



ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

*Symposium on
Physician Well-Being*

November 17-18, 2015

Summary and Proposal to the
ACGME Board of Directors

Table of Contents

Executive Summary	1 - 5
Detailed Proposal	6 - 7
Timeline	8 - 13
Appendix 1	15- 38
Appendix 2	39 - 66
Appendix 3	67 - 79

Executive Summary

Background

In October, 2014, the ACGME Board of Directors formed a planning committee to create a national symposium to address issues related to physician well-being including:

- Building resilience;
- Fostering/nurturing well-being;
- Recognition; intervention;
- Reducing stigmatization;
- Helping grieving communities heal

The Symposium Planning Committee (SPC) consisted of the following representatives from various areas of graduate medical education:

Co-Chairs:

Carol Bernstein, MD

Timothy Brigham, MDiv, PhD

ACGME Board Members:

Stanley W. Ashley, MD, Carol A. Bernstein, MD, Wallace A. Carter, MD, Jordan Cohen, MD, William A. McDade, MD, Edwin L. Zalneraitis, MD

ACGME Council of Review Committee Residents:

Timothy J. Daskivich, MD, Dinchen Jardine, MD, Heather E.W. Schultz, MD

Program and Content Experts:

Ralph S. Greco, MD, Liselotte (Lotte) Dyrbye, MD, Hanna Sherman, MD

Public Member:

Mr. Howard Feldman

ACGME Administration:

Dewitt C. Baldwin, Jr., MD, Kevin B. Weiss, MD, MPH, Debra Dooley, Amy Beane

DIO: Lyuba Konopasek, MD

Symposium Development

The SPC established that the overall purpose of the symposium was to advise the ACGME Board of Directors (through its own efforts and in collaboration with others) as to how the Board could positively impact change to improve well-being for residents, faculty and practicing physicians. The overall goals of the symposium were:

1. To understand the problem across the continuum of training and practice
2. To advise the ACGME Board of Directors on how it can be an effective agent of positive, transformational change for resident well-being and the creation of more humane training environments.

3. To begin a national dialogue on physician well-being that leads to positive, transformational change in the learning environment culture for medical students, residents faculty members and practicing physicians.
4. To begin ongoing collaborations and relationships with other organizations inside and outside the house of medicine to effect positive transformational change for the well-being of residents, fellows, medical students, practicing physicians and other healthcare professionals and in the culture of medicine/medical education.

The SPC decided that the symposium would be held in November 2015 with a select group of invitees comprised of the medical continuum leadership, designated institutional officials, program directors, PD organization leadership, residents and fellows at large, and representatives from the ACGME Board of Directors, Council on Review Committee Chairs, and Council of Review Committee Residents. Through thoughtful reflection, the SPC developed an expanded list of other invitees with expertise in the areas related to physician well-being. Attendance was limited to 100, with additional ACGME staff serving as hosts, moderators and conference staff.

Agenda/Format

The SPC selected speakers in the relevant areas and developed an agenda for the two-day symposium (Appendix 1). Day 1 consisted of a series of lectures from noted experts in the field and a Modified World Café small group exercise (Appendix 1) which was designed to give all attendees the opportunity to reflect in a series of small groups on three questions:

- Question 1: From what you've heard so far, what has real meaning for you? What surprised you? What's missing from this picture?
- Question 2: In relation to physician well-being, what does the perfect learning/practice environment in programs and institutions look like? How can that vision be turned into reality?
- Question 3: What can the ACGME do, either by itself or in collaboration with others, to foster and improve physician well-being (e.g. promote resilience, aid in early identification and recognition of distressed residents, reduce stigmatization, ensure access to care, etc.) and intervene to help grieving communities heal?

An additional small group exercise was used to prioritize the responses from the World Café exercise.

Attendees closed the day with a very emotional segment in which a personal story of a fellow who died by suicide was shared by his former medical school roommate, sister and the associate residency program director of the program in which he trained.

In order to gain further insight and expand the knowledge-base of participants, Day 2 began with a powerful presentation from an organization outside of medicine. The Chief Medical Officer of the NCAA shared the challenges, lessons learned, and action steps the NCAA is taking to improve the well-being of

athletes at all university division levels and drew parallels to the developmental trajectory of physician training and practice.

Next, a report out of the previous day's activities was shared and the top responses to the questions were determined. The symposium concluded with a small group exercise focusing on the following questions:

Question 1: From your personal and/or organizational perspective, what are the next steps you think the profession needs to take in order to sustain this effort?

Question 2: What would you be able (willing) to commit to do personally/organizationally over the next year?

Question 3: Over the next four years, would you be willing to commit to attending an annual meeting convened by the ACGME to learn about the progress across the continuum and throughout the profession and to report on your and/or your organization's progress on enhancing physician well-being and changing the culture

After time for deliberation, all of the tables reported out their top ideas. After a short presentation, the symposium concluded.

Results

Staff collated both the top ideas and all of the remaining thoughts from the flip charts (Appendix 2).

The top prioritized ideas from the Modified World Café questions were identified as follows:

Question 1: From what you've heard so far, what has real meaning for you? What surprised you, what challenged you? What's missing from this picture?

- Make the business case to key stake holders, c-suite, insurers, and other health care professionals to address burnout in terms of return on investment. Package the message to leadership on why we need to change.
- Recognize that this is both an individual and system issue, this has to be addressed on both levels.

Question 2: In relation to physician well-being, what does the perfect learning/practice environment in programs and institutions look like? How can that vision be turned into reality?

- All programs must have a systematic screening process for burnout/depression linked to automatic actions and resources for positive screenings.
- Alignment between institutional leadership and faculty in the learning environment in order to facilitate a commitment to establish a culture of respect and accountability for maintaining it in the context of patient care and resident learning.

Question 3: What can the ACGME do, either by itself or in collaboration with others, to foster and improve physician well-being (e.g. promote resilience, aid in early identification and recognition of distressed residents, reduce stigmatization, ensure access to care, etc.) and intervene to help grieving communities heal?

- In collaboration with key stakeholders, redefine professionalism to include self-care and wellness.
- ACGME should create online resources for wellness to include self-assessment, curricular materials and best practices.
- ACGME should work with experts to create toolkit for program directors (e.g. Personal experience of PD's, speaker bureau, etc.).

The results of Day 2 were identified by the major themes (Appendix 2) which included:

- Collaborate/partner externally;
- Awareness/dissemination of information;
- Wellness programs;
- Tool kit/resources;
- Study/data/research;
- Research/data collecting;
- Institutional leadership/C-Suite involvement;
- Signed commitments;
- Surveys/assessment;
- CLER;
- Education;
- Faculty;
- Post symposium information;
- Mentorship;
- PR/marketing/JGME;
- Milestones;
- Program requirements;
- Interdepartmental involvement and support;
- Emotional support;
- Forum to discuss

Evaluation

The symposium was evaluated through an evaluation online and 64 out of 100+ participants responded (Appendix 3). The evaluation was comprised of the following scale:

- Very High

- High
- Moderate
- Low
- Very Low

Respondent ratings:

- 100% of the respondents rated the overall symposium either very high or high and that the content was relevant and useful;
- 98% rated the faculty's ability to stimulate interest in the content as either very high or high;
- 88% rated the small group experience as either very high or high.
- The quality of the speakers were rated by 98% of the attendees as either very high or high
- The quality of the course materials were rated either very high or high by 94% of the attendees.
- A detailed synopsis along with comments can be found in Appendix 3.

Next Steps

The SPC is recommending that the ACGME Board approve an action plan that includes the following two elements:

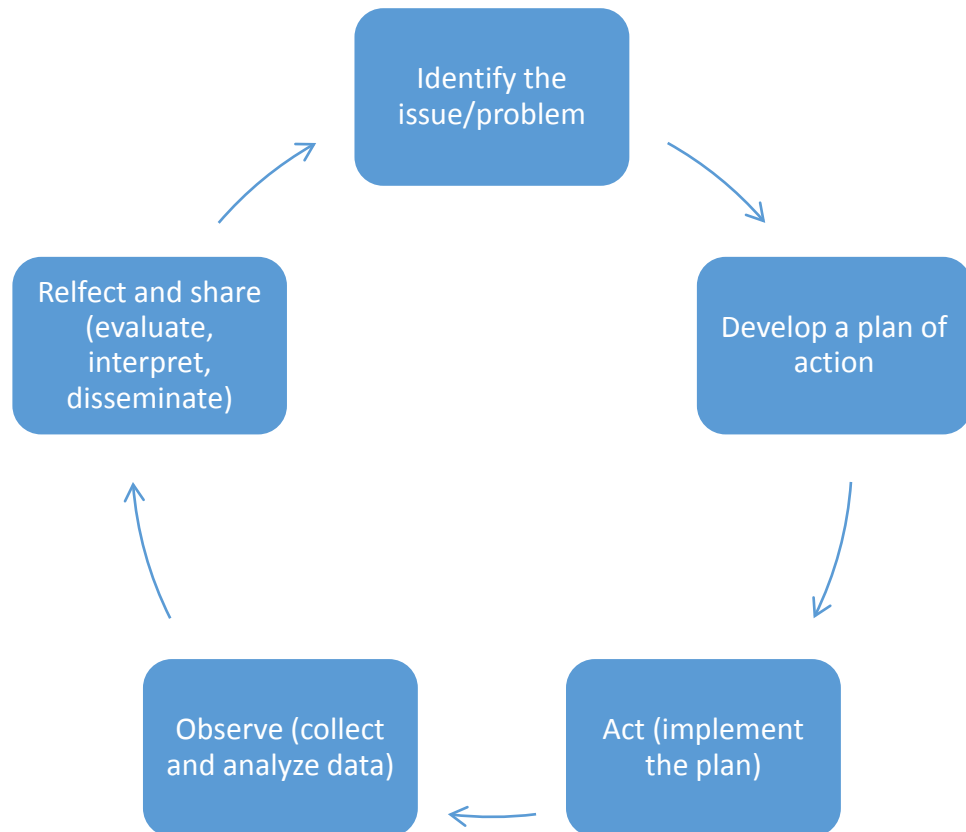
1. The creation of an on-going physician well-being task force composed of board members, administration and selected external experts/stakeholders to work together to facilitate change.
2. A process that focuses on six areas of impact to create meaningful and lasting change. The areas of impact are:

- Building Awareness
- ACGME Levers for Change
- Ongoing Dissemination
- Research
- Continuum Collaboration
- Large Scale Culture/System Change

The Action Plan and Timeline will be presented at the February 5, 2016 ACGME Board of Directors.

Action Plan:

To present a process for endorsement to the ACGME Board of Directors that describes a pathway for moving forward to positively impact resident/faculty/practicing physician well-being. The process would be longitudinal and continuous and use a modified action research approach to change (done in collaboration with others in the profession).

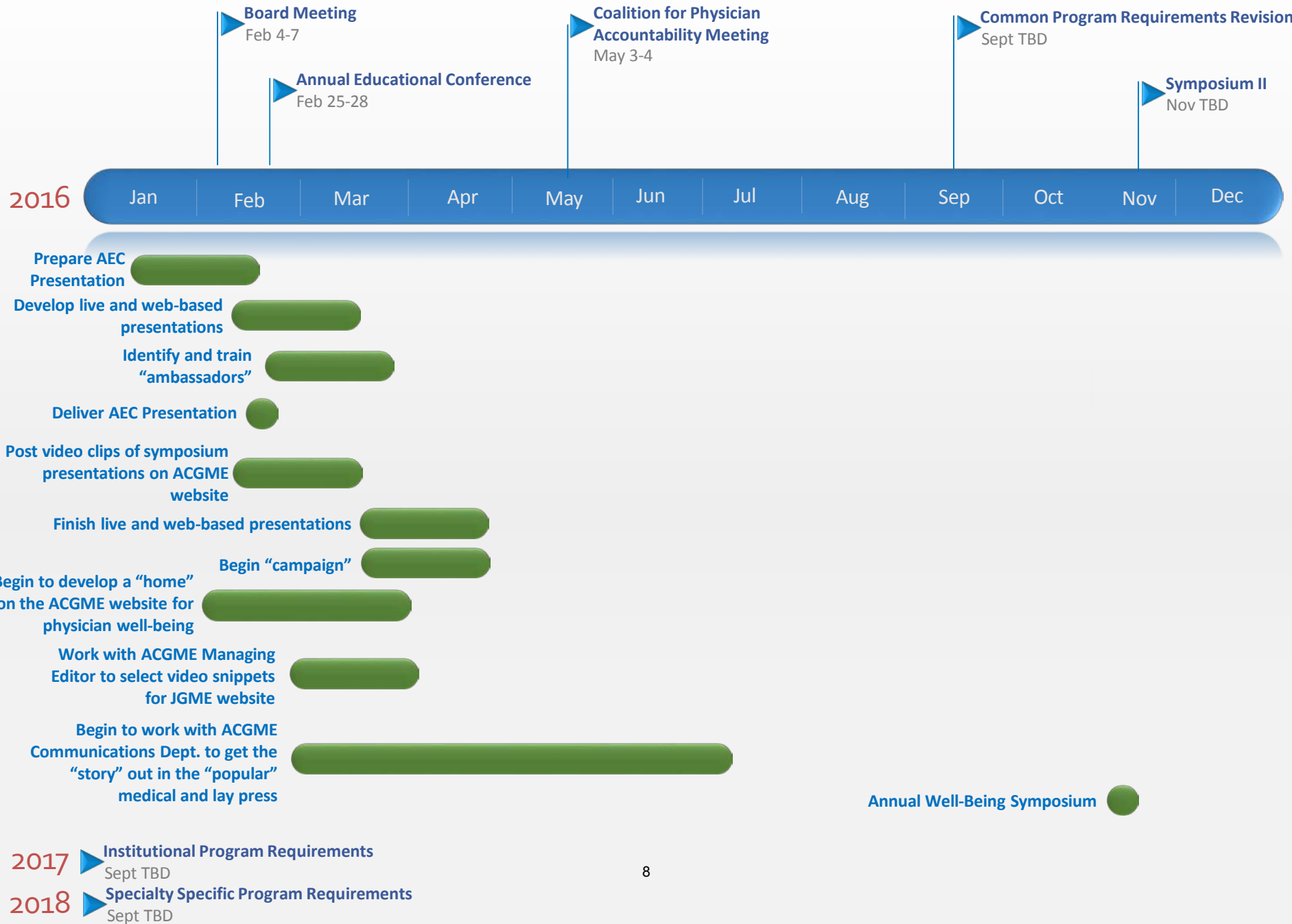


Proposal:

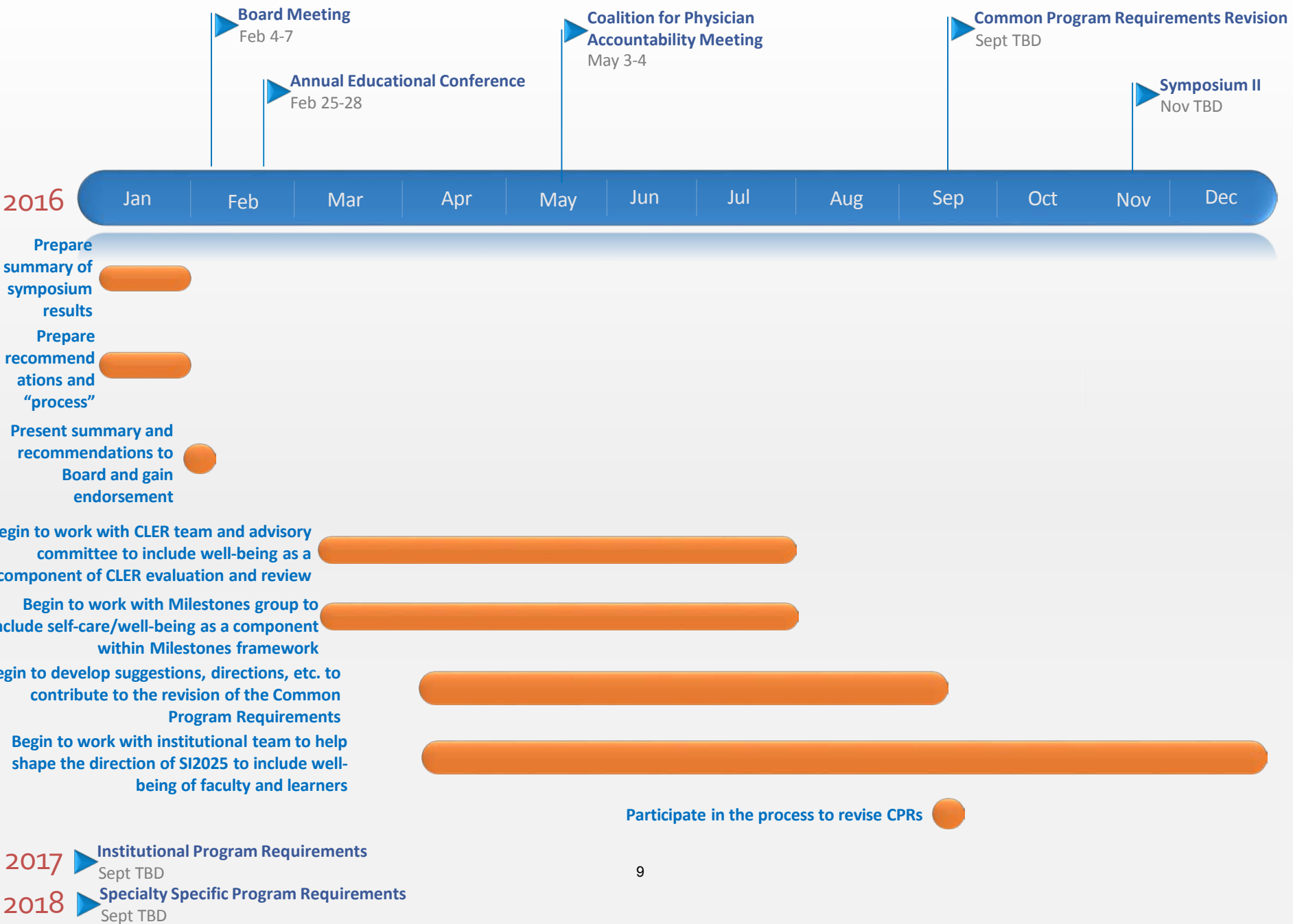
The small group task force identified six areas of impact on which the ACGME needs to focus on in order to create meaningful and long-lasting change. The process would include an on-going task force composed of Board members, administration, and selected external experts/stake holders to work together to facilitate change in this area.

