



THE AMERICAN ORTHOPAEDIC ASSOCIATION®

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CORD Webinar

Addressing Resident and Faculty Wellbeing
8:00pm – 9:00pm EDT

Continue the conversation
on Twitter: @aoa1887;
#AOACORDHEAL

8:00PM Introduction

8:05PM Burnout

8:15PM Women, Wellbeing, and Burnout

8:25PM Wellbeing of Underrepresented Minorities in Orthopaedics

8:35PM Wellbeing Resources

8:45PM Q&A/Discussion

8:55PM Summary & Adjourn

Raise your hand to verbally ask a question.

All questions will be addressed during the Q&A session following all presentations.

Ways to participate

01



Raise your hand to ask a question **verbally** during the Q&A session at the end. In order of hands raised, when it's your turn, you will receive a notification, telling you to un-mute yourself.

02



Chat with panelists and/or all attendees. Send a chat to panelists if you have a technical issue.

03



Ask questions in the Q&A box if you'd prefer not to be unmuted and would like a written response to your question.

CORD WEBINAR – Addressing Resident and Faculty Wellbeing

Moderator



Kimberly J. Templeton, MD,
FAMWA, FAOA

Panelists



Brent Ponce, MD, FAOA



Carol Bernstein, MD



Gabriella E. Ode, MD



THE AMERICAN ORTHOPAEDIC ASSOCIATION®
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Faculty Development Lecture Series



Wellness & Burnout

Kim Templeton, MD, FAOA
Professor, Program Director
Department of Orthopaedic Surgery
University of Kansas Medical Center

Brent Ponce, MD, FAOA
Professor, Vice Chair Clinical Affairs
Department of Orthopaedic Surgery
University of Alabama at Birmingham

Wellness and Burnout Lecture AOA/SOMOS Faculty Development Lecture Series

PowerPoint lecture
available for download by
CORD Affiliates on the
CORD webpage

(https://www.aoassn.org/AOAiMIS/CORD/Faculty_Development_Lectures/CORD/AOA_SOMOS_Lecture_Series.aspx)

Wellness & Burnout

Brent Ponce, MD, FAOA

Professor, Vice Chair Clinical Affairs

Department of Orthopaedic Surgery

University of Alabama at Birmingham

Objectives

Wellness & Burnout

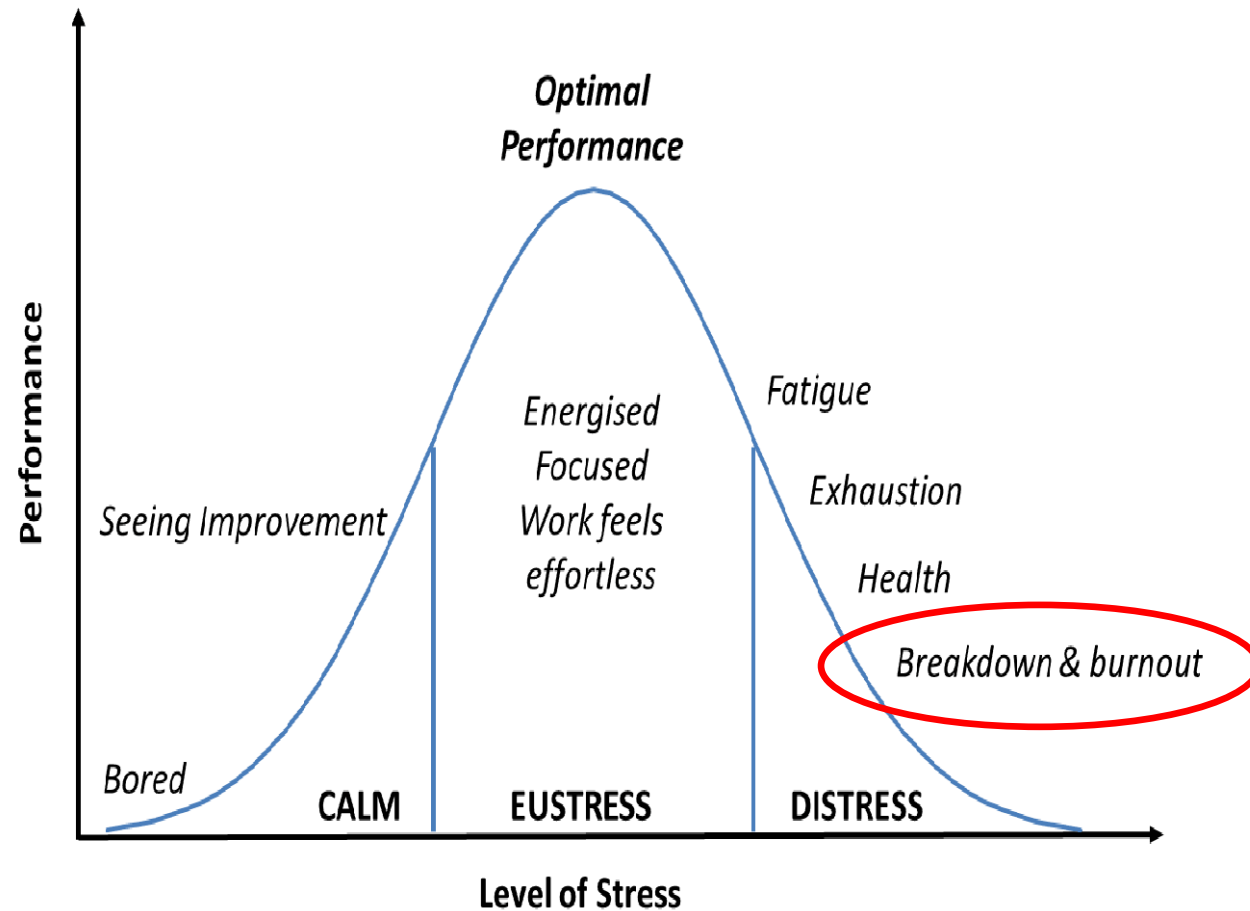
- 1) Definitions
- 2) Presentation
- 3) Risk factors
- 4) Impact

Definition

Wellness

- A multidimensional state of being, describing the existence of positive mental/physical health in an individual as exemplified by quality of life
- It is not:
 - The same as physical fitness
 - Just the lack of burnout
- It is:
 - What one is rather than what one does
- New ACGME mandates
 - Section VI.C of the current Common Program Requirements of the ACGME includes new mandates for programs and sponsoring institutions to focus on wellbeing

Stress Response → Performance

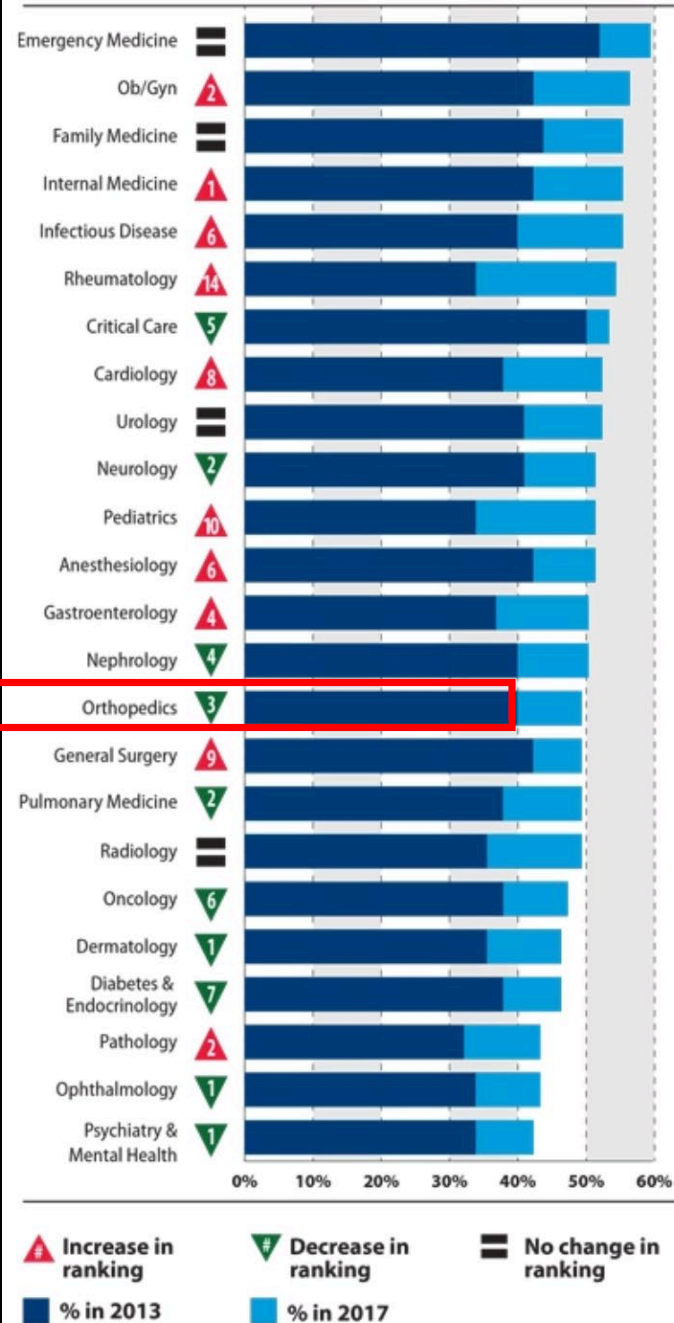


Definition

Burnout

- As described by Maslach and Jackson, it is a syndrome of:
 - Increased emotional exhaustion
 - A depletion of emotional energy, distinct from physical exhaustion or mental fatigue
 - Increased depersonalization
 - A problem in careers that value & mandate personal sensitivity to service recipients
 - Lower sense of personal accomplishment
 - Usually lags behind other symptoms in physicians
- ICD -11 defines burnout as:
 - *"a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy"*.
- Focuses upon one's relationship with work
 - "A job related dysphoria in an individual without major psychopathy"

Changes in burnout by specialty 2013–2017



In Ortho...

Medscape Lifestyle Reports

- 2013
 - Overall 40% burnout
 - Orthopaedics: 40%
- 2017
 - >14,000 physicians from over 30 specialties
 - Overall 51% burnout (25% increase)
 - Orthopaedics: 49%
- 2020
 - >15,000 physicians from over 29 specialties
 - Overall 42% burnout
 - Orthopaedics: 34%

In Ortho Residents & Faculty...

64 Programs

- 384 Residents (27% response rate)
- 264 Full-Time Faculty (24%)
- Emotional Exhaustion
 - 32% of residents and 28% of faculty
- Depersonalization
 - 56% of residents and 25% of faculty
- Low Personal Accomplishment
 - 18% of residents and 10% of faculty

Update 2020

Clin Orthop Relat Res (2020) 478:1709-1718
DOI 10.1097/CORR.0000000000001310

Clinical Orthopaedics
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A Publication of The Association of Bone and Joint Surgeons®

Clinical Research

What Is the Prevalence of Burnout, Depression, and Substance Use Among Orthopaedic Surgery Residents and What Are the Risk Factors? A Collaborative Orthopaedic Educational Research Group Survey Study

Paul M. Lichstein MD, Jun Kit He BA, Daniel Estok MD, John C. Prather MD,
George S. Dyer MD, Brent A. Ponce MD, and the Collaborative Orthopaedic Educational Research Group

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Clin Orthop Relat Res (2020) 478:1706-1708
DOI 10.1097/CORR.0000000000001366

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Editor's Spotlight/Take 5

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Editor's Spotlight/Take 5: What Is the Prevalence of Burnout, Depression, and Substance Use Among Orthopaedic Surgery Residents and What Are the Risk Factors? A Collaborative Orthopaedic Educational Research Group Survey Study

Seth S. Leopold MD



Paul Lichstein MD

In Ortho Residents

- 46 MD/DO orthopaedic programs
 - 671/1147 responses (58.5% response rate)
- Anonymous online survey with 34 questions
 - Instruments to assess...
 - Burnout (abbreviated Maslach Burnout Inventory)
 - Alcohol consumption (Alcohol Use Disorder Identification Test - Consumption)
 - Illicit drug use (Single Question)
 - Depression (Patient Health Questionnaire-2)
 - Variables associated with well-being:
 - General demographics
 - Educational debt
 - Sleep and work habits
 - Health maintenance
 - Perceived peer/program support



