

## SPRING 2020: Physician Wellness

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### President's Message

## During Times of Crisis, Anesthesiologists Rise to the Occasion



**By Jeffrey Green, MD, FASA**  
*VSA President*



Dr. Jeffrey A. Green  
*VSA President*

Virginia Commonwealth University, a large state-funded Level 1 Trauma center where I practice, is rarely below 95% occupancy and usually, we are at or over 100% capacity.

While it is nice to be busy, recently I have considered this situation a worrisome liability. With the threat of COVID-19 looming, our anesthesiologists are soon to be inundated with patients in a way that will likely overrun resources at all of our facilities, including equipment, drugs, supplies and personnel.

By the time you read this article you may already be at that point. However, I believe

we are ready to meet the challenge and will demonstrate our reliability and outstanding value to the healthcare system.

The impact of the COVID-19 crisis on anesthesiologists cannot be overstated. It is likely that we will never encounter a global event like this again in our careers. How we respond to the crisis will reflect our training and preparedness in our discipline.

Anesthesiologists are uniquely trained to rescue and manage the respiratory impairment and critical organ dysfunction that COVID-19 patients will demonstrate. Anesthesiologists are experts in respiratory physiology and management, in critical care procedures such as intubation and intravenous access, and in the rapid response and triage of many critical patients in a multi-casualty event.

Many years of stressful operating room and strenuous ICU practice aids our resilience. As has always been the case in my

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### Feature Article

## Effects of Sleep and Fatigue on Anesthesiologists

**By Lauren K. Dunn, MD, PhD  
and Amanda M. Kleiman, MD**  
*Department of Anesthesiology,  
University of Virginia*



Dr. Lauren K. Dunn



Dr. Amanda M. Kleiman

A significant challenge of our specialty is that anesthesiology practice necessitates coverage of patient care 24 hours a day. This involves extended shifts and overnight work, which contribute to fatigue and sleep disruption. Sleep deprivation has been associated with irritability and mood changes, difficulty concentrating, and disorientation.

Regulating bodies, including the Accreditation Council for Graduate Medical Education (ACGME), have attempted to combat the fatigue associated with long work hours. Implementations include duty hour restrictions limiting shift length and, amount of total weekly hours worked among physician trainees.

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## UPDATE

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### Administrative Office

VSA  
2209 Dickens Road  
Richmond, VA 23230-2005  
Phone: (804) 565-6356  
Fax: (804) 282-0090  
vsa@societyhq.com • www.vsahq.org

**Stewart Hinckley**  
Executive Director  
stewart@societyhq.com

**Andrew Mann**  
Association Executive  
andrew@societyhq.com

### Newsletter Editors

**Editor**  
Brooke Trainer, MD  
brookealbright@gmail.com

**Resident Editor**  
Daniel H. Gouger, MD  
Daniel.Gouger@vcuhealth.org

The **VSA Update** newsletter is the publication of the Virginia Society of Anesthesiologists, Inc. It is published quarterly. In January, a special annual legislative issue is published. The VSA encourages physicians to submit announcements of changes in professional status including name changes, mergers, retirements, and additions to their groups, as well as notices of illness or death. Anecdotes of experiences with carriers, hospital administration, patient complaints, or risk management issues may be useful to share with your colleagues. Editorial comment in italics may, on occasion, accompany articles. Letters to the editor, news and comments are welcome and should be directed to: Brooke Trainer, MD • brookealbright@gmail.com.

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## President's Message, from page 1

*We must be willing to use our training and experience to the highest degree possible since our normal role as anesthesiologists likely will change temporarily in the coming weeks.*

25 years of anesthesia experience, we rise to the occasion despite any personal or professional barriers to ensure our patients have the care they need.

There is a cost to what we do. Though not surprising, anesthesiologists rank high on the burnout and physician suicide rates among professionals. We internalize and absorb the suffering that our patients experience as part of delivering their care and treatment. I personally believe it is innate compassion and empathy that draws us to become physicians; though, this later contributes to the moral injury we endure while we treat illness.

The stress and significance of what we see and do on a daily basis is enough to push any of us to the edge or over it. Although the physical risk of what we do is low, the emotional and psychological impact is real.

I have noticed the anxiety and stress in the voices of the surgeons, nurses, and anesthesiologist colleagues over the last couple of weeks due to the uncertainty of the crisis. This is an expected and understandable human reaction to an unpredictable situation.

However, as it becomes clearer that we are faced with an unprecedented public health crisis, we must meet the onerous task with resolve. We must support each other and look for signs of fatigue and stress in our colleagues. We must remind each other to protect our families and ourselves first.

We must heed the warnings of officials to stay home, isolate, and help to "flatten the curve." We must help elderly relatives and neighbors obtain food, supplies, and

prescription medicines. We must read accounts from our colleagues in Italy and Seattle, and learn the lessons gained from their experience.

We must use our creativity and thoughtfulness when resources such as N95 masks, PAPRs, and negative pressure ICU rooms are exhausted. We must educate ourselves on how to treat, transport, intubate, and ventilate COVID-19 patients. We must support our colleagues in quarantine or those who become infected, by making sure they stay home in isolation or receive the medical care they need.

We must be willing to use our training and experience to the highest degree possible since our normal role as anesthesiologists likely will change temporarily in the coming weeks.

These times ahead will be a trying for all of us. Now more than ever, we should help, support, and protect one another as much as possible, physically as well as mentally, and emotionally.

Both the VSA and ASA are here for you. There is information available for anesthesiologists to help understand how to manage COVID-19 patients at [www.asahq.org](http://www.asahq.org). There are recommendations for how to protect yourself and your family from the risk of infection.

A resource I have found personally helpful is the private group called "Anesthesiologist Group" on Facebook. A great deal of information sharing and helpful posts can be found with timely and relevant information for anesthesiologists. I would encourage you to read and share stories and tips related to your experience during this pandemic.

In addition, please reach out to your local VSA contact or to me personally at [Jeffrey.green@vcuhealth.org](mailto:Jeffrey.green@vcuhealth.org) if there is anything the VSA can do to help you through this crisis. Despite all of the "doom and gloom" we hear related to the worsening crisis, I believe we are stronger and more resilient working through this together.

To quote Gene Krantz, NASA Apollo 13 Flight Director, "I believe this is going to be our finest hour."

## Save The Dates

Due to the rapidly evolving status of events surrounding COVID 19, we advise checking society and meeting websites for more timely updates

## The VSA encourages your Practice Administrators to join!

*We have two options:*

1. If 90% or more of a group's physician anesthesiologists are VSA Active members in good standing and all members will be on a single group bill, the annual dues are FREE.
2. If less than 90% of a group's physician anesthesiologists are ASA Active members in good standing, or the group does not participate in group dues billing, the annual dues are \$75.00

To have your Practice Administrator join, click here: <https://www.asahq.org/member-center/join-asa/educational>

- On this page, click on the category you're interested in – in this case, its: Anesthesia Practice Administrators and Executives – Educational Member
- Click on the + sign next to the title
- Within the box that opens, will give you the full details and the membership rate(s)

Please contact Greg Leasure, Membership Manager, at [greg@societyhq.com](mailto:greg@societyhq.com) if you have any questions

## Feature Article: Sleep and Fatigue, from page 1

Many studies have investigated the effect of duty hour regulations on the quality of patient care and resident education and have shown that shorter shift length is associated with decreased medical errors, motor vehicle collisions, and percutaneous injuries.

In order to meet with duty hour restrictions, many anesthesiology residency programs have trialed various schedules, including development of night float systems. Among surgical residents, implementation of a night float system led to reduced fatigue, more time for sleep and independent reading and, increased family time compared to 24-hour call. Nurses and patients reported improved communication and quality of patient care.<sup>8</sup>

Since little is known about the effect of night float on quantity and quality of sleep or resident performance, our Education Research Group at the University of Virginia has sought to better understand the true effects of call and night float on physician sleep.

In one study, we observed changes in sleep among anesthesia residents assigned to work six consecutive night float shifts. Residents were asked to wear a portable EEG device to track changes in the amount and quality of sleep.

We observed that during an average night, residents slept only 5.9 hours, nearly two hours less than the recommended eight hours. During night float, residents slept 1.4 hours less each day. During the three days after working the night float shift, the total amount of sleep time returned to baseline.

However, residents spent significantly less time in deep or REM sleep, which are considered to be restorative phases of sleep. This study showed that sleep is significantly impaired when residents are assigned to work night float and that more than three days are necessary to recover after working 6-consecutive night shifts.

To determine the effect of night float and changes in sleep on task performance, we completed two studies examining the effect of night float work on driving performance in a high-fidelity driving simulator. Previous studies found an increase in the likelihood of motor vehicle accidents and near-miss incidents after an extended work shift.

We sought to determine the effects of a



shorter but still potentially deleterious night float shift. In the first study, we compared driving performance after a six-day week of night float to performance during a normal week of day shifts.

Residents were asked to drive the two-mile, four-lane oval track in the center of their current lane, to maintain speed at 45 mph, and to avoid obstacles when they appeared. We looked at five outcome variables in the driving simulator including speed, lane position, throttle, steering, and the number of collisions with obstacles. We found that physicians have greater difficulty controlling speed and driving performance with increased reaction times and minor and major lapses in attention in the driving simulator following six consecutive night shifts when compared with performance after a “normal” night of sleep.

While the negative effects of night float on driving may be less than a more standard 24-hour call system, there are still significant effects on driving simulator performance. We feel this change may be representative of other deleterious effects on completion of other tasks, such as clinical tasks and decision making at the end of a shift.

As a follow-up to this study, we compared simulator driving following a week of night float after consuming a caffeinated energy drink containing 160 mg of caffeine to an uncaffeinated energy drink utilizing a

crossover design.

We examined the same driving simulator variables in this study and found that residents who consumed the caffeinated energy drink had increased variability in throttle, steering, and speed during the first 10 minutes of open-road driving but proceeded to demonstrate improved driving performance with fewer obstacle collisions. Improved driving performance was most apparent during the last 30 minutes of the simulated drive. This study suggests that caffeine is not a substitute for sleep but that it may help to improve driving performance when fatigued.

### Conclusion/Future Directions

In addition to other areas of interest, our Education Research Group at the University of Virginia aims to better understand the effect of fatigue on anesthesiology resident performance and well-being. The optimal duration of night float work and the impact of various coverage strategies on resident well-being is largely unknown.

Our research suggests not only that night float work has a measurable impact on sleep but also that this likely translates to an effect on task completion, including driving simulator performance. Future avenues for research include the examining the effect of fatigue on resident performance and testing interventions to improve sleep and combat physician fatigue.



