ORIGINAL RESEARCH ARTICLE

Physicians' Views on a Wellbeing Course Gifted to Them: A Qualitative Study

Patricia Lynn Dobkin; Camila Velez

Perm J 2020;24:19.228

E-pub: 11/20/2020

https://doi.org/10.7812/TPP/19.228

ABSTRACT

Introduction: Given concerns about staff burnout and distress, the Chief of the Department of Medicine sponsored the Physician Wellbeing program making it cost-free for doctors at a large academic medical setting. Ninety doctors registered within the 1-year pilot project time frame. Following a Mind-Body Medicine online and Mindful Medical Practice workshop a qualitative study was conducted to identify physicians' views about the initiative. Physicians who agreed to take part following the workshops were the participants in the study.

Methods: Focus groups and individual interviews were conducted following 4 workshops. Participants (N = 15) were queried about helpful and unhelpful aspects of the program. Thematic framework analysis was employed for data analysis.

Results: Four themes regarding participants' views on the well-being course were identified. These were: 1) online curriculum (from engaging to disengaging); 2) intimate sharing amongst physicians in the workshop; 3) reflecting on and practicing wellness; and 4) a valuable "gift" from the Department of Medicine. Workshops were highly valued as they provided an opportunity to practice what was learned online as well as engage in fruitful exchanges amongst colleagues.

Conclusions: Physicians supported the integration of wellness programs into medical settings where stress is an inherent aspect of the work environment. They were grateful for the "gift" of being valued and supported by the administration.

INTRODUCTION

Health care systems are constantly undergoing rapid changes to better serve and care for an aging population while simultaneously seeking to reduce costs and introduce technological advances to streamline processes.[1] These changes may lead to unintended negative consequences, especially if the ailing aspects of health care systems are not recognized, addressed, and transformed. First, no matter whether the health care system is universal, provided by health maintenance organizations or veterans' administrations, costs are skyrocketing. Second, people are living longer with chronic conditions. More palliative care, whether it is provided in hospital, residences, or via hospice in patients' homes, is essential. Third, health care systems are changing at a pace that may be detrimental to health care providers and their patients. Change is inherently stressful and can result in suboptimal patient care (eg, medication errors).

Facing these changes and challenges are physicians and allied health care professionals (HCPs) (eg, nurses and social workers) who are essential for the optimal functioning of health care systems. In 2017, the Canadian Medical Association (CMA) conducted the CMA National Physician Health Survey to assess the state of physician health in Canada. Of the 2547 physicians and 400 residents who responded, 30% reported burnout, 34% met criteria for depression, and 8% experienced suicidal ideation in the past year.[2] Moreover, West found that for house staff (USA), up to half of physicians, a third of nurses and as many as two-thirds of other HCPs were experiencing symptoms of burnout.[3]

It is well documented that an increase in distress and decline in empathy begins in medical school and worsens dramatically during residency.[4,5] This is a clear call for action because unwell providers commit more medical errors, their patients are dissatisfied, and the likelihood for litigation is higher.[6,7] Furthermore, burnout is associated with job dissatisfaction, reduction in work effort, and attrition from medical practice.[8] Importantly, burnout compromises the well-being of the physician and is associated with a host of negative outcomes including substance abuse/dependence, suicidal ideation, and decreased quality of life.[9,10]

As stated by the CMA's Policy on Physician Health, physician well-being is critical to "the long-term sustainability of the physician workforce and health systems."[11] Addressing and fostering physicians' well-being and resilience is a shared responsibility of individual physicians and the health care systems and institutions in which they work.

West and colleagues conducted a systematic review and meta-analysis of interventions aimed at prevention or treatment of physician burnout.[12] "Bottom up" strategies (ie, focus on the individual) included mindfulness-based programs, stress management training, and small group curricula. "Top down" (ie, organizational changes) included duty hour limitation and modifications in clinical processes. Randomized clinical trials and cohort study results concurred in that two components of burnout were reduced: emotional exhaustion and depersonalization for both approaches. The authors stated, "Although the magnitude of the reductions in burnout domain scores appears modest, evidence has linked 1-point changes in burnout scores with

Key words: qualitative research, physicians' well-being, mindfulness

meaningful differences in important adverse outcomes." Notably, a few adverse events were cited when duty hours were reduced (eg, residents' satisfaction with training decreased). Yet, only 3 randomized trials examined system changes.