In Ortho Residents

Survey Responses

- Burnout reported in 52% of residents
 - 35% Emotional Exhaustion (32%)
 - 45% Depersonalization (56%)
 - 20% Low personal accomplishment (18%)
- 61% of residents met AUDIT-C criteria for alcohol misuse
- 7% of residents used recreational drugs in the past year
- 10% of residents sought assistance for burnout
- + Depression screening in 13%
- Factors associated with increased burnout included early training year, educational debt, unmanageable work volume, fewer hours of sleep, infrequent exercise, inadequate resources and education on burnout, illicit drug use, and lack of co-resident and program support

Potential Impact of Burnout

- Individual
- Employment/education
- Relationships
- Societal

Burnout – Individual Impact

- Negative attitude
- Loss of professionalism
- OITE Scores
- Physical illness
- Mental health issues
 - anxiety
 - depression
 - suicidality
- Substance use
- Attrition from medicine

Depression

Burnout

Negative Attitudes

Ratanawongsa et al., JGIM (2008)

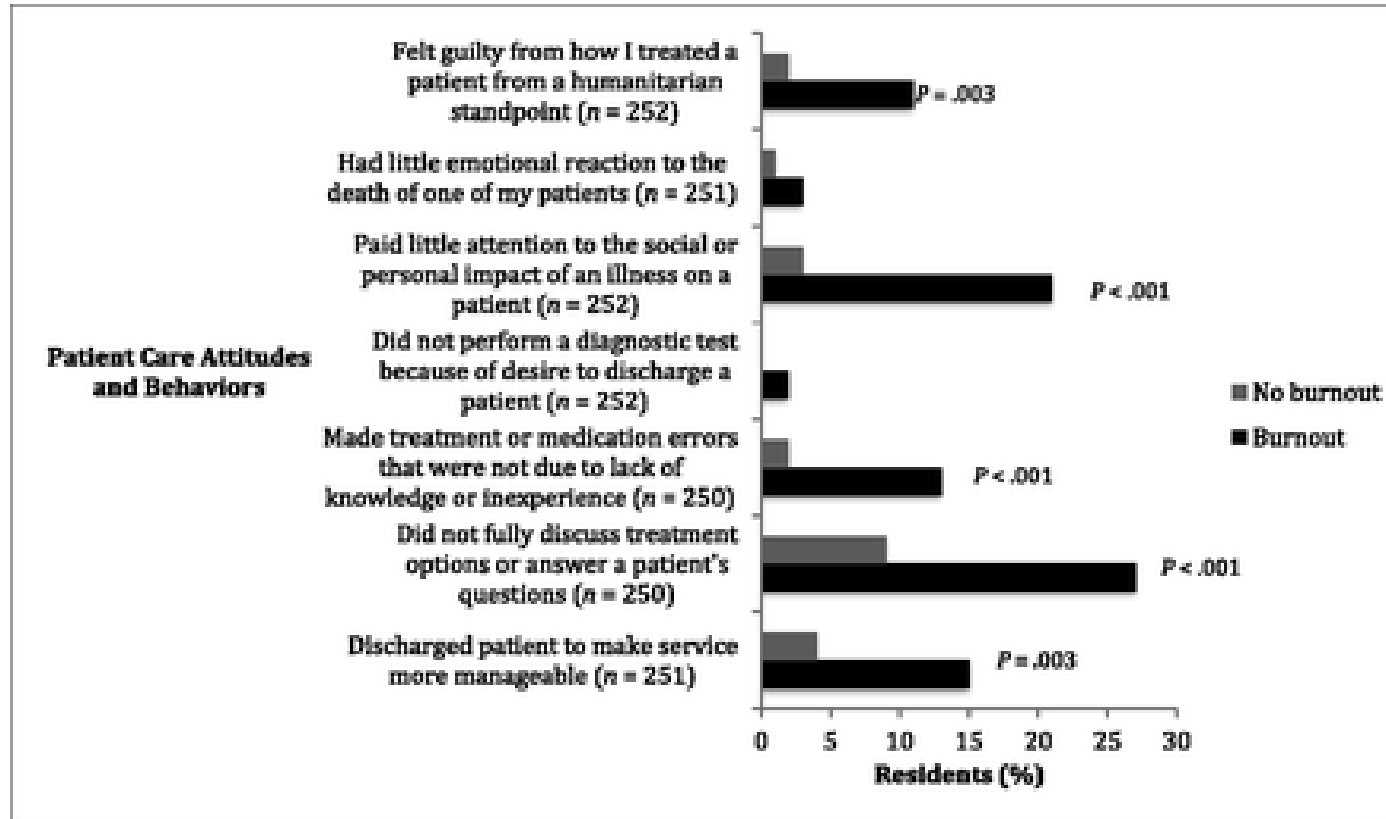
- MBI + Audiotaped encounters analyzed
- Patients of high-burnout doctors received 2x as many negative rapport-building statements

Dyrbye et al., JAMA (2010) – systematic review

- 7 U.S. medical schools – 2682 students
- Assessed MBI, PRIME-MD, SF-8 QOL
- 52.8% burnout
 - More likely to engage in unprofessional behavior
 - Less likely to hold altruistic views regarding physicians' responsibility
 - Less likely to want to provide care for the medically underserved

Patient Care Attitudes/Behaviors

- Baer et al 2017



- Burnout > odds (p<0.01) of suboptimal patient care attitudes and behaviors



- Findings consistent with study from Shanafelt TD et al. Ann Intern Med 2002

Performance - OITE Scores

TOPICS IN TRAINING

Orthopaedic Resident Burnout Is Associated with Poor In-Training Examination Performance

Eric J. Strauss, MD, Danielle H. Markus, BA, Matthew T. Kingery, BA, Joseph Zuckerman, MD, and Kenneth A. Egol, MD

Investigation performed at the Department of Orthopedic Surgery, NYU Langone Health, New York, NY

- Burnout present among all residents in all PGYs of training
 - Most prevalent during 2nd year of training
 - Each burnout index (Emotional Exhaustion, Depersonalization, Personal Accomplishment) associated with worse OITE performance when controlling against general test-taking ability

Physical Illness

Systematic Review

- 36 prospective studies analyzed
- Burnout was significant predictor of: hypercholesterolemia, DM2, coronary heart disease, CVD hospitalization, MSK pain, prolonged fatigue, headaches, GI issues, respiratory problems, severe injuries, mortality <45yo

Mental Health

- Psychological effects of burnout: insomnia, depressive symptoms, use of psychotropic and antidepressants, and hospitalization for mental disorders and psychological ill-health problems

Substance Abuse

Oreskovich et al. Arch Surg (2012)

- Problematic alcohol use by AUDIT – 15% among surgeons Vs. 9% US population in study of 7900 surgeons
 - 14% of male surgeons, 25% of female surgeons endorsed problematic alcohol use
 - Among physicians having a recent major medical error, 77% scored “having alcohol problems”

Oreskovich et al., Amer J. Addictions (2015)

- 7,288 physicians surveys assessing Burnout (MBI), substance abuse (ASSIST, AUDIT-C) & depression (PRIME MD)
 - Burnout > in physicians with alcohol abuse/dependence
 - Mental, physical & emotional QOL were < with alcohol abuse/dependence

Suicide

Taking Their Own Lives – The High Rate of Physician Suicide; NEJM 2005 E. Schernhammer

- “Although physicians tend to have healthier lifestyles than those of the general public and thus to live longer, it has been known for some time that suicide rates among doctors are higher than those in the general population.”
 - Men 40%, Females 130% increase Vs. General population

Suicidal Ideation Among American Surgeons Arch Surg 2011; Shanafelt et al.

- 1 of 16 surgeons (7905 surgeons surveyed) reported Suicidal Ideation (SI) in past year
 - Only 26% of surgeons with SI sought psych help
- SI was 1.5-3x more common in Surgeons 45-54yo Vs. General population
- Burnout (all MBI domains), depression and recent medical error associated with SI

Effects on Employer and Society

- Patient safety/quality issues
- Increased turnover & absenteeism
- Decreased patient satisfaction
- Decreased work
- Increase costs

Patient Safety, Quality & Satisfaction

- 47 studies involving 42,473 physicians
- Burnout associated with...
 - Increased risk of patient safety incidents
 - Poorer quality of care
 - Reduced patient satisfaction
- Link between burnout and professionalism – larger in residents and early-career (≤ 5 years post-grad)

Healthcare Turnover & Absenteeism

Zhang and Feng, BMC Health Services Research (2011)

- Turnover intention was negatively associated with job satisfaction and positively with burnout (MBI)

Crowe et al., Prehospital Emergency Care (2018)

- 1168 EMT's & 1482 paramedics
- Missing 10+ days of work due to sickness → personal, work-related and patient-related burnout
- Leaving EMS job → personal, work-related and patient related burnout

Shanafelt et al 2016 Mayo Clin Proc Assessed professional effort (FTE)

- Correlation between Burnout (MBI) and Job Satisfaction
 - Each point increase in emotional exhaustion and satisfaction was associated with FTE reduction

Burnout – Societal Financial Burden

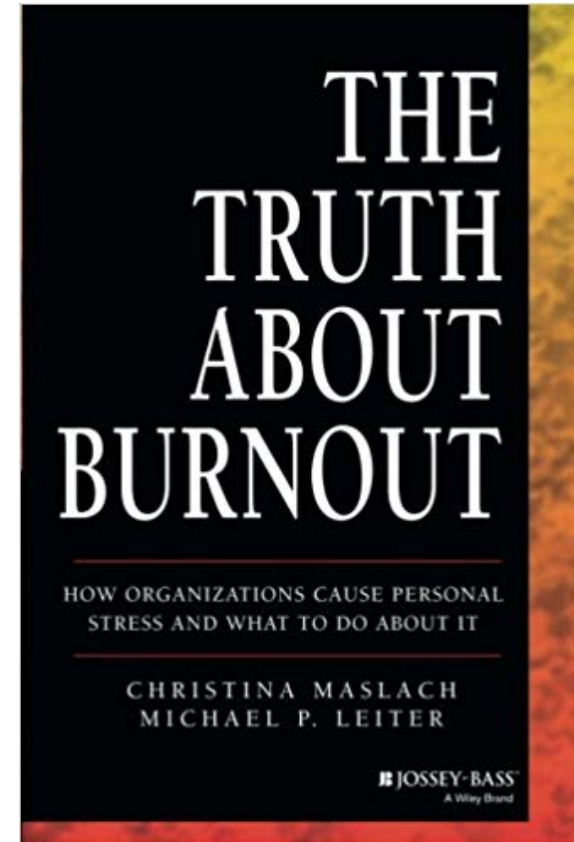
- Cost consequence analysis focusing on turnover and reduced clinical work hours
 - Conservative estimate
 - did not include reduced quality of care and malpractice lawsuits
- 4.6 billion/year
 - \$7,600/physician
- A financial case in addition to ethical grounds

Contributors to Burnout

- Work
- Individual
- Combination of Work + Individual Variables

Contributors to Burnout - Work

- Inefficient work environment
 - EMR, non-meaningful work
- Excessive workload
 - Long hours, overnight /weekend duties, doing work at home
- Loss of support from colleagues
- Loss of control, autonomy and meaning at work
- Organizational Climate
 - Negative leadership, limited collaboration and advancement opportunities
 - Lack of alignment between individual and organizational priorities



Contributors to Burnout – Individual

- Age
 - Under 55yo 2x risk
- Educational Debt
 - Nearly 20% increase
- Gender
 - Female 20-60% increased odds
- Relationship Status
 - Children age
 - Under 21yo >50% increase
 - Partner occupation
 - Non-physician healthcare professional increases risk >20%
 - Work-home interaction/conflict
 - Imposter syndrome

Summary

- Wellness what one is rather than one does, not just the lack of burnout
- Burnout in orthopaedics is a prevalent and pressing concern resulting from work, individual variables, or a combination of the two
- Leads to dramatic impacts in multiple areas:
 - Employer and Society – patient safety, satisfaction and quality of care
 - Societal financial burden – turnover and reduced clinical work hours
 - Individual impacts – mental health, physical illness
- Must move forward for ourselves, families and patients



Gender Differences in Burnout

Council of Orthopaedic Residency Directors

August 12, 2020

Carol A. Bernstein, MD

**Professor and Vice Chair, Faculty Development
Past President, American Psychiatric Association**

Departments of Psychiatry and Behavioral Sciences and
Obstetrics & Gynecology and Women's Health
Albert Einstein College of Medicine
Montefiore Health System
Bronx, NY





With Thanks To:

- Kim Templeton, MD
- Ariela Marshall, MD
- Hina Talib, MD



Gender differences?