# Prevent Burnout: Focus on Your ONE Thing

By Brooke Albright-Trainer, MD  
Editor, VSA UPDATE



Dr. Brooke Albright-Trainer

Burnout Syndrome (BOS) among health care workers is increasingly recognized as a serious medical condition, but what are we doing to prevent or treat the problem?

Few resources exist for healthcare professionals looking to seek emotional and mental help. Often times, healthcare workers fail to report these issues due to the stigma and moral obligation to perform well, the fear of being perceived as incompetent or weak, or possibly the fear of reprisal or retaliation.

With this newsletter's theme centered on "Physician Wellness", I feel it is important to discuss real solutions to the problem. Institutions seem to be placing more emphasis on educating their staff on recognizing burnout, yet we are far from figuring out how to manage the problem.

Working for the government and now an academic institution, I have heard plenty of lectures on the definition of Burnout Syndrome, its prevalence, and the stigma's surrounding reporting it. But what can I do to manage burnout?

I found myself asking this question after the birth of my first child. Within a 12-month span, I experienced four out of five major life stressors: moved to a new state after separating from the military, newlywed, and started a new job with a baby on the way.

Looking back, I realize I likely had all of the signs and symptoms of Burnout Syndrome, and possibly worse. I didn't have time to read much then, but fortunately I found an audiobook, which really helped make my life more manageable, allowing me to get through those really tough times.

The book "The ONE Thing: The Surprisingly Simple Truth Behind Extraordinary Results" by Gary Keller is a #1 Wall Street Journal bestseller and speaks to many simple concepts, which if successfully applied,



can help improve one's overall well being, while at the same time increasing their productivity.

Many 'Mindfulness' concepts require us to take time off away from work or family, reserving time for 'self-reflection'. Though this is important, it is not always practical or feasible. As physicians, with so many people relying on us, from our own family to our patients, how do we find time for ourselves?

Lessons from this book provide a guide in how to better protect and manage one's time, thereby leading to less stress, more productivity, and overall improved wellbeing.

In no particularly order, allow me to review for you the major concepts and take-aways of this book, which I believe can be applied by everyone with the goal of giving healthcare workers a more substantial tool for managing burnout syndrome.

## Lesson 1: There is no such thing as "Multitasking"

This can vary from day to day, from hour to hour, but the overall concept is you should focus on ONE thing at a time. Don't allow yourself to flip between these important priorities. The author emphasizes over and over that multitasking is a complete misnomer... it is simply not possible to be productive at many tasks at once!

I learned this concept the hard way while out on maternity leave with my first child. Throughout my pregnancy I made a "to do" list, with my husband, of everything I want-

ed to accomplish. I seriously thought I would get so much done because, when in my life have I ever had three months off work?

But a couple weeks after the baby came, and I looked around and realized the list had only got longer and I had not completed a single task, I broke down and cried. I felt like such a failure. I always considered myself to be such an "amazing multi-tasker", but now I couldn't even find time to change out of my pajamas! (I think many moms out there can relate.)

Reading the book, "The ONE Thing" changed everything for me. My priority became the baby, and he was the one thing I decided to focus on. I threw away the "to do" list and decided everything else could wait. It allowed me to focus on his wellbeing, and that became the basis for which I measured my own success. I began to feel proud of the way my son was growing and developing.

After this realization, I felt a huge burden lift off my shoulders. I no longer allowed myself to focus on all the things I didn't do, but rather on the things I DID do. With a new frame of mind, my overall outlook changed and I allowed myself to be more positive, thereby helping my own wellbeing. I even began to dedicate time to myself, soon realizing that this was the most important time each day. In the end, others also noticed I was happier and less stressed.

## Lesson 2: Willpower is a limited resource

When you have a lot to get done during the day, how do you decide what to get done first? Often times we are not only limited by time, but also by willpower. Consider willpower a limited resource and use it wisely.

The brain is incredibly powerful but it has no endurance. For these reasons, it is critically important we reserve strength for our most meaningful tasks. As a child, our parents decided what was most important for us. In a sense, this was less stressful. As adults, we have to prioritize which activities are the most productive, or the most meaningful.

"To do" lists serve to get ideas down on paper so we don't later forget about them,

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but they can also serve to torment us as we begin to feel bogged down with inconsequential tasks, and then feel guilty when the lists grow and nothing gets done. The author, Gary Keller, suggests we focus on long-term goals that equate to success and call it our “success list”.

Extraordinary results require focused attention and time, both of which are limited; thus, by prioritizing the most meaningful tasks first, we work towards the most likely path of success.

### Lesson 3: Minimize distractions

Anesthesiologists are surrounded by constant distractions. In the span of 15 minutes at work, you overhear the hospital operator announce an emergency code on the overhead intercom, followed by a fire drill alarm, the sound of a beeping pager, and a colleague reminding you that the surgeon is waiting to brief you on your next patient.

Not to mention the constant social media and text message updates you receive from your cell phone sending unnecessary distracting news feeds from friends, or even distant remote colleagues who you may not even know. All the while your email inbox keeps flooding you with new emails most of which are likely low priority, which only distract you throughout your workday.

Meanwhile, you have a grant deadline approaching fast and haven’t even started the proposal. As the author Gary Keller says, “All of these things constantly distract you from your task at hand, from your ONE thing, from your priority”.

Researchers at Reuters.com found that U.S. office workers get interrupted on the job as often as 11 times an hour, costing as much as \$588 billion to U.S. business each year. Yet amidst all of these distractions you still assume that you can outperform and recover from these distractions with enough effort to complete your highest priority task...you call this “multi-tasking”.

As I previously stated, there is no such thing as multi-tasking. The idea or theory of multitasking is not real, it’s an illusion. It is simply not possible to do two simultaneous tasks completely well, especially if those tasks are complex. It is simply not physically or mentally possible to handle several tasks at once, while trying to focus your attention on one complex task.



These constant distractions are only contributing to your increased stress. On the other hand, it may be possible to handle all of these distractions if you have a low complexity issue that you are trying to tackle. But realize that the low complex issue is usually something of low priority.

Something of higher priority usually requires more focus and attention, and constant distractions take you away from focusing on that task, and increases the time it takes to finish that task.

Ultimately, distractions lead to increased stress and anxiety that are realized only after adding up all the time wasted. Consider the time you waste on distractions day to day, and imagine how much you would accomplish if you could minimize those distractions.

### Lesson 4: “Time Block” your most important tasks

This concept of protecting your time and fully committing to blocking it out for yourself is not selfish...it is absolutely necessary. It is necessary for you to protect your critical thinking. In the end, this will protect your well being, lower your anxiety, and lower your stress levels.

The concept of protecting time to focus on complex priorities, which are usually your highest priority, is known as “Time-Blocking”. Time blocking is a strategy to increase

your productivity by prioritizing and scheduling time for the things that mean most. Time blocking means that you dedicate a time to one thing with absolutely no distractions or interruptions. You find a quiet place away from others who will interrupt you and dedicate a block of time to the one thing you have determined to be most important on your list of priorities to accomplish.

Goal planning can be one example of something you need to time block at regular intervals. This is especially true for your most complex and highest priorities, those tasks most likely to advance your goals and future success.

### Lesson 5: Reward yourself

Vacations are absolutely just as important to plan as planning for a big project. Several successful people launch each year by blocking time just to plan their vacations for the year. This shows yourself, and everyone else, that you deserve time off, have earned it, and can afford it.

Planning your vacations in advance also allows for you to be productive in between vacation time. By planning time to recharge, you also give yourself a reward to look forward to after being so productive. And when you return from your vacation, you will be more rested, more relaxed, and recharged to

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# Occupational Stress and Wellbeing

By Lynda Wells, MD  
UVA Health Systems



Dr. Lynda Wells

Occupational Stress and Wellbeing...what a time to be invited to provide this article! To address “the elephant in the room”, pandemics are strongly positively correlated with occupational stress and significantly negatively correlated with wellbeing. More later...

Twelve years ago, I wrote an article on “Occupational Stress in Anesthesia” for the ASA Monitor (1). Although much appears to be the same, our appreciation of certain aspects of work/life stress and wellbeing are better informed.

The literature has grown exponentially, and some authors have ventured to suggest practical solutions to implement stress-relieving and work/life enriching solutions. In the interests of pragmatism, I have focused on more recent publications to inform this update.

The fundamentals of occupational stress and wellbeing are well documented and

*“Once the physician as a “commodity” had a price tag, healthcare organizations became more responsive and willing to collaborate with physicians to provide a therapeutic work environment.*

have not changed (1). Societal norms have shifted in the last decade and the values of generations X, Y and millennials are starting to mold the specialty and alter the balance of stressors and relievers at play.

It is estimated in the burnout literature that only 20% of stressors can be modified by the individual alone. The remaining 80% represents systems issues related to institutional infrastructure and values.

At first, the solution to burnout and combating occupational stress was laid at the feet of the individual. Resources to increase resilience, improve communication, resolve conflict, reduce fatigue, increase physical activity, enhance social engagement, improve general health and enrich personal relationships were created and endorsed.

Improving the aspects of work stress and personal wellbeing under our individual control is effective and worthwhile.

However, healthcare organizations were less willing to acknowledge and address their contributions to burnout and occupational stress until the monetary costs of physician loss, decreased productivity, and increased errors were revealed. Once the physician as a “commodity” had a price tag, healthcare organizations became more responsive and willing to collaborate with physicians to provide a therapeutic work environment.

Han (5) estimates the annual cost of physician burnout in the US to be \$ 2.6 – 6.3 billion (95% \$ 3.7 – 5.3 billion). The cost at the organizational level per physician is quoted as \$ 4,100 – 10,200 (95% \$ 6,100 – 8,700).

Building on this realization that physicians and their wellbeing are essential to the maintenance and integrity of healthcare organizations, recommendations of how to communicate our needs with healthcare executives have been forthcoming.

While at the Mayo Clinic, Rochester, MN, Tait Shanafelt MD, Director of the Program on Physician Well-being and John Noseworthy MD, CEO, Mayo Clinic, published an

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be more productive as a result.

Everyone needs rest to function better and you are no different. Resting the mind is as important, and some would argue more important, than working the mind.

Equally important to your health is adequate nutrition. Skipping a meal because of time constraints or other pressures does not pay off. Instead, it costs more. Our brains consume 1/5 of our nutrition. Complex tasks including problem solving, short-term memory, and our ability to focus are all accomplished in the prefrontal cortex of the brain.

