ANTWIONE HAYWOOD | PHOTO

Shifts in Medical Education

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BY SEUNGYUP SUN

Seungyup Sun: Thank you for sitting down with me today. Could we start with your educational background and your path to medical student education?
Antwione Haywood: What's most interesting is starting even before myself. I have four siblings and most of us have terminal degrees. But my mom has a 6th grade education and immigrated here. I think people who search for the American dream often want life to be so much better for their kids. And when you're in a space where everyone is talented, it's hard to step back and reflect back on your accomplishments or have some sense of gratitude to the possibilities that have played out.

I grew up in LA and went to college in Virginia at Old Dominion University. I had these great experiences with student government and as a resident assistant. At some point, an advisor told me that I could work with college students in a similar capacity and get paid to do it. So, for the past 15 years or so, I've been studying and practicing the art of working with college-level students. My background and training are in college-age student development and the development of human potential.

I received a masters from the University of Kansas and then a doctorate from IU Bloomington. In between all that, I've also worked for Drexel University in Philadelphia, the higher learning commission in Chicago, and Purdue before being recruited for this position. In many ways, it's my job to fill in the gaps by providing subject matter expertise in student affairs.

SS: In what ways do you find that you're helping to fill in those gaps?

AH: There are several things that our students today take for granted that were nonexistent when I first arrived. For one, students weren't assigned advisors until the end of 3rd year. And that was the model. When you're in the thick of medical training, you don't realize how that sounds. So, my role is to share what the current practices are in higher education and what students are expecting.

And there are little things here and there that I've helped develop. For example, the connection days. We used to have mega-blocks, which were blocks consisting of three clerkships and no days off in between. The only clerkships that had what were called "changeover days" were those with inpatient services, where you may go from four weeks of inpatient to four weeks of outpatient rotation. Outside of that, it was very possible you could end a rotation on Thursday in Evansville and start the next rotation on Friday in South Bend.

SS: During your six years at IUSM, what are some of the biggest shifts you've seen in medical education?

AH: One of the things I'm particularly proud of is orientation. Last year, in the class of 2023, they had less than three hours of didactic time at orientation. Previous students spent a lot of time in a lecture hall with a lot of people talking at them. There's this idea in many organizations: when you have leaders reflect back, there's no great rationale for why we do things the way we do. So, what is the rationale for talking to people for two days straight? Instead, we spent a lot of time developing a thrive mentality and trying to do a better job of creating pride, community, and a sense of belonging. We went from the service project being optional to it being the first experience for all students. It's amazing to have 370 students participate in service across the area. We also did all kinds of small group activities around wellness, community building, and dealing with conflict.

With regards to the curriculum, I was on a committee responsible for making the argument for why we should go to pass-fail. I was also a representative on the curriculum counsel steering committee where I, along with others, brought up questions around curricular inequities. Before your time, every campus delivered a Phase 1 experience differently. Different classes, different credit hours, different grading schema… it felt like nine different medical schools. And we had grades and rankings. To me, a logical question was how can you have a ranking system that's not based on equitable evaluation of students? The Phase 1 curriculum has come a long way. Curricular experiences in the clinical years are continuing to become better too.

Outside of the curriculum, I've been happy and pleased with the efforts of medical student council. It used to be, in my opinion, a campus activities programming board. They've really shifted to representing the student voice in a governance capacity and expanding its reach by making sure relevant leaders and issues are brought to the forefront of the student body.

My baby project that has taken off has been around wellness. My personal interests and passions are around lifestyles and prevention medicine. I'm a certified life coach, I'm a trainer for Mind, Body, and Medicine, and I teach physical fitness classes. I work behind the scenes to develop relevant evidence-based medicine to support why we should be teaching more lifestyle and preventative approaches in our curriculum.

SS: Why do you think we should be incorporating those approaches in our curriculum?

AH: Lots of people ask, "How do we deal with burnout?" I think the issue is that we think about burnout as an acute disease. Burnout didn't just happen yesterday. It's really the collection of symptoms that have built up over time that have led to your anxiety or depression. And what we can do in the front end is to educate about pitfalls and preventative practices from the start.

For example, it's hard to feel the effects that lack of sleep have on patient care when you're involved. Maybe there's usefulness in studies showing that residents or physicians who lack sleep have safety issues. Or maybe it's useful to just show what happens in your brain when you don't sleep. We could be teaching that. Information is power. And then people could develop in a prescriptive way preventative tools to support them. So, on exam week or a busy rotation, when you know you're going to be working late at night, you can prepare for that. What ends up happening currently is that you're already deep in it and you don't have the knowledge and tools to be well.

