

This issue of the *Forum* is dedicated to the SGIM Annual Meeting on April 19-22, 2017: Resilience & Grit: Pursuing Organizational Change & Preventing Burnout in GIM.

Register is still open online or in person.

For more information, see: <http://connect.sgim.org/sgim17/registration/fees>

## PERSPECTIVE: PART I

### Our Physician Wellness Ecosystem

Tiffany Leung, MD

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*“Seen in different contexts, human nature...turns out to be plural and pluralistic; for different environments produce discernible differences not only across but within societies, in talent, temperament, human relations, and particularly in the ways in which each culture and subculture brings up the next generation.”*

—U. Bronfenbrenner, 1979<sup>1</sup>

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In recent years, professional organizations in health care and medicine have initiated strategic plans towards understanding physician burnout and implementing interventions to address this disturbing phenomenon. Physicians and physicians-in-training experience higher rates of mental health conditions, substance abuse, and suicide than the general population.<sup>2</sup> Additionally, burnout is associated with reduced patient health outcomes and lower patient satisfaction, and possibly increased costs.<sup>2</sup> It follows that interventions to improve work conditions for physicians, the “quadruple aim,” could also facilitate improved patient care.<sup>3</sup>

It can be easy to target individual physicians, yet there are clearly identifiable contributors to physician burnout at other levels. Consider a socioecological model, a concept originating from developmental psychology, which when applied to medicine could have at its core a physician—a human being living, learning, and developing in a dynamic environment.<sup>4</sup> In their immediate environment, stressors include time, interpersonal relationships, and most of all demands of the Electronic health record (EHR). Expanding outward further, changes in the U.S. health care ecosystem resulting from passage of the Affordable Care Act in 2014, have resulted in huge increases in the number of patients seeking care and increasing panel sizes for the individual physician. With a projected ongoing increase in patients accessing care, there still remains a projected total physician shortage of more than 60,000 physicians by 2025 further intensifying the stress on this system.<sup>7</sup>

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## National Meeting Workshop Preview! From Flint to Ferguson: The Role of Academic Medicine in Advocacy for the Underserved

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From Flint to Ferguson, New Orleans to Baltimore, New York City to Dallas, the nation has been overwhelmed over the last two years by destructive events that have impacted individuals and families, particularly those of minority communities, in unimaginable ways. As the environmental health issues surrounding the lead-contaminated waters in Michigan rose along with the floodwaters in Louisiana, so too did the recurring theme throughout the country of gun violence in the streets—the vulnerability of these underserved communities is more exposed than ever.

More recently, a new presidential administration has ushered in a rash of policies that have been considered or implemented and will affect immigrant populations while the proposed reform of the Affordable Care Act raises concern for the future availability of health insurance to many who only recently obtained coverage, including a large portion of the homeless population.

Though the politics around these issues are complex and sometimes divisive, it is clear that the physician

has an ethical and social responsibility to advocate for the health and well-being of the individuals under his or her care in the midst of difficult and momentous times.

As general internal medicine physicians, particularly in academic medical centers, we are regularly at the frontlines, managing chronic diseases and acute episodes of illness among patients who experience structural racism or disparate health risks in their communities. In the nearly 15 years since the Institute of Medicine's report "Unequal Treatment" revealed disparities in access and care of minority populations in the United States and the consequential poor health outcomes seen in these communities, scientists and physicians continue to study these factors with great perseverance. However, as the body of evidence increasingly demonstrates the impact that the environment outside of the clinical setting has on a patient's presentation, physicians often have been ill-prepared to effectively engage with patients in addressing these social determinants of health beyond the individual patient interaction.

As we gather for the 2017 SGIM Annual Meeting in Washington, D.C., in the backdrop of the Capitol Building, the opportunity to broaden our understanding of the role we as physicians can play in advocating for our patients and, in turn, promote health equity is imperative. From the idealistic first-year medical student to the seasoned primary care physician, we hope to share how we may harness the unique position that physicians are in to be a voice for our patients, taking advocacy from the streets to the State House, in our local communities or in our nation's capital. Through this work-

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## Missing Notes and Gaining Time

Eileen E. Reynolds, MD

How do detail-oriented, caring doctors allow missing notes to burden their lives or alter their careers? Are there ways to prevent the occasional “missing note” from multiplying exponentially?



Across multiple academic medical centers and the now-nearly-three decades of my professional life as a physician, I've known at least five general internists whose careers have been indelibly altered by “missing notes.”

What is a “missing note?” That's pretty obvious—it is the missing documentation required of a patient visit, the note that the provider never wrote. These missing notes can happen both in the inpatient setting (consults seen by a resident but never staffed formally by a faculty member; consults performed by a faculty member, teams contacted, but formal notes never written; or inpatient attending notes that go unwritten some days) and in the outpatient setting.

When I was a resident and junior faculty member in the early 1990s at UCSF, our outpatient notes were handwritten on carbon copy paper. Inpatient notes then were either handwritten right into the inpatient three-ring binder, or, sometimes (for faculty), were dictated and transcribed by the following morning. It must have been hard for administrators to track “missing notes” because there were no automated systems for matching visits with notes or notes with bills. Rather, the missing notes were palpable only to those caring for a patient who had had numerous visits but few notes. I can remember trying to reconstruct the plan of care for complicated, elderly patients in the absence of documentation by using computerized lab values and bags of pill bottles brought to visits. And I can remember finding many cardboard

boxes full of blank paper forms awaiting never-written notes after a colleague departed.

