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ORIGINAL RESEARCH

Wellness Principles Correlate With More Favorable Burnout Scores in Junior Anesthesiology Residents

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INTRODUCTION

As medical literature has come to acknowledge physician distress, the term *burnout* has become affiliated with poor patient care and lack of physician wellbeing. Burnout, distinguished by 3 components—emotional exhaustion, depersonalization, and reduced feelings of personal achievement—is a long-term stress reaction to work or caregiving.^{1,2} Burnout has been shown to be present across all specialties in medicine and has been measured by a validated psychological testing instrument, the Maslach Burnout Inventory (MBI).³⁻⁶ Burnout has been linked to depression, clouding of decision-making, medical errors, and compromised patient safety.⁷

Burnout is of paramount importance, specifically within the field of anesthesiology because it has been linked to substance abuse, stress, and depression.⁸ Burnout was observed to have a prevalence of 41% in anesthesiology residents with 17% reporting both high-level burnout and depression.⁹ In this self-report study, the trainees with high-level burnout and depression committed more medication errors.⁹ In a medical field where access to controlled substances is unparalleled, burnout in anesthesiologists and resident anesthesiologists creates an extremely vulnerable physician population for potential substance use disorder.¹⁰ In fact, 80% of anesthesiology residency programs reported experience with anesthesiology resident substance use disorder, with 19% reporting a death in their program before an intervention

was able to be provided.¹¹ Implementation of wellness curricula outside of anesthesiology have shown benefits for improving mental health among both attending-level physicians¹² and residents¹³⁻¹⁴; however, few proven interventions exist specifically to adequately combat burnout in anesthesiology residents.

Our anesthesiology residency program developed and implemented a resident wellness curriculum, which included a wellness course provided to the categorical interns during their first postgraduate year. Our primary objective was to determine if those who participated in the wellness course would have more favorable burnout scores (lower emotional exhaustion, less depersonalization, and higher personal achievement) than those who did not participate in the course. Our secondary objectives were to determine if the perceived ability to implement the wellness principles (regardless of wellness course participation) would correlate with lower burnout and to examine the contribution of other wellness-related factors to perceived burnout. Our hypothesis was that those who participated in the wellness course would have lower levels of burnout as defined by lower emotional exhaustion and depersonalization, and higher personal achievement scores.

MATERIALS AND METHODS

Study Design

This was a prospective, case-control survey/questionnaire study involving postgraduate year (PGY)-1 anesthesiology categorical

interns who had participated in a wellness course (COURSE) and PGY-2 anesthesiology residents who had not participated (CONTROL). The primary outcome investigated was the burnout scores based on the MBI between the COURSE and CONTROL groups 6 months into their PGY-2 year. Secondary outcomes examined were factors contributing to burnout. The study period was from October 2016 through December 2017. All aspects of this study were conducted in accordance with our University of Pittsburgh Institutional Review Board protocol (PRO16060133).

Subject Selection

All PGY-1 (n = 16) and PGY-2 (n = 16) anesthesiology trainees from a single residency program were invited to voluntarily and anonymously complete the study survey/questionnaires. All COURSE trainees participated in an inaugural wellness course (October 2016) as part of their PGY-1 training. None of the CONTROL trainees experienced this course because it was not part of the curriculum during their time as PGY-1 trainees. Trainees not present during survey/questionnaire administration were excluded from participation due to our IRB requirement to maintain subject anonymity. A waiver for the requirement for written informed consent was obtained given no subject identifiers were recorded at any point in time in this survey/questionnaire study.

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Wellness Course

All of our PGY-1 interns participate in an Anesthesiology Practice and Principles rotation each fall. This rotation includes protected nonclinical time for an entire rotation block during which the interns received numerous lectures on many of the nonmedical aspects of anesthesiology. The wellness course was implemented during this rotation and comprised 3 parts.

The first part consisted of a 1-hour didactic lecture that was provided on the first day of the rotation. This lecture discussed burnout, stress, fatigue, and depression among physicians and, in particular, anesthesiologists. This lecture also introduced wellness principles (Fish! Philosophy, Burnsville, Minnesota) that the trainees were encouraged to implement daily. The 4 Fish! Principles include the following: (1) play, (2) be there, (3) make their day, and (4) choose your attitude.¹⁵

The second component aimed to reinforce daily use of the Fish! Principles. Commercially available, short online activities were delivered via e-mail to each trainee every day (Mindsetter, Lengley, BC, Canada) for a period of 3 weeks. Each daily exercise focused on real-world application of a single Fish! Principle. On average, each daily activity took around 3 minutes to complete. We wanted participation to be voluntary, so these daily activities were not mandatory.

