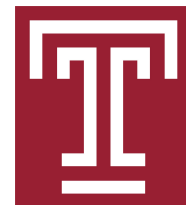


Optimizing Practitioner Wellbeing: Opportunities and Challenges in Modern Medicine



Ryan Serdenes DO

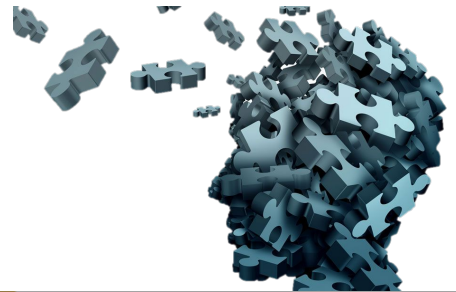
*Chair of the Medical Staff Wellness Committee
Psychiatry Residency Associate Program Director
Chief of Inpatient CL Psychiatry
Temple University Hospital*



I have no financial or non-financial disclosures at this time

OBJECTIVES

- ❑ Review the literature of clinician wellbeing and outline current national trends
- ❑ Identify practical pearls regarding improving individual and institutional wellbeing
- ❑ Highlight wellness resources within my institution and outline efforts of the practitioner wellness committee



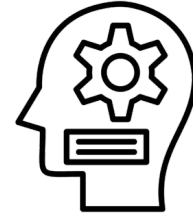
What is “Wellbeing” and “Burnout”?





Wellbeing is a state in which an individual is able to experience the following:

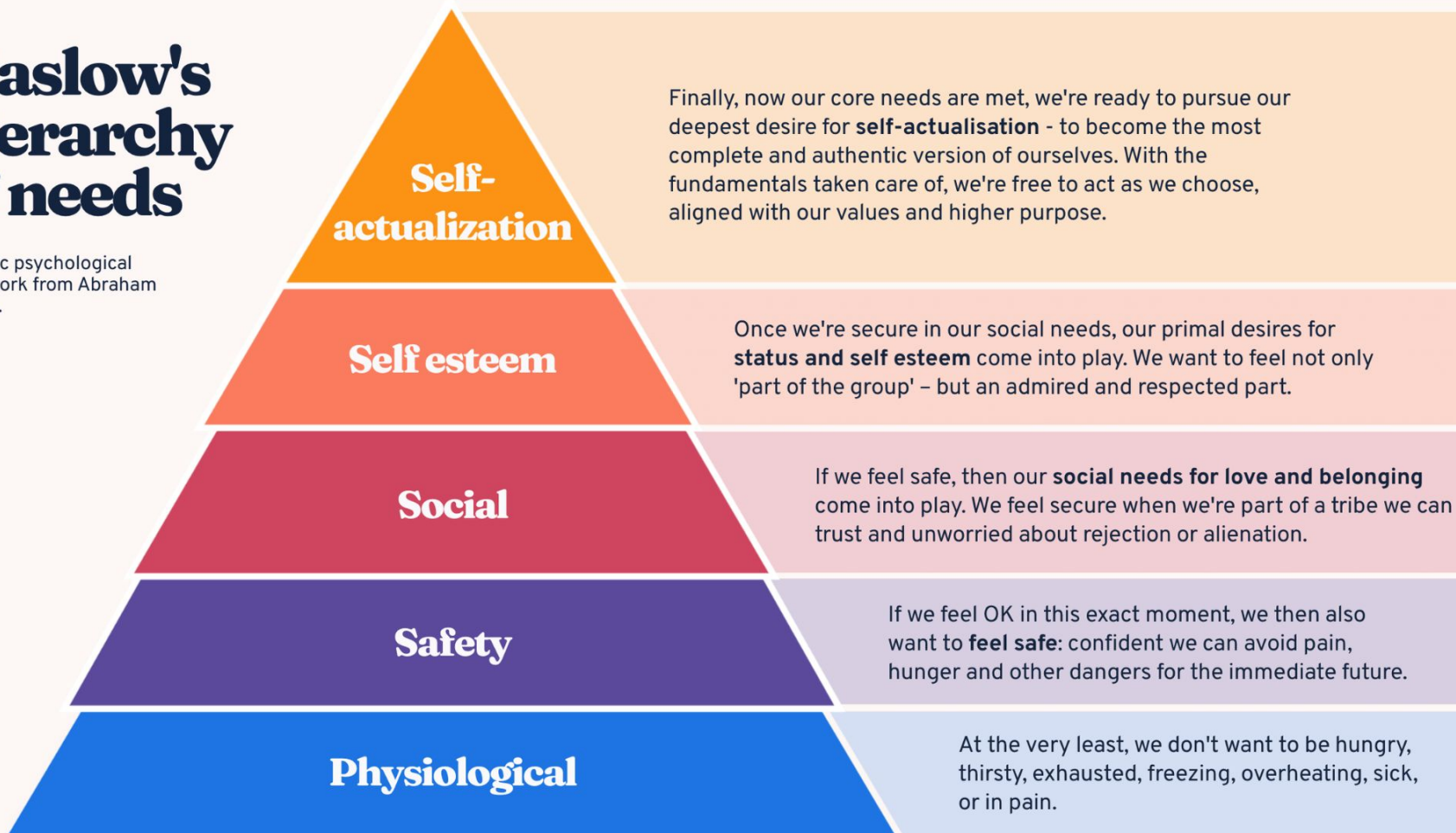
1. Ability to realize the potential of their own abilities
2. Can cope with the normal stresses of life
3. Work productively and is able to make a contribution to their community
4. State of complete physical, mental and social well-being and not merely the absence of disease



World Health Organization, 2019

Maslow's hierarchy of needs

A classic psychological framework from Abraham Maslow.



Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by **three dimensions**:

1. Feelings of energy depletion or exhaustion



2. Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job



3. Reduced professional efficacy

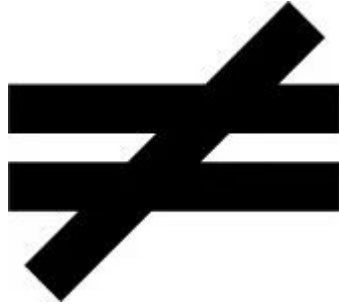


Note: Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life.

World Health Organization, 2019



Wellbeing

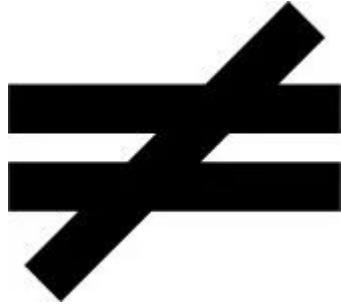


Burnout

Wellbeing is NOT just the absence of burn-out



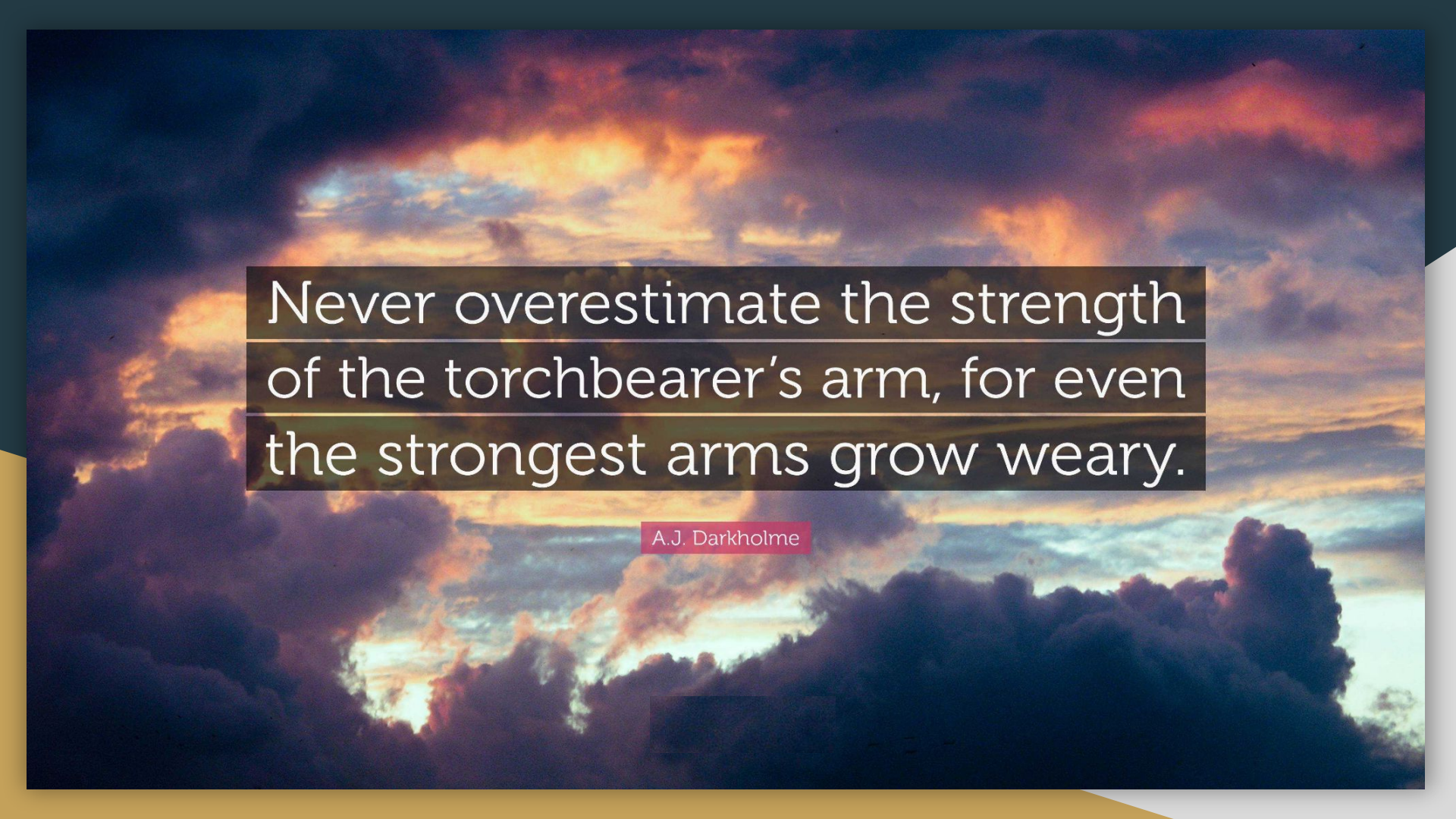
Wellbeing



Clinician Wellness



Overview of Literature & National Trends



Never overestimate the strength
of the torchbearer's arm, for even
the strongest arms grow weary.