Since then, I've encountered multiple similar situations. For example, two faculty members, both former chief residents, working at two different academic medical centers who provided wonderful care for inpatients and outpatients but did not regularly document any of the care. Their careers were indelibly altered because these two *did* bill for those services (thus, by Medicare's definition, they acted fraudulently), because the piles of missing notes were Everest-like by the time they were found (lapses in oversight leading to more than a year's worth of missing notes), and because these two simply could not or would not comply with remediation plans.

And I know of other outpatient providers who fall slowly and inexorably behind in their notes—a few a day, a dozen a week—slowly falling further behind instead of acting on their intention to catch up and then keep up.

Now that we have the electronic ability (or requirement) to match visits with notes, it's easier to find and track faculty (and residents) who get behind. While most of us keep up pretty well and only have few “missing notes,” there are still piles of “missing notes” clustered around a small number of faculty. If I know of a bunch of these problems, many of you do, too; it's a serious issue.

How do well-meaning, clinically outstanding, detail-oriented, caring doctors allow missing notes to burden their lives or alter their careers? What

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themes emerge? Are there ways to prevent the occasional “missing note” from multiplying exponentially?

My literature searches returned zero references on missing notes, so there's nothing to learn there. I have not had in-depth conversations with each of these faculty members but I listened and learned from some and from others who struggle to keep up. Here are a few rationales that they and others have shared about why the notes pile up:

- **Patient care is the highest priority.** Writing a note seems to prioritize administrative medicine over the next patient. When running late to see the next patient, it just doesn't seem
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## Performance Improvement for Practice Redesign: An Annual Meeting Pre-Course and You

Alfred Burger, MD, Brent G. Petty, MD, Richard Gitomer, MD, MBA, Lisa M. Vinci, MD, MS, and Nathan Spell, MD

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**T**he Quality Improvement and Patient Safety Subcommittee of the Clinical Practice Committee will host its Annual Meeting pre-course again this year. Building on the success of previous years, the course will continue to emphasize rigorous quality improvement methods for improving process performance using interactive case-based learning. SGIM members are leaders at their own institutions and often called upon to institute change. The one-day session “Invigorate Your Practice: Performance Improvement for Practice Redesign” will provide attendees with the skills to maximally leverage your efforts to effectively change your processes and alter the culture in your practices. To this end, we invite practice teams to participate.

In keeping with the Annual Meet-

ing theme of “Resilience and Grit,” the case study will bring focus to organizational change at the practice level, where so many ineffective and inefficient processes wear us down and contribute to burn out. While using an ambulatory practice as an example, participants in the course will be invited to consider their own practices during the course and how these methods can be applied back home, whether in the outpatient or inpatient setting.

This session will review the key concepts that can further your skills at any level. We will start with a framework to analyze your local environment and determine how best to approach redesign in your practice. You will consider your stakeholders and learn strategies to engage them through change management princi-

ples. We will cover creating an effective and focused SMART aim statement to guide your project. Learn how to create appropriate measures and to identify and prioritize the opportunities for improvement, using such tools as process maps, Ishikawa (fishbone) diagrams, and Pareto charts. We will review the PDSA cycle and how to implement sustainable changes through rapid cycles of improvement. We will teach you how to create a run chart to analyze and represent your data and with an overlay of key events.

After participating in this course, feel a renewed sense of mastery over your environment, where you can bring together your inter-professional colleagues to redesign practice and take control of chaos!

SGIM

### MAINTENANCE OF CERTIFICATION (MOC) CREDIT WILL BE AVAILABLE TO ALL ABIM-CERTIFIED PHYSICIANS WHO ATTEND THE SGIM 2017 ANNUAL MEETING!

1 MOC credit will be granted for every CME hour

There will be NO added fee for MOC

Each person will still be required to apply online for CME credit after the meeting

#### ***What do you need to do to get MOC at the annual meeting?***

***It's as easy as 1-2-3!***

1. Before you go to Washington, read the e-mails from SGIM that provide the MOC questions.
2. While you are enjoying the meeting content, think about the MOC questions.
3. When you receive the meeting evaluation complete the MOC questions.

## The Role of Mindfulness in Mitigating Burnout

John Schorling, MD, MPH

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**B**urnout affects more than half of all practicing physicians in the United States, with 54% meeting criteria for emotional exhaustion or depersonalization.<sup>1</sup> The rate for general internists in this study exceeded the overall average. A study of academic internal medicine practices by Linzer and colleagues found that 38% of providers were experiencing high levels of burnout, and 67% high stress levels.<sup>2</sup> We found very similar rates of burnout (40%) and high stress (66%) in a recent survey of all Department of Medicine faculty members at the University of Virginia using the same instrument (the MiniZ). According to the AMA, burnout rates among physicians increased from 46% to 54% between 2011 and 2014. Why is this so?

Several explanations for this have been postulated. For example, two principal work-related factors that contribute to burnout are high workload and low control over work. Both of these describe the current work environment for many physicians and health care providers. Productivity expectations continue to rise as do the pressures to lower costs and reimbursement. At the same time, physicians are dealing with the increasing complexity of electronic medical records. All of this is in the context of decreasing physician autonomy as more physicians choose employment models which limit their control over their work environments. This combination of high workload and low control is a recipe for burnout. Additional work factors contributing to burnout that Maslach and Leiter have described include not feeling rewarded, a lack of community, perceived lack of fairness, and institutional values inconsistent with personal values.<sup>3</sup>

System issues and responses are important, but individual factors can also contribute to burnout. Often primary among these are compulsive or perfectionist personality traits. A compulsive triad has been described that is common among physicians<sup>4</sup>—self-doubt (i.e., we are often our biggest critics and cannot live up to our own expectations), an exaggerated sense of self-importance that leads us to feel responsible for things that are actually out of our control (such as whether patients choose to follow our recommendations), and excessive feelings of guilt when things don't go well.