Blood supply to the prefrontal cortex is in the periphery of the brain and is therefore one of the last to be fed, so to speak, and thus is crucially dependent on adequate nu-

trition. Foods that elevate your blood sugar for longer periods of time, such as complex carbohydrates are the fuel of choice for high achievers.

The small amount of time you save in skipping a meal will be lost by the delayed focus and inattention you experience later. Be good to yourself by feeding your brain, and the results will pay off.

### Conclusion

We can now recognize signs and symptoms of burnout, yet we remain reluctant to treat the problem, especially within ourselves. If newly diagnosed with cancer, would we wait to seek therapy?

As physicians, we of course understand

that treating the disease is just as important, if not more, than diagnosing it. The solution to burnout is known yet we still do not seek ways to treat or prevent the disease.

When you find yourself not wanting to talk about work when you go home, or not wanting to wake up and go to work, then it might be time to reassess your level of burnout.

Take care of yourself. Don't let it go to far. When in doubt, consider some of the lessons I have shared from Gary Keller's book, “The ONE Thing” which if successfully applied, offer a more substantial tool for preventing and managing burnout syndrome.



article outlining nine organizational strategies that can be applied to promote physician engagement and reduce burnout (6).

They specifically looked at seven domains that drive burnout and engagement in physicians (workload and job demands; efficiency and resources; meaning in work; culture and values; control and flexibility; social support and community at work; work-life integration) and aligned them with key influences based on individual, work unit, organizational and national factors (see Fig 3, ref 6). The paper concludes with “Leadership and attention from the highest level of the organization are the keys to making progress”.

One framework to effect these changes that can be applied to all healthcare organizations and practice settings utilizes Maslow’s hierarchy of needs (7). Shapiro’s group (8) adapted the model to direct leaders to address physician’s basic physical and mental health needs first; patient and physician physical safety second; next higher order needs, including respect from colleagues, patients, processes, and the EMR; appreciation and connection; and lastly, time and resources to heal patients and contribute to the greater good. A similar use of an adapted hierarchy from the United Kingdom was published in *Anaesthesia News* (9) with regard to meeting an anesthesiologist’s basic needs and patient safety.

Although not explicitly stated, the Mayo Clinic approach requires mutual trust. The association of trust with clinician satisfaction and retention was studied in 165 clinicians (13.3% physicians) over 34 primary care clinics (10). The objective was to examine organizational characteristics associated with trust.

Key organizational characteristics associated with trust included work control, an emphasis on quality, communication, cohesiveness, and values alignment. Embracing these characteristics increased trust, and fostered loyalty, greater satisfaction and decreased stress. Lack of control at work, as occurs when protocol-based care is enforced, is associated with lack of trust, dissatisfaction and reduced clinician retention. It is likely these findings are transferable to other practice settings and specialties.

The “digital age” has brought its own pros and cons to our personal and professional



lives. Despite initial optimism that internet connectivity and social media would improve productivity, efficiency, and professional and social wellbeing, this has not been the case.

Studies show that the electronic medical record (EMR) has increased physician dissatisfaction. This is almost entirely due to its poor usability. Usability is defined as “the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency and satisfaction in a specified context of use” (2). The System Usability Scale (SUS), an industry

*“The advent of social media offered a unique opportunity to mitigate this isolation by allowing real time contact with colleagues to discuss cases, consult the literature and guidelines, and seek advice. Recent evidence suggests that as workplace and social applications have merged, social media use is now contributing to life stress in general.”*

standard, gave the EMR a score of 45 which is an F on the grade scale and “unacceptable” on the acceptability range. By comparison, using an ATM scores SUS 82, a microwave SUS 87 and a Google search SUS 93 all of which are “acceptable”. A SUS of 68 is the

average across industries.

Melnick et al (2) demonstrated an association between perceived EMR usability and physician burnout. Within the study they noted that anesthesiologists rated the EMR more favorably than other specialties and that those working in academic centers rated the EMR lower than those in private practice and Veterans Administration hospitals.

One explanation of why the healthcare industry utilizes such a poor system may be revealed in the definition of usability. The specific goals of physicians are to facilitate and inform patient care. Those of healthcare organizations are to optimize billing.

The solitary nature of our work contributes to occupational stress. The advent of social media offered a unique opportunity to mitigate this isolation by allowing real time contact with colleagues to discuss cases, consult the literature and guidelines, and seek advice. Recent evidence suggests that as workplace and social applications have merged, social media use is now contributing to life stress in general.

Zivnуска et al (3) explored the impact of social media reactions and addiction on job performance and wellbeing. Their approach was based on conservation resources theory which proposes that “employees actively seek to preserve, protect, and rebuild their individual resources (i.e., conditions or energies valued by the individual)”.

The benefits of social media for social networking and crowd sourcing information were compared to the individual resource costs of these activities. Social media is so interactive that it tends to be reinforcing. This has led to internet and social media addictions.

Social media addiction is defined as “the excessive use and habitual monitoring of social media, manifested in compulsive use that comes at the expense of other activi-



ties". It is similar to compulsive gambling. Even when there is no compulsion to use social media the reactions to information posted (e.g. anger, jealousy, distrust, etc.), especially when linked to peers, can have detrimental psychological and emotional effects that affect job performance.

Social media reactions are defined as the "emotions that people experience in response to reading other people's social media posts". In this study, 96 university students who worked at least 30 hours/week were scored for social media addiction and reactions, work-family balance, job burnout, and job performance. Social media addiction was linked to lower work-family balance.

Social media reactions were linked to emotional burnout which linked to job burnout. Both had a negative impact on job performance. Although this study has not been replicated in a physician population its findings are cautionary.

Another aspect of occupation stress and work-life integration that has received recent attention is the quality of respite between work periods. In a study in non-physicians (4), recovery from workplace demands was divided into four components: psychological detachment, relaxation, control and mastery.

The concept of recovery is based on the premise that each individual has a finite number of resources (i.e. time, attention and energy) to devote to work and nonwork demands. Recovering from work fatigue was important to employees' life satisfaction and well-being.

As one might expect, psychological detachment (switching off from work when not working), relaxation, and control and mastery over one's personal time were positively correlated for restoration and better work-life integration. Control and mastery were also linked with work-family enrichment.

The quality of recovery is immediately relevant to the demands of today in anticipation of the Covid-19 infections in Virginia.

Emergency work schedules should be fashioned to allow adequate physical, psychological and emotional recovery between shifts. Enrichment is required.

Consideration should be given to providing mental health resources and psycholog-

ical support in addition to PPE, testing kits, ventilators, etc. Online resources lack the "human touch" and compassionate interaction needed to alleviate acute emotional, psychological and spiritual distress.

Person-to-person via telephone hotline, video link, etc., should be available. Psychiatrists, psychologists, therapists, etc., could staff this resource. This would maintain the viability of clinical providers including anesthesiologists and intensivists who will likely work most closely with the sickest patients and are a limited resource.

Advice regarding how to avoid unnecessary stress during the Covid-19 crisis abounds. Evidence supports promoting facts and minimizing speculation. Acting on facts while making contingency plans is more wholesome than speculation.

The Virginia experience will be unique. This is what we know from observing other people's experience. It cannot be predicted but it will be like no other. We will lead and we will forge processes and patient care frameworks that work for us, in our institutions, for our patients. We should not be bound by "what other people did" if it is not right for us. We should have the courage to lead. We certainly have the intelligence, knowledge, skills and expertise to do so.

At home, be intentional in how you use your time – both when solitary and with family. Create structure and write down a schedule. This is especially helpful to children but is also recommended for adults as a way to stave off depression.

Perform frequent reality checks. Put your energy into things you can achieve. Do not dwell on frustrations if a solution is not present. Show appreciation for yourself and your family. Love yourself and others. Yoga...exercise...meditation...reading...art...hobbies...family games...painting the living room...tending a garden...running...whatever gives you balance...

One of the best pieces of advice I have heard was on NPR from an infectious diseases specialist (I did not catch his name) who advocated getting enough sleep (this is restorative and boosts the immune system) and to stop listening to the news/radio/social media about covid-19 (the stress of all the doom and gloom reduces immune function and makes one more susceptible to the virus).

Use social media to maintain social ties and check in once a day to the WHO/CDC websites and other reliable sources to find out how the pandemic is doing. The ASA and VSA are there too to give you up-to-date and relevant information.

Be safe and be well!!

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# Mindfulness Practice Within University of Virginia's School of Medicine

By Anja Miller, MD Candidate

University of Virginia School of Medicine



Anja Miller

There are few institutions throughout the nation that describe and emphasize the importance of mindfulness training as a part of their medical school curriculum.

The research is overwhelmingly clear: mindfulness training shows benefits for practitioners by promoting improved relations to the inter-

disciplinary team and their patients, reduced burnout, enhanced self-care through reduction of stress, improved patient satisfaction, and a greater sense of meaning" (1).

My preferred definition for mindfulness is adapted from Jon Kabat-Zinn: to be mindful is to pay attention in a particular way—non-judgmentally and in the present moment (2).

What is so beautiful about self-awareness and mindfulness practice for medical practitioners is that it is not only for thy self, but it is for thy patient. There is a simple question that has been repeated throughout my medical education and drives a physician's care: "What is best for the patient?"

This, of course, involves not only a provider's medical knowledge and technical

skill, but also one's broader awareness of a patient's multifaceted, often non-medical needs.

Mindfulness practices are simple techniques that can provide practitioners with an avenue to leave stressors behind and focus emotional and intellectual energy on the most essential needs of the patient.

Medical education has been designed to cultivate the development of medical knowledge and technical skill. There has never been any doubt about that. Medical education, however, is lacking formal guidance in developing an operating system with which to deal with the strong emotions and thoughts that one encounters throughout

*Continued on page 11*

## Letter to the Editor

By John J. Danyi, MD

I spent 30 years practicing anesthesia, half of that as a member of the VSA, until two years ago. It was then, after enormous stress, that I attempted suicide.

I'd never heard about physician wellness programs. I was not aware that physicians had a much higher rate of suicide in the general population, or that anesthesiologists had a much higher risk than that of most other medical specialties, or that stress and burnout have become epidemic.

Since that time, I have spoken with a number of anesthesiologists, currently practicing and retired, and the stories they told me of the trauma they have witnessed and experienced have been heart-breaking. Many of them told me they had never shared those stories with anyone.

While I think that the attempt to make individual practitioners more resilient is a worthwhile goal, there is no degree of resilience which cannot be eventually exhausted.