- ▶ No significant differences between male and female residents in incidence of burnout; however
- ▶ Women were more likely to suffer from high fatigue depression
- ▶ Being a resident/fellow or early career (<5 years of practice), male, and married were independently associated with lower risk of depression

Dyrbye et al 2014


Gender-Based Differences in Burnout

TABLE 3. Multivariate Models Among Practicing Physicians in 2017^a

Outcome	Predictor	OR (95% CI)	P value
Burned out ^b	Age ≥65 y (vs age <35 y)	0.435 (0.320-0.591)	<.001
	Female (vs male)	1.329 (1.156-1.528)	<.001
	Married (vs single)	0.719 (0.593-0.872)	<.001
	Hours worked per week (for each additional hour)	1.021 (1.017-1.026)	<.001

Table 1 Gender differences in rates of high burnout symptoms amongst physicians in selected international studies (results reported as odds ratios with 95% confidence intervals for rates amongst women versus men)

Study	Population	Rate of high emotional exhaustion	Rate of high depersonalization	Rate of overall burnout
McMurray <i>et al.</i> , 2000 [18]	US nonsurgical physicians	NR	NR	1.60 (95% CI NR, <i>P</i> < 0.05)
Toyry <i>et al.</i> , 2004 [110]	Physicians in Finland with children	1.74 (1.45–2.09)	0.63 (0.52–0.76)	NR
West <i>et al.</i> , 2011 [33]	US internal medicine residents	1.31 (1.20–1.42)	1.10 (1.00–1.21)	1.22 (1.12–1.33)
Shanafelt <i>et al.</i> , 2012 [105]	US surgeons	NR	NR	1.41 (1.17–1.71)
Wang <i>et al.</i> , 2014 [112]	Chinese physicians in Shanghai	NR	NR	1.09 (0.72–1.62)
Shanafelt <i>et al.</i> , 2015 [37]	US physicians	NR	NR	1.29 (1.14–1.46)



What factors might contribute to burnout and decreased satisfaction among women?

- Reduced retention/promotion
- Difficulty finding (female) mentors
- Lower pay
- Increased caregiver responsibilities
- Maternal discrimination
- Infertility
- Imposter syndrome
- Sexual harassment, bias, and discrimination



Impact of gendered expectations

What impact do external pressures have on the risk for burnout?

- ▶ Women are more likely to have the majority of responsibilities at home
- ▶ More likely to deal with issues when scheduled childcare falls through
- ▶ Women physicians in practice have been found to be more dissatisfied with work-life balance (Shanafelt 2012)



Impact of work-life integration

No data for residents

- ▶ Study of hospitalists and outpatient general internists
- ▶ 40-50% noted work-home conflict in the preceding 3 weeks
- ▶ Resolved in favor of work 30%
- ▶ Resolved in favor of home 10-12%
- ▶ 50-60% met both needs

Results not stratified by physician gender

Roberts et al 2014



Impact of parenthood


- ▶ Little data for residents
- ▶ Survey of physicians in Germany found that women physicians with children were more likely to suffer emotional exhaustion
- ▶ HOWEVER, relationship to colleagues and support from those more senior (“superior”) had an even greater impact on emotional exhaustion risk (for both males and females)
- ▶ Impact on parental leave policies? Provision of childcare services?

Richter et al 2014

PERSPECTIVES IN HOSPITAL MEDICINE

Collateral Damage: How COVID-19 Is Adversely Impacting Women Physicians

J Hosp Med. Published Online First July 20, 2020. DOI
10.12788/jhm.3470 | DOI 10.12788/jhm.3470

By: Yemisi Jones, MD , Vanessa Durand, DO ,
Kayce Morton, DO , Mary Ottolini, MD, MPH, MEd ,
Erin Shaughnessy, MD, MSHCM , Nancy D Spector,
MD , Jennifer O'Toole, MD, MEd



THE INVISIBLE LOAD OF MOTHERHOOD: FRONTLINE MOMS DURING COVID

@_HAPPYASAMOTHER X @TEENHEALTHDOC



WORRYING ABOUT
RISK TO SELF AND
FAMILY



HONORING OATH
TO CARE



CLEANING RITUALS
AFTER WORK



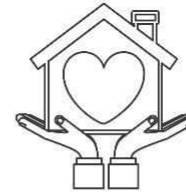
TAKING SCHOOL'S,
FRIEND'S & FAMILY'S
QUESTIONS



TRYING TO KEEP UP
WITH DISTANCE
LEARNING



FINDING ESSENTIAL
CHILD CARE



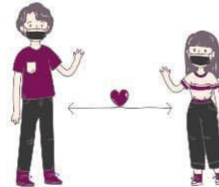
MISSING TIME
HOME WITH KIDS



COMPASSION
FATIGUE FOR KIDS
AND PATIENTS



PTSD AND BURNOUT
FROM BEING
FRONTLINE



ENFORCING MASKS &
DISTANCING WHEN
OTHERS AREN'T



FEELING
DISCONNECTED
FROM OTHER MOMS



GUILT OF ASKING
MORE FROM
PARTNER

Gender-Based Differences in Work-Life Integration (WLI)

- “My work schedule leaves me enough time for my personal/family life”
 - Strongly agree or agree = satisfied

TABLE 3. Multivariate Models Among Practicing Physicians in 2017^a

Satisfied with WLI ^b	Age 35-44 y (vs age <35 y)	0.630 (0.475-0.835)	.001
	Age 45-54 y (vs age <35 y)	0.648 (0.488-0.860)	.003
	Age 55-64 y (vs age <35 y)	0.643 (0.486-0.851)	.002
	Female (vs male)	0.512 (0.444-0.592)	<.001
	Hours worked per week (for each additional hour)	0.944 (0.939-0.948)	<.001



Burnout and WLI are not one and the same

- Recent data from AMA physician survey
 - Sample of US physicians across all specialties
 - >30,000 physicians invited to participate; 5445 (17.9%) completed the survey
 - 3603 responders had complete data and were included in the analysis
 - Follow-up survey of non-responders suggested participants were representative of the overall sample

Burnout and WLI are not the same

- Female MDs overall reported higher prevalence of burnout
 - Burnout rates = 50.1% women, 40.0% men ($p < 0.001$)
 - Differences were observed for overall burnout and for emotional exhaustion
- Female MDs also reported less WLI satisfaction
 - Satisfaction = 36.6% women, 46.6% men ($p < 0.0001$)

Burnout and WLI are not one and the same

- Burnout multivariable analysis
 - Took into account age, relationship status, number of children, hours worked/week, specialty
 - No statistically significant gender-based differences Both women and men in AP significantly less likely to report burnout than men in PP
 - No differences in burnout rates between women and men in PP

Marshall et al [under review]

©2015 MFMER | slide-7

Burnout and WLI are not the same

- WLI multivariable analysis
 - Took into account age, relationship status, number of children, hours worked/week, specialty, **burnout**
 - Women in both AP and PP were less likely to be satisfied with WLI than men in PP
 - No differences between rates of satisfaction with WLI comparing men in AP versus men in PP

Marshall et al [under review]

What factors contribute to burnout and decreased satisfaction with WLI ?



Shanafelt and Noseworthy, [Mayo Clin Proc](#), 2017



Imposter syndrome

- ▶ First described among women but found in both women and men
- ▶ Those suffering from imposter syndrome believe themselves less intelligent or competent than perceived by others
- ▶ Fear that they are intellectual frauds, despite excellent evaluations and test scores
- ▶ If women residents are more likely to cope with stress using self-blame (Spataro et al 2016), is this a result of, or feed into, imposter syndrome?
- ▶ Personality characteristic? A result of training? Part of professional identity development?
- ▶ May be more motivated, but...
- ▶ Also more likely to suffer from distress, depression, anxiety



Imposter syndrome

- ▶ Survey of 181 family medicine residents
- ▶ 90% thought that they were receiving adequate training
- ▶ 41% of women vs 24% of men scored as imposters
- ▶ 60% of women(43% of men) worried about their ability to practice after residency
- ▶ Those with high scores on the Imposter Scale were more likely to be depressed, anxious, and had lower self-esteem

Oriel et al 2004



Sexual harassment/gender discrimination

- ▶ AMA definition

“Behaviors perceived as inappropriate sexual advances, sexist jokes or slurs, the exchange of rewards for sexual favors, sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature”

- ▶ Sexist comments

- ▶ Intended humor or jokes about sex or gender


- ▶ Lewd cartoons, e-mails, letters

- ▶ Sexual innuendoes, comments, remarks

- ▶ All forms impact the victim's confidence, can lead to imposter syndrome, stress, impact on burnout?, can lead to other physical/mental health issues



Other forms of abuse


- Verbal
 - Physical
 - Academic harassment
 - Gender discrimination
 - Racial discrimination
- 



Harassment and Gender Discrimination

- ▶ Systematic review and meta-analysis
- ▶ 177 articles reviewed (1987-2011)
- ▶ 6 countries, including the US and Canada
- ▶ Higher prevalence of harassment and gender discrimination among females
- ▶ Gender discrimination most common form of abuse among residents (prevalence 66.6%), followed by verbal abuse (58%), and sexual harassment (36%)
- ▶ Increases risks for depression and anxiety

Fnais et al 2014



Sexual harassment and gender bias among faculty

- ▶ Survey of recipients of K-awards in 2006-2009
- ▶ Women were significantly more likely than men to
 - perceive gender bias
 - personally experience gender bias
 - personally experienced harassment
- ▶ Women who had experienced these perceived a negative impact on self-confidence and negative impact on their careers

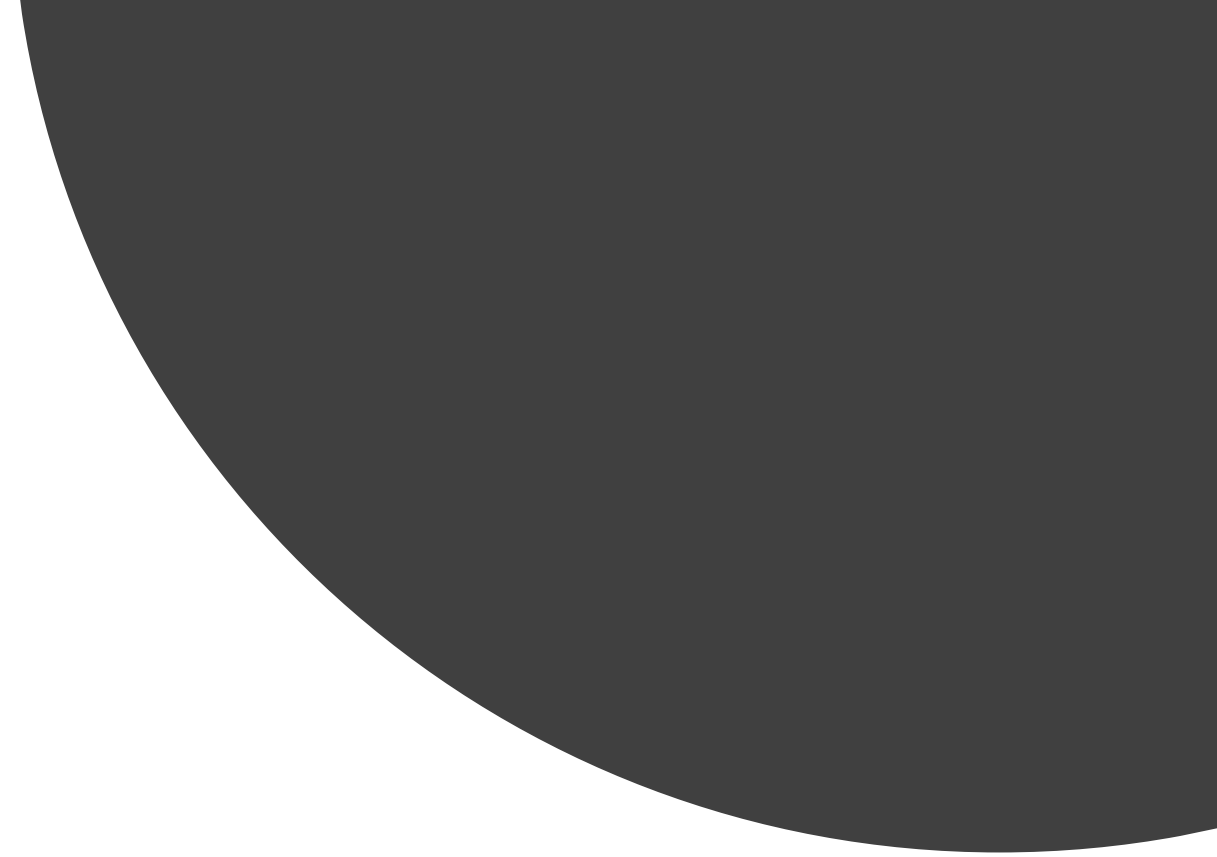
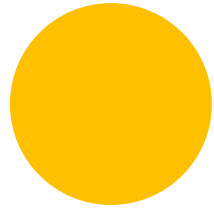
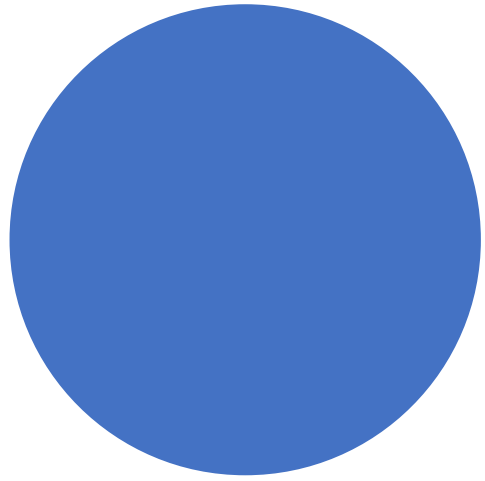
Jagsi et al 2016