There's something called the G.I. Joe fallacy. Back in the 80s, there was this cartoon called G.I. Joe and they always ended it by saying, "Now you know. And knowing is half the battle." They call it a fallacy because reality is not like that. Again, as an example, medical students are very smart people; I don't have to break down to you that you should be sleeping eight hours a day. You've likely seen some data that sleep is important. Yet, I feel like if I spoke to every medical student about how much they slept, most of them would say they sleep less than 7 hours knowing that it's

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probably bad for them.

The reality is that we don't connect the science and knowledge to ourselves. We never look at medicine with the lens that we benefit the most from knowing that information. It's the same analogy of being in an airplane where they tell you to put on your oxygen mask and life vest first before worrying about the person next to you. Self-care is important and I think what happens to many students is that they dismiss a practice before even trying it, looking at the evidence, and considering how knowing that information might help someone else.

SS: What are your thoughts on cultural aspects of medical training that impact wellness?
AH: There's this concept called Maslow's hierarchy of needs. At a fundamental level, people don't make rational decisions if their basic needs aren't met, such as food, sleep, shelter, etc.

At a basic level, there are things that we don't address that are real problems. Debt load is a major concern for students and as a result, they make poor decisions when it comes to food choices. As much as everyone loves free Yats or pizza, you know processed foods are not the best for your body. But it's hard to pass up on because it's free, you're broke graduate students, and it saves you time from cooking. Then does this kind of food become your habit or a thing you do occasionally?

The second layer of that is around safety. It's hard to feel psychologically safe in medicine because you're always being evaluated. In Phase 1, you're being compared based on your score. In Phases 2 and 3, you're essentially focused on impression management with faculty who don't know you but need to make an assessment of how well you're doing based on limited interactions. It's such a simple concept but it really plays out in how people operate behaviorally. There are other models of graduate school; for example, there are systems where everyone is considered a junior colleague, much like PhD students are considered in their labs. There are systems with no grades that are instead criterion based; you either know the content or are working towards learning it. In the clinical environment, there are models such as having a coach or seeing yourself as an apprentice. I imagine implementing those models would have a profound impact on the psychological safety of students, and thus their decision-making and wellness.

SS: How do you personally find a work-life balance and what are your keys to happiness?
AH: My routine: I go to bed early. When I was a student, I used to go to bed around midnight. Now I go to bed around 9 or 9:30 PM. I wake up around 5 AM and I have some time to myself. I go to the gym every morning and do a fasted workout. Your body releases cortisol and insulin in the morning and that's part of what wakes you up, so I go through that practice. And I take pride in taking my son to school every day.

When I park in Lockfield, I do a 10-minutes or less meditation and reflect on three things I'm grateful for. I also do a little bit of free writing. I've found the only way I do it is by making it a part of something that's right in my face and I can't avoid. I sit, I meditate, and I reflect on what I'm thankful for.

And I'm pretty good at checking out once I leave work. I'll look at my email to see if there are any emergencies or if there's a message from a student. If it's an emergency, I'll respond. If it's a student that's across the state that doesn't know me well, I'll respond and let them know that I've seen their email but that I'll respond in a business day or so. I think people deserve that courtesy to know that you're listening to them. I want to acknowledge their interest but let them know that I have some boundaries.

The final piece is that through a lot of the practices that I've been exposed to, including spirituality, I've realized the only thing I can control are my own emotions. I've evolved around not idolizing other people, whether it's my spouse or my son, because I can't control their actions. I can only display the love and kindness that I want to. When you put all of your purpose into something that you can't control, like how do you compare to someone else or whether your kid is an exact mini-me of you, those things are going to lead to disappointment because rarely do things work out 100% how you want them to. It's been important to my mindful practices to be more forgiving of others and more reliant on controlling my own behaviors, anger, and frustration. And when you do that, it gives you power. Once I started getting into this stuff, it's become a gateway into other dimensions of wellness and support. I try to experience as much as I can and practice what I preach.

SS: For medical students interested in education, do you have any advice on how they can get involved?
AH: There's a lot of potential in our scholarly concentrations. A lot of disciplines say that they want people who have depth in a field of study and a range of skills. You want T-shaped individuals: people with broad aspects of knowledge outside of their depth of knowledge so that they can connect with people and be a better person.

Post-graduate, there are lots of deans and leaders I've seen who went back and got a masters in higher education, curriculum and instruction, educational psychology, or a related field. There's an entire profession out there with various pathways that can support an interest in education. Certainly, some students have pursued degrees in anatomy education.

One of the first things students can do is to get involved in committees, learn about the curriculum, learn about student affairs, learn about course design, and then share their voice. The second big step is getting involved in a scholarly concentration that supports medical education, and then ultimately pursuing post-graduate education.

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