Another way to view "top down" is focus on leadership in an organization. Shanafelt and colleagues studied the relationship between physician supervisors' leadership qualities with burnout and work-related satisfaction for 2183 doctors.[13] For each 1-point, increase in a composite leadership score was associated with a 3.3% decrease in the likelihood of burnout ($p < 0.001$) and a 9.0% increase in the likelihood of satisfaction ($p < 0.001$) of the physicians supervised.

When the Chief of the Department of Medicine at the McGill University Heath Center (MUHC) agreed to sponsor the University of Arizona Physician Wellbeing course (ie, pay licensing fees) for all medical doctors in the department, including "cost-free" CME credits, it was with the agreement that 3-hour workshops would complement the online self-study methodology. The online work preceded the workshop—providing the opportunity to learn about mind-body medicine first and practice one of three exercises (eg, journaling) for 2 weeks (as prescribed in 1 of the modules). Given the pilot project nature of the endeavor, a qualitative study was conducted to learn about participants' views of the course. The fact that the project was approved and funded within a large medical center reflects the "top-down" aspect of the project.

METHODS

The McGill University Faculty of Medicine IRB approval was secured prior to the focus groups and individual interviews. Participants signed an informed consent form. To ensure that participants felt "safe" to take the PWB program (given that their email addresses include their names), no data were collected on demographics, other than specialty (eg, internal medicine, gastroenterology, palliative medicine). CME approval and certificates for 4.5 Section 1 and 3 Section 3 credits were secured prior to beginning the course.

Recruitment

An introduction video (made by PLD) was posted online to help doctors decide if they wanted to register for the entire course. A description was of it included in the department newsletter (1 month before the program began) and an announcement was posted on the hospital website. Finally, emails from the department head's office were sent inviting participation of up to 100 doctors (out of a cohort of about 400). Once registered, participants were given full access to the online program.

Interventions

Physician Wellbeing Online Modules

1. Self-Assessment (burnout, wellness, resiliency, stress response)
2. Introduction to Wellness
3. Wellness Inventory
4. Burnout
5. Resiliency
6. Mind and Spirit
7. Resiliency Practice
8. Personal and Professional "time-out" ie, 2-week practice period (gratitude journal or meditation practice, or finding meaning at work)
9. Personal Development Plan
10. Self-Assessment (post-tests from module 1)

Mindful Medical Practice (MMP) Workshop[14,15]

Epstein published the seminal paper *Mindful Practice*[16] and more recently a book, reviewing decades of research and clinical experiences pertaining to being mindful and relationship-based care.[17] Our faculty have been offering MMP courses for 13 years, including medical students,[18] residents, and physicians.[19] An 8-week program modeled on Mindfulness-Based Stress Reduction (MBSR), half-day, full-day, and weekend workshops have been provided—each modified to suit the needs of health care professionals.[20] Characteristics of a mindful clinician (eg, attentive, curious, beginner's mind, and being fully present with their patients), effective communication, and deep-listening skills are emphasized.[21,22] All are offered in a small group setting with the intention to end professional isolation and provide a safe forum to share clinical experiences.

The 3-hour MMP workshop covered topics such as resilience, finding meaning at work, and MMP. Groups of 10-16 were conducted in a conference room at the hospital either during early evening hours or on Saturday. Healthy snacks were served. Given that participants were from various departments and in different phases of their careers, most did not know other group members. The facilitator (PLD) is a clinical psychologist, trained in group dynamics, and is certified as a MBSR instructor. She emailed participants 1 month (several times) prior to the workshop to encourage completion of the online work. During the workshop, a narrative medicine exercise, body scan meditation, and discussions pertaining to online learning and relevant experiences occurred. For example, subgroups of 3 doctors were formed to discuss their 2-week practices (eg, meditation and journaling). As required for CME credits, an evaluation form was completed at the end of the workshop and an invitation to participate in a focus group was extended.

