Changing the Conversation From Burnout to Wellness: Physician Well-being in Residency Training Programs

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Abstract

Background The existing literature either does not address physician wellness or defines it as a lack of burnout. The goal of this article is to call attention to this important gap in the literature and provide ideas for how to fill it. We need a culture change, and we propose that this change begin within graduate medical education.

Methods We describe a case example of culture change and definitions of wellness at William Beaumont Hospitals, Troy Family Medicine Residency Program, a community-based, university-affiliated program in suburban Detroit, Michigan.

Results We developed a toolbox of practical steps to create a culture that emphasizes wellness. We present a general timeline illustrating necessary steps toward accomplishing a true cultural change.

Discussion The time has come for academic medicine to move beyond a simple discussion of physician burnout. To do this, we must first develop a shared definition of physician wellness followed by interventional strategies to bolster it. The benefits of cultural change include providing a more positive educational environment for residents and faculty, raising awareness of burnout and its symptoms, decreasing the stigma associated with admitting burnout symptoms, enabling the development of prevention strategies, and creating a more positive, strength-based approach to understanding the toll of physician-patient relationships on physicians.

Introduction

Physician burnout is well defined in the literature[1] as a state of emotional exhaustion, depersonalization, and decreased feelings of personal accomplishment. Transient burnout is probably inevitable over the course of a medical career, as evidenced by the extremely high prevalence data,[2] but what does it mean for a physician to be well? Is it fewer episodes of burnout? Is it shorter recovery time? Is it resilience? No clear answers currently exist in the literature.[2] In fact, physician wellness essentially remains undefined in the medical and academic medicine literature.[2] There have been published efforts to boost wellness through self-reflective practice[3]; workshops, lectures, and support groups[4]; and other multidimensional programs.[5] However, if we don't know what wellness is, then how do we know if the interventions work?

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DOI: 10.4300/JGME-D-09-00026.1

Many who have addressed physician wellness[2,6] imply, by default, that it is a lack of burnout, but this is as inadequate as defining health as a lack of disease. It is also inadequate to apply this generic definition of wellness to physicians because of the inherent conflict they experience in balancing their personal lives with being a physician. For example, the Accreditation Council for Graduate Medical Education (ACGME) mandates competency in professionalism, stating that residents must demonstrate a "responsiveness to patient needs that supersedes self-interest."[6] If being well means having a balance between work and personal life, physicians may not achieve this. The ACGME statement is powerful in that it requires physicians in training to learn self-sacrifice as part of professional identity. The acculturation of physicians to the idea that self-care is secondary is pervasive in academic medicine.[7–11] How can physicians achieve a relative level of wellness, and again, what does that mean?

What is clear is that the status quo of measuring burnout alone as an indicator of wellness must change if we are to move toward primary and secondary prevention efforts. We must move beyond the pathological focus upon physician burnout and begin a conversation about what makes a physician well. We need a culture change, and we propose that this change begin within graduate medical education. Residency is a formative time in physician development when schemata of patient relationships, work habits, and self-care are developed.[7,11]

This article describes a case example and "how to" guide for creating a culture of wellness. We present a general timeline illustrating necessary steps toward accomplishing a true cultural change. The goal is to provide a framework for those wishing to change the conversation from burnout to wellness. The benefits of cultural change include providing a more positive educational environment for residents and faculty, raising awareness of burnout and its symptoms, decreasing the stigma associated with admitting burnout symptoms, enabling the development of prevention strategies, and creating a more positive, strength-based approach to understanding the toll of physician-patient relationships on physicians.

