

## Fostering Student, Resident, and Faculty Wellness to Produce Healthy Doctors and a Healthy Population

**A**s I began a recent shift in the emergency department, I noticed that one of our residents, consulting for a cardiology patient, had red welts covering his face. “Richard,” I said, “What happened to your face?”

“I don’t know,” he said.

“Have you seen anyone? A doctor?”

“No. I took an antihistamine. I haven’t had any time. I’m on a 24-hour shift today for Cardiology. There’s no one to cover. I’ve just been too busy. Do you think it’s serious?”

“I don’t know,” I said. “I’m not sure what it is. Maybe hives. But you need to have someone examine you. I think you should stop what you’re doing and go over to the Fast Track. Dr. Jonas is there and she can talk with you and figure out what to do. We can handle the cardiology patient here for now, and we’ll talk later.”

“Are you sure? I don’t feel that bad. I don’t want to make extra work for everyone else.”

After assuring Richard that we would be able to manage without him, another resident arrived for her regularly scheduled ED shift with me. She had been ill all day, vomiting and feeling feverish. She said that it was probably some kind of intestinal infection that had been going around and thought that if we would just give her a liter of IV fluid she could make it through the shift. I felt her pulse, which was over 120, and her forehead was hot and sweaty. I looked at our full list of patients waiting to be seen and the long list of tasks that needed to be done, and I was tempted to agree with her plan. I was not sure how we would manage without her, and a replacement would be difficult to find at this late hour. Then I remembered how

I had scolded the other resident about not caring for himself and realized I was reinforcing the same attitude. I am still embarrassed about my initial reaction, but I suspect it is not at all atypical in our stressed clinical environment, where patients often wait far too long for care. I spoke with one of the other faculty in the department, we rearranged our resident teams so that we could cover for the ill resident, and I sent her home.

These two events, occurring on the same day, made me stop for a moment and consider the strangeness of our attitudes about self-care for physicians and trainees. In how many occupations would we expect people who were clearly ill to continue working without seeking medical care? How would we feel if we knew the person piloting our airplane was febrile and vomiting? Would we want the pilot to just drink some fluids and fly the plane? How would we feel if our child’s teacher was covered with a rash? And yet we physicians often work when we are ill because we do not want to give our colleagues more to do, or perhaps because we believe it would be a sign of weakness to ask for help. Unfortunately, this attitude has been passed down through the generations of physicians and become inculcated into medicine’s cultural norms. Perhaps that is one reason why we now have a serious problems with physician, resident, and student burnout, depression, and suicide. How did we get to this unfortunate place, and what can we do about it?

There is a long history of physicians ignoring the need to care for themselves. Thompson et al,<sup>1</sup> after a series of interviews with physicians, reported that

a sense of conscience towards patients and colleagues and the working arrangements of the practice were cited as reasons for working through illness and expecting colleagues to do likewise.

Rates of physician burnout,<sup>2</sup> depression, and suicide<sup>3</sup> greatly exceed those of nonphysicians. Shanafelt et al<sup>2</sup> surveyed

U.S. physicians and nonphysicians and found that in 2012, 37.5% of physicians were burned out compared with 27.6% of nonphysicians ( $P < .001$ ). A few years earlier, Schernhammer and Colditz<sup>3</sup> had found that female physicians had double the rate of suicide found in the general population, and male physicians had a rate that was about one and one-half times the rate in the general population.

Residents and medical students suffer even higher rates of burnout and depression than do practicing physicians. Dyrbye et al<sup>4</sup> surveyed U.S. medical students, residents, and early-career physicians (those who had completed their residencies no more than five years earlier). The data from their respondents indicated that 55.9% of medical students, 60.3% of residents, and 51.4% of early-career physicians were burned out, and 58.2% of medical students and 50.8% of residents screened positive for depression. In this issue of *Academic Medicine*, Jackson et al<sup>5</sup> also demonstrate an association between burnout and alcohol abuse in U.S. medical students. These figures are truly alarming and should leave no doubt as to the seriousness and extent of the current distress of trainees and practicing physicians.

While recognition of the problem is one important step required for change, it does not necessarily provide guidance for a solution. In the rest of this editorial, I suggest a framework for addressing student, resident, and faculty physician burnout and share some ideas about how to create a culture of wellness to prevent burnout. The framework describes three kinds of proposed interventions: those focused on supporting individuals, those focused on improving the social support network of faculty and colleagues, and those focused on improving the learning and health care environment.