1. Building Awareness
 - a. Education
 - i. Build Awareness of the issue
 1. Develop presentations and identify “ambassadors” to:
 - a. Communicate the magnitude of the problem
 - i. Depression
 - ii. Burnout
 - iii. Etc.
 - b. Propose, write solutions
 - c. Communicate the “direction” of the effort (“Here’s what we’re doing”)
 2. Web-based
 - a. Set up website for physician well-being
 - b. Video clips from the symposium
 - c. Etc.
 - b. Communication
 - i. ACGME set up a well-being website
 1. Video clips from symposium
 2. Tell the story to medical and lay press
 - c. Scholarly
 - i. JGME
 - ii. Others
2. Work within the ACGME to maximize levers for change in relation to physician well-being
 - a. Gain Board endorsement of the proposed process
 - b. Requirements
 - i. Common Program Requirements
 - ii. Institutional
 - c. CLER
 - d. Milestones
3. Ongoing Dissemination
 - a. Education
 - b. Communication
 - i. ACGME/External
 - c. Scholarly
4. Continuum Collaboration
 - a. Coalition for Physician Accountability
 - b. IOM
 - c. Annual Symposiums
5. Research
 - a. ACGME continuing research (Baldwin/Yaghmour)
 - b. Stimulating research within the field
 - c. Disseminating in the annual symposiums
6. Large-scale Culture Change
 - a. CEOs
 - b. Payors

Building Awareness



Using ACGME Levers to Influence Change



On-Going Dissemination



Establish on-going, permanent presence in AEC and Annual Symposium

Develop, populate, and maintain an on-line site for:

- 1. Toolkits
- 2. Learning Communities
- 3. Sharing Ideas
- 4. Best Practices
- 5. Resources
- 6. Screening Tools
- 7. Check Lists

Annual Well-Being Symposium

2017 Institutional Program Requirements
Sept TBD

2018 Specialty Specific Program Requirements
Sept TBD

Continuum Collaboration



Possible IOM Workshop Discussion

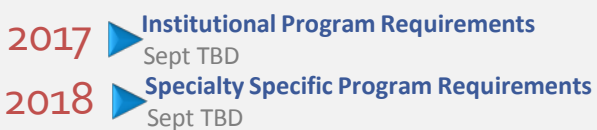
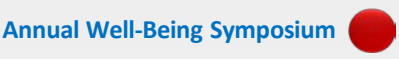
Presentation at the Coalition for Physician Accountability for information and decision making

Annual Well-Being Symposium to report and measure progress

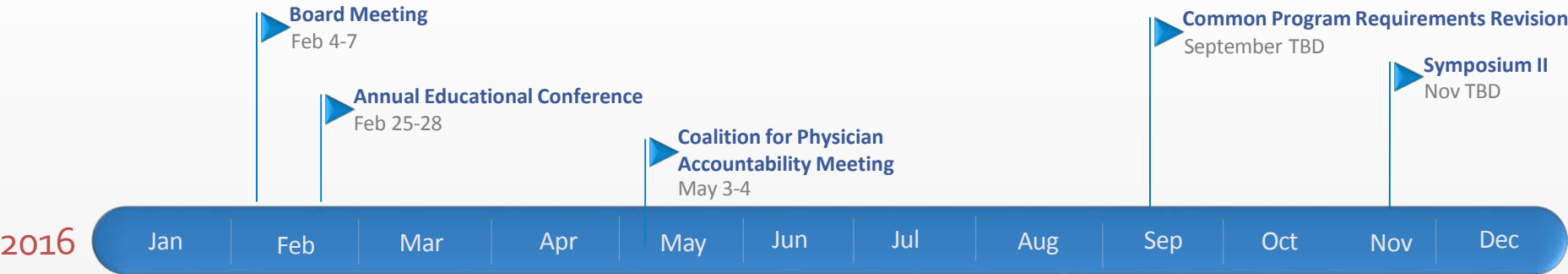
2017 Institutional Program Requirements
Sept TBD

2018 Specialty Specific Program Requirements
Sept TBD

Research



Culture Change



Planning to impact and change culture by engaging key stakeholders:

1. C-Suite
2. Insurers
3. Funders
4. Other Health Care Professionals
5. Other



2017 ▶ Institutional Program Requirements
Sept TBD

2018 ▶ Specialty Specific Program Requirements
Sept TBD

Appendix

Appendix 1: Program

Pages: 15 - 38

- Goals of Symposium
- Symposium Planning Committee
- Symposium Agenda
- Symposium Speaker Biographies
- Symposium Attendee List
- Modified World Café Model

Appendix 2: Results

Pages: 39 - 66

- Day 1 Final Consensus
- Day 1 Initial Priority Items
- Flip Chart Notes Day 1 and 2

Appendix 3: Evaluation

Pages: 67 - 79

APPENDIX 1

GOALS OF THE SYMPOSIUM

- **UNDERSTAND** the problem across the continuum.
- **ADVISE** the ACGME Board of Directors on how it can be an effective agent of positive, transformational change for resident/fellow well-being and the creation of more humane training environments.
- **BEGIN** a national dialogue on physician well-being that leads to positive, transformational change in the learning environment culture for medical students, residents/fellows, faculty members, and practicing physicians.
- **BEGIN** ongoing collaborations and relationships with other organizations inside and outside of the house of medicine to effect positive transformational change for the well-being of residents, fellows, medical students, practicing physicians and other health care professionals and to the culture of medicine/medical education.

THANK YOU

A special thanks to the members of the Symposium Planning Committee for their introspective insight, expertise, and commitment in creating this important conference:

CAROL BERNSTEIN, MD*

JUDITH FELDMAN

TIMOTHY BRIGHAM, MDIV, PHD*

RHODA FELDMAN

STANLEY ASHLEY, MD

RALPH GRECO, MD

DEWITT BALDWIN, MD

DINCHEN JARDINE, MD

AMY BEANE

LYUBA KONOPASEK, MD

WALLACE CARTER, MD

WILLIAM MCDADE, MD

JORDAN COHEN, MD, MACP

HEATHER SCHULTZ, MD

TIMOTHY DASKIVICH, MD

HANNA SHERMAN, MD

DEBRA DOOLEY

EDWIN ZALNERAITIS, MD

LISELOTTE (LOTTE) DYRBYE, MD

KEVIN WEISS, MD

HOWARD FELDMAN

LAUREN WOJNAROWSKI, MA

*Co-Chair

AGENDA

MONDAY | 11.16.15

6:30 PM – 8:00 PM

📍 Louvre Foyer

WELCOMING RECEPTION

DAY ONE SYMPOSIUM | TUESDAY | 11.17.15

7:30 AM – 8:00 AM

📍 Louvre Foyer

CONTINENTAL BREAKFAST

8:00 AM – 8:15 AM

📍 Louvre 1-3

WELCOME, AGENDA SETTING AND OPENING REMARKS

Carol Bernstein, MD

Timothy Brigham, MDiv, PhD

- Agenda
- Ground Rules
- Introductions

8:15 AM – 8:45 AM

📍 Louvre 1-3

WHY ARE WE HERE?

Thomas Nasca, MD, MACP

MODERATOR: LYUBA KONOPASEK, MD

8:45 AM – 9:15 AM

PREVALENCE, DRIVERS, AND CONSEQUENCES OF BURNOUT
AMONGST TRAINEES

Liselotte (Lotte) Dyrbye, MD

9:15 AM – 9:45 AM

PHYSICIAN MENTAL HEALTH AND SUICIDE PREVENTION

Christine Moutier, MD

9:45 AM – 10:15 AM

INTERVENTIONS TO REDUCE PHYSICIAN BURNOUT AND PROMOTE
PHYSICIAN WELL-BEING

Colin West, MD

AGENDA

10:15 AM – 10:35 AM	PANEL DISCUSSION
10:35 AM – 11:00 AM	BREAK
MODERATOR: STANLEY ASHLEY, MD	
11:00 AM – 11:30 AM	RUNNING ON EMPTY: RESIDENTS AT RISK Richard Levin, MD
11:30 AM – 12:00 PM	SOME COUNTERINTUITIVE THOUGHTS ABOUT ORGANIZATIONAL CULTURE, HOW IT AFFECTS US AND HOW IT CHANGES Anthony Suchman, MD
12:00 – 12:20 PM	PANEL DISCUSSION
12:20 PM – 1:00 PM	LUNCH
MODERATOR: DINCHEN JARDINE, MD	
1:00 PM – 1:30 PM	THE WHOLE IS MORE THAN THE SUM OF ITS PARTS: TOWARD A CONCEPTUAL MODEL FOR PHYSICIAN WELL BEING DeWitt Baldwin, MD
1:30 PM – 1:45 PM	QUESTIONS/ANSWERS
1:45 PM – 2:05 PM	UNDERSTANDING THE ACGME Thomas Nasca, MD, MACP

AGENDA

2:05 PM – 2:20 PM

BREAK

2:20 PM – 4:40 PM

BREAKOUTS — MODIFIED WORLD CAFÉ MODEL

2:20 PM 📍 Louvre 1–3

ROUND 1

2:45 PM 📍 Louvre 1–3

ROUND 2

3:10 PM 📍 Louvre 1–3

ROUND 3

3:35 PM 📍 Louvre 1–3

ROUND 4

4:00 PM 📍 Teyler,
Montrose,
Louvre

ROUND 5

4:40 PM – 5:10 PM

A PERSONAL STORY

Tim Daskivich, MD

Judith Feldman

5:10 PM – 5:30 PM

ONE PROGRAM'S RESPONSE TO A TRAGIC EVENT

Claudia Mueller, MD

5:30 PM – 5:45 PM

WRAP UP – DISCUSSION, NEXT STEPS FOR TOMORROW

Timothy Brigham, MDiv, PhD

5:45 PM

ADJOURN

DAY TWO SYMPOSIUM | WEDNESDAY | 11.18.15

7:30 AM – 8:00 AM

CONTINENTAL BREAKFAST

8:00 AM – 9:45 AM

The Elite Athlete: Lessons Learned for Medical Residents

Brian Hainline, MD

Moderator: Wallace Carter, MD

AGENDA

9:45 AM – 10:00 AM	BREAK
10:00 AM – 12:00 PM	Report Out and Discussion of Yesterday's Results Moderator: Jordan Cohen, MD, MACP
12:00PM – 1:00 PM	Lunch
1:00 PM – 2:00 PM	Group Exercise
2:00 PM – 3:00 PM	Report Out from Small Groups Moderator: William McDade, MD
3:00 PM – 3:15 PM	BREAK
3:15 PM – 4:00 PM	WHERE DO WE GO FROM HERE? Carol Bernstein, MD Thomas Nasca, MD, MACP
4:00 PM – 4:15 PM	CLOSING REMARKS Timothy Brigham, MDiv, PhD

SPEAKER BIOGRAPHIES

CAROL BERNSTEIN, MD

Dr. Bernstein is Associate Professor of Psychiatry, Vice Chair for Education in Psychiatry, and Director of Residency Training in Psychiatry at the NYU School of Medicine. From 2001-2011, Dr. Bernstein also served as the Associate Dean for Graduate Medical Education and the designated institutional official for ACGME-accredited training programs at NYU. Dr. Bernstein is a past-President of the American Psychiatric Association (APA) and has served the Association as Vice-President, Treasurer, and Trustee-at-Large, and as chair of multiple committees. She has served as a spokesperson for the American Psychiatric Association on many occasions, and received the 1997 Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill (NAMI). She has been the recipient of the APA/National Institute of Mental Health Vestermark Award in Psychiatric Education and the APA Alexandra Symonds Award for contributions in the advancement of women in leadership and in women's health. Dr. Bernstein has devoted her entire career in medicine to the education and training of the next generation of psychiatrists.

Dr. Bernstein completed medical school at the Columbia University College of Physicians and Surgeons. Following an internship in internal medicine at St. Luke's/Roosevelt Medical Center in New York, she completed her psychiatric residency training at Columbia University and the New York State Psychiatric Institute. Dr. Bernstein is active in many national psychiatric associations in addition to the APA – these include the American College of Psychiatrists (she was elected to the Board of Regents in February of 2012) and the Group for the Advancement of Psychiatry and the American Board of Psychiatry and Neurology, among others. In 2003, Dr. Bernstein was selected as a Fellow in ELAM (Executive Leadership in Academic Medicine), a national program designed to promote leadership for women in medicine. In 2005, Dr. Bernstein completed the Physician Leadership Development Program at NYU, as well as the Graduate Medical Education Leadership Program of the ACGME. In 2010, Dr. Bernstein was appointed to the ACGME Board of Directors – the body that accredits the more than 9,000 residency and fellowship programs in the United States. Dr. Bernstein has written numerous articles and chapters on psychiatric education and has served as a peer reviewer for both the *American Journal of Psychiatry* and *Academic Psychiatry*. She has served on the Editorial Boards of *Academic Psychiatry*, *the Journal of Psychiatric Services*, and *Focus*, has presented at more than 70 conferences and meetings, and has been the recipient of a number of visiting professorships. Dr. Bernstein hosts a weekly call-in show for consumers on Sirius Radio's Doctor Radio Channel, which is sponsored by the NYU Langone Medical Center.

TIMOTHY BRIGHAM, MDIV, PHD

Dr. Brigham is the Chief of Staff and Senior Vice President, Department of Education at the ACGME. Dr. Brigham's responsibilities as head of the Department of Education include the ACGME's Annual Educational Conference, the Milestones Project, and the development of new educational programs for the ACGME.

SPEAKER BIOGRAPHIES

Prior to joining the ACGME in 2008, Dr. Brigham served since 1989 in several capacities at Jefferson Medical College, including as associate dean for Graduate Medical Education and Continuing Medical Education and, most recently, as senior associate dean for Organizational Development and chief of staff and associate professor of Medicine. Dr. Brigham has been involved in physician faculty development, resident education, and chief resident and program director development. He is widely sought after as a teacher, speaker, group facilitator, and consultant in a variety of areas, including resident stress and well-being; chief resident, program director and chairperson leadership development; medical student, resident, and faculty teaching development; and group and team organizational development.

Dr. Brigham holds a PhD in psychological studies in education from Temple University, a master's degree in counseling and human relations from Villanova University, and a master's of divinity from Palmer Theological Seminary.

DEWITT BALDWIN, MD

A pediatrician, family physician, and psychiatrist, Dr. Baldwin was educated at Yale Medical School, completing residencies at the University of Minnesota, Yale University, and Boston University. He is a Diplomate of the National Board of Medical Examiners, the American Board of Pediatrics, and the American Board of Family Practice. He was a member of the planning committees and founding faculties of the Universities of Connecticut and Nevada Medical Schools.

Dr. Baldwin served as President of Earlham College in Richmond, Indiana before going to the American Medical Association in 1985 as director of the Division of Medical Education and Research Information. He currently holds the titles of Senior Scholar-in-Residence at the ACGME, professor emeritus of psychiatry and the behavioral sciences, University of Nevada School of Medicine, and adjunct professor of clinical psychiatry, Northwestern University School of Medicine. In 2003, he received the degree of Doctor of Science (Honoris Causa) from the Northeastern Ohio Universities College of Medicine, and in 2011, he received the degree of Doctor of Humane Letters (honoris causa) from Rosalind Franklin University. He has published over 200 scholarly articles and three books.

JORDAN J. COHEN, MD, MACP

Dr. Cohen is president emeritus of the Association of American Medical Colleges (AAMC) and emeritus professor of medicine, George Washington School of Medicine. He also serves as Chairman of the Board of the Arnold P. Gold Foundation for Humanism in Medicine.

As president and chief executive officer of the AAMC from 1994 to 2006, Dr. Cohen led the association's support and service to the nation's medical schools and teaching hospitals. He launched new initiatives in each of the association's mission areas of education, research, and patient care; expanded and modernized the association's services for medical students, applicants, residents, and

SPEAKER BIOGRAPHIES

constituents; strengthened the association's communications, advocacy, and data gathering efforts; and established many initiatives for improving medical education and clinical care. As the voice of academic medicine for more than a decade, Dr. Cohen also spoke extensively on the need to promote greater racial and ethnic diversity in medicine, to uphold professional and scientific values, and to transform the nation's health care system.

Prior to his leadership of the AAMC, he served as dean of the medical school and professor of medicine at the State University of New York at Stony Brook, and president of the medical staff at University Hospital. Before that, Dr. Cohen was professor and associate chairman of medicine at the University of Chicago-Pritzker School of Medicine, and physician-in-chief and chairman of the Department of Medicine at the Michael Reese Hospital and Medical Center. From 2006 to 2012, he was professor of medicine and public health at George Washington University.

Dr. Cohen currently serves on the Boards of the ACGME and the Sidra Medical and Research Center in Doha, Qatar. He also serves on the Editorial Board of the *Journal of the American Medical Association (JAMA)*. He chaired the VA's National Academic Affiliation Council, and co-chaired the Institute of Medicine's Global Forum on Innovations in Health Professional Education. He is a former chair of the American Board of Internal Medicine, and serves on the visiting committees of Harvard Medical School, University of Chicago-Pritzker School of Medicine, University of Pittsburgh School of Medicine, and the Weill Cornell College of Medicine-Qatar.

He is a past-president of the Association of Program Directors of Internal Medicine, was a member of the Boards of Directors of the Josiah Macy Jr. Foundation of New York, the National Library of Medicine, the China Medical Board, the Morehouse School of Medicine, and the Qatar Foundation for Education, Science & Community Development.

Dr. Cohen is a graduate of Yale University and Harvard Medical School and completed his postgraduate training in internal medicine on the Harvard service at the Boston City Hospital. He also completed a fellowship in nephrology at the Tufts-New England Medical Center. He has authored more than 100 publications and is a former editor of *Kidney International's Nephrology Forum*.