Finally, at the end of the 3-week time period, a wellness workshop that was developed around using the Fish! Principles within the workplace. This 1-hour workshop involved splitting the main group into 4 subgroups. The small groups explored both obstacles and opportunities for being able to implement the principles daily at work. There was also large group discussion regarding specific scenarios where the principles could be best implemented.

The wellness course was facilitated by 1 of the authors (PSA). In addition to serving as the Chair of the Anesthesiology Resident Wellness Committee, he also serves on the institutional Graduate Medical Education WELL (Well-Being, Environment, Living, and Learning) Committee as well as the institutional Physician THRIVE initiative for faculty.

QUESTIONNAIRES

Both the CONTROL (no wellness course exposure) and COURSE groups completed the survey/questionnaires 6 months into their PGY-2 year. For the COURSE group, this was 14 months after completing the wellness course. All survey/questionnaires were completed on de-identified paper forms that were entered into a secure database.

Initial questions aimed to gather demographic information for both COURSE and CONTROL groups. Information collected included age, gender, marital status, presence of children, closeness of support systems (family members, close friends), and home within a 1-hour drive, debt, and history of a chronic medical condition and/or depression. Next was a survey that comprised 21 items and used a 9-point Likert scale (Supplemental Methods). These items investigated each resident's perceived ability to implement the wellness principles in daily work-life, regardless of whether or not they participated in the wellness course. These were a mix of positive and negative items with all negative-item scores inverted for analysis, with higher Likert scores indicating a higher perceived ability to implement the wellness principles. Four validated questionnaires were administered to determine levels of burnout (MBI),¹⁶ depression (Beck Depression Inventory),¹⁷ stress (Cohen Stress Scale),¹⁸ and sleep quality (Pittsburgh Sleep Quality Index [PSQI]).¹⁹ Higher scores for the MBI components of emotional exhaustion and depersonalization indicate higher burnout, whereas lower personal achievement scores indicate higher-level burnout. Higher Cohen, Beck, and PSQI scores indicate higher stress, depression, and worsened sleep quality, respectively. Finally, resident feedback questions asked the COURSE group how often they could implement the wellness principles and whether they agreed that would be useful to continue providing this wellness course.

Statistical Methods

Descriptive statistics are presented as count with percentage, mean with standard deviation, or median with interquartile range (IQR) for nonnormally distributed data. No data were transformed. Confidence intervals were derived for continuous pairwise

comparisons (95% confidence intervals for medians derived as described by McGill, et al).²⁰ Initially, baseline characteristics at 6 months into the PGY-2 year were compared between the COURSE and CONTROL groups using a Pearson chi-squared test or Fisher exact test (as appropriate) and Wilcoxon rank-sum testing.

To study our primary hypothesis that COURSE trainees would have more favorable burnout scores than CONTROL trainees, we performed pairwise comparisons. Again, a Pearson chi-squared test or Fisher exact test and Student *t* tests or Wilcoxon rank-sum tests were used to assess significance for the differences in the 3 burnout parameters (emotional exhaustion, depersonalization, and personal achievement), as well as the other wellness outcomes of stress, depression, and sleep quality, including each trainee's perceived ability to implement the wellness principles (regardless if they participated in the course or not). The Cronbach α was derived to estimate internal consistency within our 21-item survey instrument aimed at examining each trainee's perceived ability to implement wellness principles.

Secondarily, we examined factors potentially contributing to burnout. Multivariable regression models were derived to examine the effect of wellness course participation, residents' perceived ability to implement wellness principles, stress, depression, and sleep quality scores for predicting each burnout component. The primary effector variable of interest was wellness course participation, perceived ability to implement the wellness principles, and the results of the other wellness questionnaires as additional covariables. Finally, we performed a post hoc analysis given our observation that, regardless of course participation, the perceived ability to implement the wellness principles correlated with less burnout. Pearson product-moment correlations were used to investigate the linear association between burnout components and the perceived ability to implement the wellness principles. An α error of .05 was considered statistically significant for this study. Statistical analysis was completed using STATA 14.2 (StataCorp, College Station, Texas).

