

IMPROVING CARE

CULTIVATING WELL-BEING WITHIN HEALTHCARE TEAMS: LESSONS FROM DIALECTICAL BEHAVIOR THERAPY

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Clinicians experience high levels of distress when caring for patients with complex needs. Team members may not know how to support one another. If unaddressed, burnout and disengagement may develop. Traditional clinician wellness programs often task individuals to seek support outside of their professional roles and teams.¹ However, such programs fail to leverage team members as valuable sources of support. We propose that clinicians would benefit from skill-building within teams to manage emotions, build mindfulness, tolerate distress, and communicate validation of varying team member perspectives. While these skills may be unfamiliar to clinicians, there is a rich history and evidence base to draw from Dialectical Behavioral Therapy (DBT). In this article, we briefly describe DBT and share lessons from our early experiences in implementing a DBT-informed care team within the Comprehensive Care Program at the University of Chicago.

Developed by psychologist Marsha Linehan in 1993, DBT has demonstrated efficacy in treating borderline personality disorder, with applications to a variety of other mental health conditions.² The goal of DBT is to develop a life worth living through organizing behavior around a set of commitments, instead of feelings, urges, and thoughts. DBT seeks synthesis between the dialectical principles of change and acceptance, with the goal of enhancing patients' and team members' motivation, capability, and skills. In addition to patient-facing components

of treatment (individual therapy, group skills training, phone coaching), a core component of DBT is the consultation team that provides a regular forum for clinicians to support one another and manage the high stress and potential burnout of treating clients with high behavioral health needs, including suicidality.³

DBT's intentional commitment to clinician well-being through embedding consultation teams within its core structure presents a radical and exciting model for health care settings; yet, guidance on implementation is currently lacking. Over the past two years, our Comprehensive Care Program at the University of Chicago adapted these DBT principles into our weekly Complex Care Rounds. The Comprehensive Care Program is a primary care program that is focused on patients at increased risk of hospitalization, and which features primary care and interprofessional team continuity across both inpatient and outpatient settings.⁴ Our Complex Care Rounds (CCR) were modeled after DBT consultation groups, designed as twice weekly, 45-minute sessions attended by an interprofessional team, including social workers, community health workers, administrators, physicians, students, and AmeriCorps volunteers. The overall goal of CCR is to facilitate team communication and enhance clinician motivation and efficacy while formulating complex needs interventions. Each month, core attendees take turns serving as facilitator and process monitor. Each

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FROM THE EDITOR

LEARN HOW TO DO NOTHING

Tiffany I. Leung, MD, MPH, FACP, FAMIA,
Editor in Chief, *SGIM Forum*

Just after beginning summer vacation this July, I shared a story with my spouse I had not thought of in years. In high school, I was proud of serving as the Features section editor of the school newspaper—perhaps a foreshadowing of my present role—finding joy and laughter in the silly shenanigans of that age among journalistically inclined friends and classmates. One year, the school newspaper participated in a national high school journalism competition: we submitted our best issue over the past academic calendar year for judging and possible award recognition and several students on our newspaper staff also entered various writing competitions. I entered the writing competition that aligned with my section. The competition involved watching a short film and then having a predetermined amount of time to write a film review. I took home a pleasantly unexpected “Honorable Mention” from that competition, considering I had struggled with the handwritten submission format, time constraint, and first-timer performance anxiety.

Years later, I look back at that relatively distant memory and realize that this September theme issue on “Physician and Patient Well-being and Mental Health” marks one year since I began serving our Society of General Internal Medicine as Editor in Chief for *SGIM Forum*. It is catastrophically inadequate to say the past year has surfaced personal and societal issues that have been trying and even traumatizing for physicians, frontline workers in healthcare and other industries, and patient populations everywhere. There is no doubt that overall mental health and well-being during the still ongoing pandemic have been seriously and negatively impacted. Yet, the tremendous opportunities for surfacing the best in people as they cope with and respond to the breadth of challenges presented are often inspirational, offering lessons behind every story to learn about the optimism, resilience, and connectedness of human nature.

In some cases, coping can be productive, turning distress into eustress. Recognizing the inadequacy of measures and protective gear for frontline health workers stimulated multiple organizational efforts, by established associations and brand-new groups, to acquire and distribute the necessary supplies. Seeing the plight of doctors facing COVID-19 surges and recurrent secondary or even primary traumas, from COVID-19 and from deferred care for non-COVID-19 illnesses, led to the

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PUT ON YOUR OXYGEN MASK FIRST BEFORE HELPING OTHERS

Monica L. Lypson, MD, MHPE, FACP, President, SGIM

SGIM members experienced COVID-19 and worked on the front lines, and some of us lost loved ones prematurely from COVID-19 or other illnesses impacted by the pandemic. We have members who questioned their roles in academic general internal medicine, not to mention their (many) other roles. We may not have been aware of the baseline stress experienced by our members, but the pandemic worsened the strain. I wonder what structural supports are in place for our members to react individually or as a group when faced with a crisis?



It has been a long year, and many of us have wounds our colleagues have no idea about. SGIM members experienced COVID-19 and worked on the front lines, and some of us lost loved ones prematurely from COVID-19 or other illnesses inevitably impacted by the pandemic. We have members who questioned their roles in academic general internal medicine, not to mention their roles as partner, child, parent, activist, and health professional. We may not have been aware of the baseline stress already experienced by many of our members, but undoubtedly the pandemic worsened the strain.

