AAMC Leadership Forum
Creating a Culture of Wellbeing and Resilience in Academic Medicine
Background: What is wellbeing and resilience and why focus on it?
Illness-Wellness Continuum

ILLNESS-WELLNESS CONTINUUM

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>POOR HEALTH</th>
<th>NEUTRAL</th>
<th>GOOD HEALTH</th>
<th>OPTIMAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple medications</td>
<td>Symptoms</td>
<td>No symptoms</td>
<td>Regular exercise</td>
<td>100% function</td>
</tr>
<tr>
<td>Poor quality of life</td>
<td>Drug therapy</td>
<td>Nutrition inconsistent</td>
<td>Good nutrition</td>
<td>Continuous development</td>
</tr>
<tr>
<td>Potential becomes limited</td>
<td>Surgery</td>
<td>Exercise sporadic</td>
<td>Wellness education</td>
<td>Active participation</td>
</tr>
<tr>
<td>Body has limited function</td>
<td>Losing normal function</td>
<td>Health not a high priority</td>
<td>Minimal nerve interference</td>
<td>Wellness lifestyle</td>
</tr>
</tbody>
</table>

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Definition of Well-being

A good or satisfactory condition of existence; a state characterized by health, happiness, and prosperity.  Dictionary.com

Well-being can be described as judging life positively and feeling good.  Centers for Disease Control
Definition of Mental Health

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

The positive dimension of mental health is stressed in WHO’s definition of health as contained in its constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

World Health Organization
Definition of Burnout

Resilience

Definition of Resilience (APA)

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences.
Physician Mental Health: Preventing Suicide and Building Resilience

Christine Moutier, M.D.
Chief Medical Officer, American Foundation for Suicide Prevention
Disclosures

Disclosures/conflicts

• None

American Foundation for Suicide Prevention (AFSP) funds 25% of all suicide studies

Acknowledgments

• Sid Zisook
• Yeates Conwell
One Medical Center’s History

• Our medical community experienced suicide losses

• Reached a turning point in 2002 - death by suicide of a prominent UCSD faculty physician

• Ready to take action

• Institutional survey found significant distress, burnout, substance use, suicidal ideation
Two-Pronged Prevention

EDUCATIONAL CAMPAIGN:
Focus: Mental Health and suicide to destigmatize help seeking and treatment.

AFSP’s web-based screening, assessment, and REFERRAL PROGRAM

Goals:
• Educate
• Destigmatize
• Optimize health
• Refer
• Improve Mental Health
• Prevent suicide
Mental Health: A Dynamic Model

- Resilience
- Burnout
- Distress
Interacting Risk and Protective Factors

- Biological Factors
- Psychological Factors
- Social and Environmental Factors

Current Life Events

BEHAVIOR
Interacting Risk and Protective Factors

Current Life Events

SUICIDE
Interacting Risk and Protective Factors

- Biological Factors
- Psychological Factors
- Social and Environmental Factors

Current Life Events

SUICIDE
Interacting Risk and Protective Factors

- Biological Factors
- Psychological Factors
- Social and Environmental Factors

Current Life Events

SUICIDE
Risk Factors for Suicide

<table>
<thead>
<tr>
<th>Mental illness</th>
<th>Aggression/impulsivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous suicide attempt</td>
<td>Triggering event</td>
</tr>
<tr>
<td>Serious physical illness/chronic pain</td>
<td>Access to lethal means</td>
</tr>
<tr>
<td>Specific symptoms</td>
<td>Suicide exposure</td>
</tr>
<tr>
<td>Family history of mental illness and suicide</td>
<td>Inflexible thinking</td>
</tr>
<tr>
<td>History of childhood trauma/adverse childhood experiences</td>
<td>Genes - stress and mood</td>
</tr>
<tr>
<td>Shame/despair</td>
<td></td>
</tr>
</tbody>
</table>
# Means Matter: Lethality