TIMOTHY DASKIVICH, MD

Dr. Daskivich was born and raised in Pittsburgh, Pennsylvania. He graduated *magna cum laude* in biochemical sciences from Harvard College in 2001. He went on to earn his MD from Harvard Medical School in 2006, and then completed an internship in general surgery and a residency in urology at UCLA in 2012. He completed a combined health services research and urologic oncology fellowship with the Robert Wood Johnson Clinical Scholars Program and Institute of Urologic Oncology at UCLA. He is currently a faculty urologic oncologist and director of health services research for the Department of Surgery at the Cedars-Sinai Medical Center. He has a research interest in comorbidity assessment and its role in treatment decision making for men with urologic cancer. He has published his work in *Annals of Internal Medicine*, *Cancer*, *Archives of Internal Medicine*, and the *Journal of Urology*.

SPEAKER BIOGRAPHIES

and his work has been supported by grants from the American Urological Association and the American Cancer Society. He was the Chair of the ACGME's Council of Review Committee Residents from 2013–2015.

**LISELOTTE
(LOTTE) DYRBYE,**
MD

Dr. Dyrbye is professor of medicine, professor of medical education, and consultant in the Division of Primary Care Internal Medicine at Mayo Clinic, Rochester, Minnesota. She is also associate chair for faculty development, staff satisfaction, and diversity for the Department of Medicine, Mayo Clinic, and associate director of the Department of Medicine Program on Physician Well-being. She is the primary investigator on Mayo Medical School's grant "Accelerating Change in Medical Education," awarded by the AMA.

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

**RALPH
GRECO,**
MD

Dr. Greco is the Johnson & Johnson Distinguished Professor at the Stanford University School of Medicine. He is also the immediate past chief of the Division of General Surgery at Stanford, and the past director of the General Surgery Training Program. Dr. Greco joined the faculty at Stanford in 2000. He graduated cum laude from Fordham University in 1964, and from the Yale University School of Medicine in 1968. His internship and residency were served at Yale New Haven Hospital where he

SPEAKER BIOGRAPHIES

was chief resident in 1972-1973. After two years of military service, he became an assistant professor at the Rutgers Medical School in 1975. He became chief of the Division of General Surgery and program director in 1982 and chief of Surgery at Robert Wood Johnson University Hospital in 1997.

Dr. Greco is a member of the American Surgical Association, the Society of University Surgeons, the Society for Biomaterials, and the Association of Program Directors in Surgery, among many other surgical societies. He is board certified in general surgery and is a Fellow of the American College of Surgeons. Dr. Greco has been the recipient of research grants from the National Heart, Lung and Blood Institute (NHLBI) and served as a consultant to the NHLBI and the National Science Foundation. Dr. Greco is the recipient of six patents on various aspects of antibiotic bonding, and has published more than 100 papers in the scientific literature. His research interests are focused on biomaterials, the host response to implantable biomaterial surfaces, and surface modification of biomaterials. When he arrived at Stanford he began a collaboration with Friedrich Prinz, chair of Mechanical Engineering in the related, but new, area of nanofabrication of new biomaterial surfaces and their potential application to a new generation of biomaterials for clinical applications. At Stanford, Dr. Greco is a surgical oncologist and currently is surgical lead of the Melanoma Program. Dr. Greco became interested in resident well-being in the aftermath of the death by suicide of one of the very finest residents who graduated the Stanford general surgery program. Losing someone only four months after their having started a fellowship in the Midwest was terribly disturbing to all the residents and faculty in the program. Together with Claudia Mueller, Rachel Callcut and residents Greg Magee, Mediget Teshome, Yulia Zak, and Arghavan Salles, The Balance in Life Program was developed within the General Surgery Training Program. A recipient of the Parker J. Palmer Courage to Teach Award from the ACGME in 2006, Dr. Greco then received the prestigious John C. Gienapp Award, the ACGME's highest honor, largely for his work on resident wellness, in 2012.

Dr. Greco summarizes his work on well-being by saying, "Surgeons can be proud of how well they have taught their residents to take the best care of the sickest patients. Now it is time to teach them to take care of themselves." Each year, 400 physicians die by suicide in the US, the equivalent of three medical school classes at Yale, Stanford, and John Hopkins. Giving residents the tools to deal with vicissitudes of life as a surgeon will provide them with a skillset they can use throughout their careers.

BRIAN HAINLINE, MD

Dr. Hainline is chief medical officer (CMO) of the National Collegiate Athletic Association (NCAA). As the NCAA's first CMO, he oversees the NCAA Sport Science Institute, a national center of excellence with the mission to promote and develop safety, excellence, and wellness in college student-athletes, and to foster life-long physical and mental development. The NCAA Sport Science Institute works collaboratively with member institutions and Centers of Excellence across the United States. For over 20 years, Dr. Hainline has been actively involved in sports medicine. He co-authored "*Drugs and the Athlete*", and played a pivotal role the development of drug testing and education protocols worldwide. He has served on the New York State Athletic Commission, the United States Olympic Committee's Sports

SPEAKER BIOGRAPHIES

Medicine Committee, and was a founding member of the Executive Committee of the American Academy of Neurology Sports Neurology Section, where he serves as vice-chair. Dr. Hainline has played a pivotal role in the development of health and safety standards in tennis, both nationally and internationally. He was CMO of the US Open Tennis Championships for 16 years, and then served as CMO of the United States Tennis Association, before moving to the NCAA. He is chair of the International Tennis Federation Sport Science & Medicine Commission, and oversaw the rollout of international wheelchair tennis competition, a sport for which he wrote the rules of eligibility for both para- and quad-tennis. Dr. Hainline is a clinical professor of neurology at New York University School of Medicine and Indiana University School of Medicine.

RICHARD LEVIN, MD

Dr. Levin is currently president and chief executive officer of the Arnold P. Gold Foundation. He is concurrently an emeritus professor of medicine in the Division of Cardiology at McGill University in Montreal and in the Leon H. Charney Division of Cardiology at New York University.

After completing his tenure as dean of the Faculty of Medicine and vice-principal for health affairs at McGill University in 2011, he served a sabbatical year as senior scholar in residence at the Association for Academic Health Centers in Washington, DC.

Dr. Levin is a physician, scholar, educational innovator, scientist, inventor, company founder, and essayist. The author of numerous papers, he has lectured widely in the United States and abroad. His honors include a Clinical Investigator Award from the National Heart, Lung and Blood Institute of the National Institutes of Health in the US, the Valentine Mott Medal, the Ester Hoffman Beller Research Award, and election to Fellowship in the Canadian Academy of Health Sciences.

Dr. Levin earned a BS in biology with Honors from Yale University in 1970, and graduated from the New York University School of Medicine, where he was elected to Alpha Omega Alpha in 1974. He was senior chief resident in internal medicine at Bellevue Hospital in 1997-1998, completed a cardiology fellowship at New York University, and then a postdoctoral fellowship in vascular biology at the Specialized Center for Research in thrombosis at Cornell University Medical College.

He has been a national board member and officer of numerous professional US organizations, including a past-president of the New York and Heritage Affiliates of the American Heart Association. Before taking on his position at McGill in September of 2006, Dr. Levin was the vice dean for Education, Faculty and Academic Affairs, and a professor of medicine at New York University School of Medicine. For 25 years, he practiced cardiology at Bellevue Hospital where he is currently an attending emeritus. In Canada, he was president of the Council of Deans of the Faculties of Medicine of Quebec and chairman of the Board of the Canadian Resident Matching Service.

Dr. Levin's scientific interests include endothelial cell biology, the prevention of atherothrombotic events, the neurobiology of empathy, the reformation of academic health centers for the support of personalized medicine and patient-centered care, and the role of new information technologies in medical education and practice.

SPEAKER BIOGRAPHIES

CHRISTINE MOUTIER, MD

Dr. Moutier knows the impact of suicide firsthand. After losing colleagues to suicide, she dedicated herself to fighting this leading cause of death. As a leader in the field of suicide prevention, Dr. Moutier joined the American Foundation for Suicide Prevention (AFSP) in 2013, and has revitalized its Education team, relaunched its Loss & Bereavement department, and expanded its support to include those with lived experience of suicide.

She has testified before the US Congress on suicide prevention, was the host of AFSP's latest documentary on surviving suicide loss, *The Journey*, and has appeared as an expert in *The New York Times*, *The Washington Post*, *Time Magazine*, *The Economist*, and *The Atlantic*, on the BBC and CNN, and in other print and television outlets.

Throughout her career, she has focused on training health care leaders, physicians, and patient groups in order to change the health care system's approach to mental health, fighting stigma and optimizing care for those suffering from mental health conditions. In addition to co-founding AFSP's San Diego Chapter, Dr. Moutier co-led a successful suicide prevention and depression awareness program for health science faculty members, residents, and students, which featured AFSP's groundbreaking Interactive Screening Program.

Since earning her medical degree and training in psychiatry at the University of California, San Diego (UCSD), Dr. Moutier has been a practicing psychiatrist, professor of psychiatry, dean in the medical school, medical director of the Inpatient Psychiatric Unit at the VA Medical Center in La Jolla, and associate director of the UCSD Outpatient Psychiatry Services Clinic, and she attended the Consultation-Liaison Service and Neuropsychiatric and Behavioral Medicine Unit at UCSD Medical Center. She also served as a co-investigator for the Sequenced Treatment Alternatives to Relieve Depression study (STAR*D), a large National Institute of Mental Health trial on the treatment of refractory depression.

Dr. Moutier has authored articles and book chapters for publications such as the *Journal of the American Medical Association*, *Academic Medicine*, *the American Journal of Psychiatry*, *the Journal of Clinical Psychiatry*, *Depression and Anxiety*, and *Academic Psychiatry*.

CLAUDIA MUELLER, PHD, MD

Claudia Mueller is an Assistant Professor (MCL) in the Department of Surgery at Stanford University School of Medicine. She joined the faculty at Stanford in 2008. Since the fall of 2012, Dr. Mueller has been the Medical Director for Stanford Children's joint venture with California Pacific Medical Center (CPMC), where she is the lead pediatric surgeon.

Dr. Mueller received an AB from Harvard College in 1992 (in psychology and folklore and mythology) and a PhD in social/personality psychology from Columbia University in 1997. Her dissertation advisor was Carol Dweck, who is now the Lewis and Virginia Eaton Professor of Psychology at Stanford

SPEAKER BIOGRAPHIES

University. Dr. Mueller's dissertation, *Praise for Intelligence Can Undermine Children's Motivation and Performance*, which was published in the *Journal of Personality and Social Psychology*, received international attention and forms the cornerstone of educational theory for many schools in the US.

While pursuing her PhD, Dr. Mueller became interested in clinical work and entered medical school at NYU, planning to become a psychiatrist. She instead became interested in surgery and remained at NYU to complete her residency in general surgery in 2006. Dr. Mueller went on to a fellowship in pediatric surgery at the University of Montreal (2006-2008).

At Stanford, Dr. Mueller was a Morgridge Endowed Faculty Scholar in Pediatric Translational Medicine from 2008-2013, and a recipient of the Katherine McCormick Faculty Award from 2009-2011. She also participated in the Stanford School of Medicine's Faculty Fellows program and was a Fellow of the Clayman Institute for Gender Research at Stanford in 2014. Her primary research focuses on the study of children's health beliefs and their influence on adherence behaviors and clinical outcomes.

Dr. Mueller currently serves as the Surgery Balance in Life Committee Advisor with Dr. Ralph Greco.

THOMAS J. NASCA, MD, MACP

Dr. Nasca is the chief executive officer of the ACGME and ACGME International. He is also professor of medicine (vol.) at Jefferson Medical College. Dr. Nasca is a graduate of the University of Notre Dame with High Honors, and an Alpha Omega Alpha graduate of Jefferson Medical College. He completed his internship, residency, and was chief medical resident at Mercy Hospital of Pittsburgh, and his nephrology fellowship at Brown University and Rhode Island Hospital.

Dr. Nasca has been involved in medical education since 1981. He was the chairman and residency program director of the Department of Medicine and director of Medical Services at The Mercy Hospital of Pittsburgh. He assumed the role of vice chairman of the Department of Medicine of Jefferson Medical College and Thomas Jefferson University Hospital in 1992, with leadership responsibility for the medical student, residency, and fellowship education programs. Dr. Nasca was then named associate dean for Education and Research for the Jefferson Health System, and associate dean for Academic Affairs and Affiliations. He was appointed acting dean of Jefferson Medical College in July 2000, and then appointed senior vice president for Academic Affairs of Thomas Jefferson University, dean of Jefferson Medical College, and president of Jefferson University Physicians in January 2001. In April 2007, Dr. Nasca was named the first Anthony F. and Gertrude M. DePalma Dean of Jefferson Medical College. He left the deanship at Jefferson to assume the leadership of the ACGME in December 2007, and in May 2009 he became the founding CEO of ACGME International, LLC.

Dr. Nasca is certified by the American Board of Internal Medicine in internal medicine and nephrology. He was member of the Council of the Association of Program Directors in Internal Medicine (APDIM), having served as both secretary treasurer and president. He served as associate

SPEAKER BIOGRAPHIES

editor of the Nephrology MKSAP for the American College of Physicians (ACP), was a member of the Internal Medicine In-Training Examination Steering and Writing Committees, the Alliance for Academic Internal Medicine (AAIM), and the Federated Council for Internal Medicine (FCIM). He is a former chair of the ACGME Review Committee for Internal Medicine, and he served as a special accreditation consultant to the Review Committee and the ACGME. Dr. Nasca was a member of the Council on Graduate Medical Education (COGME) of the Department of Health and Human Services (HHS) and the US Congress. His professional memberships have included the International Society of Nephrology, American Society of Nephrology, ACP, American Society for Apheresis, and APDIM. He is a former member of the Council of Deans of the Association of American Medical Colleges (AAMC), the Board of the Educational Commission for Foreign Medical Graduates (ECFMG), and the National Board of Medical Examiners (NBME). He was a Fellow of the College of Physicians of Philadelphia, and was elected a Master of the American College of Physicians in 2006. Dr. Nasca served on the Initiative to Transform Medical Education (ITME) of the American Medical Association and the Committee to Evaluate the US Medical Licensing Examination (CEUP), and is a past member of the Liaison Committee on Medical Education (LCME). Among many honors and honorary degrees, Dr. Nasca has received the Dema C. Daley Founders Award for Excellence in Internal Medicine Education from the APDIM, the Rev. Clarence Shaffrey, S.J. Award from St. Joseph's University in Philadelphia, and the 2010 Jefferson Medical College Alumni Achievement Award. He was named one of the 50 most powerful/influential physician executives in 2009, 2010, 2011, 2012 and 2013 by *Modern Healthcare*. He is the author of over 120 peer-reviewed articles, chapters, and other publications, and has delivered more than 350 invited lectures and presentations worldwide on topics related to medical education.

ANTHONY SUCHMAN, MD

Dr. Suchman is a practicing physician, organizational consultant, and clinical professor of medicine at the University of Rochester School of Medicine and Dentistry. His current work focuses on organizational change and how people can work together more effectively across all levels of health care. As senior consultant and founder of Relationship Centered Health Care, he works with clinicians, administrators, patient advocates, and board members in health care organizations worldwide to advance the practice of relationship-centered administration, the organizational behavior and culture needed backstage to support staff members in providing relationship-centered care to patients and their families. He has pioneered applications of relational coordination – a theory and related survey developed by Jody Hoffer Gittel that measures how teams coordinate complex interdependent tasks – in improving team performance and work environments. His most recent book, *Leading Change in Healthcare: Transforming organizations using complexity, positive psychology and Relationship-centered Care*, co-authored with David Sluyter and Penny Williamson, was published in 2011 by Radcliffe Publishing of London and New York.

After earning his BA (psychology) and MD at Cornell University, Dr. Suchman completed a residency in internal medicine and fellowships in general internal medicine (clinical epidemiology

SPEAKER BIOGRAPHIES

and health services research) and behavioral and psychosocial medicine (mind/body interactions and medical interviewing) at the University of Rochester. He subsequently earned an MA in organizational change, studying with Ralph Stacey at the University of Hertfordshire's Complexity and Management Centre.

As a health services researcher on the faculty of the University of Rochester, Dr. Suchman studied patient-clinician relationships, medical decision-making, physician satisfaction, and the spiritual dimensions of medical care. Through his teaching and writing (more than 95 articles and book chapters and the book *Partnerships in Health care: Transforming Relational Process*) he became a leading proponent of a partnership-based clinical approach known as relationship-centered care.

After 15 years of academic pursuits, he became interested in health care organizations, particularly in how administrative processes and the behavior of leaders affect patients and family members, staff members, and processes of care. To explore the potential of integrated health care systems to engage patients as active partners and provide coordinated, effective, and humane care, Dr. Suchman led the formation of the Highland Physicians Organization and was its first executive director. He then helped to establish the Strong Health Managed Care Organization and was its first CEO and CMO. Dr. Suchman chaired the Board of the American Academy on Communication in Healthcare from 2000-2008, and is currently a Board member of Brandeis University's Relational Coordination Research Collaborative. With Seattle-based consultant Diane Rawlins and under the auspices of the University of Rochester, Dr. Suchman teaches a 10-month course, *Leading Organizations to Health*, that prepares organizational leaders and consultants for the challenging work of leading change.

**COLIN
WEST,
MD**

Originally from Seattle, Dr. West received both his MD and PhD in biostatistics from the University of Iowa in 1999. He completed residency and chief residency in internal medicine at Mayo, and joined the faculty there in general internal medicine in 2004. He is currently professor of medicine, medical education, and biostatistics at Mayo. He directs the evidence-based medicine curriculum for the Medical School, and is an associate program director within the internal medicine residency program. He is also the research chair of general internal medicine. Dr. West's research has focused on medical education and physician well-being, and he is co-director of the Mayo Clinic Program on Physician Well-Being. Working closely with Tait Shanafelt and Lotte Dyrbye, his work documenting the epidemiology and consequences of physician distress, as well as emerging research on solutions, has been widely published in prominent journals including *JAMA*, *Annals of Internal Medicine*, and *JAMA Internal Medicine*.

