Identifying (& Managing) Impairment in Your Peers

Duke Community & Family Medicine

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Goal:

Take as good care of yourself and one another as you will care for your patients!
Objectives:

• Review the epidemiology of physician (primarily med student and resident) impairment

• Analyze predictable situations
Population Health

Medical Resident Burnout Reaches Epidemic Levels

Paulino Anderson
May 17, 2015

TORONTO, Canada — Burnout rates among medical residents are reaching epidemic levels, new research suggests.

A survey conducted by investigators at the University of North Carolina, Chapel Hill, showed that approximately 70% of residents met criteria for burnout.

"We can't continue to ignore this problem of burnout," said Emily Holmes, MD, chief resident, University of North Carolina, Chapel Hill. "Burned out residents become burned out physicians."

Dr Holmes presented the results here at the American Psychiatric Association (APA) 2015 Annual Meeting.

Burnout by Specialty

Burnout is defined as the combination of emotional burnout, depersonalization, and low personal accomplishment. "So it's looking at your schedule in the morning and thinking, how am I going to get through it all," said Dr Holmes. "It becomes harder and harder to do what you need to do in a day's time."

According to the investigators, burned out residents are more likely to self-report that they have provided suboptimal care and have made medical errors. To better understand which factors most contribute to burnout and which interventions may be most helpful in alleviating it, the investigators surveyed 504 resident physicians via electronic survey between May and June 2014.

Residents from all specialties at the University of North Carolina were asked to complete the voluntary, institutional review board–approved electronic survey, which included the Maslach Burnout Inventory, a tool that measures burnout, and the Patient Health Questionnaire.

Why Do Doctors Commit Suicide?

By PRANAY SINHA  SEPT. 4, 2014

NEW HAVEN — TWO weeks ago, two medical residents, in their second month of residency training in different programs, jumped to their deaths in separate incidents in New York City. I did not know them, and cannot presume to speak for them or their circumstances. But I imagine that they had celebrated their medical school graduation this spring just as my friends and I did. I imagine they began their residencies with the same enthusiasm for healing as we did. And I imagine that they experienced fatigue, emotional exhaustion and crippling self-doubt at the beginning of those residencies — I know I did.

The statistics on physician suicide are frightening:

Doctors are more than twice as likely to kill themselves as nonphysicians (and female physicians three times more likely than their male counterparts).

Some ask doctors commit suicide ever war. You're ubiquitous at

The Atlantic
**Burnout in Rural Physician Assistants: An Initial Study**

Marc A. Benson, PhD; Teri Peterson, EdD; Lisa Salazar, MS; Wesley Morris, MPAS, PA-C; Rebecca Hall, BS; Bernadette Howlett, PhD; Paula Phelps, MHE, PA-C

**Purpose** To assess the prevalence and causes of burnout in rural physician assistants. (PA in this article refers to personal accomplishment. To avoid confusion, we will spell out physician assistant throughout the article, instead of using PA to refer to both physician assistant and personal accomplishment.)

**Methods** Physician assistants who practice in rural communities were asked to complete the Maslach Burnout Inventory. A preliminary assessment of burnout was determined using the 3 Maslach Burnout Inventory subscale scores: emotional exhaustion, depersonalization, and personal accomplishment, as well as causes of burnout assessed for a correlation to personal and professional factors.

**Results** Burnout within the rural physician assistant population as recorded by those responding to this survey (response rate = 11.3%) was measured to have high to moderate emotional exhaustion and depersonalization subscores (64% each) and a low to moderate personal accomplishment subscore (46%).

**Conclusions** The rural physician assistant population who responded to this survey exhibited burnout correlating to feelings of professional isolation and various workplace conditions such as the adequacy of administrative support and control over workload. To begin addressing burnout within this community, we suggest adjusting rural physician assistant workload and support, enhancing professional communications, and addressing burnout prevention techniques within physician assistant training programs.

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**Feature Editor's Note:** Predictions of health care professional shortages has included the more recent phenomena of burnout as more individuals abruptly leave the profession in what otherwise might be the prime of their lives. Of greater concern, burnout now serves as a predictor of potential suicide in physicians and other health care providers. This study uses an established survey tool to determine factors leading to burnout among physician assistants serving rural America, where many believe physician assistants are well-suited to help increase health care access for the growing medically underserved population. The authors offer recommendations for teaching the next generation of our profession about avoiding burnout.

