# Promotion of Wellness and Mental Health Awareness Among Physicians in Training: Perspective of a National, Multispecialty Panel of Residents and Fellows

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## Abstract

**Background** Physicians in training are at high risk for depression, and physicians in practice have a substantially elevated risk of suicide compared to the general population. The graduate medical education community is currently mobilizing efforts to improve resident wellness.

**Objective** We sought to provide a trainee perspective on current resources to support resident wellness and resources that need to be developed to ensure an optimal learning environment.

**Methods** The ACGME Council of Review Committee Residents, a 29-member multispecialty group of residents and fellows, conducted an appreciative inquiry exercise to (1) identify existing resources to address resident wellness; (2) envision the ideal learning environment to promote wellness; and (3) determine how the existing infrastructure could be modified to approach the ideal. The information was aggregated to identify consensus themes from group discussion.

**Results** National policy on resident wellness should (1) increase awareness of the stress of residency and destigmatize depression in trainees; (2) develop systems to identify and treat depression in trainees in a confidential way to reduce barriers to accessing help; (3) enhance mentoring by senior peers and faculty; (4) promote a supportive culture; and (5) encourage additional study of the problem to deepen our understanding of the issue.

**Conclusions** A multispecialty, national panel of trainees identified actionable goals to broaden efforts in programs and sponsoring institutions to promote resident wellness and mental health awareness. Engagement of all stakeholders within the graduate medical education community will be critical to developing a comprehensive solution to this important issue.

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## Introduction

In August 2014, 2 resident physicians died by suicide within 2 weeks of each other in separate incidents in New York City. The temporal and physical proximity of these tragic events, and a poignant op-ed piece in *The New York Times* implicating the culture of medicine in promoting an environment where physicians ignore their own well-being,[1] have renewed interest in medicine's ongoing struggle with depression and suicide. Systematic reviews and meta-analyses have consistently found significantly higher suicide rates among medical professionals in practice, with male and female physicians at 40% and 130% higher risk, respectively, compared with gender- and age-matched individuals in the general population.[2] While

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The views expressed in this article are those of the author(s) and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, National Institutes of Health, the Department of Health and Human Services, or the US government.

The Council of Review Committee Residents would like to thank Marsha Miller and Amy Beane for their efforts in assisting with pile sorting and production of the manuscript. We would also like to thank Timothy Brigham, MDiv, PhD, and Dewitt "Bud" Baldwin Jr, MD, for their assistance in designing the appreciative inquiry exercise and expert guidance.

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**DOI: http://dx.doi.org/10.4300/JGME-07-01-42**

BOX **Appreciative Inquiry Questions**

1. Discovery: Think of a time in residency that was difficult for you but you emerged from as a more resilient resident. What in the learning environment helped you effectively manage this difficult time?
2. Dream: Describe the characteristics of an ideal learning environment that would help learners manage this transformational journey.
3. Design: What must be done to achieve such a learning environment?
4. Destiny: What can the Accreditation Council for Graduate Medical Education do to effectuate these changes in the learning environment? What role can the Council of Review Committee Residents play?

resident physicians are not at an increased risk for suicide, studies have shown that the rate of depression among physicians in training is approximately 22% to 35%, compared with 17% in the general population,[3] and high rates of burnout, suicidal ideation, and depression are seen as early as in medical school.[4–6] These data support the notion that depression and suicide are indeed occupational hazards for physicians, and that these problems start early in training.

The events in New York have caused self-reflection in the graduate medical education (GME) community. The Accreditation Council for Graduate Medical Education (ACGME) is convening a symposium of stakeholders—scholars, physician educators, residents, and advocates—to better characterize the problem and identify ways to improve resident wellness and resiliency.[7] Resident groups like the American Medical Association Resident/Fellow Section[8] and the Junior Doctor Network internationally[9] are calling attention to the need to improve physician well-being during training. Individual institutions are providing leadership in this area by creating dedicated wellness programs for physicians in training.[10] Despite these efforts, there is little information from the resident and fellow perspective on the utility of existing resources, and what resources are lacking.

The ACGME Council of Review Committee Residents (CRCR), which encompasses 29 residents and fellows representing all ACGME-accredited specialties, met to discuss the need for promotion of wellness and mental health in GME from the perspective of the physician in training. The group is geographically diverse and represents the perspectives of medical, surgical, and hospital-based residents and fellows. We used appreciative inquiry[11] to identify the best current resources for promotion of wellness during training, what resources ideally should exist, and how the gap between the current reality and the ideal may be bridged. We aggregated the information to identify the major themes that emerged from the exercise to provide concise, meaningful recommendations to the GME community.

## Approach

### Idea Generation

The 29 members of the CRCR comprise the resident representatives of all specialty Review Committees, the Institutional Review Committee, and the Clinical Learning Environment Review Committee. All participants in the discussion gave verbal consent to have the data aggregated for this article. Twenty-eight CRCR members participated in the exercise.