Gender-based discrimination

- ▶ Survey through Assn of Women Surgeons
- ▶ Among residents, 67% experienced, 64% observed gender-based discrimination during residency
- ▶ 60% from men, 40% from women
- ▶ Sources of discrimination: superiors, peers, support staff, patients
- ▶ Women less likely to speak up
- ▶ Can lead to decreased career satisfaction

Bruce et al 2015



Experiences of Underrepresented Minorities in Orthopaedics and Impact on Wellbeing

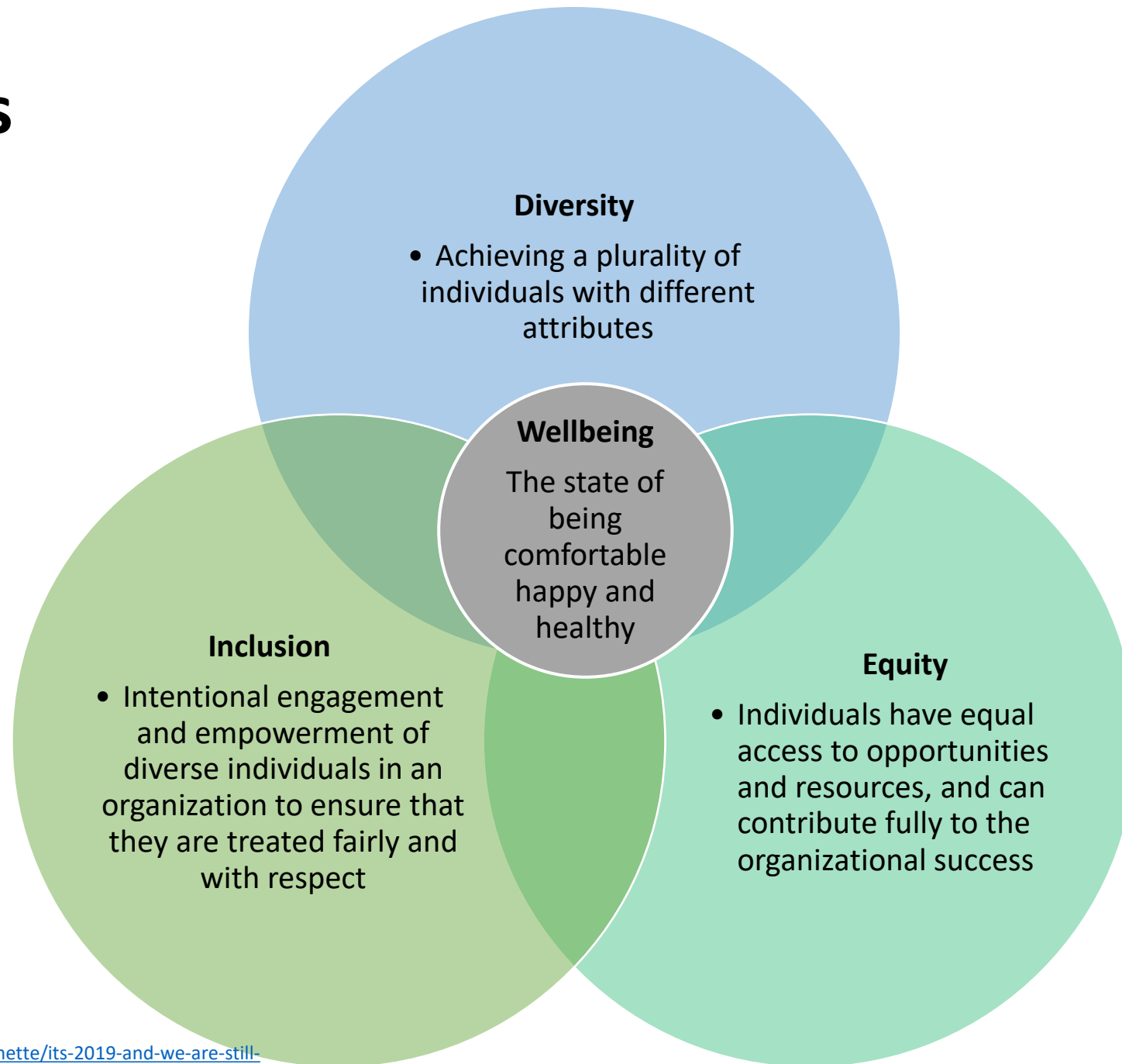
Gabriella Ode, MD

Sports Medicine and Shoulder Surgery

Prisma Health – Upstate, Greenville, SC

Clinical Assistant Professor, USC-
Greenville SOM

Definitions



Definitions

Racial Microaggressions

Defined by Sue et al in 2007 as:

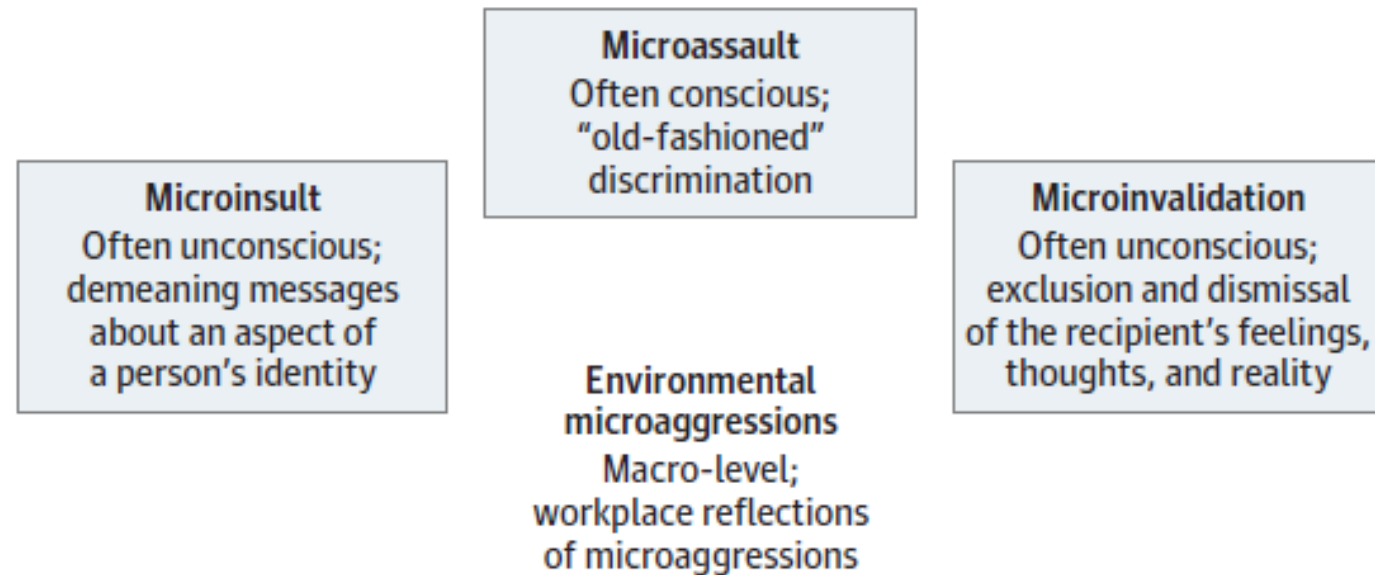
- **“Brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative racial slights and insults to the target person or group”**
- Delineated 4 types of microaggressions

JAMA Surgery | Special Communication

Recognizing and Reacting to Microaggressions in Medicine and Surgery

Madeline B. Torres, MD; Arghavan Salles, MD, PhD; Amalia Cochran, MD

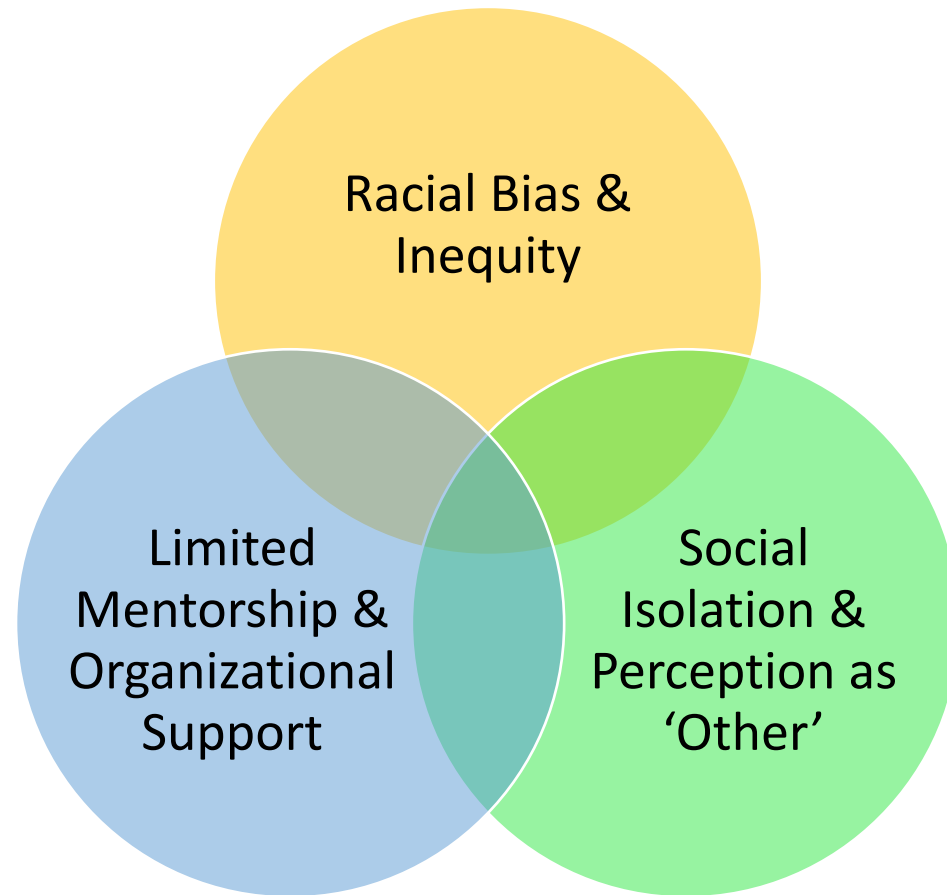
Figure. Summary of the 4 Types of Microaggressions



Sue DW, et al. Racial microaggressions in everyday life: implications for clinical practice. *American Psychologist*. 2007a; 62:271–286.