A.J. Darkholme

Patterns in Physician Burnout in a Stable-Linked Cohort

Marcus V. Ortega, MD^{1,2}; Michael K. Hidrue, PhD²; Sara R. Lehrhoff, MA²; et al

Results A total of 1373 physicians (72.9% of the original 2017 cohort) participated in all 3 surveys. The cohort included 690 (50.3%) male, 921 (67.1%) White, and 1189 (86.6%) non-Hispanic individuals. The response rates were 93.0% in 2017, 93.0% in 2019, and 92.0% in 2021. Concerning years of experience, the cohort was relatively well distributed, with the highest number and proportion of physicians (478 [34.8%]) reporting between 11 and 20 years of experience. Within this group, burnout declined from 44.4% (610 physicians) in 2017 to 41.9% (575) in 2019 ($P=.18$) before increasing to 50.4% (692) in 2021 ($P<.001$).

Burnout is increasing overtime!

Advanced nurse practitioner well-being: A 4-year cohort mixed methods study

NursingOpen
WILEY

Emily Wood¹ | Rachel King² | Steve Robertson^{2,3,4} | Angela Tod² |
Michaela Senek¹ | Beth Taylor² | Tony Ryan²

TABLE 3 Annual responses to individual survey questions about motivation and satisfaction.

Question	Calculation of results reported	2019	2020	2021	2022
I look forward to going to work	% of staff selecting 'Often' / 'Always'	77.9	73.0	77.0	61.1 ^{a,b}
I am enthusiastic about my job	% of staff selecting 'Often' / 'Always'	91.9	82.9	81.4	81.1 ^b
I am able to do my job to a standard I am personally pleased with	% of staff selecting 'Agree' / 'Strongly Agree'	84.9	81.8	73.2	72.2 ^b
I am satisfied with the quality of care I give to patients / service users	% of staff selecting 'Agree' / 'Strongly Agree'	91.9	92.0	92.8	88.0
I am able to deliver the care I aspire to	% of staff selecting 'Agree' / 'Strongly Agree'	72.1	80.7	80.4	67.6 ^a

Similar Wellbeing Trend in APP Groups

Advanced Practice Providers' Wellness Essential for Health Care Organizations

Ashley Choudoir, MSN, APNP, NP-C; Fahad Aziz, MD

Figure 1. Stressors Leading to Advance Practice Provider Burnout

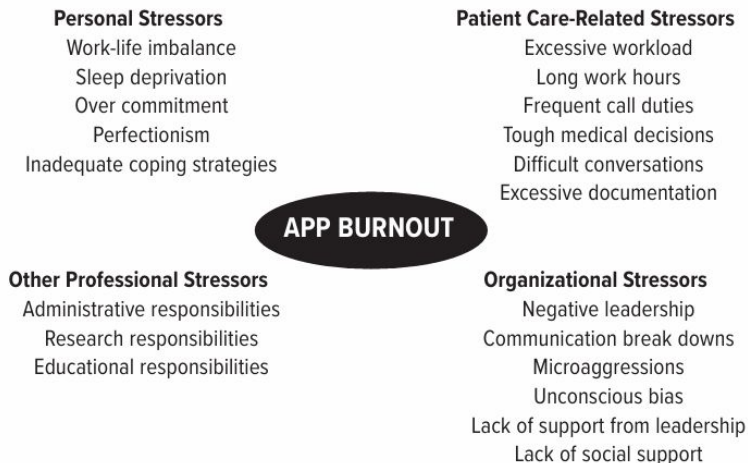
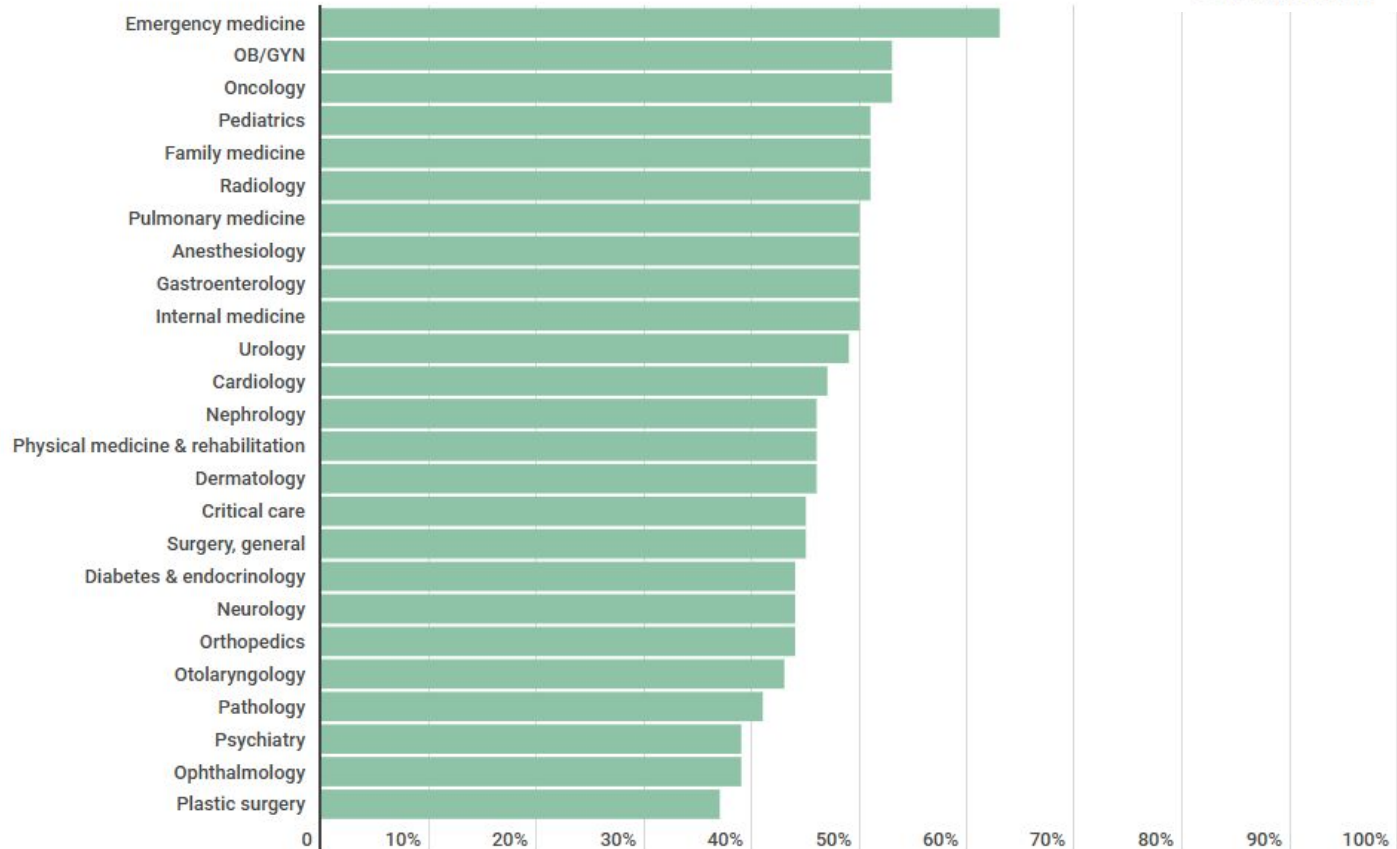


Figure 2. Advance Practice Provider (APP) Wellness Model



Burnout By Specialty

Source: Medscape



Prevalence and correlates of depression, anxiety, and burnout among physicians and postgraduate medical trainees: a scoping review of recent literature

[Samuel Obeng Nkrumah](#)^{1,*}, [Medard Kofi Adu](#)¹, [Belinda Agyapong](#)², [Raquel da Luz Dias](#)¹, [Vincent Israel Opoku Agyapong](#)^{1,2}

Following titles and abstracts screening, 196 publications were selected for full-text review, with 92 articles ultimately included in the analysis. The results revealed significant variability in the prevalence of burnout, depression, and anxiety. Burnout rates among physicians ranged from 4.7 to 90.1% and from 18.3 to 94% among residents. Depression prevalence ranged from 4.8 to 66.5% in physicians and from 7.7 to 93% in residents. Anxiety rates were between 8 and 78.9% in physicians and 10 to 63.9% in residents. Notably, women reported higher rates of all three conditions compared to men. Key factors influencing these mental health conditions included demographics (age, gender, education, financial status, family situation, occupation), psychological conditions, social factors (stigma, family life), work organization (workload, work conditions), and COVID-19-related issues (caring for COVID-19 patients, fear of infection, working in high-risk areas, concerns about personal protective equipment (PPE), and testing positive).



**Similar prevalence of burnout
between residents and attendings**

Predictors of Well-Being in Resident Physicians: A Descriptive and Psychometric Study

ALIYA KASSAM, PHD
JOAN HORTON, MD
ILYA SHOIMER, MD
SCOTT PATTEN, MD, PHD

Abstract

Background It is important to describe the characteristics of well-being in resident physicians to develop resident wellness initiatives in postgraduate medical education.