I wonder at times what structural supports are in place for our members to react individually or as a group when faced with bereavement, burnout, and other crises? What

are the resources offered to clinicians seeking support for their mental health? What are effective macro-level interventions?

As mentioned in this month's CEO Q&A, Mark Linzer and colleagues recognized the need to address systematic structures leading to burnout long before this current crisis. To that end, ACLGIM leadership partnered with Dr. Linzer's group to understand physician burnout in GIM.¹ That work led to the development of the WELL Program.²

Regarding mental health, many of our members have several options as they seek assistance through their personal storms. Many may have turned to colleagues in local affinity groups, such as spiritual homes, social justice, and sororal or professional organizations.

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Q & A WITH SGIM'S CEO AND THE ACP'S VICE PRESIDENT FOR CLINICAL EDUCATION ABOUT IMPROVING PHYSICIAN WELL-BEING

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How did SGIM help launch professional society programming to improve physician well-being?

In 2015, SGIM's Association of Chiefs and Leaders in General Internal Medicine (ACLGIM) created the Work Life & Wellness Program. Led by Dr. Mark Linzer, ACLGIM surveyed divisions of general internal medicine (GIM) to assess physician burnout levels in GIM. Many divisions used the survey data to make changes. With data in hand, divisions were able to ask institutional leaders for help in improving the work life of their faculty. ACLGIM learned that leaders were hungry for expertise on how to lead such change.

ACLGIM launched the Wellness Engaged Longitudinal Leaders Program in 2017 to build a community of wellness champions in GIM. The year-long program covered the mechanisms of stress, favorable and unfavorable work conditions, ways to measure work conditions, challenges related to use of the electronic health record (EHR), system-level interventions for changing the work environment, and examples of resilience training. The resulting cohorts of wellness champions had the knowledge and skills to effectively advocate for better work conditions at their institutions.

ACLGIM also created an online community using GIM Connect to facilitate regular discussion of physician wellness and burnout. The discussions generated a library of articles, surveys, and tools.

What is the ACP doing to improve physician well-being?

Since 2017, the ACP has been taking action to address clinician burnout and provide guidance and resources that foster communities of well-being for internists to best serve patients and optimize professional fulfillment. ACP has integrated clinician well-being and professional fulfillment into its mission and core values, creating a standing Physician Well-being and Professional

Fulfillment Committee, encouraging interdisciplinary efforts, and deploying resources to promote the well-being of internists and their teams.

The ACP developed a multipronged approach and a comprehensive set of resources to support just-in-time and long-term needs,¹ including:

- 1) Improving the practice and organizational environment by giving members high-quality information, resources, tools, and support to help their practices thrive in the growing value-based payment environment;
- 2) Fostering local communities of well-being with over 150 ACP Well-being Champions who support ACP chapter members, practices, and organizations in combating burnout;
- 3) Promoting individual well-being by offering online resources and educational courses at ACP's Internal Medicine Meeting and chapter meetings;
- 4) Advocating for system changes with policy recommendations through ACP's Patients Before Paperwork Initiative.²

As individual and system needs converge along with mental health consequences of the COVID-19 pandemic, ACP develops products and services to meet members where they are. In March, ACP launched the I.M. Emotional Support Hub with publicly available confidential peer-support, counseling, crisis links, and well-being resources.¹ To facilitate culture change and improve the well-being of the next generation of internists, ACP launched the Resident Well-being Learning Series.¹ Aligned with new requirements for resident training, these online modules are free to ACP members (\$25 for non-members) and may be completed individually or in facilitated groups using a flipped classroom model.

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SNOWBALLING: THE PERILS OF EDUCATIONAL DEBT ON PHYSICIAN WELLNESS

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Dr. Williams is a 30-year-old Internal Medicine residency graduate who is pursuing a career in General Internal Medicine. This physician is looking forward to equitable and appropriate compensation for their skill set. The agreed upon salary is \$200,000 (USD). The contract is for two years without any bonus structure for the first two years. In addition, there is an agreed upon \$15,000 moving expense allowance and \$5,000/year retention bonus. This salary is three to four times what was made during residency.

The need to address debt accumulated from years of higher education tuition is more apparent than ever. Dr. Williams is like 73% of all U.S. medical graduates who carries student loan debt that totals \$241,000, a figure that places them at the mean debt level for all indebted U.S. medical graduates.¹ By comparison, in 1978 the average physician graduated with \$13,500 in total student loan debt (\$53,648 in today's dollars).¹ Like many physicians, there has been no formal or meaningful financial education during undergraduate, graduate, or post-graduate education. The loans carry an overall 5.8% interest rate (again average). Using a 20-year payback period, this will equate to \$407,738 paid in total. Dr. Williams has never faced this amount of debt before and is unsure on how to proceed.

This scenario begs the following question: How does debt affect overall physician well-being? This column presents a brief history of education loan debt, a quick literature review of the relationship of debt to wellness, and areas of need for further investigation.