Methods

The Beginning of Change

William Beaumont Hospitals (WBH), Troy Family Medicine Residency Program is a community-based, university-affiliated program that was established in 1979 in suburban Detroit. Currently, the program educates 22 residents and employs 8 physician faculty, 2 health psychology faculty, an administrative faculty member, and a nursing faculty member. Our hospital culture supports a healthy workplace. The program's mission statement is "to provide outstanding education and quality patient care in a supportive academic environment."[12] Historically, the approach to physician wellness was to communicate human compassion, care, and concern without much of a structured strategy. However, our program took a more-structured and proactive approach to wellness when behavioral issues arose for individual residents. A program-sponsored annual weekend retreat in late January for residents, faculty, and their families is an existing preventive element. The purpose is for team building and providing renewal during the dark winter months in Michigan. We choose from 1 of 3 rotating cities in Michigan that offer a full-service hotel and family-oriented activities. All residents and faculty attend, and families are invited. Outside call coverage is arranged for the entire weekend, and the entire retreat is funded by resident-generated income from school physicals. Friday evening involves a "gathering in" with food, a game, and socialization. Saturday morning involves breakfast and a team-building or wellness-oriented experience (eg, Myers-Briggs Type Inventory workshop or meditation and yoga) for residents and faculty. Lunch is provided for everyone, and the third-year residents provide some comic relief for the group. After lunch, residents and faculty are free to spend the remainder of the time as they like.

The beginning of our program's cultural change occurred in 2003, when we hired a new faculty member with an established interest in physician well-being. She was empowered by the program leadership with the time and purpose to collaboratively develop a wellness-specific curriculum. This curriculum has evolved over 6 years, during which time this faculty member acted as a "wellness champion." Though the responsibility of wellness must be shared within a program, the point of having at least one faculty member who monitors and champions wellness cannot be underscored enough. This enables physician wellness to be a part of the daily fabric of residency education. This person ensures that wellness is not forgotten among the many competing priorities in academic medicine. A faculty advocate may send out articles, place wellness on resident and faculty meeting agendas, remind residents and faculty about wellness meetings, and ensure that wellness is incorporated into the daily operations of the residency program.

Wellness Toolbox

We provide a Wellness Toolbox in BOX 1 that illustrates the various "tools" implemented at WBH since 2003. We provide this as an example of our journey to understand, define, and promote wellness within residency training. These wellness tools are relatively inexpensive and

BOX 1 **Wellness Toolbox**

1. Designate a faculty who owns wellness and has time to champion it, and then enlist the help of the chief resident(s). These individuals can develop a plan, based on the program's needs or needs assessment, for the next steps.
2. Define wellness.
3. Administer a burnout tool (eg, Maslach Burnout Inventory) twice a year to faculty and residents. Provide individual and group feedback.
4. Provide lectures on wellness, burnout, writing a mission statement, positive psychology, and cognitive-behavioral counseling techniques.
5. Schedule "difficult patient" panels twice a year to discuss, as a group, how to manage difficult situations and interactions.
6. Schedule class meetings every other month with faculty mentors who model the human side of medicine.
7. Develop a list of psychological and primary care providers tailored for residents. Put it on a shared server.
8. Schedule 1-day faculty retreats for renewal.
9. Assign "wellness partners" for faculty and residents with emotional, physical, spiritual, and social goals. Send quarterly reminders.
10. Develop a professionalism contract for faculty and residents with annual review.
11. Make wellness an agenda item on monthly faculty and resident meetings.
12. Develop a physician support group (see the work of Rachel Naomi Remen, MD[13]).
13. Ask residents to set quarterly wellness goals during advisor meetings.
14. Assign gregarious office staff to schedule "fun" social events for the entire office (eg, sporting events).
15. Involve residents in faculty meetings, committees, etc, to increase sense of control.
16. Schedule a yearly retreat with team-building and self-awareness exercises.
17. Empower faculty and residents to confront concerns as they see them, both in residents and faculty.
18. Encourage faculty to provide positive feedback.
19. Take time to publicly celebrate accomplishments, even transitions from postgraduate year 1 to 2 to 3. Hand out appreciation lists.
20. Change the culture over time. Create an environment that does not focus on pathology.

BOX 2 **Definition of Wellness**

"The William Beaumont Family Medicine Residency Program" values a holistic philosophy of care for self and patients. Central to this care is a focus on the development and maintenance of a wellness orientation.
Wellness is defined as a dynamic and ongoing process involving self-awareness and healthy choices resulting in a successful, balanced lifestyle.
Wellness:
Incorporates balance between the physical, emotional, intellectual, social, and spiritual realms;
Results in a sense of accomplishment, satisfaction, and belonging;
Provides protection from the unique demands of medical training and beyond.
Key components to developing and maintaining wellness:
Feeling engaged and empowered with good boundaries;
Maintaining physical health with adequate rest, healthy diet, and regular exercise whenever possible;
Having confidence in self, the faculty, and the program;
Communicating effectively within and outside of the residency program;
Taking time away from work and leaving work behind (eg, evenings, weekends, vacations);
Being present in the moment;
Being able to recognize signs of burnout or the need to renew before burnout occurs;
Compassionately recognizing and accepting humanity in oneself and in others.

achievable. The first two items in the toolbox are strongly recommended at the start. The next steps should be based on the recommendations of the faculty advocate and chief resident.