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**INTRODUCTION**

Burnout syndrome in health care providers is associated with poor mental and physical health, which may lead to suboptimal patient care and high provider turnover.1,2 Conceived by Herbert Freudenberger to describe individuals suffering from job-related psychological and physical exhaustion, and measured by use of the Maslach Burnout Inventory (MBI), burnout is assessed using 3 indices or subscales: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA).3 The MBI has been administered in multiple studies to evaluate burnout among health care professionals; however, none have investigated burnout in the rural physician assistant population. Each subscale is assessed by a unique set of questions that examines the health care providers' attitude toward their workload (EL), attitude toward patients (DP), and feelings of personal accomplishment (PA). This study sought to examine the prevalence of burnout among rural physician assistants and the contributing personal and professional factors that may be associated with this syndrome.

**METHODS**

**Subject Population**

Rural populations not designated as metropolitan areas (< 30,000 individuals) were selected from a United States Post Office ap code list and cross-referenced to an American Academy of Physician Assistants mailing list of clinically active physician assistants who self-identified as practicing in rural communities.4 Physician assistants appearing in both lists (1427) were identified as candidates for this study. An Initial paper mailing that described the intent of the study was delivered to the survey population, followed by a single separate paper mailing that directed subjects to the URL of the electronic survey (SurveyMonkey, Palo Alto, CA). The Idaho State University Institutional Review Board evaluated and approved this study (no. 3572).

**Instrumentation**

The electronic survey included the MBI—Human Services Survey and several demographic survey items. Participants had 5 weeks to complete the survey. After the survey was closed, the responses were downloaded into a Microsoft Excel spreadsheet, and then transferred into IBM-SPSS version 21.0.
Critical Review on Suicide Among Nurses
What About Work-Related Factors?

Marie Alderson1, Xavier Parent-Rocheleau2, and Brian Mishara3

1Faculty of Nursing, Université de Montréal, Succ. Centre-Ville, Montréal, QC, Canada
2École des Sciences de la Gestion, Université du Québec à Montréal, QC, Canada
3CRISÉ-Université du Québec à Montréal, QC, Canada

Abstract. Background: Research shows that there is a high prevalence of suicide among nurses. Despite this, it has been 15 years since the last literature review on the subject was published. Aim: The aim of this article is to review the knowledge currently available on the risk of suicide among nurses and on contributory risk factors. Method: A search was conducted in electronic databases using keywords related to prevalence and risk factors of suicide among nurses. The abstracts were analysed by reviewers according to selection criteria. Selected articles were submitted to a full text review and their key elements were summarized. Results: Only nine articles were eligible for inclusion in this review. The results of this literature review highlight both the troubling high prevalence of suicide among nurses as well as the persistent lack of studies that examine this issue. Conclusions: Considering that the effects of severe stress and work settings are associated with high stress, distress, or psychiatric problems, we highlight the relevance of investigating work-related factors associated with nurses’ risk of suicide. Several avenues for future studies are discussed as well as possible research methods.

Keywords: nurse, workplace, occupation and suicide, stress, access to means

Recently, the mental health of nurses has justifiably become a particular concern for researchers. Burnout (Sandin, Hochwander, & Lisspers, 2011; Van Bogaert, Clarke, Willems, & Monelera, 2013) and emotional exhaustion (Choi, Hooker, & Martin, 2012; Stoerdorff-Boesen, & Vandenbergh, 2001) depression (Mark & Smith, 2012; Odlar, Kern, & Forbes, 2010), and psychological distress (Alderson, 2008; Bernholer & Sorrell, 2014; De Villiers & De Vos, 2013; Wilson, Gooren, Bonn, & Meltzer, 2013) in nurses have been the subject of several studies. An extensive public inquiry on the health of nursing personnel in Canada found that nurses were twice as likely to suffer from depression (10%) than the general population (5%). Odlar et al. (2010); Shields & Wilkins, 2006). Several recent reported cases confirm the importance of this body of research by illustrating that mental illness in nurses and work-related problems can end in a worst-case scenario: suicide. In 2010, five nurses employed at a Quebec university hospital completed suicide within a few months (Samson, 2010). In 2013, two nurses at a regional Quebec hospital took their own lives within a few days of each other (Radio-Canada Nouvelles, 2013). However, unlike other health-care professionals, such as physicians (Center et al., 2003; Schernhammer & Colditz, 2004) and veterinarians (Platt, Hawton, Simkin, & Mellinby, 2010), data on suicide among nurses are limited. While the two studies entirely dedicated to suicide in this population in the last decade (Fessanich et al., 2002; Hawton et al., 2002) include data on prevalence and risk factors, other available data come from multiple population studies, and provide little information on actual factors that could explain the elevated risk of suicide among nurses.