Table 1. PWB Online & On-site CME Course Evaluation
(Summary of four workshops)

1. How useful were the online self-assessment questionnaires?

Definitely useful	Moderately	Somewhat	Slightly	Not at all
5	4	3	2	1
16	**16**	**8**	**2**	

MEAN: 4.14

2. How helpful was it to be able to read the online responses to reflections written by peers?

Definitely helpful	Moderately	Somewhat	Slightly	Not at all
5	4	3	2	1
9	**7**	**15**	**7**	**3**

MEAN: 3.29

3. Please comment on how successfully the following learning objectives were met:
Increase physician resiliency and hardiness: □ Yes □ No □ Not Sure
28 2 13
Provide strategies for coping with stress: □ Yes □ No □ Not Sure
38 5
Provide strategies on decreasing physician burnout: □ Yes □ No □ Not Sure
35 1 7
Practice mindfulness: □ Yes □ No □ Not Sure
39 4

4. The course content (online and workshop) has enhanced my knowledge:

Strongly Agree	Moderately	Neutral	Slightly	Strongly Disagree
5	4	3	2	1
15	**23**	**3**		

MEAN: 4.29

5. Indicate which CanMEDS roles you felt were addressed during this educational activity.
Collaborator: **22**
Communicator: **36**
Medical Expert: **8**
Health Advocate: **23**
Manager: **11**
Professional: **37**
Scholar: **12**

RESULTS

Recruitment took place twice. The first cohort (Fall) included 57 doctors. Of the 57, 6 never logged in, 38 (66.7%) completed the online work, and 45 attended 1 of 4 workshops. The second cohort (Summer) took place 10 months following the first launch; 33 registered, 8 never went online, 6 (18.2%) completed the online work, and 10 attended the final workshop. Across both cohorts, the number of times logged in varied across participants (1-29 times) as did the number of hours online per person (< 1 hour-7 hours).

Table 1 summarizes the results of the CME evaluation forms completed only by physicians who attended workshops.

Qualitative Data Collection

Participants' views were collected from May to July 2019 by the second author; she was independent of all other aspects of the program. Data collection was performed in 2 phases, first via focus groups, and second via individual interviews. For each focus group, we attempted to schedule 6 individuals, a number recommended in the literature for group size.[23] Even though 30/45 (66.6%) from the first cohort agreed to attend a focus group and responded to online scheduling, attendance was poor. Nonetheless, 3 focus groups were completed, including 2-5 participants each, ranging from 60-75 minutes in duration (n = 10). To address recruitment barriers and further contextualize the phenomenon, 5 single individual phone interviews were completed; these ranged from 15-30 minutes in duration. An experienced master's level qualitative data collector (CV) conducted all focus groups and individual interviews. A research assistant (RA) was present during the focus group to obtain informed consent, help with logistics, and take notes during the interview.[23]

To enhance consistency of data collection, the same semi-structured interview protocol comprised of 9 open-ended questions was used to guide the focus group and individual interviews. Each interview addressed participant experiences of the course particularly related to helpful and unhelpful aspects. All interviews were audio-recorded and transcribed verbatim by the RA without any identifying participant details.

Data Analysis

Thematic framework analysis was employed for data analysis, because this approach is appropriate for both individual and focus group interviews. [24,25] This process involves 5 interconnected stages: familiarization, identifying a thematic framework, indexing, charting, mapping, and interpretation. It started with familiarization with the data by reading each interview transcript multiple times, while often listening to the accompanying recording to garner an overall sense of the transcript. Subsequently, a line-by-line analysis of each transcript was performed, highlighting quotes that pertained to the PWB experience (both online and during the workshop) and writing notes at the margin of the transcript to facilitate the development of a thematic framework. The stages of indexing and charting involved sorting the highlighted quotes and making comparisons both within and between participant cases. Highlighted quotes that reflected similar concepts were then grouped into themes for each transcript. Sub-themes within each theme were further organized.

Once each transcript was analyzed, themes and subthemes were compared across all interviews. The process of interpretation involved movement between understanding individual quotes, seeing relationships between participant quotes, and establishing links between all data.[26] Interpretation of quotes was facilitated by considering the frequency, emotion, context, and specificity of the coded data. Ultimately, a detailed description that captures participants' PWB course experiences was developed, emphasizing commonalities and differences in their experiences.

To enhance rigor (trustworthiness) an operationalized set of criteria was used.[26,27] To ensure credibility, this study used: 1) member checking by soliciting feedback from the participants about the representativeness of emerging findings; 2) team debriefing after each focus group; and 3) multiple sources of data (ie, focus group transcripts, individual interview transcripts, and field notes and reflections) to explore and contextualize phenomenon. To facilitate transferability of the study findings to similar setting, we offer a detailed description of the context surrounding the findings, such as the setting of the study. To enhance dependability and allow for replication, we provide a comprehensive account of all research procedures (eg, recruitment challenges). Last, for confirmability, we maintained a detailed audit trail of all the steps taken during the study.