SYMPOSIUM ATTENDEE LIST

KAREN ADAMS, MD

Oregon Health &
Science University

ELIZABETH AMES, MD

University of Vermont

PAIGE AMIDON, MBA, MPH

ACGME

SEPIDEH AMIN-HANJANI,

MD, FAANS, FACS, FAHA

University of Illinois Hospital
& Health Sciences System

JIM ANDERSON, MD

Oregon Health &
Science University

JOAN ANZIA, MD

Northwestern
Memorial Hospital

STANLEY ASHLEY, MD*

Brigham and
Women's Hospital

DEWITT BALDWIN, MD

ACGME

MIRIAM BAR-ON, MD

University of Nevada
School of Medicine

BARBARA BARZANSKY,

PHD, MHPE

Liaison Committee on
Medical Education

HASAN BAZARI, MD

Massachusetts
General Hospital

AMY BEANE

ACGME

CAROL BERNSTEIN, MD*

New York University
School of Medicine

MARK BIXBY, MD

ACGME

DONALD BRADY, MD*

Vanderbilt University

LOIS BREADY, MD

University of Texas Health
Science Center School of
Medicine at San Antonio

TIMOTHY BRIGHAM, MDIV, PHD

ACGME

STEVEN BROWN, MD

Banner University Medical
Center Phoenix

JENNIFER BUESCHER, MD

ACGME

STEPHANIE BURNHAM,

C-TAGME

Vanderbilt University

LAURINDA CALONGNE, EDD

Our Lady of the Lake
Regional Medical Center

PETER CAREK, MD, MS*

University of Florida

WALLACE CARTER, MD

Weill Cornell Med College,
Cornell University

BARETTA CASEY,

MD, MPH, FAAFP

ACGME

EMMANUEL CASSIMATIS, MD

Educational Commission for
Foreign Medical Graduates

DEANNA CHAUKOS, MD

Massachusetts
General Hospital

PAUL CHELMINSKI,

MD, MPH, FACP

University of North Carolina

*ACGME Board Member

SYMPOSIUM ATTENDEE LIST

SHEA CHENEY, MD
Denver Health

PATRICK COCKS, MD, FACP
NYU School of Medicine

JORDAN COHEN, MD, MACP
ACGME Board of Directors

JOHN COMBES, MD
American Hospital Association

RICARDO CORREA, MD
University of Miami

JON COURAND, MD, FAAP
The University of Texas Health
Science Center at San Antonio

JAMIE COWAN, MD
University of Michigan

ALISSA CRAFT, DO
American Osteopathic
Association

AMBER CROWDER, MD
Tripler Army Medical Center

TIMOTHY DASKIVICH, MD
Cedars-Sinai Medical Center

SUSAN DAY, MD
ACGME

ROBIN DIBNER, MD
ACGME

MONIQUE DIEUVIL, MD
University of Florida

DEBRA DOOLEY
ACGME

JOHN DUVAL, MBA*
Medical College of Virginia

**LISELOTTE (LOTTE) DYRBYE,
MD, MHPE, FACP**
Mayo Clinic

SYDNEY EY, PHD
Oregon Health &
Science University

RHODA FELDMAN
Planning Committee
Public Member

JUDITH FELDMAN
Planning Committee
Public Member

HOWARD FELDMAN
Planning Committee
Public Member

SIDNEY FELDMAN, MD
Planning Committee
Public Member

**STACI FISCHER,
MD, FACP, FIDSA**
ACGME

KOREN GANAS, PSYD, HSPP
Deaconess Health System

KELLIE GATES, MD
Loyola University

MATTHEW GOLDMAN, MD, MS
Columbia University - NY
State Psychiatric Institute

RALPH GRECO, MD
Stanford University
School of Medicine

RICHARD GREEN, MD
Naval Medical
Center, San Diego

SOUK GREINER
ACGME

CONNIE HAAN, MD
ACGME

**FREDERIC HAFFERTY,
PHD, MPHIL, MA**
Mayo Clinic

BRIAN HAINLINE, MD
National Collegiate
Athletic Association

SYMPOSIUM ATTENDEE LIST

AVIAD HARAMATI, PHD
Georgetown University
School of Medicine

DIANE HARTMANN, MD, MS*
University of Rochester,
Strong Memorial Hospital

ARTHUR HENGERER, MD
Federation of
State Medical Boards

ERIC HOLMBOE, MD, MACP, FRCP
ACGME

JOHN HOPPER, MD
ACGME

SANA HUSSAIN, MD
The Christ Hospital/
University of Cincinnati

**HALAH IBRAHIM,
MD, MEHP, FACP**
NYU Abu Dhabi

**MICHELLE JANNEY,
PHD, RN, NEA-BC, FAAN**
Indiana University Health

LCDR DINCHEN JARDINE, MD
Naval Medical
Center Portsmouth, VA

KENNETH JONES, PHD
Department of
Veterans Affairs

WOODSON JONES, MD
San Antonio Uniformed
Services Health Education
Consortium (SAUSHEC)

NORMAN KAHN, MD
Council of Medical
Specialty Societies

BENJAMIN KENNEDY, MD
Columbia University

DARRELL KIRCH, MD
Association of American
Medical Colleges

PAUL KLIMO, MD
University of Tennessee

LYUBA KONOPASEK, MD
New York -
Presbyterian Hospital

DAVID KOUNTZ, MD
Meridian Health

CATHERINE M. KUHN, MD
Duke University
School of Medicine

BRIANA LAU, MD
John Wayne Cancer Institute

**RICHARD LEVIN, MD, FACP,
FACC, FAHA**
The Arnold P. Gold Foundation

MARY LIEH-LAI, MD, FAAP, FCCP
ACGME

TIMOTHY LINEBERRY, MD
Aurora Health Care

LOUIS LING, MD
ACGME

KENNETH LUDMERER, MD*
Washington University
School of Medicine

KATHY MALLOY
ACGME

BRYAN MARTIN, DO
Ohio State University Hospital

MELISSA MAURO, MD
Department of Medicine
Atlantic Health /
Morristown Medical Center

LAUREL MAYER, MD
Columbia University

*ACGME Board Member

SYMPOSIUM ATTENDEE LIST

MAUREEN MCATEER

Marian University College of
Osteopathic Medicine

CLAUDIA MUELLER, PHD, MD

Stanford University
School of Medicine

LAVONNE ORTEGA, MD, MPH

Centers for Disease
Control and Prevention

WILLIAM MCDADE, MD, PHD*

University of Chicago

RICHARD MURPHY

ACGME

MUKTA PANDA, MD, FACP

University of
Tennessee-Chattanooga

RICHARD MCDONOUGH, MD

Advocate Healthcare

MICHAEL MYERS, MD

State University of
New York –Downstate

HERDLEY PAOLINI, PHD, LP

Health and Health Care
Center for Courage & Renewal

GRAHAM MCMAHON, MD, MMSC

Accreditation Council for
Continuing Medical Education

THOMAS NASCA, MD, MACP

ACGME

DANIEL PARRA

ACGME

DONALD MELNICK, MD, MACP

National Board of
Medical Examiners

ROBIN NEWTON,

MD, FACP, CSSBB, (ASQ)
ACGME

CARL PATOW, MD, MPH, FACS

ACGME

TERRIE MENDELSON, MD

ACGME

KAREN NICHOLS, DO, MA, MACOI, CS*

Midwestern University

ELIZABETH PAYNE,

MAED, C-TAGME

University of Texas Health
Science Center School of
Medicine at San Antonio

REBECCA MILLER, MS

ACGME

LOIS MARGARET NORA,

MD, JD, MBA

American Board of
Medical Specialties

LORENZO PENCE, DO, FACOF

ACGME

KIMBALL MOHN, MD

Association for Hospital
Medical Education

JOHN OGUNKEYE, MS

ACGME

INGRID PHILIBERT, PHD, MBA

ACGME

CHRISTINE MOUTIER, MD

American Foundation for
Suicide Prevention

LAWRENCE OPAS, MD

Los Angeles County-USC
Medical Center Office of GME

MARK PIAN, MD

ACGME

SYMPOSIUM ATTENDEE LIST

KIMBERLY PIERCE-BOGGS
Alliance of Independent
Academic Medical Centers

DALE RAY, MMM, MD
ACGME

ANDREA RIO, MA
ACGME

MEGAN ROKOP, PHD
University of
Massachusetts Boston

EMILY ROWLAND, MD
Brown University

JOSEPH SAKRAN, MD
Medical University
of South Carolina

MELISSA SCHORI, MD
ACGME

**HENRY SCHULTZ,
MD, MACP***
Mayo Clinic

DONNA SCHWABE, PHD
San Antonio
Military Medical Center

JOANNE SCHWARTZBERG, MD
ACGME

SRIJAN SEN, MD, PHD
University of Michigan

JANET SERWINT, MD
Johns Hopkins University

VICTORIA SHAFFER
ACGME

TINA SHAH, MD, MPH
University of Chicago

**STEVEN SHANNON,
DO, MPH**
American Association
of Colleges of
Osteopathic Medicine

JO SHAPIRO, MD
Brigham and
Women's Hospital

PHILIP SHAYNE, MD
Emory University
School of Medicine

TITUS SHEERS, MD, MBA
Akron General

HANNA SHERMAN, MD
Health and Health
Care for the Center for
Courage and Renewal

SUSAN SKOCHELAK, MD, MPH
American Medical Association

STUART SLAVIN, MD, MED
St. Louis University

STEPHEN SMITH, MD
ACGME

CHRISTOPHER SNYDER, MD
Novant Health

**ANTHONY SUCHMAN,
MD, MA, FACP**
Relationship Centered
Health Care LLC

**PEDRO TANAKA,
MD, PHD, MACD**
Stanford University
School of Medicine

KYLA TERHUNE, MD, FACS
Vanderbilt University

MARY TONGES, PHD, RN, FAAN
UNC Hospitals

*ACGME Board Member

SYMPOSIUM ATTENDEE LIST

FRANKLIN TRIMM, MD
University of South Alabama
Children's & Women's Hospital

MARIE TRONTELL, MD
ACGME

WHITNEY VANN, MD
ProHealth Care

JULIE VERDI, MD
Virginia Tech/Carillon Clinic

ROBIN WAGNER, RN, MHSA
ACGME

JESSALYNN WATANABE
ACGME

ELIZABETH WEDEMEYER, MD
ACGME

KEVIN WEISS, MD, MPH, MHSA
ACGME

COLIN WEST, MD, PHD, FACP
Mayo Clinic

JACKIE WIERZBICKI, MD
Southern Illinois University

MARK WILSON, MD, MPH
University of Iowa

MAX WOHLAUER, MD
Cleveland Clinic

LAUREN WOJNAROWSKI, MA
ACGME

NICHOLAS YAGHMOUR, MPP
ACGME

JAMES ZAIDAN, MD, MBA
Emory University
School of Medicine

EDWIN ZALNERAITIS, MD*
University of Connecticut
School of Medicine

SALAH ZEINELDINE, MD, FACP
American University of Beirut

**ROWEN ZETTERMAN, MD,
MACP, MACG***
University of Nebraska

Explanation of the Modified World Café*

The World Café is a natural & effective way to host meaningful conversations that awaken collective wisdom & engage collaborative action. Drawing on seven integrated design principles, the World Café methodology is a simple, effective, and flexible format for hosting large group dialogue.

World Café can be modified to meet a wide variety of needs. Specifics of context, numbers, purpose, location, and other circumstances are factored into each event's unique invitation, design, and question choice, but the following five components comprise the basic model:

- 1) **Setting:** Create a “special” environment, most often modeled after a café, i.e. small round tables covered with a checkered or white linen tablecloth, butcher block paper, colored pens, a vase of flowers, and optional “talking stick” item. There should be four chairs at each table (optimally) – and no more than five.
- 2) **Welcome and Introduction:** The host begins with a warm welcome and an introduction to the World Café process, setting the context, sharing the Café Etiquette, and putting participants at ease.
- 3) **Small Group Rounds:** The process begins with the first of three or more twenty minute rounds of conversation for the small group seated around a table. At the end of the twenty minutes, each member of the group moves to a different new table. They may or may not choose to leave one person as the “table host” for the next round, who welcomes the next group and briefly fills them in on what happened in the previous round.
- 4) **Questions:** each round is prefaced with a question specially crafted for the specific context and desired purpose of the World Café. The same questions can be used for more than one round, or they can be built upon each other to focus the conversation or guide its direction.
- 5) **Harvest:** After the small groups (and/or in between rounds, as needed), individuals are invited to share insights or other results from their conversations with the rest of the large group. These results are reflected visually in a variety of ways, most often using graphic recording in the front of the room.

The following seven World Café design principles are an integrated set of ideas and practices that form the basis of the pattern embodied in the World Café process.

1) Set the Context

Pay attention to the reason you are bringing people together, and what you want to achieve. Knowing the purpose and parameters of your meeting enables you to consider and choose the most important elements to realize your goals: e.g. who should be part of the conversation, what themes or questions will be most pertinent, what sorts of harvest will be more useful, etc..

2) Create Hospitable Space

Café hosts around the world emphasize the power and importance of creating a hospitable space—one that feels safe and inviting. When people feel comfortable to be themselves, they do their most creative thinking, speaking, and listening. In particular, consider how your invitation and your physical set-up contribute to creating a welcoming atmosphere.

3) Explore Questions that Matter

Knowledge emerges in response to compelling questions. Find questions that are relevant to the real-life concerns of the group. Powerful questions that “travel well” help attract collective energy, insight, and action as they move throughout a system. Depending on the timeframe available and your objectives,

your Café may explore a single question or use a progressively deeper line of inquiry through several conversational rounds.

4) Encourage Everyone's Contribution

As leaders we are increasingly aware of the importance of participation, but most people don't only want to participate, they want to actively contribute to making a difference. It is important to encourage everyone in your meeting to contribute their ideas and perspectives, while also allowing anyone who wants to participate by simply listening to do so.

5) Connect Diverse Perspectives

The opportunity to move between tables, meet new people, actively contribute your thinking, and link the essence of your discoveries to ever-widening circles of thought is one of the distinguishing characteristics of the Café. As participants carry key ideas or themes to new tables, they exchange perspectives, greatly enriching the possibility for surprising new insights.

6) Listen together for Patterns and Insights

Listening is a gift we give to one another. The quality of our listening is perhaps the most important factor determining the success of a Café. Through practicing shared listening and paying attention to themes, patterns and insights, we begin to sense a connection to the larger whole. Encourage people to listen for what is not being spoken along with what is being shared.

7) Share Collective Discoveries

Conversations held at one table reflect a pattern of wholeness that connects with the conversations at the other tables. The last phase of the Café, often called the "harvest", involves making this pattern of wholeness visible to everyone in a large group conversation. Invite a few minutes of silent reflection on the patterns, themes and deeper questions experienced in the small group conversations and call them out to share with the larger group. Make sure you have a way to capture the harvest – working with a graphic recorder is recommended.

*www.theworldcafe.org

APPENDIX 2

Final Symposium Consensus from World Café

Question 1: From what you've heard so far, what has real meaning for you? What surprised you, what challenged you? What's missing from this picture?

- Make business case to key stake holders, c-suite, insurers, and other health care professionals to address burnout and return on investment. Packaging message to leadership on why we need to change. (13 votes)
- Recognize that this is both an individual and system issue, this has to be addressed on both sides. (12 votes)

Question 2: In relation to physician well-being, what does the perfect learning/practice environment in programs and institutions look like? How can that vision be turned into reality?

- All programs must have a systematic screening process for wellness, linked to automatic actions and resources for positive screenings (11 votes)
- Alignment between institutional leadership and faculty in the learning environment in a commitment to establish a culture of respect and accountability for maintaining it in the context of patient care and resident learning. (11 votes)

Question 3: What can the ACGME do, either by itself or in collaboration with others, to foster and improve physician well-being (e.g. promote resilience, aid in early identification and recognition of distressed residents, reduce stigmatization, ensure access to care, etc) and intervene to help grieving communities heal?

- In collaboration with key stakeholders, redefine professionalism to include self-care and wellness. (10 votes)
- ACGME should create online resources for wellness to include self-assessment, curriculum and best practices. (8 votes – tied)
- ACGME should work with experts to create toolkit for program directors (e.g. Personal experience of PD's, speaker bureau, etc.). (8 votes – tied)

Initial Priority Items from World Café

Question 1: From what you've heard so far, what has real meaning for you? What surprised you, what challenged you? What's missing from this picture?

- A. Recognize that this is both an individual and system issue, this has to be addressed on both sides.
- B. Screening for burnout and being proactive, using tools, and having services.
- C. Make business case to key stake holders, c-suite, insurers, and other health care professionals to address burnout and return on investment. Packaging message to leadership on why we need to change.
- D. Loss of personal meaning, face to face interaction, satisfaction, patient relationships, and incorporation of new technology.
- E. Need to give physicians the skills they need to handle suboptimal events, such as coping skills.

Question 2: In relation to physician well-being, what does the perfect learning/practice environment in programs and institutions look like? How can that vision be turned into reality?

- F. All programs must have a systematic screening process for wellness, linked to automatic actions and resources for positive screenings.
- G. Programs will establish mentoring programs with trained mentors to provide one on one regular counseling with access to appropriate resources for meeting resident needs.
- H. Alignment between institutional leadership and faculty in the learning environment in a commitment to establish a culture of respect and accountability for maintaining it in the context of patient care and resident learning.
- I. Interprofessional teams with manageable work intensity, all working "at the top of their license" to share tasks for optimal care and learning.

Question 3: What can the ACGME do, either by itself or in collaboration with others, to foster and improve physician well-being (e.g. promote resilience, aid in early identification and recognition of distressed residents, reduce stigmatization, ensure access to care, etc) and intervene to help grieving communities heal?

- J. ACGME should create online resources for wellness to include self-assessment, curriculum and best practices.
- K. ACGME should fund wellness research, especially intervention studies.
- L. In collaboration with key stakeholders, redefine professionalism to include self-care and wellness.
- M. ACGME should create a rapid response team and share best practices to educate PD's.
- N. ACGME should work with experts to create toolkit for program directors (e.g. Personal experience of PD's, speaker bureau, etc.).

**Symposium on Physician Well-Being
Day 1 Condensed World Café Flip Chart Notes**

Question 1: From what you've heard so far, what has real meaning for you? What surprised you, what challenged you? What's missing from this picture?

