Burn-out in Medical school

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Pediatrician (allergy and immunology)

Clinical teacher and mentor

1,080 undergraduate medical students (six-year program), 700 postgraduate medical students
Overview

- Burn-out and related frameworks
- Burn-out and medical school learning environment
- Thai medical school burn-out situation
- Proposed intervention
Physician burnout: a global crisis

Hui Wang, a 30-year-old Chinese ophthalmologist, experienced sudden cardiac death on June 30, after working with fever for 6 days in Beijing. Hui was the father of a 5-year-old girl, and married to a doctor; who donated his organs to two patients after his death. The emotion circumstances of Hui’s devotion to his work and his family’s suffer elevation have triggered an outpouring of grief and sympathy online, with many people expressing their condolences to his family, as well as raising concerns about physician burnout in China. It is not the first case of a doctor collapsing after work in recent years in China. According to a viewpoint published in the Chinese Medical Journal, reports on sudden deaths among Chinese physicians sharply escalate from 2018 to 2020, and most of the deaths, resulting from heavy work load, were male surgeons and anesthesiologists in tertiary hospitals in large cities. ‘Sudden deaths among physicians are not rare, and this case series represents the tip of a larger iceberg’, states the article. In fact, the large iceberg might refer to the physician burnout in China, since SHH (the largest Chinese physicians' online community) reported that more than two-thirds of Chinese physicians were suffering from burnout in 2019.

Physician burnout, defined as a work-related syndrome including emotional exhaustion, depersonalisation, and a sense of reduced personal accomplishment, is not only a serious concern in China but also has reached global epidemic levels. Evidence shows that burnout affects more than half of practicing physicians in the USA and is rising. The 2018 Survey of American Physicians Practice Patterns and Perspectives reported that 78% of physicians had burnout, an increase of 4% since 2016. Furthermore, 80% of doctors in a British Medical Association 2015 survey were at high or very high risk of burnout, with junior doctors most at risk, followed by general practitioner teams. Increasingly, physician burnout has been recognized as a public health crisis in many high-income countries because it not only affects physicians’ personal lives and work satisfaction but also creates serious pressure on the whole health-care system—particularly threatening patients’ care and safety.

There are tremendous controversies and barriers in dealing with physician burnout. Despite wide discussions and many publications, there are striking differences in the understanding of what constitutes burnout. Lisa Robbins and colleagues reported at least 162 unique definitions for measuring mental burnout or burnout sub-scale criteria, and there was substantial variability in prevalence estimates of burnout among physicians and variation in burnout assessment and study quality. The 15th revision of the ICD (ICD-11) in May, 2019, provided a more detailed definition of burnout, characterising it as a syndrome of three dimensions—feelings of energy depletion or exhaustion, increased mental distance from one’s job or feelings of cynicism or negativism about one’s job, and reduced professional efficacy. Notably, Burnout has been further emphasised in ICD-11 as an occupational phenomenon rather than a medical condition. The need for health system reform in response to physician burnout cannot be delayed.

Additionally, workplace ethics and culture vary among different countries, and there is a scarcity of data on physician burnout in low-income and middle-income countries (LMICs). Colin West and colleagues report a systematic review and meta-analysis on interventions to prevent and reduce physician burnout in LMICs, but most of the included studies of sufficient quality were done in high-income countries. Disturbingly, physician burnout is still a hidden but rapidly growing epidemic in LMICs, given the soaring and large demands for health-care services in these countries.

Addressing physician burnout on an individual level will not be enough, and meaningful steps to address the crisis and its fundamental causes must be taken at systemic and institutional levels with concrete efforts from all relevant stakeholders. Tackling physician burnout requires placing the problem within different contexts of workplace culture, specialties, and gender. Physician wellbeing has long been under-recognized in LMICs, and physicians’ suicide death and suicide due to overwork—the consequences of extreme burnout—have not been uncommon in many Asian countries. With rapid development of medical sciences, it is time to use medical advances to benefit the health and wellbeing of all people, including physicians themselves. [The Lancet]
Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed: three dimensions

- feelings of energy depletion or exhaustion
- increased mental distance from one’s job, or feelings of negativism or cynicism related to one's job
- reduced professional efficacy (sense of competence and achievement)

Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life.
Framework: The revised Job Demands-Resources (JD-R) model

- Job demand
- Resources
  - Personal
  - Job
- Strain (burnout)
- Well-being (engagement)
- Negative outcome
- Positive outcome

Schaufeli and Bakker, 2004
Adapting **Maslow's Hierarchy of Needs** as a Framework for Resident Wellness

- **Physiological needs**
  - Food
  - Sleep
  - Physical Health
  - Mental health

Hale et al. Teaching and Learning in Medicine 2018
Adapting Maslow's Hierarchy of Needs as a Framework for Resident Wellness

Safety needs
- Personal security
- Physical security
Adapting Maslow's Hierarchy of Needs as a Framework for Resident Wellness

Love/sense of belonging
- Group gathering
- Support family/relationships
- Shared reflection (peer mentoring)
Adapting Maslow's Hierarchy of Needs as a Framework for Resident Wellness

Esteem needs
- Respect
- Fairness
- Control
Adapting Maslow's Hierarchy of Needs as a Framework for Resident Wellness

Self-actualization
- Mentorship
- Support for academic flexibility
- Fellowship and job support
- Track programme

Mentorship
Support for academic flexibility
Fellowship and job support
Track programme
What is the impact?

**Professional**
- Decreased empathy
- Cheating/dishonest behaviours
- Dishonesty regarding patient care
- Problems identifying and managing conflicts of interest
- Decreased altruistic professional values
- Inappropriate prescribing behaviours
- Decreased personal accountability regarding impaired colleagues
- Dropping out of medical school
- Influence on specialty choice
- Suboptimal patient care
- Medical errors
- Decreased medical knowledge

**Personal**
- Suicidal ideation
- Greater sense of stigma regarding mental health problems
- Motor vehicle incidents

Liselotte Dyrbye & Tait Shanafelt. Medical Education (2016)
Overview

- Burn-out and framework
- **Burn-out and medical school learning environment**
- Thai medical school burn-out situation
- Proposed interventions
Burnout in medical students before residency: A systematic review and meta-analysis 2019

- Prevalence from 24 studies
- The information about the prevalence of each subset of burnout dimensions was given in nine studies including 7,588 students
- There is no significant gender difference in burnout

A narrative review on burnout experienced by medical students and residents

Factors within **the learning and work environment**, rather than individual attributes, are the major drivers of burnout
A narrative review on burnout experienced by medical students and residents

Stage-specific stressors: medical students
- Human dissection
- First death experience

Stage-specific stressors: residents
- Responsibility for patient care
- Research productivity
- Medical licensure requirements
- Job search
- Lack of control
- Excessive administrative tasks

Liselotte Dyrbye & Tait Shanafelt. Medical Education (2016)
A narrative review on burnout experienced by medical students and residents

Stressors for both medical students and residents (at all stages of training)

- Adjustment
- Competition
- Patient and family suffering
- Specialty/sub-specialty decision making
- High stake assessments
- Lack of personal time
- Financial concerns related to student debt
- Negative personal life events

Liselotte Dyrbye & Tait Shanafelt. Medical Education (2016)
A narrative review on burnout experienced by medical students and residents

<table>
<thead>
<tr>
<th>Learning and work environment factors associated with burnout</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical students</strong></td>
</tr>
<tr>
<td>- Poor learning environment</td>
</tr>
<tr>
<td>- <strong>Inadequate support</strong> from faculty staff, medical school staff and peers</td>
</tr>
<tr>
<td>- Education of medical students is not a priority for faculty staff</td>
</tr>
<tr>
<td>- Disorganised clinical rotations</td>
</tr>
<tr>
<td>- Poor supervision</td>
</tr>
<tr>
<td>- Cynical residents</td>
</tr>
<tr>
<td>- Little variety of medical problems encountered</td>
</tr>
<tr>
<td>- Mistreatment</td>
</tr>
<tr>
<td>- Grading schema</td>
</tr>
<tr>
<td><strong>Residents</strong></td>
</tr>
<tr>
<td>- Work compression</td>
</tr>
<tr>
<td>- Excessive workload</td>
</tr>
<tr>
<td>- Overnight call frequency</td>
</tr>
<tr>
<td>- Work-hours</td>
</tr>
<tr>
<td>- Limited autonomy</td>
</tr>
<tr>
<td>- Lack of timely feedback</td>
</tr>
<tr>
<td>- Stressful relationships with supervisors</td>
</tr>
<tr>
<td>- Uncertainty about the future</td>
</tr>
<tr>
<td>- Medical error</td>
</tr>
<tr>
<td>- Perception that personal needs are inconsequential to training programme</td>
</tr>
</tbody>
</table>