Objective To characterize the predictors of well-being in resident physicians by assessing personal and work-related burnout, work dissatisfaction, nutritional needs while on call, and sleep needs while on call.

Methods We set up an online survey in 2012 to collect data from current residents at the University of Calgary in Canada. The WHO-Five Well-Being Index, personal and work-related subscales of the Copenhagen Burnout Inventory, questions on work dissatisfaction, as well as sleep and nutrition management needs while on call, were used in the survey. Descriptive statistics, univariate analysis, and linear regression were applied to the data.

Results The survey response rate was 45% (317 of 706) of eligible residents, with a mean age of 30.9 years ($SD = 4.3$). Fifty-three percent (168 of 317) of residents had a well-being score of 13 or less, indicating poor mental well-being. There were significant differences between men and women with respect to personal burnout (47.9 versus 54.2, $P = .002$) and work-related burnout (46.4 versus 50.4, $P = .008$). The only significant predictors of well-being overall were personal burnout and work dissatisfaction.

Conclusions Survey results suggest that a high proportion of residents at this institution have low well-being. This study did not find work-related burnout to be a significant predictor of well-being, after adjustment for other variables.

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Personal burnout and work dissatisfaction were the only significant predictors of well-being after adjusting for sex, age, PGY, work-related burnout, nutrition, and sleep needs as well as interaction variables. The personal burnout ($b = -0.14$, $P < .001$) and work dissatisfaction ($b = -0.06$, $P < .001$) subscales were significantly negatively correlated with well-being.

Work Dissatisfaction is negatively correlated with wellbeing

TABLE 1 WORK DISSATISFACTION SCALE^a

- | |
|--|
| 1. Do you find that you are prone to negative thinking about your work? |
| 2. Do you find yourself getting easily irritated by small problems at work? |
| 3. Do you feel misunderstood by your coworkers? |
| 4. Do you feel that you have no one to talk to? |
| 5. Do you feel like you are achieving less than you should at work? |
| 6. Do you feel like you are not getting what you want out of your work? |
| 7. Do you feel that organizational politics or bureaucracy inhibits your ability to do a good job at work? |

^a Response options: 0, always; 1, often; 2, sometimes; 3, seldom; 4, never/almost never.

Original Investigation | Health Policy

Trends and Factors Associated With Physician Burnout at a Multispecialty Academic Faculty Practice Organization

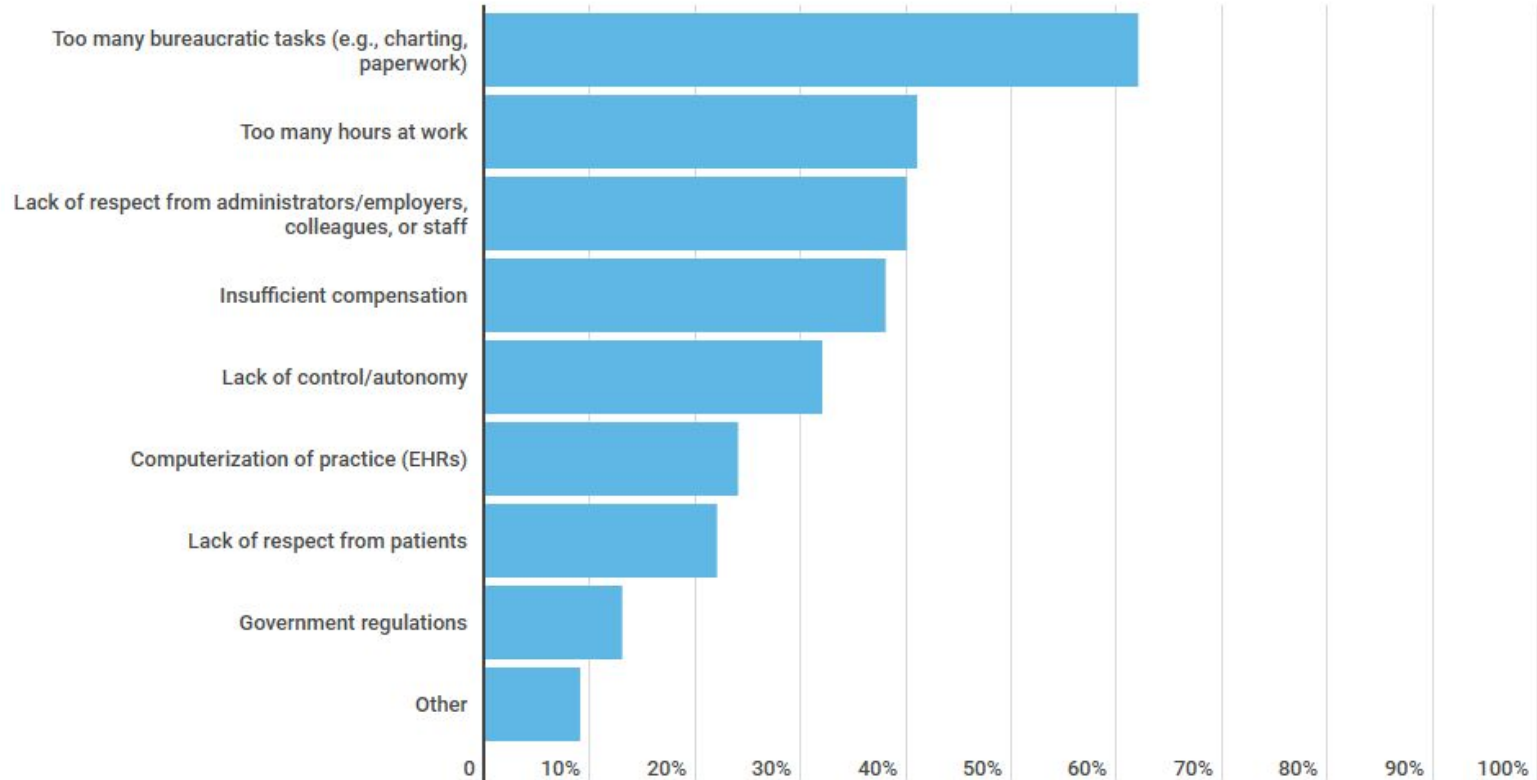
Marcela G. del Carmen, MD, MPH^{1,2}; John Herman, MD³; Sandhya Rao, MD^{4,5}; *et al*

Results Respondents included 1027 men (57.9%) and 747 women (42.1%) in 2014 and 962 men (51.1%) and 759 women (40.3%) in 2017. The mean (SD) number of years since training completion was 15.3 (11.3) in the 2014 survey data and 15.1 (11.3) in the 2017 data. Burnout increased from 40.6% to 45.6% between the 2 points. The increased rate was associated with an increase in exhaustion (from 52.9% in 2014 to 57.7% in 2017; difference, 4.8%; 95% CI, 1.6%-8.0%; $P = .004$) and cynicism (from 44.8% in 2014 to 51.1% in 2017; difference, 6.3%; 95% CI, 3.1%-9.6%; $P < .001$). Compared with midcareer physicians (11-20 years since training), early-career physicians (≤ 10 years since training) were more susceptible to burnout (odds ratio, 1.36; 95% CI, 1.05-1.77), while physicians in their late career (> 30 years since training) were less vulnerable (odds ratio, 0.59; 95% CI, 0.40-0.88).

Early career physicians are more susceptible to burnout

Contributors to Clinician Burnout

Source: Medscape



Predictors of Burnout Among Physicians: Evidence From a National Study in Portugal

Alexandra Marques-Pinto^{1*}, Sérgio Moreira¹, Rui Costa-Lopes², Nídia Zózimo³ and Jorge Vala²

¹ Centro de Investigação em Ciência Psicológica (CICPSI), Faculdade de Psicologia, Universidade de Lisboa, Lisbon, Portugal, ² Instituto de Ciências Sociais, Universidade de Lisboa, Lisbon, Portugal, ³ Centro Hospitalar Lisboa Norte, Lisbon, Portugal

The aims of this research on burnout among physicians were threefold, (1) to characterize the burnout symptoms' prevalence among Portuguese physicians, (2) to test the hypothesis that organizational demands and resources add, on top of other factors, to the explanatory level of burnout; and (3) to explore the predictors of organizational demands and resources. Data collection was conducted online at the national level in Portugal, with 9,176 complete replies and a response rate of 21%. Predictors stemming from theoretical models of an intra-individual, occupational, organizational, and socio-psychological nature were measured using an online/paper survey. Results were analyzed through a significantly modified version of the Maslach Burnout Inventory (MBI) after transformations to address the fit of this measure in this sample. Results show that 66% of physicians have high levels of emotional exhaustion, 33% high levels of depersonalization, and 39% high levels of decrease of personal accomplishment. Moreover, a first set of hierarchical multiple regression models with burnout symptoms reveals that **organizational resources, demands of the relationship with the patients and of work schedule are consistently important predictors of emotional exhaustion** and depersonalization on top of other theoretically relevant predictors. A second set of regression models with the organizational-level variables shows that, aside from organizational variables, other context variables, like procedural justice and teamwork, have the most substantial predictive value. These results highlight the importance of recognizing physicians' burnout as a phenomenon that is predicted by a wide variety of factors, but also the importance of attending to the particular role of circumstantial factors that may be addressed in future interventions.