RESULTS

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Sixteen COURSE trainees (100%) participated in the wellness course as PGY-1s and 15/16 (93%) completed the 1-year follow-up survey/questionnaires. Thirteen/16 (81%) CONTROL trainees without wellness course exposure also completed the same survey/questionnaires. The only statistically significant difference between the groups' measured baseline characteristics 6 months into the PGY-2 year was that a higher proportion of COURSE trainees were repaying school loans (Table 1). Our 21-item survey instrument aimed at investigating the residents' perceived abilities to implement the wellness principles in daily work-life yielded an average inter-item covariance of 0.323 and a scale reliability coefficient of 0.801.

There was no statistically significant difference in any of the MBI component scores between the COURSE and CONTROL trainees, although there was a trend toward lower depersonalization scores in the COURSE group (Table 2). Given the sample size of our study, we were 80% powered to detect absolute mean differences of 8, 7, and 6 points for emotional exhaustion, depersonalization, and personal achievement, respectively, at $\alpha = .05$. There was no significant difference in the perceived ability to implement the wellness principles regardless of whether or not the residents participated in the wellness course (Table 2).

Multivariable regression models were generated with each of the 3 burnout components for outcomes and course participation, the perceived ability to implement the wellness principles, Cohen stress score, Beck depression score, and PSQI as predictors. Overall models were significant for each burnout component (Table 3). Wellness course participation was a significant predictor for lower emotional exhaustion (Table 3). A higher perceived ability to implement the wellness principles was an independent predictor for better scores in every burnout component. Higher Cohen stress and Beck depression scores were independent predictors for worse emotional exhaustion and depersonalization, respectively (Table 3).

COURSE trainees showed significant inverse correlations between the MBI components of depersonalization and person-

al achievement scores and their perceived ability to implement the wellness principles (Figure 1A). CONTROL trainees and the combined entire study cohort showed significant correlations with all 3 MBI burnout components (Figure 1B and 1C).

To evaluate the wellness course, feedback questionnaires were given to COURSE participants. Thirteen of 16 (81%) completed the feedback with 10/13 (77%) who felt the wellness course would be useful to continue for future residents. Furthermore, 5/13 (38%) felt they could implement the course principles at least on a monthly basis, while an additional 5/13 (38%) responded they could implement the principles on a weekly basis.

DISCUSSION

When directly comparing 1 anesthesiology residency class that participated in a wellness course versus 1 residency class that did not, we were unable to detect statistically significant differences in burnout scores or the degree of each burnout component between the 2 classes. However, those in the COURSE group showed a trend toward lower depersonalization scores. Furthermore, in our multivariable models, COURSE participation was a significant predictor of lower emotional exhaustion scores after adjusting for stress, depression, and sleep quality. Thus, there may be some indication that our wellness course may have provided some benefit in 2/3 MBI burnout components. Should the wellness course have had a measurable effect on these 2 burnout components, it is possible that the principles of "play" and "choose your attitude" could have resulted in less emotional exhaustion because these are associated with trying to make the workplace and the workday more fun. In addition, the principles of "be there" and "make their day" could have resulted in less depersonalization, given that these are aimed at making more positive interpersonal interactions.

Interestingly, regardless of course participation, anesthesiology residents who more strongly felt they could implement wellness principles had significantly better burnout scores. Overall, those who felt more strongly that they could implement the wellness principles had lower emotional exhaustion and depersonalization scores and higher

personal achievement scores. Given this observation was merely correlative, it remains unclear if those who are less burned out find it easier to implement the principles, or vice versa. Regardless, these results suggest that those who feel they are able to practice the Fish! Principles may be less likely to feel burned out.

Our data suggest that each class may have a particular "personality" and/or sets of stressors that make them different but that being able to implement wellness principles may help all residents improve their perceived burnout. Furthermore, more longitudinal and/or repeated exposures to wellness training and principles are likely necessary to yield more effective results for reducing resident burnout.

Limitations

Limitations of this study include being underpowered given we compared 2 residency classes within 1 institution, each at a transition point of being 6 months into their clinical anesthesiology PGY-2 years. In addition, this population was limited to a large urban university anesthesiology residency program, which could limit the generalizability of the results. We did not administer baseline questionnaires to the study groups; therefore, we cannot be sure that there were no differences in the various wellness parameters prior to the study intervention period. Also, while the principles taught were those from an internationally known and respected wellness philosophy, our wellness course was internally derived and not a commercially produced, validated wellness course. Last, after the wellness course, there was no consistent reinforcement of material or a maintenance phase. Residents did not have a postcourse guide to assist them in remembering or implementing the material that was learned.

