

Organizational strategy to improve the medical well-being of an academic gynecology unit in Uruguay

FERNANDA NOZAR⁽¹⁾, JUAN J. DAPUETO⁽²⁾, SANTIAGO ARTUCIO GIOSCIA⁽¹⁾, JIMENA BOFFA⁽³⁾, DAHIANA SÁNCHEZ⁽¹⁾, ELOÍSA KLASSE⁽²⁾, MERCEDES VIERA⁽³⁾, LEONEL BRIOZZO⁽¹⁾

(1) Unidad Académica Clínica Ginecotológica A. Facultad de Medicina, Universidad de la República (Uruguay).
Correos electrónicos:
fernandanozar@gmail.com,
sartucio@gmail.com,
dahianasanchez02@gmail.com,
leobriozzo@hotmail.com
ORCID: 0000-0003-2820-2141
ORCID: 0000-0002-1172-996X
ORCID: 0000-0002-8006-8667
ORCID: 0000-0002-6772-3188

(2) Programa de Bienestar de Profesionales de la Salud. Administrado por la Fundación Manuel Pérez. Facultad de Medicina, Universidad de la República (Uruguay).
Correos electrónicos:
jdapuelo@bienestarsalud.uy,
eklasse@bienestarsalud.uy
ORCID: 0000-0002-0072-0636
ORCID: 0009-0005-5404-4003

(3) Unidad Académica de Psicología Médica. Facultad de Medicina, Universidad de la República (Uruguay).
Correos electrónicos:
jimenaoffa@gmail.com,
mercedesvieraaspiroz@gmail.com
ORCID: 0000-0001-5163-4087
ORCID: 0009-0008-1425-7444

ABSTRACT

Introduction: Physician well-being has gained relevance in health care, especially in the face of the “burnout epidemic.” This study aims to evaluate the implementation and effectiveness of a program to improve the well-being of the staff of the Academic Unit of Gynecology and Obstetrics A of the Faculty of Medicine of the University of the Republic, Uruguay. **Method:** A descriptive study was developed following a logical model of program evaluation. An organizational strategy focused on identifying stress factors and promoting well-being was implemented. The intervention included qualitative surveys, focus groups, and the formation of a Well-Being Referent Team (ERB), trained to guide the continuous improvement process. **Results:** Priorities were identified in the dimensions of workload, resources, community at work, organizational culture, and work-life balance. Throughout the process, key actions were implemented to improve the work environment and team effectiveness. The commitment of unit leaders and collaborative work with external consultants were fundamental to the success of the program. **Discussion:** Organizational interventions, although more complex, appear to be more effective in promoting well-being. The changes achieved at this initial stage suggest a positive impact, although long-term monitoring is required to ensure the sustainability of improvements. **Conclusions:** The innovative experience presented offers a roadmap for improving the well-being of health personnel in academic and healthcare contexts, highlighting the importance of leadership and collaboration in these processes. **Key words:** professional burnout, work engagement, occupational stress, academic medical center, Obstetrics and Gynecology Department, Hospital, Uruguay

INTRODUCTION

Promoting medical well-being has become a priority in the health field. In Uruguay, efforts have been made to promote good professional practices and foster the well-being of the health team, both in the Faculty of Medicine⁽¹⁾ and in the Medical College of Uruguay⁽²⁾.

Burnout and professional commitment have become key objectives for health institutions due to what has been called the "burnout epidemic"⁽³⁾. Gynecology is not immune to this reality, facing stress conditions exacerbated by training and health care demands, and limited resources⁽⁴⁾. In turn, there is evidence that job burnout affects the educational climate and academic results⁽⁵⁾.

The objective of this work was to study: 1) the feasibility of implementation and identify difficulties and achievements in the process and 2) the effectiveness in achieving results, of a program aimed at improving the well-being of the staff of the Academic Unit of Gynecology and Obstetrics A of the Faculty of Medicine of the University of the Republic, Uruguay, in 2023.