Fifteen years have passed since the publication of the only literature review on suicide among nurses (Hawton & Vidiess, 1999). The authors reviewed studies published between 1970 and 1998 focusing on data collected in the United Kingdom, the United States, Canada, Iceland, and Sweden. Analysis of answers to the five main questions guiding their research found clear evidence that nurses were at risk for suicide, and according to the data available at that time, the factors contributing to this risk were nurses’ knowledge and access to medication that could be taken to complete suicide, mental illness (particularly depression), stress, occupational stress, smoking, and substance abuse. However, the authors highlighted the need for further research to adequately explain the higher rate of suicide among nurses than in the general population.

Despite the high prevalence of suicide among nurses (Hawton, Agerbo, Simkin, Platt, & Mellinby, 2011), downsizing, and a deterioration of working conditions for nurses in some countries (Hamelin-Bemant, Lavose-Tremblay, Viens, & Lefauros, 2007), there have not been any
Is there an epidemic of physician suicide?

• We don’t know.

• What we do know:
  – MD burnout is increasing (by 10% in the past 3 years)
  – MDs are at higher risk of suicide than:
    • The general population
    • Other professionals of similar education and SES

Physicians and Suicide

• Physicians are more likely to commit suicide than the general population
  – Male MDs: RR=1.41 (95%CI: 1.21-1.65)
  – Female MDs: RR=2.27 (95%CI: 1.90-2.73)

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• Suicide rates correlate inversely with occupational skill level\(^2\)
  – Least skilled (e.g. laborers, simple manual workers): RR=1.8 (95%CI: 1.5-2.3)
  – Most skilled (e.g. MDs, managers, professionals): RR=0.7 (95%CI: 0.5-0.9)

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• Physicians are the exception

### ORs for Suicide for Selected Highly Skilled Occupations, 1990¹

<table>
<thead>
<tr>
<th>Occupation</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>5.43</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td><strong>2.31</strong></td>
</tr>
<tr>
<td>Nurse</td>
<td>1.58</td>
</tr>
<tr>
<td>Social worker</td>
<td>1.52</td>
</tr>
<tr>
<td>Mathematician</td>
<td>1.47</td>
</tr>
<tr>
<td>Lawyer</td>
<td>1.36</td>
</tr>
<tr>
<td>Professor</td>
<td>1.32</td>
</tr>
</tbody>
</table>


### ORs vs Gen Population for Suicide for Selected Occupations, 2012²

<table>
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<tr>
<th>Occupation</th>
<th>OR</th>
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<tbody>
<tr>
<td>Physician</td>
<td><strong>1.87</strong></td>
</tr>
<tr>
<td>Dentist</td>
<td>1.67</td>
</tr>
<tr>
<td>Veterinarian</td>
<td>1.54</td>
</tr>
<tr>
<td>Finance worker</td>
<td>1.51</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>1.50</td>
</tr>
<tr>
<td>Lawyer</td>
<td>1.33</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1.29</td>
</tr>
</tbody>
</table>

The "Continuum of Distress"

Stress → Burnout → Depression → Suicide
How do physicians compare with the US population?

<table>
<thead>
<tr>
<th></th>
<th>Work-Related Stress(^1)</th>
<th>Burnout(^2,3)</th>
<th>Depression (point prevalence)(^2,4,5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Population</td>
<td>26-40%</td>
<td>28%</td>
<td>6-8%</td>
</tr>
<tr>
<td>All Physicians</td>
<td>80%</td>
<td>38-63%</td>
<td>12-20%</td>
</tr>
<tr>
<td>Physicians in Training</td>
<td>?</td>
<td>43-76%</td>
<td>15-30%</td>
</tr>
</tbody>
</table>

5. Depression Guideline Panel, Depression in Primary Care, vol.1, Detection and Diagnosis, Clinical Practice Guideline, no. 5, AHCPR pub. no. 93-0550 (Rockville, Md.: U.S. Department of HHS, Public Health Sec, Agency for Health Care Policy and Research, April 1993), 36.
Burnout

- **What is burnout?**
  - Three components:
    - **Exhaustion**: emotionally drained and physically overextended
    - **Cynicism (depersonalization)**: distant, callous attitude; demotivation and withdrawal
    - **Reduced Efficacy**: feelings of inadequacy and incompetence, lack of self-confidence
  - “A long-term mismatch between the demands associated with the job and the resources of the worker”