Thematic Structure

Participants spoke about their experiences of the program at length, addressing both helpful and unhelpful aspects of the course. The 4 themes that emerged are presented below, along with supporting verbatim excerpts from participant interview transcripts.

Online Curriculum—From Engaging to Disengaging

Participants' description of the online curriculum is conceptualized on a continuum, ranging from highly engaging to highly disengaging experiences. When talking about the online curriculum, participants concentrated on three major aspects, namely its content, approach, and

format. Eleven participants found the online content to be stimulating, with some participants describing the whole curriculum as "particularly good," "useful," and "really interesting." Four participants mentioned enjoying the "varying techniques" and "many different aspects of well-being that were covered" in the curriculum. Additionally, 6 participants appreciated how the audio-visual materials, specifically, the TED talks, heightened their experience of the course. For instance, Dr B noted: "I thought the audio-visual content was well balanced. I thought that it enhanced the experience, whether it be a TED talk or other things … It helped make things get through."

A few participants also commented on the experiential component of the course and how it allowed them to not only learn the material in a cognitive way, but also to practice it. Dr S explained: "I thought it was a good thing that you had to do a 2-week practice of one tool … because it was an occasion to try something out, it was also forcing us to do it, in a sense, instead of just describing it."

Additionally, 4 participants indicated that they appreciated the evidence-based approach of the course, as wellness is often presented in ways that lack scientific rigor and is associated with "artsy," "goody stuff," and "symbolic interaction." Dr B explained:

"Reading referenced information was good stabilizers … I wanted to get some kind of footing that were indisputable. There are data where you can dispute them, but at least you know there was some verified information referenced, which I was looking forward to seeing some of that."

Seven participants emphasized how the online format was convenient, flexible, and accessible, which facilitated their engagement with the course. Dr T commented on the value of the online format: "having the ability to access things online anytime from home was really helpful … I can do it at the end of the day … after the kids are asleep." A few participants also highlighted the website as user-friendly, labeling it as efficient and straightforward.

Participants also addressed aspects of the online curriculum that they deemed unhelpful and which contributed to some disengagement from the course. Four participants experienced the online curriculum content as tedious, with some describing it as repetitive, elementary, too theoretical, and not particularly exciting. For example, Dr H seemed to have experienced the online modules as a chore, which led to some impatience:

"The modules were long. You know I was thinking, 'Am I finished yet?' … But then it wasn't the last one yet … that was just impatience on my part. That wasn't very negative. It was just I think a normal human kind of thinking 'Oh, there's work to do'. I like live things. [The online] I found it a little dead."

Three participants questioned the applicability of the online curriculum to their realities as experienced physicians, given that the curriculum was designed for residents. For example, in Dr G's case, this perceived lack of relevance contributed to the experience of the course as a burden, which resulted in unmindful engagement at times:

"The program was designed for residents just starting on a career. And the problem with that, is that it's not transferrable [to people at my stage] … It was a burden to continue doing the exercises because the relevance was not apparent. In many cases, I just clicked without thinking, especially near the end of a very long series of questions, just to get to the next page."

While 2 participants appreciated the efforts of the course to be evidence-based, they described the scientific background of the course as "superficial." For example, Dr J noted that the scientific content was over-emphasized in the course, as many generalizations that were not directly linked to wellness or performance were made:

"It became a bit of sort of a sore point as I was going through it, that the these phrases and [physiological] stuff were being brought in to sort of justify this is why you should be doing it, rather than saying 'Look, there is some evidence about this, there is some physiological stuff that we know about, but a lot of this is behavioral' … That lost me after a while, and I got a little frustrated."

Intimate Sharing Among Physicians in the Workshop

Most participants identified discussions with other physicians at the workshop as the most helpful and impactful component of the course. These participants revealed that it was important and meaningful to have an open conversation about personal stories with other physicians from different practices and stages in their career. For example, Dr H reflected on the authenticity, openness, and positive impact of the workshop:

"The part that worked best for me was in the in person … I really liked [that it] was very real because people were there at different phases of their career … I mean it was so authentic … [There was a] huge amount of openness … So that was very powerful and really made me think, 'We're doing a good thing here. This is really good to hear other people's experiences.'"

Four of the participants further highlighted the strengths of the in-person workshop compared to learning about physician well-being online or through theoretical methods. Dr M explained the importance of this interactive and experiential component for physicians:

"Having an open discussion about real-life techniques to encourage well-being. That's what I found the most interesting with regards to the course. We are given opportunities to read about information online and articles about physician well-being, but it doesn't compare to being in a

classroom with other attendings and hearing personal stories of which I think helped the most."

