by suicide. Doing so is important to helping a grieving community heal and to prevent contagion. The document “After a Suicide: A Toolkit for Physician Residency/Fellowship Programs” developed by the American Foundation of Suicide Prevention and the Mayo Clinic provides a framework for how to develop a suicide response plan, and how to respond should such an event occur.

Individual Resources

Self-assessment

Self-assessment of one’s level of distress is difficult, even for physicians. In a study involving over 1100 US surgeons the surgeon’s subjective self-assessment of their well-being relative to colleagues was poor with 89% believing their well-being was at or above average. Residency programs must offer self-assessment tools to residents according to Common Program Requirements. Self-assessment should rely on well-validated instruments assessing important dimensions of well-being relevant to residents and provide immediate or near immediate individualized feedback.

Well-Being Index

The online Resident Well-Being Index is a web-based self-assessment tool that relies on the well-validated resident well-being index. Residents who choose to set up an account can anonymously assess their level of well-being and receive both immediate feedback on how it compares to residents at their institution as well as nationally and access to resources to help promote wellness. Use of an electronic version of the Physician Well-Being Index has been shown to improve self-calibration and promote behavioral change to improve personal well-being. Additional information can be found at: https://www.mededwebs.com/well-being-index.

The tool is free for individual physicians, residents, and medical students to self-assess and track their well-being over time. For locally tailored resources or access to institution/residency specific reports (aggregate, de-identified data) a subscription is needed. An institutional license is available that provide access to the physician, resident, medical student, nurse, advance practice provider, and other health care worker version of the tool. The tool has been used by more than 35,000 individuals and takes less than 1 minute to use.

American Foundation for Suicide Prevention Interactive Screening Program

Another option for organizations is the American Foundation for Suicide Prevention Interactive Screening Program. With this program institutional counseling service provider or Employee Assistance Program obtains a license for a customized website where employees can take a brief questionnaire for stress and depression. The questionnaire is then reviewed by institutional EAP or counseling service provider and a personalize message is left for the employee. The employee logs back in to the website to obtain their message and can exchange messages with the counselor, get feedback and encouragement, and request an appointment or referral.
**Promote Health**

Promoting health by providing no or low cost access to fitness facilities, healthy food options while at work, relaxation or quiet rooms, and access to preventative care should be offered to residents.

**Treatment for mental health concerns**

24/7 access to confidential, affordable mental health assessment, counseling, and treatment is required as part of the common program requirements. Care for mental health concerns can be provided in a variety of ways, including, Employee Assistance Program, primary care physician, integrated behavioral health, and psychiatry/psychology. Care should be taken to reduce barriers to access care, including attention to stigma of mental health issues.

**Resources**

Make the Difference: Preventing Medical Trainee Suicide
https://www.youtube.com/watch?v=I9GRxF9qEBA

After a Suicide: A Toolkit for Physician Residency/Fellowship Programs
http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pdf


Well-Being Index https://www.mededwebs.com/well-being-index or text EZWBI to 797979

American Foundation for Suicide Prevention Interactive Screening Program https://afsp.org/our-work/interactive-screening-program/

**Bibliography**

**Overview**


Prevalence

Drivers of Burnout

Consequences


**Interventions, Organizational and Individual Strategies**


**Measurement tools**


### ACGME Common Program Requirements VI Well-Being

<table>
<thead>
<tr>
<th>Section</th>
<th>Common Program Requirements</th>
<th>Checklist</th>
</tr>
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<tbody>
<tr>
<td>Professionalism VI.B.4.c).(2) (educate)</td>
<td>Residents and faculty members must demonstrate an understanding of their personal role in the: assurance of fitness for work, including recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team</td>
<td></td>
</tr>
<tr>
<td>Well-being VI.C.1.a) (work environ.)</td>
<td>Efforts to enhance meaning in work (minimize non physician obligations, provide administrative support, promote progressive autonomy and flexibility, and enhance professional relationships)</td>
<td></td>
</tr>
<tr>
<td>VI.C.1.b) (work environ.)</td>
<td>Attention to scheduling, work intensity, and work compression</td>
<td></td>
</tr>
<tr>
<td>VI.C.1.c) (work environ.)</td>
<td>Evaluate workplace safety data and address safety of residents and faculty</td>
<td></td>
</tr>
<tr>
<td>VI.C.1.d) (Policies and procedures)</td>
<td>Policies and programs that encourage optimal resident and faculty well-being</td>
<td></td>
</tr>
<tr>
<td>VI.C.1.d)(1) (Policies and procedures)</td>
<td>Residents must be given opportunity to attend medical, mental health, and dental care appointments, including during scheduled work hours</td>
<td></td>
</tr>
<tr>
<td>VI.C.1.e) (educate)</td>
<td>Attention to resident and faculty burnout, depression, and substance abuse. Must educate faculty and residents in identification of symptoms of burnout, depression, substance abuse, including means to assist those who experience these conditions. Residents and faculty must also be educated to recognize these symptoms in themselves and how to seek appropriate care</td>
<td></td>
</tr>
<tr>
<td>VI.C.1.e)(1) (educate)</td>
<td>Encourage residents and faculty to alert PD or other personnel or programs when they are concerned that another resident, fellow, or faculty may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence</td>
<td></td>
</tr>
<tr>
<td>VI.C.1.e)(2) (resource)</td>
<td>Provide access to appropriate tools for self-screening</td>
<td></td>
</tr>
<tr>
<td>VI.C.1.e)(3) (resource)</td>
<td>Provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24/7</td>
<td></td>
</tr>
<tr>
<td>VI.C.2 (Policies and procedures)</td>
<td>Policies and procedures to ensure coverage of patient care in event that a resident may be unable to perform patient care responsibilities. Implementation of policies without fear of negative consequences for the resident who is unable to work</td>
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Achieving Excellence: Hiring the Best. Developing the Best. Keeping the Best.