<table>
<thead>
<tr>
<th>Means Matter: Lethality</th>
<th>Fatal</th>
<th>Nonfatal</th>
<th>Total</th>
<th>% Fatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearm</td>
<td>16,869</td>
<td>2,980</td>
<td>19,849</td>
<td>85%</td>
</tr>
<tr>
<td>Suffocation</td>
<td>6,198</td>
<td>2,761</td>
<td>8,959</td>
<td>69%</td>
</tr>
<tr>
<td>Poisoning/overdose</td>
<td>5,191</td>
<td>215,814</td>
<td>221,005</td>
<td>2%</td>
</tr>
<tr>
<td>Fall</td>
<td>651</td>
<td>1,434</td>
<td>2,085</td>
<td>31%</td>
</tr>
<tr>
<td>Cut/pierce</td>
<td>458</td>
<td>62,817</td>
<td>63,275</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1,109</td>
<td>35,089</td>
<td>36,198</td>
<td>3%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>146</td>
<td>2,097</td>
<td>2,243</td>
<td>7%</td>
</tr>
<tr>
<td>Total</td>
<td>30,622</td>
<td>322,991</td>
<td>353,613</td>
<td>9%</td>
</tr>
</tbody>
</table>

### Protective Factors

- Social support
- Connectedness
- Strong therapeutic alliance
- Accessing mental health care
- Positive attitude toward mental health treatment
- Coping skills
- Problem solving skills
- Cultural beliefs
- Religious affiliation
- Biological/psychological Resilience
<table>
<thead>
<tr>
<th>Picture of Physician Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental disorders (depression)</strong></td>
</tr>
<tr>
<td><strong>Methods</strong></td>
</tr>
<tr>
<td><strong>Mental health conditions</strong></td>
</tr>
<tr>
<td><strong>Psychosocial</strong></td>
</tr>
<tr>
<td><strong>Toxicology</strong></td>
</tr>
</tbody>
</table>

Cultural beliefs and stigma
Suicide rates are linked to cultural beliefs

Dutch study of regions with high and low suicide rates:
• Stigma - strongly inversely correlated with help seeking
• Region with a higher suicide rate - stigma and shame about mental health problems much higher, help seeking lower

Stigma reduction is a core component of successful suicide prevention programs (USAF 33%, 7 years, UCSD)
Low rates of seeking help among medical students

- Only 22 percent of those screening positive for depression used mental health services
- Only 42 percent of those with suicidal ideation received treatment

Reasons for not seeking help:

- lack of time (48%)
- lack of confidentiality (37%)
- stigma (30%)
- cost (28%)
- fear of documentation on academic record (24%)
Among practicing physicians, barriers to mental health care include:

- Discrimination in medical licensing
- Hospital privileges
- Health insurance
- Malpractice insurance

35 percent of physicians do not have a regular source of health care.
# Depression, Stigma and Suicidal Ideation

<table>
<thead>
<tr>
<th>Stigma Variable</th>
<th>% non-depressed students saying “yes”</th>
<th>% depressed students saying “yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telling a counselor I am depressed would be risky</td>
<td>17</td>
<td>53</td>
</tr>
<tr>
<td>If I were depressed, I would seek treatment</td>
<td>87</td>
<td>46</td>
</tr>
<tr>
<td>Seeking help for depression would make me feel less intelligent as a medical student</td>
<td>21</td>
<td>46</td>
</tr>
<tr>
<td>If depressed, fellow students would respect opinions less</td>
<td>24</td>
<td>56</td>
</tr>
<tr>
<td>If depressed, application for residency would be less competitive</td>
<td>58</td>
<td>76</td>
</tr>
<tr>
<td>Medical students with depression can snap out if it if they wanted to</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Depression is a sign of personal weakness</td>
<td>7</td>
<td>17</td>
</tr>
</tbody>
</table>
Depression During Internship (N=740 interns)
Percentage with “Depression” (PHQ >10)

Mean PHQ-9 increased from 2.4 to 6.4

Sen et al, Arch Gen Psych 2010
Cognitive Behavioral Therapy (CBT) for Preventing Suicide Ideation in Medical Interns

Can CBT inoculate interns from suicidal thinking?