The working hypothesis was that the implementation of a strategy with an organizational, multimodal, structured approach could detect and correct weaknesses and reinforce the strengths of the work organization in the academic unit in a timely manner and contribute to the design of an improvement plan. It was then defined to study the feasibility of implementation, identifying difficulties and achievements in the process and the effectiveness of the implementation of a program aimed at improving the well-being of the staff of the Academic Unit (UA) Gynecological Clinic of the Faculty of Medicine of the University of the Republic, Uruguay, in 2023. A descriptive study of the most relevant aspects in the development and implementation process of the program is presented, following the logical model for program evaluation⁽⁶⁾. The conceptual framework, the context, the description of activities are reviewed and some products are presented.

METHODOLOGY

CONCEPTUAL FRAMEWORK

Physician well-being is a multidimensional state in which healthcare professionals experience satisfaction, motivation, and energy in their work, while being able to cope with work stress without compromising their physical and emotional health. This well-being is based on both individual factors and organizational support, including effective leadership, a culture that encourages self-care and self-reflection, and the availability of resources to prevent burnout^(8, 9). Furthermore, physician well-being depends on a sustainable balance between professional demands and personal resources⁽¹⁰⁾, as well as a culture that enables physicians to seek help when needed^(2, 11).

Burnout^(7, 12) or burnout syndrome⁽¹³⁾ is understood as a health condition resulting from work stress that has not been

successfully processed, which manifests itself as exhaustion, emotional discomfort, cynicism regarding work. Professional fulfillment⁽¹⁴⁾ is expressed as the sense of commitment, reward and satisfaction with the career.

Interventions to improve well-being can be directed at individuals, groups or organizations, with a growing emphasis on systemic approaches that consider these three types of interventions together. Actions are distinguished at the primary level (modifying stress-generating factors), secondary level (addressing personal or group situations of work-related discomfort) and tertiary level (addressing established mental health problems)⁽¹⁵⁾.

CONTEXT

The UA Gynecotological Clinic A (UA GineA) of the Faculty of Medicine (FM) of the Universidad de la Republica (Udelar) carries out teaching functions at the undergraduate and graduate levels, assistance, research and outreach to society. It has its original physical base at the Women's Hospital of the Pereira Rossell Hospital Center, but also in several Associated Teaching Centers (CEDA), in Montevideo and the interior of the country, which adds complexity to the operation of the UA, both in its structure and in the labor relationship of its members⁽¹⁶⁾.

At the time of implementing the intervention, 63 active members of the UA (25 teachers and 38 residents) were also invited to participate; in addition, 13 residents who had completed their training in April 2023 were invited to participate, a total of 76 people.

PROGRAM FEATURES AND ACTIVITIES

Following the holding of workshops with members of the UA in 2022 and the evaluation of the intervention through a survey with open questions, it was concluded that a certain level of recognition of the problem of occupational burnout had been achieved and that there were opportunities to implement the proposed solutions effectively and to address the problem as a whole.

Thus, it was proposed, within the central objectives to be developed in 2023, to carry out an institutional strategy to improve well-being to be implemented in the UA GineA both in the CHPR and in the CEDA.

To this end, a collaborative work environment was created between the team of the Fundación Bienestar de Profesionales de la Salud – Bienestar en Salud, - a non-profit organization dedicated to promoting medical well-being - and the management team of the UA. GineA. It was decided to develop an organizational strategy focused on the primary level of intervention, consisting of the identification of high-priority factors generating work-related stress, which were acting at the level of individuals, the functioning of clinical units, the healthcare organization - including the relationship with other academic units, associated disciplines and other

sectors of the hospital -, and the health system. The Bienestar en Salud training team carried out an agreement with the management of the service, coordinated all group instances, implemented the research for the diagnosis of the situation, processed the data in order to ensure confidentiality and generated the reports for the referents, for the management of the UA and for the staff.