Mindfulness has been shown to decrease burnout among physicians in a number of studies. Krasner and colleagues at the University of Rochester showed that burnout rates decreased significantly among primary care physicians who participated in an eight-week mindful communication course, and that these improvements persisted for 15 months.<sup>5</sup> At the University of Virginia, we have studied the impact of a mindfulness course for health care providers from a variety of specialties modeled on Mindfulness-based Stress Reduction which resulted in significant improvements in all three measures of burnout as measured by the Maslach Burnout Inventory.<sup>6</sup> In a recent meta-analysis, West and colleagues found that mindfulness interventions resulted in somewhat greater reductions in both emotional exhaustion and depersonalization than other interventions.<sup>7</sup>

Mindfulness is defined as intentional present-moment awareness without judgment. As physicians, we often expend time caught up in thinking, planning, worrying, and

judging ourselves and our experiences. Stressors, such as EMR burdens, time constraints and personal demands, detract from our ability to attend to our own experiences in the present moment as we engage with patients. In contrast, when we intentionally focus on our present-moment experience, we can begin to assess how we are feeling, both physically and emotionally. When we pause to observe how we are feeling, we can then choose our responses rather than be hijacked by them. For example, if we see the name of a patient on our schedule who we may have found difficult to deal with in the past, we may easily slip into telling ourselves a negative story about them. This might include thoughts about how they are non-adherent and demanding, and we may feel that we just don't have time to deal with them. By the time we get into the room, we may already be activated and defensive, and may find it hard to be empathic. In addition, we may negatively judge ourselves for having these negative feelings.

On the other hand, if we take time to pause first to pay attention to our feelings and realize we're tensing up, we can then choose to take a few breaths, and acknowledge the conflict between our negative emotions and our professional obligation to proceed. We can recognize that being activated before beginning the patient encounter is unlikely to achieve our goals of being efficient and empathic. It is helpful to understand that feelings, which arise from the limbic system, are not under conscious control. Therefore, guilt resulting from these negative emotions does not make physiologic sense.

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## Supporting Residents through Mental Health Crises

Elisabeth Poorman, MD

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One in three doctors in training is currently depressed.<sup>1</sup> There is growing recognition among medical schools, residency programs, and even the office of the Surgeon General that this epidemic is devastating to our community. Yet, we continue to treat this as an individual problem, reaching out to trainees only when they are already suffering and further singling them out.

Recently, I wrote an article publicly discussing my own depression in residency.<sup>2</sup> The reaction has been supportive and warm, but in one respect very puzzling: I'm often called *brave* for speaking openly about my struggle. This feels strange to me because from what I can tell, experiencing mental health issues in residency is almost as common as drinking coffee: there are some doctors who can get through training without it, but I can count them on my fingers.

Our mental health crisis is a crisis of culture. It is the result of long hours, trauma, sleeplessness, lack of patient contact, and abuse. It will not be solved with sporadic interventions. It is a crisis of leadership, with previous generations of physicians justifying the abuses they experienced and failing to recognize how training is changing. It is a crisis of honesty, with educators and employers telling us to seek help while making it impossible for us to do so.

I commend educators for recognizing this is a serious problem and worthy of their attention. However, the solutions are not going to be

simple. Here are few guiding principles for how medical education must change:

**1. We must separate wellness initiatives from mental health support.** Depression is not going to be cured with monthly mindfulness exercises.

**2. Confidentiality concerns in residency are very real and complex.** Even the appearance that a liaison may divulge personal information keeps many from seeking care in the first place. There should be prominently visible mental health liaisons at every program that are firewalled from other residency activities and in no way involved in evaluations.

**3. Residents who are still in training must feel ownership over this process and empowered to raise concerns.**

We will never know if our initiatives are working if the people they are meant to help cannot evaluate them.

As educational leaders, we also need to acknowledge the ways that we penalize trainees for prioritizing self-care. Are trainees judged for taking sick days and made to make them up? When picking residents and fellows, does a history of depression or leave of absence negatively impact applicants? When picking chief residents, do we choose only those who did not struggle in training and therefore

may not know how to respond to crises and burnout?

As advocates, we need to demand that license applications stop asking physicians about mental health issues that have not affected patient care. There is no evidence that mental health issues affect the quality of a physician's work when they are properly treated. Asking about mental health issues further stigmatizes these near-universal disorders and discourages doctors and medical students from seeking care. Ironically, not seeking care is what endangers our patients and colleagues.

On a more fundamental level, we need to acknowledge and change the basic structures that can make our jobs so demoralizing: endless paperwork, brief patient encounters, and the tendency of hospital administrations to squeeze every ounce of productivity out of us, even when it jeopardizes patient safety. Our profession is at a breaking point. We cannot afford to lose the joy of medicine by refusing to confront the ways that it is broken. Failing to do so will eventually break us all.

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One in three doctors in training is currently depressed. There is growing recognition that this epidemic is devastating to our community. Why do we continue to treat this as an individual problem?

