Resident Wellness Update
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Overview

- Burnout, Depression, Substance Abuse
- Current initiatives at Northwestern
- Utilization Data
What is Physician Wellness?
(a brief reminder)
Physician Well-being

“Quality of life, which includes the absence of ill-being and the presence of positive physical, mental, social, and integrated well-being experienced in connection with activities and environments that allow physicians to develop their full potentials across personal and work-life domains”
3 Components of Burnout

- Emotional exhaustion:
  - Lacking emotional capacity to perform one’s work
  - feeling frustrated
  - tired of going to work
  - hard to deal with others at work

- Depersonalization:
  - being less empathic with patients/others
  - detached from work
  - seeing patients as diagnoses/objects/sources of frustration
  - thoughts and feelings seem unreal or not belonging to oneself

- Low sense of personal accomplishment
  - experiencing work as unrewarding, “going through the motions”
### Burnout among residents versus other careers

<table>
<thead>
<tr>
<th></th>
<th>Residents</th>
<th>Other College Grads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>50%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Positive Depression Screen</td>
<td>50.7%</td>
<td>41.1%</td>
</tr>
<tr>
<td>Suicidal thoughts in past 12 months</td>
<td>No measurable difference</td>
<td></td>
</tr>
<tr>
<td>Quality of life</td>
<td></td>
<td>Modestly higher</td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td>Modestly higher</td>
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DRIVERS OF BURNOUT

- Excess stress mediated by long hours, fatigue and work compression as well as the intensity of work environment
- Loss of meaning in medicine and patient care: Decreased support, increased responsibility, without autonomy and flexibility
- Challenges in institutional cultures: perceived lack of peer support, lack of professionalism, disengaged leadership
- Problems with work-life balance
COMPARISON TIME

KEY POINTS

- Burnout is the individual’s response to a systemic problem!
- Burnout needs a systemic organizational response
- Both individual focused and organization focused interventions can reduce burnout
- Organization based interventions are more effective for burnout
Depression in physicians

- Signs: diminished interest, low mood, hopelessness, in and out of work

- Occurs at same rate as general population,
  - 12.8% lifetime prevalence for males, 19.5% in females
  - 12-mo prevalence: males 7.7%, females 12.9%

**PREDICTORS OF INCREASED DEPRESSIVE SYMPTOMS DURING INTERNSHIP**

**Baseline Factors**
- Personal history of depression
- Female sex
- US medical graduate
- Difficult early family environment
- 5-HTTLPR polymorphism

**Within-Internship Factors**
- Higher mean work hours
- Perceived medical errors
- Stressful life events

*Sen et al. Arch Gen Psych, 2010*
GENDER DISCREPANCIES IN SUICIDE RATES

- Multiple studies

- Suicide ratio for physicians compared with aged matched controls in the general population:
  - 1.41 times higher for men
  - 2.27 times higher for women

*Schernhammer E, Colditz G. Am J Psych, 2004*
**Risk and protective factors for suicide among physicians**

<table>
<thead>
<tr>
<th>Risks</th>
<th>Protective factors</th>
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<tbody>
<tr>
<td>*Mood disorders</td>
<td>Effective treatment</td>
</tr>
<tr>
<td>*Substance use disorders</td>
<td>Social and family support</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>Resilience and coping skills</td>
</tr>
<tr>
<td>Caucasian</td>
<td>Religious faith</td>
</tr>
<tr>
<td>Marital disruption</td>
<td>Restricted access to lethal means</td>
</tr>
<tr>
<td>Job problems</td>
<td>Marriage: protective for men but not women?</td>
</tr>
<tr>
<td>Untreated physical illness</td>
<td></td>
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<tr>
<td>Access to lethal means</td>
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</table>

*Strongest predictors
DIFFERENCES IN ASSOCIATED FACTORS IN PHYSICIAN SUICIDE VS. THE GENERAL POPULATION

- Less likely to have had a recent death of friend/family
- More likely to have had a job problem
- Higher measurable levels of benzodiazepines and barbiturates
- Older
- Presence of known mental illness
- Major barriers to help-seeking, diagnosis and treatment due to stigma

Gold, et. al, General Hospital Psychiatry, January 2013
Substance use disorders

- Alcohol most common
- Excellent prognosis (with treatment and monitoring)
- 5-year relapse rate of physicians who are monitored: 19% (1/3 of general population)
- Illinois Professionals Health Program (IPHP)
  - Support services
  - Treatment monitoring
  - Advocacy (with employers, licensing, etc)
  - Independent from licensing boards
Barriers to care: Northwestern specific

- No time in schedule: 77%
- Confidentiality: 58%
- Stigma (concern about what others think): 55%
- Don’t want care at NMH: 55%
- Cost: 53%
- Lose trust of peers: 45%
- Licensure concerns: 44%
Stress Management and Resiliency
RESILIENCE

• The capacity to bounce back, to withstand hardship, and to repair yourself

• Positive adaptation in the face of stress or disruptive change

• Based on a combination of factors:
  • Internal attributes (genetics, optimism)
  • External (modeling, trauma)
  • Skills (problem solving, finding meaning/purpose, practicing mindfulness)

Wolin 1993, Werner & Smith, 1992
BUILDING RESILIENCE

Personal characteristics
Humour, ‘bounce back’, adaptability, optimism, confidence, organisation, flexibility, tolerance, using professional boundaries, teamworker, sense of self-worth

Workplace characteristics
Strong management support, team culture, a secure base, buffering capacity, time for reflection

Social network
Family/social support, leisure time, interests outwith work

Resilient health professional

Challenges
Workload, time pressures, lack of communication, information overload, challenging patients, rural environment

CAN WE BUILD RESILIENCE?