Less organizational resources and poor work schedule predict burnout

Predictors and Outcomes of Burnout in Primary Care Physicians

[Joseph Rabatin](#), [Eric Williams](#), [...], and [Mark Linzer](#)  [+3](#) [View all authors and affiliations](#)

Objective: To assess relationships between primary care work conditions, physician burnout, quality of care, and medical errors. **Methods:** Cross-sectional and longitudinal analyses of data from the MEMO (Minimizing Error, Maximizing Outcome) Study. Two surveys of 422 family physicians and general internists, administered 1 year apart, queried physician job satisfaction, stress and burnout, organizational culture, and intent to leave within 2 years. A chart audit of 1795 of their adult patients with diabetes and/or hypertension assessed care quality and medical errors. **Key Results:** Women physicians were almost twice as likely as men to report burnout (36% vs 19%, $P < .001$). Burned out clinicians reported less satisfaction ($P < .001$), more job stress ($P < .001$), more time pressure during visits ($P < .01$), more chaotic work conditions ($P < .001$), and less work control ($P < .001$). Their workplaces were less likely to emphasize work-life balance ($P < .001$) and they noted more intent to leave the practice (56% vs 21%, $P < .001$). There were no consistent relationships between burnout, care quality, and medical errors. **Conclusions:** Burnout is highly associated with adverse work conditions and a greater intention to leave the practice, but not with adverse patient outcomes. Care quality thus appears to be preserved at great personal cost to primary care physicians. Efforts focused on workplace redesign and physician self-care are warranted to sustain the primary care workforce.

- *Time Pressure + Less Control = More Burnout*
 - *Women 2X likely to have Burnout*

Poor leadership support = more burnout

Predictors of burnout among US healthcare providers: a systematic review

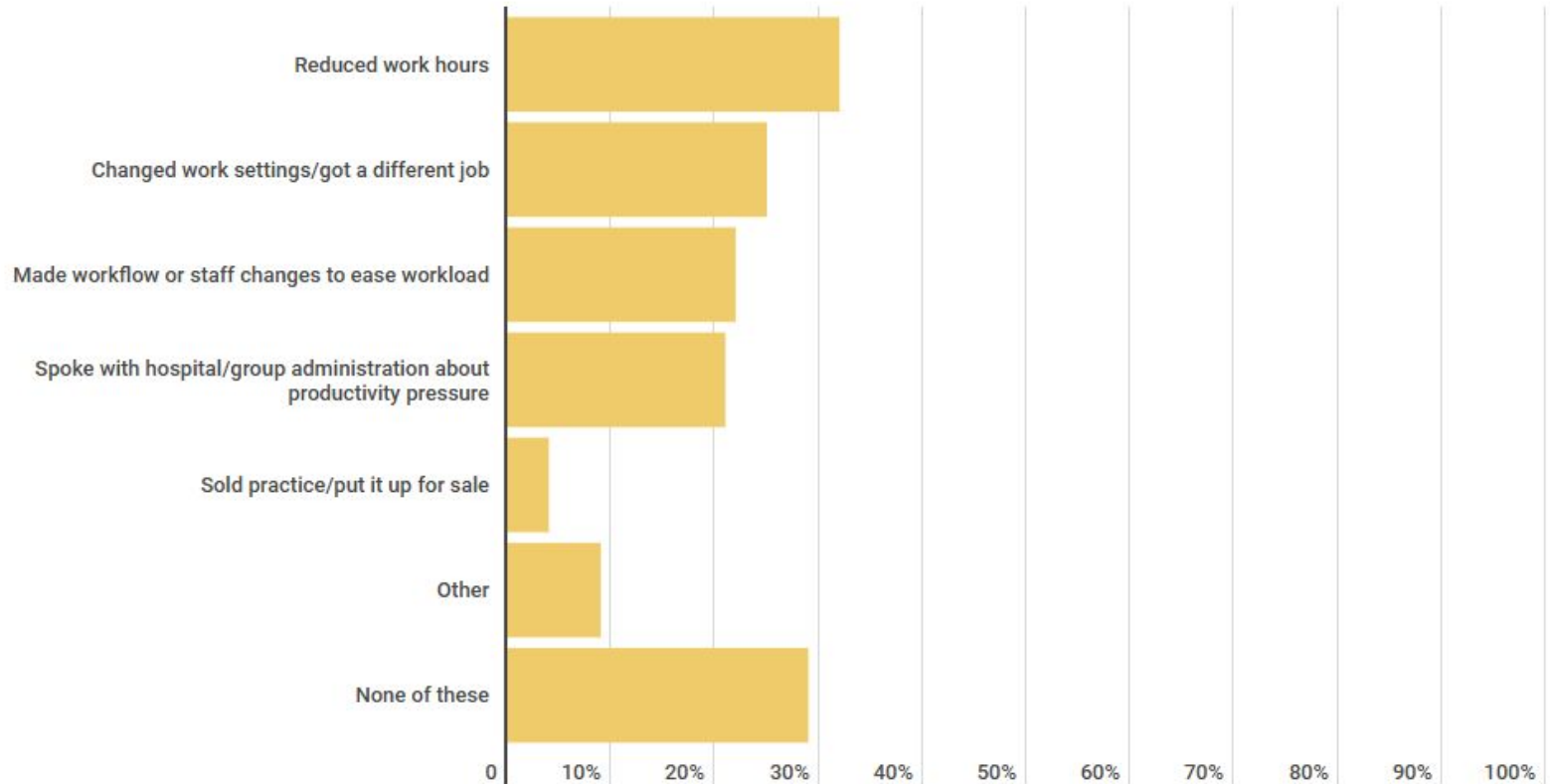
[Lisa S Meredith](#) ^{1,✉}, [Kathryn Bouskill](#) ¹, [Joan Chang](#) ², [Jody Larkin](#) ¹, [Aneesa Motala](#) ^{1,3}, [Susanne Hempel](#) ^{1,3}

The 141 identified studies evaluated a range of burnout predictors. Findings for demographic characteristics were conflicting or show no association. Workplace factors, such as workload, work/life balance, job autonomy and perceived support from leadership, had stronger associations with risk for burnout. Mental health factors, such as anxiety, and physical health risks may increase the risk, although the direction of these associations is unclear as few prospective studies exist to address this question. Factors such as social support appear to have a protective effect.

Social Support = less burnout

Consequences of Clinician Burnout

Source: Medscape



Original Investigation | Occupational Health

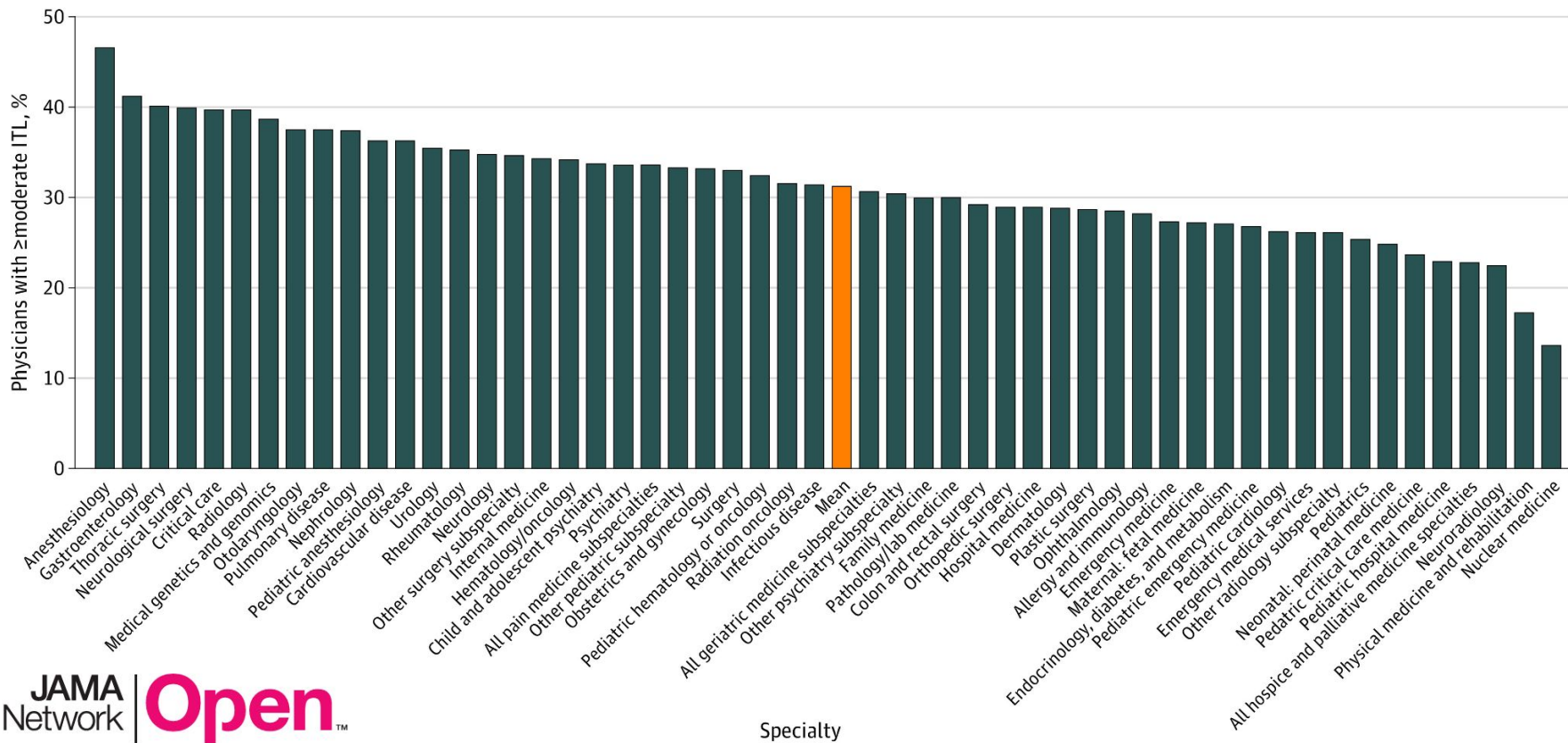
Well-Being Parameters and Intention to Leave Current Institution Among Academic Physicians