Leaders with an executive profile and high commitment were identified to form a Wellbeing Referent Team (WRT). The external advisory team from Bienestar en Salud (EAT) provided advice and training to this group in order to guide in the implementation of improvement strategies and leave installed capacities in the Service to give continuity to the process. The EAT and the WRT worked interactively with face-to-face sessions, virtual meetings and in discussion forums and presentation of reading materials through the educational platform Moodle on topics of professional wellbeing, burnout, resilience and to clearly define the roles, dedication, recognition expected by the referents and which tasks were outside their role⁽¹⁷⁾.

The model suggested by Shanafelt et al.⁽⁸⁾ was followed, which includes: recognizing and assessing the problem, capitalizing on the influence of leaders, designing a roadmap with definition of high priority areas, and developing and implementing interventions in specific work units.

Once the plan was developed, it was presented publicly at a meeting that involved the entire UA. The qualitative research on work stress factors and occupational burnout began with an initial survey with open questions, interviews with the WRT considered as qualified informants, and was complemented with two focus groups, one for residents and one for teachers. The exchange material was analyzed based on emerging themes with support from categories developed from the initial survey.

Participation was voluntary and individuals agreed to participate and to have the session recorded confidentially. The material was used to identify emerging issues from different work units (care areas at the CHPR, guards, operation of equipment in different CEDAs), as well as proposals for changes. A quantitative survey was also included to identify and describe work conditions and risk factors at work with items taken from the CoPsoQ-istas21 Method Manual⁽¹⁸⁾ shown in **Table 2**.

ETHICAL CONSIDERATIONS

This study was approved by the CHPR Research Ethics Committee.

Participation in all these events was voluntary and anonymous. Participants gave their prior consent to each of the activities. Personal data was processed confidentially and personal data protection requirements were met.

RESULTS

Of the total number of UA members invited to participate in the intervention, 61 responded to the quantitative survey (response rate = 80.3%). The response rate by group and the sociodemographic characteristics of the staff who responded to the survey appear in **Table 1** (n=61). The median age was 32 years (range: 26 - 65 years), residents were evenly distributed between the CHPR and the CEDA; of the teachers who responded, 28% held assistant or adjunct professor positions (with fixed-term contracts) and only 7% held stable positions (full professor and associate professors). The majority (61%) worked professionally in other institutions. The perception of occupational risk factors is shown in **Table 2**.

Table 1. Sociodemographic data

	Mean (SD)	Median	Range
Age (years)		32	26-65
Number of Children		0	0-3
Days with health problems	3.51(3.37)	2	0-30
Stop doing usual tasks due to health problems	0.93(2.28)	0	0-10
Gender			
		(N)	(%)
Female		50	82
Male		11	18
Marital status:			
Single		29	47
Married		15	25
Unmarried couple		16	26
Divorced		1	2
Live alone or with other person(s)			
Alone		13	21
With another person		48	79
Position held			
CHPR Residents		21	34
CEDA residents		19	31
Teaching Assistant		11	18
Assistant Professors		6	10
Associate Professors and Professor		4	7
Develop professional tasks in other institutions			
Yes		37	61
No		24	39

SD: Standard deviation. CHPR: Pereira Rossell Hospital Center; CEDA: Associated Teaching Centers