Brief History of Educational Debt

In 1840, Harvard University is reportedly the first U.S. university to offer a private student loan.² Following this was a relatively dormant period with regards to change until legislative actions functioned to improve access to higher education by allowing more people to access financing. The period following World War II, spurred by the GI Bill, increased the number of people who wanted to attend college—a service that remains available today and is still frequently used by veterans. In the 1980s and 90s, the burden of student debt started to be tracked

more closely. The average undergraduate debt increased from 25% of students carrying up to \$10,000 to all students with a bachelor's degree carrying an average of \$15,000 in debt. In 2012, the average debt was \$30,000, for a total of over one trillion dollars in total debt.² By 2021, the average debt is \$39,351 and over \$1.56 trillion in total debt.¹

“Debt burdens exceeding \$150,000 (which is lower than the aforementioned average debt) was directly associated with burnout among Oncology trainees (OR 2.14)”

For physicians, the numbers are more dramatic. Of all U.S. medical school graduates, 73% have student loan debt. The average debt is an astounding \$241,000.¹ While

the percentage of indebted students has decreased since 2012 from 86% to 73%, the average total dollar amount of debt per indebted physician continues to climb. Furthermore, this rate has and continues to accelerate faster than inflation (2.3% versus 1.7%).³

Currently, there are bills proposed looking to improve federal repayment plans, enhance existing federal loan forgiveness programs, cancel up to \$50,000 in debt per borrower which is the Student Loan Debt Relief Act of 2019, and fully privatize the student loan industry.

Review of the Literature

PubMed and SCOPUS search engines utilizing the phrase “physician well-being” from the year 2000 through June 2021 produced greater than 250,000 results. We then added the filter of debt and finance to the search, and filtered for clinical trials, meta-analysis, and systematic reviews. We did not find any interventional studies directed at lowering student loan debt and its effect on physician well-being.

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ICE CREAM AND YOGA WON'T DO—WE NEED STRUCTURAL CHANGE TO ADDRESS HEALTHCARE PROVIDER BURNOUT

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Have you been offered a “free” wellness workshop at your hospital or clinic?

Our guess is that you have. While the meditation session may have given you a brief respite and maybe the food even tasted good, neither did a thing for the pile of patient messages, prior authorizations, and forms waiting for you back at your desk. Nor did these interventions give you more time with your patients, offer your patients better access to medications or mental health resources, or hand you the N95 mask that you so desperately needed last year. And they certainly didn't reduce the burnout that you and your colleagues experienced pre-COVID, during COVID, and—dare we say it—that will continue to endure post-COVID.

Neither wellness initiatives nor burnout among healthcare providers are

new, but this past year feels different as well-intentioned initiatives were utterly eclipsed by the depth of the issues faced by healthcare professionals who witnessed the horror of their patients dying alone in a landscape beset by uncontrolled contagion. Working in health care has always entailed personal risks, but 2020-21 was a mortal outlier as more than 3,600 healthcare workers, dutifully going to work bedecked with a tenuous-to-nonexistent supply of adequate personal protective equipment (PPE), succumbed to COVID-19.¹

The healthcare system's response to these tragedies has been a relentless spate of resilience workshops, mental health resources, and meditation sessions to enhance our so-called *wellness*. The problem with trying to throw wellness initiatives at an existential threat such as COVID-19 is that these small gestures fundamentally miss the mark. By a lot. Healthcare professionals are

already some of the most resilient people—a study of physicians showed that while they have above average resilience, they still suffer from burnout.² This high level of resilience is no doubt also true of nurses, medical assistants, and all healthcare professionals who continue to care for patients in times of crisis. The marginal benefit, then, of squeezing more resilience out of a population with baseline high resiliency is likely to be small. And yet, the greater the distress, the more inexorably wellness program invitations fill our e-mail inboxes,

as if obstinately yoked to burnout by the misconception that distress is due to the individual failings of healthcare professionals. In a truly bizarre mismatch of need and intervention, we were even offered ice cream during the 2020 fall surge in COVID cases and hospitalizations. Those

“free” wellness sessions? They aren't really free—no one is taking your hospital shift or seeing your clinic patients so that you can attend.

So, is increasing resiliency wrong? Well, it never hurts to become more resilient. There's nothing wrong with mindfulness, building compassion, expressing gratitude, supporting one another, and furthering one's personal resiliency. Institutional efforts to increase resiliency or express gratitude may indeed be helpful and we applaud our colleagues who work in these domains.³ But that cannot be our only set of strategies. Interventions that rely on building individual resilience reflect a misunderstanding of the problem, rather than what we so desperately need: structural and organizational change to prevent the normalization of the work environments that cause burnout in the first place.

“We cannot keep throwing wellness initiatives up as the solution to the pervasive epidemic of healthcare provider burnout—the COVID-19 pandemic has shown us that we need major structural change in the way we work and care for one another.”

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What else, then, should be done?

First, consider why healthcare professionals are burnt out both now and before we ever heard of COVID-19. Studies have shown that the anxieties faced by healthcare workers in the COVID-19 era include uncertainty in being heard by leadership, access to equipment, training if deployed to other clinical areas, support for personal and family needs, and care if they are themselves infected.^{4,5} These are in addition to the longstanding causes of stress (pre-COVID) for healthcare workers which include extensive hours spent on electronic health record data entry (usually done “after hours”), lack of autonomy, emotional exhaustion, and difficulty maintaining a work-life balance.