Liselotte Dyrbye & Tait Shanafelt. Medical Education (2016)
Outline

- Burn-out and framework
- Burn-out and medical school learning environment
- Thai medical school burn-out situation
- Proposed intervention
A cross-sectional study was conducted among undergraduate medical students in Ramathibodi Hospital, Mahidol University, Bangkok, Thailand.

UG medical students Year2-5
(n=545, 76.1% response rate, female 52.1%)

Thai version of the MBI-SS is fit with Thai context
Thai Undergraduated medical students 2016

- Low personal accomplishment: 54.8% burnout, 65% non-burnout
- Emotional exhaustion: 57.4% burnout, 65% non-burnout
- Depersonalization: 28.4% burnout, 65% non-burnout

## Correlations between burnout, its subscales and factors

<table>
<thead>
<tr>
<th>variables</th>
<th>Burnout</th>
<th></th>
<th>Professional efficacy</th>
<th></th>
<th>Emotional exhaustion</th>
<th></th>
<th>Depersonalization</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>correlation</td>
<td>p-value</td>
<td>correlation</td>
<td>p-value</td>
<td>correlation</td>
<td>p-value</td>
<td>correlation</td>
<td>p-value</td>
</tr>
<tr>
<td>Year&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.055</td>
<td>0.203</td>
<td>0.083</td>
<td>0.652</td>
<td>0.063</td>
<td>0.131</td>
<td>0.029</td>
<td>0.501</td>
</tr>
<tr>
<td>Grade Point Average</td>
<td>-0.119*</td>
<td>0.002</td>
<td>0.234</td>
<td>&lt;0.001</td>
<td>-0.053</td>
<td>0.265</td>
<td>-0.112*</td>
<td>0.017</td>
</tr>
<tr>
<td>Gender&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-0.139*</td>
<td>0.003</td>
<td>0.104*</td>
<td>0.020</td>
<td>-0.064</td>
<td>0.153</td>
<td>0.059</td>
<td>0.200</td>
</tr>
<tr>
<td>Depression screening (PHQ9)</td>
<td>0.294*</td>
<td>&lt;0.001</td>
<td>-0.273*</td>
<td>&lt;0.001</td>
<td>0.469*</td>
<td>&lt;0.001</td>
<td>0.411*</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

RESEARCH ARTICLE

Exploring burnout and the association with the educational climate in pediatric residents in Thailand

Pongtong Puranithee1, Fred C. J. Stevens2, Samart Pakkasama1, Adisak Plitponkampim1,4, Sakda Arj-Ong Vallibhakara3,4, Jamiu O. Busari3, Sylvia Heeneman5 and Walther N. K. A. van Mook2,6

Abstract

Background: This study, undertaken in Bangkok, Thailand, explored the extent to which paediatric residents in a non-Western setting experienced burnout and the potential association with factors in the medical educational climate and work-related quality of life.

Methods: An exploratory sequential mixed methods design was employed in a cross-sectional study. The initial, quantitative phase used the validated Maslach Burnout Inventory, the Postgraduate Hospital Educational Environmental Measure (PHEEM) and Work-Related Quality of Life scale (WRQoL). Regression analysis was used to identify the correlation between burnout and educational climate.

- An exploratory sequential mixed methods design was employed in a cross-sectional study.
- Quantitative phase: the validated Maslach Burnout Inventory, the Postgraduate Hospital Educational Environmental Measure (PHEEM) and Work-Related Quality of Life scale (WRQoL). Regression analysis was used to identify the correlation between burnout and educational climate.
- Qualitative phase: residents in all years with high levels of burnout on subscales were interviewed individually.