Jennifer A. Ligibel, MD; Nicolette Goularte, PhD; Jennifer I. Berliner, MD; Steven B. Bird, MD; Chantal M. L. R. Brazeau, MD; Susannah G. Rowe, MD, MPH; Miriam T. Stewart, MD; Mickey T. Trockel, MD, PhD

Table 1. Characteristics of Survey Respondents

Characteristics	Respondents, No. (%) (N = 18 719)
Gender	
Female	8037 (42.9)
Male	8381 (44.8)
Missing or gender identification other than male or female	2301 (12.3)
Age, y	
≤39	3915 (20.9)
40-59	8855 (47.3)
≥60	2532 (13.5)
Missing	3417 (18.3)
Ethnicity	
Hispanic or Latina/Latino/Latinx	294 (1.6)
Not Hispanic or Latina/Latino/Latinx	13 114 (70.1)
Missing	5311 (28.4)
Race	
Asian	2388 (12.8)
White	10 599 (56.6)
Other ^a	1039 (5.6)
Missing	4693 (25.1)

Figure 1. Intention to Leave (ITL) by Medical Specialty





Independent variable ^a and model ^b	Odds ratio (95% CI)	P value	Bonferroni-adjusted P value	Nagelkerke pseudo R ²
Personal-organizational values alignment ^c				
Model 0	0.71 (0.70-0.72)	<.001	<.001	0.20
Model 1	0.71 (0.70-0.72)	<.001	<.001	0.22
Model 2	0.81 (0.80-0.82)	<.001	<.001	0.29
Supportive leadership behaviors ^c				
Model 0	0.74 (0.73-0.75)	<.001	<.001	0.14
Model 1	0.74 (0.72-0.75)	<.001	<.001	0.17
Model 2	0.83 (0.82-0.84)	<.001	<.001	0.28
Peer support ^c				
Model 0	0.80 (0.79-0.82)	<.001	<.001	0.08
Model 1	0.81 (0.79-0.82)	<.001	<.001	0.12
Model 2	0.93 (0.91-0.95)	<.001	<.001	0.26
Professional fulfillment ^c				
Model 0	0.66 (0.65-0.67)	<.001	<.001	0.19
Model 1	0.64 (0.63-0.65)	<.001	<.001	0.23
Model 2b	0.72 (0.71-0.74)	<.001	<.001	0.25

Independent variable ^a and model ^b	Odds ratio (95% CI)	P value	Bonferroni-adjusted P value	Nagelkerke pseudo R ²
Negative impact of work on personal relationships ^c				
Model 0	1.22 (1.20-1.23)	<.001	<.001	0.10
Model 1	1.23 (1.22-1.25)	<.001	<.001	0.14
Model 2	1.09 (1.07-1.11)	<.001	<.001	0.26
EHR hassles				
Model 0	1.13 (1.11-1.15)	<.001	<.001	0.03
Model 1	1.15 (1.12-1.17)	<.001	<.001	0.07
Model 2	1.04 (1.02-1.06)	<.001	.01	0.24
Anxiety				
Model 0	1.25 (1.22-1.27)	<.001	<.001	0.05
Model 1	1.27 (1.24-1.30)	<.001	<.001	0.08
Model 2	1.02 (0.99-1.04)	.21	NA	0.25
Depression ^c				
Model 0	1.35 (1.33-1.38)	<.001	<.001	0.10
Model 1	1.37 (1.34-1.40)	<.001	<.001	0.13
Model 2	1.08 (1.05-1.10)	<.001	<.001	0.25

Mental illness and suicide among physicians

[Prof Samuel B Harvey, PhD](#)  ^a  · [Prof Ronald M Epstein, MD](#) ^b · [Prof Nicholas Glozier, PhD](#) ^c · [Katherine Petrie, BSc](#) ^{a,d} · [Jessica Strudwick, BPsych](#) ^a · [Aimee Gayed, PhD](#) ^a · et al. [Show more](#)

depression symptoms were reported regardless of the country and specialty being examined, with a pooled estimate of depression caseness (the number of physicians scoring highly enough on a measure of depression to be considered as having clinically significant depressive symptoms) of 28.8% (95% CI 25.3–32.5).⁴ Fewer studies have examined anxiety disorders among physicians, with the small number of cross-sectional studies suggesting rates of generalised anxiety disorder as high as 24%,¹⁶ and rates of post-traumatic stress disorder ranging between 4% and 16%.^{17,18}

High Prevalence of Physicians with Depression, GAD, and PTSD

Outcomes of Physicians with Substance Use Disorders in State Physician Health Programs: A Narrative Review

Matthew Goldenberg D.O.¹, Karen Miotto M.D.², Gregory E Skipper M.D.³, Jesse Sanford B.A.²

Abstract

The prevalence rate of addiction among physicians is similar to the general population, with approximately 10% to 12% of U.S.-based physicians developing substance use disorders (SUDs) during their lifetimes. To address this public health concern, physician health programs (PHPs) have been created to facilitate the early identification, evaluation, treatment, and monitoring of physicians. Although a number of published studies provide outcome information from PHPs, there has been no comprehensive review of the related literature. The objective of this narrative review is to summarize the treatment outcomes, including treatment types, rates of relapse, rates of contract completion or extension, as well as licensure and work status rates of a nationally representative physician cohort and related subpopulations from a single dataset. Based on the studies included in this review, our findings reveal that physicians who completed their PHP contracts have more favorable treatment outcomes than members of the general population who receive mainstream treatment. In addition, our review describes unique features of physician rehabilitation facilitated by PHPs. However, further prospective research is needed to ensure a standardized and comparable dataset and facilitate performance improvement.

**1 in 10 physicians
develop a SUD**

Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States

BMJ 2008 ; 337 doi: <https://doi.org/10.1136/bmj.a2038> (Published 04 November 2008)

Cite this as: *BMJ* 2008;337:a2038

Results 155 of 802 physicians (19.3%) with known outcomes failed the programme, usually early during treatment. Of the 647 (80.7%) who completed treatment and resumed practice under supervision and monitoring, alcohol or drug misuse was detected by urine testing in 126 (19%) over five years; 33 (26%) of these had a repeat positive test result. At five year follow-up, 631 (78.7%) physicians were licensed and working, 87 (10.8%) had their licences revoked, 28 (3.5%) had retired, 30 (3.7%) had died, and 26 (3.2%) had unknown status.

Most physicians with SUD can improve with treatment!

Mental illness and suicide among physicians

[Samuel B Harvey](#)^{a,*}, [Ronald M Epstein](#)^b, [Nicholas Glozier](#)^c, [Katherine Petrie](#)^{a,d}, [Jessica Strudwick](#)^a, [Aimee](#)

[Gayed](#)^a, [Kimberlie Dean](#)^{d,e}, [Max Henderson](#)^f

**At least 1 physician
completes suicide each day**

General and most cause-specific mortality rates are low in physicians compared with the general population,⁴⁶ presumably due to an enhanced version of the healthy worker effect, which occurs when observational studies **underestimate mortality rates** in employed populations compared with the general population because employed populations exclude individuals who are ill or disabled and therefore unable to work.⁴⁷ Education and high incomes might also drive lower mortality rates. However, suicide rates appear to be a notable exception,⁴⁸ with a 2019 systematic review and meta-analysis calculating an overall standardised mortality rate of 1.44 for suicides among physicians.⁴⁹ Female physicians appear to be at particular risk, with a 2020 meta-analysis reporting female physicians had a suicide rate that was significantly higher than women in the general population.⁵⁰ **Estimates suggest that, in the USA, one doctor dies by suicide per day**¹⁰ Although physicians have similar prevalence rates of depression and anxiety to those reported by other occupations, they are at disparate risk of suicide. This risk contrasts with the general trend for greater risk of suicide in lower skilled occupational groups.⁵¹ **In a Danish national register-based study, physicians had a higher risk of suicide than any of the 55 other occupations considered, and risk estimates further increased after sociodemographic factors were taken into account.**⁵²

Research

Suicide rates among physicians compared with the general population in studies from 20 countries: gender stratified systematic review and meta-analysis

BMJ 2024 ; 386 doi: <https://doi.org/10.1136/bmj-2023-078964> (Published 21 August 2024)

Cite this as: *BMJ* 2024;386:e078964

Results Among 39 included studies, 38 studies for male physicians and 26 for female physicians were eligible for analyses, with a total of 3303 suicides in male physicians and 587 in female physicians (observation periods 1935-2020 and 1960-2020, respectively). Across all studies, the suicide rate ratio for male physicians was 1.05 (95% confidence interval 0.90 to 1.22). For female physicians, the rate ratio was significantly higher at 1.76 (1.40 to 2.21). Heterogeneity was high for both analyses. Meta-regression revealed a significant effect of the midpoint of study observation period, indicating decreasing effect sizes over time. The suicide rate ratio for male physicians compared with other professions was 1.81 (1.55 to 2.12).