Second, we must take these factors into account when implementing a structural response. We need approaches that treat the causes, rather than the symptoms, of burnout. Rather than calling healthcare workers heroes, we should acknowledge that the need for heroism is a structural failure in our healthcare systems. For physicians, interventions to improve the workplace environment should be founded on the underlying principles of returning physicians to patient care, building autonomy, reducing uncompensated work, and reclaiming work-life balance. To achieve these goals, health system leaders can direct efforts and funds towards building team-based care, allowing for flexibility in scheduling, and decreasing the administrative burdens currently falling onto physicians. The relatively new position of Chief Wellness Officer (CWO) should be empowered to make structural changes.⁶ For example, when front-line healthcare workers required protection from loss of paid time off in order to appropriately quarantine, the CWO should work with human resources to craft emergency policies that incentivize doing the right thing. Similarly, instead of adding a wellness session that healthcare workers are too busy, stressed,

or tired to attend, the CWO should advocate for adequate rest and time to participate.

When making decisions that affect patient care and the well-being of front-line healthcare workers, leadership should solicit input from those very workers whose own lives are affected and who see first-hand what patients need. If anything, the COVID-19 pandemic may have exposed just how disenfranchised rank-and-file front-line workers are from healthcare decisions in the first place—much has been written about crisis leadership and messaging, with relatively little attention paid to how to optimally involve those in the trenches.

Now that vaccinations, despite suboptimal uptake, have at least offered in some locations the potential for an end to the first phase of this pandemic, it may be tempting to just try to go back to the way things were. While we agree that even a return to pre-COVID norms is a victory after the devastation wrought by the pandemic, complacency now is a danger to ourselves and to our patients. As healthcare professionals, we are trapped by heroism, ensnared by martyrdom. Within these mythic confines, it appears unseemly for healthcare workers to advocate for better working conditions for themselves. But we urge you to reconsider—it is long past time that an actual reckoning took place in health care.

We need leadership that can rise to the unprecedented nature of these times. We need to meet crises with compassion and keep our morals and values straight. We need to not pretend that the dangerous combination of wellness and heroism is the solution to a broken healthcare system that requires structural change. This will require a careful examination of healthcare costs and financing in order to appropriately reallocate resources. So, no—free ice cream and a yoga mat won’t cut it. We cannot meditate our way out of this mess. We don’t want to be heroes—we want to practice with grace, energy,

and humanity. We can’t do it with the system we have.

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THE SLEEPWALKERS: ANOTHER WAKE-UP CALL FOR MEDICAL RESIDENCY

Gaetan Sgro, MD

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My earliest memory is of watching a cowboy movie on an old Zenith television and being ushered upstairs by my Granny with the promise of a new brother by morning. I know that I was exactly two years, two hundred and ninety-five days old because Granny was right.

I remember the old barn decked with dented pots and pans we'd pass on the way to my first swimming lessons. I remember the way my pencils would rest in the bowl of my grade school desk. I remember the names of every homeroom teacher, every pool manager, and teammates I haven't seen in decades. When my dad asked recently, "What was the restaurant where Cousin' Dan dropped the whole pizza on the floor?" I answered, "The Tomato Patch," without hesitation.

One period I do not remember is my medical residency. That three-year span at the end of my twenties is a haze—I recall only the outlines of rotations, snapshots of "on call" rooms and nursing stations. Memories that should be vivid in my mind—my favorite clinic patients; getting engaged; getting married; Granny's final days—have faded prematurely.

With a decade into life as an academic hospitalist and parent of two young daughters, my memory has made an improbable recovery. So, what happened during residency? In three words: I didn't sleep.

Having trained during what many of my predecessors view as the relaxed, post-"duty hour" restrictions era, I was supposed to have benefitted from reforms that currently include: scheduled clinical and educational work limited to 80 hours per week; a cap of 28 hours on each extended, "in-house call" shift; and a minimum of 8 hours off between shifts, collectively intended to improve residents' quality of life and to prevent drowsy doctors from making mistakes.

In its 2020 version of Common Program Requirements,¹ the Accreditation Council for Graduate Medical Education (ACGME) notes that, "Residents have a responsibility to return to work rested...[and] are encouraged to prioritize sleep over other discretionary activities." To put this in perspective, a resident given 8

hours off between shifts who prioritizes the 7 hours of sleep per night recommended by the CDC is left with 1 hour to accomplish the following discretionary activities: commute home; prepare dinner; eat; exercise; maintain relationships; care for children or other family members; shower; eat breakfast; commute to work; breathe.

Medical training is physically demanding by design—specifically, the designs of one cocaine-fueled surgeon practicing at the turn of the 20th century, when doctors believed in dousing head lice with gasoline and pacifying teething babies with opiates and, notwithstanding the introduction of measurable competencies and heightened expectations for scholarly productivity, success in residency is still measured foremost in terms of survival. This exceptionally low bar makes it easy to dismiss calls for humane working conditions as mere bellyaching from an entitled generation.

The harmful effects² of acute sleep deprivation are serious and wide-ranging: worsened glycemic control, impaired immunity, weight gain, depressed mood, and increased alcohol use. Chronic sleep deprivation significantly increases one's risk of developing both coronary artery disease and dementia.

