Published in final edited form as:

Acad Psychiatry. 2018 August ; 42(4): 542–547. doi:10.1007/s40596-018-0882-x.

An Intervention Framework for Institutions to Meet New ACGME Common Program Requirements for Physician Well-Being

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In the past 5 years, increased attention has been focused on the issues relating to physician health and well-being, particularly among trainees [1, 2]. The mental health effects of medical training are becoming increasingly well-documented, with high rates of burnout, depression, and suicide among residents, fellows, and physicians in practice [3, 4]. It has been reported that burnout rates are as high as 75% among residents [5] and that within 3 months of the start of internship, rates of moderate levels of depression climb from 4 to 26% and continue at that level throughout the year [6].

As institutions grapple with these disturbing trends, both burnout and depression must be addressed. Burnout is a work-related syndrome characterized by emotional exhaustion, depersonalization, and sense of low personal accomplishment [7]. It is subtle and insidious and often resembles depression. Depression is a psychiatric illness characterized by low mood; tearfulness; alterations in sleep, appetite, concentration, and attention; feelings of guilt, hopelessness; and anhedonia. Both burnout and depression are independently related to increased risk for suicidal ideation [8, 9].

Burnout and depression in house staff also have direct effects on patient care. Residents suffering from burnout are more likely to self-report medical errors, and interns who meet screening criteria for depression are more likely to highlight the bureaucratic burdens of internship, disappointment with the teaching faculty, feelings of isolation, and uncertainty about career choice [10]. These experiences detract from the significant and meaningful patient interactions and the social support received during intern year that are described by interns without depression [10].

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Compliance with Ethical Standards The enclosed work does not involve research and therefore was not submitted to an institutional review board.

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

Identifying Critical Targets

As the ever-shifting landscape of the healthcare system continues to demand more from both trainees and faculty, many physicians believe that solutions must be developed now [11]. However, these issues are complex and the way to address them most effectively is not clear. While it is imperative to change the historically competitive culture of medicine and the excessive workload challenges that contribute to burnout, short-term efforts must accompany these long-term efforts to appropriately impact the well-being of physicians currently in practice.

As institutions try to implement culture change and address the rising burnout epidemic, well-being champions must identify their objectives and priorities. Academic systems face difficult choices in focusing limited resources on promoting physician well-being, decreasing stress, minimizing burnout, identifying and treating depression, and preventing the next suicide. The Accreditation Council for Graduate Medical Education (ACGME) has recently rolled out new Common Program Requirements that require every residency program to address physician well-being, burnout, self-care, and mental health issues.

Limited resources necessitate a strategic approach. A recent review and meta-analysis of interventions suggests that interventions should focus on both individual and organizational factors [12]. Interventions promoting resilience can also align well with programs preventing burnout and depression [13]. Nevertheless, current research studies on interventions aimed at improving trainee well-being are primarily exploratory or in pilot stages [9]. Therefore, we propose the following framework to address both organizational and individual factors.

Seven Actions for Intervention

Primary goals for comprehensive intervention programs are to promote well-being and resilience among the physician workforce while simultaneously addressing the negative sequelae of burnout and depression. Konopasek and Slavin proposed a departmental resident well-being program that can be modified and expanded to outline institutional approaches as well [14]. The Johns Hopkins Bloomberg School of Public Health recently published an evidenced-based review of corporate wellness practices that target specific organizational health promotion factors and describe the business case to support them [15]. In Table 1, we have integrated the literature into the following seven broad categories and organized them according to the new ACGME Common Program Requirements.

1. Educate and Increase Awareness

Early interventions should include educational opportunities to increase awareness among physicians about burnout, depression, substance abuse, suicide, and stigma [1, 16]. The promotion of resilience can be encouraged by education focused on sleep hygiene, nutrition, exercise, housing options, and social activities [17]. Explicit information regarding the epidemiology of psychiatric illnesses and identification of institutional mental and physical health resources are equally important.

Such educational activities are best conducted in high-yield venues such as orientation sessions for incoming trainees or employees, departmental grand rounds, and didactic sessions either in training curricula or Graduate Medical Education (GME) and Continuing Medical Education (CME) settings. These sessions can be supplemented with standardized presentation slides housed in an electronic resource library. Speakers might include local “Physician Wellness Champions” as well as staff psychiatrists who are knowledgeable about depression and suicide. Local faculty members can be organized into a “Speaker’s Bureau” available to all departments. Wellness newsletters can be published at regular intervals to supplement and reinforce these educational initiatives.