From my own experience, I can tell you that the stigma associated with getting help for depression keeps many of us from seeking out that help.

After my suicide attempt, I was required

*But depression carries stigma that other illnesses do not, and effective treatment for depression (and its twin, burnout) is useless if the stigma associated with using that treatment prevents those who need it from seeking it out.*

by the institution where I worked to resign my staff privileges and was reported to the National Practitioner Data Bank... for not showing up to work on the day of my suicide attempt, and for "failure to disclose" my depression.

None of my physician colleagues offered any support of any kind afterwards. I was required to be monitored by the Virginia HPMP, a profoundly unhelpful and counterproductive experience. None of those things would have happened had I been hit by a bus or suffered a heart attack.

But depression carries stigma that other illnesses do not, and effective treatment for depression (and its twin, burnout) is useless if the stigma associated with using that treatment prevents those who need it from seeking it out.

Wellness programs that fail to address that stigma are simply never going to prove adequate to the task. No amount of yoga is going to suffice, however salubrious it might appear.

If we are really committed to providing the best care to our patients, we must be committed to taking care of ourselves and one another. There is no pathology that can be treated effectively by treating it as taboo or shaming those who suffer from it.

Unfortunately, those who suffer with depression are currently being treated that way, with the very real potential to negatively impact one's professional staff membership and licensure.

This is going to require a cultural shift on the part of physicians and the organizations to which we belong. We need to candidly acknowledge and treat our own suffering, as well as that of our patients.

No one else understands what we go through more than we do.

one's medical training.

In an effort to provide such an opportunity, 'Compassionate Awareness and Living Mindfully' or CALM, was founded by medical students at the University of Virginia, in connection with students from the School of Nursing.

From its inception, CALM has grown as a student-led initiative, striving to provide students with the opportunity to live compassionately, practice mindfulness, and grow a sense of community within the medical school and the health system as a whole.

CALM members hope to provide a space where students can contemplate difficult clinical scenarios, develop techniques to incorporate mindfulness and reflection into clinical practice, and to contribute to building a humanistic medical culture more globally.

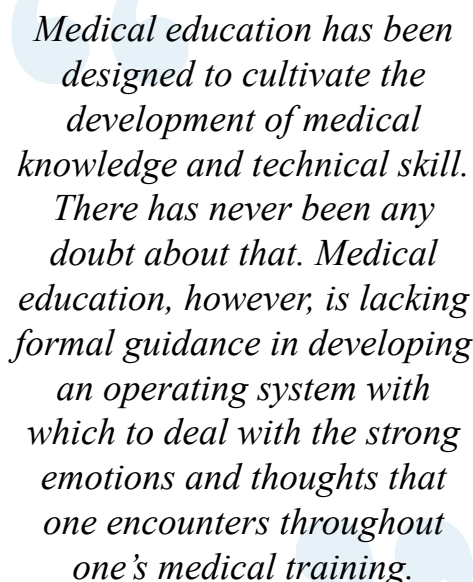
Last year, several leaders from CALM met with key faculty of the medical school to brainstorm on how to best incorporate mindfulness more formally into the medical education. These efforts culminated with the birth of a 'Mindfulness Curriculum'.

As a result, all first-year students at the University of Virginia School of Medicine had the opportunity to engage in two 30-minute mindfulness practices as a part of their required clinical training course. This included options in yoga, meditation, writing, and biofeedback.

Additionally, two lectures that describe the physiological changes that manifest with practicing mindfulness were incorporated into the pre-clinical curriculum. These developments were received positively by both students and faculty and will be repeated for all first-year medical students this spring.

Given the success of these initial efforts, the student leaders of CALM plan to continue to organize initiatives that not only provide an opportunity for students to experience a novel practice, but also promote community through shared vulnerability and self-development, through collective reflection.

In addition to the new 'Mindfulness Cur-



*Medical education has been designed to cultivate the development of medical knowledge and technical skill. There has never been any doubt about that. Medical education, however, is lacking formal guidance in developing an operating system with which to deal with the strong emotions and thoughts that one encounters throughout one's medical training.*

riculum', CALM holds regular open meditations, sessions to debrief challenging clinical and academic experiences, and panels to guide fellow students in navigating through turning points of their academic careers.

One such panel focused on failure, which led to discussions of vulnerability and coping with the stressors that come with medical school.

CALM has invited lecturers to explore mindfulness from providers' perspectives, encouraged intra-professional dialogue between nursing and medical students, and organized an annual mindfulness retreat with support from the UVA Medical Alumni Association and the UVA School of Nursing's Compassionate Care Initiative. A student-member of CALM also recently partnered with the University of Virginia Compassionate Care Initiative to present a poster at last year's Gold Humanism Summit on how these retreats reduce stress and encourage further mindfulness practice.

The most powerful element of CALM, in my opinion, has been the mentorship-like relationships that have naturally formed—

providing a space in which students feel safe to discuss the vulnerabilities of their patients alongside their own.

While the newly implemented 'Mindfulness Curriculum' offers students an introduction to a number of mindfulness practices, mindfulness in medicine can take many forms, and often is present in various clinical settings.

An anesthesia mentor of mine recently shared how she incorporates mindfulness practice into her work with patients requiring a spinal anesthetic as part of their care for cesarean deliveries. She describes that in moments of heightened emotion and physiologic stress, mindfulness has helped her patients focus their attention on themselves and the baby instead of the excitement of the operating room.

She encourages her patients to use 'square breathing' in which patients inhale for as long as they exhale (practically, 2-3 seconds in a pregnant patient). This not only has physiological benefits such as increases oxygenation and decreasing atelectasis, but it also allows patients to prove to themselves that their breathing is, in fact, adequate, and gives them something to focus on besides their surgery.

My hope with this essay was to provide an introduction to the importance of mindfulness practice for physicians, describe the progress in growing mindfulness education at the University of Virginia School of Medicine, and to provide an example of what 'mindfulness at work' may look like.

While the efforts of CALM and the 'Mindfulness Curriculum' are just in their infancy, I am more encouraged than ever about a holistic development of the next generation of clinicians in order to fully care and nurture their patients and medical community as a whole.

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# Wellness in the Anesthesiologist: The Neurobiological Benefits of Physical Exercise

By Denise D. Lester, MD

Central Virginia VA Medical Center,  
Richmond



Dr. Denise D. Lester

Anesthesiology departments around the globe have started a new trend: “Anesthesiology Wellness Programs”.

These programs may have varying constructs and design, but they all have the same mission of encouraging

physical activity and mental well-being among their anesthesiologists with a common goal to improve productivity and morale.

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies eight dimensions of wellness that focus on optimization: emotional, spiritual, intellectual, physical, environmental, financial, occupational, and social.

In addition, SAMHSA recognizes compromisers of wellness such as: lack of support, trauma, unhelpful thinking styles, chronic illness/disability, substance use. Most wellness programs will attempt to enhance the “optimizers” of wellness and at the same time deter the “compromisers” of wellness.

## Examples of Anesthesiology Physical Exercise Wellness Programs and the Rationale for their Utilization

In 2010 Stanford University School of Medicine developed one of the inaugural Anesthesia Wellness Programs<sup>1</sup>. This program known by the acronym ‘PRIME’ (The Peer Support and Resiliency in Medicine Program) introduced anesthesiology staff to trained wellness faculty members and scheduled formal wellness sessions focusing on topics such as self-sacrifice, critical thinking, efficiency, self-care, emotional literacy, relationships, and healthy behaviors.

The sessions were confidential and non-judgemental, starting at the CA-1 year

with a Mindfulness Based Stress Reduction Program retreat. Inter and intramural personal factors leading to wellness are explored and social supportive networks are made.

Sessions every six weeks continue throughout the year via time protected trainings. The staff also have wellness support via 24-hour “WellConnect” (teleconferencing), daily “Physician Coaching”, a Physician Resource Network “PRN” with legally protected conversations from physician peer support, and the “Wellness Help Center” (free walk in counseling).

Stanford reports that their program is a safe space for staff to receive supportive skills to enhance communication, relationships and healthy behaviors including physical exercise.

The University of Florida (UF) Department of Anesthesiology Wellness Program was formed in March 2018 with a mission of encouraging physical activity and mental wellbeing among their members<sup>2</sup>.

They began with a webpage entitled “The Wellness Bridge” and posted links to the UF Health and Wellness Program’s events and challenges. They then developed their Anesthesiology Wellness Newsletter and began publishing upcoming wellness departmental group challenges.

Examples included a “daily walking challenge” and a “plank and drank challenge” (promoting core strength and proper hydration). They strengthened the program by adding a “Wellness Wednesday”, where employees gather with lunch to watch livestream experts discuss wellness-related topics.

One member reported she accomplished 60,000 steps daily because of the motivation of the group “daily walking challenge”. Her favorite challenge was the “Plank Photo Challenge” where staff held plank positions that formed the initials of the school web address.

The founders of the program feel that the program has “increased awareness of positive health behaviors and motivated department employees to voluntarily adopt healthier behaviors, provide opportunities, and a supportive environment to foster pos-

itive lifestyle changes”.

## Does data demonstrate anesthesiologists are impacted by physical exercise?

The above mentioned are examples of the multitude of anesthesiology wellness programs utilizing physical exercise. There are many more recognized programs, such as the Duke Anesthesiology Wellness Connection<sup>3</sup> and the University of Virginia Anesthesiology PRISM program (Promoting Resilience and Integrated Stress Management)<sup>4</sup>.

Several studies show benefit including a 2019 publication studying the relationship of physical exercise and chronic fatigue in 78 healthy anesthesiologists between the ages of 30-40 years old at four hospitals in China<sup>5</sup>.

This study was developed after 10 young anesthesiologists (aged between 30-45) had fatal cardiac arrests in 2014 solely due to heavy and stressful anesthesiology workloads. These statistics were noted in a year the ratio of anesthesiologists to surgeons increased to 1:6 from a prior ratio of 1:1.5, suggesting a shortage of anesthesiologists and a markedly increased workload.

Work overload makes anesthesiologists vulnerable to fatigue which can progress to chronic fatigue. Koyoma in 2010, demonstrated that chronic fatigue impairs activities and contributes to serious medical conditions such as cardiovascular diseases, epileptic seizures, and death<sup>6</sup>. Chronic fatigue is defined as fatigue lasting at least six months and does not disappear after an ordinary rest<sup>7</sup>. Regular exercise can reduce chronic fatigue.

Additionally, occupational fatigue not only includes physical fatigue but also an equally important psychological fatigue. Regular exercise has shown to effectively relieve chronic fatigue and reduce the risk of developing cardiovascular morbidity and mortality<sup>8</sup>.