Burnout

• What causes burnout?
  – Excessive workload
  – Insufficient control over resources needed to do one's work
  – Lack of appropriate rewards (financial, social, intrinsic)
  – Loss of positive connection with others in the workplace (conflict or isolation)
  – Perceived unfairness
  – Conflict between values (work vs family, individual vs organization)

• Why does burnout matter?
  – Predictive of severe injuries, insomnia, heart disease, accelerated biological aging, depression, anxiety, and all-cause mortality

Burnout

- Inversely correlated with level of education

<table>
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<tr>
<th>Level of Education</th>
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<tr>
<td>High school</td>
<td>1.00</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>0.80</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>0.71</td>
</tr>
<tr>
<td>Professional or doctoral degree other than MD/DO</td>
<td>0.64</td>
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</table>

• Physicians are the exception

Position Statements

Professional obligations pertaining to incompetence, impairment or unethical conduct of licensees

It is the position of the North Carolina Medical Board that its licensees have a professional obligation to act when confronted with an impaired or incompetent colleague or one who has engaged in unethical conduct.

When appropriate, an offer of personal assistance to the colleague may be the most compassionate and effective intervention. When this would not be appropriate or sufficient to address the problem, licensees have a duty to report the matter to the institution best positioned to deal with the problem. For example, impaired licensees should be reported to the North Carolina Physicians Health Program. Incompetent licensees should be reported to the clinical authority empowered to take appropriate action. Licensees also may report to the North Carolina Medical Board, and when there is no other institution reasonably likely to be able to deal with the problem, this will be the only way of discharging the duty to report.

This duty is subordinate to the duty to maintain patient confidences. In other words, when the colleague is a patient or when matters concerning a colleague are brought to the licensee's attention by a patient, the licensee must give appropriate consideration to preserving the patient's confidences in deciding whether to report the colleague.
RESILIENCE
(EMOTIONAL EXHAUSTION/INNOVATION FATIGUE)

Definition
Resilience is a function of your ability to cope, and the availability of resources related to health and well being.

Items (all items are reverse scored so that a higher score is better)
1. I feel fatigued when I get up in the morning and have to face another day on the job
2. I feel burned out from my work
3. Events in this work setting affect my life in an emotionally unhealthy way

Intervention
Resilience is the “pace-ometer,” for a work setting, as it tells you the pace and intensity of interventions and efforts that are likely to be successful and sustainable. If resilience is high, taking on significant teamwork or safety related interventions is reasonable if this unit falls below 60% on either teamwork climate or safety climate. However, if this unit falls below 60% on teamwork and/or safety climate, and the resilience score is also below 60%, then an initial focus on resilience and work-life balance is important as a first step.
Among surgeons.... whose well-being was in the lowest 30% relative to national physician norms, the majority (>70%) believed that their well-being was at or above average, including approximately 25% who believed that their well-being was above average. These findings illustrate poor calibration and lack of awareness—b
National Cluster-Randomized Trial of Duty-Hour Flexibility in Surgical Training


ABSTRACT

BACKGROUND
Concerns persist regarding the effect of current surgical resident duty-hour policies on patient outcomes, resident education, and resident well-being.

METHOIDS
We conducted a national, cluster-randomized, pragmatic, multi-center trial involving 117 general surgery residency programs in the United States (2014-2015 academic year) whose programs were randomly assigned to current Accreditation Council for Graduate Medical Education (ACME) duty-hour policies (standard-duty policy group) or more flexible policies (that waived rules on maximum shift length and time off between shifts (flexible-duty policy group). Outcomes included the 30-day rate of postoperative death or serious complications (primary outcome), other postoperative complications, and resident perceptions and satisfaction regarding their well-being, education, and patient care.

RESULTS
In an analysis of data from 113,992 patients, flexible, less-restrictive duty-hour policies were not associated with an increased rate of death or serious complications (0.4% in the flexible-duty policy group and 0.8% in the standard-duty policy group, P=0.02) with added odds ratios for the flexible-duty policy group, 0.689 (95% confidence interval, 0.51-1.01). Between groups, a noninferiority criteria was satisfied for all secondary composite outcomes studied. Among 475 residents, those in programs assigned to flexible policies did not report significantly greater dissatisfaction with overall education quality (11.9% in the flexible-duty policy group and 9.9% in the standard-duty policy group, P=0.90) or well-being (43.9% and 42.4%, respectively, P=0.28). Residents in flexible-duty policies were less likely than those in standard-duty policies to report having done an operation (2.6% vs. 3.9%, P=0.008) or handing off active patient issues (12.0% vs. 19.3%, P=0.001).