Perhaps most unsettling is the link between sleep disturbance and an increased risk³ for suicidal behaviors, given that women residents are twice as likely as age-matched peers to die by suicide.

I tend not to reflect on difficult experiences, and in my earlier years as a clinician educator I viewed the deprivations of residency as integral to the training process. But the gaps in my memory have exposed the absurdity of that rationalization. A mountain of evidence confirms that memory fails without sleep, with one study⁴ going so far as to demonstrate atrophy of the brain's memory center among people with chronic sleep-deprivation. One can only hope the hippocampus grows back.

Redesigning a system and changing a culture that have for more than a century taken for granted the superhuman contributions of young doctors is daunting. In terms of financing, residency programs don't control their

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UNBURDENING THE THINGS THEY CARRY

Jennifer Caputo-Seidler, MD

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It could have happened. You could have done well, weaned off your oxygen, and returned home to the family whose love for you echoes through the phone. But you didn't survive. You got so sick so fast, and within 24 hours of our meeting, you were gone.

"We don't believe it's her time," your family told me. An hour later, your heart stopped, and as my team worked to revive you, I told your kids you weren't going to make it.

"Let her go," your daughter managed to say. My heart raced with your daughter's cries in my ear as your heart beat no more.

As I finished sharing this story, the five people on the screen reflected back at me, eyes filled with tears. Then, one by one, each of them started to give me feedback on the story I'd written, what had resonated with their own experience or touched them even if the situation was foreign to them. They commented on specific word choices, narrative structure, and the emotion the story provoked.

This is the Things They Carry Project, "free writing workshops to help healthcare workers and first responders process traumatic memories and make sense of their experiences."¹ The project was founded by Kerry Malawista, Ph.D., a psychoanalyst who discovered writing as a means of healing amid her own grief after the death of her 18-year-old daughter. Healthcare workers can sign up for a series of three 90-minute workshops that take place on Zoom—the groups are led by a writer and a trained psychotherapist. During each session, participants have time to write about their experiences over the past year and then share those writings with the group.

Through writing and sharing stories from the frontlines of the COVID-19 pandemic, the project hopes to help healthcare workers begin to process and heal from this trauma. "For our writing to be a healing experience, we honor our pain, loss, and grief."² How we write about traumatic experiences determines the healing power of the act of writing. When done well, writing mimics the work of mourning and can be a transformative experience.

A healing narrative tells precisely what happened and does so with a richness of detail.² While many frontline healthcare workers may describe the COVID-19 pandemic as the worst experience of their careers, it is in the specifics that the writing becomes therapeutic. Examples shared in the workshop include the last words a patient said before being intubated and crying in the car on the drive home after an ICU shift while on the phone with a sibling.

A healing narrative connects feelings to events and notes how feelings in the moment may differ from emotions later when reflecting on the event and writing about it.² A common theme in the workshop is that participants did not have time to feel anything in the moment. For many, it was all they could do to move from crisis to crisis. As a dedicated space to reflect on the experience of the pandemic, Things They Carry is the first opportunity for many to feel at all.

Finally, a healing narrative goes beyond telling the story to reveal insights gained from the lived experience.² Through the sharing of stories with other healthcare workers, a community is being created within this project. The expertise of the writers and therapists guide participants to explore their stories more deeply and from different lenses. This process of reflection is where healing begins.

For those interested in joining this community and engaging in the work of writing to heal, workshops are ongoing, and the schedule can be found on the project's website www.thingstheycarryproject.org.

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meeting begins with the process monitor reviewing and reaffirming the commitment of all team members to abide by the team’s consultation agreements, which are a set of shared assumptions built from DBT principles (see table).⁵ By their nature, assumptions cannot be proven, and yet each team member agrees to operate as if they are true when joining the consultation group, thus reducing the team’s distraction and struggle to get to certainty. Following consultation agreement review, the facilitator triages cases for discussion based on a patient/clinician needs hierarchy, with 1-3 cases discussed at each meeting. During the case consultations, team members consider both the needs of clinician and patient when providing validation, sharing perspectives, and suggesting resources. The process monitor reviews the group processes at the end of each meeting, flagging the team if an agreement is not observed during the session.

We present the following three early lessons from implementation:

Lesson 1: Transforming a traditional medical team to a DBT-informed care team requires a shift in the group’s assumptions, focus, approach to care, and group processes.⁵ A core assumption of DBT is that team members and relationships between team members and patients need support. Thus, the focus of the group’s work shifts from patients alone to patients, team members and team culture. The dialectic of acceptance and change is emphasized in the approach to both the care of patients as well as the work of team members. Team members work together not only to share information and coordinate patient care, but also to intentionally reflect on group process, with openness to mistakes and shared vulnerability. Our team observed that the shift toward a DBT approach takes time and practice, with

Complex Care Rounds Consultation Agreements⁵

Consultation Agreement	Description
1. Both/and stance	We agree to accept a “both/and” perspective when approaching patients, one another, and complex needs. When caught between conflicting opinions, we agree to look for the truth in both positions and to search for synthesis by asking questions such as “What is being left out?”
2. Making every moment count	We agree that the primary goal of this team is to improve our own skills. We agree not to treat patients or each other as fragile.
3. Let’s get real	We agree that consistency among team members toward a patient or one another is NOT expected. We will honor and seek diversity in our approaches.
4. Know thyself	We agree that all team members are to observe their own personal and professional limits without fear of judgment. We take responsibility for observing and communicating our own limits and agree not to judge limits different from our own. Ask ourselves “What do I need in order to continue to do my work well?”
5. WTF? What’s the function?	We agree to search for empathetic, non-pejorative behaviorally specific language to describe patients/our own behavior. We agree to assume our teammates and our patients are trying their best and want to improve.
6. To err is human	We agree that all team members are to observe their own personal and professional limits without fear of judgment. We take responsibility for observing and communicating our own limits. Ask ourselves, “What do I need in order to continue to do my work well?” We agree not to judge limits different from our own.

more rapid assimilation of newer members when these members are integrated into an established team.