Physicians have a greater odds of suicide compared to the general population—especially female physicians

National Incidence of Physician Suicide and Associated Features

Hirsh Makhija, MS¹; Judy E. Davidson, DNP, RN, MCCM^{1,2}; Kelly C. Lee, PharmD, MAS³; [et al](#)

» Author Affiliations | Article Information

Physicians have a higher odds of mental health challenges prior to suicide attempts

Results A total of 448 physician (354 [79%] male and 94 [21%] female; mean [SD] age, 60 [16] years) and 97 467 general population (76 697 [79%] male and 20 770 [21%] female; mean [SD] age, 51 [17] years) suicides were identified. Female physicians had higher rates of suicide than female nonphysicians in 2017 (IRR, 1.88; 95% CI, 1.19-2.83) and 2019 (IRR, 1.75; 95% CI, 1.09-2.65), with overall higher 2017 to 2021 suicide risk (IRR, 1.53; 95% CI, 1.23-1.87). Male physicians had lower 2017 to 2021 suicide risk than male nonphysicians (IRR, 0.84; 95% CI, 0.75-0.93). Compared to the general population and including all available jurisdiction data, physicians had higher odds of depressed mood (aOR, 1.35; 95% CI, 1.14-1.61; $P < .001$) as well as mental health (aOR, 1.66; 95% CI, 1.39-1.97; $P < .001$), job (aOR, 2.66; 95% CI, 2.11-3.35; $P < .001$), and legal (aOR, 1.40; 95% CI, 1.06-1.84; $P = .02$) problems preceding suicide as well as use of poisoning (aOR, 1.85; 95% CI, 1.50-2.30; $P < .001$) and sharp instruments (aOR, 4.58; 95% CI, 3.47-6.06; $P < .001$). Physicians also had higher odds of positive toxicology for caffeine; poison; cardiovascular agents; benzodiazepines; anxiolytics, nonbenzodiazepines, or hypnotics; and drugs not prescribed for home use.

Work and legal stressors were common prior to suicide attempts

Factors associated with suicide in physicians: a silent stigma and public health problem that has not been studied in depth

[Narda Katherine Rátiva Hernández](#)¹, [Tania Yaritza Carrero-Barragán](#)², [Andrés Felipe Ardila](#)³, [Juan Diego Rodríguez-Salazar](#)⁴, [Ivan David Lozada-Martínez](#)⁵, [Elisa Velez-Jaramillo](#)⁶, [Daniel Aicardo Ortega Delgado](#)¹, [Ornella Fiorillo Moreno](#)^{7,8}, [Elkin Navarro Quiroz](#)^{9,*}

► Front Psychiatry. 2023 Aug 14;14:1222972. doi: [10.3389/fpsyt.2023.1222972](https://doi.org/10.3389/fpsyt.2023.1222972)

12% experience SI

A study conducted in Brazil evaluated factors associated with suicide risk in physicians and nurses. It was found that, out of 131 physicians, suicidal ideation occurred in 12.2% (n = 16) of them, and there was a relatively high frequency of suicide attempts and successful cases of suicide among their family and friends (with a frequency ranging from 15.2 to 43.5%).

Work & Legal Stressors are associated with SI

frequency between healthcare providers and the general population. When healthcare providers were analyzed, 63.2% (n = 485) of suicides were non-surgeon physicians, while surgeons accounted for 13.4% (n = 103). The probability of suicide increased in the following order: 1) Older age (OR 1.003 per year; 95% CI: 1.002–1.004, $p < 0.001$); 2) Receiving psychiatric treatment (OR 1.32; 95% CI: 1.09–1.61; $p = 0.005$); 3) Physical health problems (OR 1.53; 95% CI: 1.25–1.87, $p < 0.001$); 4) Work-related problems (OR, 1.72; 95% CI, 1.35–2.20; $p < 0.001$); 5) Legal problems (OR 1.80; 95% CI: 1.19–2.71, $p = 0.006$); and 6) Ancestry

Practice management

A gender-based analysis of predictors and sequelae of burnout among practicing American vascular surgeons

Conclusions

The prevalence of burnout among vascular surgeons is high. **Women vascular surgeons have double the rates of SI compared with male vascular surgeons.** Taken together, this study demonstrated that many of the same factors are associated with burnout in women and men, which include not enough family time, conflict between work and personal life, and work-related pain. Additional factors in men included conflict between work and family, work-related pain, and electronic medical record dissatisfaction.

Women Physicians x2 Risk of SI

Approaches to Wellness

Institutional



VS



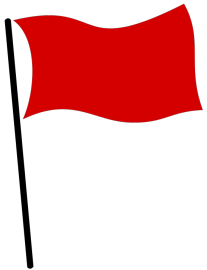
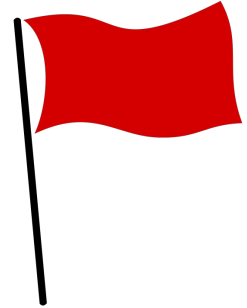
Individual

Wellness Practical Pearls



Identifying Common Red Flags

- ❑ Worsening Sleep Quality -or- Consistent Low Energy
- ❑ Significant Appetite / Weight Changes
- ❑ Consistently Low or Labile Mood
- ❑ Coping with Substances
- ❑ Neglecting Self Care (eg Showering, Healthcare)
- ❑ Passive Death Wish and/or Suicidal Ideations



Work Quality is Usually Impaired LAST for Clinicians

-Occupational Impairment in Clinicians Usually Occurs Late-

Psychiatric Symptoms
+
Substance Use



Functional Impairment
Outside of Work



Occupational
Impairment



Adequate Occupational Function
≠ Rule Out Psychiatric Illness

Barriers to Clinicians Receiving Treatment

- ❑ Societal **Stigma**
- ❑ Common Maladaptive Traits:
 - ❑ **Masochism** “Wounded Healer”
 - ❑ **Perfectionism**
- ❑ **Time** to Engage in Treatment
- ❑ Poor **Resource Awareness**
- ❑ Emotional Barriers: **Guilt, Shame, Fear**
- ❑ **Self-Treatment**



Common Clinician Psychological Profile: Pathway to Illness

- ❑ Early **Relational Patterns** Predict Future Drives
- ❑ Unconscious **Need to Suffer** to Feel Worthy
- ❑ Idealization of Self Sacrifice
- ❑ Harsh Superego Creates **Guilt**
- ❑ **Training reinforces** “self sacrifice” equates to success and moral virtue



Common Clinician Psychological Profile: Self Defeating Traits

- ❑ Defense Against Aggression: “I’m the problem; I just need to work harder” can preserve idealized images of mentors, hospitals, or the profession
- ❑ Defense Against Helplessness: “I can handle working 100 hours a week” feels more bearable than acknowledging true helplessness→ suffering becomes assertion of agency despite systemic constraints
- ❑ Preservation of Attachment: “I can’t disappoint them” Over-compliance and self-denial help maintain attachment to institutions / leaders



What Helps?



Seeking Community



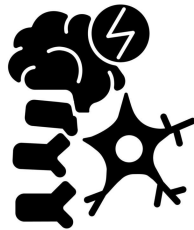
Pharmacotherapy



Self Care



Psychotherapy

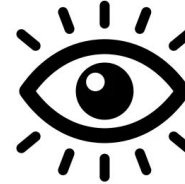


Neuromodulation

Redefining the following:



MISSION



VISION



VALUES

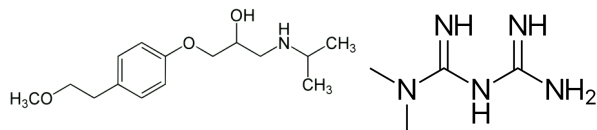
~Similar Kinds of Therapeutic Modalities~

Medicine

Interventional



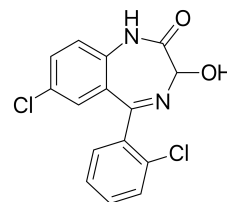
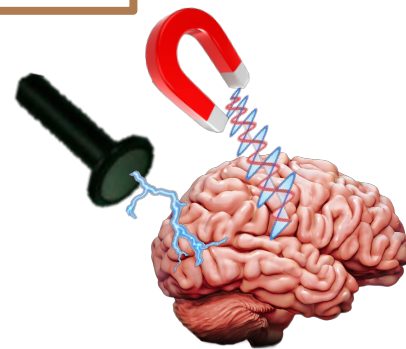
Rehabilitation



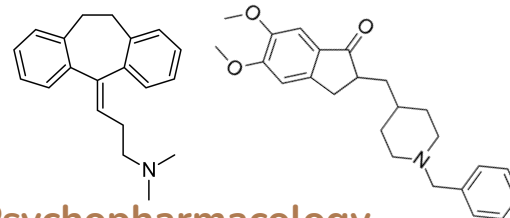
Pharmacology

Psychiatry

Neuromodulation



Psychotherapy



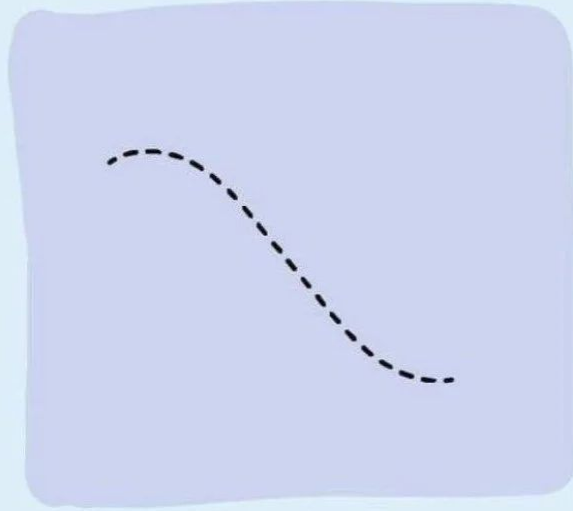
Psychopharmacology

What can Clinicians Practically Do?