Anesthesiology Resident Burnout Effect

The importance of this investigation is grounded by the professional and personal effect that burnout has been shown to have on residents, specifically those in anesthesiology.^{8,9} For instance, anesthesiology residents experience unique workplace conditions, such as open access to addictive medications. Exhaustion, depersonalization, and a lack of personal achievement

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may predispose individuals to trialing opioids, benzodiazepines, or other substances to self-medicate.⁸ This is supported by evidence that burnout is affiliated with substance abuse.²¹ By providing a wellness course that can reduce resident burnout, we may be able to help reduce urges for trialing harmful substances that are attributable to resident burnout.

In addition, despite once being thought of as an affliction of physicians nearing retirement, it has been shown that burnout can begin as early as medical school and can affect nearly half of matriculating students, increasing with year of schooling.²² Further, medical students can be subject to experiencing depression (27.2%) and suicidal ideation (11.1%).²³ For those who have not experienced burnout in medical school, there is a high possibility of burnout to evolve into fruition during residency.^{24,25} Understanding this makes residency (or perhaps earlier) an ideal time for wellness interventions to help residents avoid burnout or process burnout in a manner that does not elicit harm to them. This justifies the early intervention provided to the residents in this study, with the goal of providing residents tools to help avoid burnout rather than trying to mitigate it.

In addition to personal difficulties, resident burnout has found itself in the spotlight because of adverse patient outcomes surrounding this issue. Burnout can yield low motivation, poor job performance, and potential compromise of patient care secondary to error.²⁶ Our wellness course lead to lower depersonalization and perhaps lower emotional exhaustion; therefore, these anesthesiology residents may be more engaged with their patients and in their work. This may result in less medical error and improved patient satisfaction.

Future Directions

Over the last 15 years, the downstream effects of resident burnout have earned enough national attention that the American Council for Graduate Medical Education (ACGME) and Council of Review Committee Residents (CRCR) have acknowledged the importance of increasing resident wellness by promoting national policies that provide support and resources to residents. In turn, residency institutions

have developed their own wellness curriculums and resiliency programs.

While our course was not a mindfulness intervention, we did show a direct correlation between mindset and various wellness outcomes. *Mindfulness* is defined as the ability for one to feel present, aware of where one is, what one is doing and not overreacting or feeling overwhelmed by the present. This concept that has been used in the development of wellness curricula over the last few decades to improve burnout.²⁷ This model has been successfully studied in a variety of health care providers.²⁷ Different implementations of mindfulness-based interventions have been documented in the literature with success. They include, but are not limited to, courses, retreats, meditation, mindful movement, and self-reflection.^{28,29} Future technological advances, such as readily available apps, will hopefully provide physicians with immediate access to mindfulness activities, meditation, and anxiety-reducing techniques to help alleviate some level of burnout. This will likely be the subject of much investigation because there seems to be no consensus on the optimal solution to this relentless and critical issue. The future of physician wellness will most certainly have an effect on how physicians are viewed by their patients and how they are perceived by society.

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Abstract

Background: Strategies to prevent or reduce burnout for anesthesiology residents remain relatively unexplored. We aimed to determine if participation in a wellness course would be associated with lower burnout.

Methods: A prospective, case-control survey/questionnaire study was implemented within a single anesthesiology residency in a large academic medical center program. One class participated in an inaugural wellness course (n = 15) promoting

particular wellness principles 4 months into their postgraduate year (PGY)-1, while another class with no course participation served as controls (n = 13). Both groups completed the Maslach Burnout Inventory (MBI) 6 months into their PGY-2 year. In addition, a survey measuring their perceived ability to implement wellness principles (regardless of course participation) as well as validated questionnaires measuring stress, depression, and sleep quality were administered.

Results: Course participants had a trend toward lower MBI depersonalization scores; however, this was not statistically significant (MBI score 7 versus 12, P = .078, Cohen d 0.71). In a multivariable model, course participation yielded lower exhaustion scores (P = .011) whereas higher stress yielded higher exhaustion scores (P = .013), and higher depression scores yielded higher depersonalization scores (P = .019). A higher perceived ability to implement the wellness principles resulted in significantly better scores in all 3 burnout components (exhaustion P = .049, depersonalization P = .004 achievement P = .001).