## What neurobiologic processes during physical exercise impact wellness?

“Exercise can make you smarter, happier, and have more neurons, depending on the dose (intensity) of training<sup>9</sup>.” Physical

*Continued on page 13*

activity induces pleiotropic effects throughout the entire body, including the brain<sup>10</sup>. The effects of physical exercise can be described by means of a hormetic (biphasic) dose-dependent response curve both on cognition and mood<sup>11</sup>.

Many of these effects have been closely related to the adult hippocampal neurogenesis (AHN). AHN is a phenomenon consisting of the formation of new neurons during adult life. These new neurons are very responsive to exercise. AHN has been related to the response to exercise<sup>12</sup>.

### Why should physical activity affect cognition?

Physical activity equals survival. Scavenging for food, evading predators, engaging sexual partners, seasonal migrations are examples of important life sustaining measures that require some form of physical activity.

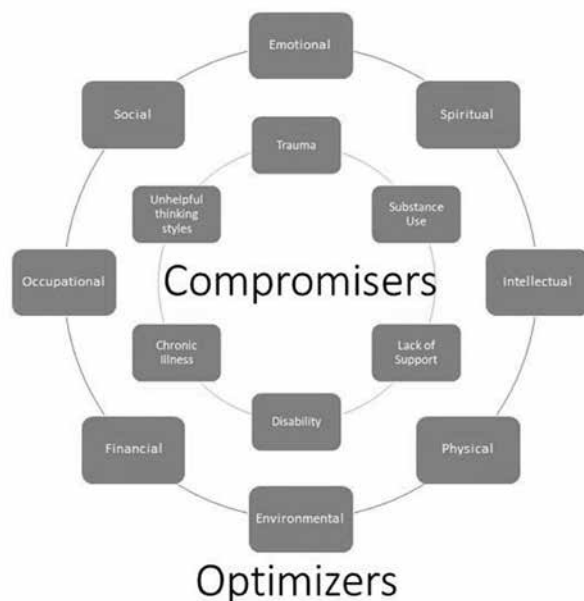
Although they are “physical” activities – they require a substantial amount of cognitive function to be effective. The relationship between a physical activity and its cognitive brain function counterpart is more than just simultaneous function. It is shown that the more rigorous the physical function - the more adaptive and functional the brain becomes<sup>13</sup>.

The method of brain processing changes based on the physical activity demand. Not only does brain function change (i.e. brain cognition & acuity) and adapt to physical exercise, but the actual brain morphology (i.e. brain tissue cells) change as the body's physical demands are increased.

This has been termed “adaptive brain plasticity” and is thought to be the way the brain adjusts the amount of neural resources needed to process complicated vs uncomplicated brain work<sup>14</sup>. Neural processes that can be altered by physical activity include: neuronal dendritic and synapse number, neural cell and processes size, neural cell metabolism, neural gene expression, blood brain barrier properties, and synaptic plasticity.

Interestingly, while the above processes affect existing neurons termed “brain metaplasticity”, there are also processes that

## Dimensions of Wellness



“recruit” new neurons from other areas of the brain to participate in the new demands for cognition during physical exercise<sup>15</sup>.

This, in essence, is analogous to adding more brain cell traffic to the demands requested by recruiting other brain neurons that display cellular plasticity capabilities.

Essentially, a bigger stronger brain much like a biceps muscle that has been driven to hypertrophy after months of bicep exercises.

### What happens specifically to our brains with physical exercise?

In humans, physical exercise induces increased blood supply, neural metabolism, and neural synaptic plasticity in areas of the brain requiring increased neuroprocessing<sup>16</sup>. Humans, as opposed to other primates, have the unique ability to change brain function with physical challenges requiring endurance - (i.e. running endurance). This is important because it suggests we should be cautious comparing animal studies to human studies regarding neurobiologic changes of the brain with physical exercise.

Despite this concern, the literature in rodents and mice, as well as in humans have both largely demonstrated long-term benefits of exercise for cognition in humans and in animals<sup>17</sup>. Much like the human studies, rodent laboratory studies with markedly

more controlled variables in study design compared to human studies, demonstrate exercise increases in cognitive performance in all brain areas, especially hippocampal tasks, by development of synaptic plasticity and neurogenesis.

The subjects with complex tasks such as water mazes<sup>18</sup>, and radial arm mazes<sup>19</sup>, develop more complex neuronal dendrites, and increased number of neuronal synapses with physical exercise.

### A neurobiologic benefit of exercise is “neuroprotection”

Regular exercise induces neuroprotection in all brain areas. Depending upon the specific disease state, several variables can be altered by physical exercise. Examples in brain disease include age of onset, disease progression, and severity of the disease state<sup>20</sup>.

Brain tissue recovery has also been studied with physical exercise. Studies have demonstrated that subjects could recover the symptomatology of some of the neurodegenerative diseases and diseases of brain insults<sup>21</sup>.

The mechanisms of recovery due to physical exercise are thought to be due to increased brain blood flow<sup>22</sup>, increased brain oxygen consumption<sup>23</sup>, growth factor signaling<sup>24,25,26</sup>, mitochondrial metabolism, and increased neurotransmitter availability and function<sup>27</sup>.

Positive effects of exercise have been found to be due to an increased activity of reactive oxygen Species (ROS), antioxidant enzymes<sup>28</sup>, and redox signaling in the body<sup>29</sup>.

Of note, other factors influence the brain function benefit of exercise and are out of the scope of this article but include the body's response to exercise based on; the ergometer used, voluntary versus forced exercise and, the research tool used to assess behavior after the exercise.

One example of this is in long distance runners. A study showed that the anxiety surrounding “forced” long distance running in treadmill work versus voluntary running was the same and was not affected by the

*Continued on page 14*

distance ran - but that the voluntary runners consistently ran the distance faster and had more GABA-A receptors develop on their brain striatum. The effect of AHN was present in both runners (voluntary and forced) but the AHN was markedly more increased in the voluntary (motivated internally vs forced) runners<sup>30</sup>.

## Too much of a good thing?

Like many other beneficial modifiers of biological function, too much physical exercise can have negative effects neurobiologically. The negative benefit of physical exercise on brain function is termed “hormetic”.

Negative stressors of exercise (i.e. thermal, metabolic, hypoxic, oxidative, and mechanical) lead to declining benefit. Literature largely reports that a hormetic “u-shape” curve is demonstrated on cognition after physical exercise depending upon duration and intensity of exercise (intense but brief or long but less intense are safer), subjects’ fitness level prior to the physical exercise<sup>31</sup>, and, the motivation of the subject to want to achieve the physical exercise provided.

There is a complex balance between exercise-induced generation of systemic ROS related factors and brain antioxidant enzymes modulating the benefits of exercise on the brain in the hormetic curve. High levels of ROS cause oxidative damage and moderate levels of ROS induce an adaptive sportive response to oxidative challenge.

Additionally, intense level exercise without recovery induces brain mitochondrial dysfunction and decreased brain-derived neurotrophic factor (BDNF) in mice<sup>32</sup>, increased activity of hypothalamic paraventricular nucleus, and concomitant increase in CRH expression<sup>33</sup>, all suggesting a direct activation of the negative stress responses.

## In Summary

Engaging in regular physical exercise - primarily a combination of short high intense intervals with adequate recovery and longer aerobic intervals, could effectively reduce anesthesiologists’ physical fatigue, situation-induced poor cognition, and negative psychological state.

However, long duration intense physical exercise without adequate recovery can lead to a negative hormetic response curve, hence negating the benefits of physical exercise on brain function and neurogenesis.

This article only describes some of the neuroscience behind the cognitive benefits of exercise. It is too large of a subject to cover the multiplicity of benefits of physical exercise on the entire human organism. It is clear that the literature states sedentary life has well-known detrimental effects on brain functioning, while exercise is one of the most efficacious tools to maintain physical wellness and healthy aging in both animal and human studies.

The proven data on physical exercise improving mood is stellar. The neurobiologic section of this article reviewed cognitive benefits, which for anesthesiologists, cognition deficit can lead to fatal and unforgivable events.

For all these reasons, anesthesiologists should consider balancing their work and exercise time in a way to prioritize both.

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## Encouraging Physician Wellness is Easy, Making it a Reality is Much Harder

By J. Mark Hylton, Jr., MD  
VCU Health Chief Resident

Within the past few years, the terms “physician/resident/provider wellness” have increased in the vocabulary of healthcare providers and administrators. As a chief resident, the well-being of my residents is very important, yet maintaining it is much easier said than done.

You may ask yourself, what is wellness anyway and where did this term come from?

Physician wellness is multi-dimensional. It is about stress management, preventing burnout, work-life balance, maximizing your quality of life and, as Dr. Dike Drummond puts it, “thriving.” Everyone has a different recipe to address these dimensions.

For some it may be traveling and exercising, while for others it may be meditation and relaxation. Ultimately, wellness is looking out for your colleague who actually needs you!

In 2017, the Accreditation Council for Graduate Medical Education (ACGME) mandated accredited residency and fellowship programs, regardless of specialty, address well-being in more detail. This initiative emphasizes that “psychological, emotional, and physical well-being are

*At VCU Health, physician wellness has become a priority just like other institutions. However, the reality of providing opportunities is much harder. Between staffing needs, financial obligations, and event interest; it is not easy.*

critical in the development of the competent, caring, and resilient physician.”

To help programs with this initiative, ACGME has created various resources including on-demand tools, educational conferences, partnerships and much more.

At VCU Health, physician wellness has become a priority just like other institutions. However, the reality of providing opportunities is much harder. Between staffing needs, financial obligations, and event interest; it is not easy.

As millennials, we value our time off more than anything, but research projects, elec-

tronic medical records and administrative tasks creep into our time off. As a result, rates of depression among providers have drastically increased.

In a 2018 Medscape survey, 42% of physicians reported symptoms of burnout. With these astounding rates it should come as no surprise that patient care is also affected.

It is imperative that department and residency program leadership step in and set the tone for establishing healthy work-life boundaries. This means carving out dedicated time that is protected from task creep. Fortunately, VCU Anesthesiology recognizes this and invests in its residents by hosting events including department picnics, holiday parties and various social gatherings.

Organized medicine can also play a valuable role in physician wellness. By sponsoring events to discuss mental health awareness, lobbying efforts against increased government regulations, and hosting social events, the VSA is doing a great job in addressing the well-being of its members.

