Wellness and Work: Mixed Messages in Residency Training

Lisa M. Meeks, PhD, MA[1], Jennifer Ramsey, MD, MS[2], Maureen Lyons, MD[3], Abby L. Spencer, MD, MS, FACP[2], and Wei Wei Lee, MD, MPH, FACP[4]

[1]Department of Family Medicine, University of Michigan Medical School, Ann Arbor, MI, USA; [2]Cleveland Clinic Foundation, Cleveland, OH, USA; [3]SSM Health Saint Louis University Hospital, St. Louis, MO, USA; [4]Department of Medicine, University of Chicago, Chicago, IL, USA.

Resident physicians are at higher risk for depression, anxiety, and burnout when compared with same-age peers, resulting in substantive personal and professional consequences. Training programs across the country have acknowledged the gravity of this situation and many have implemented programs and curricula that address wellness and resilience, yet the benefits of such initiatives are still largely unknown. While the development of wellness programming is well intentioned, it is often incongruent with the residency training environment. The mixed messaging that occurs when wellness programs are implemented in environments that do not support self-care may unintentionally cause resident distress. Indeed, outside of the time dedicated to wellness curricula, residents are often rewarded for self-sacrifice. In this commentary, we describe how the complexities of the medical system and culture contribute to mixed messaging and we explore the potential impact on residents. We offer recommendations to strengthen wellness programs through efforts to promote structural change in the training environment.

KEY WORDS: workforce; burnout; medical education-curriculum development; self-care; postgraduate medical education; wellness; resilience.

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INTRODUCTION

Burnout among physicians is higher than in any other field in the USA and is characterized by exhaustion, cynicism, and reduced effectiveness.[1, 2] Multiple studies document an upward of 50% prevalence in burnout among residents,[3–5] coupled with symptoms of depression and anxiety.[6–9] The largest contributors to burnout include time pressure, chaotic environments, a lack of control over work conditions, and a lack of shared vision between providers and administrators.[2] These high levels of burnout negatively impact individual residents and their patients by contributing to medical errors, lapses in professionalism, and poor patient satisfaction.[10] In addition, burnout is also a key contributor to substance abuse, strained relationships, attrition, and physician suicide.[11–14] In a 2018 commentary, leaders from the National Academy of Medicine, The Association of American Medical Colleges, and The Accreditation Council for Graduate Medical Education declared that clinician burnout, depression, and suicide had reached a "crisis level."[15]

In response to the high prevalence of burnout, training programs around the country have developed wellness initiatives to improve resident well-being.[16] While the preliminary data on the impact of wellness programs on resident and faculty well-being is promising, academically rigorous research on the impact of resident-specific interventions is still needed.[17–20] Despite efforts to enhance well-being, residents identify that finding time to focus on their own medical and self-care is one of the biggest challenges in the current learning environment.[21–25]

Residents are often expected to balance learning, patient care, teaching, and documentation while working 80-hour weeks for months on end. When life events related to physical or mental health, relationships, or family occur, there is little flexibility in the system to allow residents to attend to their needs.[21, 26, 27] Instead, residents who require time off for health or personal reasons must navigate a complex coverage system, which could include the redistribution of work to their peers. Moreover, requesting time away from work often necessitates disclosure of a mental or physical health concern or disability to their superiors, who are often the same individuals responsible for writing their letters of recommendation and advocating for them to future training programs or employers.[21] These conflicts leave residents hesitant to disclose these issues or to request time off for fear of a lack of confidentiality, stigma, documentation on academic record, and downstream consequences for licensure and employment.[28–32]

In addition, many well-meaning wellness initiatives disproportionately focus on individual factors without adequate attention to systematic contributors to burnout, despite research that points to the learning environment as a major driver of resident burnout.[33–35]

MIXED MESSAGES

As a profession, our response to the burnout crisis has been primarily educational. We develop curricula to teach trainees the symptoms of burnout and offer training that focuses on personal resilience (i.e., meditation, mindfulness, etc.).[22, 36] While the literature suggests that meditation, mindfulness, and yoga may be protective against burnout, the efficacy of these

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programs lacks robust evidence-based support.[22, 37–40] The expectation to engage in wellness activities in addition to their other responsibilities may place an additional burden on trainees and suggests that burnout results from residents' personal failure to engage in wellness programming.

