PJP

SPECIAL ARTICLE

SUPPORTING MEDICAL EDUCATORS TO ENSURE WELLNESS OF MEDICAL STUDENTS

CONSTANTINE DELLA, MD, FPPA

Most medical faculty members assume various roles such as educator, administrator, clinician, and researcher. (1) Furthermore, they act as role models for students and instruments to improve student wellness. Strategies geared towards the faculty can therefore promote a top-down approach to enhancing student wellness. (2) Unfortunately, there is a dearth of data about this. If we expect the faculty to take care of students' wellness, then we must ascertain the faculty's wellness as well.

"Wellness" refers to a multidimensional and dynamic state of optimal wellbeing. (3,4) Specifically, the World Health Organization defines it as "the realization of the fullest potential of an individual physically, psychologically, socially, spiritually and economically and the fulfillment of [the] individual's roles in family, workplace and community settings." (3) The American Medical Association defines it as being composed of six important markers namely, nutrition, fitness, emotional health, preventative care, financial health, and mindset and behavior adaptability. (5,6) Another model of wellness describes eight dimensions: professional (occupation, vocational), social (family, community), emotional (mental), spiritual (values), intellectual, physical (fitness, nutrition), environmental, and financial. (3) The individual must strive to achieve wellness because it does not come naturally. The inherently multidimensional nature of wellness makes quantitative research challenging. The Gallup-Healthways Well-Being Index Composite Score is one attempt in quantifying it. It emphasizes the presence of health rather than the absence of disease.

In addition, it describes well-being across the following domains: life evaluation, emotional health, physical health, healthy behavior, work environment, and basic access. (2)

In the Philippines, wellness activities are being conducted for medical faculty but these are not organized, systematized, and institutionalized. This presentation will discuss how wellness initiatives for medical faculty are designed and implemented abroad. It will highlight the critical role that medical school leadership possesses in making faculty wellness a priority.

Medical schools currently face difficulty attracting and retaining faculty. Many factors have been identified to explain this problem. These include the income gap between private practice and academia, available time for family and personal life, quality of departments, teaching load, and rigorous and inflexible work schedule. (7,8) Studies have also shown that many physicians continue to experience high rates of burnout and decreased wellbeing. (9)

Research shows that the rate of burnout is similar for academic medical faculty and physicians in general. Among the different types of medical faculty, the rates of burnout are similar, whether they belong to clinical departments involved in patient care, clinical departments not involved in patient care, or basic science departments. What varies are the factors that contribute to burnout. (1) The high prevalence of burnout among medical faculty in the West is reflected in the first nationwide study on medical faculty burnout in South Korea. Faculty members from 40 medical schools participated in the study. Using the

Maslach Burnout Inventory, the following rates for burnout parameters were obtained: 34% experienced emotional exhaustion, 66.3% experienced depersonalization, and 92.4% experienced reduced personal accomplishment. (10)

(Paper was delivered on 15 June 2023 at the 55th Annual Convention of the Association of Philippine Medical Colleges)

Burnout among medical faculty has been associated with work-life conflict, lack of acknowledgement and appreciation, decreased number of faculty, inadequate resources, ambiguity about future growth in the academe, job demands, long working hours, and excessive regulation by the government or university. (10,11,12) Burnout has been closely linked with personal and professional repercussions among physicians. Personal consequences include broken relationships, alcohol and substance use, depression, and suicide. Professional repercussions include decreased quality of care and increased medical errors, decreased patient satisfaction, decreased productivity and professional effort, and physician turnover. (13)

Physician burnout has become more pronounced during the COVID-19 pandemic. Prior to the pandemic, more than 45% of physicians were vulnerable to burnout. Compared to the general population, physicians were more likely to experience burnout and to be dissatisfied with work-life balance. (14) During the pandemic, burnout rate steadily increased such that in the US, one in five physicians intended to leave practice. (15) What about academic physicians in particular?

A study among Canadian medical faculty revealed a burnout rate of almost 76%. Rates were higher among women and early career faculty members, an observation that was also noted in South Korea. (10, 16)

How then can medical schools foster faculty engagement in academia while acknowledging the challenges and uncertainty of our time? Experts believe that instituting interventions that improve physician wellness and reduce burnout have been shown to decrease physician turnover. The mistaken notion that physicians themselves are solely responsible for burnout and professional satisfaction lead organizations or administrations to focus on strategies (e.g., stress management workshops, mindfulness training, resilience training) that are insufficient to produce meaningful outcomes. (2) Experts believe that systemic factors such as organizational pressures and work stressors and not personal resilience contribute to burnout among healthcare professionals. (9)