- Suicide Ideation increases more than 4-fold during first 3 months of internship
- Rates of help seeking low
- 199 interns in 2 hospitals (Yale, USC)
- Web-based CBT 4 weeks pre-internship vs. attention control

Interns who received CBT were significantly less likely to develop Suicide Ideation

- 12% CBT group vs. 21.2% control group
- Intervention= 4 modules web-based CBT - MoodGYM


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Interactive Screening Program

HOW ISP WORKS

CONNECTION
Individuals voluntarily complete an anonymous questionnaire to assess their mental health.

ENGAGEMENT
A site-based counselor reviews the questionnaire and engages in an anonymous dialogue via the ISP website.

TREATMENT
The counselor connects the individuals to the appropriate mental health service.
Prevention Targets

**Education**
Stakeholders, mental health, resources, policies, self-Rx

**Mental healthcare barrier reduction**
Privacy, access, cost

**Culture change**
Safety, respect, support seeking
Overview: What is the current state of wellbeing and resiliency in Academic Medicine?

Colin P. West, M.D., Ph.D., FACP
Matriculating medical students have lower distress than age-similar college graduates


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Matriculating medical students have better quality of life than age-similar college graduates

2012, 7 U.S. medical schools & population sample (slide from Dyrbye)
What happens to distress relative to population after beginning medical school?

Brazeau et al., 2014

2012, 7 U.S. medical schools & population sample (slide from Dyrbye)
## Burnout among Residents

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>51.5%</td>
</tr>
<tr>
<td>Emotional exhaustion</td>
<td>45.8%</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>28.9%</td>
</tr>
</tbody>
</table>

2008 national survey data (West et al., JAMA 2011)
## Burnout among Practicing Physicians

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>45.8%</td>
</tr>
<tr>
<td>Emotional exhaustion</td>
<td>37.9%</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

2011 national survey data (Shanafelt et al., Arch Intern Med 2012)
### Burnout Increase Through Time

<table>
<thead>
<tr>
<th>Greater burnout:</th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>45.8%</td>
<td>54.4%</td>
</tr>
<tr>
<td>Emotional exhaustion</td>
<td>37.9%</td>
<td>46.9%</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>29.4%</td>
<td>34.6%</td>
</tr>
</tbody>
</table>

*Greater burnout: female, more work hours, private practice*

Burnout by Specialty (National)

- Emergency Medicine
- Urology
- Physical Medicine and Rehabilitation
- Family Medicine
- Radiology
- Orthopedic Surgery
- General Internal Medicine
- Neurology
- Dermatology
- Anesthesiology

Mean Burnout Among All Physicians Participating
Burnout by Specialty (National)

- Otolaryngology
- Internal Medicine Subspecialty
- General Surgery Subspecialty
- Pathology
- Obstetrics and Gynecology
- General Surgery
- Ophthalmology
- Neurosurgery
- Psychiatry
- Pediatric Subspecialty
- General Pediatrics
- Radiation Oncology
- Other
- Preventive Medicine/Occupational Medicine

% Reporting burnout

- 2011
- 2014

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Brief Summary of Epidemiology

• Medical students matriculate with BETTER well-being than their age-group peers

• Early in medical school, this reverses

• Poor well-being persists through medical school and residency into practice:
  o National physician burnout rate exceeds 54%
  o Affects all specialties, perhaps worst in “front line” areas of medicine
Brief Summary of Epidemiology

- Global phenomenon
  - Limited data across academic medicine continuum internationally, but results generally appear consistent with U.S. data
  - Direct comparisons difficult
  - Data on other health care professionals also limited, but suggest burnout is common (e.g., 36.5% among Pennsylvania nurses)

Cimiotti JP et al., Am J Infect Control 2012
But doesn't burnout and distress affect everyone?
### 2014 AMA Survey
Employed Physicians vs. Employed U.S. Population