CONCLUSIONS
As compared with standard-duty-hours policies, flexible, less-restrictive duty-hour policies for surgical residents were associated with noninferiority patient outcomes and no significant difference in residents’ satisfaction with overall well-being and education quality.

QUIZ
Practicing physicians of which specialty are **most** likely to report they experience burnout?

A. Urology  
B. General Surgery  
C. Psychiatry  
D. General Internal Medicine  
E. Family Medicine  
F. Oncology
Which Physicians Are Most Burned Out?

Critical Care 55%
Urology 55%
Emergency Medicine 55%
Family Medicine 54%
Internal Medicine 54%
Pediatrics 53%
Surgery 51%
Ob/Gyn 51%
Neurology 51%
Radiology 50%
Cardiology 50%
Anesthesiology 50%
Gastroenterology 49%
Rheumatology 47%
Infectious Disease 47%
Nephrology 47%
Orthopedics 47%
Oncology 46%
Pathology 45%
Plastic Surgery 45%
Pulmonary Medicine 43%
Dermatology 43%
Diabetes & Endocrinology 41%
Ophthalmology 41%
Psychiatry & Mental Health 40%
Practicing physicians of which specialty report the most severe burnout?

A. Pediatrics
B. Family Medicine
C. Neurology
D. Internal Medicine
E. Ob-gyn
F. Emergency Medicine
Among physicians, who reports more burnout?

A. Women physicians
B. Male physicians
C. Neither; they report the same level of burnout
Among internal medicine residents, residents in which year have the highest risk of burnout?

A. PGY1
B. PGY2
C. PGY3
D. None of the above, the rates are essentially the same across years
Maslach Burnout Inventory

- 3 = burnout
- PGY2 3.1
- Night float
- Ambulatory/consults 2.2
A resident is diagnosed with substance abuse during residency training. Which of the following is always true?
The resident will

A. Lose their medical license
B. Be dismissed from the residency program
C. Require a three month inpatient treatment program
D. All of the above
E. None of the above
It is a sign of personal weakness or inadequacy to receive treatment for emotional or mental health problems.

2. Residency directors would pass over my application if they were aware I had an emotional/mental health problem (e.g., depression, anxiety).

3. My supervisors would see me in a less favorable way if they believed that I had an emotional/mental health problem.

4. Fellow students would see me in a less favorable way if they came to know that I had received treatment for emotional/mental health problems.

5. Patients would not want me as their doctor if they were aware I had received treatment for an emotional/mental health problem.

6. Mental health care provided by my school-affiliated institution to medical students is truly confidential.

7. The dean at my medical school could access my personal medical record if he/she wished to do so.

8. Residency program directors at the institution associated with my medical school could access my personal medical record if they wished to do so.

9. If I sought care for an emotional/mental health problem, it might end up in my academic record.

10. If I were to receive treatment for an emotional/mental health problem, I would hide it from people.

Figure 2 Percentage of medical student respondents endorsing each stigma item, by burnout. Respondents with burnout were more unfavorable views, with all but Item 5 (P = .16) and Item 7 (P = .42) being statistically significantly different. A respondent’s views were unfavorable if she or he agreed or strongly agreed with the item, except for Item 6, for which views were considered unfavorable if the strongly disagreed or disagreed.

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The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students With Burnout

Lynette N. Tyler, MD, MPH; Anne Sack, MD; Steven J. Buring, MD, PhD; Charalambos Bazata, MD; Christine Moutou, MD; E. Stanford Maile, MD; Daniel Satter, M.D., Flexman, MD, PhD; and Todd D. Sklaroff, MD

Abstract

Purpose

Because of the high prevalence of burnout among medical students and its association with professional and personal consequences, the authors evaluated the help-seeking behaviors of medical students with burnout and compared their stigma perceptions with those of the general U.S. population and age-matched individuals.

Method

The authors surveyed students at six medical schools in 2012. They measured burnout, symptoms of depression, and quality of life using validated instruments and explored help-seeking behaviors, perceived stigma, personal experiences, and attitudes toward seeking mental health treatment.

Results

Of 2,449 invited students, 873 (35.9%) responded. A third of respondents with burnout (154/454; 33.9%) sought help for an emotional/mental health problem in the last 12 months. Respondents with burnout were more likely than those without burnout to agree or strongly agree with all 8 of 10 perceived stigma items. Respondents with burnout who sought help in the last 12 months were twice as likely to report having observed supervisory negative judgment (9/166; 5.5%) and attitudes toward seeking mental health treatment.

Conclusions

Only a third of medical students with burnout seek help. Perceived stigma, negative personal experiences, and the hidden curriculum may contribute.