Source: own elaboration

Table 2. Working conditions and risk factors at work

	(N)	(%)
Overall job satisfaction (total responses 61)		
Very dissatisfied	0	0
Dissatisfied	6	10
Satisfied	45	74
Very satisfied	10	16
Type of work shifts (total responses 61)		
Fragmented workday (morning and afternoon)	34	56
Fixed shift tomorrow	9	15
Rotating shifts except night	2	3
Rotating shifts, including night shifts	16	26
How often do they change your start and end times or work days? (total responses 61)		
Always	2	3.3
Many times	11	18
Sometimes	10	16.4
Only once	19	31.1
Never	19	31.1
What is the margin of adaptation in the entry and exit times? (total responses 61)		
No margin	34	55.7
You can choose from several pre-established fixed schedules	6	9.8
You have 30 minutes of tolerance	11	18
It has between 30 and 60 minutes of tolerance	3	4.9
You have more than an hour to spare	7	11.5
How many Saturdays do you work per month? (total responses 61)		
None	2	3.3
Some exceptionally	2	3.3
One a month	5	8.2
Two a month	9	14.8
Three or more a month	43	70.5
How many Sundays do you work per month? (total responses 61)		
None	3	4.9
Some exceptionally	7	11.5
One a month	13	21.3
Two a month	23	37.7
Three or more a month	15	24.6
Can you leave your workplace for at least one hour for personal or family reasons? (total responses 61)		
Always	16	26.2
Many times	20	32.8
Sometimes	12	19.7
Only once	11	18
Never	2	3.3

Source: own elaboration

PREPARATION OF THE ROADMAP

The priority problems and proposals for change arising from the situation diagnosis (initial survey and focus groups) complemented with the data from the survey of work conditions and risk factors were summarized and systematized by the EAT based on the dimensions proposed by Shanafelt et al.⁽⁸⁾: to adapt the workload and job demands, promote efficiency and improve resources, modify those negative aspects of the prevailing culture of medicine and promote organizational values, generate instances of social support and community at work, improve work-life integration, increase control and flexibility in relation to tasks, adapt the expectations of the organization while respecting the meaning that work has for the person. In each of these dimensions, those individual factors, those of the work unit, those of the healthcare organization and those of the health system that could be modified were identified. Each week, the EAT presented this information to the WRT through the educational platform with priority and feasible proposals for change. The following dimensions were identified as priority

areas: workload and work demands, efficiency and resources, support and community at work, organizational culture and work-life integration. The dimensions control and flexibility and meaning of work did not appear as priorities in the perception of the staff, so no actions were implemented at this stage. At the end of this process, two intensive work sessions of three hours each were allocated to create the final roadmap. Despite this schedule, the WRT managed to implement actions throughout the process.

The dimensions identified as priorities, the proposed actions and some results of implementation are presented in **Chart 1**.

Dimension	Problems identified	Actions implemented
Workload and demands at work	Need to adjust workload during times of greater physical and psychological fatigue.	Protected spaces were created for the development of training activities (which residents call "protected mornings") on the day following a night shift, defined as a space in which both residents and teaching assistants are exempt from clinical care of patients and dedicate that time to exclusively academic activities, readings, research, reflective activities on practice, development of postgraduate work, exchange with the tutor teacher, in a friendly and enjoyable environment.
	Need to adjust working hours on weekends.	Shifts were reorganized so that all residents and assistants had at least one full weekend off per month.
Efficiency and resources	Lack of collaborative work areas between members of the academic unit	Spaces and times were adapted to facilitate interactive meetings
	Perception of health care tasks that are beyond the competencies of the training level	Adaptation of the level of care complexity to the level of training development with support for residents in health care tasks by teachers, in accordance with the levels of autonomy.
Work-life integration	Interference outside of working hours and during leisure time	Communications (messages, calls, emails) outside of working hours were restricted at all levels, limiting them to strictly necessary situations.
Support and Community at Work	Lack of meeting spaces outside of strictly clinical and academic activities	Recreational and educational activities were carried out outside the academic unit, with the participation of members of all the centers in a relaxed and constructive environment.
	Attention to people at risk of occupational burnout or who have emotional problems.	The Wellbeing Referent Team continuous monitoring of staff made it possible to carry out individual interventions in cases where burnout, emotional distress, difficulties in carrying out routine tasks, and relational problems were detected.
Organizational culture	Residents' perception of communication barriers and "lack of response to residents' demands" from teaching assistants	We worked with teachers and tutors on the importance of communication and feedback in private, personalized and protected environments.
	Feeling of non-constructive feedback	The need to train teachers to incorporate positive aspects in the process of acquiring clinical skills or competencies in formative assessment was highlighted, aiming to improve the experience of being assessed and thus achieve better educational results. Spaces for exchange between teachers and residents were created to promote changes in educational practices, generate new training opportunities, improve relational and professional practices and collectively stimulate research.
	Perception of the members of the Associated Teaching Centers of "distance" with respect to the Direction of the academic unit at the Pereira Rosell Hospital Center	Several visits were made by teachers from the Management team to the Associated Teaching Centers, both in Montevideo and in the interior of the country.
Dimension	Pending issues identified	Proposal for actions to be implemented
Efficiency and resources	Residents' perception of lack of "individualization" of the graduate curriculum	Personalize the curriculum by enhancing the skills and abilities of each resident, guiding the resident toward those areas of the specialty for which he or she has greater capabilities and possibilities for personal and professional development. To this end, it is proposed to adapt the postgraduate activities in such a way that the greatest percentage of care activities are within options defined from this personalized orientation, in agreement with teaching tutors.
	Need for greater teacher professionalization	Define possible improvements in the development of teacher training activities and the incorporation of new teaching-learning strategies.
Organizational culture	Insufficient positive recognition by evaluators (at various levels of the organizational structure)	The aim is to encourage recognition of people by promoting a sense of belonging, self-esteem, the ability to make contributions, a sense of work, a culture of medicine oriented towards mutual collaboration and good relationships within the team, with patients and their families.

