Wellness and Medical Schools

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Outline

1. Define the components of wellness
2. Relate wellness to faculty development
How I got interested in this topic

Meeting of the psychiatry interest group student Board, fall 2012
- distressed and suicidal students were using these students as peer therapists, due to worries about access, stigma, and confidentiality concerns when seeking care through prescribed channels

Listening to:
- our medical students in my role as Director of Psychiatry Undergraduate Education
- our residents and fellows in my role as Assistant Dean for GME
  - Duty hour audits, work–environment concerns, internal reviews
- Our faculty during internal reviews
- My psychiatry colleagues involved in wellness nationally
- My patients and my clinical practice orientation
  - Helping people change, treating anxiety using CBT and relaxation training and mindfulness as well as meds, working with patients in the context of their families, conflict resolution, biopsychosocial formulation and treatment.
What is “wellness”?

Dictionary definition:
- the quality or state of being healthy in body and mind, especially as the result of deliberate effort.
- an approach to healthcare that emphasizes preventing illness and prolonging life, as opposed to emphasizing treating diseases.

- Biological
- Psychological
- Social
- Spiritual
How do we stay healthy and happy?

- Stress management
- Healthy habits (nutrition, exercise, sleep)
- Work–life balance
- Healthy work environment (physical aspects, as well as conflict resolution, being able to be effective, sufficient resources and support, recognition, lack of bullying)
- Play
- Love and relationships
- Positive engagement in work
  - Flow (Mihály Csíkszentmihályi)
- Being a part of community, making a contribution, finding meaning
- Mindfulness
- Science of Happiness
Whose wellness are we targeting?

- Students
- Residents and fellows
- Faculty
- Staff
- Patients
- Their families
  - Because all of the above are affected by family illness, stress, conflict, separation (e.g., not seeing their little ones due to long work hours)
What do we mean when we talk about “wellness in medical schools”?

1. Providing intervention and treatment to the distressed
   - Responding to impaired job/role performance in UGME/OSA and GME, *versus*:
   - Identifying the need for (and providing) personal treatment
   - Many students arrive with diagnoses, others develop problems while here
     - Employee Assistance Program, Counseling Center
     - Access to care, stigma
What else do we mean when we talk about “wellness in medical schools”?

2. Creating an environment and infrastructure that systematically supports individuals and groups
   - Prevention programs
   - Process groups
   - Support systems (counseling, advisors, academic support, study skills)
   - Building mentoring relationships
   - Encouraging self-reflection and group discussion about common challenges
And—what else do we mean when we talk about “wellness in medical schools”?

3. Providing training about how to stay well, for ourselves AND our patients
   ◦ Knowledge
   ◦ Skills
   ◦ Attitudes
What does faculty development have to do with wellness in medical schools?

- Faculty development through the life cycle (Faculty Affairs), AND:
  - Faculty development in wellness education
    - curriculum development
    - Learning and then teaching wellness concepts
      - e.g., Mindfulness training centers
    - clinical teaching
    - Research
  - AND: Faculty development in working with students in distress
    - Academic difficulty
    - Personal problems
Teach a man to fish, and you feed him for a lifetime

- We are in the business of training physicians.
- Part of being a good doctor is to be able to help our patients become and stay well.
  - Physicians need to educate patients about how to make healthy choices, in addition to fixing what’s wrong
  - Physicians need to help patients cope with what life has sent their way
  - Physicians need to identify obstacles to wellness and advocate for change
  - Physicians need to know how to motivate patients to take an active role in making healthy choices
Put the oxygen mask on the caregiver first

- How can we expect our students to be able to help their patients to stay well, if our students don’t know how to do this themselves?
- Have we educated our students “well”?
- What are we currently teaching our students about wellness?
  - Curricular mapping needed
Practice what we preach

AND: How can we expect our students to learn these skills from our faculty, if the faculty is not proficient in these areas?

Are our faculty members “well”-trained?
  ◦ Knowledge, attitude, skills

Are our faculty members role models in wellness?

As an institution, are we creating a work environment that models wellness and provides support?
If we don’t take the initiative, regulatory bodies will do it for us

- **LCME**
  - MS–26. A medical education program must have an effective system of personal counseling for its medical students that includes programs to promote the well-being of medical students and facilitate their adjustment to the physical and emotional demands of medical education.
  - MS–27–A. The health professionals at a medical education program who provide psychiatric/psychological counseling or other sensitive health services to a medical student must have no involvement in the academic assessment or promotion of the medical student receiving those services.

- **ACGME Resident and Faculty Surveys**
  - Part of the Next Accreditation System includes Clinical Learning Environment Review
    - Duty Hours Oversight, Fatigue Management and Mitigation
Stresses on medical students

- Academic demands in competitive environment
  - For many, adjusting to no longer being at the top of their class
- Loan indebtedness (one of my advisees is $300K in debt so far)
- Long hours (for those with families, rarely seeing them, with competing needs. Terrible parenting dilemmas)
- Cutting corners on sleep and exercise and healthy eating (and attending class!) in order to keep up with academic and clinical demands
  - Who has time to attend an extra elective on stress management, relaxation, or mindfulness?
  - M–3 class survey (89 respondents); 14.8% use stimulants
- Making a career choice
More stresses on medical students

- Emotional stress of adapting to challenges of the physician role (dying patients, making mistakes)
- Getting yelled at/bullied by stressed residents and faculty
- Needing to appear competent or even invulnerable
  - How to get help? Admit they have problems? Will it negatively affect their evaluations and future residencies? Stigma
- Trying to navigate the system to access services
Stresses on residents

- All of the above, plus:
- 80 hour work weeks
  - Duty hour audit example: Peds resident with three little kids who “never saw the whites of their eyes” all week long because she left before they woke up and got home after they went to sleep
  - Day/night shift schedule switches to comply with new ACGME rules
- Increased patient responsibility
Stresses on faculty

- All of the above, plus:
  - Juggling competing time demands from various roles
    - Research
    - Clinical RVUs
    - Teaching and Mentoring
      - Often the first to go, when everything else is “required”
    - Administration (increased documentation, compliance with monitoring organizations, EMR)
  - All this in a difficult economic environment with decreased support staff and a physical plant that is deteriorating
The physician suicide rate is 2–3x that of the general population.

Studies have shown that 27 – 30% of interns are clinically depressed; 25% of interns experience suicidal ideation.

25% of students get depressed during medical school.

Divorce rates among physicians are 10–20% higher than those of the general population.

Prevalence of alcoholism and drug abuse similar to general population, but higher rates of prescription drug abuse and increased tendency to self-medicate.

Burnout rates are estimated to be between 20–45% among physicians and as high as 76% among IM residents across the country.