In closing, I encourage each of you to take time for yourself and reflect on your own well-being. Do not let the stressors of being a physician get you down. We joined this profession because of how great it is! And don't forget that!

# 2020 Virginia General Assembly Session: Health Care Legislation Overview

By James Pickral and Lauren Schmitt  
*Commonwealth Strategy Group*

The 2020 Virginia legislative session adjourned on Thursday, March 12. This was five days past the originally scheduled adjournment date. The delay was mainly due to the large numbers of bills filed this year, the nature of those bills, and the budget. Without a doubt, this was a historic legislative session in Virginia.

After the November election, the Democrats now have the majority of both the House of Delegates and Senate. Democratic leadership was clear that they were going to pursue their top policy priorities right away. And they did exactly that - with the legislature passing bills bringing sweeping reform and a change in policy to most issues.

These include independent redistricting, gun safety measures, increasing the minimum wage, allowing collective bargaining for state employees, marijuana decriminalization, passing the Equal Rights Amendment, rolling back restrictions on reproductive health care services, driving privilege cards for undocumented immigrants, no-excuse absentee voting, and many more. Even with all of these issues being debated this year, health care was still a priority.

Read below for an update on health-care related bills.

## Surprise Billing

Legislators were determined this year to resolve the issue of “surprise billing” for patients who go to an in-network hospital but receive care from an out-of-network provider. The physician community introduced bills sponsored by Delegate Luke Torian and Senator Barbara Favola that were identical to the proposal we had last year and would only apply to emergency services.

The health plans had bills that would have implemented a fee schedule based on the health plans’ in-network rate or 125% of Medicare (whichever is lower) for both emergency AND non-emergency services.

We were able to successfully defeat the health plans’ fee schedule, but legislators and the patient advocates insisted we address

both emergencies and non-emergencies.

A proposal was then offered based on the Washington State model, which applies to emergencies and non-emergencies services at an in-network hospital IF the services involve surgical or ancillary services and are provided by an out-of-network provider.

After researching this proposal and discussing with our physician colleagues in Washington, we determined that this was a good option for physicians and certainly better than any of the other proposals on the table. The physician community supported this new bill and were pleased when the legislature passed it unanimously.

The bill contains the following components:

- Pays providers a “commercially reasonable amount” that is undefined so there is no benchmark that can then impact in-network payments.
- For the purposes of arbitration and for determining the “best offers” for the baseball style arbitration, a data set will be created based on commercial health insurance claims (excluding Medicaid and Medicare) and will be prepared using the All Payer Claims Database, in collaboration with providers and health insurers, for use by providers, facilities, insurers, and arbitrators.

The data set will include:

- Median in-network allowed amount
- Median OON allowed amount
- Median billed charges

The bill includes “baseball style” independent dispute resolution and takes patients out of the middle of the billing process. It is also a huge win for us that it doesn’t put a benchmark in the Code and allows the arbiter to consider physician charges when determining a fair payment.

## Pharmacy Benefit Managers

The General Assembly passed legislation this year, that has already been signed into law by the Governor, that will require licensure for Pharmacy Benefit Managers

(PBMs) under the Bureau of Insurance. SB 251 (Edwards) and HB 1290 (Hodges) will regulate the PBMs and provide more oversight into their business practices.

## Certificate of Public Need

COPN reform continues to be a hotly debated issue at the General Assembly. The Governor and Secretary of Health and Human Resources had convened a workgroup over the summer and fall to try and find consensus on this issue between the different stakeholders. They were unable to come up with consensus legislation.

However, some of the stakeholders involved introduced their own bills - including physicians. Senator Petersen introduced this legislation, SB 503, that was based on a compromise proposal discussed during the Governor’s COPN work group.

This would have created an expedited review process for specific projects and amended the charity care conditions to require certificate holders accept some type of mix of Medicaid, Medicare or Tricare patients.

Not surprising, the hospitals opposed this and it died in the Senate. The hospital association introduced their own bill, that is a lot of process and administrative reforms.

This bill is headed to the Governor’s desk where he will have the opportunity to sign, veto or make amendments to the bill.

## Physician Wellness

Recognizing the importance of promoting physician wellness, the Medical Society of Virginia (MSV) made it one of their priority issues during the 2020 Virginia General Assembly Session. We are pleased that their legislation passed unanimously and will next go to the Governor for his signature.

HB 115, carried by Delegate Patrick Hope, and SB 120, carried by Senator George Barker, will help address the physician burnout crisis by allowing for the creation of a peer-to-peer wellness program amongst health care providers.

Many physicians in Virginia fear seeking

*Continued on page 17*

# MSV Supports Life-Changing Legislation to Combat The Physician Burnout Crisis In Virginia

By Clifford L. Deal III, MD, FACS



Dr. Clifford L. Deal III

As a breast cancer surgeon, my key role on the patient's care team is to excise the tumor and remove the key source of cancer in the body. However, as we all know, there are many more components to healing the pa-

tient than one surgical procedure.

One aspect of care, which drastically affects the physical health of our patients, especially those who have received life altering diagnosis, is caring for their mental health needs.

Physician's physical health is no different. To achieve peak physical health, we cannot ignore our mental health.

Physician burnout is a phrase constantly sprawled across healthcare magazines and online articles. We seem to be comfortable noting that our profession does have a crisis on our hands, sharing research data points

such as:

- Physician burnout is on the rise. Compared to other professions, physicians generally have higher rates of emotional exhaustion and depersonalization.
- Rates of depression are higher in medical students and residents (15 to 30%) than in the general population.
- Nearly one physician a day takes his or her life. Studies indicate physicians commit suicide at a rate of one to 1.5

*Continued on page 18*

## Legislative Overview, from page 16

help because if a physician has disclosed personal mental health concerns their co-worker or employer is legally required to report the physician to the Board of Medicine.

This new legislation will remove these roadblocks to instead allow for early intervention.

The wellness program will provide confidential support services where physicians can receive 24/7 counseling from peers and behavioral health professionals.

The program is modeled after Lawyers Helping Lawyers. The Medical Society of Virginia worked with the Virginia Trial Lawyers Association to ensure the bill does not jeopardize the state's existing disciplinary process, but rather allows physicians to receive the support they need, when they need it.

### Scope of Practice

As usual, there were multiple bills this year regarding the scope of practice of other health care professionals:

### Pharmacists

Legislation was introduced this year that would have expanded the scope of practice for pharmacists and naturopathic providers. HB 1506 (Del. Sickles) and SB 1026 (Sen. Dunnavant), as originally introduced, would have greatly expanded pharmacists' scope of practice and allowed them to provide vaccinations, test for the flu, strep and UTIs and many other services they are not

qualified to do.

The physician community strongly opposed the bills in that form due to significant patient safety concerns. The patrons worked with the House of Medicine to come up with a compromise that does not threaten patient safety.

### Certified Registered Nurse Anesthetists

Senator John Bell and Delegate Dawn Adams introduced legislation this year (SB 264 and HB 1059) that would have provided prescriptive authority to CRNAs.

The physician community opposed the original form of this bill, but there was overwhelming support amongst legislators. After working with the patrons and the Virginia Association of Nurse Anesthetists, we were able to successfully limit the bill to only apply as part of the periprocedural care of a patient.

The bill also maintained physician supervision of CRNAs, so a supervising physician could simply not allow the CRNA to have prescriptive authority. Once the bill was amended, the physician community took a neutral stance.

The legislation passed both houses and has already been signed into law by Governor Northam.

### Naturopaths

HB 1040 (Del. Rasoul) and SB 858 (Sen. Petersen) would have given naturopathic providers licensure and allowed them to call

themselves "naturopathic doctors."

These bills were defeated and instead, the Department of Health Professions will conduct a study on whether licensure is needed for this profession.

### Immunizations

The physician community had a big victory this session with the passage of HB 1090, carried by Delegate Hope. This bill will ensure that the list of mandated vaccinations for school entry is science-based and not subject to politics.

It brings Virginia's list in line with the current ACIP recommendations by adding vaccines for Rotavirus, Meningitis, Hepatitis A and HPV for boys. The most important component of the bill is that it allows the Department of Health to add future vaccinations to the list without getting approval from the General Assembly.

### Reimbursement

In 2019 the General Assembly brought all physician Medicaid reimbursement up the 70 percent of Medicare. Due to an error by the Department of Medical Assistant Services, anesthesiology did not receive this increase.

The House and the Senate rectified this in the budget this year. The budget is currently awaiting the Governor's signature.



# Physician Burnout: A Few Thoughts

By Paul Rein, DO

Physician burnout is one of the big topics of the day. As an older anesthesiologist I am fascinated by the burnout discussion. I wonder how we got to this point where burnout is such a major topic. I finished my residency in 1982, and became an assistant professor at MCV.

After four and-a-half years, I entered the private practice world where I still am. I am fortunate to have several irons in the fire, while being able to still work in a field that I truly love.

Burnout? Nope! Let me give you a few points to think about.

Several things have changed over the last 38 years that have led to the burnout epidemic. Not necessarily in order of importance, Over the last 25 years, with the advent of the internet and the power of social media, think about these numbers.

A recent survey of Americans revealed that 42% of our awake time is spent viewing a TV, smartphone, computer, tablet or other electronic device. The average internet user spends more than two hours a day social networking.

If one gets eight hours sleep a night, that means one spends almost seven hours a day staring at a screen. The biggest downside for this is we are using less of our prefrontal cortex, the most uniquely human part of our brain, which affects judgment.

Suicide rates since 1996 have increased

in every state. Antidepressant medication prescriptions have increased 400% since the 1990's. All this is a sign of decreasing use of the most human part of our brain.

Then there is the issue of money. The cost of schooling from undergraduate to medical school has increased substantially over the last 25 years. While the expense has increased, the inability of those with debt to understand the importance to getting rid of debt has also increased.

We spend money on many luxuries, from automobiles, electronics, vacations and more, before paying off our debt. I recently heard a physician on a radio show asking for help with her finances. She owes \$350,000 from school debt. She has been practicing for five years and makes \$300,000 per year.

She had anxiety about her inability to pay off her debt, while revealing that she and her husband are building a house costing \$800,000, and have two cars costing \$80,000.

She had high anxiety because she didn't know how to get her debt paid off.

Obviously, what she could do, but had the inability to understand, was to live on less for two years in order to pay off her debt rather than building a house and having expensive cars.

It's easy to understand what is causing her stress. Unfortunately, this is all too common.

In my opinion however, the most important cause of burnout is the loss of CONTROL of our professional life.