Top Themes:

Patient care/patient safety x 16
Burnout statistics x 13
Need for culture changes x 12
Problems arising in medical school x 10
Stress management x 9
Available information/ideas/tools x 8
Teach/educate faculty and programs x 7
Need for mentors/role models x 7
Key stakeholder involvement x 6
IMG resistance to burnout x 5
Screening for burnout/depression x 5
Time with patients x 5
Gender issues x 5
Data/research x 4
Distinction between depression and burnout x 4
Generational differences x 4
Duty hours x 4
Technology x 4
Workload x 4
Work-Life balance x 3

Missing:

- Technology to facilitate physician/patient relationships
- Humanistic care as related to wellness
- Impact of personal life on professional
- Culture that admits/permits mistakes
- Opportunity celebrate accomplishment
- Role of diversity in culture
- Stress as good & bad
- Medicine is in denial as to issues with mental health
- Generational differences
- Identified issues that fall through cracks once they enter training (time, meds, flu)
- After training (Graph- Difference between academics and practice).
- Quality role models
- Challenge in medical school
- Expertise in burnout-prevention
- Celebration of success
- Inspiring future generations
- Stress as a positive influence
- Reduction in anxiety

- System/culture support for well-being
- Key stakeholders (C-Suite, Insurers, other Healthcare Professionals)
- Information on EBM interventions
- Vocabulary, precision
- Can we screen for resilience?
- What is working with other occupations? (E.g. military, airlines)
- Data about what works
- Package the message of why we need to change (for sharing)
- Understanding of factors that distinguish those who are burnt out vs. not.
- Business case for administration
- Linking wellness to patient care
- CEO/Stakeholders
- ACGME regulation
- Attention to exploration of gender issues, normal life stressors that may affect work life.
- Role of interprofessionalism care team, work within hospital (MD, RN, Pharmacy) - work flow, transitions
- Impact of decreased time with patients
- Loss of team mentality within residency across other hospital staff, given the duty hour restrictions on time and shortened relations.
- Productivity- At what expense?
- Disseminating information of successful programs/models
- How to evaluate wellness as priority
- How to address competition between health system financials vs. physicians wellness
- Does forced resilience training work?
- Mandatory training
- Fellowship even more potentially isolated
- Pernicious effect of “toxic programs”
- Reframing our messages to medical students
- Conflicting the problems: distinction between depression and suicide is burnout
- Recognize scope of problem
- Commitment to take action to improve wellness
- Duty hours- Solutions and unintended consequences
- Response to external pressures
- How to handle technology vs. human
- Balancing self-care/patient care/ system demands
- Impact of productivity/business pressures
- Customize for setting/specialty
- We value what we assess/measure.
- Importance of role models/contact isolation
- Gender issues
- Need skills for handling suboptimal environment/setting, 24/7
- How to disseminate information on successful programs.
- How to maintain the wellness students come in with.
- Attention to social-emotional learning and continued adult/faculty development at every level.
- Hospital practice pressures of financial/productivity models
- Transition to system-based care (EMR, Productivity, forms) without adequate training/tools.

- Lack of acknowledgment that our industry is different from others (don't make widgets)
- How to give individuals the skills they need to handle suboptimal environments.
- Need to teach physicians about appropriate limit setting, (self-limits/boundaries):
- Residents are not taught how to do this, e.g. I don't call patients during certain hours to protect time for self.
- Need to teach residents how to seek out mentors and role models for difficult situations.
- How to handle expectations of patients and hospital systems that physicians should be accessible 24/7 via electronic media (connect to limit setting)
- We're losing the art of communication (iPhone, e-mail, texting, my chart)
- Balance need for flexibility and empowerment with those who will abuse the privilege.
- Remove stigma of identification and impact on licensure – include informing resident of impact on licensure
- What's missing: issues of substance abuse
- Vulnerability of female physicians – is there a separate issue that need to be identified?
- Major challenge – how to make services truly available to those in need; truly understand state board requirements to clarify what must be reported
- Need to directly address work load “as lean as could be”
- Need to talk about recognizing the work-life challenges
- Intergenerational differences that pose a real challenge to create this supportive environment
- Not enough discussion about “low value” vs “high value” care and the impact of excessive physician documentation requirements generating meaningless notes
- Need to assure that licensing bodies recognize this openness as a positive reaction to environment and not stigmatization to those seeking appropriate help
- Current generation may be amenable to counseling
- Need for all-inclusive approach
- Unstated theme -> Solutions with unintended consequences (Duty hours)

Surprised

- How you're trained impacts you first years post grad
- Complexity theory in this domain is interesting
- Shared issue internationally
- Known for a long time & nothing done about it
- Duty hours did not really focus on well-being, more on medical errors
- Same culture issues involved with patient safety and well-being - Patient safety issues may have added to burdens
- Medical students with mental health issues below general population and deteriorate within three months.
- Availability of a validated tool to measure stress
- How training influences future practice
- Statistics
- US medical grads vs. IMGs/resilience? Foreign Medical graduates are better at handling stress than US graduates- What is it about US vs. other cultures that not predisposed to resilience?
- Not surprised RE: Foreign Medical Graduate Data- Different life experience at young age.
- Toleration of toxic environment, IMGs more resilient than US grads. Longstanding problem not yet addressed.
- Enter medical school “fine” but decline in four years

- Isolation as physicians with community/society makes us vulnerable (Mentoring/role model)
- 40-50% burnout and we tolerate it? (Preconditioned to tolerate)
- ACGME recognizing strengths and limitations and being upfront about limitations.
- Awareness of participants of scope of problem.
- ACGME call to action to other organizations to also address wellness
- That culture in medicine can be changed (Indiana University)
- Surprise that hard for trainees to be honest of environments without retribution.
- How early the problem starts in medical school
- Sense that the profession is the victim
- Not hearing much from the “patient voice”
- Not hearing much from the “financial voice”
- Number of suicides... 4 medical school class, impact on workforce
- Need to digest information: Lots of information
- Complexity of the problem
- Multipronged approach to education
- Like to hear more about FSMB: Strategy, Standardize and improve consistence on what they do
RE: Well-being
- Self-Assessment tool
- “Surprise” need to think more globally about culture, “What is it I don’t see”
- Problem of post-modernism/nihilistic thinking
- Theme of connections- “In this together”
- Burnout is both individual and environmental in origin and interventions must be targeted at both
- Importance of good screening for both burnout and depression (self-assessment, survey, etc)
- Taxonomy – burnout is different from depression
- Individuals in systems are hesitant to acknowledge depression
- Impressed about openness of medical students to talk about this
- Struck by successful suicide incidence is higher in female physician than males – is the current environment somehow more toxic in females than males?
- Acknowledging depression (burnout is already acknowledged and destigmatized)
- 14% Suicidal Ideation in 4th year MS was surprising

Challenged

- Simulation vs. over simulation
- Individualization of stress tolerance
- Not enough waking hours with duty hour standards.
- Acute stress = Good; Chronic Stress = Not good
- How do we keep pace with technology and keep the human element
- Health care professions should be less burned out and have better well-being than age matched controls
- Competitiveness needs to be addressed
- “Patient First” may make it harder to take care of self (Is this “system first?”)
- How to balance self and good patient care
- Duty hours regulations -> More work in less time
- How to deal best with external social-political processes
- Confidential web screening

- What have people done that has helped even if not research based?
- Potential list of easy to do ideas
- Levels of training as wellness
- Specialty may require different solutions
- Non GME influences on learning environment are missing
- How do we assess and drive change in the system?
- Milestones about how to assess and measure the culture? What we assess is a reflection of what we value
- We are asking faculty with a higher rate of burnout compared to trainees to being the ones to counsel, recognize, and trainees
- Changing from “fixing” the individual to changing the system.
- Balance rigor of training and tradeoff with wellness.
- Having flexible answers to reflect best practices and individual challenges (Heal thyself first).
- Learning to assess accurately for the relational component.
- Having systems attend to these issues
- Improve prevention, focus on wellness for the future of healthcare.
- How to teach coping skills
- Identify people at risk.
- How do you make the business case to address burnout, e.g. (return on investment)
- How do we define and measure well being
- Lack of faculty role models (positive)
- Changing top-down approach
- Collaboration from multiple leaders
- Finances/funding
- Production of data to show cost benefit.
- Retention & quality outcomes
- Changing stigma
- No toolkit
- What are targets?
- Generational differences (hierarchy pyramid)
- Cost of intervention
- Lack of validated measures (but need to act now) Immediacy of program vs. lack of mythological approach.

Real Meaning

- Loss of Faculty to Faculty Interactions- Electronic Health Records
- Loss of Meaning- Personal Satisfaction
- Loss of Meaningful Relationships
- Process → ACGME making this an issue. Recognition that consequences are beyond the individual (patient safety, quality, etc.).
- Both individual and system importance of resilience- how to build these skills.
- Started with suicide, moved to burnout/depression. They are different, what is the target?
- Does residency ruin good people?
- Environment creates a stress. What about hospitals?
- Who is missing in the conversation? (Residents)
- What is the positive/negative role of funding? Research funding

- Publish rate of resident suicide.
- Develop resilience strategy
- What are we trying to achieve?
- National dialogue
- Prevalence of burnout
- Workload compression
- Restore and maintain meaning in work
- Conference is meaningful
- Residents invited
- Peer support missing
- Physician well-being is a shared responsibility
- People in power actually care
- Humbleness of medicine to engage in self-reflective process
- Optimism for action to create change
- Large representation with many stakeholders
- Even a small change will be large change in culture of wellness
- Finding others also interested in wellness
- Increased priority of wellness
- Increased credibility
- Levin's presentation
- Times are different
- Tech/Computer work has replaced work that helped create empathy
- It is a problem across continuum.
- Suicide is not the metric. Burnout?

Question 2: In relation to physician well-being, what does the perfect learning/practice environment in programs and institutions look like? How can that vision be turned into reality?

Top Themes:

Safe, supportive environment for residents x 59
Resources for self-care (for trainees) x 41
Protected teaching time for faculty x 37
Faculty development x 25
More time with patients x 24
Adequate time for social interaction x 20
Financial support for teaching (ERVU) x 17
Decreasing administrative burdens x 13
Patient Safety and Quality x 12
Administrative/C-Suite support x 10
Personal development (for trainees) x 9
Breaking down silos between programs x 8
Monitoring performance/proper assessment x 8
Adequate time with mentors x 6
Feedback x 5
Data that well-being improves bottom line x 4

Programs

Program Clinical Learning Environment

- Uniform usage of patient safety and quality important in terms across all faculty in all programs
- Tracking performance in non-punitive/non-judgmental ways
- Conflict resolved/dealt with quickly
- Clear expectations for residents/learning and team members
- Teaching adaptability for future changes and emphasizing enduring clinical skills
- Adequate time with patients, mentors, faculty, peers
- Attention paid to personal development and interprofessional skills/relationships
- Autonomy at program/institutional level
- Facilitating team work
- Remove toxicity of environment to address positive or remediate unprofessional behavior
- Open door policy – comfortable with dialogue with PD – safe environment
- Fellow residents promote safe environment
- Opportunities for improvement following mistakes
- Constructive criticism/improve feedback process
- More mentoring
- More faculty-trainee interaction
- Supportive administration – understanding training model
- Non-condescending environment
- Well-defined expectation – upfront – for residents and all team members
- Inventory of hands-on skills at the start of residency
- Adequate number of patient interactions
- Designated/protected social/team building
- Data/measurement with tools
- Opportunities to discuss issues

- Leadership establishes safe environment (jeopardy system, backup, messaging)
- Patients deserve 30 minutes of time – Osler was right
- Individual coaching with time management, multi-tasking
- More time for in-depth discussion/care
- Streamline documentations so more time for doing with patients
- Not stress free: right challenges
- Mistakes are used for growth challenges
- Generational shift – last 10 years have been about negative feedback
- Team activities – share work in effective ways
- Alter job description
- Redesign systems for care
- Faculty, staff, and learners all skilled in science of quality and patient safety as they are in health care
- Addresses the stacking of administrative expectations on physicians – determine if necessary (evidence based)
- Find a way to talk to one another face to face or effective proxy (skype, etc.)
- Confidential assessment program
- Continuously adjust service learning – balance according to learner
- Less EMR (Electronic Medical Records) work- face to face interactions with patients
- Advisor: Professional advisor for career, maintain objective
- Mentor: Traditional, someone who writes letters of recommendation
- Everyone gets baseline training, then specific for those who have a role.
- Patient Load needs to be decreased
- Safe, supportive mentoring relationships
- Careful screening selection of residents
- Create a safe space for the resident voice – council, committee, etc.

Program Culture

- Culture of respect/accountability
- Close meaningful relationships between learners and faculty
- Culturally competent environment
- Community-building around values
- Culture change as continuous quality improvement
- Culture of caring about and for each other
- Inquiry/questions encouraged
- Resident/faculty engagement; relationship longitudinal together inpatient care
- Focus on continuous improvement and growth – culture of safety
- Respect – unconditional positive regard for the contributions of all talents (especially the trainees)
- Mission driven and mission documented culture
- Flexibility which feeds innovation
- Fostering authentic relationship within program outside of role
- Early exposure (orientation) – set cultural expectations
- Leadership/role modeling/exemplars – the right ones
- Promotion of humanism
- Culture change: move away from top-down approach...push towards the right drivers

- Engagement at all levels
- Connectedness – mutual support
- Inspire learners to change
- Creative tension (good vs/ bad stress)
- Relationship centered
- Respectful – open to all points of vision
- Nurturing
- Empowering
- Team based – each to max of license
- Competitive environment that supports learning from one another
- Everyone create an environment where all can participate (speak up) without fear of retribution (flatten hierarchy)
- Humanize communication pathways (creatively)
- Lack of fear; and be open with opinions/feelings
- Respect collegiality
- Get Away from Service, “Cheap Labor”, Mentality

Education

- Value shift to value learning; supervision etc. vs. patient care/service
- Balance of supervision – appropriate for level of demonstrated competence
- Value education at all institutional levels (incentives)
- Learning plan – individualized
- Teaching while shielding of residents from managing medical malpractice/liability
- Graduated accountability along with responsibility
- Modeling and preparation for practice after training
- Teaching seen as value added
- Educational curriculum to speak about issues
- Layering education on top
- Reflective time for learning
- Time to meet learning objectives
- Opportunities for learning – didactics/resident presentations
- Peer mediation training for chief residents and faculty.

Well-Being Initiatives

- Training to identify burnout from coordinators
- Close relationship between learners and faculty with frequent check in to proactively assess situation before issue
- Measures for joy-value-respect
- Data on burn-out and resilience to track, trend, intervene
- Work-home integration – holistic wellness respected by all
- Understanding of the continuum of wellness
- Everyone supported in mental health at every level of training
- Ok to disclose mental health needs – burnout, emotional exhaustion, depression
- Opportunity for self-reflection and self-care
- Address issues which cause burnout
- Dedicated peer support

- Wellness center
- On-site behavioral health provider
- Free screening with wellness program
- Intended (not circumstantial) well-being (not as add on or after thought)
- Identify barriers to getting help for burnout
- Have wellness curriculum (mindfulness, etc)
- Well-being as expectation – residents, PD, faculty
- Protected time for doctor appointment
- Confidentiality when getting help
- Scheduled time off for preventive care
- Sharing experiences/struggles between residents to increase awareness and acceptance
- System that allows for leaves of absence/emergencies
- Wellness learning self-care
- Facilities for exercise – promotion of exercise/balance
- Mechanisms for self-assessment linked with opportunities to get help
- Address time pressure/self-care issue
- Faculty reaching out to residents in need – especially if brought to their attention
- Matrix of resources – ex: music groups, religious needs
- No stigma associated for getting any type of health care
- Provide learning about stress, what other resources to tap into when it occurs
- Create common taxonomy for well-being
- Access to help confidential
- Shower (facilities) for self-care
- Yoga
- Healthy food
- Easy to access care “case manager”, medical, psychiatric care
- Use standard burnout metrics i.e. in military
- Education on what is confidential

Faculty

- Increase faculty development opportunities
- Maintain and strengthen faculty
- Breed quality individuals
- Faculty wellness
- Time to teach
- Training in leadership skills and management skills
- Time for faculty to mentor
- Faculty need to have same resources as residents – counseling, jeopardy system, mentorship, ongoing development of skills, etc.
- Development skills for mentoring/coaching
- Faculty development around role as educator

Work Load/Intensity

- Manageable number of patients
- Monitor work load intensity
- Minimize non-educational tasks

- Balance/blend for work intensity appropriate for optimal learning
- Flexible work schedule – including personal time
- Work-Life balance
- Define physician tasks – protect from non-physician tasks

Institutions

Institution

- Engagement of the c-suite
- Support from the top down
- Evidence well-being improves the bottom line; perfect differs between programs
- Decision making transparency
- Leaders take action
- Consistency across programs within an institution
- Institution wide culture
- Learning organizations/adapt to change
- Leadership has to be engaged at every level and exhibit model behavior
- Ensure that environment is stigma free (legal)
- Institutional efforts to have all staff have task-skill alignment
- Teamwork with other professional disciplines
- Seek out the ways to build on strengths and help identify gaps for improvement
- Abandon fee for service model
- Aligning mission of institution and education
- Flexible – willing to engage system wide
- Execs and clinical care decision work together
- Revise business structure
- Strategy to engage the public on this issue proactively
- Interaction between programs (different specialties and staff)
- Protected time has to come from the top.
- Within mission statement include well-being of employees
 - Documented by structure, practice, and proven
 - With intentional well-being considered within all policies
- Have policies revisited to assess for wellness

Finance

- Separate financial burden from teaching/learning but also balance business of medicine learning
- Appropriately compensate educators
- Increase income – where is value?
- Support for teaching and learning as much as clinical RVUs and research
- Revise business structure (funds flow)
- Possible legislation – how things get reimbursed
- Create a business case for this environment
 - Patient safety metrics
 - Happy employees and doctors = happy patients = great patient experiences scores = money
- System for financially recognizing education (EVUs)
- Spend GME money on education – accountability for how its spent

- Share income with teacher

Question 3: What can the ACGME do, either by itself or in collaboration with others, to foster and improve physician well-being (e.g. promote resilience, aid in early identification and recognition of distressed residents, reduce stigmatization, ensure access to care, etc) and intervene to help grieving communities heal?