Puranithee et al. BMC Medical Education (2019) 19:245
Thai Postgraduate: Pediatric residents

• 41 paediatric residents
• 0 had high levels related to burnout in all three
• 17% showed high levels in two out of three domains
• Emotional exhaustion and educational climate (perceptions of role autonomy, perceptions of teaching, perceptions of social support) were correlated with work-related quality of life
No association between any burnout subscales and factors

- age, gender, marital status, age, gender, year of training, marital status
- responsibility for the family’s or own financial burden
- sleep hours per night, study time (hours) per week and non-academic leisure time (hours) per week
# Pearson correlation coefficients between educational environment and work-related quality of life

<table>
<thead>
<tr>
<th></th>
<th>Perceptions of role autonomy</th>
<th>Perceptions of teaching</th>
<th>Perceptions of social support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee engagement</strong></td>
<td>0.611**</td>
<td>0.713**</td>
<td>0.579**</td>
</tr>
<tr>
<td><strong>Control at work</strong></td>
<td>0.380*</td>
<td>0.604**</td>
<td>0.469**</td>
</tr>
<tr>
<td><strong>Home-work interface</strong></td>
<td>0.390*</td>
<td>0.198</td>
<td>0.394*</td>
</tr>
<tr>
<td><strong>General well-being</strong></td>
<td>0.593**</td>
<td>0.408**</td>
<td>0.659**</td>
</tr>
<tr>
<td><strong>Job and career satisfaction</strong></td>
<td>0.261</td>
<td>0.510**</td>
<td>0.320*</td>
</tr>
<tr>
<td><strong>Working conditions</strong></td>
<td>0.617**</td>
<td>0.468**</td>
<td>0.629**</td>
</tr>
<tr>
<td><strong>Stress at work</strong></td>
<td>-0.094</td>
<td>-0.357*</td>
<td>-0.097</td>
</tr>
</tbody>
</table>

Pearson correlation is significant at the 0.01 level (2-tailed)

*Pearson correlation is significant at the 0.05 level (2-tailed)
Qualitative part, individual interviews: Educational climate

<table>
<thead>
<tr>
<th>Themes</th>
<th>examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate tasks</td>
<td>unnecessary or useless work which contributed to exhaustion</td>
</tr>
<tr>
<td>Teachers, teaching styles, and role as a teacher</td>
<td>unsafe atmosphere of some learning activities</td>
</tr>
<tr>
<td>Knowledge insecurity to perform tasks</td>
<td>insecure in their knowledge and felt a gap regarding patient care and consequently lacked the confidence to teach the students</td>
</tr>
</tbody>
</table>
Qualitative part, individual interviews:
Work-related quality of life

<table>
<thead>
<tr>
<th>The time dimension</th>
<th>extra personal time spent on ward rounds or other work related activities contributed to burnout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life crisis during training and home-work unbalance</td>
<td>critical life events occurred in their private lives</td>
</tr>
<tr>
<td>Physical environment and facilities</td>
<td>better facilities such as more dormitories and a better quality of available restaurants after office hours</td>
</tr>
<tr>
<td>Role and work allocation clarity</td>
<td>unexpected workload or repetitive work</td>
</tr>
</tbody>
</table>
Conclusion

• a non-Western setting, demonstrated a positive relation between educational climate and work-related quality of life

• To help reduce the risk of burnout, the following factors were identified:
  • minimize unnecessary or duplicated workload
  • schedule time arrangements to avoid extension of regular duty hours
  • clearly define role expectations
  • teachers and teaching styles (including unsafe environment)

• Additional studies focusing on teaching styles, safe learning climate and mistreatment in a non-Western context are needed
Overview

- Burn-out and frameworks
- Burn-out and medical school learning environment
- Thai medical school burn-out situation

- Proposed interventions
Our study provides the most comprehensive systematic review and meta-analysis to date of all studies assessing the effect of interventions on burnout among physicians

- 15 randomised controlled trials and 37 observational studies
- **Effective individual-focused** strategies include mindfulness-based approaches, stress management training, and small group curricula.
- **Effective organisational approaches** include duty hour requirements and locally developed modifications to clinical work processes.
Question: Are interventions for reducing burnout in physicians effective?