Chart 1. Problems identified

Source: own elaboration

DISCUSSION

Systematic review studies suggest that health workers benefited from different types of workplace well-being improvement interventions, aimed at both the secondary - people-focused - and primary - organization-focused - levels⁽¹⁵⁾. In our case, we opted to implement an intervention at the organizational level, seeking greater effectiveness even at the cost of greater complexity^(15, 19). From the perspective of the Job Demand-Resource Model (JD-R)^(10, 14), the following aspects were promoted: a) a decrease in job demands or requirements (less pressure regarding certain care or academic objectives, b) greater regulation of

the physical and emotional overload of the role of resident or teacher), c) an improvement in work resources in terms of interpersonal and social relationships (greater support from supervisors and coworkers, proposals to improve team climate), d) changes in work organization (greater role clarity, participation in decision-making) and e) the level of the task (performance feedback, variety of skills, importance of the task, task identity, autonomy). Although the goals were not fully met or with the same degree of development, relevant changes and a greater awareness of the importance of continuing to work on these areas are observed. The commitment of the UA leadership and a team of well-being experts with a high level of commitment and execution capabilities were key to achieving the proposed goals. These types of processes are not possible without the agreement and collaboration of the organization's leaders. Working with an external consulting team made it possible to provide resources to install a process of continuous improvement of the health care areas, training of human resources, as well as cultural change of the teams. We recognize several limitations in this work. The changes presented in the roadmap are in an initial phase of implementation, so it cannot be assured that they will be sustained over time. A quantitative evaluation of results from the perspective of the members of the UA is still pending, which is in process. However, we believe that, as an innovative experience without precedents in the region, the work scheme presented can serve as a guide for professionals involved in improving the conditions of healthcare teams.

REFERENCES:

1. Dapuetto JJ, Viera M, Samenow C, Swiggart WH, Steiger J. A Tale of Two Countries: Innovation and Collaboration Aimed at Changing the Culture of Medicine in Uruguay. *HEC Forum*. 2018 Dec 1;30(4):329–39.
2. Dapuetto JJ, Klasse E, Campos N, Rodríguez Andrada B, Romero Agüit S, Braquehais MD, et al. Design and implementation of the Professional Wellbeing Programme of the Medical Council Association of Uruguay. *Rev Colomb Psiquiatr*. 2021 Apr 12.
3. Shanafelt TD, Hasan O, Dyrbye LN, Sinsky C, Satele D, Sloan J, et al. Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014. *Mayo Clin Proc*. 2015 Dec;90(12):1600–13.
4. Morgan HK, Winkel AF, Nguyen AT, Carson S, Ogburn T, Woodland MB. Obstetrics and Gynecology Residents' Perspectives on Wellness: Findings From a National Survey. *Obstet Gynecol*. 2019 Mar 1;133(3):552–7.
5. Goñi M, Danza A, Urgoiti M, Durante E. Correlación entre clima educativo y síndrome de burnout en practicantes internos de la carrera de Doctor en Medicina de Uruguay. *Rev Méd Urug*. 2015;31(4):272–81.
6. Frye AW, Hemmer PA. Program evaluation models and related theories: AMEE Guide No. 67. *Med Teach*. 2012 May 19;34(5):e288–99.
7. Maslach C, Jackson SE. The measurement of experienced burnout. *J Organ Behav*. 1981;2(2):99–113.
8. Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being. *Mayo Clin Proc*. 2017 Jan;92(1):129–46.
9. Dyrbye LN, Meyers D, Ripp J, Dalal N, Bird SB, Sen S. A Pragmatic Approach for Organizations to Measure Health Care Professional Well-Being. *NAM Perspect*. 2018 Oct 1;8(10):1–11.
10. Demerouti E, Bakker AB, Nachreiner F, Schaufeli WB. The job demands-resources model of burnout. *J Appl Psychol*. 2001;86(3):499–512.
11. Braquehais MD, Tresidder A, DuPont RL. Service provision to physicians with mental health and addiction problems. *Curr Opin Psychiatry*. 2015 Jul;28(4):324–9.
12. Maslach C. What have we learned about burnout and health? *Psychol Heal*. 2001;16(5):607–11.
13. Organización Mundial de la Salud. Herramientas de codificación de la CIE-11. https://icd.who.int/ct11/icd11_mms/es/release.
14. Bakker AB, Demerouti E, Sanz-Vergel A. Job Demands-Resources Theory: Ten Years Later. *Annu Rev Organ Psychol Organ Behav*. 2023 Jan 23;10:25–53.
15. Cohen C, Pignata S, Bezak E, Tie M, Childs J. Workplace interventions to improve well-being and reduce burnout for nurses, physicians and allied healthcare professionals: a systematic review. *BMJ Open*. 2023;13:71203.
16. Nozar F, Briozzo L, Gallino V, Fiol V, Piastrini M, Coppola F, et al. Descentralización de los escenarios de enseñanza-aprendizaje de los posgrados de Ginecología. *Rev Médica del Uruguay*. 2019 Jul 16;35(3):218–23.
17. Shanafelt TD, Sinsky CA. Establishing a Chief Wellness Officer Position Create the Organizational Groundwork for Professional Well-Being. 2020.
18. Moncada S, Llorens C, Andrés R, Moreno N, Molinero E. Manual del método CoPsoQ-istas21 (versión 2) para la evaluación y la prevención de los riesgos psicosociales en empresas con 25 o más trabajadores y trabajadoras - VERSIÓN MEDIA. Barcelona; 2014.
19. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet*. 2016 Nov;388(10057):2272–81.

Editor's note: The editor responsible for the publication of this work was the Editorial Committee of AnFaMed in collaboration with Adriana Fernández.

Authorial contribution: All authors contributed equally to the preparation of the manuscript: conceptualization, data curation, formal analysis, methodology, validation and writing: original draft, review and editing.

Data availability: This is a research with qualitative methodology so it is not possible to make the data available without affecting the confidentiality and anonymity of the people.

Corresponding author:

Juan J. Dapuetto, MD, PhD

Director, Health Professionals Wellness Program

José Ellauri 721/301

11300, Montevideo, Uruguay

Telephone: +598 99619434

Email: jdapuetto@bienestarsalud.uy; alternative email: jdapuetto@gmail.com