Chapter 4
Measuring and Maintaining Faculty Health

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Abstract  Faculty health in an academic medical center deserves specific and focused attention, as the health of the faculty affects the health of academic peers, students, patients, and the community. The stigma of illness persists in the culture of medicine and serves as a barrier to the seeking of help by faculty members in need. Measures of wellness can be used in the workplace to determine the presence and level of burnout and illness, and encourage the use of resources. The results of such measures can lend support for the creation of a wellness program for the faculty. An effective wellness program addresses aspects of prevention and health promotion, education, intervention, research, and identification of available resources. Specific steps are outlined to facilitate the development of such a faculty wellness program to maintain faculty health.

Keywords  Faculty health, stigma in medicine, burnout, faculty wellness program, healthy medical workplace

The workplace is a key determinant of health. While this is true of all workplaces, it is especially true in academic medical centers, where the culture of medicine enables denial of faculty health problems and sustenance of unhealthy behaviors, thereby perpetuating factors leading to an unhealthy medical workplace. The medical faculty train doctors and scientists, and serve as a role model for behaviors within medicine. Further, healthy health care professionals serve as healthy role models for their patients. Encouraging and supporting a healthy medical faculty, therefore, will have a far-reaching positive impact on the health of physicians, their patients, and the community at large.

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Stigma in the Culture of Medicine

It is not easy for doctors to admit that they may need help in becoming healthier. The culture of medicine sets high expectations of its clinicians, educators, and scientists. It promotes hardwork, conscientiousness, perfectionism, compulsiveness, and thoroughness. It encourages self-sacrifice and delay of personal gratification. These personality traits and attitudes of physicians were well-described by Gabbard and Menninger in their work with physician couples [1].

Ideal faculty members come in to work early and leave late and are always available. They pay attention to every detail, are careful, highly responsible, reliable, and trustworthy. They are tough, strong, and in control. They can handle anything and everything. They take care of others and are ready to help when needed. This perception is reinforced by their teachers, their training, their colleagues, their students, and their patients. It can lead to misperceptions.

Many in academic medicine believe: “It is wrong to get ill and to need and ask for help.”

An Emergency Medicine doctor completed her entire shift although she was having a miscarriage, bleeding heavily, and feeling weak. That day, she had assessed and admitted 3 other women to hospital who were also experiencing a miscarriage, but felt that she needed to continue to work and not irresponsibly burden her colleagues.

The family doctor spent the whole night up with her 9-month old baby, who was rubbing his face into her and crying inconsolably—an unusual state for this baby. He felt hot to the touch and was unable to sleep. She was not sure if the situation was serious enough to take him to the hospital and was relieved when he finally fell asleep around dawn. She felt surprised when she checked in on him in the morning and found him sleeping, with pus and blood draining from his ear. She felt guilty at having made him endure the pain of otitis media.

The senior scientist was still reeling from his visit to the doctor, where he heard he had bowel cancer. He decided to wait and find out the exact pathology and staging before he told his colleagues “so they would believe him when he asked for time off for his treatments.”

While the concept of no needs/no help is believed to be true for physical illnesses, it feels even truer for mental illnesses.

A physician suffered an acute myocardial infarction and was hospitalized in the cardiac unit of his hospital. His department sent a card and flowers, and many of his colleagues stopped by his hospital room to visit and offer support and encouragement. At the same time, another colleague from the same department was diagnosed with severe depression and was admitted to the same hospital’s psychiatric unit. There were no cards, flowers, or visits for him. The physician with the myocardial infarction remarked, “I had the more noble disease.”

A resident spoke to me about his developing depression. The attending physician in charge of his team became angry at him for coming to work late each morning and yelled at him publicly while rounding with the team on the ward. I asked him if the attending physician had asked him if he was well. He replied,