Some participants spoke about factors that influenced group dynamics at the workshop. Four participants expressed their appreciation toward the facilitator's approach during the workshop, because the facilitator made participants feel safe and engaged. Dr M explained: "[I felt very open to share my experiences. [The facilitator] made it a comfortable atmosphere for everyone, so it was very enjoyable." A few participants mentioned that they would have liked more space for exploring participant's journeys and experiences within the workshop. Dr J expressed this desire, "I thought the workshop was going to be a little bit more of a space to explore some issues, because people come to this from very different angles and so understanding why people are pursuing this, I think is important." Last, 3 participants spoke about the detrimental impact of participants who displayed a negative attitude during the workshop. Dr C commented on how this influenced her experience, "Unfortunately, one of the things I remember the most was a person who clearly did not want to be there. It became so distracting … eye rolls and snapping and sighs and this and that." Similarly, Dr J addressed the impact of such behavior on group dynamics: "I had the sense that a number of people resented being there. They got there a bit late and were just like "Ugh, I just want to go to sleep" … That didn't help the atmosphere of the sharing."

Reflecting on and Practicing Wellness

Most participants described how the course afforded them an opportunity to reflect on their own well-being and partake in practices to promote their wellness. The reflective journey started with the completion of the self-assessment questionnaires on burnout and resilience. Seven participants described the results as illuminating and revealing. For example, Dr S commented: "It was enlightening in a sense … To see it in numbers, in a language that you could kind of relate to … To know where you are on the spectrum of certain aspect or trait, it can be a wake-up call." Indeed, 6 participants explained how the self-assessment results served as an impetus for change and to work on their wellness. Dr E described how the burnout inventory results reaffirmed her commitment towards her wellness: "[The results] made me realize that it is time to sort of take a step back and assess the situation and try and gain a little bit of control." Of note, 3 participants found the results to be valid but not necessarily motivating for change, 3 participants could not recall this experience, and 1 participant challenged the validity of the test results.

Additionally, most of the participants addressed how they appreciated the opportunity to practice diverse wellness exercises and reflect on their progress throughout the course. The exercises that were most frequently identified as helpful by the participants were the gratitude journal (ie, noting three things they were grateful for each day) and mindfulness. For example, Dr M stated, "I feel my outlook was more positive … Waking up in the morning, starting off on a positive note and thinking of things I'm grateful for. All these has allowed me to be more mindful and in the moment." Additionally, Dr M explained how the course helped her to become more fully connect with her patients, because she was more mindful about the whole person and deriving pleasure from the encounter:

"The course stated to try to find pleasure with each patient and try to make more of a connection with each patient … It was something I was taking for granted … I feel like I'm able to be more in the moment with my patients. I feel I understand more what it is exactly that they're going through more than just medical. So, if anything, [the course has] improved, the empathy aspect of the doctor-patient relationship."

Furthermore, 3 participants specifically addressed how the program helped them to reflect on and deconstruct negative messages regarding well-being and self-care that they had internalized during training and that are sustained by the culture of medicine. For instance, Dr N explained, "I was actively trained in the 1970s to not look after myself … It's a huge statement to say I'm more self-aware and looking for ways to integrate these techniques … into one's daily life." In a similar vein, Dr J noted how the course highlighted the potential relevance of physician self-care to sustainability and patient care, which runs counter to cultural messages of how physicians must operate:

"I was intrigued by … this idea that … physician well-being translates into better care because that's somewhat counter to the general thread of medical student training etc., which is that you run yourself into the wall because you're trying to do everything that you can … You're trying to get this idea across that what you are doing is not only not gonna be sustainable long-term, but it's probably meaning that you're not delivering the best care. But we don't have enough evidence yet to really back the argument, but hopefully that will come."

Last, 2 participants reflected on how the program's approach lacked resonance with their personal style of wellness, and as such, they did not benefit from it. For example, Dr G identified the course's mostly solitary approach as the issue, noting he would benefit more from interpersonal interactions with other physicians:

"The problem is that it's not a personal journey that needs to be validated by others. By doing it alone in a room with a computer, you can make the same mistakes … If that were a consistent, collegial, cooperative, relationship-based endeavor, that would go a much longer way."