Top Themes
Resources/Toolkit x 41
Data/Research x 26
Institutional/Program Requirements x 23
CLER x 21
Collaborate/partner with organizations within the continuum x 17
Incentives x 14
Surveys x 11
Core Competencies x 6
Education x 6
Marketing/PR x 6
Milestones x 5
Self-Study x4

Working with other organizations/communities

- Dialogue with NBME to consider addressing well-being thru the exam.
- Work with hospital associations aligned with doctors. Partner with the Joint Commission
- Need partnership to achieve objectives.
- Collaboration with other organizations
- Identify partners for longitudinal support (AMA, AHA, ACCME)
- FSMB, etc – work together to change language on licensing application forms – decrease stigmatization
- Whatever ACGME does, it should also be done by AAMC and the specialty organization groups.
- ACGME create a team of people with expertise who can provide consultation. Could be a collaborations with others.
- Culture change needed at medical school and residency levels.
- Need to intervene/change attitude during medical school when attitudes are formed.
- Partnering with foundations - Like Gold foundation to promote wellness
- Collaborate with alphabet soups of organizations to improve awareness/access to resources for physician well-being.
- Collaboratively mount a campaign with shared goals (across all organizations)
 - Destigmatize along entire continuum
 - Tools for promotion, recognition
 - Testing along continuum
- Partner with other organizations to collect data for faculty and residents- 0
- Acknowledge shared nature of problem (must be a joint campaign_
- Strong standards to address mistreatment in line w/LCME
- Including AHA or equivalent in discussion/intervention, (including CEOs and senior leaders)
- Identifying partners for wellness support of practicing allies (AMA, AHA, AAMC)
- AMA/ACGME lobbying for wellness support in healthcare form
- Engage psychiatric community to help.
- MBUE licensing exam/MCAT

- FSMB Credentialing- Questions to decrease barrier
- Champion this cause among other organizations
- ACGME collectively influence other groups in healthcare to provide more support, (AHA, AMC, Joint Commission)
- ACGME to partner with other organizations. Identify and award exemplars.
- Partnerships: Specialty Groups, (AAMC, ACCME) Continuum of Medical Education.
- Lobby government for payment reform. Impact on education and wellness.
- Outreach on policy of state medical boards
- Are residencies evolving in the way medical schools are? Do they need to change?
- Addressing wellness at medical school level, CME/Hospital Medical Staff
- Diagnosis vs. impairment with licensing boards must be addressed.
- Partnering with resident organization and program coordinators
- Partner with C-Suite orgs-educate.
- What is going on in medical schools to do this? Role modeling from residents/fellows?
- Transition between college and undergraduate medical education
- Destigmatize it by sharing data with CEO's, leadership, not just GME community, talk about it every day.
- Collaborate with other industries as to their success with wellness programs.
- Collaboration with community partners to develop national standards in prevention, access, and interventional in all aspects of physician wellness.
- Collaboration and learn from other industries/companies about their best practices/successes in employee wellness.
- Open the Conversation to the Continuum- Medical Students and Residents
- Work with psych PDs to identify toolkit (rapid response) personal experience of PDs, speaker bureau, sharing today's slides)
- Work with FFMB to identify and share data on state licensing board policies & restrictions
- Policy outreach to boards to achieve uniform and non-stigmatizing policies.
- Organizational partners develop an equivalent to the ELAM- like program specific to institutional leaders in wellness

CLER

- CLER should have one team member with a focus on well-being so that well-being is consistent /addressed. Need data-CLER can help.
- Use CLER to identify factors that contribute to and protect against burnout.
- Use CLER to assess and encourage GME to assess. Use of institutional resources to support well-being such as counseling and EAP. Also should be addresses in ACGME Standards.
- Incorporate wellness into CLER
- Strong CLER → Resilient physicians; Poor CLER → Burned out physicians
- The learning environment correlates with outcome (personal, quality of care, patient outcomes)
- Consider possible ACGME interventions that may advise programs/institutions (CLER)
- Behaviorist on CLER Team
- Address well-being during CLER visit.
- Recognition of healthy workplace e.g. Via CLER, award
- Incorporating burnout screening into CLER visits
- Integrating wellness into pursuing excellence initiative.
- Within CLER: Put survey/screening tools within that setting to gather specialty specific data.

- Have CLER provide relative valuation (improving/not) in areas, provide suggestions.
- USE CLER visits to provide best practices
- Incorporate burnout screening into CLER visits. Residents/fellows/faculty
- 1st Do No Harm – Increased requests. Having someone from the outside (e.g., ACGME) come in to look at how well I am taking care of my residents/fellows- CLER visit vs. requirements.
- ACGME should develop a group that can travel to a program to help residents- major loss, suicides and/or train the trainer at ACGME meetings, etc.
- Assess at CLER Visit
- Wellness/resilience as part of CLER under Professionalism
- Expansion of the CLER Program to increase the survey process around physician wellness.

Education

- Resident and Faculty Education
- Regional Conference
- Resident Education
- Prioritizing education
- Educate faculty, Program Directors, Institutions on the signs/symptoms of depression so that we recognize it to allow for earlier intervention.
- Burnout- temporary/chronic (education)
- Educate DIOs, PDs, faculty, Residents, Fellows: Depression, burnout, suicide
- Help program directors determine which residents are in an early stage of burnout.
- Peer mediation training for chief residents and faculty
- Need to give physicians the skills they need to handle suboptimal events, “coping skills.”
- Web-based curriculum for PDs and faculty on identifying burnout and depression and having initial conversation with trainees
- Host programs on how to deal with suicide/disasters (including lessons learned)
- Educate Program Directors and Program Coordinators: Faculty Development, (Train the Trainer).
- Create Model, train leaders
- Faculty Development
- Involving Chief residents, peer development
- Educating residents on what are implications (RE: License, Etc.)
- Part of Chief Resident Training courses.
- Educating Medical Staff
- Development of a physician wellness/leadership training program (i.e., ELAM-like): Open by nomination from institutions.
- Establish training/resources for the support of Program Directors; Faculty (Physician Development)

Resources/Toolkit

- ACGME create website with educational resources on suicide, burnout, well-being. Include self-assessment tools.
- Develop resource regarding possible intervention, (focus on teaching, not retribution).
- Tool kit/response – in place for use in crisis
- Online resources for wellness to include self-assessment, curriculum & best practices
- Create a “roadmap” for programs when tragedy occurs.

- Private/off-record resources (hotline)
- ACGME providing a physician/resident hotline.
- Publicize key features of wellness to Program Directors -> Faculty Development
- Creation of crisis hotline
- Support development of anonymous reporting mechanism
- Promote on-line tools to assess wellness
- Resources: Manuscripts; Assessment tools (screening tools)
- Where to put our efforts to address the problem?
- Develop self-awareness tools.
- Share peer support program development ideas.
- Offer screening tools: Anonymous, but proof of participation. Repeat on a regular basis. Safety of confidentiality.
- General guidelines for supporting a community or program following a suicide or other death (psychiatry PD group)
- Critical response (protocol) team, toolkit, program
- Dissemination of information on resilience/wellness curriculum.
- Awareness/support for institutional resources to help programs
- Video resources (trigger tapes)
- Provision of resources
- Something to tap into for grieving communities (ACGME Resource/DIO Leadership Course)
- Tools for Recognition of Distress
- ACGME SWAT team
- Identify and disseminate curriculum for faculty and PDs on identifying burnout and depression and having initial conversation with resident.
- Toolkit resource for DIOs & PDs for handling resident death (including suicide)
- Team support- who to call. (ex. Psychiatry PD group)
- Vignettes of Real life stories: local physician sought assistance with local resources available. Power of story-telling. Disaster plan examples, flexible schedules, etc. Speaker bureau.
- Have "Disaster" plan (requirements on RRT for crisis short of suicidal ideation.
- Concierge practice: What are the factors if they are more satisfied?
- ACGME develop and publicize toolkits and opportunities available to the medical community on wellness.
- Resources for implementing new ideas
- Mental health resource availability list- anonymous, affordable, convenient.
- Develop a program for intervention after a tragedy (travel, regional experts, train the trainer). Share what worked and what didn't work.
- Develop resilience programs for all residents/fellows with appropriate partners→ continuous, not "one & done" @ orientation.
- Rapid response by programs, ACGME rapid response team (share best practices), educate PDs

Milestones

- ACGME focus on professionalism, should include self-care. Could be a milestone.
- Use milestones to develop skill set/toolbox on how to be "my brother's keeper"
- Milestone across resident programs.
- Well-being added to professionalism milestone. Rested for work/self-care.

Survey

- Use ACGME resident survey to assess well-being but not to use that data for accreditation decisions. Data could go back to program and/or institution.
- ACGME collects data not linked to accreditation and separate from CLER (institutional base line) – what are you doing in your institution?
- Survey questions w/out consequences
- Data Collection and Dissemination
 - Survey Wellness Continuously
 - Organizational Measures
- Need to develop residents' trust. Would provide national data. Resident well-being survey could be voluntary.
- Resident survey not effective because residents do not answer honestly, paranoia.
- Faculty survey should address well-being
- Add burnout screening to resident/fellow survey but make it anonymous (+/-) implications
- How do we do some regular self-surveys on burnout? Encouraging self-surveys?
- Survey current practices, identify best practices

Research/Data

- ACGME should support research on physician burnout and suicide as well as effective interventions. How to measure effectiveness of interventions.
- What key factors do resilient residents possess?
- Measure of trait of resilience
- Inventory of current licensing practices across the states
- Obtain better suicide data
- Determine consequences of burnout
- Data dissemination
- Collaborative Research - Individual, Program, Institutional
- Research ways to engage joy in training/practice
- Burnout measures and looking upstream from suicide.
- Make data on burnout/suicide available to all programs and residents, (Present data at the AEC)
- Describe state by state licensing issues and stigma associated w/mental illness.
- ACGME funding intervention studies and other research/patient safety
- Provide/develop data on burnout/suicide with more power to see if changes are statistically significant.
- Don't focus solely on data, do the right thing.
- Share data broadly: Resources, screening tools, manuscripts, slides, intervention protocols
- Research Where to spend our \$ and what works.
- Need a repository of existing programs
- Study resilience people and factors interventions
- Need to research why mental health declines as a student and through career and why suicidal ideation increases through age. Is there a difference between academics and research?
- Specialty specific data: Important
- Develop metrics for work compression with nonclinical work and then track those data. Maybe the best metric is burnout.
- Share best practices learned at institutions, including costs...
- Documentation

- Cost-containment – work with funders to fund studies (feasibility) as a business proposition
- Identify exemplars & facilitate dissemination
- Workload intensity → needs study/standards
- Support qualitative research on resident wellness/burnout
- Identifying Sub-suicidal distress
- Finding out what works and disseminating information on what works
- Adverse events analysis with opportunity for improvement/system analysis
- Resident level data with collaboration of mental health program.
- The intensity of workload- we need to look at this, measure, appreciate this.
- Look at models where physician well-being is being managed well.
- Research request- longitudinal data to look at verification of lifespan
- Start the process even before you have data on well-being or otherwise.
- Extensive research of physician suicide.
- Development of National Standards for access to medical/mental health for trainees.
- Study the impact of payment reform on education/wellness.
- Study those who are resistant.

Incentives

- Encourage faculty members who are willing to share their own personal stories. Look for ways to incentivize Institutional and or physician wellness award.
- Wellness benefits, discounts, award/reward, incentives
- Recognition for wellness
- Support/Commend local programs/institutions
- Incentivize programs to improve resident/fellow wellness.
- Incentivize- awards, etc.
- Miss opportunity to celebrate positive achievements.
- Incentives are not aligned
- Healthy Workplace Award - National Recognition; Local Recognition; Program
- Destigmatization increased value on well-being efforts.
- Wellness Seal of Approval for Program Specialty
- Aligning Incentives- fixing the system, not just the people
- Develop a recognition (parallel to Parker Palmer Award) for institutions with wellness programs with exemplary outcomes.
- ACGME wellness award for program/institution- center of excellence. Help recruitment.

Institutional/Program Requirements

- Institutional requirements & health insurance requirements
- Make business case to key stake holders, (C-Suite, Insurers, and Other Health Care Professions) to address burnout and return of investment. Packaging message to leadership on why we need to change
- Striking a balance between RVUs and wellness (business incentives) 1
- Use accreditation standards to achieve an EVU- Emotional value unit or educational value unit.
- Institutional requirements RE: Wellness, Mental Health, Etc.
- Need to train trainees how to deal with problems.
- Mandate screening
- Mandatory counseling

- Require mental health insurance coverage that covers care outside of the resident's institution.
- Requirement to have wellness- allow broad integration.
- Work hours reevaluated.
- Strongly suggested mental health screens. At DIO level- (maybe mandate) to unmask/keep confidential (not PD) to identify those that need help or an unaffiliated Healthcare provider at an outside site.
- Need safety when self-reporting
- ACGME mandate for mental health services (appropriate time and place)
- Behavioral Health Specialists linked to program.
- Institutional requirements
- Want more 1 on 1 patient time.
- Eliminate professional/financial consequences of mental health diagnosis
- Chief resident for physician wellness
- Mandate all institutions incorporate that all trainees have annual care by mental health professions

Marketing/PR

- Combine with marketing.
- ACGME to "market" our commitment to fostering well-being/collaboration with other groups.
- Need to share stories of success to inspire other programs.
- Be an exemplar for mapping/spread conversation (Track and record)
- Talk/analyze after event
- Connecting and publicizing good programs and solutions.

Core Competencies

- 7th competency- Self Care- Core Value
- Well-being + self-care come a personal and professional responsibility
- ACGME core competencies
- Wellbeing as a 7th competence (milestones)
- Redo professionalism to include self-care to wellness.
- Link professionalism to sustainable practice to wellness- like Canada, England (Study places that do it well/better)

Self-Study

- Add burnout/wellness assessment to program self-study- including plans for improvement
- Self-study: Describe your process for accessing help, providing support when residents struggle or there is a suicide- What are your plans to improve?
- Burnout and wellness assessment as part of self-study

Symposium on Physician Well-Being Day 2 Condensed Flip Chart Notes

Top Themes:

Collaborate/partner externally x 49
Awareness/dissemination of information x 34
Wellness programs x 34
Tool kit/resources x 27
Study/data/research x 22
Research/data collecting x 20
Institutional leadership/C-Suite involvement x 20
Signed commitments x 16
Surveys/assessment x 14
CLER x 13
Education x 13
Faculty x 8
Post symposium information x 6
Mentorship x 5
PR/marketing/JGME x 5
Milestones x 4
Program requirements x 3
Interdepartmental involvement and support x 3
Emotional support x 3
Forum to discuss x 3

1. From your personal and/or organizational perspective, what are the next steps you think the profession needs to take in order to sustain this effort?

ACGME Role

Tool Kit

- Develop/identify available tool kits, including ones which include family of residents
- Blueprint – “What do I (PD) do in the middle of the night?”
- Library of resources
- Training resources
- Assessment tools
- Step by step (like CCC guidance)
- Blueprint process and map
- ACGME task force to study assessment tools and resources/referrals.
- Include marketing tools
- Formulate consultative services for programs without capabilities to create own wellness initiatives
- Find ways to encourage funding and support of ongoing wellness research
- Validated screening tools

CLER

- Medicine must make a statement about the work environment
- If physician community is not well, it will affect patient care and satisfaction

- Wellness as a quality, safety, and public health issue
- Redefine professionalism to include wellness
- Go deeper with CLER protocol 3
- New pathways
- Expand gaze of CLER to include workload, work intensity, and quality of faculty/resident interactions in addition to safety/quality

Surveys/Assessments

- Resident survey not address wellness but link to Dr. Baldwin's
- Comparison with faculty survey
- DIO report on current available wellness programs and synopsis on activity (annual)
- Add burnout related questions to ACGME resident survey - 1st as exploratory and not for accreditation
- Independent survey, unattached from accreditation (To DIOs, PDs via PD survey, via National PD organizations)
- Include wellness in faculty survey
- Survey graduates of program following completion of residency

Post Symposium Information

- Synopsis of this meeting
- Videos/Documentaries
- "Snippets" – 10 slides
- Most important things to take home
- Summary on ACGME website
- Presentation of symposium highlights

General

- Help us! Support us! No more unfunded mandates!
- Collaborative efforts with industry (non-pharmaceutical)
- Standardize on state level evaluation of mental health and impact on licensure/disability
- Assign CME credit/incentives for people who read the message
- Offer recognition for programs and/or institutions who model wellness
- Identify an individual with broad institutional influence to support movement

PR/Marketing/JGME

- Dissemination of awareness: Via ACGME
- Publicize efforts/heighten visibility
- Major national conferences should have a wellness agenda
- Need communication strategy
- Personalize narratives of physician burnout and depression – ie put a face to the topic

Research/Data Collecting

- ACGME reps meet with chairs/deans – outreach
- Collect best practices
- Identify what we consider "best practice" and research these – on going
- Share/formulate analysis of costs of not focusing on faculty and resident wellness

- Use data from this meeting

Forum

- Create repository/message board to share ideas and programs, etc. to continue discussion of wellness
- Providing additional forums, focus groups for ongoing communication (social media, listservs, journals)

Milestones

- School of medicine – make this a core curricular Milestone – education
- Wellness as part of Milestones (ie. Self-awareness, self-reflection)

Program Requirements

- ACGME Institution and program requirements modification for expectation setting RE: (MD) Learner wellness
- Program Requirement that will require a wellness curriculum

Education

- Faculty/physician education
 - Contributors to burnout/suicide risk
 - Generate a baseline understanding
 - Destigmatize the feelings of needing help/support
- Prepare DIOs for this role

Collaborate externally

- Nursing
- Military
- Athletics
- Corporate entities (Apple, Google, Etc.)
- Other professions (airline)
- LCME
- ACCME
- AAMC
- Gold Foundation
- AMA
- Program Director organizations
- Program Coordinator organizations
- AACOM
- AOA
- AAIM
- AHME
- AAMC
- NBME
 - How to manage the stress of the process
 - Effective ways to study known by NBME
 - Organize oneself to prepare for testing
 - Draw attention to systems based practice content in testing content.