An important first step in changing the focus from burnout to wellness and health promotion in academic medicine is to define physician wellness as something more than lack of impairment. This was not our program's first step, but in retrospect, it probably should have been. In 2009, faculty and residents were asked to contribute suggestions to create a shared definition of wellness (BOX 2). As can be seen, our definition of wellness is broad. Because it was difficult to develop a brief definition that encompassed all of the elements that people valued, we added a "key components" addendum. This more explicitly highlights the values specific to our residency program.

Measuring Burnout

Another element in our wellness program is the use of the Maslach Burnout Inventory (MBI).[1] The MBI is considered the gold standard in measuring physician burnout. It consists of 3 scales (Emotional Exhaustion, Depersonalization, and Personal Accomplishment) with separate cutoff scores that, when taken together, represent measured burnout. We have anonymously administered the MBI to residents at least twice a year since 2005. We provide individual results along with an explanation of these results to each resident. The combined results are then discussed at a confidential resident-only meeting led by the chief resident, who focuses on preventive measures. Use of the MBI has been instrumental in allowing residents to quantify their own level of burnout, raise self-awareness, and become more proactive in maintaining their own wellness. Our program faculty also discuss these anonymous results at faculty meetings in an attempt to determine their significance and their possible root causes. We particularly focus on low scores in the Personal Accomplishment scale and how we might bolster that score as a potential protective measure. We are actively seeking to find or develop an instrument to measure wellness.

Residents' reactions to taking the MBI have evolved with time. There was some initial concern about the anonymity of the survey, resulting in inconsistent completion. The faculty secretaries now indicate that the surveys are promptly returned without negative comment. Residents appreciate that the faculty go to these lengths to make their well-being a priority. Some residents think that the MBI results restate the obvious, that is, resident training and burnout go hand in hand. Others believe that feelings of burnout will vary depending on the rotation experience.

Other Interventions

The daily lecture series often includes wellness-centered topics in a variety of formats. We organize panel discussions in which program faculty and outside attending physicians discuss and answer questions on topics such as work-life balance, career options and advancement, and the management of difficult patients. We also provide lectures on wellness, particularly during postgraduate year 1 orientation, that include how to write a mission statement for residency education. Other lectures on wellness have included positive psychology (eg, excerpts from *Authentic Happiness*[14]) and how to change negative thinking with cognitive-behavioral therapy (eg, excerpts from *The Feeling Good Handbook*[15]).

The concept of class meetings, where 2 or 3 faculty members are assigned as mentors to each class of residents, was previously established in our program. The class meetings were held semiregularly, although scheduling factors at times interfered with this goal. To increase consistency, we set aside one noon conference time every other month for classes to meet on- or off-site. Faculty mentors discuss wellness topics with residents, such as feelings of insecurity, celebrating accomplishments, handling errors, and burnout scores. Faculty also model the human side of medicine. At the end of each academic year, advisors plan some celebration to mark accomplishments, often providing each resident with an accumulated list of positive remarks about that person obtained from peers, faculty, and clinical and nonclinical staff.

In 2008, we developed a resident physician support group, facilitated by key faculty members and loosely based on the work of Rachel Naomi Remen, MD,[16] and Rabow and McPhee.[17] This group meets once a month over the noon hour. (Residents requested no after hours meetings, as these take away from family time.) The agenda often includes discussing current events, mentoring, reading and discussing literary works, reflective writing, and sharing

meaningful experiences. Emphasis is on celebrating the joys of medicine and maintaining passion for the privilege of service.