2. Designate Time for Reflection

Facilitated group opportunities for discussion have also been associated with reduced burnout [18]. While many formats for group reflection have been developed for physicians, key features include maintaining consistent membership, facilitation, and structure. Ideally, 10 to 15 participants with consistent attendance should participate in a group. Participation in such groups, especially for trainees, must take place during “protected time,” dedicated to this purpose. Facilitation should be conducted by faculty with experience in group process whenever possible; compensation for this work should receive serious consideration. Additional leadership can be provided by other personnel such as chaplains, psychologists, social workers, care coordinators, and peer co-facilitators. Meetings might occur anywhere from weekly to monthly and can either follow a protocol (e.g., Balint) or allow for open-ended processing [19].

In addition to ongoing group reflection, certain sentinel events (e.g., deaths, codes, errors, poor outcomes) frequently require additional consideration. A faculty professionalism and peer support program and “Debrief Protocols” for physicians, nurses, and other members of the care team to both review the clinical details of a seminal event and to provide support have been found to be useful [20].

3. Teach Practical Skills

Many wellness initiatives among physicians have focused on mindfulness-based stress reduction and cognitive-behavioral techniques. By developing a greater awareness of internal stress, physicians can be better equipped to tolerate the daily rigors of medical and surgical practice. Mindfulness techniques are low-cost and broadly implementable and may involve guided sessions as well as mobile app-based software [13]. These skills can also be enhanced through physical activities such as on-site yoga or exercise classes that may further alleviate stress and foster resilience.

Simple introductory evidence-based cognitive-behavioral therapy skills (e.g., daily mood ratings, cognitive reappraisal) can also be taught in person by experienced therapists, and online modules such as MoodGym are under development [21]. Additional techniques drawing from positive psychology, narrative medicine, and the medical humanities provide concrete approaches to developing regular reflection practices [22].

4. Build Community

In addition to efforts to increase awareness throughout the workforce, interventions directed at expanding mentorship can be vital for younger physicians who are prone to burnout. Developing “buddy” or “big sibling” programs among trainees can help promote camaraderie and informal support. Coaching programs in which experienced faculty members are paired with trainees or early career physicians either within or across specialties can provide opportunities for reflection and support that are outside the boundaries of formal mentorship [23]. These activities can be augmented by annual retreats, semi-annual chairman rounds, and regular social events to further promote a sense of community. In addition, several studies have demonstrated that such programs reduce burnout not only among house staff but also among faculty as well [23].

5. Ensure Access to Care

Given the rising levels of burnout among physicians, including trainees, a “universal precautions” approach should be employed in which all physicians are educated about warning signs of burnout, its relationship to depression and anxiety, and links to institutional resources. Anonymous screenings for depression linked to confidential referrals for those with positive screens should be considered [1, 24] as well as depression screenings in annual health exams. Early detection of depression is as important as early detection of other medical conditions and can help prevent progression of symptoms leading to impairment and potentially suicide [25]. Additional services should be in place for at-risk physicians and those who are in crisis. Walk-in appointment availability would be ideal [26], and 24-h emergency facilities and after-hours crisis phone lines are important additional resources. Barriers to care should be anticipated and addressed explicitly, including health insurance coverage, affordability, confidentiality, and state-specific requirements for disclosing mental health treatment on medical licensure applications [27].

6. Improve Workplace Environment

Well-being efforts have increasingly recognized the importance of making meaningful changes to the work environment [12]. Step one is to conduct a structured assessment of current workplace challenges. Subsequently, institutions can work with operations leaders and quality improvement committees to address inefficiencies in physician work flow and, eventually, to develop comprehensive strategic plans to address workforce issues [12].

7. Transform Institutional Culture

Modifications to workplace culture are long-term institutional goals. Even small changes can have large impacts, such as healthy food options in the cafeteria or local campaigns to normalize taking breaks during the workday, particularly during high-stress rotations for both house staff and faculty. Implementation of policies about duty hours, fatigue management, sick days, and the use of personal days to tend to basic needs (doctor and dentist appointments, etc.) [28] have now been recommended by the ACGME in the updated Common Program Requirements and could be extended to all staff [29]. Additionally, physician work flow should be studied and solutions developed to maximize physician time with patients and decrease non-physician administrative burdens.

The creation of an institutional clinician well-being committee could facilitate implementation of programs and could also help coordinate participation in research studies designed to assess the benefits of well-being programs [6]. Resident/fellow forums required by the ACGME in its Institutional Requirements can also help empower trainees to address well-being concerns [30].

Challenges of Implementation

As the awareness of physician burnout, depression, and suicide continues to emerge as a challenge to the delivery of safe, effective patient care, institutions must confront balancing the urgency of reform with competing financial needs and regulatory requirements. Even the most motivated physician “champions” are frequently over-burdened with multiple responsibilities, and finding time as well as financial support for these activities remains problematic.