## Teaching Mindful Practice®

Howard Leaman, MD, D-ABIM; (Sleep Medicine); D-ABPM (Occupational Medicine-FACOEM)

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**M**indful Practice® courses have been taught at University of Rochester since 2007, and recently, training has been made available for participants to teach this program. The author describes experiences leading up to taking and teaching the Mindful Practice® program that may provide insight and motivation to others wishing to explore that path to address current issues adversely affecting the practice of medicine.<sup>3,4</sup>

### My Years of Living Mindlessly:

After more than 30 years of practice culminating with patients “piled high and stacked deep,” I wondered how much longer I could continue to push through the days and nights of endless transactions and incessant demands. Despite my efforts to “keep up,” patient satisfaction had reached its nadir. Skiing, my favorite sport, over which my wife and I had bonded, was but a distant memory. Something had to change. The word *burnout* was not yet in my lexicon, but it was certainly my lived experience. I was more than tired; I had lost my compass. Seeking meaning and change, I found Mindful Practice® a CME-accredited course.<sup>1</sup>

We arrived in Rochester, New York, a jumbled bunch of docs, nurse practitioners, social workers, among others. Sitting together as a group of 50, with our instructors, Mick Krasner, Ron Epstein, Fred Marshall, and Florence Meleo-Meyer, was like no other CME I’d ever attended. Rather than giving a tightly scripted PowerPoint, leaders encouraged *talking* among ourselves and were actually curious about what we participants had to say. We would sit silently for a few minutes, and then each leader took turns opening discussions on a topic.

Over the 3.5 days, we learned meditation and meditated, were led through discussions, and told our own stories of our most meaningful personal clinical experiences (with a focus on which particular personal strengths made success possible in difficult situations). We learned to listen differently, and communicated with colleagues in ways that I had not experienced since medical school.

We left the center, cohesive and connected with shared purpose and vision of why we chose medicine. I had connected, listened (*really* listened), and been heard. When it was over, I was surprised to be sad to be leaving a CME program.

When I returned to work, staff and coworkers noticed a difference in me. I discovered I could change clinic scheduling (eliminating double and triple booked appointments) and I changed my approach with patients and our clinic staff (more focused on context). Within a short time, my patient satisfaction score rose from 20% to 70% (excellent) and stayed there.

People became curious “What did you do?” My medical director asked “Can you teach this?” I then registered for the “Advanced Mindful Practice®” workshop at the University of Rochester. In preparation, Ron Epstein had suggested readings and that we “work on our own practices,” so, along with my wife I attended a silent retreat.<sup>5,6</sup>

The Advanced workshop was similar to the earlier one, but with more in-depth focus on process and embodiment of principles of mindfulness.

### Teaching Mindful Practice®:

Upon return from the advanced workshop, I wrote a proposal to

teach Mindful Practice at Intermountain, was directed to our Employee Assistance Program (Live Well®) and met with the director, where I was introduced to another individual: “This is Marc, he’ll be your co-teacher for Mindful Practice®.” I requested, and was given a contract amendment that included “Teaching Mindfulness” to cover my activities in this area, and we started teaching (please see text box).

### Mindful Practice® Training at Intermountain Healthcare:

- Grand Rounds (Multiple)
- Invited Presentations (Multiple)
- Introduction to Mindfulness (multiple two-hour classes)
- Mindful Practice eight-week programs (2.5 hours each week over eight weeks)<sup>2</sup>

### Experiences of the Teachers: Continuing Medical Education Accreditation (CME):

We elected to apply for CME accreditation for our courses. Because of the robust evidence for efficacy of this program, and the fact that it meets the underlying criteria for CME, it was approved. This gave validity to our approach and allowed the CME department to publicize the program. Mindful Practice® program announcements were sent to every physician and Advanced Practice Clinician in the region, and our program was announced on their website and in newsletters for medical and general staff. We experienced some challenges attracting participants to some of the programs. These were overcome by building in more lead time for the CME accreditation on page 13

# The Mayo Clinic Program on Physician Well-Being: Studying Solutions to Physician Burnout

Colin West, MD, PhD, FACP

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**B**urnout and other aspects of distress have been recognized in recent years as a pervasive problem among physicians in the United States. The first national survey was conducted in 2011—the problem certainly existed before then but was not well documented. Burnout and distress have negative impacts on patients, physicians, health care organizations, and medicine as a profession. Conversely, heightened well-being, including reduced burnout and increased engagement, is linked to positive outcomes across these same stakeholders.

The Mayo Clinic Department of Medicine created the Program on Physician Well-Being (PPWB) in 2007 to better understand the entire spectrum of personal, professional, and organizational factors that influence physician well-being. Led by Drs. Tait Shanafelt, Lotte Dyrbye, and Colin West, with connections across disciplines including medicine, psychology, and health science research, the focus in the first few years was on establishing the epidemiology of burnout and distress. This work included prevalence studies as well as examination of factors associated with distress and well-being. As difficult as it may be to comprehend given current discussions around these issues, whether or not burnout was a real concern was not commonly recognized until quite recently. However, greater understanding of the scope of the problem has stimulated efforts to develop solutions. Although many questions remain unanswered, evidence now supports both individual-focused and organizational approaches to reduce and prevent physician burnout.<sup>1</sup> Aligned with this evidence, the PPWB has conducted applied randomized trials of interventions designed to reduce distress and promote well-being, including organizationally-supported

physician small-group meetings oriented around topics reflecting common stressful physician experiences.

These groups build on the fact that a sense of shared community is one of the great virtues of physician-hood. Mutual support from colleagues to help deal with the challenges of being a physician has long helped physicians manage the stress related to practicing medicine and helped physicians derive meaning from their work. Unfortunately, increased productivity expectations and other changes to the practice of medicine over the last several decades have decreased the time physicians have to interact with colleagues and have eroded these connections. The goal of the PPWB studies was to evaluate the ability of organizationally supported interventions to encourage collegiality, shared experience, connectedness, mutual support, and meaning in work; thereby, promoting well-being and a reduction of burnout and distress.