Although self-directed strategies such as mindfulness practice help reduce stress, anxiety, and burnout, systemic factors that lead to such consequences must also be addressed. (2) Self-directed strategies disregard organization-centric or administration-centric factors that are primary drivers of burnout. Framing the issue as a personal problem may push physicians to look for solutions that are personally beneficial but disadvantageous to the organization such as reducing professional work effort. (13) Providing interventions geared towards equipping administration and the faculty with the capacity to optimize their roles as educators and role models is an example. This strategy will facilitate a top-down approach aimed at increasing medical student wellness. (2) Strategies addressing organizational issues have not been effectively developed because of two main reasons. First, it is believed that steps geared towards achieving physician wellbeing will conflict with organizational goals. Second, all wellness initiatives are costly. In reality, physician wellness is critical to achieving organizational objectives and many effective wellness strategies are not cost prohibitive. It is imperative that system-level strategies should be implemented in order to ensure medical faculty wellness. The Mayo Clinic in the US has evolved the following nine evidence-based organizational strategies to promote physician wellness: 1) acknowledge and assess problems related to wellbeing; 2) harness the power of leadership; 3) develop and implement targeted interventions; 4) cultivate a sense of 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; and 9) facilitate and fund organizational science. (13)

Organizations are urged to promote meaningful interaction among faculty members and provide protected time for faculty for their wellness activities. (17) The New York University Long Island School of Medicine in the US executed a wellness initiative that was created primarily for

medical faculty. (18)

They formed the Committee for Professional Health and Wellbeing that systematically addressed occupational hazards of burnout. They invited members who were highly passionate and persistent in the field of wellbeing. In order to develop a multi-disciplinary approach, this committee created an Executive Committee that, in turn, crafted a wellness ambassador program. This program ensured that the wellness initiatives were rolled out departmentally throughout the medical school. The ambassadors had to participate in 50% of committee meetings and document wellness activities for their departments. The ambassadors were also tasked to ensure that their interventions promoted connection with colleagues and reinvigorated a sense of meaning in work. This committee paved the way for sharing and discussing ideas among the various departments. The initiatives that were designed by certain departments created a ripple effect such that other departments replicated wellness strategies that they learned from others. For instance, the departments of Obstetrics and Gynecology and Surgery implemented an Annual Wellness Week that focused on different emotional, physical, environmental, and mental components of wellness each day. In order to promote faculty engagement, the departments of Pathology and Obstetrics and Gynecology ran structured annual retreats and social gatherings that focused on stress reduction and mindfulness. In order to promote camaraderie, the department of Foundations of Medicine conducted monthly department walks (called Infinity walks) at a local park. The department of Radiology implemented a “Wellness Wednesday” that comprised of outdoor activities, financial planning, and summer socials. The divisions of Maternal-Fetal Medicine and Gynecologic Oncology carried out weekly “check ins” and debriefings during division meetings and an activity entitled “Three Good Things Exercise.” The department of Pediatrics led a wellness activity called “Gratitude Month” that entailed the posting of thank-you notes at “Appreciation Stations” and “Gratitude Calendar” that involved hanging daily prompts at workstations. The committee also developed structured educational Wellbeing Grand Rounds that aimed to discuss topics such as work-life balance, resiliency, and mindfulness. In order to encourage participation, faculty members who attended the lectures were granted CME credits. Ultimately, the departments were given the autonomy to design programs that served them best given the differences among specialties and work units. (18)

The virtual platform enabled faculty across departments or divisions to conveniently and effectively share significant life roles and events. This process was a motivating force for faculty to pursue their academic and personal growth. The committee promoted their own internal faculty as keynote speakers in faculty development events. They ensured that their wellness initiatives were shaped by locally generated data from surveys or studies. For instance, the departmental wellness ambassadors used the responses to wellness-oriented questions from an employee engagement survey in designing wellness programs. Furthermore, this survey was redistributed annually in order to document change and progress. (18)

The committee provided the following general guidelines for institutions that are looking for ways to reengage their faculty: 1) offer flexible learning environments for faculty development events in order to accommodate different time schedules and geographical locations; 2) provide opportunities that foster conversations about life roles and hobbies; 3) obtain support from institutional leadership that advocates for faculty wellness; 4) organize committees and task forces that will promote faculty wellness through departmental activities; and 5) accept and adapt faculty feedback. The critical need for medical school leadership to make faculty wellness a priority was consistently highlighted by their dean who was highly supportive of their wellness initiatives. (18) Other authors affirmed that harnessing the power of leadership can set the tone of institutional culture and make wellness efforts even more effective. (13) This leadership must gradually enact organizational or system-level changes the impact of which would be felt over time. (5)