Furthermore, efforts to promote physician well-being are directly impacted by the stigma about acknowledging mental illness and seeking treatment both within the medical profession and in society at large. In particular, discrimination in licensure, advancement, and credentialing remain significant obstacles to creating lasting change, although meaningful efforts are being initiated to address these issues [27].

Strategies for Success

In order to develop effective initiatives, advocacy principles can be applied to the “business case” for addressing well-being. Relevant arguments might include the following:

- To improve patient safety and the quality of care
- To improve the patient experience and reduce medical errors
- To improve retention of faculty and staff
- To improve quality of life for trainees and faculty and promote long-lasting careers in medicine
- To reduce adverse outcomes such as suicide, depression and substance abuse
- To promote the development of institutional leadership which can help change the culture of medicine

Fortunately, executive leaders around the country are beginning to identify clinician engagement and well-being as an indispensable organizational priority, as exemplified by the creation of a Chief Wellness Officer position in a major health care system [12].

Conclusion

Promoting physician well-being should be a fundamental goal of health care systems to safeguard the health of those currently in practice, guarantee successful training of the next generation, and improve the health of our patients. Ongoing research will help clarify which elements of a well-being program are most effective. Nevertheless, a range of interventions

already exists that can help build resilience, identify those at risk, and provide services for those in need.

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Table 1

ACGME Common Program Requirements and associated interventions

ACGME Common Program Requirement Section VI.C. Well-Being states that a program's responsibility must include:	Associated interventions
Efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships. (1.a)	<ul style="list-style-type: none"> • Provide protected time for discussion groups <ul style="list-style-type: none"> – Membership: ideally 10–15 participants with consistent attendance – Facilitation: faculty (from psychiatry and/or within each department), chaplains, peer co-facilitators, etc. – Structure: follow protocol (e.g., Balint) or open-ended processing • Disseminate debrief protocols for seminal events (deaths, codes, errors) • Organize semi-annual Chairman Rounds
Attention to scheduling, work intensity, and work compression that impacts resident well-being. (1.b) Evaluating workplace safety data and addressing the safety of residents and faculty members. (1.c)	<ul style="list-style-type: none"> • Work with institutional operations leaders and Quality Improvement committees to address inefficiencies in physician work flow • Support monthly Chief Resident meetings
Policies and programs that encourage optimal resident and faculty member well-being. (1.d)	<ul style="list-style-type: none"> • Establish an institutional Well-Being Committee and Resident/Fellow Forum (described separately in Institutional Requirements) • Develop and maintain training in: <ul style="list-style-type: none"> – Mindfulness-based stress reduction techniques – Stress awareness and Cognitive-Behavioral techniques – Positive psychology • Facilitate narrative practice and medical humanities • Arrange physical exercise groups
Resident must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (1.d.1)	<ul style="list-style-type: none"> • Promote clear and standardized policies for taking personal days to care for self, sick pull, and maternity/paternity leave • Distribute rotation schedules and days off early to make full use of time away from work
Attention to resident and faculty member burnout, depression, substance abuse. The program, in partnership with the Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. (1.e)	<ul style="list-style-type: none"> • Offer orientation sessions for incoming residents, annual departmental Grand Rounds, and/or regular didactic sessions on the following: <ul style="list-style-type: none"> – Physician burnout, depression, substance abuse, suicide, and stigma – Epidemiology of psychiatric illness and comorbidity – Sleep hygiene, nutrition, gyms, housing, fun activities – Both mental and physical health resources • Create a Speakers Bureau of local and national experts to help give above talks • Create an electronic resource library (e.g., centralized website with policies, contacts, and treatment information) • Publish a regular well-being newsletter • Participate in existing and innovative research studies
Encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another	<ul style="list-style-type: none"> • Arrange annual retreats and regular social events • Expand mentorship and coaching programs

ACGME Common Program Requirement Section VI.C. Well-Being states that a program's responsibility must include:	Associated interventions
resident, fellow or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence. (1.e.1)	<ul style="list-style-type: none"> – Among residents (i.e., “buddy/big sib” program) – Between residents and faculty (within or across specialty interests)
Provide access to appropriate tools for self-screening. (1.e.2)	<ul style="list-style-type: none"> • Employ “universal precautions” approach for burnout • Consider using anonymous tools to screen for depression (e.g. American Foundation for Suicide Prevention Interactive Screening Program) which are linked to mental health services
Provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 h a day, seven days a week. (1.e.3)	<ul style="list-style-type: none"> • Define a clear system for referrals to individual treatment, including instructions on using employer-based insurance • Ensure access to mental health care, including the following: <ul style="list-style-type: none"> – Institutionally based faculty and house staff mental health services – Walk-in well-being center • After-hours emergency phone line through GME or psychiatrist-on-call
There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (2)	<ul style="list-style-type: none"> • Promote clear and standardized policies for taking personal days and for coverage of relevant services