ARTICLE

MENTAL HEALTH AWARENESS

Five Action Steps to Address the Mental Health Needs of the Future Physician Workforce

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Ask any physician, and I'm sure they'll agree that completing their residency felt like running a marathon—or five.

The prolonged time frame of resident training programs, extensive workweeks, and the pressure of mastering clinical accuracy while maintaining patient safety leave a resident with little time to devote to personal well-being and health.[1] In fact, the rate of depression or depressive symptomology during residency has been reported to be as high as 43%, which is far greater than the general public or other learner groups.[1,2]

Depression among Residents

Historically, GME program curricula ensured that physicians in training were equipped with the knowledge and skills to be clinically competent, but there was little to no focus on work-life balance or mental health. In 2017, the ACGME revised the common program requirements to incorporate psychological, emotional, and physician well-being as foundational necessities for a positive learning and working environment.[3]

However, despite the new emphasis by the ACGME and national support from numerous professional associations, institutional and program leaders continue to grapple with numerous barriers to mental healthcare resource use for physicians in training. Likewise, residents may be resistant to openly discuss challenges or ask for needed assistance due to the prevailing culture and stigma associated with mental illness, especially when starting in a new program.[4]

Differentiating Burnout and Depression

Working conditions have dramatically changed during the 21st century, leading to persistent burnout in organizational leaders and professionals worldwide.[5] Prolonged exposure to these stressful conditions can tax an individual's emotional and cognitive resources[6,7] and double their chances of experiencing a health-related illness attributable to burnout.[8]

- **Burnout** is a workplace-related condition that represents an individual's response to their environment when they do not have sufficient resources to support the demands of their job.[9,10] While burnout can proceed into clinical depression in some individuals, it is not synonymous with depression.[8]
- **Depression** is context independent and has a defined clinical presentation and associated diagnosis.[11]

However, both burnout and depressive symptomology can be associated with adverse outcomes in the physician workforce, ranging from increased medical errors and impaired professional behavior to increased substance use and suicidal thoughts or actions.[12,13,14]

The fluidity of definitions for burnout and depression creates additional ambiguity for organizational and program leaders on how best to support their residents.[11] This ambiguity can also create an additional barrier to seeking treatment for mental health illness, as our physicians in training may not be able to differentiate between occupational-induced or situational burnout and depressive symptomology.[11]

All of this points to a strong need for institutions and programs to remain attentive to the changing and ongoing needs of their residents.[2] Below, we've outlined five action steps that organizational leaders should consider in order to provide comprehensive and holistic support programs for their residents.

1 ACTION STEP ONE: Provide Innovative, Targeted Support to Residents

Accredited GME programs must provide frequent communication and training for residents, fellows, and program leaders to identify signs of depression in themselves and others, as well as formal policies and pathways to seek help.[15] However, communication is not enough. A 2024 study[16] found that the more depressive symptomology reported by a resident, the less likely they are to seek help or think that help can improve their health.

This uniquely challenges medical education and organizational leaders in developing support for residents who are struggling. In addition, organizations will need to accept the reality that residents need targeted interventions that may be more costly or have limited scalability.

It is not enough for institutions to simply "teach" about depression; instead, they must provide multiple, varied pathways to address individual needs, remove barriers to care, and create a culture that openly talks about the benefits of mental healthcare.

2 ACTION STEP TWO: Improve Access to Services for Those Transitioning to Residency

While every sponsoring institution must provide access to health benefits for residents, fellows, and their dependents on the first day of eligibility,[15] the wait time to see a mental health provider can be considerably long. In some cities, the average wait time can be over 60 days,[17] which is well into an intern's rotational schedule, creating additional stressors during their transition into residency.

Institutional sponsors of GME programs should develop partnerships with primary care and mental health providers to proactively block appointments for residents to establish care during the few weeks leading up and into orientation. Virtual and web-based care platforms can also be used to provide additional confidentiality and increase accessibility.

3 ACTION STEP THREE: Implement Opt-Out Programming as the Standard

Another promising solution for both reducing the stigma associated with preventive and prolonged mental healthcare and encouraging students to access these services is the use of an opt-out program.[18]

Most institutional sponsors provide residents with access to mental health counseling and care through a self-initiated (i.e., "opt in") process. However, under an opt-out program, residents are automatically scheduled for an appointment with a mental health provider and granted dedicated time to attend the appointment.[14,11, 19,20] Residents can cancel the appointment at any time.[19] Research on resident opt-out programs indicates that as many as 93% of residents keep their initial appointments.[19]

An opt-out program signals to a resident that mental healthcare is valued by the program and institution.[20] More importantly, an opt-out program proactively connects residents to a provider and establishes a relationship before a crisis occurs.[19]

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4 ACTION STEP FOUR: Encourage Confirmational Faculty Behavior to Reduce Stigma

The stigma surrounding mental illness in our physician workforce continues to be perpetuated by not talking openly about the real and perceived barriers that discourage physicians from seeking help.[21]

Physicians, like many professionals, believe that acknowledging mental health challenges may negatively impact their careers, change the way their colleagues perceive them, or call into question their identity of self-sufficiency, especially at the beginning of their career as independent providers.[21,22] However, by actively pushing back against this narrative and framing well-being as a leadership competency, program leaders and faculty can decrease the negative stigma associated with self-care improvement.[23]

Modeling behaviors that are more aligned with contemporary beliefs about mental health and well-being pays dividends in a teaching environment. Residency is a fundamental experiential learning setting where learners are imprinted with practice patterns observed and experienced in their environments.[24] The imprinting process emphasizes what is modeled and practiced, which often overshadows the provided curriculum for decades past their formal residency training.[24]

Faculty often send mixed signals to residents when they communicate the importance of self-care yet come to work sick, forgo their own well-being, or comment when others take time for themselves.[25] More importantly, faculty should be transparent about their own mental health struggles and self-care processes in dealing with the challenges of their profession. Providers are more willing to engage in self-reflection and pursue mental health resources when these activities are modeled by their mentors.[26]

5 **ACTION STEP FIVE: Identify Barriers to Individuals Thriving in Your Working and Learning Environment**

In addition to encouraging individual behaviors, organizations must systematically assess their working and learning environment to identify and address policies, procedures, processes, and cultural norms that reinforce a stigma around mental health.

For example, a common practice that perpetuates providers' reluctance to seek mental healthcare is the use of hospital credentialing questions or peer review forms with broad or invasive mental health questions that treat mental health conditions as impairments rather than illnesses. As important is an organization's deliberate practice to reduce harmful environmental influence by identifying and addressing:

- Imposition of heavy workloads.
- Lost autonomy and control.
- Process inefficiencies.
- Increased clerical burden.
- Misalignment of culture and values.
- Unhealthy work-life balance.
- Absence of a work community.
- Lack of connection to the meaning of medicine.[23]

Only once organizational and individual values, culture, normative practices, and behaviors are aligned can we begin to train a healthy physician workforce.

ACTION STEPS RECAP

1	Provide Innovative, Targeted Support to Residents
2	Improve Access to Services for Those Transitioning to Residency
3	Implement Opt-Out Programming as the Standard
4	Encourage Confirmational Faculty Behavior to Reduce Stigma
5	Identify Barriers to Individuals Thriving in Your Working and Learning Environment

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