## Mayo COMPASS Groups

The first of these small-group interventions involved protected time during the workday, trained facilitators, and assigned physician groups. The intervention was effective in improving engagement and meaning as well as reducing some domains of burnout, but we sought to determine if simpler approaches might deliver equivalent outcomes.<sup>2</sup> To this end, we completed a trial of physician-led small groups in which Mayo Clinic paid for the groups' meals but the groups determined their own meeting times and membership. The groups were called COMPASS (Colleagues Meeting to Promote and Sustain Satisfaction) groups, and are also known internally as Physician Engagement Groups (PEGs).

Groups consisted of 6-10 physicians, with one group leader responsible for facilitating scheduling of 12

hour-long meetings over six months. We asked each group to meet in a relatively private setting (e.g., a restaurant near campus or a reserved meeting room) rather than more public spaces where interruptions would be more likely. Group leaders were provided with 3-4 discussion questions for each session. At least the first 15 minutes of each session were dedicated to semi-structured discussion involving: i) check in and ii) dialogue about one of the assigned questions for the session as selected by the group. The remainder of the time could be used either for additional discussion or socializing and building relationships with colleagues. Participants were reimbursed up to \$20 for each session, with payment considered taxable income.

After finding similar benefits from this approach as those seen in the prior study, along with increased job satisfaction and reduced social isolation,<sup>3</sup> Mayo Clinic leadership extended this program to all physicians and scientists at Mayo Clinic in October 2015, with funding derived from clinical sources within each hosting department. As of January 2017, nearly 1,300 physicians and scientists have signed up in a group, representing one-third of eligible individuals across all Mayo Clinic sites. At the end of the first six-month period, a survey of group leaders indicated that >95% reported the groups were valuable and that they planned to continue with them. Given these results, Mayo Clinic leadership has continued its support of this initiative.

## Lessons Learned

Despite the relative success of this program, implementation has provided lessons for other institutions and practices considering a similar effort. First, administrative support is required to keep track of groups and

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## Promoting Physician Wellness: Making the Future of Medicine Better

Manasa S. Ayyala, MD

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I had dinner with my uncle, a non-medical professional, the night before attending the International Conference on Physician Health™ (ICPH) in Boston, Massachusetts. My uncle, with a look of disbelief, blurted out “But why would there be a conference on physician wellness? Don’t doctors know how to care for themselves—they tell others how to care for themselves!” He felt this was the ultimate irony, and remarked to me how physicians already had the secret to wellness. From his perspective, physicians were trusted by people with their lives, witness to their most vulnerable moments, and privy to secrets to which even their closest friends and family were unaware.

How could they not know how to be well?

If only it was this simple.

I remember starting medical school with an overwhelming sense of excitement clouded by an additional emotion that I came to realize was fear. I asked my assigned advisor that day “How do I avoid becoming jaded?” and he replied “The fact that that you are already asking is how.” I was already fearful. Something about the physicians I had been around, including my own primary care doctor, scared me into feeling that I was giving up a part of myself and that this was expected. I pledged to myself that I would never lose sight of the humanity of medicine.

But, it was hard at times. Life happens at the same time as the practice of medicine, and it is easy to perceive that there is no time left for self-care.

It is now increasingly clear that there is a problem. We know that physician burnout is reaching epi-

demically with prevalence near 50%.<sup>1</sup> Physicians who experience burnout are more likely to report making recent medical errors, score lower on tests that measure empathy, and leave medicine altogether.<sup>2</sup> Burnout in physicians is characterized by emotional exhaustion, feelings of depersonalization, and reduced feelings of personal accomplishment due to chronic stress.<sup>3</sup> Evidence has linked even small increases in burnout scores to large changes in self-perceived major medical errors and increased suicidal ideation.<sup>4</sup>

Data show that medical students enter medical school as psychologically healthy as their peers who are not in medical school.<sup>5</sup> However, after training, rates of depression and burnout increase compared to their peers. In one study of seven medical schools in the US, approximately 50% of medical students met criteria for experiencing burnout and 10% had experienced suicidal ideation during medical school. Burnout was associated with increased likelihood of subsequent suicidal ideation and recovery from burnout with less suicidal ideation.<sup>6</sup> A national survey of internal medicine residents revealed that more than half met criteria for burnout. High rates of burnout are cited across medical specialties and internationally.<sup>5,7,8</sup>

I feel hopeful as I see the national conversation turned to improving wellness and focused on understanding, implementing and evaluating programs that not only work on reducing burnout but improving resiliency and self-care. These programs at the individual and organization levels do make a difference.<sup>9</sup> National organizations

such as SGIM are making this a priority and I look forward to taking part in the annual meeting, “Resilience & Grit: Pursuing Organizational Change & Preventing Burnout in GIM.” Medical institutions, organizations, and individual physicians share in this responsibility and opportunity to create change.

As we look toward the future of physician wellness as a priority, I believe we can realize that my uncle may be right. Maybe we do know how to be well. And maybe we need to consider adding the practice of physician wellness to the practice of medicine.

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## PRESIDENT'S COLUMN

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important to stop and document the last patient's visit. Similarly, on the inpatient side, if there are many ill inpatients to see, then prioritizing the writing of a note makes the next sick patient seem less important.