In 2017, a Resident Wellness Consensus Summit was inaugurated in the US. Part of this summit’s output was a proposal for an evidence-based wellness curriculum that contained modules that focus on the spectrum of wellness and burnout. A study showed that running small group discussions on these topics significantly increased empowerment and work engagement and decreased rates of burnout, emotional

exhaustion, and depersonalization. This curriculum may also be applicable to medical faculty. The following topics may be included in these wellness initiatives: 1) introduction to wellness (introduction to physician wellness and burnout and the wellness curriculum); 2) why wellness matters (building awareness on burnout, depression, and mental health issues in medical faculty; wellness is not the absence of distress); 3) wellness activities of physicians (how physicians stay well through relationships, religion and spirituality, self-care, work, and approach to life); 4) sleep (education on sleep hygiene and scheduling); 5) nutrition (education on the basics of nutrition and how to eat a healthy, balanced diet, particularly for people with busy lifestyles); 6) physical fitness (education on the basics and scientifically proven benefits of physical fitness, as well as how to get started on an exercise program); 7) financial health (overview of the basics of budgeting and living within your means); 8) mindfulness and reflection (overview of the concept, scientifically-proven benefits, unwarranted stigma, and practice of mindfulness for the busy faculty); 9) building support network (discussion about the importance of a support network for the faculty in promoting wellness and building resiliency);10) physician suicide (education on risk factors for depression and suicide specific for physicians, and how to recognize them in oneself);11) “I Need Help” (education on how to get mental health help for oneself, with a focus on systems that ensure confidentiality); 12) wellness in the workplace (discussion about how individual wellness depends on the supportive workplace wellness culture). (4)

A wellness program possesses a multidimensional approach that integrates individual needs, institutional and cultural barriers to wellness, and systemic issues that contribute to stress. (8) At an individual level, wellness is achieved when the faculty practice healthy habits on a daily basis allowing a balance in the physical, emotional, intellectual, social, spiritual, environmental, and occupational aspects of being.

Activities and strategies throughout the academic year include retreats, mental health leaves, recreational and leisure activities, exercise, conducive workspaces, retreat zones or quiet spaces with relaxation apps, open air sitting areas, a simple gym area, a snack/hydration station, self-care workshops, and communication and stress management trainings. Avenues for psychosocial support include check-ins with each other, group peer support (structured group sharing), and therapy sessions. The faculty must be made aware of such interventions using multiple channels of communication such as regular emails, fliers posted in work areas, a wellness website, and announcements in team meetings. Ultimately, these programs must be able to reduce the barriers to accessing wellness services. Studies have identified several barriers that include concerns about confidentiality, stigma and stoicism, demanding clinical schedules, and identifying therapists experienced in working with physicians. (5,19)

Wellness programs should foster a culture that allows open exchange of ideas and flexibility in responding to issues as they emerge. Wellness programs must allow the medical faculty to become an integral part of program policy changes and to participate in program improvements. Consequently, wellness programs become more successful and leadership and communication skills are enhanced among the faculty. The differences in experiences of the learning environment among subgroups of faculty does not permit a singular approach to wellness. Understanding such diversity will guide whatever changes to the learning environment are made. (5, 7, 8, 17, 20) The concept of the learning environment (LE) is defined by two main dimensions namely, psychosocial and socio-material dimensions. Individual characteristics that contribute to or respond to the LE, interpersonal interactions, and institutional policies, culture, and regulation constitute the layers of the psychosocial dimension. The socio-material dimension defines how the faculty interacts with the physical and virtual worlds that they operate in. (3) Incorporating web-based and other digital resources will contribute to the success of wellness programs because this provides the faculty and students the opportunity to learn at their own pace. (9) At present, the relationship between wellness and LE is not well understood and needs to be studied using high quality research. (3)

As medical education continues to adapt to technology and the challenges of a post-

pandemic landscape, faculty and administration will continue to play pivotal roles in student wellness. (2) It is essential that we understand the diversity of medical faculty because a one-size-fits-all approach to wellness initiatives may not be effective. (8) Institutions must take into account the impact of workplace culture on faculty wellness. By identifying and addressing issues arising from day-to-day experiences, institutional and departmental leaders can help build faculty resilience. Further research is essential in studying factors that contribute to wellness among groups of academic medical faculty. (1) Ultimately, embedding a culture of wellness that is openly and intently supported by administration should be a goal of every medical school.

In conclusion, academic medical faculty assume various roles and this predisposes them to burnout. In order for a wellness program for medical students to succeed, the faculty should also be recipients of wellness strategies or interventions themselves and not just implementers of the program. Strategies that ensure medical faculty wellness should not only be individual-centric but also organization-centric. Finally, no wellness program will succeed unless the power of leadership is harnessed.