Findings: This meta-analysis of 20 controlled interventions on 1550 physicians found that existing interventions were associated with small and significant reductions in burnout. The strongest evidence for effectiveness was found for organization-directed interventions, but these interventions were rare.

Meaning: More effective models of interventions are needed to mitigate risk for burnout in physicians. Such models could be organization-directed approaches that promote healthy individual-organization relationships.
Nine organizational strategies to promote engagement and reduces burnout

1. Acknowledge and assess the problem
2. Harness the power of leadership
3. Develop and implement targeted work unit interventions
4. Cultivate community at work
5. Use rewards and incentives wisely
6. Align values and strengthen culture
7. Promote flexibility and work-life integration
8. Provide resources to promote resilience and self-care
9. Facilitate and fund organizational science
Interventions Designed to Improve the Learning Environment in the Health Professions: A Scoping Review

Larry Gruppen[1], David M. Irby[2], Steven J. Durning[3], Lauren A. Maggio[3]


Corresponding Author: Prof Larry Gruppen (lgruppen@umich.edu)

Categories: Curriculum Planning, Education Management and Leadership, Educational Strategies, Educational Theory

DOI: https://doi.org/10.15694/mep.2018.0000211.1

Published Date: 12/09/2018

Abstract

Purpose: To identify and describe interventions designed to affect the learning environment (LE) in health professions education, summarize factors that influence the LE, and determine gaps that require additional research. The LE can be thought of as a dynamic and complex construct co-created by people in a particular setting. A positive LE represents a welcoming climate for learning, which enhances satisfaction, well-being, academic performance and collaboration, while a negative LE restricts participation and learning, leading to emotional exhaustion, depersonalization and burnout.

Method: A six-step scoping review methodology was followed to identify and report on literature that describes interventions to affect the LE. A comprehensive search of databases, expert consultation and scoping of included studies was conducted. This paper provides a summary of some of these results.
Interventions Designed to Improve the Learning Environment in the Health Professions: A Scoping Review

• LEs describe the dynamic, co-constructed perceptions, experiences and behaviors of participants in the physical and virtual spaces within which learning occurs. But more importantly, it also refers to the tone of the educational climate or culture, and the routine way people interact.

• Educational learning environments (LE) dramatically affect the way participants think and feel, engage and work
  • burnout, depersonalization and emotional exhaustion; satisfaction and well-being; identity formation; performance and collaboration

• Positive LEs support learning and are welcoming, collaborative and respectful

• Negative LEs are destructive and restrict participation and learning
Components of Learning Environment

1. **Personal Component**: The individual learner interacts with the LE through activity, develops perceptions of the LE, and engages in personal growth through clarity about goals, selection of relevant and meaningful learning; and in the process professional identity and increasing autonomy.

Interventions or factors positively associated with the personal component of LE:

- time focused on direct patient care
- having a community of peers
- a good quality of life and high levels of resilience
- learning in a "meaningful" place
- trust in a regulated system to support
Components of Learning Environment

1. **Personal Component**: The individual learner interacts with the LE through activity, develops perceptions of the LE, and engages in personal growth through clarity about goals, selection of relevant and meaningful learning; and in the process professional identity and increasing autonomy.

2. **Social Component**: Learners engage with others and navigate multiple relationships, which shapes their perceptions of and experiences with the LE.

3. **Organizational Component**: Organizations provide structure, guidance and support for learning, including curriculum resources and artifacts, geographic placements, accreditation rules as well as organizational practices, culture and policies.

4. **Physical and Virtual Component**: informational infrastructures and resources.
Fostering a constructive LE
Social Component

• Studies reinforced the importance of interpersonal relationships
  • teacher and learner (e.g. face-to-face or blended instruction and longitudinal clinical mentoring), learner to learner (e.g. peer instruction and support), as well as faculty to faculty (e.g. leadership performance)

• Studies underpinned the importance of longitudinal relationships as well as the value of setting and revisiting expectations about performance and relationships
  • The descriptive studies highlighted the role of a strong teaching culture, strong role model skills and values, multiple levels of learners working together (e.g. near peer teaching) as well as the need to avoid mistreatment, unclear expectations, and insufficient supervision without feedback
Components of Learning Environment

1. **Personal Component**: The individual learner interacts with the LE through activity, develops perceptions of the LE, and engages in personal growth through clarity about goals, selection of relevant and meaningful learning; and in the process professional identity and increasing autonomy.