- **The scheduled visit length is for time to spend face to face with the patient.** If the visit length is 15 minutes, then the patient should "get" 15 minutes of the doctor's time. There is almost always more to do than time available and short-changing the patient means that more will be left undone.
- **Patients don't like to be kept waiting.** Stopping to document before moving on contributes to tardiness and seems to devalue the time spent waiting by the next patient. We all run a bit late during practice sessions; leaving the notes until after it's over helps with time management during the session itself.
- **Perfect can be the enemy of good.** It's hard to write a great note while rushing on to the next patient.
- **Once behind with note writing, it gets harder to catch up.** It makes sense to start back at the beginning, but those visits were a long time ago so they are the hardest to write. Just getting started is a challenge and so the pile grows.
- **Time management doesn't come naturally to everyone.** No one ever emphasized administrative medicine during medical school and residency. Having an organized plan for documenting visits was something that was not part of training, and it's hard.

Interventions need to be multifactorial. Some of the solution needs to be about expectation management—think about the visit length as including two minutes for documentation, and then provide exceptional care, with an acceptable note. Writing notes is part of caring

for the patient (unless you are in the lucky minority of generalists who work with scribes).

But some of this should be about skill building. Time management is indeed not part of the typical student curriculum or residency program. Yet, it is clearly one of the most fundamental skills required for success by every physician. We know the EMR contributes to burnout; how much of that could be ameliorated by better time management techniques is not clear. There is little evidence-base about time management strategies but much lay literature.

The following are a few strategies that might have helped those faculty members suffering under missing note piles:

1. **Anything that you must do, that takes less than two minutes, just do it.**<sup>1</sup> This advice comes from David Allen's book *Getting Things Done* and is particularly relevant to missing notes. Documenting during or immediately after a visit really does take about two minutes; leaving it until the end of the session, the end of the day, or the end of the week then requires reconstruction of what happened in the visit and takes much longer. Just instituting this

change will gain back all that time spent in reconstruction.

2. **Keep an action-item to-do list.** I bet your to-do list says things like "do taxes" or "write review article" or even "catch up on missing notes." Those are substantial projects, not to-do items. How about "gather W-2 forms" or "do literature search for review article" or "dictate five missing notes." Those seem more achievable; listing achievable chunks will help get more things accomplished.
3. **Learn to delegate.** While you can't delegate your notes (except to a scribe) there are other things you can delegate, and it's an investment in building skills and saving time to learn to rely on others, to supervise, check, teach, and return.<sup>2</sup> It comes naturally to many residents supervising interns, but less naturally when we act as an administrator or supervisor for staff.
4. **Spend at least 20% of your time working in the "not urgent, important" part of the 2X2 table (see below).** Experts suggest that spending 20% of your time in box 2 will get you 80% of your productivity. Avoid the place we all spend a lot of time—urgent but not important.

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**Classification of Tasks: Urgency and Importance**

	Urgent	Not Urgent
Important	1	2
Not Important	3	4

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## PERSPECTIVE: PART I

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Viewing physician burnout appropriately in a more comprehensive context, the seemingly narrow focus on individually targeted solutions appears rather myopic. Arguably, this is because workshops and seminars that target the individual practitioner are easier to implement. Changes in health care systems and in health policy are more challenging undertakings. While health care organizations may not be in a position to lobby or advocate for the interests of individual physicians, they should seek to embrace a culture of wellness and respond genuinely to the concerns of their physicians, as several academic medical centers are beginning to do for their physicians and physicians-in-training. Some have a dedicated center for wellness, with a stated mission to promote physician wellness and fulfillment. Specific objectives could include research elements, supportive services, such as peer support or social activities and forums, as well as aforementioned seminars and workshops on mindfulness-based stress reduction, compassion training, or other related subjects. In some institutions, engagement in certain services, such as stress-reduction coaching and exercise classes, could also be tied to employee incentives for physicians as employees. Of course, this is a vital role for professional organizations, including SGIM, to provide not only a forum for sharing experience and knowledge about interventions to promote cultures of wellness in dif-

ferent settings but also to act as a powerful advocate on behalf of its members.

Ultimately, there is no single correct approach to promoting physician wellness and reducing burnout. While tools that enhance physician self-care and empowerment are necessary for the individual, they are insufficient interventions to ameliorate physician burnout for the health care system as a whole. Interventions to improve the work environment must be multifaceted and must be a responsibility of *all* participants in the system, from the individual physician to those in positions to affect changes in the health care system. Although many challenges remain, one hopes that fewer physicians in the future will react as my colleagues today in feeling blamed, pressured to perform, and consequently, less well and more burnt out. The growing attention and concern regarding physician burnout in the health care community evoke optimism, and I believe we should all feel a growing personal motivation to participate in such changes. These are promising signs of evolution in our physician wellness ecosystem.

**“...this diversity suggests the possibility of ecologies as yet untried that hold a potential for human natures yet unseen, perhaps possessed of a wiser blend of power and compassion than has thus far been manifested.”**

—U. Bronfenbrenner, 1979<sup>1</sup>

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## PRESIDENT'S COLUMN

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Part of the problem with missing notes is that they may fall into the “urgent, not important” box once they have been missing for a while.

In the end, time management skill building, along with expectation management, might have prevented some of these piles of missing notes or the resultant career im-

pact. Just like a small bowel obstruction, don't let the sun set on a missing note. And, as Mark Twain reportedly said:

*The secret of getting ahead is getting started. The secret of getting started is breaking your complex overwhelming tasks into small manageable tasks, and then starting on the first one.*

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## BEST PRACTICES: PART I

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What we *do* have control over is our response to the situation once we recognize the feelings. We can pause to decide how to respond most effectively. This enables us to also reduce any guilt we experience as a result of these feelings and, rather than judging ourselves, accept that the work we are doing is hard.