- Realistic recognition (Overcoming denial/culture)
- Exercise, sleep, nutrition
- Supportive professional relationships
- Boundaries
- Time away from work
- Passion for one’s work

- Hobbies outside medicine
- Humor
- Supportive personal relationships
- Practicing mindfulness
- Focusing on positive emotions like gratitude and optimism

Swetz J Palliative Med, 2009
A wellbeing plan may include the following types of organizational interventions:

1. **Educate and Increase Awareness**
2. **Designate Time for Reflection**
   - Groups, debrief protocols
3. **Teach Practical Skills**
   - Mindfulness, CBT, exercise
4. **Build Community**
   - Mentoring and coaching programs
   - Opportunities to socialize at work
5. **Ensure Access to Care**
6. **Improve Workplace Environment**
   - Review workloads and schedules with physician input, autonomy, flexibility
   - Adequate staffing to reduce admin/clerical tasks for physicians
   - Personnel optimized to work at top of licenses in most meaningful work
7. **Transform Institutional Culture**

*Developed by ML Goldman, CA Bernstein, LS Mayer*
Why are we doing this?

- Untreated mental illness and substance abuse are highest risk factors for suicide
- Focus on lowering obstacles:
  - Scheduling
  - Confidentiality
  - Stigma
  - Cost
  - Unaware of how to get started
How are we doing this?

- Psychiatrist available at short notice (within 1-2 days)
- Flexible hours
- Flexible meeting location
- FREE to the resident (funded by GME)
- Confidential
  - GME doesn’t know who called
  - No visible chart
Wellness Program vs Fitness for Duty

**Wellness Program**
- Resident-driven
  - PD can suggest treatment, but resident makes the call
- Confidential
- Voluntary

**Fitness for Duty**
- When PD is concerned about a resident’s safety or the safety of their patients
- Required, not voluntary
- Not confidential
- Can lead to requirements, such as mandatory treatment and random drug screens
What happens when a resident calls the Wellness Program?

- Meet in person quickly for evaluation and treatment plan
  - Maintain treatment relationship until another is established
- Talk on the phone,
  - Example: adverse outcome discussion
- Help triage and coordinate care
  - Example: Help resident find an outpatient provider
Important details

- Completely optional to residents, never mandated
- Confidential – No feedback to program (unless resident asks for this)
- 100% for the benefit of the housestaff
2017-2018 Academic Year Data

**Gender Distribution**
- Male: 32%
- Female: 68%

**Chief complaint**
- Depression: 39%
- Anxiety: 27%
- Stress/Burnout: 34%
2018 July – December Data

Gender distribution
- Male: 39%
- Female: 61%

Chief Complaint
- Depression: 37%
- Anxiety: 22%
- Stress/Burnout/Adjustment: 41%
2017-2018 Academic Year Data

Utilization Per Year of Training

- PGY 1: High Utilization
- PGY 2: Moderate Utilization
- PGY 3: Moderate Utilization
- PGY 4: Low Utilization
- PGY 5: Very Low Utilization
- PGY 6: No Utilization
- PGY 7+: Minimal Utilization
2018 July – December Data

Utilization Per Year of Training

- PGY 1
- PGY 2
- PGY 3
- PGY 4
- PGY 5
- PGY 6
- PGY 7
2017-2018 Academic Year Data

Program Distribution
Utilization by Program

2018 July – December Data
Wellness Program Initiatives (it’s been a busy year…)

- SMART-R
  - “Stress Management and Resiliency Training for Residents”
  - Developed at Harvard
  - Evidence-based
  - Workbook-based
  - Uses components of
    - CBT
    - Positive Psychology research
    - Mindfulness-Based Stress Reduction
  - Pediatrics, OBGYN, and Surgery for now…
  - …and we are coming for you soon!
Wellness Program Initiatives (it’s been a busy year…)

- Screener Pilot Program
- Todd Junkins, LCSW
- Pediatrics only
- Set an appointment with each intern
  - Choice to “opt out”
- Goals include:
  - Reducing stigma of meeting with a mental health provider
  - Provide resources in the moment if needed
  - Provide a future go-to resource if needed
Wellness Program Initiatives (it’s been a busy year…)

- Various group meetings
  - CCU Remembrance Rounds
- Surgery “difficult cases” conference
- Peer support initiatives for anesthesiology, possibly surgery
- Resident Panel discussions for Pediatrics
“We’ll continue to monitor the anti-depressants, but this scan is encouraging.”