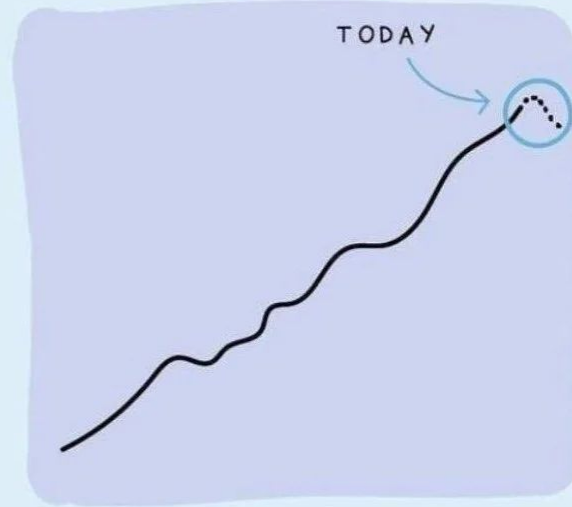
- ❑ **One Intentional Check-In Per Day:**
“How is my body feeling?” “What is my mood?” “What do I need in the next hour to be well?”
- ❑ **One Micro-Boundary Daily:**
“I’m getting food before the next case”
“I’m taking a bathroom break during the meeting”
- ❑ **5 Slow Mindful Diaphragmatic Breaths Per Day:**
“I will do deep breathing every morning before work”
- ❑ **Write Down One Specific Moment of Competence Daily:**
“I provided a thorough sign-out to a peer”

What can Clinicians Practically Do?

- ❑ **One Deliberate Social Touchpoint Per Day:**
“I will talk with my colleague not about work once today”
- ❑ **One Physical Care Activity:**
“I’m going to take a short walk in the hospital during a break”
“I’ll eat one healthy snack today”
- ❑ **Stop One Maladaptive Habit Once per Day:**
“I’m not going to chart review in bed today”



DON'T LET A BAD DAY



TODAY

DISTRACT YOU FROM
ALL THE PROGRESS
YOU'VE MADE



Organizational strategies to reduce physician burnout and improve professional fulfillment

Kristine Olson, MD, MSc,^{a,*} Daniel Marchalik MD,^b Heather Farley, MD,^c
Shannon M. Dean, MD,^d Elizabeth C. Lawrence, MD, FACP,^e Maryam S. Hamidi, PhD,
^f Susannah Rowe MD, MPH,^g Joanne M. McCool, MSOD,^h
Cormac A. O'Donovan, MD,ⁱ Mark A. Micek, MD, MPH,^d and Miriam T. Stewart, MD^h

To promote workplace efficiency, the clinical and administrative workload should be supported by sufficient resources to maintain quality, productivity, and work-life balance.

TABLE 1. Organizational strategies and tactics to improve physician well-being

Domain	Strategy	Tactics
Culture of wellness	Leadership development	- Select, assess, develop leaders who demonstrate the twelve leadership traits associated with physician well-being (engaging, empowering, developing, valuing) and Transformational, Servant, or Collaborative Leadership styles^{34-36,38} - Egalitarian leadership selection process³⁴ - Fidelity to mission, vision, values³⁰ - Appeal to intrinsic motivations²⁶⁻²⁸ - Communicate for value-alignment^{32,33} - Employ leadership structures that include physicians^{19,20,31} - Participative decision-making, including the perspectives of frontline physicians^{19,20,31,37}
	Control and autonomy	"Job-crafting" to allowing physicians to shape their jobs to their needs and preferences^{47,48} - Accommodate time for the professional activities most meaningful to physicians (~20%).^{33,39,40}
	Teamwork	- Design team-based care models that allow all team members to function effectively at the top of their licenses in the delivery of care^{19,20,31,52-55} - Accommodate "share the care" for team documentation, shared in-baskets, non-physician assist with order entry, protocolled and templated encounters⁵⁴ - Develop teams (willingness, mutual support, shared performance, clear goals, clear roles and abilities, situational awareness, safe to speak up, conflict resolution without retribution or politics)^{34,51} - Adequate staffing to manage the workload, absences and turnover^{57,58}
	Collegiality and community	- Gather and reflect on physicians' work-life experiences, preferably in protected time slots during the work day. Examples include: - Balint groups and Schwartz rounds⁶³⁻⁶⁵ - Brief 15-minute resilience exercises with multi-disciplinary teams near their work-unit⁶² - Meals together with a brief facilitated discussion⁶¹ - Physician lounges^{59,60}
	Appreciation	- Give and receive appreciation^{60,67} - Recognize "above-and-beyond" physician contributions to the organization with meaningful rewards or services that ease the workload or work-life integration⁶⁸
	Equity, diversity, and inclusion	- Align climate (beliefs and attitudes) with culture (policies)⁷¹ - Make it an organizational imperative (avoid relegating the organizational responsibility to those affected)^{71,73-76} - Establish goals and procedures to reduce the impact of implicit bias and to achieve EDI.^{71,75} - Normalize diversity^{71,75} - Support physician parents (ex. lactation facilities, on-site child care)⁷⁷⁻⁸¹

TABLE 1. Organizational strategies and tactics to improve physician well-being

Domain	Strategy	Tactics
Efficiency of practice	Electronic health record (EHR)	- Improve EHR usability and interoperability^{91-93,102} - Regarding the addition of new EHR tasks: refrain, evaluate impact, regularly review, reduce, eliminate⁹¹⁻⁹³ - When possible, EHR tasks should be simplified, automated, shared.⁹¹⁻⁹³ - Allow interprofessional sharing of EHR work with other non-physician team members.^{54,102} - Real or virtual scribes, dictation, to mitigate the documentation burden¹⁰³⁻¹⁰⁶ - EHR training and support to optimize use of tools and efficiencies¹¹⁰⁻¹¹⁹
	Workplace efficiency	- Provide adequate time during the workday for required documentation⁸⁴⁻⁸⁶ - Engage frontline physician in redesign of the clinical structures and processes.^{19,20,31-34,120-122} - Engage frontline physicians in clinical redesign teams to improve workplace efficiency and quality of care^{19,20,31,33,34,120-124} - Assess and improve structures and resources,^{33,45-48,57-58} processes,¹²⁰⁻¹²⁴ administrative complexity,⁸²⁻¹¹⁹ and teamwork.^{51,52-56} - Seek solutions at all levels: individuals, work-units, departments, the organization, policy and law³⁰
Personal resilience	Supporting healthy life-style behaviors	- Design effective team-based care models^{19,20,31,52-55} - Role-modeling of resilient healthy habits by leaders and physicians¹²⁹ - Make healthy choices readily available (hydration and nutritious food, exercise facilities, sleep pods, mindfulness practice, stand-up desks, etc.)^{129,132-135} - Reduce or eliminate the expectation that work be done after-hours (e.g. EHR tasks, emails, or other compliance tasks)³⁸
	Peer support	- Develop a confidential proactive peer support program¹⁴¹⁻¹⁴⁴ - Secure confidential mental health services for distressed physicians¹³⁷

The Stanford Model of Occupational Well-Being



Culture of Wellness

This domain encompasses organizational values, leadership behaviors, and workplace norms that promote personal and professional growth, community, agency, and compassion for patients, colleagues, and self.

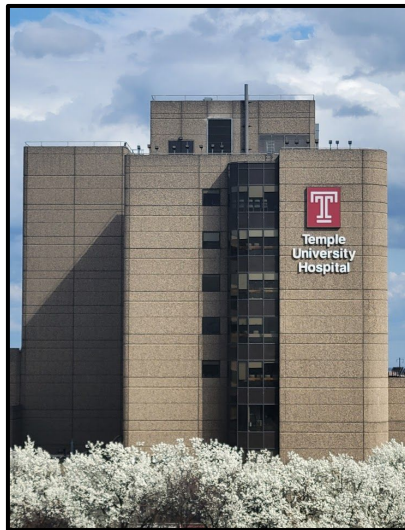
Workplace Efficiency

This domain depends on workplace systems, processes, and practices that promote safety, quality, effectiveness, work-life integration, and positive patient and colleague interactions, while minimizing wasted time and effort.

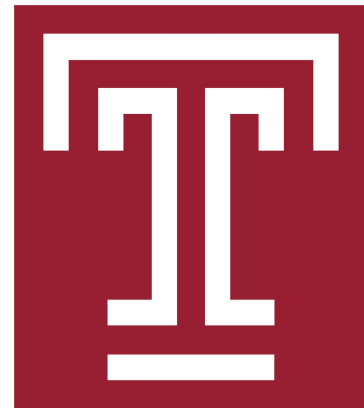
Individual Factors

This domain includes a broad set of variables that are expressed directly through individuals, including personal resources, behaviors, and attitudes that contribute to well-being, including culturally influenced individual responses to workplace demands and stressors.





Overview of the Temple Medical Staff Practitioner Wellness Committee



Mission & Vision

The mission of the Wellness Committee is to promote and support the wellbeing of all medical staff through evidence-based programs, events, education, and resources.

The vision of the Medical Staff Wellness Committee is a clinical community where every medical staff member thrives personally and professionally in an environment prioritizing wellness, compassion, and continual growth.