Finally, one of the factors that seems to contribute to burnout is repeated exposure to strong emotions which can result in empathic distress. Evidence suggests that empathy is largely mediated in such a way that when we are faced with suffering in another corresponding parts of our brains are stimulated so that we actually experience some of the same emotions as that other person.<sup>8</sup> The closer we feel to the other person, the more the areas of activation overlap. This has been referred to as the “merging of self and other.” Faced with repeated experiences with patients who are suffering, we may begin to repress these feelings and block them out, resulting in depersonalization.

The concept of paying attention to our present-moment experience without judging it may be simple, but in practice is not easy. We can cultivate this ability through meditation, or formal mindfulness practice. This is called *practice* because it requires repetition to change neural pathways and gain the capacity apply this skill real-time, in the moment, during our everyday lives. Taking a mindfulness course, such as Mindfulness-Based Stress Reduction, is an ideal evidence-based way to learn this technique. An-

other option is to listen to guided meditations for 5 to 10 minutes several times a day, and gradually increase this over time. Many tools are readily available, including mindfulness apps for Smartphones, and instructional videos. One resource, the University of Virginia Mindfulness Center’s Web site (<https://med.virginia.edu/mindfulness-center/>)<sup>9</sup>, contains free, downloadable guided meditations.

In addition to practicing formal meditation, pausing to practice mindfulness throughout the day is helpful. This simply entails remembering to stop to take a deep breath and notice the feelings, sensations and thoughts that are present. As soon as we pause like this, space opens for us to choose our responses with more awareness. STOP is an acronym that can aid in doing this: **S** stands for Stopping; **T** is for Taking a few breaths; **O** is for Observing present-moment experience with kindness; and, **P** stands for Proceeding with awareness. A time to consider doing this is when using hand sanitizer before entering a patient’s room. At UVA, we call this *gelling in and breathing*. It’s an easy place to start.

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## MEDICAL EDUCATION: PART I

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tation process, addressing the length of the program, carefully targeting marketing material to include more than the formal CME announcement (Who, What, Why, How), and soliciting past participants (and the CME committee) to strategize and help publicize upcoming programs. Thus far, more than 100 physicians and APCs participated in Mindful Practice® programs at Intermountain Health Care.

**Co-facilitation:** We found that it was critical to have a partnership of two facilitators. While I had no experience teaching mindfulness, and Marc, my training partner, was not a physician; both of us had extensive practice and teaching experience. Our partnership helped ensure that at least one of us would be present and emotionally available for the participants for the entire session. In addition, many of our classes experienced situations where one of the facilitators would have to separate from the group to address logistical and other issues while the other kept the program on track. Fortunately, I was assigned to Marc, a very experienced and deeply embodied mindfulness teacher (LCSW, EAP counselor) who added richness and depth to the program that would not have been otherwise possible. That said, we had constant discussion to balance meditation, discussion, and didactic program content.

**Our Experiences Teaching:** Despite extensive teaching experience, preparing for teaching Mindful Practice® was different. Although the curriculum and teaching manual was kindly made available to Mindful Practice® participants by the authors at University of Rochester, the na-

ture of this education is “guided discovery” and requires teaching from “lived experience” rather than from a script. The curriculum was necessary but only a starting point for teaching. We anticipated and were quick to notice that “participants have miraculous bullsh\*t detectors.” To fully understand the curriculum, it was crucial that we not only read all the references (in the slides and manual) but also reflect deeply on our connection to them. Only then could I begin to feel prepared to go into a room full of tired, sometimes skeptical physicians.

### Teaching Outcomes/Learning

**Outcomes:** Participant engagement and growth (as measured by follow up surveys) was substantial. Our outcomes were similar to those of Krasner and Beckman.<sup>1,2</sup> Burnout and mindfulness improved, as measured by Maslach Burnout Inventory and Mindful Attention Awareness Scale. Participant comments indicated other growth areas (please see text box).

Reflecting on factors contributing to our success from participant reviews and discussions, we credit the authors of Mindful Practice® (Krasner, Epstein, et al.) for training us and permitting use, our own institutional support for the program, and our own prior experiences in teaching and clinical practice. Our own experiences suffering from and recovering from burnout, and the embodiment of the principles of Mindful Practice® allowed us to create a safe and relaxed environment permitting participants to open up to deeply personal experiences and viewing them (and themselves) from another perspective.

**Questions:** The results of our work in Mindful Practice® caught the attention of our organization and we were called to attend meetings with senior executives to discuss further training at Intermountain. Notable questions “Does it have to be *that long?*” (What is the minimum dose?), “What is the R.O.I. (return on investment) of this program?” (“Is it worth the cost?”), “Will this work for docs with bad patient satisfaction?”

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#### Participant Reviews of Intermountain Mindful Practice Eight-week Course 2016.

“It opened up my mind in staggering ways—unbelievably valuable.”

“The didactic and practice are both relevant. . .an important-life changing content.”

“Less rushed, more present, hopefully more thoughtful.”

“I am much happier and enjoy people more.”

“Mindfulness is already helping me in my daily practice-less distracted, increased focus, more effective.”

## Medical Student Perspective: Why More Medical Students Should Attend the SGIM Annual Meeting

Alison M. Holliday, MPH

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I am a third-year student at Harvard Medical School and had the privilege of attending the 2016 SGIM Annual Meeting “Generalists Engaged in Population Health.” After leaving the conference inspired, and after meeting only one other medical student at the conference, I feel compelled to encourage more medical students to attend next year. The Annual Meeting was not even on my radar until my mentor encouraged me to attend; I submitted my research, and to my surprise was selected to give an oral presentation and nominated for a national award. Mentors, please encourage your students to attend like mine did! Presenting my work was an incredible honor and opportunity, and I learned more than I had anticipated at the conference.