A Valuable "Gift" from the MUHC Department of Medicine

All participants expressed their appreciation and gratitude for the Department of Medicine's active involvement and sponsorship of the PWB. Participants described the Department's support as "powerful," "valuable," and an "important shift," as it affirmed that the Department cares about its physicians, recognizes the challenges that physicians are currently facing, and is taking important steps to improve the staff's well-being. Dr D addressed the significance of the Department's decision to fund and sponsor this initiative:

"Symbolically it was actually very important that it was sponsored by the department of medicine [and] that it was free … I'm sure all of us could have afforded to pay for it, but the fact that the department of medicine thought that it was important enough, that they were offering it to us a gift was … very valuable. I thought that it implied that the Department of Medicine was concerned about its faculty, which was very nice."

Furthermore, Dr V mentioned how the Department's support made her feel seen and understood: "[The Department's support meant that] people care about us … there was recognition that there's a whole human element to our work and I was very touched actually. I thought 'Oh good, the faculty, they just so get me.'" Additionally, some participants hinted at how the Department's support represented a cultural shift regarding physician wellness. Dr L illustrated this premise: "What usually comes out of the department of medicine from my perspective is academics, research, and to have something come out that was about you and helping you as a person and to cope … I thought was a major shift actually." Dr H perceived that the Department's novel approach was not only healthy, but also acted as a facilitator to physician engagement in the course:

"I think in the distant past the Department of Medicine wouldn't have supported anything like this or put energy into anything like this. They would've assumed this is not their issue. That was very healthy that they did, and I think that the fact that the Department supported it made people more likely to do it."

Last, even the 2 participants who did not particularly benefit from the course conveyed the relevance and helpfulness of this initiative. For example, Dr J explained: "For me [the course] was superficial and didn't quite do the things I was hoping it would, but I don't want to take away from the fact that I still think it's a very important step in the right direction."

DISCUSSION

The two-part PWB course offered one step towards physician well-being, supported from the "top" while carried out by the "bottom." The physicians who agreed to speak with us acknowledged the importance of providing concrete means to maintain wellness in the context of hospital service to patients across specialties and years of practice. The fact that the workshops were provided onsite may have encouraged them to register. Yet, time is perceived as a taxing stressor;[28] thus, asking physicians to "do more" to take care of themselves may seem paradoxical. Nonetheless, when framed as "well doctors promote wellness in their patients," many allowed themselves to participate. For some, online access provided the flexibility needed to learn where and when they could.

We observed an openness to learning new strategies for personal, educational, and professional development. Not surprisingly, engagement online varied—as seen in the first theme as well as the numbers and hours of online work and attendance at workshops. To date, there is no published literature on the PWB online course. Preliminary analyses of 617 residents' reports were sent [to PLD] when negotiating the contract. At 2 UAZ sites, junior doctors rated the online program technology as "smooth to use" (mean = 4.6). This was replicated in our study. Reading peer online reflections was rated as somewhat helpful by our group (mean = 3.3) and by UAZ respondents (mean = 3.2). Here, more detailed comments, such as positive experiences with audio-visual tools and negative views (eg, redundancy of material), were chronicled.

The workshop aspect of the course was valued as it provided an opportunity to share experiences in person with other doctors. Our findings concur with Brown and colleagues' conclusions for wellness workshops that were integrated into faculty development for new faculty members in another academic Canadian medical setting.[29]

The culture of medicine can be callous (eg, the expectation to work despite illness) or worse (eg, bullying and harassment from colleagues and patients).[5] There has been a call for a shift in how institutions address self-care and how it is viewed by staff (see CanMEDS).[30] This was reflected in our results. As expected, for some MDs, self-assessment served as a motivator to discover pathways towards resilience. Being offered an opportunity to practice, both online and during the workshop was viewed as helpful. Gratitude was expressed for the "gift" from the Chief of Medicine. This served as encouragement and the sense of "being seen and cared for" ie, recognized and appreciated. It should be noted, however, that during workshops the issue of "systemic" problems was raised. That is, if the work environment and regulatory demands (eg, EMRs)[31] do not change, expecting the "bottom" to do the "heavy lifting" seemed unjust. Stanford University Medical Center's approach can serve as a model to deal with this legitimate concern.[32]

When the first author presented the proposal to the MUHC executive committee one skeptical member asked it made sense to ask burned out doctors to do more. We emphasized that the program could be viewed as primary

(or secondary) prevention, with an emphasis on maintaining resilience. Unsympathetic views towards "weakness" reflects a darker side of the medical culture. Thus, one must tread with care when inviting participation. Rather than dealing with "what is wrong with you," it is better to suggest how to strengthen what is "right." Presenting the course as part of faculty development is recommended.

