Key Takeaways

Building Faculty and Resident Resilience

What is burnout?

- Burnout is prolonged, work-related stress resulting in loss of physical, emotional, and mental energy. This leads to detachment and loss of satisfaction or a sense of accomplishment.

How do we measure burnout?

- The Maslach Burnout Inventory (MBI) is the most recognized instrument to assess features of burnout such as exhaustion, cynicism, and inefficacy.[1]
- Of 7,288 physicians surveyed with the MBI in 2012, 45.8% reported at least one symptom of burnout. Among physicians at the front lines (family medicine, general internal medicine, and emergency medicine), that rate went to 60%.[2]

Why should we be concerned about burnout?

- Adverse effects on quality of care, safety, institutional costs for turnover, professionalism.

References:

1. Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). The Maslach Burnout Inventory (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.

2. Shanafelt, T.D., Boone S., et al. *Burnout and satisfaction with work-life balance among US physicians relative to the general* population. Archives of Internal Medicine, 2012 Oct 8; 172(18)1377-85.

Key Takeaways

Building Faculty and Resident Resilience

What is resilience?

- "Resilience is the capacity to respond to stress in a healthy way such that goals are achieved at minimal psychological and physical cost; resilient individuals "bounce back" after challenges while also growing stronger."[3]

What does building resilience look like?

Intention
Skills (e.g. mindfulness, self-efficacy, self-compassion)
Community
Institutional Support
+
= Resilience

Burnout	Resilience
Withdrawn	Present
Emotionally exhausted	Energized
Defeated	Bouncing back
Going through the motions	Fully engaged
Brittle, rigid	Bending, not breaking
Cynical, hopeless	Capacity for positivity
Hypercritical	A light touch
Feeling ineffective	Becoming stronger
Treading water	Moving forward
Dreading change	Welcoming change

Download our statement on the learning environment & resource collection on wellness here: **www.aamc.org/wellnesscollection**

References:

3. Epstein, R. and Krasner, M.S. *Physician Resilience: What it Means, Why it Matters, and how to Promote It.* Academic Medicine, 2013 March; 88(3)301-303.

Spotlight
The Future of Education Across the Continuum

This plenary introduced CFAS participants to several important transformations impacting the medical education continuum:

- The integration of basic science education across all 4 years of medical school
- The 4th year of medical school: evaluating its efficacy, and the impact of a pilot to hybridize the 4th year of medical school and the 1st year of residency
- Competency-based education and Essential Professional Activities (EPAs) for entering residency: shifting from fixed time:variable outcome to variable time:fixed outcome.
- Extending the length of residency training: the impact of a post-fellowship year to improve readiness for practice among surgical trainees

Council of Faculty and Academic Societies

AAMC

Other Plenaries

The Economics of Academic Medicine

- Participants learned about the key funding sources and their current challenges to the missions of academic medicine from the perspectives of an NIH official, a former dean/current foundation president, a former dean/current insurance executive, and a current dean.
- Discussion centered around the role of faculty in advancing and preserving key funding streams by advocating for GME and NIH.

Career Development and the Faculty Lifecycle

- Participants considered faculty career development issues from the perspectives of a physician scientist, an expert on mentorship, a physician educator, and a research dean.
- Discussion centered on how to ease transition points.

Council of Faculty and Academic Societies

AAMC

Spotlight: Tips on getting involved with faculty governance

1. Opt for committees that are relevant to your career track. For instance, if you want to work in GME administration, start with the curriculum committee.
2. Be sure to gauge the value of participation against the costs to your limited supply of energy, time, and effort.
3. Benefits of participation include building your network and understanding the perspectives of faculty from different disciplines.
4. Faculty governance bodies are also a safe place to practice skills of influence, persuasion, collaboration, and leadership.
5. Some things to be ready for: the process of shared governance is slow; lots of meetings; your potential for impact is unclear.
6. Above all, take it seriously, keep your commitments, and try to improve the system in ways that will advance the school and make faculty lives, including yours, better.
7. Over time, you can advance onto more influential committees—such as merits and promotions or budget and planning—by building a campus reputation as a very effective contributor.

These tips are courtesy of the concurrent session speakers for *The Structure and Role of Faculty Governance*:

- Gabriela K. Popescu, Ph.D., Professor of Biochemistry, Anesthesiology and Neuroscience, Member, Faculty Senate Executive Committee, University of Buffalo State University of New York School of Medicine & Biomedical Sciences
- Vivian Reznik, M.D., M.P.H., Assistant Vice Chancellor for Faculty Affairs, Professor of Pediatrics and Family & Preventive Medicine, University of California, San Diego School of Medicine
- Roberta E. Sonnino, M.D., FACS, FAAP, Vice Dean for Faculty Affairs and Professional Development, Associate Provost for Medical Affairs, Wayne State University School of Medicine

State of the Physician Workforce

The AAMC commissioned a new report on the state of the physician workforce from the economic modeling and forecasting firm IHS Inc: *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025*. Its contents were discussed during the meeting's Leadership Lunch.

Key Findings:

- Demand for physicians continues to grow faster than supply.
- Total physician demand is projected to grow by up to 17%, with population aging/growth accounting for the majority.
- By 2025, demand for physicians will exceed supply by a range of 46,000 to 90,000.
- Total shortages in 2025 vary by specialty grouping and include:
  A shortfall of between 12,500 and 31,100 primary care physicians.
  A shortfall of between 28,200 and 63,700 non-primary care physicians, including:
  5,100 to 12,300 medical specialists; 23,100 to 31,600 surgical specialists; 2,400 to 20,200 other specialists.

The physician shortage will persist under every likely scenario, including increased use of advanced practice nurses; greater use of alternate settings such as retail clinics; delayed physician retirement; rapid changes in payment and delivery (e.g., ACOs, bundled payments); and other modeled scenarios.

Addressing the shortage will require a multi-pronged approach, including innovation in delivery; greater use of technology; improved, efficient use of all health professionals on the care team; and an increase in federal support for residency training. The study's results confirm that no single solution will be sufficient on its own to resolve physician shortages.

Download the full report:
www.aamc.org/ihsreport