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D'aksawarka and colleagues surveyed medical students and residents, finding a high prevalence of burnout and its association with professional and personal consequences. This study aimed to evaluate the help-seeking behaviors of medical students with burnout and compared their stigma perceptions with those of the general U.S. population and age-matched individuals.

Despite the challenges, the results indicate that burnout is not only prevalent among medical students but also has a significant impact on their help-seeking behaviors and stigma perceptions. The findings suggest that medical students with burnout are more likely to seek help for emotional/mental health problems compared to those without burnout. This highlights the importance of addressing burnout and its effects on medical students, including providing support and resources to encourage them to seek treatment.
Residents and faculty at a peer institution reported they were *least* likely to seek assistance for:

A. Legal situation
B. A medical error
C. A serious adverse patient event
D. Personal Substance abuse issue
E. Burnout
F. Personal Physical illness
Affirmative responses (probably or definitely would) to the statement, "Please indicate whether you would or would not seek support for the following difficulties

- Personal Fatigue
- Interpersonal Conflict Outside Workplace
- Personal Burnout
- Mental Illness in Family Member
- Personal Life Struggles
- Physical Illness in Family Member
- Poor Patient Outcome Regardless of Responsibility
- Mental Illness in Self
- Interpersonal Conflict in Workplace
- Physical Illness in Self
- Involved in Adverse Patient Event
- Substance Abuse
- Involved in Medical Error
- Legal Situation

Figure 1 Residents’ concerns about potential jeopardy to training status from specific health issues.

Responses are in answer to the question:

How concerned would you be that your training status or future professional opportunities might be jeopardized if your residency training director or your clinical supervisor learned that you had a current problem with ….

Means are from a Health Issue Item × Gender × Residency Area × Training Level repeated-measures MANOVA. Health Issue main effect P < .0001; Item × Gender interaction P < .01. Recent health concern for a respondent defined as personal concern for the issue during the past year rated 5 to 9 on a scale of:

- 1 = no concern
e- 5 = some concern
e- 9 = great concern

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**Delivering Care, Avoiding Stigma: Residents' Attitudes Toward Obtaining Personal Health Care**

- Dunn, Laura B.; Green Hammond, Katherine A.; Roberts, Laura Weiss
A nurse tells you they believe they smell alcohol on another resident’s breath. If the resident does have a substance abuse disorder, what’s the likelihood they will be successful with treatment?

A. < 10 percent
B. 26 percent
C. 47 percent
D. 67 percent
E. 90 percent
Background: There have been few studies on the prevalence of substance use disorders (SUDs) in the physician population at large or have any studies compared the prevalence of SUDs in American physicians by specialty.

Methods: We conducted a national study of SUDs in a large sample of U.S. physicians from all specialty disciplines using the American Physician Maturity Substance Use Disorders (SUDs) were measured using validated instruments.

Results: Of the 47.2% physicians who received an invitation to participate, 7,781 (29.7%) completed surveys. 12.9% of male physicians and 21.4% of female physicians met diagnostic criteria for alcohol abuse or dependence. Abuse of prescription drugs and use of illicit drugs was rare. Factors independently associated with alcohol abuse or dependence were age (OR = 0.95, p < 0.001), having children (OR = 0.74, p < 0.001), and being in any specialty other than internal medicine (OR = 1.77, p < 0.001).

Conclusions: Alcohol abuse or dependence is a significant problem among American physicians. Since prognosis for recovery of physicians from chemical dependency is exceptionally poor, organized approaches for the early identification of problematic alcohol consumption in physicians followed by intervention and treatment where indicated should be strongly supported. (Am J Addict 2015;24:30-38)
You are concerned your colleague has “burnout”. They are very concerned about talking with the program director or faculty. In your opinion, what are the best 1-3 resources you would suggest to prevent/mitigate burnout?
Contact Us
NCPHP
220 Horizon Dr.
Suite 201
Raleigh, NC 27615
919–870–4480
919–870–4484 (Fax)
800–783–6792
State Programs

All state member Physician Health Programs (PHPs) are listed below. To qualify, state member programs must have compensated staff and/or a compensated Medical Director, and/or a voluntary committee chairperson/staff member. All state programs must also have the support of organized medicine in their state.

The State PHP Survey is the comprehensive survey distributed to all state members, and it outlines the full range of program structures and services that may be available. Please review this survey before you read about individual state programs.