Here is a list of my top six reasons why medical students should attend #SGIM17:

1. *You don't have to be a doctor to have an impact.*  
There are many ways for medical students to contribute at the SGIM Annual Meeting, and physicians want to hear what you have to say. Start research or a clinical vignette now in preparation for next year. Medical students certainly have a lot to learn about medicine, but they also have a unique perspective on patient care to contribute at these meetings.
2. *Mentors want to mentor.*  
The importance of mentorship in shaping careers is a theme we often hear in medical school and a theme that continued at all SGIM meetings. There are many accomplished physicians at the SGIM Annual Meeting who benefited from mentors in the

past and who are eager to pay it forward. There was even a room at the 2016 conference dedicated to helping students engage in research and find mentors. You would be surprised at what can come out of a casual conversation over breakfast.

3. *You can have a work family.*  
When I asked physicians what brought them to SGIM Annual Meeting, many responded that they come year after year to see colleagues from all over the country. To me, the SGIM community looks less like colleagues and more like family—laughter, hugs, and excellent dinner conversation abounds. SGIM members are people with common interests looking to push boundaries and be better together. Medical students should join the conversation—join SGIM, and be welcomed into the family.
4. *You can build your skills.*  
Very practically, SGIM offers medical students opportunities to build skills that you are not taught in medical school. Giving a good presentation takes practice; the more opportunities you have, the better you will become. As a result of giving an oral presentation last year, I now have a better appreciation for how to respond to audience questions. Some of the workshops last year included information on how to lean in, how to expand your career into patient-centered outcomes research, how to be a successful leader, advice on research design, how to publish a clinical vignette, and how to prepare for a career in academic internal medicine.

5. *People are likely working on what you are interested in.*

On average it takes three years for research to be published, so excellent research related to your interests might be completed without you knowing it. Last year at SGIM, I met fellow researchers working in the same field whose papers had not yet been published, and now, we have the opportunity to collaborate. Attending this large, national conference is an efficient, fun way to meet others who share your interests and to stay on top of the latest internal medicine news. I now follow colleagues on Twitter to continue to stay up-to-date.

6. *It is important to set aside time to reflect on what drives you.*  
Everyone knows that medical school is hard, and after long hospital shifts or all-nighters of studying it is easy to forget to reflect on why you were drawn to medicine in the first place. The SGIM Annual Meeting offers ample time for self-reflection. I left the conference feeling motivated with many lists of goals: to tackle population health-related problems, to contact people about their research, to carry inspirational quotes with me (“If you’ve always succeeded, then you’ve failed” from Dr. Suzanne Fletcher was my favorite), to start possible initiatives at my medical school, to share lessons learned with classmates.

To me, the conference served as a refreshing reminder of why I chose this career ahead of me and of what a privilege it is to be in the profession I am in.

## BEST PRACTICES: PART II

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maintain a point of contact should issues arise, even as the groups are responsible for their own scheduling. To support this, an internal Web site was developed with links to contact information, lists of discussion topics, and other guidance for participants. The program also has a dedicated support staff member with a small amount of institutionally directed time for this role. Second, many groups have wished to extend their enrollment beyond the 12-session initial plan. Discussion topics are available to support roughly three passes through the program. Beyond that, groups may need to repeat topics as additional ones are developed. Third, some individuals will only participate if enough close colleagues also sign up whereas others will only participate in groups outside of their clinical circles. Flexibility in group assignments is critical to respect these wishes and provide each participant with the optimal setting for maximal benefit. Fourth, reimbursement through existing institutional mechanisms such as a corporate travel card is much less resource-intensive than processing thousands of one-off receipts for payment.

According to participants, the most challenging aspect of the COM-

PASS groups, however, has been actually making the time to engage meaningfully with their colleagues. This challenge speaks to the importance of efforts to prioritize opportunities for physicians to engage together as a community. Many SGIM members view the regional and annual SGIM meetings as central to their sense of belonging, but local physician communities are perhaps even more critical. Mayo Clinic recognizes this and has promoted the COMPASS groups through repeated messaging and has continued to fully fund the program. In addition, this opportunity is presented to all new staff during their orientation process. Many physicians have joined in the “second wave” of groups based on word-of-mouth from members of earlier groups, so even as finding time to meet proves challenging, groups find value in the program and have continued to enroll.

### Summary

There is no single solution to the physician burnout crisis. However, each additional evidence-based tool we can add to the menu for physicians increases the chance that every physician can benefit from at

least one approach. SGIM members have led the way in developing and studying both individual-focused and organizational or practice-level solutions. We are proud to contribute alongside our colleagues in a shared effort to improve our lives as physicians and meet our high standards in serving our patients.

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shop, participants will receive an overall introduction to the influence of social determinants of health, including the physical environment, income, education, housing and food security, and how advocacy can be used as a way to address them. Drawing from the experiences of workshop faculty from across the nation, participants will receive necessary tools—including communication and presentation skills—to advance the care of their patients, including how to work with members of the community as well as politicians at the local and national levels. We hope these skills will lay a foundation on how to successfully incorporate advocacy work into otherwise

demanding professional lives.

As the news reports show, physicians around the country are speaking out to preserve the rights of their patients and fellow Americans. Medical schools and residency training programs from Montefiore Medical Center to the Cambridge Health Alliance are beginning to think creatively as to how to best prepare young physicians for the role of an advocate. As this session concludes, the goal is for participants to leave with greater confidence and skills to take on advocacy as a part of their profession with passion, resilience, and grit.

Looking forward to seeing you in D.C.!

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