### Supporting Individuals

Each student, resident, and faculty physician has unique strengths and

*Acad Med.* 2016;91:1185–1188.  
doi: 10.1097/ACM.0000000000001298

An AM Rounds blog post on this editorial and the articles discussed within it is available at [academicmedicineblog.org](http://academicmedicineblog.org).

vulnerabilities. The same stressors do not always result in the same responses—one person may respond differently from another. It is important to recognize and support those who may be most affected by a difficult work environment through access to counseling, mental health care, and physical health care. Ey et al<sup>6</sup> describe a wellness program for residents and identify factors related to whether the residents would use the services. While 42% of the residents said they were very likely to consider using the program for counseling, many other residents had concerns related to the program's helpfulness, stigma, confidentiality, and adequate time to use the services. Dyrbye et al<sup>7</sup> have also shown that medical students may not seek needed care for burnout because of concerns about stigma and lack of confidentiality.

The implementation of a policy of time off dedicated to health needs as described by Cedfeldt et al<sup>8</sup> can improve residents' willingness to seek medical care, but even with a time-off policy, residents still express concern about the impacts of time away on peers and patients. In this issue, Carvour et al<sup>9</sup> propose a patient-centered medical home for residents with extended hours, co-location of mental health services, and inclusion of a care coordinator who could assist with appointments. Such a model might improve the efficiency of medical care for residents such that they would not be as concerned about the impact of a short time away on their colleagues or loss of confidentiality. Individual-level interventions that build resilience, such as mindfulness programs and self-awareness programs,<sup>10</sup> exercise, and meditation can also help residents and students recognize and treat their ongoing levels of stress but may not address other unmet needs.

Maslow<sup>11</sup> described a hierarchy of needs and suggested that those needs at the lowest levels, such as food or sleep, must be satisfied before the needs further up the hierarchy can be met. Residency education requires individuals to attain the highest level of the Maslow hierarchy for optimal creativity, problem solving, and learning. The Accreditation Council for Graduate Medical Education (ACGME) includes stipulations about the availability of food, duty hours, sleep rooms, and health insurance in its institutional requirements because it

recognizes the importance of a healthy, rested learner for the educational process to be successful. While the ACGME requires institutions to monitor duty hours, it does not require any monitoring of resident wellness, nor does its annual resident survey ask about wellness.

### Improving the Social Support Network of Faculty and Colleagues

Residents and medical students are highly motivated to gain the knowledge and skills of a physician. Residents and students often forgo many aspects of their individual wellness in exchange for the opportunity to meet their educational and career goals. They learn clinical skills by caring for patients with a variety of health problems under the supervision of experienced physicians. Residents' mastery of those skills is critically dependent upon the faculty who teach, mentor, coach, and evaluate their readiness for independent practice, and is also dependent on the learning environment that supports their relationships with their teachers. Ludmerer<sup>12</sup> described the relationships that characterized residency education prior to World War 2.

Faculty and residents knew each other well; strong professional and personal relationships with each other were commonplace.... Camaraderie among the resident staff was high, there was a strong feeling of being appreciated and part of a family...

He goes on to contrast these relationships with those elements in current residency education that attempt to address resident burnout and stress with regulations such as duty hours rules.

The new rules do not guarantee adequate amenities while on call, a faculty that knows and cares about the house staff, stimulating conferences and rounds, the ready availability of advisors and mentors, a fair policy about parental leave, the immediate accessibility of help, or a strong sense of camaraderie.

What Ludmerer has identified is the erosion of the compact between residents and their faculty teachers in which the faculty and residents had developed a trusting mentor relationship in exchange for the resident's willingness to provide a variety of hospital clinical services. The amount and nature of those clinical

services were (and remain) negotiable and dependent upon the changing clinical environment. However, if the faculty are burned out and unwilling to teach or support the residents' educational goals, the relationship can break down and lead to distress for the learners, who feel exploited. Mata et al<sup>13</sup> in this issue describe the importance of social relationships with colleagues, family, and friends for interns whom they screened for signs of depression. Those who screened positive for depression cited a malignant program culture and bureaucracy at work as major factors for their stress. Social support from friends, family, and colleagues was most important in helping all interns through their year. One said:

I have an amazing support network of people who stand by me through thick and thin—both medical and nonmedical. I do not know what I would have done without them.