<table>
<thead>
<tr>
<th></th>
<th>Physicians</th>
<th>Population</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=5313</td>
<td>n=5392</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>38%</td>
<td>46%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age (median)</td>
<td>53</td>
<td>52</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hrs/Wk (median)</td>
<td>50</td>
<td>40</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Burnout*</td>
<td>49%</td>
<td>28%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Dissatisfied WLB</td>
<td>49%</td>
<td>20%</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

* As assessed using the single-item measures for emotional exhaustion and depersonalization adapted from the full MBI. Area under the ROC curve for the EE and DP single items relative to that of their respective full MBI domain score in previous studies were 0.94 and 0.93

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## 2011 AMA Survey

Adjusting for:
- Age, gender, relationship status, hours worked/week, education
- Education (reference group - high school graduates):

<table>
<thead>
<tr>
<th>Degree</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelors</td>
<td>0.8</td>
</tr>
<tr>
<td>Masters</td>
<td>0.71</td>
</tr>
<tr>
<td>Doctorate or non-MD/DO professional</td>
<td>0.6</td>
</tr>
<tr>
<td>MD/DO</td>
<td>1.36</td>
</tr>
</tbody>
</table>
Consequences of Physician Burnout

- Medical errors\(^1\)-\(^3\)
- Impaired professionalism\(^5\),\(^6\)
- Reduced patient satisfaction\(^7\)
- Staff turnover and reduced hours\(^8\),\(^12\)
- Depression and suicidal ideation\(^9\),\(^10\)
- Motor vehicle crashes and near-misses\(^11\)

A Public Health Crisis!

<table>
<thead>
<tr>
<th>Burnout in U.S. alone:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Students</td>
</tr>
<tr>
<td>&gt;40,000</td>
<td></td>
</tr>
<tr>
<td>&gt;60,000</td>
<td>Residents and Fellows</td>
</tr>
<tr>
<td>&gt;490,000</td>
<td>Physicians</td>
</tr>
</tbody>
</table>

Plus other health care and biomedical science professionals

Individual or system problem?
Physician Distress: Key Drivers

- Excessive workload
- Inefficient work environment, inadequate support
- Problems with work-life integration
- Loss autonomy/flexibility/control
- Loss of values and meaning in work
The Evidence in Total

Systematic review on interventions for physician burnout, commissioned by Arnold P. Gold Foundation Research Institute (West 2015):

- **15 RCT’s, 37 non-RCT’s**
  - Results similar for RCT and non-RCT studies

- **24 studies of residents (7 RCT’s totaling 308 participants)**

- **19 studies of organizational/structural interventions (3 RCT’s, only 1 in residents with total n=41)**
  - 10 of Duty Hour Requirements (0 RCT’s, 1 study of 2011 DHR’s)
The Evidence in Total

Emotional exhaustion (EE):
• -2.8 points, p<0.001
• Rate of High EE: -14%, p<0.001

Depersonalization (DP):
• -0.7 points, p=0.003
• Rate of High DP: -4%, p=0.04

Overall Burnout Rate:
• -10%, p<0.001

Benefits similar for individual-focused and structural interventions (but we need both)
The Evidence in Total

Individual-focused interventions:
• Meditation techniques
• Stress management training, including MBSR
• Communication skills training
• Self-care workshops, exercise program
• Small group curricula, Balint groups
  ▪ Community, connectedness, meaning
The Evidence in Total

Structural interventions:

• Duty Hour Requirements for trainees
  o Unclear but possibly negative impact on attendings

• Shorter attending rotations

• Shorter resident shifts in ICU

• Locally-developed practice interventions
Other Current Approaches

• Pass/fail curricula
• Learning and peer communities
• Promote culture of well-being and support
• Examples:

  [Logos of Mayo Clinic, Georgetown University, Stanford University, Vanderbilt University]
# Physician Well-Being: Recommended Approaches