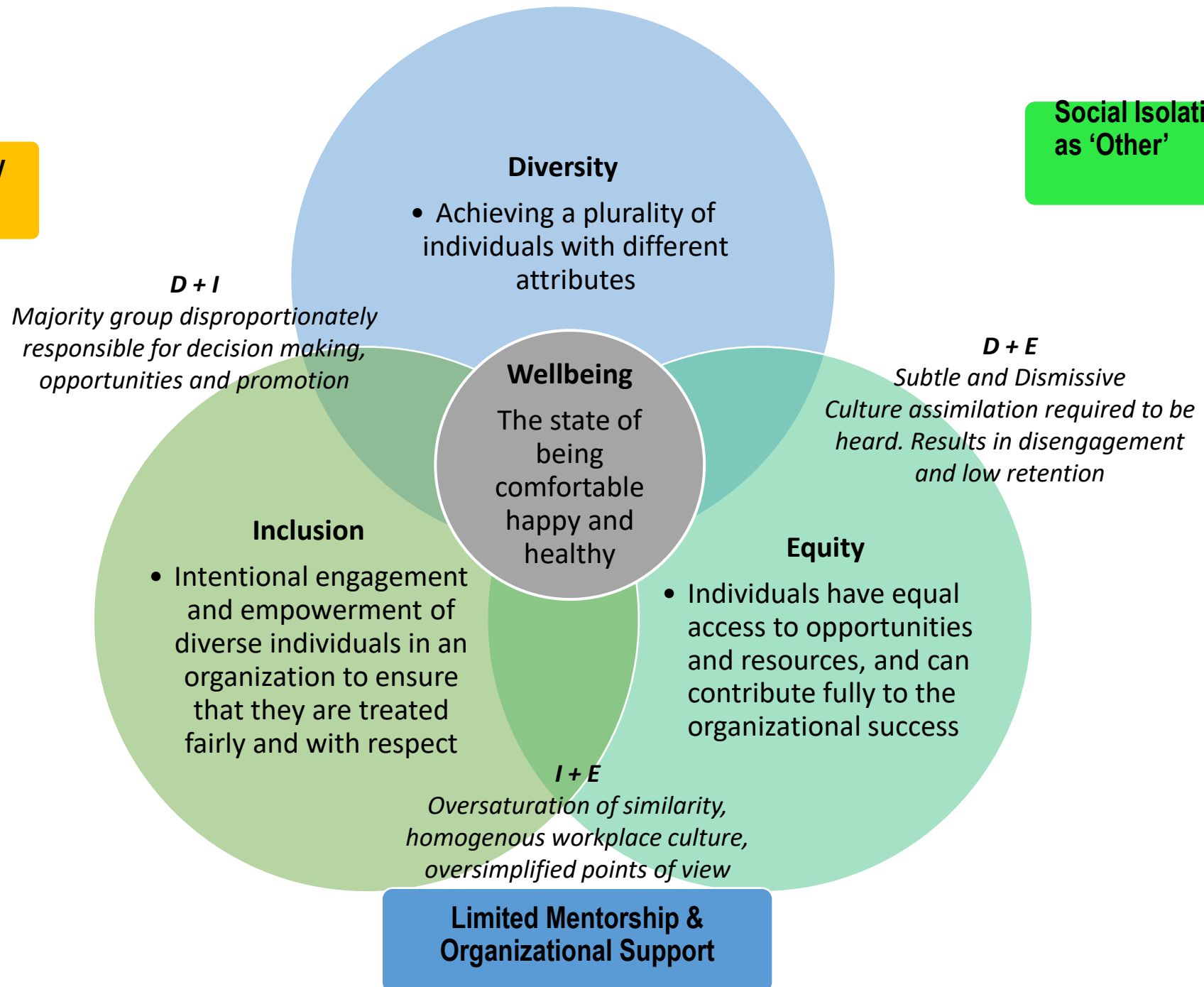
Sue DW, et al. Racial microaggression in everyday life. *American Psychologist*. 2007b; 62:271–286.

Challenges faced by URM in Medicine



Racial Bias & Inequity

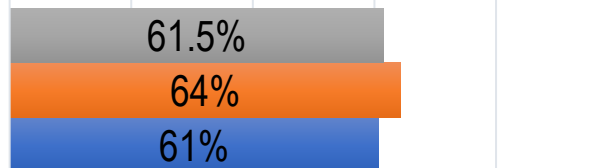
Social Isolation & Perception as 'Other'



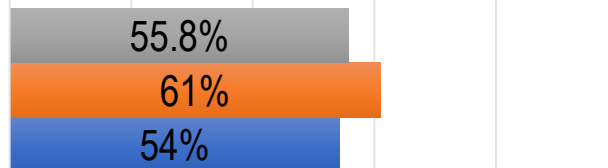
Racial Microaggressions Experienced by Black Orthopaedic Surgeons in Residency (n=279)

Microassaults
(Microaggressions characterized by verbal or nonverbal attacks clearly intended to offend the recipient; Often conscious)

Had racially explicit statements directed toward them in the workplace

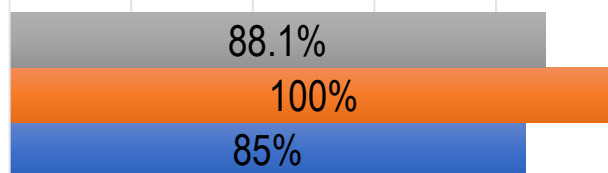


Witnessed racially explicit comments or imagery (including pictures, videos, other media) in the workplace



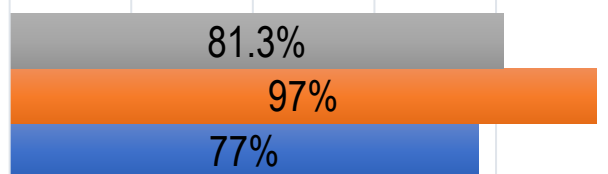
Microinsults
(Subtle snubs or humiliations that convey a demeaning message to the recipient in a way that may be unintentional to the perpetrator; Often unconscious)

Mistaken for non-physician medical staff (e.g. PA, nurse, etc) by a patient or hospital staff



*

Mistaken for non-medical staff (janitorial services, nutritional services, etc) by a patient or hospital staff



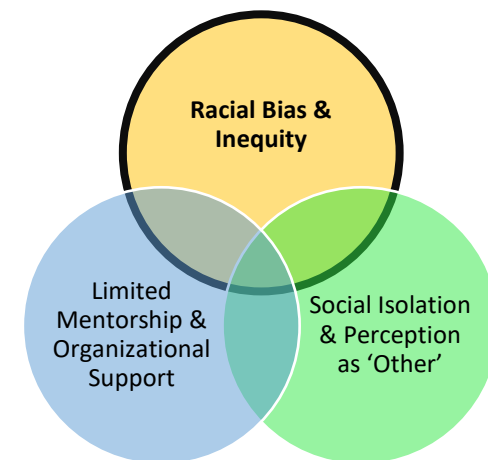
*

0% 20% 40% 60% 80% 100%

■ All (n=278) ■ Female (N=59) ■ Male (n=219)

Overall, racially explicit statements received by black orthopaedic surgeons in residency came from:

- Patients - 139 (50%)
- Attending Faculty - 108 (38.8%)
- Residents - 80 (28.8%)
- Nurses/NPs/PAs - 42 (15.1%)
- Office Staff - 23 (8.3%)
- Surgical Staff - 44 (15.8%)
- Other - 16 (5.8%)



* Denotes statistically significant difference by sex (p<0.05)

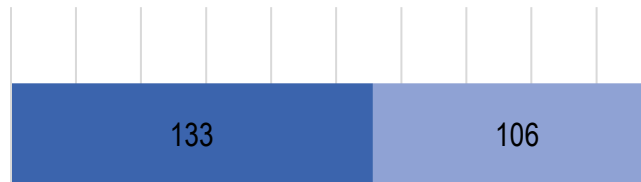
Unpublished Gladden Society Residency Survey Results (July 2020)

219 Black Orthopaedic Surgeons + 60 Current Residents/Fellows

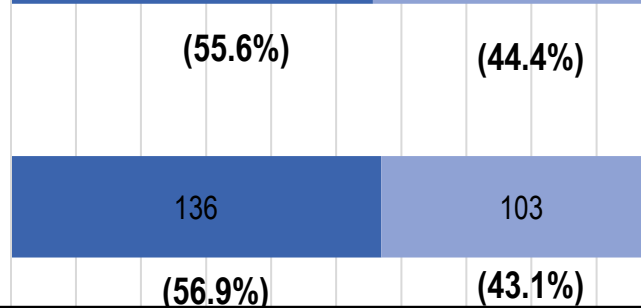
Racial Microaggressions Experienced in Orthopaedic Workplace by Black Practicing Orthopaedic Surgeons (n=248)

Microassaults
(Microaggressions characterized by verbal or nonverbal attacks clearly intended to offend the recipient; Often conscious)

Had racially explicit statements directed toward them in the workplace



Witnessed racially explicit comments or imagery (including pictures, videos, other media) in the workplace

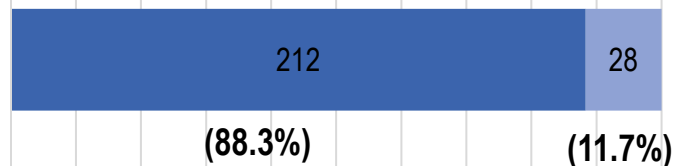


Overall, racially explicit statements received by black orthopaedic surgeons in the workplace came from:

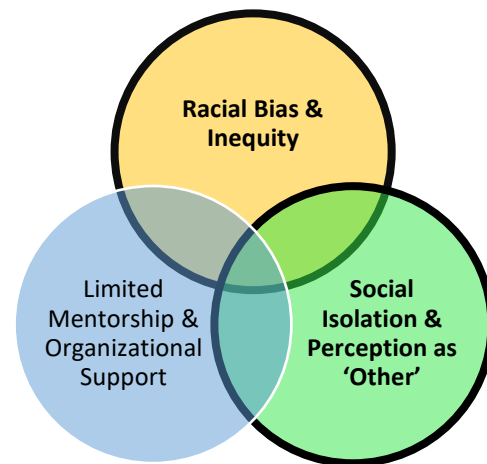
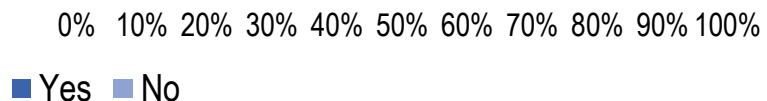
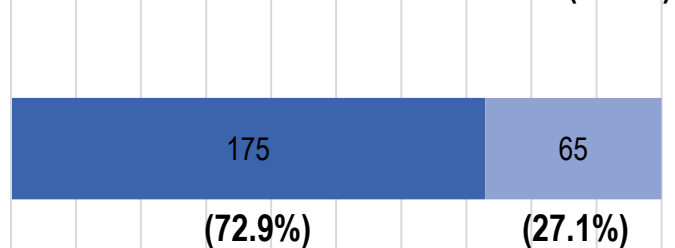
- Patients - 118 (47.6%)
- Attending Faculty - 54 (21.8%)
- Residents - 17 (6.9%)
- Nurses/NPs/PAs – 20 (8.1%)
- Office Staff - 14 (5.6%)
- Surgical Staff - 27 (10.9%)
- Other - 15 (6.0%)

Microinsults
(Subtle snubs or humiliations that convey a demeaning message to the recipient in a way that may be unintentional to the perpetrator; Often unconscious)

Mistaken for non-physician medical staff (e.g. PA, nurse, etc) by a patient or hospital staff



Mistaken for non-medical staff (janitorial services, nutritional services, etc) by a patient or hospital staff

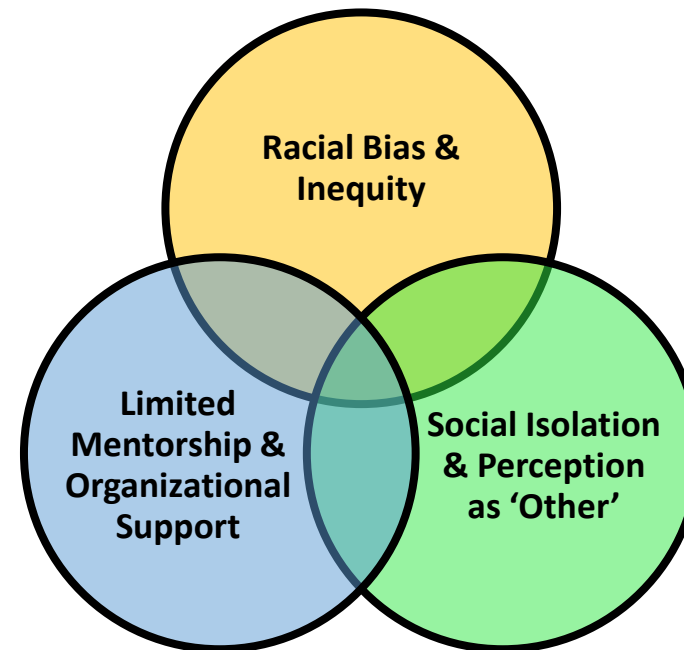


**Unpublished Gladden Society
 Attending Survey Results
 (July 2020)**
 248 Black Orthopaedic Surgeon in Practice

Perceived Occupational Discrimination Among Black Orthopaedic Surgeons

Overall, how would you rate the extent of occupational discrimination against Black orthopaedic surgeons?
(n=233)

- No Discrimination – 6 (2.6%)
- A Little Discrimination – 45 (19.3%)
- **Some to A Lot of Discrimination - 182 (78.1%)**



The New York Times

August 11, 2020

For Doctors of Color, Microaggressions Are All Too Familiar

“They ask you if you’re coming in to take the trash out — stuff they wouldn’t ask a physician who was a white male.”