My informal discussions with current leaders of the Association of American Medical Colleges' Organization of Resident Representatives confirmed this important source of support for residents.

Eckleberry-Hunt et al,<sup>14</sup> in their creation of a wellness initiative for residents, recognized that faculty wellness and motivation were intimately tied to resident and student wellness and incorporated faculty wellness into their resident wellness program. Shapiro and Galowitz<sup>15</sup> in this issue describe a program using trained peer counselors who provide support for faculty and residents during some of the most stressful moments of medical practice, such as after an adverse patient care outcome, a medical error, or during malpractice litigation. Specific programs such as these can improve the peer support networking that often occurs as part of the educational program for residents and create a foundation of trust and security that can augment other wellness activities. Inclusion of nurses and other health professionals in social and educational activities could broaden support networks and help extend the wellness culture to include all health professions.

### Improving the Learning and Health Care Environment

In addition to efforts to support individual residents and faculty in

developing wellness habits and resources, the work and education environment, whether it be a clinic or hospital, must be critically examined. At the most fundamental level we must evaluate how much of what residents and students do is truly educational and how well the work environment supports the educational activities. While exploitation of housestaff has a long history of symbiosis with medical education, its current manifestation has stripped away many of the relationships that gave meaning to the time the residents spent in their residency programs. Time with patients is increasingly being replaced with time on computers documenting information for billing or to fulfill various policies and regulations that have no learning value.<sup>16</sup> Faculty who used to provide the bridge between clinical scholarship and clinical care have been replaced by clinicians who may have little commitment to the educational goals of the residents, have no connection to the research activities of the academic health center, and juggle numerous schedules that fragment their time with a team. Hospital administrative decisions that affect the day-to-day ease of practice of residents are increasingly beyond the control of residents or faculty, leaving them powerless to improve the work environment. While the ACGME has recognized the critical role of the learning environment and instituted a process of review known as the Clinical Learning Environment Review (CLER),<sup>17</sup> it is uncertain whether this process will help to create a culture of resident wellness. Perhaps there is a way to link resident wellness to the areas of focus of CLER (which are quality, safety, care transitions, supervision, professionalism, and fatigue management) and in so doing better align the goals of resident education and those of the care delivery system.

Wallace et al<sup>18</sup> have suggested that physician wellness should be measured and be considered a quality measure because physicians who are unwell may provide suboptimal care. It seems to me that if payers for health care penalized hospitals with poor physician wellness scores by reducing payments, as they now do for high readmission rates, perhaps hospitals would accord physician wellness a greater importance. The ACGME could also include resident wellness measures as a part of the CLER

visit process. Bodenheimer and Sinsky<sup>19</sup> have called for inclusion of physician wellness with the other goals of the health care system, making the argument that physician burnout endangers the delivery of high-quality health care. They suggest several ways of improving physician wellness through better teamwork and reduced administrative paperwork.

Eckleberry-Hunt et al<sup>14</sup> describe a wellness initiative that involved changing the culture through designating people and time to address key components of a wellness culture. They defined wellness as “a dynamic and ongoing process involving self-awareness and healthy choices resulting in a successful, balanced life style.” They monitored themselves through administration of the Maslach Burnout Scale<sup>20</sup>; discussed results in confidential group meetings; and offered lectures, support groups, and counseling support access. Through these and other activities they were able to open conversations about wellness and burnout and recognize the association between faculty wellness and resident wellness. Slavin and Chibnall<sup>21</sup> in a Commentary in this issue also describe the importance of tracking mental health (in their example, they focused on medical students) as part of an overall program to provide meaning, improve wellness, and reduce burnout.

### A Crucial Link

Ultimately, we must recognize that physician, resident, and student wellness are integral to the success of our health care system and that physician wellness will help us meet the health care needs of our population. We can begin the process by recognizing the crucial link between physician wellness and health care system performance, sharing our best ideas and models for supporting learner and faculty wellness, providing incentives for excellence in wellness, measuring our progress, and committing resources to an ongoing improvement cycle. As educators, we should be the leaders in understanding how to nurture our learners, faculty, and practicing physicians. We should be the role models of our health care system in helping our physicians and students maintain their wellness, which will allow them to find the joy in practice

that ensures a high-performing health care system.

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*Editor's Note: The opinions expressed in this editorial do not necessarily reflect the opinions of the AAMC or its members.*

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