Conclusion: Residents who felt they could implement wellness principles had lower burnout, regardless of course participation. Our brief course exposure had only marginal independent effects, suggesting that more longitudinal and repeated exposures to wellness training are likely required to produce a more effective outcome for mitigating burnout.

Keywords: Burnout, wellness course, anesthesiology residents, stress, depression

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Figures

Table 1. Between-Groups Comparison of PGY-2 (CA-1) Resident Characteristics Who Did (COURSE) Versus Did Not (CONTROL) Participate in the Wellness Course

Criteria	CONTROL	COURSE	P value
	n = 13	n = 15	
Age, y ^a	29 (27-31)	27 (27-28)	0.089
Male, n (%)	11 (85)	10 (67)	0.396
Married, n (%)	6 (46)	7 (47)	0.978
Have kids, n (%)	2 (15)	3 (20)	>0.999
Have a pet, n (%)	3 (23)	5 (33)	0.686
Family nearby, n (%)	5 (38)	7 (47)	0.662
Close friends nearby, n (%)	10 (77)	13 (87)	0.639
Can easily visit home, n (%)	7 (54)	10 (67)	0.488
>\$250K school loans, n (%)	3 (23)	6 (40)	0.435
Paying back loans, n (%)	5 (42)	13 (87)	0.037
>\$5K on credit card, n (%)	2 (15)	1 (7)	0.583
>\$10K on credit card, n (%)	1 (8)	0 (0)	0.464
Chronic health condition, n (%)	1 (8)	0 (0)	0.464
Current treatment for depression, n (%)	2 (15)	0 (0)	0.206
Past treatment for depression, n (%)	3 (23)	1 (7)	0.311

^aData are presented as median (IQR).

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Table 2. Between Groups Comparison of PGY-2 Resident Responses to Various Wellness Questionnaires at Follow Up

	CONTROL		COURSE		Effect Size (Cohen d)	P value
	n = 13		n = 15			
	Score	95%CI	Score	95%CI		
Emotional Exhaustion Score, mean (SD)	12 (7.7)	7.3-16.7	10.2 (6.7)	6.5-13.9	0.25	0.514
Emotional Exhaustion Category, n (%)						
Low burnout	10 (77)		14 (93)			0.311
Moderate burnout	3 (23)		1 (7)			
Depersonalization Score	12 (10-15)	9.8-14.2	7 (6-12)	4.6-9.4	0.71	0.078
Depersonalization Category, n (%)						
Low burnout	2 (15)		2 (13)			0.113
Moderate burnout	2 (15)		8 (53)			
High burnout	9 (69)		5 (33)			
Personal Achievement Score, median (IQR)	44 (42-45)	42.7-45.3	39 (35-45)	34.9-43.1	0.51	0.195
Personal Achievement Category, n (%)						
Low burnout	10 (77)		7 (47)			0.317
Moderate burnout	2 (15)		5 (33)			
High burnout	1 (8)		3 (20)			
Cohen Stress Score, mean (SD)	11.5 (4.8)	8.5-14.4	20.5 (2.4)	19.2-21.8	-2.4	<0.001
Cohen Stress Category, n (%)						
Low	5 (38)		0 (0)			<0.001
Average	7 (54)		0 (0)			
Moderate	0 (0)		7 (47)			
High	1 (8)		8 (53)			
Beck Depression Score, median (IQR)	4 (2-5)	2.7-5.3	3 (0-6)	0.6-5.4	0.34	0.194
Beck Depression Category, n (%)						
No depression	11 (85)		14 (93)			0.444
Evidence of depression	2 (15)		1 (7)			
Global PSQI Score, mean (SD)	5.8 (2)	4.6-7.1	4.7 (1.4)	3.9-5.5	0.64	0.103
Perceived ability to implement wellness principles, mean (SD)	6.5 (0.7)	6-6.9	6.5 (0.6)	6.2-6.9	-0.07	0.846

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Figures continued

Table 3. Multivariable regression models for predictors of the 3 burnout components