Realizing that residents may need additional confidential resources and treatment, we developed a list of local psychologists, psychiatrists, and social workers who accept our employee insurance plan and are well-suited for working with physicians. This list of resources is housed on our shared computer server so that it can be accessed by anyone anonymously. We also developed a list of recommended primary care physicians who do not teach for the program. This list was also placed on the shared server to encourage preventive medical care. During orientation and at times when burnout is measured, residents are reminded of these two resources.

Results

Culture Shifts

In 2007, we began to notice some cultural shifts. Faculty began talking more spontaneously among themselves about their own wellness, demonstrating increased comfort with the topic. The ''wellness champion'' was not the only individual to bring up the issue. At a faculty retreat in 2007, faculty chose wellness partners and set wellness goals in multiple domains. An example set of goals might include (1) emotional—talking to a wellness partner about feelings of being overwhelmed or awed, (2) physical—improving nutrition and increasing exercise, (3) social—doing something fun once a week, and (4) spiritual—experimenting with meditation or yoga. The goals are updated as needed or annually. The wellness partners agreed to meet with each other at least quarterly to ''check in,'' but this occurs more often. Some have breakfast or lunch dates, while others regularly get in touch ''on the fly.'' The program secretary also sends monthly reminders to faculty to schedule meetings for accountability and support. Time has even been carved out during a faculty meeting to check in with our wellness partners. The goal is for everyone to have a ''go to'' person who understands the stressors of academic medicine and supports growth and wellness.

Also in 2007, the faculty designed a professionalism contract for themselves and residents, which is reviewed and signed annually (BOX 3). This contract provides an extensive list of professional behaviors under the headings Service, Ownership, Attitude, and Respect, as well as consequences of nonadherence to the contract. This contract serves not only as a reminder of behaviors that professionals should exhibit but allows each of them to hold one other accountable to these standards.

Currently, more faculty and residents comfortably and openly discuss their own feelings of burnout and signs of burnout that they see in others. The years 2008 and 2009 brought monumental change to the program. This included construction of a new family medicine center, implementation of a new electronic medical record, ACGME Residency Review Committee and American Osteopathic Association site visits, and the challenging economic circumstances in Michigan. The ability to recognize and discuss burnout with others has been acknowledged by both faculty and residents as a major source of support in these challenging times.

Ongoing Efforts

We continue to make changes and additions to the program to promote wellness for both faculty and residents. The faculty recently agreed to anonymously complete the MBI twice a year. We provide individual results to each faculty, and a group summary is discussed at a faculty meeting. Faculty voluntarily disclose burnout levels, stressors, interventions, and prevention strategies during group discussions. Every month a different faculty member is responsible for leading a discussion or exercise on a selected wellness topic during one of our faculty meetings. Beginning in the 2009 academic year, the residents were also randomly assigned a wellness partner. The chief resident reviews the goals of the wellness partners and reminds residents quarterly to connect with each other. The faculty added ''wellness goals'' to the academic advisor meeting format in order to encourage residents to set quarterly goals and to monitor self-reported progress. In addition, a monthly notice is sent to faculty reminding them to recognize and praise residents' good performance if they have not done so recently. Office staff are also empowered to schedule fun social events (eg, attending baseball games) for staff, faculty, and residents.

Our efforts at creating a culture of wellness have been based on the limited literature base, accumulated experience and intuition, and the comments of residents and faculty. There is no prescribed method of implementing a wellness program in residency training. We started by measuring burnout among residents because that was included in the bulk of the published literature. When we discovered that the burnout measurements didn't tell us what to do next, we started thinking about ways to bolster wellness. It was not until much later that we considered an association between faculty wellness and resident wellness. At that point, we began talking about faculty wellness. Ideally, wellness programs should include the needs of residents and faculty. That being said, residents and faculty have different developmental needs, and separate interventions are recommended for both groups and for the program as a whole.

Resistance

It is important to keep in mind that attempts to change a culture will meet with some level of resistance. In our case, resistance was less of an issue because of strong leadership support, a cohesive faculty, and the history of integration of behavioral medicine into family medicine education. In other programs, talk about self-care may be met with resistance

BOX 3 **Example Professionalism Contract**

RESIDENT PROFESSIONAL RESPONSIBILITIES CONTRACT

The Beaumont Standards will be known, owned, and energized by all who wear the Beaumont badge.