Historically, when we finished our training, we would for the most part go out in private practice, work a few years, become a partner and control our practice. Over the past decade, many practices have been taken over by large national companies. This has led to a loss of control of "our money" and how we practice.

We are told we will supervise three to four CRNA's daily, we will get a certain number of weeks vacation, you will be paid a certain amount of dollars per year and maybe get a raise once in a while. In the meantime, a 25 year-old MBA walks around keeping track of you.

After at least 12 years of education post high school, your boss will be the 25 year-old MBA.

Well over 50% of us have lost control over our practices. That is big. Loss of CONTROL over the practice, time and money is a major cause of burnout, but it's seldom mentioned.

Rather than our understanding that, we put our heads down and accept it. We are told that mindfulness, yoga, Tai Chi, medication, aerobic exercise and more will help eliminate burnout.

Wrong! My recommendation: Try and regain CONTROL of your practice, pay off your debts before anything else, positive social relationships, aerobic exercise, stay away from pharmaceuticals, reduce time spent with electronics, and read real books.

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## MSV Legislation, from page 17

times higher for male physicians and two to four times higher for female physicians in comparison to general population.

We can continue to share data points to prove physicians have been constantly bombarded with moral injury by the business of medicine. This hasn't made an impact to slow down the rate of physician suicide, now up to nearly one physician colleagues across the nation takes their life each day.

When the Medical Society of Virginia (MSV) researched the roots of our burnout problem it became clear the overarching problem was that there is no program available to provide ongoing, confidential, physician wellness support.

Currently, if a physician discloses personal mental health concerns, their employer is

legally required to report the physician to the Board of Medicine. In a study evaluating physicians-in-training, the most frequently cited barriers to seeking treatment were time (91.5%), preference to manage problems on their own (75.1%), lack of convenient access (61.8%), and concerns about confidentiality (57.3%).iv

I am honored to share news that MSV has created life-changing legislation to make a tangible difference in our burnout crisis in Virginia.

During the 2020 General Assembly Session, HB 115 (Hope) and SB 120 (Barker) were passed and will now be sent to the Governor for signature. The intent of these bills is to create a "safe haven" for physicians, outside of their employers, in order to get the support they need. This added security

of confidentiality removes the barriers of seeking treatment, reduces stigma, and ends the fear of losing their job or their license.

When the legislation is codified, MSV will be launching a Physician Wellbeing Program. The program will provide confidential support services where physicians can receive 24/7 counseling from peers and behavioral health professionals.

The program is modeled after Lawyers Helping Lawyers. MSV worked with the Virginia Trial Lawyers Association to ensure the bill does not jeopardize the state's existing disciplinary process, but rather allows physicians to receive the support they need, when they need it.

MSV will be sharing more information about this resource this summer.

# A Short History of Wellness and Burnout in Physicians

By Christa L. Riley MD

Pick up any medical specialty society journal and you most likely will find an article about physician wellness, work-life balance, or the more concerning topic, physician burnout.

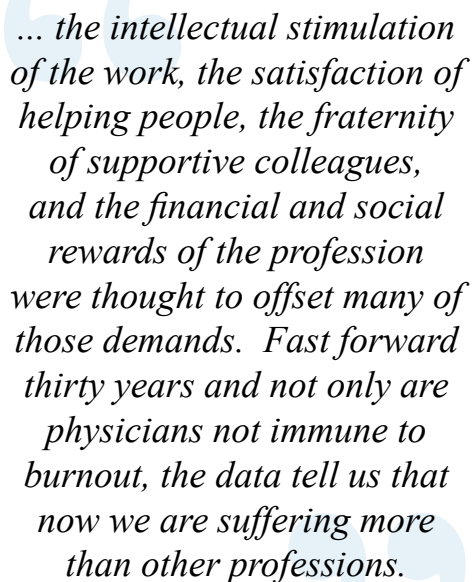
The collective discussion on these ideas suggests a recent urgency for physicians. A PubMed search for terms related to physician well-being confirms increasing research over the last 40 years. In the 1980s there were approximately 46 articles on the topics. The number of articles more than tripled in the 1990s and tripled again by 2010. Since 2010 there have been more than 2600 articles that explore physician wellness and burnout.

All that research would suggest an expert understanding of how to cultivate physician well-being, but sadly the data say otherwise. More physicians are leaving clinical practice and physician suicide rates are higher than any other profession. Traditional corporate wellness programs have been ineffective for varied reasons. Understanding the evolution of our concept of wellness in the U.S. and the history of physician burnout may help us resist and modify the forces that reduce our control of medical practice.

The way we conceptualize wellness today was largely shaped in the 1950s and 1960s, but the origins of wellness are much older. Between 3000 and 1500 BC Ayurveda, a holistic system that aimed to create harmony between mind, body, and spirit to prevent illness, developed as an oral tradition. It was later recorded in the sacred Hindu texts, the Vedas. The practice of Yoga and meditation were a major part of the tradition and are increasingly practiced today.

Traditional Chinese Medicine (TCM) developed around the same time and was influenced by Taoism and Buddhism. TCM also was a holistic approach to achieving health through harmony. Practices that evolved out of TCM include acupuncture, herbal medicine, and tai chi. These are increasingly practiced today.

In 500 BC Hippocrates was probably the



*... the intellectual stimulation of the work, the satisfaction of helping people, the fraternity of supportive colleagues, and the financial and social rewards of the profession were thought to offset many of those demands. Fast forward thirty years and not only are physicians not immune to burnout, the data tell us that now we are suffering more than other professions.*

first physician to emphasize preventing sickness instead of treating disease. He argued that disease was a product of diet, lifestyle, and environmental factors.

The first use of the word wellness in the English language occurred in the 1650s according to the Oxford English Dictionary and literally meant the opposite of illness or the state of being in good health.

Through the 1800s physicians and clergy focused on diet, exercise, herbalism, mentally guided healing, and spiritual healing. A physician named Halbert L. Dunn presented a series of 29 lectures called High-Level Wellness and in 1961 published his ideas in a book by the same name. He described high-level wellness as an integrated method of functioning which is oriented toward maximizing an individual's potential within the environment where they are operating. Dunn's idea of wellness is closer to our current interpretation of wellness. Improved wellness leads to better performance.

Workplace wellness was not unheard of before the 1960s. In 17th century Italy, a physician named Bernardino Ramazzini wrote about occupational diseases that people developed from long hours of repetitive

work and looked for preventative measures to address these maladies.

A Welsh social reformer, Robert Marcus Owen, proposed a radical change to work hours, the eight-hour workday, to protect the well-being of the workforce. He coined the term "eight hours labor, eight hours recreation, eight hours rest". The Ford Motor Company was one of the first corporations to implement Owen's ideal in the United States.

Employee Assistance Programs began to emerge in the 1950s but were primarily focused on mental health issues and alcoholism. As the financial burden of healthcare shifted from government to employer, workplace wellness efforts were developed to contain costs and prevent productivity loss.

These efforts included health assessments, lifestyle and behavioral change education and support, fitness center membership subsidies, supportive social and physical work environment, and integration of workplace wellness into the management structure.

The attachment of performance to wellness accelerated corporate interest in workplace wellness as industries looked for ways to increase worker productivity. From 1980 to 2000 workplace wellness programs became a lot more common bringing the concept of wellness into the mainstream.

The term burnout was coined in 1974 by psychologist Herbert Freudenberger when he observed emotional depletion and psychosomatic symptoms in the volunteer staff at a free clinic in the East Village of New York City.

He borrowed the term from drug addict slang which hints at the future tendency to lay blame on the sufferer. Freudenberger defined the symptoms of burnout as exhaustion, cynicism, and inefficacy.

Christina Maslach refined the definition in the 1980s and described burnout as a "tri-partite pathology of emotional exhaustion, depersonalization, and reduced sense of personal accomplishment". She developed the Maslach Burnout Inventory (MBI), a

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*Continued on page 20*

## Dr. Howard Green Named Physician Director of Surgical Services at WMC

By Casey Dowling, DO, FASA  
*Winchester Anesthesiologists*

Howard M. Green, MD has been named Physician Director of Surgical Services at Winchester Medical Center in Winchester Virginia.

This is a brand-new position created to increase safety and quality by reducing variations in care. Dr. Green will be work-



Dr. Howard M. Green

ing collaboratively with physicians, hospital staff and administration.

As a practicing physician anesthesiologist, Dr. Green has a long history of promoting quality and

safety.

He initiated Departmental Practice Drills for various topics such as Malignant Hyperthermia and Local Anesthetic Toxicity. He is a TeamSTEPPS Master Trainer, and a Certified Professional in Patient Safety.

He has also been integral in working toward WMC becoming a High Reliability Organization.

### History, from page 19

22-item questionnaire that is the criterion standard tool for measuring burnout.

During the 1980s, burnout was considered to affect all professions but interestingly physicians were considered to not be affected. Although medicine is a demanding profession, the intellectual stimulation of the work, the satisfaction of helping people, the fraternity of supportive colleagues, and the financial and social rewards of the profession were thought to offset many of those demands. Fast forward thirty years and not only are physicians not immune to burnout, the data tell us that now we are suffering more than other professions.

If burnout is a pathology, what treatment can workplace wellness programs offer? Resilience is presented as the bulwark against burnout. Resilience training aims to help us adapt to and exploit situations of uncertainty. This sounds fantastic until we consider the origins of the idea.

Resilience was an idea discussed in ecology literature in the 1970s and referred to how ecosystems responded to disaster. The term was then incorporated into socioecological frameworks to describe how communities respond to major changes in social, political, or environmental systems. Resilience later became a political strategy for responding to global strife or terrorism.

Early studies focused on risk factors and protective factors among children from hostile environments. Now, resilience is particularly understood to be an ability to cope and

return to a degree of normal function after a crisis. These positive understandings of the resilience concept dismiss responsibility of the system, disaster, or crisis and serve to construct a system in which the status quo is accepted by the individual instead of resisted or changed by the individual.

While attempts to cultivate resilience are certainly well intentioned, these attempts assume that the system in which the physician is working is in a desirable state. This type of training is designed to return the physician to a state of good health and engagement but only within the system at hand, effectively shifting the responsibility of systemic problems to the physician.

Focusing on resilience is an acceptance of defeat. Resistance may be a more appropriate response to burnout, a demand to address the fundamental system concerns in medicine. This should be the primary focus of wellness initiatives.

A special thanks to Roy Brown, Research and Education Librarian, Tompkins-McCaw Library for the Health Sciences, Virginia Commonwealth University, for his assistance in researching this topic.