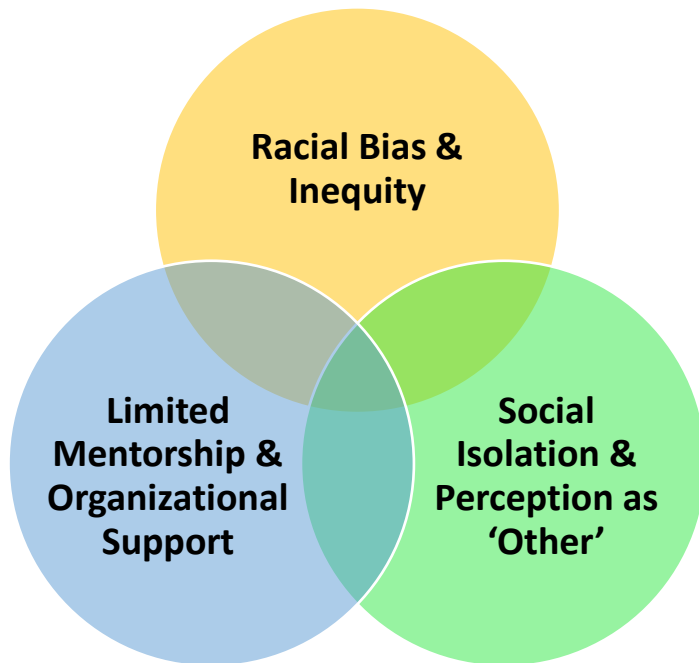
Is this just an
orthopaedic
surgery
problem?

No

Bright CM, Duefield CA,
Stone VE. Perceived
barriers and biases in
the medical education
experience by gender
and race.

J Natl Med Assoc.

1998;90(11):681-688.



- Underrepresented minority in medicine (URMM) students (Black, Latino and Native American) were significantly more likely to report that **race affected their educational experience** compared to their white counterparts.

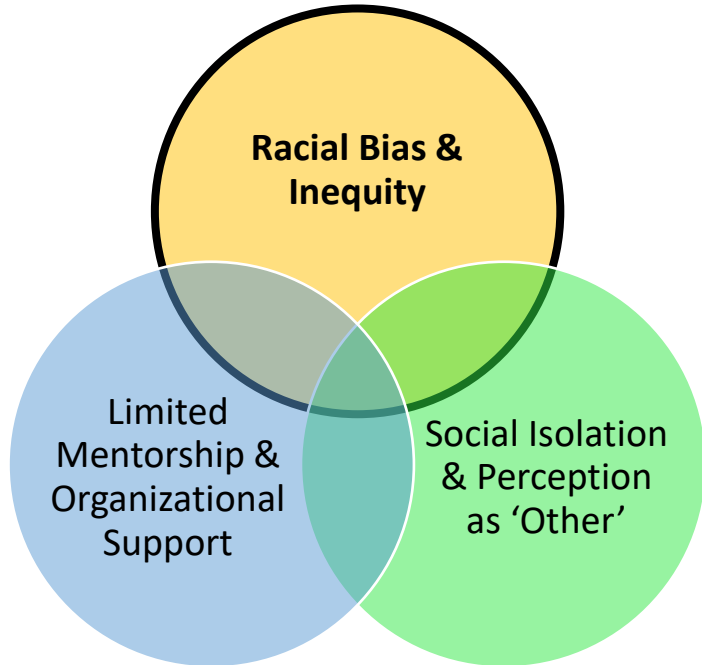
Were more likely to perceive that their race required them to be twice as good in order to be treated as an equal to other students.

Had more trouble establishing a peer-support network

Had greater difficulty finding same-race role models

Osseo-Asare et al. "Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace."

JAMA network open access
7 Sep. 2018



- Semistructured qualitative interviews of 27 URM residents from different specialties asking how they view the role of race/ethnicity in their training experience.

- **3 Major themes described:**

Theme 1: Daily Barrage of Microaggressions and Bias

Alien in one's own land

"Wow, you've really come a long way. You know, like, you know, being like a Mexican, that's just...I didn't expect somebody to be that well educated."

Assumption of lower status

"There were instances where they would just call me 'Nurse' or would think that I'm everything except for a doctor."

Exoticization and assumptions of similarity

"There was an African American resident a year before me. We would constantly get confused. Even now.... We don't look anything alike."

Explicit bias

"There was a situation where...we went in a room to see a patient, and the father was irate, and then he went out to the hallway and one of the things he said to the nurses was that they sent the big black guy in the room to intimidate me."

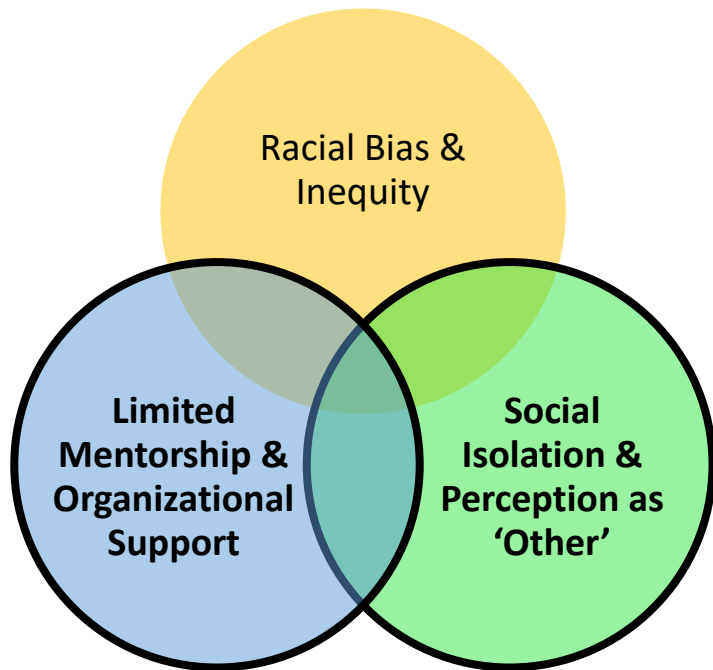
Barriers to reporting discrimination

"Oh, I've brought it up in the past, and it was just kind of pushed aside."

Fear of repercussions

"They didn't [report it] because it was actually their director who made the comment and then that director is a part of this committee... you're trying to balance not upsetting someone too much where they feel like there's going to be repercussions."

Osseo-Asare et al.
 “Minority Resident
 Physicians' Views on the
 Role of Race/Ethnicity in
 Their Training Experiences
 in the Workplace.”
JAMA network open vol.
 Sep. 2018



Theme 2: Minority Residents Tasked as Race/Ethnicity Ambassadors

Race/ethnicity ambassador

“...you get tapped to do various things, and some of it is stuff that you’re interested in and some of it is because they need, not necessarily a token individual, but somebody to be representative of all of the ideas of minorities because you have that insight.”

Theme 3: Challenges Negotiating Professional and Personal Identity While Seen as “Other”

Pressure to assimilate

“You just told someone who’s had an Afro for the last 2 years who finally got their hair flatironed once, and you’re like ‘Oh, your hair looks so professional!’”

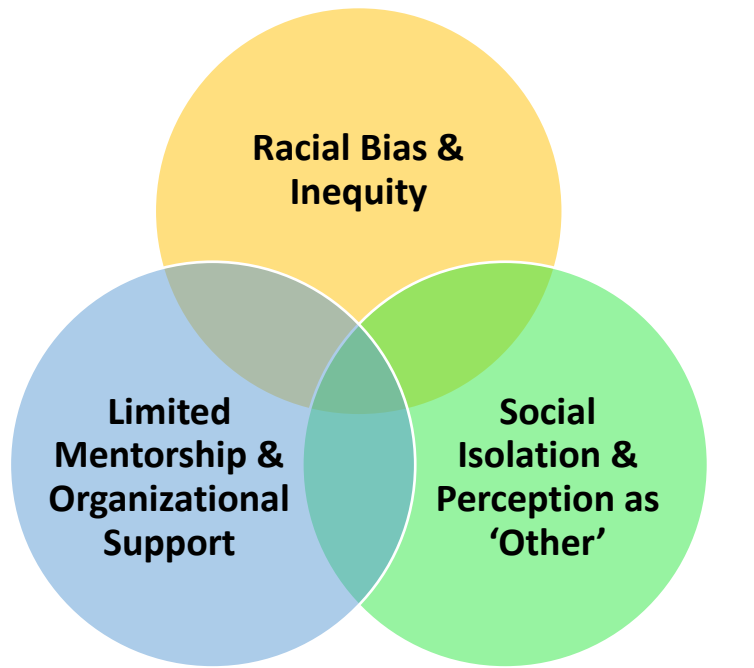
Coping mechanisms

“With a smile. I took it.”
 “...you want to make sure that you’re good, and you want to make sure that you’re smart, and that you’re brilliant, and that they don’t have anything to say about you.”

Social isolation and scarce professional mentorship

“There aren’t a ton of people of color in positions of leadership or as attendings.”

The URM Faculty Experience

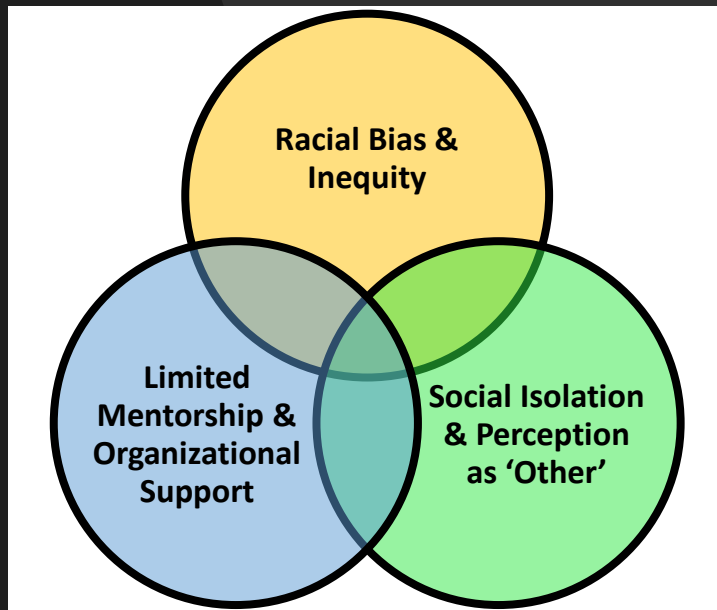


Peterson, Neeraja B et al. "Faculty self-reported experience with racial and ethnic discrimination in academic medicine." *Journal of general internal medicine* vol. 19,3 (2004)

- Among 1,979 surveyed medical school faculty:
 - **48%** of URM faculty reported experiencing **racial/ethnic discrimination by a superior or colleague**
- Faculty that experienced discrimination **had significantly lower career satisfaction than other faculty despite**
 - comparable salaries
 - comparable # of publications
 - similar academic rank.



The 'minority tax' in academic medicine



Rodriguez JE, Campbell KM, Pololi LH. Addressing disparities in academic medicine: what of the minority tax? *BMC Med Educ.* 2015;15:6.