There is emerging evidence that organizationally directed wellness interventions may be more effective in combatting burnout,[37] which supports the notion that burnout is a systemic issue rather than an individual one. Additionally, residents report that personal resilience training, in a system that remains dysfunctional, is ineffective, and that effective interventions to reduce burnout must include improving workplace conditions.[41]

RESPONSE FROM REGULATING BODIES AND LEADING PROFESSIONAL ASSOCIATIONS

Accrediting agencies, physician and medical education associations underscore the importance of well-being in the development of the competent, caring, and resilient physician. The new Accreditation Council for Graduate Medical Education (ACGME) standards call for a residency training culture focused on physician well-being and programs are required to provide 24/7 access to urgent and emergent care and confidential mental health assessments, counseling, and treatment.[42] The new standards also call on programs to create formalized systems for identifying burnout and depression in residents.[42] In addition, the Clinical Learning Environment Review (CLER) program requires residency programs to focus on workload and work conditions to address fatigue and burnout.[43, 44]

Others, including the National Academy of Medicine (NAM), also identify burnout as a critical issue requiring sustained attention and action at organizational, state, and national levels and in response developed the Action Collaborative on Clinician Wellbeing and Resilience.[45] The American Medical Association (AMA), as part of their STEPS Forward series, offers five educational modules on professional well-being, including a burnout prevention module for residents and fellows.[46] While the aforementioned initiatives call for programmatic integration of wellness, they do not address the barrier of protected time to engage with recommended self-care. Unfortunately, mandated policies and organizational guidance in the absence of systemic change makes translating these policies into practice challenging.

INSTITUTIONAL POLICIES AND PRACTICE MISMATCH

Despite the increased spotlight on physician well-being and institutional efforts to promote wellness, the culture and practice of medicine continues to send mixed messages. Residents are told that self-care is critical to avoiding burnout, yet that same messaging is absent for their faculty leadership. Working while sick, sacrificing personal relationships for work, and forgoing self-care are the norm, not the exception.[47, 48] In addition, even when residency programs provide protected time off to attend health appointments, trainees and faculty physicians remain reluctant to seek mental healthcare given the stigma and potential downstream consequences.[17, 42, 49, 50] Faculty who are not aware of the research on physician burnout, depression, anxiety, and suicide may label trainees who engage in self-care as soft, needy, or unprepared for the real world, thereby perpetuating expectations for residents to work through challenges that might otherwise be addressed.[51]

FORWARD FOCUS

Wellness programs should include a combination of personal resilience training and initiatives to address organizational issues that contribute to burnout. More research is needed to identify the systemic solutions to improve physician well-being and address burnout and must rigorously explore the impact of wellness initiatives on trainee well-being and patient outcomes.[34] Critical commentaries call for fundamental changes in our training programs and recommend structural changes to promote resident autonomy, strong social relatedness, adequate sleep, and time away from work.[52, 53] A consistent recommendation is for training programs to demonstrate their commitment to resident well-being by creating schedules with built-in time off for health and well-being appointments.[52, 54–56]

In addition to individualized efforts at hospitals and residency programs, systemic change will involve regulators, payers, accreditation agencies, policymakers, and patients.[57, 58] The path forward must first focus on systems that measure and track physician well-being as an institutional goal and create opportunities and time for physicians to engage in program development.[59]

Another recommendation is that health systems adequately staff their hospitals with resident and non-resident personnel and reduce documentation burden on trainees for non-educational purposes. One example of a successful intervention to reduce burnout is the University of Colorado's Ambulatory Process Excellence (APEX) team-based care model for family medicine residents, which expanded the scope of practice for medical assistants to include documentation assistance in addition to other clinical and administrative support. Researchers found that the team-based care model allowed providers more time for patient engagement, improved quality of care, and decreased physician burnout rates by 50%.[60]

Finally, accrediting bodies need to hold training institutions accountable for implementing and monitoring the effectiveness of wellness initiatives and ensure adequate support for leave and healthcare appointments. When policies become realistic practices, the training community sends one clear message to our medical trainees: your well-being is important.

CONCLUSION

The medical community's response to burnout through the creation of wellness programs may inadvertently send confusing and frustrating "mixed messages." As a profession, we must operate with one voice—and model and reward the behaviors we recommend. Our words, actions, systems, and curricula must align to support choices and behaviors which seek personal and professional balance in addition to clinical and educational excellence. Until such time as our actions match our messages, the intended goals of wellness training will go unrealized.

Corresponding Author: *Wei Wei Lee, MD, MPH, FACP; Department of MedicineUniversity of Chicago, Chicago, IL, USA (e-mail: wlee6@uchicago.edu).*

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