We chose the appreciate inquiry approach to structure our discussion on resident wellness. Appreciative inquiry is a form of action research that attempts to generate ideas for solving a problem by identifying and building on the best available current resources.[11] It avoids focusing on the negative aspects of training, and capitalizes on the strengths of the current learning environment. The general steps of appreciative inquiry are to determine the "best of what is," then "what might be," "what can be," and finally "what should be." Another way of describing these stages is to label them "Discovery," "Dream," "Design," and "Destiny." We use this annotation for the summary of our discussion.

The 28 CRCR members were assigned to 4 groups. Participants were asked to consider the questions shown in the BOX. Participants in each group were asked to individually answer these questions, and their ideas were recorded on a whiteboard until all ideas were exhausted. The large group discussed all ideas from the small group discussions. This exercise identified common themes and narrowed the ideas to those deemed most important.

### Aggregation of the Data From the Appreciative Inquiry Exercise

The ideas that resulted from the appreciative inquiry exercise then were analyzed for thematic content. Five members of the writing team (J.T., R.C., D.A.J., B.C.S., K.M.J.) independently categorized answers to each of the 4 questions into broad themes. The themes were discussed, and the writing group reached consensus on the themes. Two individuals outside of the writing team re-sorted the individual answers into the consensus themes as a validation of the consensus themes. Consistency between the 2 external raters was 75% for Discovery, 49% for Dream, 60% for Design, and 69% for Destiny.

## Results

The discussion about the role of the learning environment in promoting wellness among trainees produced a rich set of ideas. Qualitative analysis of the individual answers to the study questions identified strong consensus on over-arching themes. Study questions and consensus themes are listed in the TABLE.

TABLE **Study Questions and Consensus Themes Derived From Individual Answers**

| Question | Consensus Themes |
|---|---|
| What in the learning environment helped you effectively manage times of difficulty during residency? | Personal support from faculty, staff, co-residents, and friends |
| | Effective mentorship by faculty and senior trainees |
| | Systems to prevent and respond to mental health issues |
| Describe the characteristics of an ideal learning environment that would help learners manage the transformational journey of residency? | Awareness and destigmatization of mental health issues |
| | Camaraderie |
| | Mentorship |
| | Service availability |
| | Supportive culture |
| What should be done to achieve such a learning environment? | Increase awareness of depression in the learning environment |
| | Institutional policies/procedures to deal with mental health issues |
| | Faculty development with regard to resident wellness |
| | Check-ins with residents at repeated intervals throughout the year regarding mental health |
| | Formalize mentorship system |
| | Formalize wellness activities |
| | Confidential mental health service availability |
| What can the ACGME do to promote these changes in the learning environment? What role can the CRCR play? | Increase awareness of risks and destigmatize depression |
| | Build systems to identify and treat depression anonymously |
| | Formalize peer and faculty mentorship |
| | Encourage supportive culture |
| | Learn more about the issue |

Abbreviations: ACGME, Accreditation Council for Graduate Medical Education; CRCR, Council of Review Committee Residents.

When asked what characteristics of the current learning environment helped trainees manage times of difficulty during residency, comments encompassed 3 themes: (1) personal support from faculty, staff, friends, and co-residents, including "empathy from faculty and from co-residents" and "encouragement from senior residents"; (2) mentorship by faculty and senior trainees; and (3) systems to prevent and respond to distress and mental health problems experienced during residency, including seeking trainee input to improve the learning environment.

In describing the characteristics of the ideal learning environment to accommodate learners in times of stress, comments encompassed 5 themes: (1) awareness and destigmatization of mental health issues ("nonjudgmental," "safe to talk about mental health issues," "emotional awareness"); (2) camaraderie ("building a cohesive unit among the residents"); (3) mentorship by faculty and senior trainees ("positive feedback in tense situations," "teaching learners to ask for help when needed"); (4) availability of mental health services ("confidential counseling" by "outside mental health providers"); and (5) a supportive culture ("support after bad events," "knowing that environment would be supportive" irrespective of the outcome).

There were 7 themes in the responses to the question regarding what should be done to achieve the ideal learning environment: (1) increase awareness of the risk for depression in trainees; (2) enhance institutional policies/procedures to deal with mental health problems during residency; (3) professional development to enhance faculty understanding of resident wellness; (4) regular "check-ins" with residents throughout the year regarding mental health that include discussions about mental health issues; (5) a more formal system of mentoring by faculty or senior residents; (6) enhanced resident wellness activities; and (7) availability of confidential mental health services. Increasing resident understanding of wellness issues should begin at orientation and should involve personal interaction and discussion, not online modules. Suggested resident wellness activities included resident retreats and protected time for personal appointments, including medical and health maintenance visits.