Service

- I will provide quality health care and improve access to that care.
- I will demonstrate a commitment to patients and the medical profession that, at times, may go beyond my own self-interest.
- I will do good deeds without the expectation of payment.
- I will be the first to offer assistance when assistance is needed.
- I will do more than just my job.
- I will be available for patients, colleagues, and staff.
- I will make scholarly contributions to family medicine.

Ownership

- I will hold myself accountable to patients, colleagues, and staff of the program.
- I will hold others accountable to the Beaumont Standards of service, ownership, attitude, and respect.
- I will commit to my own professional and personal growth.
- I will commit to a just distribution of limited health care resources.
- I will communicate information in a clear, timely manner.
- I will collaborate with the health care team.
- I will avoid conflicts of interest.

Attitude

- I will adhere to the highest levels of ethical and professional conduct.
- I will be compassionate in my work with patients and colleagues.
- I will show appreciation of others' talents and skills.
- I will know that I am not perfect, but I will reflect on how I can improve.
- I will lead by demonstrating a positive example for others in my attitude and demeanor.
- I will exercise good judgment in ambiguous circumstances.
- I will closely guard why I chose family medicine.
- I will closely guard my dreams.

Respect

- I will empower patients to make informed, autonomous decisions.
- I will be sensitive to differences in age, gender, culture, religion, ethnicity, sexual preference, socioeconomic status, beliefs, behaviors, and disabilities.
- I will listen with an open mind to what others have to say.
- I will first directly approach the person with whom I have concerns.
- I will respect my own limitations of competence, time, and energy.
- I will conduct myself with integrity and dignity.
- I will pay attention to my own wellness needs and to those around me.
- I will not waste the time, energy, and resources of others by making excuses or because of poor planning.
- I will complete my assigned duties and responsibilities in a timely manner, such as attending morning report, lectures, workshops, and mandatory meetings; and completing documentation, patient care, call, home study, coursework, and rotational requirements.
- I will respect difficult patients by not having public discussions about my concerns.
- I will create ethical and appropriate boundaries between myself, patients, staff, and colleagues.
- I will be honest with myself and others and trust that this will be reciprocated.
- I will avoid impairment (eg, substance abuse) and seek help if I become impaired.
- I will take care of my physical, emotional, and spiritual needs.
- I will be alert for signs of burnout, including irritability, sadness, exhaustion, carelessness, negativity, and lack of empathy.

In return, the faculty will adhere to the above standards and:

- Provide positive role models.
- Provide the tools necessary to be a competent Family Physician.
- Answer questions in a timely manner.
- Help to the best of their ability.
- Demonstrate respect and compassion.
- Hold you to high standards and accountability when you are not meeting your responsibilities and promises.
- Approach you when we are concerned about your well-being and/or academic progress.
- Provide resources for assistance when you are struggling.
- Challenge you.

I understand that by signing this contract, I am entering into a formal contract of professional behavior with the William Beaumont Family Medicine Residency Program. If I do not abide by the terms of this contract, I am subject to consequences to be determined by the program director. I also understand that I have the right to hold faculty and colleagues accountable to the program director for the terms of this contract.

because it may be perceived as suggesting weakness. We recommend performing a program-specific needs assessment, introducing change slowly, and involving residency leadership at every level. For those who believe self-care is an unnecessary part of residency education, provide evidence that physician burnout is related to medical errors.[18–20] A wellness program may also enhance recruiting by acknowledging the needs of a new generation of medical students.[21] Larger programs may face additional hurdles related to communication and cohesion, and in these programs a wellness committee or task force may be a viable option. Informed persistence may be the best remedy for resistance.

Conclusion

It is possible to change the conversation from burnout to wellness, and the time for that change is now. Leadership support, a designated advocate, creative collaboration,

patience, and persistence are essential elements in changing to a wellness culture in medical education. Enlisting the support of the chief resident is well advised. Most important is to recognize that physician wellness is more than simply the absence of burnout, although attending to burnout is a great first step. More is needed than this, however. We need to begin talking about what wellness for physicians actually is rather than what it is not. A culture shift toward focusing on physician wellness is essential to primary and secondary prevention efforts, and it will create an environment that builds upon strengths rather than searching for weakness.

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