- **Minority tax** - Defined as the tax of extra administrative and clinical responsibilities placed on minority faculty in the name of efforts to achieve diversity. **Also includes the burden of:**

Experiencing racism

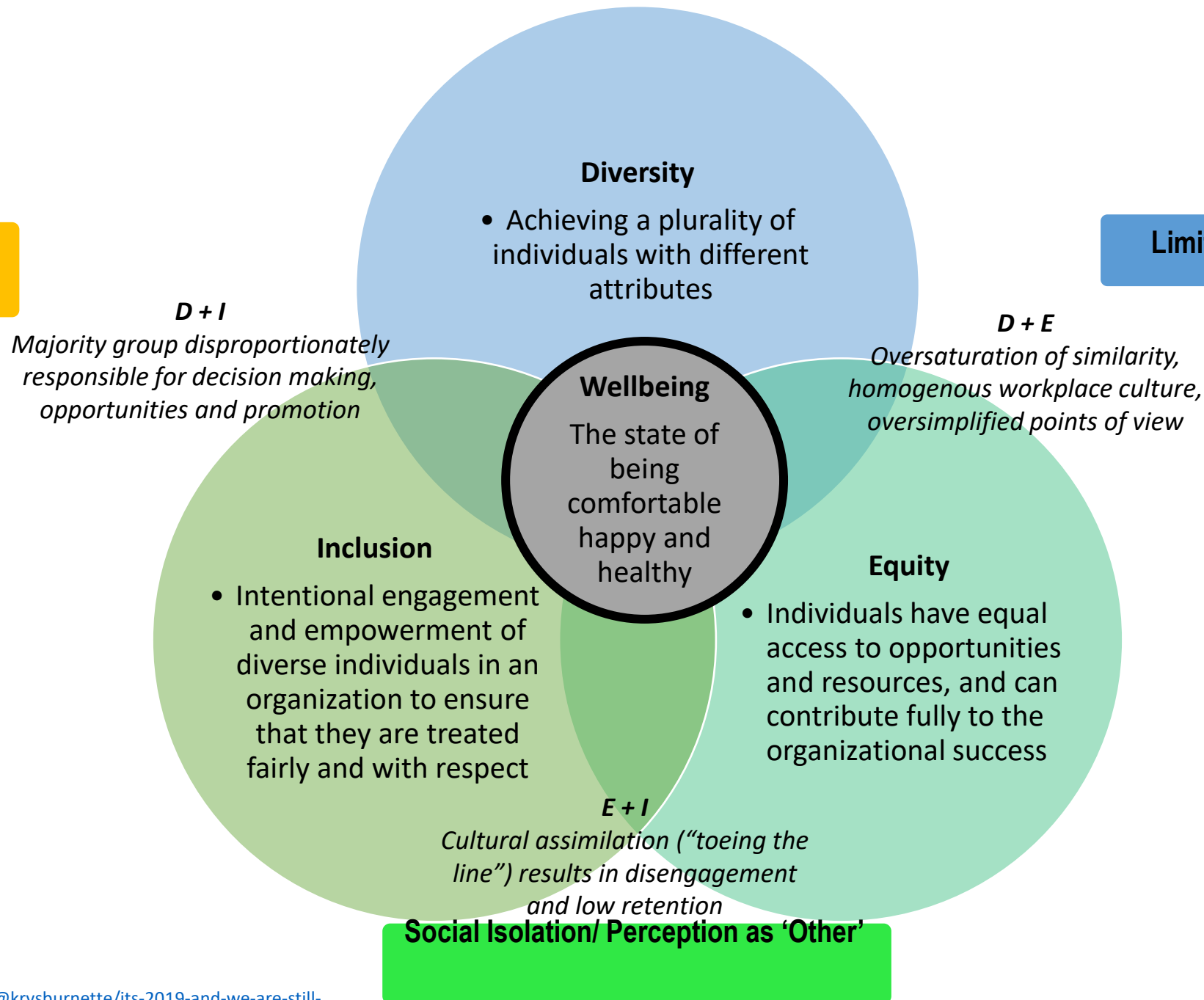
Increased social isolation

Less access to both mentorship and job advancement opportunities compared to non URMM peers

- Campbell KM, Hudson BD, Tumin D. Releasing the Net to Promote Minority Faculty Success in Academic Medicine. *J Racial Ethn Health Disparities.* 2020;7(2):202-206.
- Campbell KM, Rodriguez JE. Addressing the minority tax: perspectives from two diversity leaders on building minority faculty success in academic medicine. *Acad Med.* 2019.
- Rodriguez JE, Campbell KM, Pololi LH. Addressing disparities in academic medicine: what of the minority tax? *BMC Med Educ.* 2015;15:6.

Racial Bias/Inequity

Limited Mentorship/Support



The What, the Why, and the How: A Review of Racial Microaggressions Research in Psychology. Wong et al. Race Soc Probl. 2014 June 1; 6(2): 181–200.



Biological Effects

- Stress depresses the immune system, increases blood pressure and heart rate, and heightens risk for hypertension

Emotional Effects

- Speculation that emotional dysregulation brings about mental health disorders.

Cognitive Effects

- Microaggression incident sets of a chain of cognitive processes aimed at understanding and making sense of the incident
 - Energy spent appraising the situation and deliberating whether or not to respond
 - Energy spent evaluating the consequences of making a response → worry of losing employment
 - Diverts the target's attention and energies from other tasks, and problem solving and learning ability

Behavioral Effects

- Hypervigilance and skepticism
- Rage and anger
- Fatigue and hopelessness
- **Strength through adversity**

Discrimination Exacts an Emotional Tax on URM's in the Workplace

- **Emotional Tax** - Defined as the combination of feeling different from peers at work because of gender, race, and/or ethnicity and the associated effects on health, well-being, and ability to thrive at work. The state of being **on guard**—**consciously preparing to deal with potential bias or discrimination**:
 - Fear of being stereotyped
 - Receiving unfair treatment, or
 - Feeling like the “other” (i.e., set apart from colleagues because of some aspect of their identity such as gender, race, or ethnicity)
- A majority of women and men across racial and ethnic groups—**58%**—**report being highly on guard**.
 - Employees who felt on guard were most likely to:
 - Face challenges to their well-being
 - Want to leave their employers --> increases risk of talent drain in the workplace

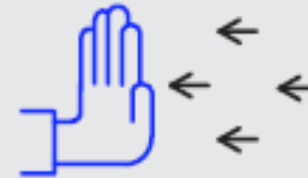


DNKA J. TRAVIS, PHD
JENNIFER THORPE-MOSCON, PHD

DAY-TO-DAY EXPERIENCES OF EMOTIONAL TAX AMONG WOMEN AND MEN OF COLOR IN THE WORKPLACE



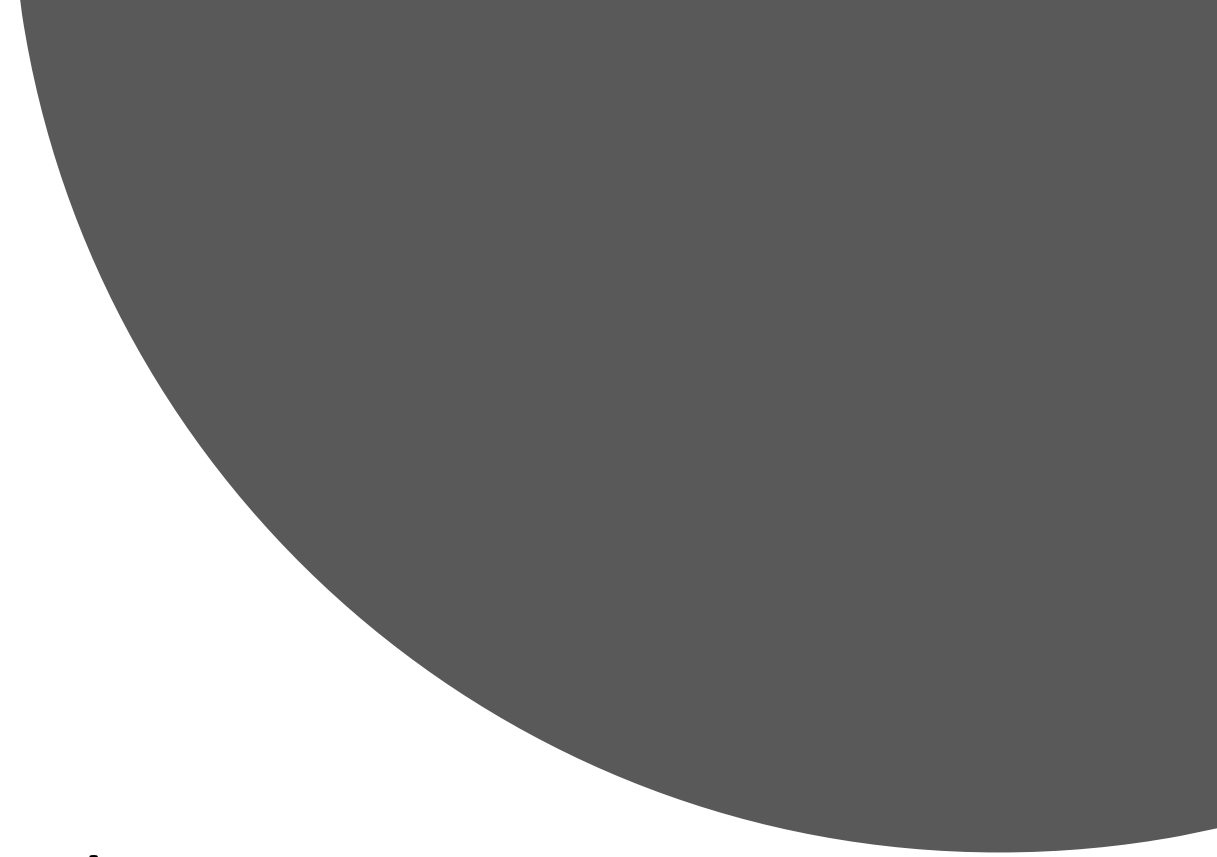
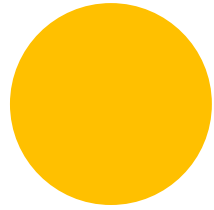
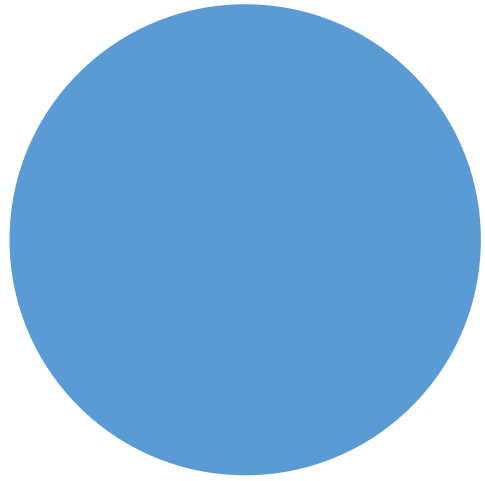
Experience of **BEING DIFFERENT** due to Gender, Race, and/or Ethnicity



Being **ON GUARD** to Protect Against Bias



RISKS to Employee Well-Being and Productivity



How can we foster
Diversity, Equity and
Inclusion to improve
Wellbeing?



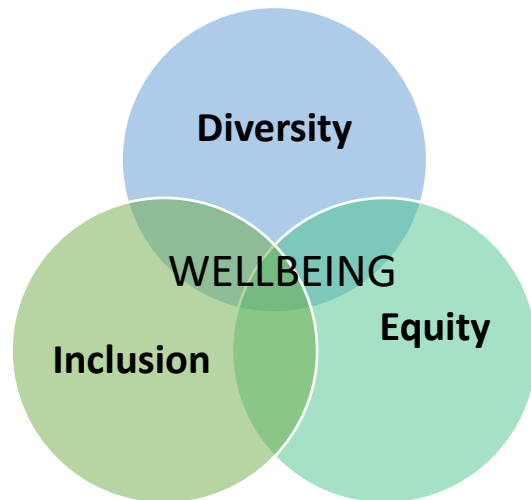
DAY-TO-DAY EXPERIENCES OF EMOTIONAL TAX

AMONG WOMEN AND
MEN OF COLOR IN
THE WORKPLACE

CATALYST
WORKPLACES THAT WORK FOR WOMEN

DNIKA J. TRAVIS, PHD
JENNIFER THORPE-MOSCON, PHD

‘Leaders must cultivate inclusive workplaces to retain these valuable employees and address potential reasons for being on guard’



Listen - Normalize talking openly about differences—paying particular attention to **listening to and affirming experiences that bridge gender, race, and ethnicity.**

Learn - Take proactive, careful stock of the day-to-day experiences of exclusion and inclusion; **don't discount subtle ways people can feel singled out or connected to their colleagues.**

Link Up - Team up with employees to leverage their drive to contribute; demonstrate through partnership the **value** you place on their contributions.