Membership Expansion

FIRST NAME FIRST
Susan Coull, MBA
Michael DeAngelis, MD, FAAEM
Shelley George, MD
Stacey Jeronis, MD, FACOG, FACS
Bhishak Kamat, MD
Thomas Mamo
Roschanak Mossabeb, MD
Jack Mydlo, MD, MBA, FACS
Theresa Pazonis, MD, MA, FRCSC, ABOS
Howard Rudnick, MD, MHA, FACP
Ryan Serdenes, DO (Chair)
FIRST NAME FIRST
Meggan Drake
Pamela Fierro, MBA
Yvette Gay-Jenkins, MA, CPCs
Melissa O'Connor
Melissa Ulas, MD, PhD

-Initial Roster-



FIRST NAME FIRST
Saira Agarwala, MD
Karissa Arthur, MD
Petra Brayo, MD, MA
Meera Chatterjee, MD
Allison Chambers, DO
Susan Coull, MBA
Michael DeAngelis, MD, FAAEM
Laura Douglass, MD
Alexander Duffy, MD
Gabriella Garcia, MD
Shelley George, MD
Stacey Jeronis, MD, FACOG, FACS
Nicole Jochym, MD
Bhishak Kamat, MD
Joseph Kauffman, CSP, COSM, MS OSH
Thomas Mamo
Roschanak Mossabeb, MD
Jack Mydlo, MD, MBA, FACS
Theresa Pazonis, MD, MA, FRCSC, ABOS
Yusuf Rahman, DO
Howard Rudnick, MD, MHA, FACP
Ari Schwell, MD
Ryan Serdenes, DO (Chair)
Thanh-Thao Thieu, OD
FIRST NAME FIRST
Meggan Drake
Pamela Fierro, MBA
Yvette Gay-Jenkins, MA, CPCs
Melissa O'Connor
Melissa Ulas, MD, PhD

-Roster After 3 mo-

PWC Focus



1

**Appreciation
Initiatives**



2

Resource Awareness



3

**Objective Metrics
&
Evidence-Based
Interventions**



4

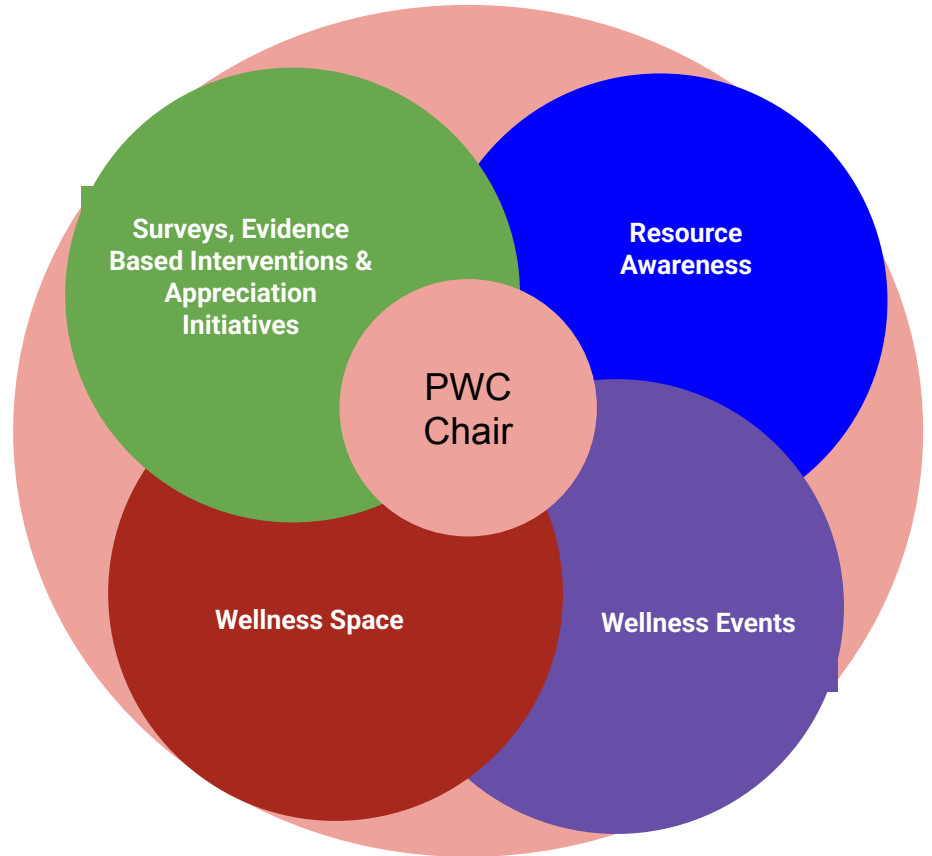
**Wellness Event
Planning**



5

**Wellness Space
Optimization**

PWC Work Group Model



Resource Awareness

The screenshot shows the Temple University Human Resources website. The header is dark with the Temple logo and 'Human Resources' text. A search bar is on the right. The navigation bar includes links for 'About HR', 'Careers at Temple', 'Employee Onboarding', and 'HR Resources'. The main heading is 'Well-Being Portal'. Below it is a breadcrumb trail: 'Home > HR Resources > Well-Being Portal'. A left sidebar lists various resources, with 'Well-Being Portal' highlighted in red. The main content area has an introductory paragraph about the portal's purpose. Below this is a 'CONTENT' section with a list of topics: 'What You'll Find in the Well-Being Portal', 'Our Commitment to You', and 'Getting Started'. A second 'What You'll Find in the Well-Being Portal' section follows, with the text 'Explore resources designed to support the various dimensions of your well-being:'. Below this are three rows, each with a topic and a red plus icon: 'Physical and Mental Health', 'Personal Finance', and 'Connect with Others'. A circular icon with a magnifying glass is in the bottom right corner.

Human Resources

Search

About HR ▾ Careers at Temple ▾ Employee Onboarding ▾ **HR Resources ▾**

Well-Being Portal

Home > HR Resources > Well-Being Portal

Our Functional Areas >

Owls for Philly: Civic Engagement Hours

Temple Employment Culture

Well-Being Portal

Outstanding Owls - Staff Recognition Program

Temple Employee Referral Program (TERP)

Quick Links

Your pathway to a healthier, happier, and more connected you starts here. Human Resources and the Well-being Division are excited to introduce the Well-Being Portal, a comprehensive hub designed to support your holistic well-being. Whether you're seeking resources for mental and physical health, financial guidance, stronger connections, or professional growth, this is your one-stop destination.

CONTENT

What You'll Find in the Well-Being Portal

Our Commitment to You

Getting Started

What You'll Find in the Well-Being Portal

Explore resources designed to support the various dimensions of your well-being:

Physical and Mental Health	+
Personal Finance	+
Connect with Others	+

Wellness Events



Wellness
Events

Objective Metrics



Temple Health Organizational Biopsy™

Executive Summary

February 2023

AMA ORGANIZATIONAL BIOPSY

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Wellness Space Planning & Completion



Wellness Space



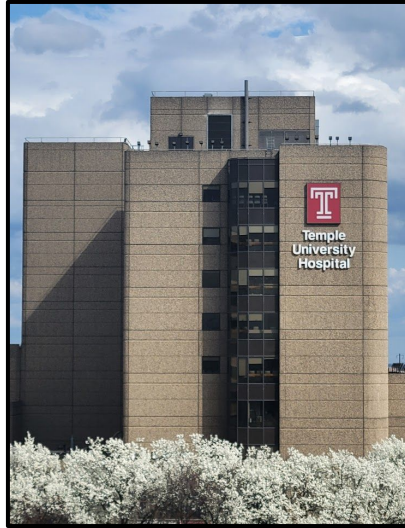
Reactive Wellness



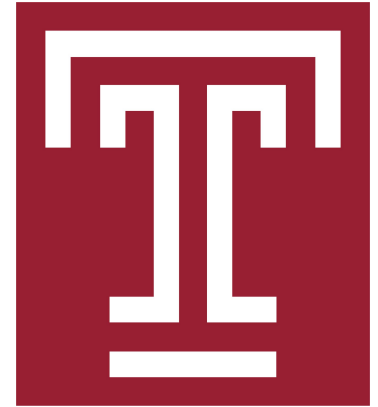
**Occupational
Health**



Collaboration between Psychiatry Dept, PWC, & Occ Health



Additional Wellness Resources



+ Meet Your Retirement Team

The People-First EAP Program That Helps Workforces Thrive

Carebridge EAP provides easy, 24-7 access to the mental health resources employees need to perform their best—all while saving your organization money.

HEADSPACE & GINGER

Ginger is now part of Headspace

Headspace now brings together its world-renowned meditation and mindfulness programs with Ginger's virtual mental healthcare — a solution that's been improving mental health outcomes for more than a decade.



Creative Beginnings Daycare

988
LIFELINE



Federation of State Physician Health Programs

- Hotlines:
 - Confidential 2-COPE Temple Hotline 215-707-2673

HOME Epic Dragon Dragon Copilot Imprivata Telemed Medical Assistant Training 2FA Gallery 1

EPOCH - EMR Provider Optimization Competencies & Happiness

An advertisement for EPOCH training. It features a blue background with a glowing blue line graphic. On the left, there is a screenshot of a software interface with text like "Patient status", "Medication", and "Update that patient's vitals are Optima". In the center, the Microsoft Dragon Copilot logo is displayed next to the Temple Health logo. On the right, the text "Attending Physicians and APPs, Register Today! Next Day Training." is written in a bold, italicized font. At the bottom right, there is a red button with the text "CLICK HERE" and a hand cursor icon.

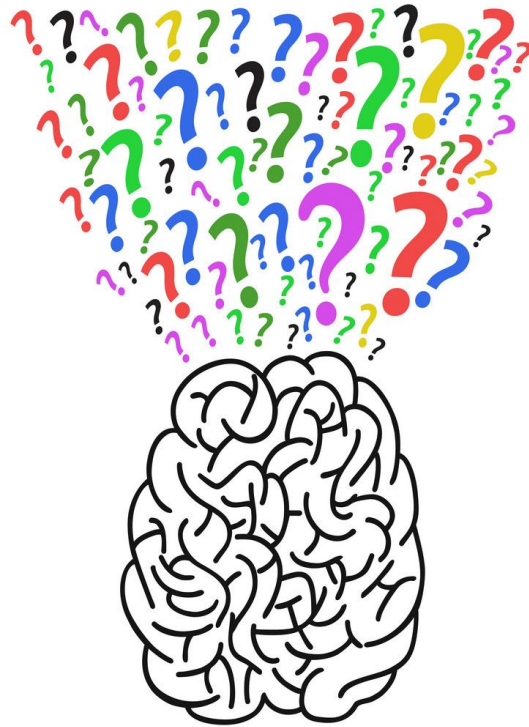


Conclusion

- ❑ Practitioner Wellness is a National Challenge
- ❑ There are individual and system barriers to wellness BUT solutions do exist!
- ❑ The Temple medical staff is actively working to improve institutional wellness

"At a cardiac arrest, the first procedure is to take your own pulse"
-Samuel Shem

Questions?



Thank You!