Building a Comprehensive Approach to Wellness in the Residency

September 15, 2017

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Dr. Dyrbye is a graduate of the University of Wisconsin Medical School where she was selected AOA and she subsequently completed an internship and residency in Internal Medicine at the University of Washington. She also holds a Masters in Health Profession Education from University of Illinois completed in 2009. She holds numerous national education leadership positions including National Board of Medical Examiners USMLE Ambulatory Medicine Test Material Development Committee, Association of American Medical Colleges Research in Medical Education (RIME) Conference Planning Committee Past Chair, and Association for Medical Educators of Europe (AMEE) Research Committee. She is a past councilor for Clerkship Directors of Internal Medicine. She has published 74 peer-reviewed publications many in elite journals. In 2008, she received the Clerkship Directors of Internal Medicine Charles H Griffith Educational research award – awarded to the single Clerkship Directors of Internal Medicine member who has made the greatest impact on medical education over the preceding year. In 2012, she received the only ABIM Professionalism Article Prize in the field of medical education and training for her article “A Multi-Institutional Study Exploring the Impact of Positive Mental Health on Medical Students’ Professionalism in an Era of High Burnout,” published in Academic Medicine. In 2014, she was award the Deans recognition award for her contributions to Mayo Medical School. Her research interests are focused on medical student competency, professionalism, and well-being and she has received 11 competitive research grants to support this work. Dr. Dyrbye is currently recognized as the world expert on medical student, resident, and physician well-being.
Faculty Development Wellness Workshop 9/15/17

Participant Ideas for Reducing Resident Stress (notecard exercise)