<table>
<thead>
<tr>
<th>State</th>
<th>Title</th>
<th>Phone</th>
<th>Email</th>
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</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>Physician Health Committee of Alaska</td>
<td>(907) 561-1944</td>
<td><a href="mailto:phcak@alaska.net">phcak@alaska.net</a></td>
</tr>
<tr>
<td>Alabama</td>
<td>Alabama Physician Health Program</td>
<td>(334) 954-2596</td>
<td><a href="mailto:staff@alabamaphp.org">staff@alabamaphp.org</a></td>
</tr>
<tr>
<td>Arkansas</td>
<td>Arkansas Medical Foundation</td>
<td>(501) 224-9911</td>
<td><a href="mailto:director@arkmedfoundation.org">director@arkmedfoundation.org</a>, <a href="mailto:staff@arkmedfoundation.org">staff@arkmedfoundation.org</a></td>
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<tr>
<td>Arizona</td>
<td>Monitored Aftercare Program (Greenberg &amp; Sucher, PC)</td>
<td>(480) 990-3111</td>
<td><a href="mailto:drsucher@greenbergandsucher.com">drsucher@greenbergandsucher.com</a>, <a href="mailto:kristy@greenbergandsucher.com">kristy@greenbergandsucher.com</a></td>
</tr>
<tr>
<td>Colorado</td>
<td>Colorado Physician Health Program</td>
<td>(800) 827-0123</td>
<td><a href="mailto:scahrp@aphp.org">scahrp@aphp.org</a></td>
</tr>
</tbody>
</table>
Personal Assistance Service (PAS)

Personal Assistance Service (PAS) is the faculty/employee assistance program of Duke University. The staff of licensed professionals offer assessment, short-term counseling, and referrals to help resolve a range of personal, work, and family problems. PAS services are available at no charge to Duke faculty and staff, and their immediate family members.

Appointments

An appointment to meet with a PAS counselor may be arranged by calling the PAS office at 919-416-1PAS (919-416-1727), Monday through Friday between 8:00 A.M. and 5:00 P.M.

The office is located at 2200 West Main Street, Erwin Square Tower, on the 4th floor in Suite 400A. Free parking is available around the building. Transportation is also available on the H5 Duke shuttle, which travels from Duke North, Duke South, Hock Plaza and Erwin Mill to Erwin Square Tower where PAS is located.

Duke Regional Employees

Beginning January 1, 2016, Duke Regional Hospital employees will receive EAP services from PAS. Please call 919-416-1727 to schedule an appointment.

Duke Raleigh Employees

For Duke Raleigh Hospital employees wanting EAP services, please call 800-327-2251.
SAVE THE DATE
12th Annual Duke Health System
Patient Safety & Quality Conference
March 23, 2017

Courses:

- Enhancing Caregiver Resilience: Burnout & Quality Improvement Full Course
  (2 days with a 2 hour follow-up webinar - Offered in January, May & November)
  - Course Description
  - Registration Information; November 15 & 16, 2016
  - Registration Information; January 23 & 24, 2017
  - Registration Information; May 23 & 24, 2017
  - Registration Information; November 14 & 15, 2017
  *Also available upon request. If interested Click Here.

- Enhancing Caregiver Resilience Essentials (1 Day)
  - Course Description
  - Registration Information; September 13, 2016
  - Registration Information; January 26, 2017
  - Registration Information; April 20, 2017
  - Registration Information; September 12, 2017

- Patient Safety Leadership Training & Certification Course
  (3 days - Offered in April & September)
  - Course Description
  - Registration Information; September 12 - 14, 2016
  - Registration Information; April 19 - 21, 2017
  - Registration Information; September 11 - 13, 2017
  *Also available upon request. If interested Click Here.

- Executive Leadership in Patient Safety & Quality (1 Day)
  *CME Credit is available for this course
  - Course Description
  - Registration Information; October 6, 2016

- TeamSTEPPS Advanced Master Trainer Curriculum
  - Course Description

- TeamSTEPPS™ Essentials - (4 Hours)
  To attend a class held at DRAH, please register in API.
  Enter Code: DMIE0039
  - Registration Information; August 26, 2016
  - Registration Information; October 14, 2016
  - Registration Information; December 9, 2016

- TeamSTEPPS™ Master Trainer Course (Internal)
  - Course Description
  - Registration Information; October 27 & 28, 2016

- TeamSTEPPS™ Master Trainer Course – National
  - Course Description
  June 16-17, 2016
  July 28-29, 2016
  - Registration Information

Want to learn more about 3 Good Things?