What about "top down" changes? Doctors want their ideas heard and their initiatives to improve quality of patient care to be understood.[28] Junior Australian doctors described "workplace issues" that were stressful, such as meal breaks cut or disrupted and discouragement to claim overtime.[5] Managers may need to address these problems. When senior doctors are capable role models who mentor trainees with empathy, they can ease transitions for junior doctors. Their presence in designing and offering wellness initiatives is encouraged.

Given that registering for the online course and attending the workshop were voluntary, our results cannot be generalized. Even though the ethics committee chair advised us that we could use the online self-assessment results if they were anonymized, we chose not to for several reasons. First, it varied when the questionnaires were completed (this was also found in the UAZ data). For example, 1 person could finish all modules in 1 month whereas another did so in 3. Second, change takes time and thus it was unlikely to find significant and meaningful transformation over a short testing period. Moreover, costs for analyses seemed to be higher than the potential usefulness of pre-program data only. Although the sample size was small, this is common in qualitative research. For example, Baathe and colleagues interviewed 7 Norwegian surgeons (one-third of the MDs in the department) who described "stretching themselves" to handle the tensions between quantity and quality, to overcome organizational shortcomings (eg, unforeseen scheduling changes).[28] The information gained through this methodology appears richer than the simple responses to the questions found on the evaluation forms. The results suggest that on-site programs for physicians are feasible and when offered by management, viewed positively. ❖

How to Cite this Article

Lynn Dobkin P, Velez C. Physicians' views on a wellbeing course gifted to them: A qualitative study. Perm J 2020;24:19.228. DOI: https://doi.org/10.7812/TPP/19.228