<table>
<thead>
<tr>
<th>Key Drivers</th>
<th>Individual</th>
<th>Organizational</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workload</strong></td>
<td>• Part-time status</td>
<td>• Productivity targets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Duty Hour Requirements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integrated career development</td>
</tr>
<tr>
<td><strong>Work Efficiency/Support</strong></td>
<td>• Efficiency/Skills Training</td>
<td>• EMR (+/-?)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Staff support</td>
</tr>
</tbody>
</table>
| **Work-Life Integration/Balance** | • Self-care  
• Mindfulness                  | • Meeting schedules                                            |
|                              |                                                 | • Off-hours clinics                                              |
|                              |                                                 | • Curricula during work hours                                   |
|                              |                                                 | • Financial support/counseling                                  |
| **Autonomy/Flexibility/Control** | • Stress management/Resiliency  
• Mindfulness  
• Engagement                   | • Physician/learner engagement                                  |
| **Meaning/Values**          | • Positive psychology                           | • Core values                                                   |
|                              | • Reflection/self-awareness                     | • Protect time with patients                                    |
|                              | • Mindfulness                                   | • Promote community                                             |
|                              | • Small group approaches                        | • Work/learning climate                                         |
|                              |                                                 |                                                                 |
Observations

We have a professional obligation to act.

Physician distress is a threat to our profession

It is unprofessional to allow this to continue

It is a SHARED RESPONSIBILITY

Evolve definition of professionalism? (West 2007)
Observations

We must assess distress

• Metric of institutional performance
  o Part of the “dashboard”

• Can be both anonymous/confidential and actionable
Observations

We need more and better studies to guide best practices:

• RCT’s
• Valid metrics
• Multi-site
• Individual-focused AND structural/organizational approaches
• Evaluate novel factors: work intensity/compression, clinical block models, etc.
Develop interventions targeted to address Five Drivers of Physician Distress:

1. Excessive workload
2. Inefficient environment, inadequate support
3. Problems with work-life integration
4. Loss autonomy/flexibility/control
5. Loss of values and meaning in work
Observations

The toolkit for these issues will contain many different tools.

There is no one solution …

… but many approaches offer benefit!
Setting Focus: What is the desired future state and how can we reach it?

Part 1: Investigating the growth factors that create and sustain a healthy work environment

Anthony Suchman, MD, MA, FACP
Part 1: Investigating the growth factors that create and sustain a healthy work environment

5 min  Individual reflection

15 min  Partners interview each other (7.5 minutes each). Worksheet under “Setting Focus” tab of Agenda Book.

20 min  In half-table groups, partners present each other’s stories (3 sentence version – really!) and lessons learned about growth factors. Take notes on a flip chart page.
Part 1: Investigating the growth factors that create and sustain a healthy work environment (cont’d)

20 min

After hearing each person’s story, cluster the themes you heard to name the growth factors.

Write the name of each factor and a one-sentence description on a large sticky note.

10 min

Widening the view: what other aspects of community care (prevention or treatment) from the presentations or elsewhere should be listed as growth factors but didn’t come up in the stories?

Write them on large sticky notes, too, with a one-sentence description.
Part 1: Investigating the growth factors that create and sustain a healthy work environment (cont’d)

10 min  Place each sticky note on your table’s Heat Map.

Choose 3 growth factors to place on the Mega Heat Map at the front of the room.

15 min  Break; one group member posts the 3 sticky notes on the Mega Heat Map, clustering them by theme.
Creating a Culture of Well-being Through Mind-Body Medicine

Aviad Haramati, PhD
Professor of Physiology and Medicine
Director, Center for Innovation and Leadership in Education (CENTILE)
Co-Director, CAM Graduate Program
Georgetown University School of Medicine

Visiting Professor, Faculty of Health Sciences
Ben Gurion University of the Negev, Beer Sheva, ISRAEL
Mind-body Medicine
Mind-body Medicine: Therapies

- Meditation
- Imagery
- Biofeedback
- Autogenic Training (self-hypnosis)
- Breathing Techniques
- Exercise
- Yoga, Tai Chi
- Group Support
Mindfulness refers to:

“the awareness that emerges through paying attention in a particular way, on purpose, in the present moment, and without judgment, to the unfolding of experience from moment to moment”

Jon Kabat-Zinn
Stress Response

Effect on the Hypothalamic-Pituitary-Adrenal Axis

“Fight-or-Flight” Response
Physiology of the Stress Response

- Moderate Loss of Resiliency
- Severe Loss of Resiliency
- Optimal Pattern
What is Mindfulness Meditation?