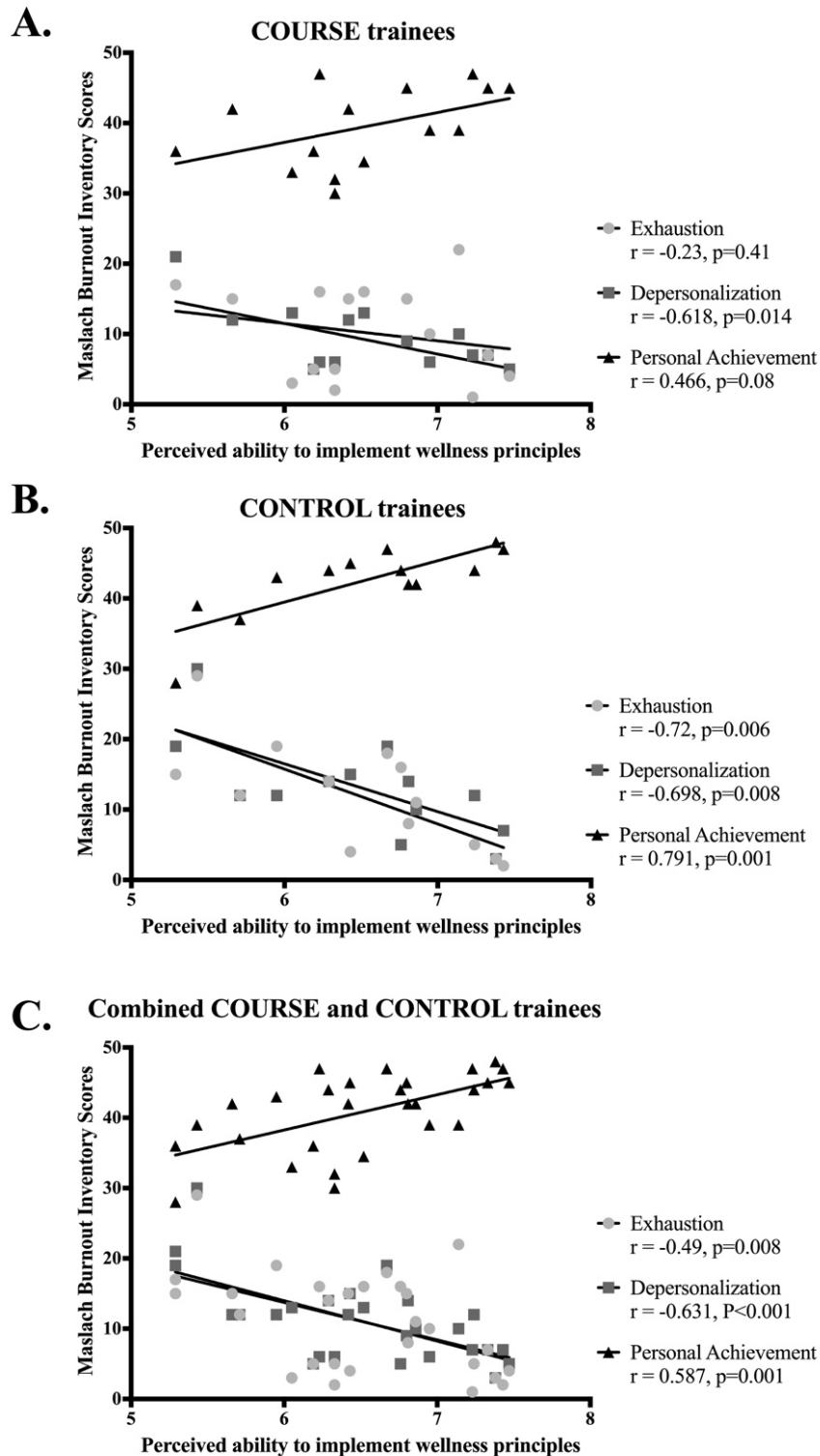
	Coefficient	95%CI	P value
Emotional Exhaustion			
Wellness course participation	-10.32	-18.07 to -2.57	.011
Perceived ability to implement wellness principles	-3.45	-6.88 to -0.02	.049
Cohen Stress score	0.89	0.21 to 1.57	.013
Beck Depression score	0.33	-0.2 to 0.86	.215
PSQI score	-1.15	-2.56 to 0.25	.102
Overall model: $P = .001$, $R^2 = .579$			
Depersonalization			
Wellness course participation	-4.47	-10.01 to 1.08	.109
Perceived ability to implement wellness principles	-3.81	-6.26 to -1.36	.004
Cohen Stress score	0.16	-0.33 to 0.65	.5
Beck Depression score	0.46	0.08 to 0.84	.019
PSQI score	-0.04	-1.04 to 0.96	.931
Overall model: $P < .001$, $R^2 = .695$			
Personal Achievement			
Wellness course participation	-6.8	-13.62 to 0.02	.051
Perceived ability to implement wellness principles	5.45	2.43 to 8.46	.001
Cohen Stress score	0.42	-0.18 to 1.02	.165
Beck Depression score	-0.13	-0.6 to 0.34	.57
PSQI score	0.24	-0.99 to 1.47	.688
Overall model: $P = .01$, $R^2 = .474$			