REFERENCES

1. Dandar VM, Grigsby RK, Bunton SA. Burnout among U.S. medical school faculty. Analysis in Brief. 2019; 19: 1.
2. Klein HJ, McCarthy SM. Student wellness trends and interventions in medical education: A narrative review. Humanities and Social Sciences Communications. 2022; 9: 92. Available from: https://doi.org/10.1057/s41599-022-01105-8.
3. Gruppen LD, Fogarasi MC. Considerations on conducting research on wellness in the context of the learning environment. Global Advances in Health and Medicine. 2021; 10: 1–9. DOI: 10.1177/2164956121989708.
4. Arnold J, Tango J, Walker I, Waranch C, McKamie J, Poonja Z, et al. (An evidence-based, longitudinal curriculum for resident physician wellness: The 2017 resident wellness consensus summit. Western Journal of Emergency Medicine. 2018; 19 (2): 337-341. DOI: 10.5811/westjem.2017.12.36244.
5. Mari S, Rachel Meyen R, Kim B. Resident-led organizational initiatives to reduce burnout and improve wellness. BMC Medical Education. 2019;19: 437. Available from: https://doi.org/10.1186/s12909-019-1756-y.
6. AMA. Preventing burnout in medical residents and fellows: 6 keys for wellness. 2016. Available from: https://wire.ama-assn.org/education/preventing-burnout-medical-residents-and-fellows-6-keys-wellness
7. Alkatan HM. Impact of trainers-related factors and "generation gap" on the quality of local residency training. International Journal of Current Research. 2015;7(12): 24221-24224.

8. Chaukos D, Zebrowski JP, Benson NM, Celik A, Chad-Friedman E, Teitelbaum A, et al, "One size does not fit all" – lessons learned from a multiple-methods study of a resident wellness curriculum across sites and specialties. BMC Medical Education. 2021; 21:576. Avaialble from: https://doi.org/10.1186/s12909-021-02995-z.

9. Hategan A, Riddell T. Bridging the gap: Responding to resident burnout and restoring well-being. *Perspect Med Educ*. 2020; 9: 117-122. Available from: https://doi.org/10.1007/s40037-020-00567-3
10. Seo J, Bae H, Kim BJ, Huh S, Ahn YJ, Jung SS, et al. Burnout of Faculty Members of Medical Schools in Korea. *J Korean Med Sci*. 2022; 37(9): e74. Available from: https://doi.org/10.3346/jkms.2022.37.e74.
11. Choudary ZA, Ehsan SB, Ayub A, Farooq HU, Tahir MM. Burnout among basic sciences faculty: A mixed method research. *Pak Armed Forces Med J*. 2022;72(4):1189-1193. DOI: https://doi.org/10.51253/pafmj.v72i4.7888.
12. Lee RS, Son Hing LS, Gnanakumaran V, Weiss SK, Lero DS, Hausdorf PA, et al. INSPIRED but tired: How medical faculty's job demands and resources lead to engagement, work-life conflict, and burnout. *Front. Psychol*. 2021; 2:609-639. doi: 10.3389/fpsyg.2021.609639.
13. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*. 2017; 92 (1):129-146. Available from: http://dx.doi.org/10.1016/j.mayocp.2016.10.004.
14. Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, et al. Pushed to their limits, 1 in 5 physicians intends to leave practice. *JAMA*. 2012. Available from: https://doi.org/10.1001/jama.2022.5074.
15. Henry TA. Medicine's Great Resignation? 1 in 5 Doctors Plan Exit in 2 Years. AMA. 2022 Jan18.Available from: https://www.ama-assn.org/practice-management/physician-health/medicine-s-great-resignation-1-5-doctors-plan-exit-2-years.
16. Crist C. Pandemic increased burnout among academic medical faculty. Medscape Medical News. 2022 Jun 24. Available from: https://www.medscape.com/viewarticle/976144
17. McKinley T. Toward useful interventions for burnout in academic medical faculty: The case for unit-specific approaches. *Journal of Continuing Education in the Health Professions*. 2022 Jan 1; 42(1):e69-e74. DOI: 10.1097/CEH.0000000000000389
18. Savitzky DC, Rekawek P, Shelov S, Nonaillada J. Re-engaging faculty during and after a health pandemic: Programmatic strategies for learning and wellness. *The Journal of Faculty Development*. 2022 Sep 1; 36(3): 87-91.
19. Ey S, Soller M, Moffit M. Protecting the well-being of medical residents and faculty physicians during the COVID-19 pandemic: Making the case for accessible, comprehensive wellness resources. *Global Advances in Health and Medicine*. 2020 Dec 3;9: 2164956120973981. doi: 10.1177/2164956120973981. PMID: 33329941; PMCID: PMC7720314.
20. Lefebvre D, Dong KA, Dance E, Rosychuk RJ, Yarema M, Blouin D, et al. Resident physician wellness curriculum: A study of efficacy and satisfaction. *Cureus*. 2019; 11(8): e5314. DOI 10.7759/cureus.5314