- ECFMG
 - Committed to ECHO- Adapting/expanding
 - Provides resources to IMGs, now to country
 - Close links through relations with ethnic medical organizations.
- Hospital leadership
- National alliances
- National specialty societies
- Professional organizations
- Medical Schools
- Joint Campaign- Public Health
- Organizations need to row the oars in the same direction
- Each group take action within their realm
- Develop a shared understanding, but don't dilute responsibility for action
- Inter-institutional best practices/sharing
- Strengthen collaboration between AMA and ACGME - continue to make a priority
- Involve APA in resident wellness

Awareness/Dissemination of Information

- Increase awareness (dissemination, statistics, impact on errors and to C-Suite using CLER).
- As a profession to continue to maintain awareness
- Promote public awareness and enlist public support
- Share best practices
- PR – spread the word, build resilience
- Publish the results of our wellness program for others to use
- Publish our Colleague in Need OSCE for use by others
- Share at national PD meetings – focus area is wellness
- ACGME annual educational conference
- Replicate this meeting at other national meetings
- Social media
- Monthly blog to Psych congress and MD health

Study/Data/Research

- Prospective study of what is being done
- Specialty specific data help educate
- Gather evidence about post-suicide program interventions
- Write papers on: Imposter syndrome; Maladaptive perfectionism (CBT? Self admin. Web-based CBT tool); Correlation with depression/burnout
- Write a wellness paper based on data that has been collected.
- Intern-organizational white paper on wellness written by IOM (Institute of Medicine)

2. What would you be able (willing) to commit to do personally/ organizationally over the next year?

Institutional

Wellness Programs

- Emphasize value of social events, retreats, etc. and how it positively impacts wellness
- Drilling, practice, simulation
- Promote a wellness program at own institution
- Inventory pre-existing institutional wellness programs to identify strengths, funding, weaknesses
- Peer support program
- Resident wellness committee
- Present burnout issue Feb 18th to our residents
- Topic during orientations – let me know if roadblocks occur
- Real-time learning/attention/red event approach
- Trying to adapt wellness models to tailor it at a personal institutional level
- Discuss this with physician wellness committee and promote engagement on a local level
- Disseminate and inform local institutions of wellness and ongoing issue of burnout
- Create wellness subcommittee/work group of GMEC or within institution.
- Student-run mental health awareness task force
- Curriculum around wellness
- Add wellness into mission statements (subspecialties)
- Respect/allow help to be sought “anonymously”

Institutional Leadership/C-Suite

- Change management
- Meet with institutional leaders (C-Suite) to discuss budget and implementation of wellness program
- Make a case for reducing work compression
 - Research cost vs. savings
- Institutional support for program implementation of wellness initiatives and resources
- Organizational commitment
- Grow awareness across organization institution of data and need with regard to (MD wellness) (vs. burnout, depression)
- CCC role in providing evaluative feedback and PD/APD conversation RE: Career goals & wellness
- Involve resident coordinators
- Needs assessment
 - Evaluation assets, opportunities, lesions, resources and needs
- Change the culture

Interdepartmental

- Cross-institutional prescription possibilities
- Specialty/interdisciplinary camaraderie in own institution with PDs
 - Retreats
 - Share
 - DIO as hub

- Engage Departments of Psychiatry across hospital/academic settings to help address wellness in other departments.

Faculty

- Leadership education
- Faculty wellness focus
- Faculty development across specialties in institution

Emotional Support

- Promote joy of work
- Find bright spots
- Humanism

Mentorship

- Encourage mentorship
- Pre-retirement mentorship
- Advisors/mentors- scheduled check-ins

Signed Commitments

- Continue writing on this subject (Dr. Kenneth Ludmerer)
- Work with ACGME educational board on the creation of a series of products from the conference, focusing on dissemination of approaches, and new research on the topic (Dr. Ingrid Philibert)
- Complete book in progress (Dr. Michael Myers)
- Present this topic/conference at a faculty development meeting (Dr. Koren Ganas)
- Present burnout issue Feb 18th to our residents (Dr. Patrick Cocks)
- Work to expand our resident wellness committee (Dr. Patrick Cocks)
- Gather evidence about post-suicide program interventions (Dr. Timothy Lineberry)
- Meet with leaders at my institution to discuss the business case – get money to do pilot interventions (Dr. Timothy Lineberry)
- Write up our peer support program to publish our work for others to use (Dr. Jo Shapiro)
- Editorial board of JGME: encourage residents/faculty to submit research and personal discussion of wellness – use journal as a forum (Dr. Max Wohlauser)
- Challenge other residents of specialties without wellness initiatives to start further exploration (Dr. Shea Cheney)
- Work to inform families of victims that their death is not in vain; presentation of symposium highlights; involve APA in resident wellness (Dr. Matthew Goldman)
- Chief resident council to evaluate wellness efforts; using and implementing psychiatry training across subspecialties to promote a bigger topic (Dr. Deanna Chaukos)
- Take resources learned here and implement them locally and regionally (Dr. Kellie Gates)
- Continue to work as a member of the planning committee to gather data and ideas and report back annually (Dr. Edwin Zalneraitis)
- Open the discussion of wellness by creating presentations (Dr. Briana Lau)

3. Over the next four years, would you be willing to commit to attending an annual meeting convened by the ACGME to learn about the progress across the continuum and throughout the profession and to report on you and/or your organizations progress on enhancing physician well-being and changing the culture?

- Yes
- Yes if we get to pick our tables
- Yes but broaden the base
 - Patient groups
 - Nursing groups
 - Residents dealing w/ suicide
- Yes but focus on the actions, not more evidence, share what is and is not working
- Partner with organizations who are already meeting
 - Canadian group on wellness
 - AMA
 - British medical society
- Yes, but/and measure change
- More residents
- Joint Sponsorship
- “Wellness” sessions at other meetings: eg: AEC
- To maintain resident contribution will require some ACGME \$ support

APPENDIX 3

ACGME Symposium on Physician Well-Being

November 17-18, 2015 (Well Being)

of responses: 65

of physician responses: 64

of non-physician responses: 1

<i>Rate the extent to which</i>	Very High	High	Moderate	Low	Very Low	Mean
1. How would you rate the symposium overall?	87.69% 87.50% 100.00%	12.31% 12.50% 0.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	4.88 4.95 5.00
2. To what extent was the content relevant and useful to you?	87.69% 89.06% 0.00%	12.31% 10.94% 100.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	4.88 4.89 4.00
3. To what extent were the faculty able to stimulate interest in the content of the symposium?	89.23% 89.06% 100.00%	9.23% 9.38% 0.00%	1.54% 1.56% 0.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	4.88 4.88 5.00
4. To what extent were the five small group experiences useful and relevant?	60.00% 60.94% 0.00%	27.69% 26.56% 100.00%	12.31% 12.50% 0.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	4.48 4.48 4.00
Additional Comments						
<p>This conference was in a category of its own- outstanding and unusual. Engaged heart and mind with data and stories, and called upon the attendees to courageously and honestly roll up their sleeves and come up with possible solutions.</p> <p>An electronic bulletin board (such as padlet) would have been useful"</p> <p>It was a fantastic beginning to a serious problem in need of resolution.</p> <p>"extremely important gathering of leaders from different areas of medicine to discuss how to bring about small and large scale changes in training and practice of medicine in order to promote well being of trainees and faculty.</p> <p>excellent presentations and small group activities (world cafe model was great) and emphasis in 2nd day on next steps. NCAA presenter was outstanding choice for setting the stage on 2nd day and broadening our perspective "</p> <p>Too many lectures, especially on day 1. There needed to be more time for reflection and discussion</p> <p>Outstanding experience ? very impressed with being able to get everybody together and overall thoughtfulness and planning involved.</p> <p>"The last report out from small groups was not very useful</p> <p>An incredible aggregation of people truly interested and expert in GME.</p> <p>It is surprising how the small group discussions were similar</p> <p>The was some repetition at the end , perhaps one less small group session needed</p> <p>The small group discussions were very helpful, The fact that the ACGME leadership was present and participated actively was reassuring and spoke volumes of the support and need for active movement towards this pandemic.</p>						

Outstanding organization and delivery in a comfortable setting that stimulated high level conversations about a topic we should have been having conversations about for years.

Wonderful symposium. Great information presented and use of small groups gave attendees opportunities to meet others and to work collaboratively.

I thought the small groups were redundant and could have been reduced to half the time. Especially the reporting out" with was very repetitive. The speakers were excellent. As good as I've heard at any symposium. Absolute experts and very engaging."

This was the best conference I've attended in recent years. The presentations at the beginning nicely set the stage for the small group sessions that followed. Each of the presenters were very effective in conveying the extent of the problem and the importance of making changes in what we do to ameliorate the suffering experiences by many medical students, residents, fellows, faculty, and community practitioners. This was a call to action that no one could walk away from unmoved.

One of the best symposiums I have ever attended!

Loved the World Cafe Model, very helpful in getting many together to produce very specific answers to questions. Speakers were all outstanding.

It was helpful that the leaders of the symposium were willing to adjust on the fly based on the direction of group input/participation. Overall, I rated every category as very high, though Dr. Levin's presentation was not as useful to me. Dr. Hainline's presentation and the ability to parallel what he does with athletes and what we do with residents was the most provocative and informative to me.

The symposium felt very successful in creating a sense of urgency, that the status quo is not acceptable. While I enjoyed the conversations and connections of the breakout groups, I would have liked deeper dialog. I felt we rushed too quickly to solutions with little opportunity to explore the diverse perceptions and perspectives of the other people at the table. So I feel that I missed a chance to widen my own understanding.

I would suggest that there be more interactive sessions a bit earlier in the session

This was an extremely relevant topic, an appropriate format with informed participants.

The final world cafe model discussion on Day 1 was a bit redundant and disorganized. Having people in dress clothes climb onto a stage without stairs was not the best plan.

Rate the extent to which	Very High	High	Moderate	Low	Very Low	Mean
5. The knowledge that I gained will change how I do my work in relation to physician well-being.	67.69% 68.75% 0.00%	29.23% 28.13% 100.00%	1.54% 1.56% 0.00%	1.54% 1.56% 0.00%	0.00% 0.00% 0.00%	4.63 4.64 4.00
6. I intend to change how I do my work in relation to physician well-being in the next four months.	69.23% 70.31% 0.00%	26.15% 25.00% 100.00%	1.54% 1.56% 0.00%	3.08% 3.13% 0.00%	0.00% 0.00% 0.00%	4.62 4.63 4.00
7. The teaching methods were effective.	58.46% 59.38% 0.00%	32.31% 31.25% 100.00%	9.23% 9.38% 0.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	4.49 4.50 4.00
Please rate	Very High	High	Moderate	Low	Very Low	Mean
8. The quality of the speakers.	86.15% 85.94% 100.00%	12.31% 12.50% 0.00%	1.54% 1.56% 0.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	4.85 4.84 5.00
9. The quality of the course materials.	69.23% 70.31% 0.00%	24.62% 23.44% 100.00%	6.15% 6.25% 0.00%	0.00% 0.00% 0.00%	0.00% 0.00% 0.00%	4.63 4.64 4.00
10. What did you experience/learn during the symposium that will be useful to you immediately and that you can apply as soon as you return to work?	n/a Learned about depression/suicide					

The hope that now is the time everyone is willing to work together to do something.
 Attempting to screen and have an open eye for Burn Out
 Disseminate some of the work that has been done
 Focus on wellness in walking rounds discussions on CLER visits
 Data on physician wellness that needs distribution.
 Prevalence of the issue
 "Tony Suchman's suggestions on small, powerful changes in our behavior daily to promote wellbeing, professionalism in all our interactions
 importance of reaching out to other related groups to partner/colaborate on this issue, need for writing up my findings to share with others
 being part of a larger discussion on culture change"
 Better and more knowledgeable attention to well-being of peers/colleagues, as well as learners
 numerous resources that are available. The need to focus on early recognition of burnout in PGY 1 residents and also in faculty.
 Back ground on the extent of the issue
 I am starting to think about how we as a CLER team can increase the focus on wellbeing.
 Extent of the problem. People to talk with and to network with.
 Background info, stats
 Periodization
 Better appreciation of burnout issues. Will begin to implement well being program and institutional support structure. Getting a committee together already.
 Will pay more attention to risk factors for depression
 Potential options for intervention.
 I have made myself and my organization available as we develop resources for a possible toolkit or a model suicide prevention program.
 "Awareness of risks of burnout and depression
 Plan for action for field
 Some techniques that other centers have used to address issue"
 The need to continue the conversation of physician well-being and to assure that my peers around me are in a state of well-being.
 the detailed, statistical basis of understanding of risk for suicide, depression, burnout
 The risk factors and extent for burnout and depression and suicide
 the importance of the system's demands on resident well-being.
 parallel stresses in professions other than medicine
 New ideas for well being.
 Statistics to raise awareness
 Awareness of Physician Well being
 Bring awareness to the institution in a more robust fashion
 The awareness of how we change the emotional attitude and success of medical students and continuation into residency.
 Raise awareness about the topic in my department.
 Data on the extent of burnout, suicide and its relationship to learning and working environment was shared with our GMEC and physician wellness is now a standing agenda item at GMEC with a small taskforce to take ownership of the issue.
 take inventory of wellness activities at home institution.
 Increased knowledge about the incidence of burnout. Importance of team leaders and peer to peer interactions.
 Better understanding of wellness, burnout and depression and the scope of the problem
 The growing realization that ultimately the quality of the learning environment depends on the quality of the health care delivery system. In a true patient-centered health care system, the learning environment is destined to be outstanding. In a commercialize system, with an emphasis on seeing patients quickly rather than solving their problems, the learning environment, medical education, and resident well being will invariably suffer.
 Keys to wellness curricula in residency. the importance of mentorship and humanistic practice.

Significance of how rapidly after entering medical education measures of well-being deteriorate.
 Methods of promoting resiliency.
 I learned more about how burnout" may be the core issue to focus on with depression and suicide being more the "tip of the iceberg." Further, I realized we need to focus on our faculty more in the aide we have already begun to bring to residents. "
 More up to date burnout data. The association between burnout, depression and suicide. The role institutional culture plays. Overwhelming support of survey tools and having behavioral health in a role in GME.
 Stigma regarding mental health issues are a significant problem, even at the highest levels, and must be addressed to fully improve the resident experience.
 The parallels to what occurs for athletes and the ability to relate that information to our residents/program directors. Also, the initial data that Dr. Nasca presented about suicide rates being higher in faculty age ranges as opposed to that of most residents was particularly provocative and highlights an area we/I must address.
 "The extent of the problem: that it takes 3 medical school graduating classes just to replace the number of doctors who die by suicide each year. And the high rate of burnout, with all the quality implications of that.
 Also great to experience the rising engagement of all the stakeholders in the room."
 That ACGME values wellness is critically important and will be helpful to me in presenting these ideas at my institution
 The increased knowledge and understanding of the impact of physician well being on the medical community.
 It is important to establish methods to address self care, connectedness and the work environment in addressing physician well-being. We can develop these skills in our learners.
 Awareness of the problem, and data to share.
 put pen to paper on some of the wellness/resilience initiatives we are already working on
 I need to make sure to take time for myself and be aware of possible symptoms of burnout. These need to be acknowledged and addressed as possible burnout instead of being attributed to stress.
 I will share the data presented on burnout

11. What did you experience/learn during the symposium that will be useful to you in your role and that you can apply in the near future?

n/a
 Same
 Start social team based activities and educational sessions on Burn Out
 See 10
 CLER. Team is assessing this
 My role as a mentor
 Create awareness
 "need to write up my findings to share re: our wellness programming efforts
 reach out more to residents and fellows to get their input
 readdress administration's lack of support for free access to nearby gym for residents/fellows
 consider what I can do each day to help address work intensity pressures on residents
 "
 better-informed for CLER site visitor role; greater insight into what is needed to improve the clinical and learning environment
 the need for a preplanned response to any tragic occurrence;
 The exercise in declaring what I would do when I returned to my institution.
 The statistics re the problem, the analogy to athletes.
 How to approach leaders on campus.
 See item 13
 same as above
 Same. Above will take a while.
 We need to quickly establish a tool for screening and make sure that Mental Health Services are available

Passing on larger information to my large group.
 I experienced and learned that medical educators are diverse in their level of experience and knowledge related to mental health and suicide risk.
 Perspective of other organizations in and around GME on this issue
 Assure my own well-being.
 same as 10
 The need to refer physicians that may need help
 different viewpoints
 guidance for programs in stressing/ teaching wellness concepts
 The usefulness of the world cafe model.
 Simple Tactics that have worked at other institutions
 Mentoring program
 develop an ongoing culture that supports conversations about vulnerability fatigue stress and burnout in a space that feels open non judgmental and safe.
 "Trying to see that the hidden curriculum is brought under control.
 Make residents aware that seeking help is not a stigma
 Realizing that the state medical boards will need to alter their perspective on mental health and care."
 Attentive to any issues regarding well-being.
 Need to implement a culture change in the institution
 use of data and information to inform the development of an institutional wellness program with offshoots to program specific opportunities.
 Sources of physician stress.
 Appallingly high incidence makes me feel tremendous sense of urgency. Reconsideration of whether some underperformance and professionalism issues that come to my attention have an underlying element of depression/burnout, and methods to improve the attention those elements receive.
 As above
 Even greater recognition of the need to work for a more humane, patient-centered health care system.
 Wellness curriculum in our residency and how to apply to our institution and to residencies nationwide.
 Heightened awareness of risks for residents/fellows for burnout/depression/suicide. Methods of promoting resiliency.
 See above
 Same as above: surveys, toolkit material for curriculum, having a behavioral health individual in place for resident concerns.
 There are many efforts underway across the country to address resident/physician mental health. Very useful to hear how other programs address the needs and how they are funded.
 Same as the above. Immediately, I can connect this to resident leadership groups and program directors but the near future piece will be translating it to core faculty and the broader range of residents/fellows.
 same
 "Importance
 conceptual framework
 Data on burnout."
 The World Café learning method is especially helpful and could be used in a variety of settings.
 The elements of helping learners develop life-long skill in establishing and sustain well-being can be incorporated into activities already in place.
 Education tools
 larger discussions with trainees about the epidemiology of burnout/mental illness to begin culture change towards addressing the problem.
 The statistics and interventions that can be done NOW. I have already started planning a presentation in collaboration with our faculty psychologist.
 I will begin using the self-assessment instrument and will share it with my Program Directors and DIO

12. What did you experience/learn during the symposium that you think will be useful to you in your role but will take more time to understand and assimilate?

n/a

Culture change

Comprehensive program to evaluate and support residents with Mental Health challenges

Developing both immediate and long-term interventions to improve physician wellness

Creating methods for change

"how to bring about culture change, impact on leadership of hospital, address work intensity issue

how to reach residents/fellows/faculty with no signs of severe distress and suicide risk "

Same

To engage all faculty and preceptors in burnout prevention and well being as a corporate metric / goal

How the national picture is going to coalesce

Dr Schuman's work in relational communication

Making real changes.