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4. **Physical and Virtual Component**: informational infrastructures and resources.
Organizational Component (limit confidence of the result)
the evidence is generally positive in indicating that some environments are perceived as better than others

• Courses or innovations to augment feedback, increase respect and well-being, and reduce mistreatment
• Faculty development programs focused on aspects of the LE rather than specific teaching skills
• Structural features like duty hour implementation, grading systems, supervisory models, and dedicated educational units
• Rural settings, smaller clinical placements, learning communities, and elective rotations, which may be surrogates for having more attention given to learners
Components of Learning Environment

1. **Personal Component**: The individual learner interacts with the LE through activity, develops perceptions of the LE, and engages in personal growth and increasing autonomy.

2. **Social Component**: Learners engage with others and navigate relationships, which shape their perceptions and experiences with the LE.

3. **Organizational Component**: Organizations provide structure, guidance, and support for learning, including curriculum resources and artifacts, geographic placements, accreditation rules, as well as organizational practices, culture, and policies.

4. **Physical and Virtual Component**: Informational infrastructures and resources.

   - The lack of identified studies and limited coverage
   - Maintenance and cleanliness of hospital facilities
Association Between Learning Environment Interventions and Medical Student Well-being: A Systematic Review (UG)

- Twenty-eight articles including at least 8224 participants met eligibility criteria.
- Medical Education Research Study Quality Instrument (MERQSI), which has a possible range of 5–18
- higher scores indicate higher design and methods quality, and a score of ≥ 14 indicates a high-quality study
<table>
<thead>
<tr>
<th>Interventions</th>
<th>average MERSQI</th>
<th>outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass/fail system</td>
<td>12.0</td>
<td>less anxiety, depression, less stress, better well-being and group cohesion scores at various study time points</td>
</tr>
<tr>
<td>Mental health programs</td>
<td>11.9</td>
<td>decrease depression and suicidal idea</td>
</tr>
<tr>
<td>Mind-body skills education/training programs</td>
<td>11.3</td>
<td>reduction in stress, increase in self-compassion, improve distress tolerance and total mood disturbance</td>
</tr>
<tr>
<td>Curriculum structure</td>
<td>9.5</td>
<td>varied</td>
</tr>
<tr>
<td>Multicomponent program reform</td>
<td>9.4</td>
<td>improved depression, stress, anxiety, cohesion and overall well-being</td>
</tr>
<tr>
<td>Miscellaneouse wellness programs</td>
<td>9.0</td>
<td>improvements in anxiety</td>
</tr>
</tbody>
</table>
| Group-based faculty advisor/mentor programs               | 8.2            | *competitively selected faculty with protected time for advising groups of students better than volunteer mentor*  
*close with some classmates, helped with anxiety*
# Ramathibodi new mentoring system 2016

<table>
<thead>
<tr>
<th>Mentor</th>
<th>volunteer n=36</th>
</tr>
</thead>
</table>
| Mentor development | -orientation 1 time  
-mentor meeting 4times/year |
| Mentee | Medical students cohort (year 2-5)  
-obligate to all |
| Ratio (mentor: mentee) | 1:5 |
| Matching | Random with grade |
| Time | -obligate  
-intra-curriculum |
| Activities | -Retreat mentor group meeting 4-6 times  
-Professional Motivation Activities  
* Early Clinical Exposure (ECE)  
* Inspirational talk  
* Non-technical skill workshop  
* Cinemeducation  
* Basic Physical Examination |
| Reflective writing | -4times/year |
Factors affecting medical students burnout and motivation in the new mentoring program
AMEE 2019 (abstract poster)

• Eighteen participants with highest levels of burnout identified at the first-phase were individually interviewed

Summary of Results

• Factors in the mentoring program students perceived as helping to alleviate burnout were:
  a) fun and relaxing atmosphere of the activities
  b) peer/group interaction with shared feelings/experiences and supports
  c) mentor’s advice and supports
  d) mentor as a role model

• Major activities students perceived to improve motivation were:
  patient/clinical-exposure experiences and mentor’s retreat sessions.
Thank you