- Intentional self-regulation of attention conducted without judgment and focused on observation of the present moment.

- When we are able to focus on just what is happening in the present moment, our minds cannot be anxious, worried or distressed about other issues.
Burnout

Stressor

Stressor

Cognitive Reappraisal

Stressor

Stressor

Positive Psychology

Stressor

Stressor

Reflection

Stressor

Appreciative Inquiry

Stressor

Finding Meaning in Work

Stressor

Mindfulness

Stressor

Meditation

Stressor

Resilience
Competency-Based Medical Education

1. Effective Communication
2. Basic Clinical Skills
3. Using Basic Science in the Practice of Medicine
4. Diagnosis, Management and Prevention
5. Life-long Learning
6. Self-Awareness, Personal Growth
7. Social/Community Contexts of Healthcare
8. Moral Reasoning and Clinical Ethics
9. Problem-solving
Mind-Body Medicine Program
at Georgetown U School of Medicine

Goal

To increase student understanding of self-awareness and self-care by providing a unique experiential and didactic introduction to Mind-Body Medicine
Mind-Body Medicine Program
at Georgetown U School of Medicine

- Format of groups:
  - 10 students and 2 faculty facilitators per group
  - Participants (voluntarily sign up for the course) meet once a week for 2 hours for 11 weeks per semester for this “journey of self-discovery”

- Structure of Each Session
  - A safe environment must be created that adheres to certain guidelines: confidentiality, respect, compassionate listening, non-judgment
  - Check-in (sharing of new reflections and insights)
  - Introduction of a new mind-body medicine skill
  - Process the experiential exercise (sharing insights)
Mind-Body Medicine Program
at Georgetown U School of Medicine

Skills and Experiences

✦ Meditation (mindfulness/awareness, concentrative)
✦ Guided Imagery (several types)
✦ Autogenic training/biofeedback
✦ Art (emphasis on non-cognitive approaches)
✦ Music (used in meditation and imagery sessions)
✦ Movement (shaking, free movement, exercise)
✦ Writing (journals, dialogues, service commitment)
✦ Group support
Implementation and Scope of the Mind-Body Medicine Skills Program

Over 14 years

- >100 trained faculty facilitators (clinicians, scientists, educators)
- >2,400 medical students participated
- >300 graduate students (MS and PhD)
- ~90 nursing students
- >200 students (Law, Business, Foreign Services Schools at GU)
- >70 faculty participants (including from curriculum committee)

Over 300 groups and over 3000 participants

*Embraced by the School of Medicine as essential for a core competency (self-awareness and self-care)*
Mind-Body Medicine Program
at Georgetown U School of Medicine

Outcomes

Perceived Stress \textit{(Perceived Stress Scale)}

Mindfulness \textit{(Freiburg Mindfulness Inventory)}

Empathy \textit{(Interpersonal Reactivity Index)}
The Impact of Mind–Body Medicine Facilitation on Affirming and Enhancing Professional Identity in Health Care Professions Faculty

Nicholas Talisman, Nancy Harazduk, MEd, MSW, Christina Rush, MA, Kristi Graves, PhD, and Aviad Haramati, PhD

Abstract

Problem

Georgetown (GUSOM) offers an in mind–body medicine curriculum and fosters self-care and stress reduction programs. We sought to describe the impact of mind–body medicine modules on student stress, identity, and professional self-confidence. We hypothesized that mind–body modules would be associated with lower perceived stress and increased self-confidence and self-compassion. We also sought to explore qualitative feedback from students regarding the mind–body curriculum.

Method

The study used a mixed-methods design, combining a quantitative survey and qualitative interviews from the first cohort (N = 43) of students. Quantitative data were collected on stress, identity, self-awareness, and self-compassion using the Perceived Stress Scale (PSS), Identity, Self-Awareness, and Self-Compassion Survey, and Mindfulness Attention Awareness Scale (MAAS). Qualitative feedback was collected through interviews and course evaluation.