- I would have regular scheduled social events each month sponsored by the department
- Laid back journal club with residents and attendings once a month
- Make mindfulness part of monthly meeting
- Therapy dogs
- Coloring
- Develop a mentorship; and get the suicide prevention video
- Teach resilience techniques
- Have a mentor/wellness program for my residents
- Set up a mentoring program and set aside time to meet with each other weekly or bi-weekly to discuss personal or professional problems
- Hire someone to do coding and order entry
- Provide quality and affordable onsite child care with extended hours without penalty
- Incorporate more open dialogue with faculty about other aspects of residents lives not just medicine
- Allow time in residents days to reflect
- Promote a sense of community by developing a group that plans activities directly in the city of the hospital
- Bring daycare facility to hospital
- Provide more ability for social time with co-workers and family
- Have more regular sessions that identify conditions that contribute to burnout and methods to address it
- Distinguish between burnout and perceived burnout by residents
- Quarterly get together sessions (residents and faculty and their families)
- Restructure administrative times to build regular work time to finish administrative duties
- More outings outside of work
- Increase admin support for residents
- Encourage more out of work activities that the residents can do together
- I would improve the mentoring the trainees receive
- Implement an exercise program
- Make the attendings write them thank you/appreciation cards
- Organize out of work social activities (golf outing, bowling, BBQ, bake Christmas cookies)
- Have them rate themselves on their own well-being to obtain a starting point for intervention
- Create a wellness evening or event geared towards the resident group
- Develop social activities to improve relationships/get ideas from residents and physicians then schedule the activities
- Team building/wellness activities throughout the year
- Reduce burnout by: partner faculty into mentorship with residents
- Provide increased clinical and administrative support including a culture shift among faculty to support and value resident education and contributions
- Personal assistants/concierge service to help with errands and personal tasks that would be housed at the hospital
- Schedule fun/active wellness activities
- Keep a friendly environment where residents can bring up their concerns
- Make duty hours less per week
- Allow flexibility when possible
- Frequent burnout assessments
- Reduce workload when possible
- Reduce paper/unnecessary work
- Increase physical exercise and socialization
- Provide 1-2x/week exercise group for residents and faculty
- Would also increase resident/faculty interaction outside work situation
- Have a counselor/social worker as a safe designated person who is readily available, that residents can go to when feeling overwhelmed or need to access resources
- Set aside administrative time for them to get their clerical/computer work done
- Tag onto ½ day academics
- Pull them all off all service one time each month to go somewhere fun for the entire day, including their families
- Wellness/stress reduce strategies on a continuum
- Monthly program sessions to foster community (dinner, discussion of stressors or a wellness type topic or case)
- Develop relationships to prevent doctors in isolation –Mentor/Mentee develop program that is interdisciplinary
- Bring in teaching/social worker to help develop individual coping mechanism
- More free time to do activities
- Encourage use of vacation time and shared holiday coverage
- Improve communication with program and faculty
- Assist in planning clear and reasonable rotation and PGY expectations and discuss them at rotation onset, midpoint and end
- Discuss results of survey with residents that was completed and discuss/solicit their ideas for focus on an action plan
- Respond to our problems/concerns and work together to bring change
- Try to increase autonomy with practical work flow solutions
- Create emotional support groups including 1 resident from each class supporting each other/knowing their not alone
- Set up a wellness program with 1 hour a 1 month of interaction
- Talk about expectation and feedback
- Identify how many residents feel burnout and why, send out a survey or self-assessment
- All-hour childcare at base hospital
- Scheduled time for wellness activities/regular breaks from patient care
- Encourage honest, proactive discussions
- Bring them coffee and donuts
- Hold regular meetings to get feedback, see what is going well and what needs to be changed
- Teach residents to be more efficient
- Give them a ½ day off each week in the afternoon
- No 24 hour calls
- Cut back their hours
- Program needs to be more organized
- Vacation time
- More positive feedback from faculty
- Give more vacation time
- Get rid of all 24 hour calls
- Maximum shift 16 hours
- Place a time cap on admissions at night
- Provide support for non-medical tasks that are now done by residents
- I want to give them option to provide solutions to clinic issues or schedules so they have some control
- I will set up meetings with fellows with agenda and to get their feedback in problems
- Give residents one ½ day off the work week, during daytime hours to get normal life/health activities done
- Put together a schedule and determine how clinical needs would get met during those times
- Implement monthly/quarterly social activities
- Hire scribes to assist with note writing
- Nutrition and exercise
- Engage their family into the hospital atmosphere
- Increase the feeling of community
- Identify residents who are not engaged with colleagues at work
- Have planned recreational time or time for group get-togethers
- Change the hours of certain rotations (8 hour work day)
- Integrate resident wellness curriculum into didactics
- Start resident wellness committee to integrate into each program
- Create small groups for hanging out so to increase community support
- Train faculty to provide effective supervision 1 on 1 to residents weekly
- Lessen the amount of modules
- Enhance outside social activities
- Mandatory counseling for all residents
- Recognize compliancy at all levels
- Due to a day off during the week
- Conduct a survey to measure burnout in medical students/residents
- Create and mind communication tool so students/residents can reach out for help
- Find a way to make the EMR process less time consuming
- Engaging in the program (their work and opinions matter in the process)
- When you’re starting to feel the pressures of residency, they have a safe place to go and talk
- Increase faculty to increase supervision
- Decrease ICU load
- Have them keep a sleep journal
- Limit moonlighting
- Reducing duty hours and patient loads
- Determine how to incorporate teachings within a reasonable time to decrease fatigue and malpractice
- Social support – have them meet with faculty outside of work
- We need to decide what is the most important thing they have to learn and focus on it
- Give them lunch for noon conference to cut back on time stress
- Improve social support between residents – more team rotations
- Improve the learning climate
- More wellness among all programs
- Quarterly wellness events put on by GME
- Wellness days 5 to 6 times a year
- Standard hospital rounds
- One or two times per month outside fun event
- Give rid of lazy attendings, identify who they are
- Increase administration support for residents
- To reduce burnout, I would establish time each month for residents to bring their family to work and have designated space to meet with them
- Make them feel needed, not feel like they are not important
- Give them food, something for them to look forward to coming into work for the day
- Help evaluate Work-Life balance and give support
- Decrease the patient volume they see
• Decrease the number of shifts
• Increase residency size
• Remove patient volume number criteria from program requirements/reduce load to increase time to learn
• Remove some attendings from resident teaching and conferences
• Send them all on a vacation with the PD and PC
• Work less hours
• Teach resilience
• I would create an anonymous grievance system, totally confidential