Lesson 2: Shared consultation agreements (or shared assumptions) are foundational to guiding consultation team discussions and team culture. These agreements aim to foster an inclusive team culture with a “both/and” perspective, promote behaviorally specific language, encourage team members to observe personal and professional limits, and acknowledge that mistakes are universal (see table). We noticed that over time the agreements became a shared language among team members and are frequently referenced to remind ourselves and each other

to search for synthesis among differing perspectives and to promote team communication.

Lesson 3: Embedding structural elements that promote a DBT approach can help operationalize the cultural transition to a DBT-informed care team. We developed a patient/clinician needs hierarchy, with an accompanying 4-point scale, to prompt team members presenting cases to rank both the patient’s need level (1 = needs interfering with health and/or life; 4 = resource needs that could improve valued living) and one’s own personal level of need/distress (1 = high level of distress impacting care provided; 4 = team member perspectives would add value). Cases are

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prioritized for discussion based on a mean of the patient and clinician need levels. The needs hierarchy helped introduce and invite new members to communicate their own needs and provided a consistent approach to prioritizing case discussions.

In summary, DBT principles provided a compelling roadmap and model for integrating clinician well-being within the structure of our healthcare team. If you are interested in incorporating DBT principles into your personal and team practice, consider the following suggestions for next steps you can take to get started: 1) Highlight both clinician's and patient's needs during case discussions by introducing the case hierarchy of patient/clinician

needs or encouraging team members to regularly share how a case has affected their well-being; and 2) Model use of consultation agreements when discussing patient care as a team by using behaviorally specific language when describing the actions of patients and acknowledging that all team members, including ourselves, make mistakes.

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FROM THE SOCIETY (continued from page 4)

What else is SGIM doing to address problems that contribute to physician burnout?

SGIM encourages members to support the efforts of the ACP and SGIM to address fundamental problems that contribute to physician burnout. One of the most important problems is inadequate investment of the health system in the essential care given by general internists. SGIM's Health Policy Committee will continue to advocate forcefully for physician payment reform that recognizes the value of cognitive care.³ In December 2020, SGIM joined the ACP and other primary care organizations in issuing a unified statement calling for fundamental change in the financing of primary care.⁴ SGIM and ACP also were sponsors of the report from the National Academy of Sciences, Engineering, and Medicine on implementing high quality primary care.⁵ SGIM is collaborating with the ACP and other organizations to advocate for action on those recommendations.

When SGIM's Council reviewed the plans of SGIM's committees and commissions for the coming year, a recurring theme was a strong desire to address challenges related to use of telemedicine in GIM practice. General internists are feeling the brunt of stresses from the huge increase in use of telemedicine, further aggravated by problems with EHR systems. Council has asked the Clinical Practice Committee to collaborate with the Health Policy Committee, Education Committee, Health Equity Commission, and Geriatrics Commission on helping members adapt to the new role of telemedicine. In addition, ACLGIM will focus on what needs to be done to transform EHR systems to better support the care that general internists aspire to give their patients. Such efforts are critical to improving professional fulfillment and the well-being of our patients.

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Using the above search parameters, only three articles were identified:

- Effect of medical student debt on mental health, academic performance and specialty choice: a systematic review
- Determinants of an urban origin student choosing rural practice: a scoping review
- Effectiveness of financial incentives in exchange for rural and underserved area return-of-service commitments: systematic review of the literature

The topics of the second and third are out of scope for this discussion. The first review, however, published in 2019 in *BMJ Open*, identified 678 potential articles, of which 52 met inclusion criteria. The results showed that medical student debt levels were negatively associated with mental well-being and academic outcomes. Additionally, high debt likely drives people to higher paying subspecialties. Interestingly, students from urban backgrounds were more likely to report the influence of debt on specialty choice compared to students from rural backgrounds. This, despite rural students often carrying higher debt loads compared to their urban peers. One important limitation of this systematic review was the noted paucity of prospective trials compared to cross-sectional studies. This has particular importance as debt and debt burden changes over time.⁴

Since 2019, Ahmed, et al., found that debt burdens exceeding \$150,000 (lower than the aforementioned average debt) was directly associated with burnout among Oncology trainees (Odds Ratio 2.14).⁵ Additional data is emerging with similar findings linking educational debt and burnout across multiple specialties.