Results

Higher mindfulness scores were positively correlated with lower perceived stress scores. Improvements in communication between colleagues, increased sense of connection with students and colleagues, increased empathy, and heightened self-confidence and self-compassion were also reported.

Conclusion

Mind–body medicine modules at GUSOM were associated with reductions in perceived stress and improvements in self-compassion, empathy, and professional identity. Qualitative feedback supported the perceived benefits of mind–body medicine education. Further research is needed to evaluate the long-term impact of mind–body medicine on student well-being and professional identity.

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Institutions Implementing Programs in Mind-Body Medicine

- Georgetown University School of Medicine (medical students, residents)
- University of Cincinnati College of Medicine (medical/allied health/5 colleges)
- University of Alabama at Birmingham School of Medicine (medical students)
- Oregon Health and Sciences University (medical students)
- University of Washington (medical students)
- University of Vermont (medical students)
- University of North Dakota Medical School (medical students)
- Charite University Medical School, Germany (medical students)
- University of Essen-Duisenberg Medical School, Germany (medical)
- University of Liverpool, UK (medical students)
- Texas College of Osteopathic Medicine (medical students)
- Stanford University, Anesthesia Residency Program
- University of Western States (chiropractic and other CAM professions)
- Oregon College of Oriental Medicine (acupuncture and DAOM)
- Mid-Sweden University, Sweden (nursing students)
- Ben Gurion University School of Nursing, Israel (faculty retreat)
Making Better Doctors – Using Mind-Body Medicine Skills as a Self-Care Element in Medical Education at the Charité University Medical School

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Stress and Its Consequences at Medical School

The education at a medical school is a time of significant psychological distress for physicians in training [1]. High workloads associated with stress are common to the medical profession, but the distress is greater than expected among

Mind-Body Medicine as a Self-Care Element in Medical Schools

The preventive aspect of MBM characterizes the earlier the better approach for implementing it as self-care element into medical education. The Association of American Medical Colleges (AAMC) and the American Osteopathic Association (AOA) have already

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"Our data and experience suggest that self-care in the form of mindfulness-based stress management and lifestyle programs can improve student wellbeing, even during high stress periods."
Lessons Learned

- Faculty stress and burnout is a serious issue and is preceded with a rise in cynicism and the decline of empathy in medical students.

- Mind-Body Medicine reflects the physiologic interface between mind and body and represents the “physiology of de-stress.”

- Approaches that can modulate stress and reverse these trends include:
  - Mindful practice
  - Enhancing self-awareness and self-care
  - Finding meaning in work

- These elements must be actively fostered at our academic health centers both in the curriculum and in the culture.
Success Factors

- Establishing a faculty/student task force to ascertain the degree of faculty and student stress and burnout at your institution
- If there is consensus that a problem exists, initiating a collaborative effort to implement suitable interventions
- Recognizing that the status quo is unacceptable
- Exploring the many effective approaches to fostering wellbeing and resilience; mind-body medicine is just one of several options
- Ensuring participants do not feel marginalized
- Developing innovative programs, assessing, reporting and disseminating the findings
Summative Comments: How will we move forward?

Darrell G. Kirch, MD
The Commitment Continuum

Resistant: Not bought in
- Wait and see

Reluctant: Go through the motions
- Do what you’re told

Existent: Self-motivated
- Go the extra mile

Compliant: Committed
- No matter what, find a way to reach your goals

Committed: Compelled
- No matter what, find a way to reach your goals

Source: Janssen Sports Leadership Center
The AAMC serves and leads the academic medicine community to improve the health of all.

AAMC Mission Statement
What we find meaningful...

assist others in attaining goals
opportunity to impact lives

meaningful contributions to patient care
relationships
shared commitment
patient care

colleagues

faculty

residents

making connections

students

patients

creating needed change

community engagement

monitoring

long-term

health equity

research

managing change

organizational success

helping others reach their potential

transforming learning within

teaching

managing changes

helping others achieve their goals

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