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Figure 1. Graphs showing linear correlation between perceived ability to implement wellness principles and each of the 3 burnout components per the MBI. (A) COURSE trainees. (B) CONTROL trainees. (C) combined study cohort.



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Supplemental Methods

BASELINE CHARACTERISTICS QUESTIONNAIRE:

ID# _____ Date: _____ Age: _____

Gender (circle one): M F

Marital Status: Single Dating <1 yr Dating >1 yr Engaged Married Divorced

How many children do you have? _____

If you have children, how many younger than 5 years old? _____

Do you have any pets? Yes No

Do you have family within a 1-hour drive? Yes No

Do you have any close friends within a 1-hour drive? Yes No
(someone you'd invite to your wedding)

Could you make it "home" easily/conveniently any time you chose? Yes No

Are your total student loans >\$250K? Yes No

Have you started paying back your school loans? Yes No

Do you have >\$5K on a credit card? Yes No ➔ >\$10K Yes No

Do you consider yourself religious? Yes No

Are you able to regularly attend religious services/events? Yes No

Are you content with your body image? Yes No

Do you have access/ability to exercise \geq 3 days/week? Yes No

Do you have a chronic health condition(s)? Yes No

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Supplemental Methods *continued*

Baseline characteristics questionnaire continued

Do you regularly take medication or see a therapist for depression? Yes No

Have you been treated for depression in the past? Yes No

WELLNESS PRINCIPLE QUESTIONNAIRE:

Please think of the following items in a general sense and how you would respond based on your typical day-to-day work activities (1 = never or lowest agreement, 9 = always or highest agreement).

	Never			Neutral			Always		
It is possible to have fun at work.	1	2	3	4	5	6	7	8	9
It is possible to incorporate play at work.	1	2	3	4	5	6	7	8	9
The people you work with would be interested to make work more like play.	1	2	3	4	5	6	7	8	9
It is difficult to be totally in the moment with each individual patient.	1	2	3	4	5	6	7	8	9
You devote all of your attention to your patient during your encounters (H&P, pre-ops, etc.).	1	2	3	4	5	6	7	8	9
You answer personal texts/tweets/posts/calls during patient encounters.	1	2	3	4	5	6	7	8	9
You go above and beyond to help patients' families understand their loved one's condition.	1	2	3	4	5	6	7	8	9
You find yourself easily distracted during patient encounters.	1	2	3	4	5	6	7	8	9
You are annoyed when patients/families ask too many medical questions.	1	2	3	4	5	6	7	8	9

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Supplemental Methods *continued*

Wellness Principle questionnaire continued

	Never			Neutral				Always	
It is possible to find ways to make their day for each patient	1	2	3	4	5	6	7	8	9
It is important to make your patients and their families smile.	1	2	3	4	5	6	7	8	9
You're happy to help a nurse with a patient, even if its not your patient and not your responsibility.	1	2	3	4	5	6	7	8	9
You make it a priority to remember patients', family member's, nurses', technicians' names.	1	2	3	4	5	6	7	8	9
A colleague is slowing you down by asking you to collect samples for research and this annoys you.	1	2	3	4	5	6	7	8	9
A family is having trouble understanding their loved one's condition so you'd find some easy to understand articles for them to read.	1	2	3	4	5	6	7	8	9
You can choose your mood.	1	2	3	4	5	6	7	8	9
When the day is going badly, it won't get any better.	1	2	3	4	5	6	7	8	9
Just telling yourself to be happy will not change your bad mood.	1	2	3	4	5	6	7	8	9
Each day would be easier if you were always in a happy mood.	1	2	3	4	5	6	7	8	9
You got little sleep the night before and are tired so you can justify being in a bad mood.	1	2	3	4	5	6	7	8	9
Being happy and energetic every day will lead to others around you being happier.	1	2	3	4	5	6	7	8	9