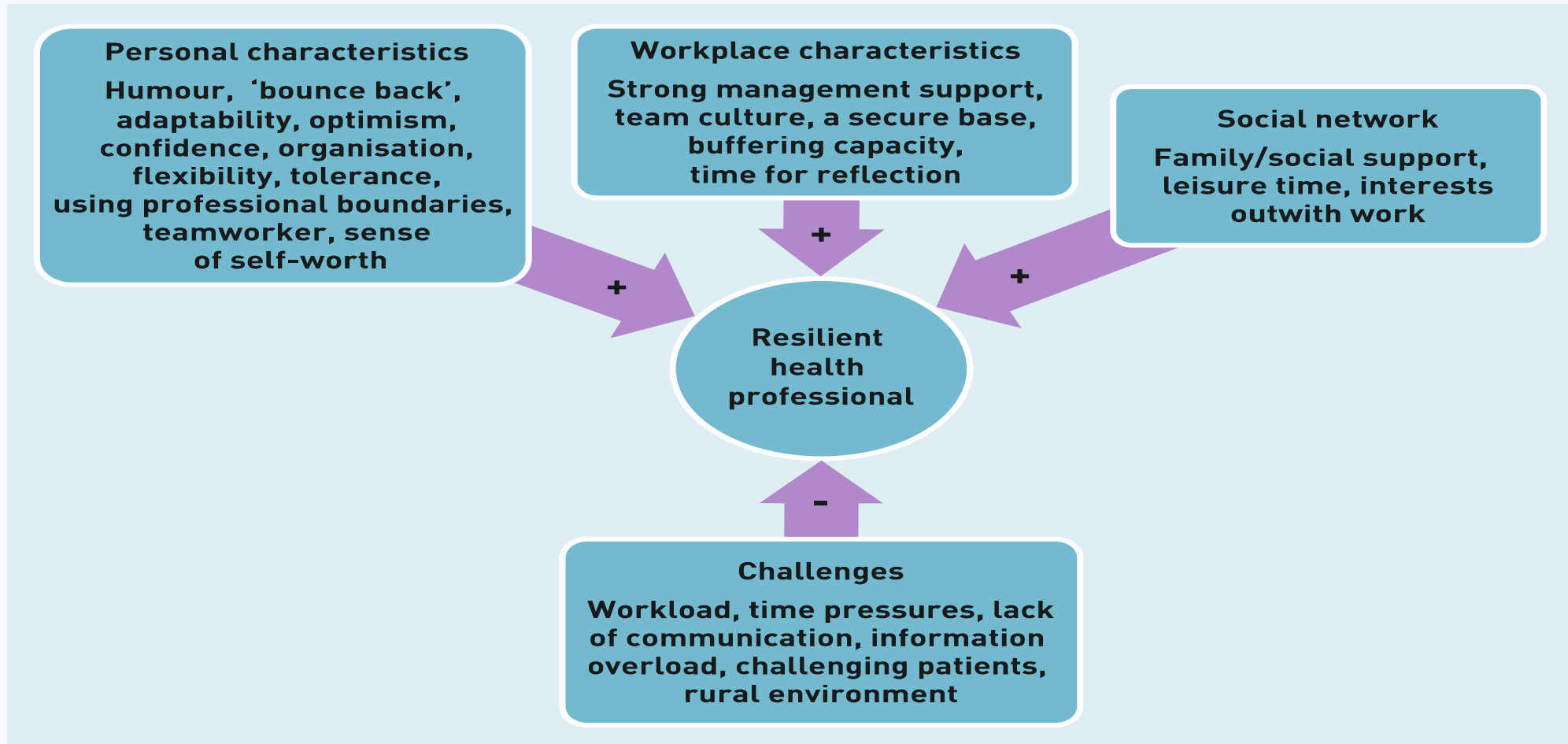
Lead - Ensure that leaders and employees are supported and held accountable for inclusive leadership behaviors. Emphasize role that all leaders have to play in creating workplaces where **everyone is valued, is heard, and has fair opportunities to succeed.**

KIMBERLY J. TEMPLETON, MD, FAMWA, FAOA

Vice-Chair and Residency Program Director

University Of Kansas-Kansas City

Resilience- Not Only An Individual Issue



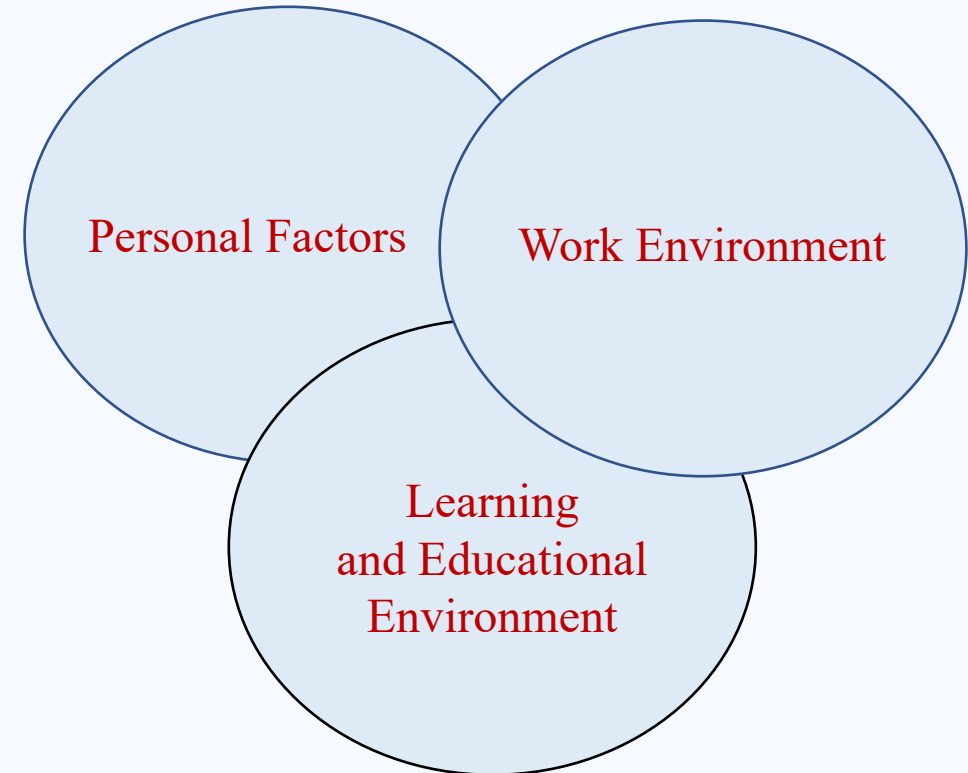
Interventions

More than work hours

Individual interventions have some impact (e.g., yoga, mindfulness)

Greater impact from

- Institutional change (work and learning environments)
- Providing additional opportunities for interaction (e.g., while at work, within professional associations)



Institutional Vs. Personal Initiatives

Activities that trended toward lower self-reported burnout but were not statistically significant:

- Engaging in physical activity greater than once per week
- Regularly engaging in hobbies outside of work
- Regularly scheduling or protecting time with partner/family/friends

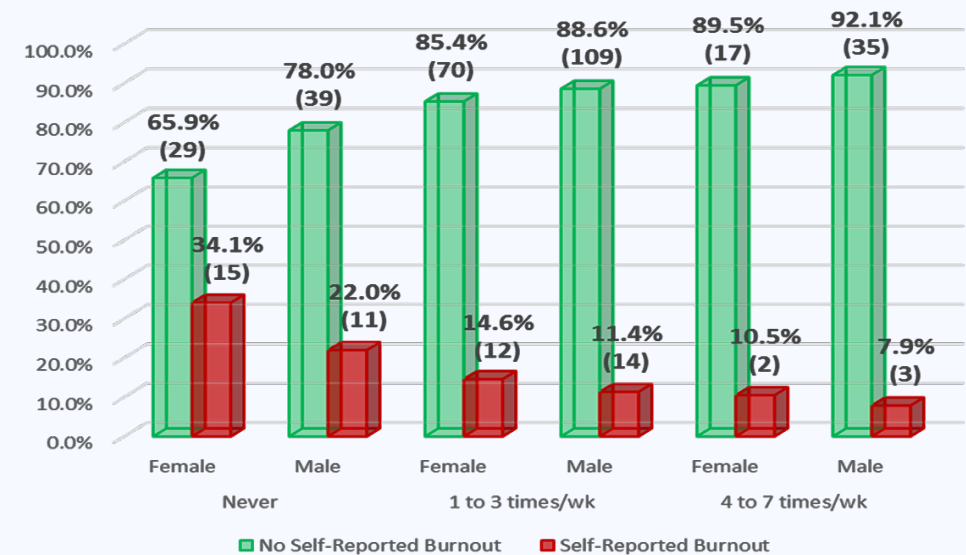
Activities that did not correlate to lower self-reported burnout:

- Practicing meditation or mindfulness
- Being Spiritual
- Performing regular self-assessments of one's well-being

Significant factors associated with decreased burnout:

- Culture supportive of resident wellness
- Initiatives to improve work efficiency

Impact of Exercise



Personal Burnout Protective Factors-Residents & Faculty

Many of the factors are on both lists

TABLE IV Resident Protective Factors*

- Leaves personal concerns out of workplace
- Perceives support from other medical families
- Has an in-program mentor
- Speaks frequently with mentor
- Draws on religion or faith
- Makes time for exercise
- Makes time for hobbies
- Takes non-work-related vacations
- Has low levels of alcohol use
- Makes time regularly to be alone with mate
- Has high overall satisfaction with life in medicine
- Perceives help from program for mate's adjustment

TABLE V Faculty Protective Factors*

- Leaves personal concerns out of workplace
- Perceives support from other medical families
- Has a colleague mentor
- Perceives work environment to be supportive
- Meditates
- Makes time for exercise
- Participates in hobbies frequently
- Has low levels of alcohol use
- Makes time regularly to be alone with mate
- Belongs to national specialty organization

Professional Development

- Negotiation skills training (different for women)
- Time management, balancing expectations, setting boundaries (especially for junior faculty)
- Leadership skills- especially when starting (or planning on) a career transition (can help to address imposter syndrome)
- Help in finding the 20% of their day that makes work rewarding

Mentoring

- For both residents and faculty
- To discuss adaptations to changing responsibilities-professional (identity) development, address imposter syndrome
- Specific feedback (especially with millennials) to identify what was done well, how others perceive his/her knowledge/capabilities, etc.
- To normalize experiences and provide input but identify issues early

How Do We Address Negative Home-work Integration?

- Support for family leave
- Options for dealing with backup child or elder care
- Opportunities to discuss how to engage partners in household and childcare duties (negotiation skills?)- can be part of mentoring



Addressing Discrimination And Harassment

- Unconscious bias training
- Changing culture
- Training in prevention, recognition, management of harassment
- Develop a *clear, effective* reporting structure for residents
- Culture cannot change unless we know what is happening
- Residents frequently do not report as they think nothing will be done and/or they will face negative consequences or think that it's just a normal part of training (especially bullying behaviors)
- Ombudsperson program? Other?

Does Harassment Training Work?

Depends on how it is delivered but probably not

- May increase unconscious biases, leading to increased stereotyping
- Noted in men and women
- Most significant in men and women who held initial biases; confirmed their views
- Noted even in women who held few biases initially; training may make them feel disempowered

Not a sufficient intervention on its own

J Tinkler, et al

Addressing The Parent Load During COVID 19

- July 2020 – open group – Montefiore Medical Center
- 40 Pediatricians
- Major Themes
 - Acknowledgement from leadership about current challenges and stresses of parenting during COVID
 - Relief from pressures of academic productivity
 - Scheduling flexibility
 - Support for non-faculty who are also struggling
 - Support from peers
 - Mental health resources

Summary

Normalize/prioritize self-care and caring for others

- Stress mental and physical health needs (and provide opportunities to address these)
- Improve access to confidential mental health resources (e.g., physician support lines, institutional resources, PHPs)
- Acknowledge roles/responsibilities outside of the workplace
- Teach/learn to develop boundaries between work and home
- Develop opportunities for socialization to address loneliness
- Provide career mentoring/sponsorship for residents and faculty
- Department wellness committee?
- Develop/adhere to no tolerance policies for bias/harassment, with clear reporting structure
- Work toward department/institutional change to improve work flow and reduce clerical tasks
- *Emphasize institutional/societal support to make this a priority*

Self-Care is Not in Conflict with Altruism

"Secure your own
oxygen mask
before assisting others"



Questions/Discussion

01



Raise your hand to ask a question **verbally** during the Q&A session at the end. In order of hands raised, when it's your turn, you will receive a notification, telling you to un-mute yourself.

02



Chat with panelists and/or all attendees. Send a chat to panelists if you have a technical issue.

03



Ask questions in the Q&A box if you'd prefer not to be unmuted and would like a written response to your question.



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Upcoming CORD Town Hall

Look for further information to come

CORD Town Hall
Date TBD

Diversity and Inclusion

Join CORD colleagues
for an open discussion and ideas for what
programs/program directors can do



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CORD WEBINAR

Addressing Resident and Faculty Wellbeing

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Questions?
Email cord@aoassn.org