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# Dr. Rein Receives Lifetime Achievement Award

## Two Colleagues Pay Tribute

On January 21, 2020 the VSA awarded Dr. Paul Rein with a Lifetime Achievement Award. Along with many colleagues congratulating him at the VSA dinner, there were a few who wrote their gratitude's and memories.

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Paul Rein hired me into my first practice 22 years ago, directly out of residency. Little did I know, upon working with Paul, that my education in the world of Anesthesia was only just beginning.

In addition to being a great clinician upon whom I could always rely for sound advice regarding patient care, Paul had a wealth of knowledge regarding the business side of anesthesia. At his figurative knee, I learned a host of practice management lessons not taught in medical school or residency. Watching Paul taught me how to interact and negotiate with hospital administrators and manage difficult colleagues. He was always very generous in sharing his personal experiences and lessons learned. He encouraged me to take on new responsibilities and challenges and to grow as a physician leader.

Paul continues to be an extremely supportive mentor, even all these years later. To this day, he is the first person I call when I need advice or insight about a work-related issue. I am hardly the only beneficiary of Paul's experience and wisdom, however. As an instructor at William and Mary, he is helping to guide young men and women interested in pursuing careers in medicine. I know he will have the same positive impact upon the next generation of doctors as he has had upon me.

At a time when the education and training of anesthesiologists is often devalued and our contributions to patient care downplayed, Paul is a tireless advocate for all the physicians in our specialty. He is heavily involved in many anesthesia issues at the



*VSA President Jeffrey Green, MD; Past President John Rowlingson, MD; Paul Rein, DO and Martha Kelley as Dr. Rein received VSA's Lifetime Achievement Award*

local, state and national levels. He is not afraid to tackle politically sensitive topics and say things he knows may not be well received, all in pursuit of the advancement of our specialty. He remains true to his beliefs always.

The VSA could select no finer a professional and physician upon whom to bestow this honor.

- Dr. Karen Sickenger  
Chief of Anesthesia/Sentara  
Medical Group

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When I left hospital administration to venture into anesthesia billing, I had no idea what I was in for! Dr. Paul Rein was the first anesthesiologist I met when I was introduced to the group as their new billing liaison. Needless to say, it was a memorable moment with many more to come.

Paul took a chance on me two years later by hiring me as the VAPCS Administrator, 13 years ago. I decided to take the leap of a long commute from Richmond to Newport News due to Paul's enthusiasm, knowledge and all-around leadership. He taught me about the dynamics of anesthesia administration including negotiating, group governance, coding, etc. I continue to learn from him.

I can't say every day has been rosy, but we respect each other and value one another as human beings. He has and always will be my mentor, adversary at times, and more importantly my friend.

Congratulations Paul. You are well deserving of this honor and many more.

Thank you for everything you've done for me, the VSA, and everyone you have helped in this wacky world of anesthesia!

- Martha Kelley, Administrator  
ACV, Inc/Virginia Anesthesia

# Advocacy in Residency: Why We Should Care, and What We Can Do?

By Alexander J. Skojec, MD  
CA-2 Resident of Anesthesiology,  
University of Virginia

The excuses hardly need repeating - we're tired. Some of us hardly have enough time for basic self-care. Without question, residency is demanding. Advocacy feels like a chore better left to someone else; someone older or someone no longer in residency.

That neither changes the precarious reality of our specialty nor absolves us from our responsibility in shepherding our specialty into the future. I seek to convince you that *you should care* about the future of anesthesiology, and I hope to inform you how to promote our specialty despite the incredible demands on your time, finances, and energy.

The American Society of Anesthesiologists (ASA) promotes a vision of our specialty that includes patient-centered physician anesthesiologist-led care teams, ending out of network payment (AKA surprise billing), and promoting truth in advertising.

These are not platitudes capable of being spoken into existence. They are daily battles fought across state capitals throughout this country every day. You may not recognize their names or faces, but anesthesiologists and our advocacy groups deliver critical, factual information to state and federal legislators, all in an effort to preserve patient safety as well as our profession's reputation.

Promoting patient safety is not limited to clinical work. Advocacy is a core component of our profession, and patients rely upon you to deliver a safe anesthetic just as much as they rely upon you to preserve the safety mechanisms that ensure they'll receive safe future anesthetics. This is your profession. Protect it.

Not everyone needs to become a politician. But we do, at this junction of our career and each year thereafter, owe a debt of gratitude to those anesthesiologists, advocacy groups, and their allies who protect the integrity of our profession.

That debt can be paid a number of ways, and I urge you to consider the following ways you, the resident anesthesiologist, can defend our specialty:

1. Meet with your lawmaker: office visits



*UVA Residents (from left to right) Alexander Skojec, MD; Peter Cooper, MD; and Matthew Lavalley, MD listen to State Senator William "Bill" DeSteph at VSA's Annual Membership Meeting and Legislative Dinner, held at Sam Miller's restaurant in Richmond in January.*

(capital or district), host fundraisers, visit sites, etc.

2. Write letters to the editor of your local newspaper or facebook group
3. Call your state and federal legislators once per week regarding a single issue
4. Volunteer for election efforts.
5. Join and fund political action committees, such as the Virginia Society of Anesthesiologists and the American Society of Anesthesiologists.

You work long hours. You have other important responsibilities. You're busy. Some of these realities may change when you graduate residency, but our profession is innately busy.

One local event exemplifies one way of performing our duty to advocate. Our state society (Virginia Society of Anesthesiologists, or VSA) held our annual meeting recently at Sam Miller's in Richmond, VA.

The VSA Annual Meeting was attended by a multitude of state legislators as well as our anesthesiologist colleagues from all corners of Virginia. The night featured a cocktail hour, guest speakers, and the meeting of our

executive board, which updated its members on the organization's current state of affairs.

Guest speakers included Dr. Randall Clark, 1st Vice President of the ASA, as well as Dr. Paul Rein, who was awarded a lifetime achievement award for his 20+ years of service to the VSA.

The event was lighthearted, warm, and informative. We shared the successes of our previous year, founded and funded our state's newly-minted Resident Component, and discussed the ways of improving and preserving the most important aspect of our profession: our patients' and communities' safety.

The night concluded with meet and greets from several of our state Senators and Congressmen who joined us for the evening.

These events create lasting memories. They inform legislators' opinions and alter the trajectory of our profession.

One of many meetings to come (ASA Legislative Conference is next up - May 11-13 in Washington DC), and we encourage you all to participate in a way that adds value to the meaning of being a Resident Anesthesiology Advocate.

## ASA Practice Management Meeting Review

**By Casey N. Dowling, DO, FASA**  
*Medical Director  
Winchester Medical Center*

Members of the VSA representing several anesthesia groups attended the ASA Practice Management Meeting in Las Vegas this January.

This conference offers a lot of information to physicians and practice managers alike. If one is new to the business side of anesthesia, the Fundamentals of Practice Management, held during Friday's Touchpoint series, was not to be missed.

The regular session held on Saturday, included many hot button items such as Gender Equality, Artificial Intelligence in Anesthesia Delivery and the Aging Anesthesiologist.

There were also two breakout sessions which gave attendees the opportunity to



*VSA members at the ASA Practice Management Meeting in January.*

share their personal experiences with other anesthesiologists and practice managers.

The ASA Practice Management Meeting will be held again in Las Vegas in January 2021.

## VPS Meeting Explores Treatment of Painful Conditions

**By Robert J. Trainer DO, MBA, FASAM**  
*Central Virginia VA Medical Center,  
Richmond VA*

On the first weekend in February the Virginia Pain Society (VPS) held its' third annual exploratory convention and scientific session at the Boar's Head in Charlottesville.

It was a multi-disciplinary meeting with subject matter experts from academic, private, and DoD facilities, ranging from general pain medicine, neurology, physical medicine and rehabilitation, psychiatry, and orthopedic surgery and including topics from headache to foot pain and plenty in between.

Since its' inception nearly four years ago, the VPS annual meeting has combined expertise from leading pain physicians, advocacy groups, and other pain medicine experts from across the nation to better provide pain solutions to Virginians.

This year, the University of Virginia sponsored the CME for the 1.5 day event totaling 11.25 CME/MOCA eligible credits. Attendance was also able to satisfy the new



*Dr. Robert J. Trainer*

Virginia Board of Medicine's opioid education requirement.

The focus was on current, future, and cutting edge themes related to management of painful conditions. Dr Marc Huntoon organized a great

lineup of speakers as chair of the meeting planning committee, while Dr Anthony Dragovich, (VPS president), and Mr. Fred Brason of Project Lazarus, (the supporting non profit foundation) were essential to creating a smooth weekend. Other members of the planning committee include Drs Goldstein, Baylor, Kohan, Tucker, Houston, E. Huntoon, and Trainer.

Exhibits from 5 device companies and 5 pharmaceutical companies aided in keeping tuition low at \$350 for physicians, \$295 for other health professionals and \$99 for residents/fellows and students. Attendees

topped 100 this year surpassing the last year's event.

Based on last years 2019 conference evaluations, new content was added to this years meeting. This content included regenerative medicine, weaning strategies for opioids, a legislative update from the Virginia Society of Anesthesiologists, Physician burnout, and integration of complementary disciplines (with a focus on regenerative medicine, nutrition, and mindfulness meditation) to name a few.

Evaluations for the 2020 meeting are pending and the bar is set high. Last year's conference attendees reported a full 81% giving the highest score with regard to the faculty, instructional design, implementation, and subject matter. As the society continues to grow, we intend to continue ongoing evaluation of our meetings. Our aim is to continue the strong collaboration with VPS members, colleagues, our patients, and all stakeholders to improve outreach and education on pain issues in the state of Virginia.



## Anesthesia Machines Needed

VSA has partnered with the Virginia Department of Emergency Management (VDEM) to compile a list of available anesthesia machines that could be relocated to areas of significant need should that situation arise. Please assist us with this extremely important effort. Contact [Jeffrey.green@vcuhealth.org](mailto:Jeffrey.green@vcuhealth.org) with more information.

## COVID-19 Resources

For up-to-date information on COVID-19, contact VSA with any questions or concerns related to the state government, public health, and healthcare system.

<https://vsahq.org/doctors/>

## Can You Help?

Nationwide critical shortage of PPE and supplies! The following list of items is most needed:

Nasal Swabs  
Surgical masks  
N95 Respirators

Protective Gowns  
Face shields  
Protective eye wear/goggles

Disposable gloves - sterile and non-sterile  
Hand sanitizer  
Bleach cleaning wipes

**If you can help please contact Polly Raible at [praible@vhha.com](mailto:praible@vhha.com).**