Knowledge Gaps

Based on the above, we were able to identify knowledge gaps that would

serve as areas of interest for research, policy change, and/or education moving forward:

1. What can professional societies, like SGIM, do to promote visibility around the issue of the costs of medical education or the burdens of debt repayment and its potential effects on subspecialty choice?
2. How can undergraduate and graduate medical education programs prepare trainees to face these mounting financial stressors upon graduation?
3. Comparative effectiveness educational trials evaluating best practices to address knowledge gaps and their effect on physician well-being and patient outcomes are needed.
4. Prospective cohort studies evaluating changes in debt level over time and its association with well-being and academic output are needed.
5. Funding opportunities to support targeted intervention to lower student debt to less than \$150,000 and evaluate its effect on standardized wellness evaluations are needed.
6. Trials evaluating the effectiveness of lowering student loan debt as a recruitment strategy to GIM and other lower paying subspecialties and as a targeted intervention to reduce burnout are needed.

Conclusion

There is an urgent need to address snowballing medical education debt, specifically as a driver of burnout and well-being. Our suggested approaches include: (1) research to better define these relationships and evaluate prospective interventions effect; (2) policy enhancement strategies to address both the cost of education and improve access or eligibility for public service loan repayment programs; (3) physician education to address known gaps in financial literacy, with the aim of

empowering physicians and aiding them in combatting the stress of debt; and (4) normalizing discussion around finance and its effect on physician well-being. Focusing on these approaches would enhance basic financial understanding and education, while also building opportunities to stop the snowball from growing out of control. Finally, the authors would encourage anyone interested in learning more to reach out directly for a list of resources or further discussion.

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own budgets or the allocation of residency positions. Most programs can't afford to shorten resident hours without offsets through hospital or government spending.

Convincing older doctors to embrace an assumption denied to them—that residents deserve to sleep as well as the rest of us—may be even more challenging, in part, because outcomes of the ACGME reforms have been disappointing.

The rigorously designed iCOMPARE trial,⁵ comparing residents' sleep patterns between programs with and without extended overnight shifts, failed to show a meaningful difference in average daily sleep over a 14-day period. And despite clear evidence that sleep deprivation causes significant impairment in both diagnostic and procedural skills—insights that will come as no surprise to college students, multi-shift workers, or new parents—studies have also failed to show reductions in medical errors as a result of duty hour reforms.

Since publication in the *New England Journal of Medicine*, the iCOMPARE data have stood as an argument against future limits, an argument that ignores the study's most overlooked finding; namely, that none of the residents in the trial

slept adequately. Whether working extended overnight shifts or shifts capped at 16 hours, residents reported at least 1 period of excessive sleepiness on more than half of their days; sleep duration of less than 7 hours on half of their days; and sleep duration of less than 6 hours on a quarter of their days.

In other words, simply eliminating our most physically punishing shifts was not enough to allow residents the minimum sleep their bodies need. Reforms to date remain inadequate. After more than a century of sleepwalking, it's long past time for us to wake.

I wish to acknowledge Jennifer Corbelli, MD, for her thoughtful review of this manuscript.

(The views and opinions expressed in this article do not necessarily reflect the official policy or position of the Department of Veterans Affairs or any agency of the U.S. government.)

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Within SGIM, members may have found solace in community with like-minded individuals in one of the approximately 60 interest groups at our 2021 SGIM Annual Meeting. This may be an ideal time to reach out and check in on someone and, more importantly, let them know you are there and it is okay to take a needed break.

Members may be sustained at the regional level or find that their support networks are more local. To highlight two of our regional locations, those calling Emory University their professional home have the largest cohort of SGIM members in the Southern Region. Emory-based SGIM members can seek out or encourage friends, trainees, and colleagues to seek support from institutional resources, such as those found on the *Emory + YOU: Your Wellness*.³ The site offers employees online mental health screening tools, counseling resources, and financial wellness programming. In the Mountain West Region, where the largest cohort of our members can be found affiliated with the University of Colorado, UCHealth set up a crisis support hotline for staff and providers.⁴ I hope highlighting these two specific resources will inspire us to remind our friends of these resources at local institutions. Employee assistance programs are only one avenue of support for our members, staff, and trainees. More work is needed at all our institutions to ensure that these programs and their staff represent and provide services that are culturally appropriate and sensitive to the diverse needs of those seeking assistance.

For our members who do not feel comfortable seeking sources of help at their place of employment or if there is an ongoing clinical need, we *must* strive to dispel the stigma related to seeking mental health services. Our collective energy should be focused on the continued

advocacy needed at the state medical board level to further evaluate the necessity of probing questions regarding mental health on state licensing applications, and if they are there to ensure there is a differentiation between current illness and impairment.⁵

As we encourage the use of mental health services, we must also be aware of their potential financial and emotional cost. The Health Policy Committee has long advocated for improving access to integrated behavioral and physical care options as well as ensuring effective implementation of mental health parity. This work over the decades has ensured that most of us we can access mental health services as part of our employer/practice-based health insurance plans. Insurance parity is only one part of access. Many find it difficult to find a mental health professional who takes insurance. The Clinical Practice Committee and our Veteran Affairs partners have long advocated for (and many our members have been successful in implementing) behavioral health services embedded within primary care. More work is needed to fully integrate behavioral health into all sites of primary care. There is also a growing recognition that immediate access to mental health services on inpatient wards for patients is needed, as complementary support of the physical and emotional care provided by our academic hospitalists.