See item 13

Same. Will work to proceed in my role with ACGME and other national venues.

How to develop larger overall system strategy

The focus/concern on the difference between burnout and depression was understandable, but concerning in that this could be a red herring that stalls the progress that we need to make as a field.

This is not an either/or issue.

What an effective approach for intervention will look like for an institution and for the profession

How this can be assimilated into my current work to help improve the well-being of physicians across the country.

The enormity of the problem of getting all of the C-suite dedicated to education

Changing culture across the house of medicine will need to start right away

need to review the research

effective teaching of wellness concepts

How best to implement these issues long term.

More long term solutions / cultural changes that need to be implemented

Well being program at my institution

How to make a case for the C suites and academic leadership to value this equal to or even more than the quantity of RVU's.

The talk of Dr. Suchman on culture and how to create change.

Change the culture in the working environment (Surgical operating room)

I need to understand the issues by a more focused review on the literature.

opportunities to take data and make them concrete programs.

Understand the high prevalence of physician distress.

Best methods of screening, appropriate amount of central vs programmatic intervention. How to best incorporate education on the topic.

Converting information into curriculum

How to change the health care delivery system for the better.

nothing.

Best ways to do ongoing monitoring of trainees for well-being and identifying those at higher risk.

We are still trying to sort out how to assess our current rates of burnout in our faculty and residents and then implement an intervention. This will take resources and support we simply do not have at this time.

There is a great need for research.

The transition from presenting information and holding discussion groups on the topic to the actual development of new programs and the enhancement of existing programs. Of course, this is where the rubber meets the road and is the real need.

...

I need to better understand how to promote physician well being.

It's important to get administrative support, and to hold the institutions to their part in addressing this problem.

Solutions/interventions

burnout prevention programs on both individual and program level

I am one of the chief residents of my residency program and I now understand that it is important to reach out to those who may appear to be struggling with burnout or depression instead of letting them suffer alone.

The importance of faculty burnout as a contributing factor to resident and fellow burnout

13. What were the major strengths of the symposium?

n/a

Collaborative environment

The speakers, the pre conference work

Bringing everybody together and share the common features

Quality of presentations

Data delivered, speakers, the potential for changing our approach to physician wellness nationally and locally

Variety of speakers and attendees

"format of excellent speakers, breaks into small groups to work on focused questions, mixing up the interactions/groups, offering range of perspectives and having variety of representatives there
best speakers: Tony Suchman, Brian Hainline, story of Dr. Feldman's life and death by his family, friends, and faculty member"

Broad representation among physician community

small size of participants; excellent speakers; well planned agenda

Interesting and engaged thought leaders

varied speakers. World cafe was particularly interesting.

The conference participants communicated a sense of urgency and insistence on the action oriented outcomes for this meeting.

Speakers

Clear presentations of current data, information about survey instruments, sense of being part of a positive movement

very compelling

Highlighted and raised awareness of this issue.

Group interactions

Attendees represented along with the general breadth of knowledge.

The combination of didactic and active process learning. Tim's wonderful style of leadership and stories from ancient texts. Tom's grounding framing of the issue as important and valid.

quality of speakers, novel topic

The participation of the major organizations in academic medicine.

Faculty / participants / planning

The panelists were experts

the enthusiasm and expertise of the participants

attendees were very engaged

The participants

Quality of the speakers

Diverse presenters and attendees

Open safe space to speak authentically

"The presence of all the stake holders of the House of Medicine realizing that a change is needed.

The strong points regarding the problem were articulated."

Everyone was able o contribute to the topic.

Discussing the topic and bringing stakeholders together. Listening to the diverse perspectives of the participants and speakers.

speakers, interaction with both colleagues and facilitators

Addressed a major problem.

Networking, quality of information and speakers

Speakers

Motivated, thoughtful, and open-minded participants; stimulating presentations and group discussions.
speakers were incredible. High power attendees.

High level of expertise of presenters. Time allowed for group and individual discussions.

Collaborative interaction between individuals from various backgrounds to come up with tangible way forward to address physician well-being.

Great collegiality, high level information and participation by MANY organizations in the House of Medicine.

"The attendees were an excellent cross-section of the stake holders who needed to be at the table for these discussions.

The ability to be flexible with the program schedule was a strength."

Breadth of attendees and speakers. Demonstration of commitment to the topic by senior ACGME leaders by their presence at the conference and Dr. Nasca's commitment to following this up again next year, so as not to lose momentum gained. Location and timing.

First that it took place; second the diversity, seniority and level of accomplishment of the people you attracted; third the spectrum of topics addressed by the speakers - enormously stimulating.

"Optimal size group

quality of speakers

group process of decision making"

The active involvement of the learners in the conference.

The major strengths were the diversity and expertise of the presenters and the participants, the organization for the format for the considerations and the focus on actions going forward.

Speaker quality

Highlight of very important topic that has impacted almost everyone in some way

diversity of faculty across the UME/GME continuum with diverse expertise and experience

The diverse group of attendees. The personal anecdotes from physicians who previously struggled with burnout or depression. The first 3 guest speakers (2 from Mayo and one from suicide prevention group).

Fast pace, broad representation of stakeholder groups

14. What were the major weaknesses of the Symposium?

n/a

Voice of the faculty, related to competing demands for time, increasing pressures for productivity and relation to wellness

None

Too many tables for day 2 (mild redundancy)

Lack of presentations from institutions who have dealt with a resident suicide to tell us what worked and what didn't work with regard to helping resident colleagues and what preventive measures they have implemented. There should also have been a speaker from the Air Force on their successful suicide recognition and prevention program

Immediate availability to the slides would have helped with enhancing memory.

Few HC professionals except MDs

"needed to have more time for experts to speak re: suicidology research/best interventions already established by Air Force, SAMSHA, Jed Foundation on campuses

no planned dinner activities--lost opportunity to network/connect "

"Inadequate representation of inter-professional healthcare community--nurses, pharmacists, and others.

Exemplars offered described fairly superficial changes (e.g., and with all due respect, refrigerator with food, sailing day, and access to psychologist), without enough examples of those who had made significant change in culture and teacher/learner relationships and interactions."

would be nice to have had the slides available at the time of the presentations.

Reporting out from the tables were lengthy and redundant

I would have liked to see sharing of a personal story or insight into a mid career physician's distressed with either a positive or negative outcome. Also prominent people need to come out of the closet about their own struggles and experiences with these issues.

None really.

Time pressure, lack of access to slides immediately

"
"

None. Only a weakness if something doesn't come from this.

Too many speakers; too many flowery" introductions - just get on with it!. "

Not applicable

None

Not as inclusive of all the medical community as it could have been.

Insufficient time to allow reflection

Mixing burnout and suicide over-simplified a complex relationship

Outcome not clearly defined. A report? action plan???

small table discussions were excessive

Too little time.

Repetition of discussion on the second day of conclusions that were reached in the small groups the first day

Not specific recs for burnout

"The presentation material and discussion questions needed to be available in real time. Hope we can receive them soon.

It would have been useful to have the leadership explicitly voice the next directions "

"There were no major weaknesses.

Will just be a process that will take time to generate change and there will be residents who will suffer before that happens.

More data is required to begin change."

As being the first of its kind I think it was very successful.

The cafe was effective until we tried to reach consensus on the question. The leaders in that session seem disorganized and unsure of the process.

starting with three lectures; perhaps have ice breaker and interaction between lectures - which were necessary but with jet lag challenging.

"Presented the negative views of being a physician (would have liked to hear more from physicians who have adjusted well and do not feel burnt out).

More specifics in terms of positive interventions (I just heard the issue is significant)."

could have used more time on nearly every topic.

Small group work could have been a bit better organized, but still very useful

Solution of the problems identified requires more time and discussion than the two days of the symposium.

I thought the small groups and reporting out was time-consuming and repetitive.

Not long enough.

There were no weaknesses.

Rather intense symposium packed with didactics and exercises. The first day of intense didactic presentations was almost too much.

None, we done on all levels.

Srijan Sen, MD did not present his research findings.

There were few core faculty present, even though the data shows they are heavily affected and are a major influence on our trainees.

Missed opportunity to learn more from all the diverse perspectives in the room. Moved to solutions too quickly (and thus too superficially) without learning more from each others different and unique perspectives. You made a great and successful effort to gather a diverse group, but I wish we had been able to explore that diversity in greater depth.

"Would be helpful to be more interactive earlier in symposium

Would have the cocktail hour after the first day instead of preceding the conference. I would have liked the opportunity to mingle more with participants. "

None

If it was possible, more time would have helped even further move the group along in identifying and planning to implement actions.

more trainees involvement

<p>The last session on day of during the World Cafe model. It was redundant. Dr. Baldwin's diagram was not helpful.</p> <p>Few solutions offered (understandably)</p>
<p>15. Was the symposium free of commercial bias?</p> <p> 100.00% 100.00% 100.00% - Yes</p> <p> 0.00% 0.00% 0.00% - No, please describe</p>
<p>No comments</p>
<p>16. Which ONE of the following best describes the impact of this activity on your performance</p> <p> 9.23% 7.81% 100.00% - This program will not change my behavior because my current practice/work life is consistent with best practice</p> <p> 0.00% 0.00% 0.00% - This activity will not change my behavior because I do not agree with the information presented</p> <p> 10.77% 10.94% 0.00% - I need more information before I can change my practice/work life behavior</p> <p> 80.00% 81.25% 0.00% - I will immediately implement the information into my practice/work life</p>
<p>17. Which of the following actions will you take as a result of participating in this symposium (please check all that apply)</p> <p> 90.77% 90.63% 100.00% - Discuss new information with colleagues at my home institution</p> <p> 78.46% 79.69% 0.00% - Pursue additional learning in physician well being</p> <p> 47.69% 46.88% 100.00% - Provide workshops on physician well-being at my home institution</p> <p> 67.69% 68.75% 0.00% - Participate in another educational activity on physician well-being</p> <p> 15.38% 14.06% 100.00% - Other</p> <p> 0.00% 0.00% 0.00% - None</p>
<p>18. What changes will you make in your daily practice/work life as a result of having attended this symposium?</p>
<p>n/a</p> <p>Include in mentoring</p> <p>Listen attentively for these issues.</p> <p>Increase attention to self care</p> <p>Start more awareness campaign among colleagues</p> <p>Awareness of both systems and individual issues in wellbeing</p> <p>As above</p> <p>Will work to enhance physician well being on both institutional and national level</p> <p>My personal wellness</p> <p>Create awareness</p> <p>See above</p> <p>"perhaps focus more on my own mindfulness</p> <p>be more thorough in risk assessment, safety planning with at risk residents, fellows</p> <p>consider ways to intervene more proactively with individuals we know are having a hard time at first (eg., IMGs)"</p> <p>See above.</p> <p>practice what I preach more: esp. weight management, activity and taking time to express gratitude.</p> <p>Seek to have my residents engage their patients more directly.</p> <p>Be more aware of the problem- both as a whole and in relation to individual trainees.</p> <p>"As above - will attempt to have input into CLER protocol 3 and new Pathways to include these areas.</p> <p>Lobby to rename and redefine the Duty Hours/Fatigue focus area in CLER to be Wellness - and not not limiting it to physicians in how we approach it. I will also suggest that CLER re recruit a psychiatrist or someone with appropriate background to help us with these efforts.</p> <p>"</p> <p>Not so much in my daily work</p> <p>List and prioritize potential interventions</p>

I will be even more aware of colleagues
 Will revamp my program's well being program
 More physician rounding on well being issues. Work to develop a support structure and education on issues.
 I will continue to work toward interventions
 I will pay more attention to well-being among my colleagues and myself
 Improved awareness overall and will look at integrating perspective into future physician planning
 Great reminder of the personal and professional responsibility we have to take care of ourselves and each other!
 transmit information to colleagues and residents; understand my own risks as well
 Improve self well-being and participate in improving the medical community's well-being.
 I am not in clinical practice. My executive/administrative work will change through increased awareness of the issues and desire to positively impact on them.
 Be more vigorous in advocating for the Hopkins" approach"
 "lectures with residents, pay more attendance to resident activities
 "
 Be aware of and be prepared to intervene for physicians who are at risk
 see above.
 incorporate concepts into fundamentals re what makes a good residency
 As above.
 pay more attention to others that may be exhibiting burnout symptoms
 Taking care of self
 "Have courage to speak about this issue personally and create invitational space on my team for others also
 "
 Will carry the message to the FSMB and look at what roll we need to play
 Take care of myself.
 Need to implement a culture change in the institution
 be more aware of signs/symptoms of burnout; encourage/require program directors to do screening at least semiannually with their semiannual evaluation sessions.
 None
 "More mindfulness. Practicing what I preach and trying to maintain some balance in my own life.
 Enhanced attention to the learning environment and more direct approaches to improving it."
 Incorporate into discussions
 Work harder to help mold a more humane learning environment, locally and nationally.
 resident well-being focus at our institution.
 Explore methods for better ongoing assessment of trainee well-being. Explore ways to implement resiliency-building measures.
 Our organization will emphasize this topic at our annual conference, through a webinar, and in a newsletter article during the next year. We will also look for other opportunities to raise awareness of this problem and to place resources in our members hands to enable them to recognize and effectively assists individuals who are suffering.
 I more attuned that ever to the issue of burnout, identification of depression and the need for strengthening further our current robust initiatives to address these issues at our institution.
 Redouble my efforts to bring wellness and resilience training to our trainees throughout the institution as well our faculty.
 I will do more outreach to the various programs at my medical center.
 Connect this information with my program directors and residents at my home institution. Continue to work with our Office of Health Promotion to assess our current programming and potential improvements. Consider working with the athletics department to invite Dr. Hainline here and do some joint programming between athletics and medicine that I think could be stimulating and helpful to both.
 Talk more about physician well-being and suicide to bring it to the attention of others. Engage them in mobilizing action.

"Focus on personal wellness
 Bring to my program"
 "institute discussions with residents
 survey of residents for wellness"
 I will be better able to assess physician well being at the institutions I visit.
 I will expand my surveillance of resident well-being, make more explicit the point of training to sustain the residents' ability to sustain their well-being and establish regular reminders of resources available.
 Improve dept awareness, and work on specialty in my role there nationally
 Enhance curriculum in programs
 daily acknowledgement of the issue
 Continued efforts to promote leadership attention to these issues.
 Joined a gym. Acknowledging signs of impending burnout and taking a sick day for mental health to refocus and recharge.
 heightened awareness of the issues of physician well being, promote further discussion among colleagues
 "
 Self-reflection and assessment on burnout symptoms in myself and our trainees"

19. Additional Comments/Suggestions for Future Efforts in this Area

n/a
 Provide solutions
 Look for exemplars of appropriate, more optimal culture for well-being or of those who have made measurable improvement in culture in their organization.
 creation of toolkit materials/screening assessments to offer to faculty and practicing physicians as well as residents and also for medical students.
 The aaACGME or consortium that addresses the future plans should engage someone with a preventive health and epidemiology approach to help with not just assessing the problem but developing interventions from a preventive health perspective, appropriate messaging and techniques that are well known to. These people but not to us in the GME arena. I have already interested someone with a broad background in this area when I told her about the conference - she would be very interesting in contributing/consulting: Dr. Barbara DeBuono - who has a broad background in epidemiology, population health, health education and marketing. She is a personal/professional friend I saw right after the conference and she was so enthusiastic when I told her about the issues.
 Again, I cannot overstate how impressed I was with the thoughtfulness and planning. I've been involved in other large strategies to improve behavior health and I'm excited about future potential to improve lives .
 Could consider a smaller working group to continue to vet ideas for steps forward. While I agree that this is a whole field owned issue, I wouldn't get bogged down if other orgs are not ready to act. The ACGME can have tremendous impact here.
 Continued collaboration across continuum
 encourage substantive followup by ACGME with other stakeholders
 More meetings!!
 Thank you for organizing this symposium, let's keep this momentum going please. When the ACGME invites us, we have the voice and courage to speak up and give voice to this important issue in a way that is heard. We want to change the culture!
 Need to get major stakeholder on board as well.
 Need followup regarding effective action plans to raise awareness and implement change to reduce burnout.
 keep up the good work.
 "Agree with the concept of meeting for a few years to keep the momentum going.

 CLER would be the best place for ACGME to address this topic. Also, ACGME is better positioned than programs or institutions to address the issues of stigma around licensure questions. (should be equivalently treated to other medical conditions)"
 ACGME should support research and expand resident survey

All responsible professional groups must band together to work for a more humane learning environment.

The investment ACGME made in covering the cost of attending the symposium was remarkable and most appreciated. Thanks for your leadership in identifying and addressing this important issue.

We will definitively need to continue to engage as a group to learn, encourage and support efforts to address this pandemic" of burnout and associated problems of depression and physician suicide. "

"Keep this conference going!!

Rapidly disseminate best practices and tools for programs.

I would hope a STANDARDIZED group of Surveys would be vetted and provided from the ACGME to programs across the country."

"1) Repeat symposium in a year

2) Sponsor/co-sponsor regional well-being symposia to broaden the reach

3) Develop a uniform affirmation or pact"" between the participating groups to publish a national statement on the importance of the issue of physician well-being""

Please keep this going, and build on this initial success. Learn from the small group experience to make it better.

"Help from ACGME on topics we discussed.

And provide these within next few months"

Continue the discussion.

It is very important to make this an ongoing effort and to track progress. It is also important to include faculty in the efforts, as a key part of the teacher-learner dyad. If they do not role model maintenance of well-being, it will be difficult (if not impossible) to attain our goal of teaching residents to sustain their well-being.

"

Please make this an annual event!"