When asked what the ACGME and CRCR can do to foster these changes, 5 recommendations emerged. The first entailed increasing awareness of the risk of depression during residency, thereby destigmatizing it. Approaches may include program and institutional outreach about mental health problems, and acknowledging and discussing depression and suicide in trainees. The second recommendation was to create a confidential approach to treat depression in trainees. The third recommendation was to develop a more formal approach to mentoring by senior peers and faculty. Promoting a more supportive culture in training programs was the fourth recommendation, including team building and resident retreats. The final recommendation was to encourage additional study of resident wellness to better understand problem areas and highlight best practices.

**Discussion**

The appreciative inquiry exercise produced a set of recommendations to enhance resident wellness that address several tangible goals: (1) increasing awareness of the risk of depression during training and destigmatizing it; (2) building systems to confidentially identify and treat depression in trainees; (3) establishing a more formal system of peer and faculty mentoring; (4) promoting a supportive culture during training; and (5) fostering efforts to learn more about resident wellness. These recommendations capture the viewpoint of those closest to the problem—residents and fellows currently in training. Some of these recommendations may be readily achieved through local education and change in practice. Others, such as systems to identify and treat depression, may be more costly and challenging to implement.

Suicide has been a persistent problem in the physician community for many years and appears to be an occupational hazard.[12–17] Studies have suggested that work-related stressors are a factor, with work-related stress having an impact on the risk for suicidal ideation among physicians in training and in practice.[13,16] The CRCR focused on the learning environment as a modifiable factor that may be transformed to support the physician in training. We selected appreciative inquiry for our discussion, since we wanted to build the system for promoting resident wellness on the existing positive aspects of the learning environment. We recognize that some of the negative aspects of physician training cannot be changed: the physical and emotional challenges, the enormous workload, and the failures small and large despite trainees' best efforts. By building our recommendations on the best of the existing infrastructure, we hoped to promote an environment where the challenges to wellness are embraced in an atmosphere of support.

In the Discovery phase of the discussion, personal support, effective mentorship, and systems to prevent and respond to issues were highlighted as key strengths in the current learning environment. A safety net of community support (through faculty, peers, staff, and family) and mentorship were identified as major contributors to wellness promotion. Residency creates family and community, as trainees spend a substantial amount of time in this setting, and as such it needs to be a supportive culture to keep its members well. While some systems currently exist to prevent and respond to mental health issues, they need to be expanded and optimized to improve their sensitivity to the high risk of depression among trainees.

In the Dream phase, we envisioned an ideal learning environment addressing wellness would include mental health awareness, camaraderie, mentorship, service availability, and a supportive culture. In the Design and Destiny phases, we focused on actionable goals for realizing this ideal learning environment, including increasing awareness and destigmatization of depression, formalizing mentorship, building systems to identify and treat depression, encouraging a supportive culture, and promoting research to better understand resident wellness. Increasing awareness of the risk of depression during training could be achieved through discussion at orientation and regular meetings and retreats. These discussions could be a testimonial by someone affected by the issue or a brief educational intervention. New York University found that their surgical residents demonstrated a surprising lack of recognition of early warning signs of depression in coresidents and initiated an interactive professionalism seminar as an interventional measure, incorporating a brief lecture and educational quiz, video clips, a standardized patient actor, and time for self-reflection.[18]

Encouraging mentorship by pairing junior and more senior residents at the start of residency could help with decreasing stressors and building camaraderie. Residents report greater confidence in their clinical and procedural skills as they progress through training, and this is correlated with decreased depression screening scores.[19] Mentorship from more senior residents could be a simple way of reducing stress during early residency by normalizing training experiences and giving advice on overcoming day-to-day hardships. Establishing confidential systems to identify and treat depression is a critical goal, although it may be more difficult to achieve due to its cost. Confidential mental health service and wellness programs, with extended hours to accommodate resident work schedules, such as those offered by the University of California, San Diego, Oregon Health & Science

University, and the University of South Florida, should be available for trainees.[20,21] Programs like these ensure that if a trainee is reluctant to seek faculty or peer interaction, he still has access to nonjudgmental dialogue and support.

Further study is needed to assess the effectiveness of the proposed enhancements to support resident wellness. Given that suicide is a rare event, it is not clear whether these interventions will have an effect on the ultimate outcome of interest. At the same time, improvements in wellness in the learning environment are worthwhile even if they do not impact suicide rates, since a physician who is emotionally well will take better care of his or her patients.

## Conclusion

Residency is a rewarding and highly challenging time in a physician's career. The emotional highs of successfully taking care of a patient, becoming skillful at a procedure, and doing research are matched with lows from the failures it takes to realize these achievements. Physicians in training are at a high risk for depression, and the learning environment has an influence on this. Making meaningful changes to improve the learning environment, to identify and address stress in residents, and to provide systems to support wellness will protect trainees and will honor the lives and accomplishments of those whose deaths prompted this nationwide dialogue.


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