“Put on your oxygen mask first before helping others...” The historical relevance of this statement has changed over the past several decades. It started as a statement of fact. This is how to address an extreme airplane emergency when you have seconds to act and taking care of oneself first will allow you to better assist someone else. I remember this statement being useful for mothers, many of whom worked outside the home. It was seen as a

reminder to care for oneself in order to be a better mother. Healthcare professionals are now facing an urgent burnout and mental health crisis. On behalf of all of us, I call for fundamental systematic structural changes similar to those noted in the CEO's Q&A that are needed in our workplaces to prevent harm—including aggressive attention to overwork, impossible electronic medical record burdens, lack of ancillary support—and allow meaningful protected time for self-care and access to mental health services.

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establishment of confidential support phone lines by community physicians and resources in support of clinician emotional as well as physical well-being. Within and beyond our medical communities, avalanches of advocacy and social justice movements have fuelled calls for change on some of the most pressing issues of our contemporary times. In these cases, distress is channelled into collective strategic and motivated change.

However, there are other cases when sometimes being productive means doing nothing. After the seemingly endless drive to be prepared for and enact plans to respond to worst case scenarios and individual tragedies with their widespread ripple effects, there is subsequently a need for pause. Yes, this partially means always holding space for oneself and for others, whether peers and professionals, patients, or even strangers.¹ But, I would suggest that this also means making mental space to refresh and come back to problems with renewed energy and

insight. One way to accomplish this is via the “art of doing nothing.”² In the Dutch language, *niksen* is a verb that translates into “to do nothing.” In short, by doing nothing, you are actually doing something: you release your mind and attention to freely wander, which can be emotionally and mentally liberating. This could mean listening to music, reading a book, or simply daydreaming—as long as it has no specific purpose to the activity. Doing nothing can permit creativity and innovation to flourish, untethered by the traditional reins that might keep driving us towards production and professional achievement.

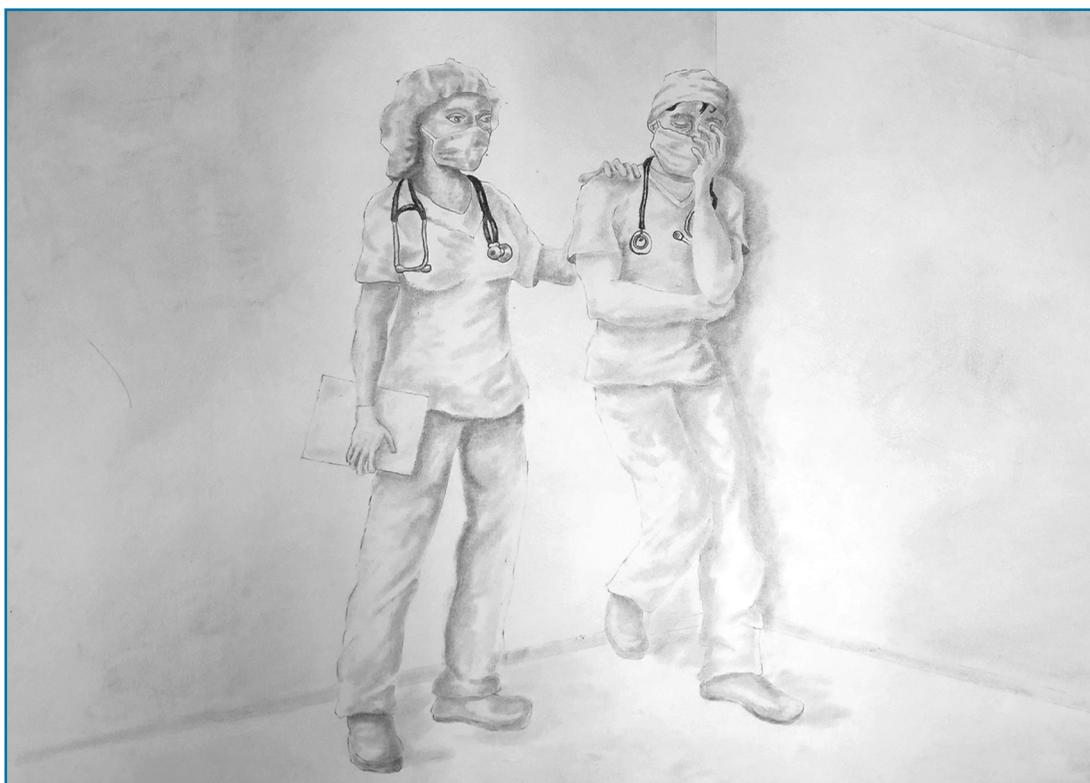
After setting aside work responsibilities as I began my summer break, my mind wandered to a nostalgic and joyful memory that I shared with a loved one. The shared memory keenly reminded me of why I enjoy serving *SGIM Forum* on this one-year anniversary. May your reading of this theme issue’s featured articles bring you closer to the

recognition that “doing nothing” actually helps you to do something for yourself and then, in turn, for others in your various roles. Only when we unburden our minds and hearts of the cumulative responsibilities that we carry, can we untether and free our minds for the compassion, love, and acceptance of our present and our future.

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Doctor with Resident. Original art by Daryl Wofford with input from his physician brother and SGIM member, Mark Linzer, MD



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