REFERENCES

1. Dyrbye LN, Shanafelt TD, Shanafelt TD, et al. Burnout among health care professionals: a call to explore and address this underrecognized threat to safe, high-quality care. NAM Perspectives 2017 Jul;7(7):1-11. DOI: https://doi.org/10.31478/201707b
2. Canadian Medical Association. CMA National Physician Health Survey – A National Snapshot, 2008. Accessed September 2019 https://www.cma.ca/Assets/assets-library/document/en/advocacy/nph-survey-e.pdf
3. West C. Burnout in healthcare: an overview and framework for interventions. Plenary at the International Conference to Promote Resilience, Empathy and Well-Being in Health Care Professionals. Washington, DC: 2017.
4. Bellini LM, Shea JA. Mood change and empathy decline persist during three years of internal medicine training. Acad Med 2005 Feb 80(2):164-7. DOI: https://doi.org/10.1097/00001888-200502000-00013, PMID:15671323
5. Forbes MP, Iyengar S, Kay M. Barriers to the psychological well-being of Australian junior doctors: a qualitative analysis. BMJ Open 2019 Jun 12;9(6):e027558. DOI: https://doi.org/10.1136/ bmjopen-2018-027558, PMID:31196900
6. Shanafelt TD, Balch CM, Bechamps G, et al. Burnout and medical errors among American surgeons. Ann Surg 2010 Jun;251(6):995-1000. DOI: https://doi.org/10.1097/SLA.0b013e3181bfdab3, PMID:19934755
7. Welp A, Meier LL, Manser, T. Emotional exhaustion and workload predict clinician-rated and objective patient safety. Front Psychol 2015 Jan;5:1573. DOI: https://doi.org/10.3389/fpsyg.2014.01573, PMID: 25657627
8. Shanafelt TD, Dyrbye LN, West CP, Sinsky CA. Potential impact of burnout on the US physician workforce. Mayo Clin Proc 2016 Nov;910(11):1667-1668. DOI: https://doi.org/10.1016/j.mayocp.2016.08.016, PMID:27814840
9. Dobkin PL. Mindfulness and compassion as antidotes to physician addiction. Ijwpc 2019 Aug;6(2):5-10. DOI: https://doi.org/10.26443/ijwpc.v6i2.202
10. Lacy BE, Chan JL. Physician burnout: the hidden health care crisis. Clin Gastroenterol Hepato. 2018 Mar;16(3):311-317. DOI: https://doi.org/10.1016/j.cgh.2017.06.043
11. Canadian Medical Association. Policy on Physician Health, 2017. Accessed September 2019. https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma_policy_physician_health_pd18-01-e.pdf.
12. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. The Lancet 2016 Nov; 388(10057):2272-2281. DOI: https://doi.org/10.1016/S0140-6736(16)31279-X
13. Shanafelt TD, Gorringe G, Menaker R, et al. Impact of organizational leadership on physician burnout and satisfaction. Mayo Clin. Proc 2015 Apr;90 (4):432-40. DOI: https://doi.org/10.1016/j.mayocp.2015.01.012, PMID:25796117
14. Dobkin PL. Mindful Medical Practice: Clinical Narratives and Therapeutic Insights. Switzerland: Springer International Publishing, 2015.
15. Dobkin PL, Hassed CS. Mindful Medical Practitioners. A Guide for Clinicians and Educators. Switzerland: Springer International Publishing, 2016.
16. Epstein RM. Mindful practice. JAMA 1999 Sep;282 (9)833–839. DOI: https://doi.org/10.1001/jama.282.9.833
17. Epstein RM. Attending: Medicine, Mindfulness, and Humanity. Windsor, ON: Scribner, 2017.
18. Garneau K, Hutchinson T, Zhao Q, Dobkin P. Cultivating person-centered medicine in future Physicians. Ejpch 2013;1 (2):468-477. DOI: https://doi.org/10.5750/ejpch.v1i2.688
19. Dobkin PL, Bernardi NF, Bagnis CI. Enhancing clinicians' well-being and patient-centered care through mindfulness. J Contin Educ Health Prof 2016;36 (1):11-6. DOI: https://doi.org/10.1097/CEH.0000000000000021, PMID:26954240
20. Dobkin PL, Hickman S, Monshat K. Holding the Heart of Mindfulness-Based Stress Reduction: Balancing Fidelity and Imagination When Adapting MBSR. Mindfulness 2014 Dec;5 (6):710-718. DOI: https://doi.org/10.1007/s12671-013-0225-7
21. Dobkin PL, Lucena RJM. Mindful medical practice and the therapeutic alliance. The International Journal of Whole Person Care 2015 Dec;3:34-45. DOI: https://doi.org/10.26443/ijwpc.v3i1.106
22. Irving J, Park-Saltzman J, Fitzpatrick M, et al. Experiences of health care professionals enrolled in mindfulness-based medical practice: a grounded theory model. Mindfulness 2014 Feb;5 (1):60-71. DOI: https://doi.org/10.1007/s12671-012-0147-9
23. Krueger RA. Focus Groups: A Practical Guide for Applied Research (2nd ed.). Thousand Oaks, CA: Sage Publications, 1994.
24. Krueger RA. Designing and Conducting Focus Group Interviews. St. Paul, MN: University of Minnesota, 2002. Accessed April 15, 2019. http://www.eiu/~ihec/KruegerFocusGroupInterviews.pdf
25. Rabiee F. Focus-group interview and data analysis. Proc Nutr Soc 2004 Nov;63 (4): 655-60. DOI: https://doi.org/10.1079/pns2004399, PMID:15831139
26. Lincoln YS, Guba EG. Naturalistic Inquiry. Beverly Hills, CA: Sage, 1985. DOI: https://doi.org/10.1016/0147-1767(85)90062-8
27. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. Efi 2004 Jul;22 (2):63-75. DOI: https://doi.org/10.3233/efi-2004-22201
28. Baathe F, Rosta J, Bringedal B, Rø KI. How do doctors experience the interactions among professional fulfilment, organisational factors and quality of patient care? A qualitative study in a Norwegian hospital. BMJ Open 2019 May;9 (5):e026971. DOI: https://doi.org/10.1136/bmjopen-2018-026971, PMID:31129585
29. Brown GE, Bharwani A, Patel KD, Lemaire JB. An orientation to wellness for new faculty of medicine members: meeting a need in faculty development. Int J Med Educ 2016 Aug; 7:255-260. DOI: https://doi.org/10.5116/ijme.578a.2064, PMID:27494833
30. Frank JR, Snell L, Sherbino J. CanMEDS Physician Competency Framework. Ottawa, ON: The Royal College of Physicians and Surgeons of Canada, 2015.
31. Kroth PJ, Morioka-Douglas N, Veres S, et al. The electronic elephant in the room: Physicians and the electronic health record. JAMIA Open 2018 Jul;1:49-56. DOI: https://doi.org/10.1093/jamiaopen/ooy016, PMID:31093606
32. https://wellmd.stanford.edu/center1.html