September 2016
November 2016
January 2017

For additional information on the WISER Study please go to:

http://www.dukepatientsafetycenter.com/
Three Good Things Exercise

Introduction
You are being asked to participate in this research study because you are a healthcare worker participating in the Three Good Things exercise. The objective of this study is to determine the effectiveness of the Three Good Things exercise in reducing stress and burnout among healthcare workers. Participation is voluntary; research studies include only people who choose to take part. Please read this consent form carefully and take your time making your decision. Please call the study team at the number listed at the end of this form for an explanation of any words or information that you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below. Dr. Karen Frush, MD at Duke University Medical Center is responsible for this study. This study is being conducted by Dr. Bryan Sexton, PhD, at Duke University Medical Center.

Procedures
The Three Good Things exercise is a positive psychology tool which simply asks participants to reflect and log three good parts of their day for 14 days, taking no longer than 5 minutes each day. The study team is interested in the specific effects of this exercise on stress, depression and burnout in healthcare workers. Surveys will be administered to research participants before they are instructed on three good things, at completion of the exercise, and again at 1, 6, and 12 month follow-ups. The surveys will take approximately 5 minutes or less. The questions are designed to evaluate resiliency at the individual and work environment level. The web-based survey will be distributed and collected electronically using the secure, HIPAA compliant Qualtrics survey research suite software. In addition, the study team will ask for your completed Three Good Things log, either electronically or in paper format. Paper logs can be faxed to Dr. Sexton's locked office, located within a key-entry only office suite, or by scanning and emailing to the study coordinator.

Risks/Discomforts
Risks are minimal for involvement in this study. There is the potential for loss of confidentiality. Your first survey will be identified by your email address, and a unique study number we create for you. It will be securely stored on the Qualtrics server for a maximum of 3 months, at which point your responses will be removed from the Qualtrics server, striped of your email address identifier, and stored on the encrypted study computer. All subsequent surveys will only be identified by your unique study number. Your responses will only be viewed by the study team and only aggregated responses will be shared or published (by reporting only combined results and never reporting individual ones). You may feel emotional or psychological distress when asked questions related to burnout or depression. However all aspects of this study are voluntary. Research subjects may choose not to participate at any time, refuse to answer any questions, or withdraw at any time. Your personal survey results will not be given to you, because none of the survey questions are sufficient for making medical or psychological diagnoses.

Consent Form
There is no compensation for participation in this research study.

Participation
Participation in this research study is completely voluntary. You have the right to withdraw at any time or refuse to participate entirely without jeopardy to your employment status or standing with your institution. You do not have to give a reason for not participating. If you desire to withdraw, please close your Internet browser and notify the study coordinator at this email: WISEstudy@dm.duke.edu.

Research Related Injury
Immediate necessary medical care is available at Duke University Medical Center in the event that you are injured as a result of your participation in this research study. However, there is no commitment by Duke University, Duke University Health System, Inc., to provide monetary compensation or free medical care to you in the event of a study-related injury.

For questions about research-related injury, contact Dr. Sexton at (919) 257-3376.

Questions about the Research
If you have questions regarding this study, you may contact Dr. Bryan Sexton at (919) 257-3376.

Questions about your Rights as a Research Participant
For questions about your rights as a research participant, or to discuss problems, concerns or suggestions related to the research, or to obtain information or offer input about the research, contact the Duke University Health System Institutional Review Board (IRB) Office at (919) 668-5111.

Once you have read this consent form, if you agree to participate, you are advised to print a copy to keep for your records.

Study Protocol ID: Pro00038083

I have read the above consent form and desire of my own free will to participate in this study with the understanding that I can withdraw at any time. I know who to contact for more information, if I have questions, and if I choose to withdraw. I have been advised to print off a copy of this consent form to keep for my records. I know that this consent form is linked to my email address, and by clicking “yes” and submitting I am agreeing to participate in this research study.

Yes
No

Survey Powered By Qualtrics
Services & Programs

LIVE FOR LIFE offers a variety of wellness opportunities, such as health assessments and education, smoking cessation programs, fitness activities and nutrition activities, to help eligible faculty, staff and family members reach their health and fitness goals. For more options, please see Wellness Benefits.

Duke Farmers Market
Shop while you work and take home fresh, local fruits and vegetables. LIVE FOR LIFE sponsors the Duke Farmers Market on Fridays beginning April 25. Take a break, walk to the Market, buy lunch-to-go, and purchase fresh fruits and vegetables from local farmers. Watch for Chefs from Duke Dining as they create tempting recipes and offer tasty treats. Pick up tips for creating nutritious meals at home.

Mobile Farmers Market
Duke's Mobile Farmers Market is a convenient way to get fresh, local produce -- and it isn't limited to vegetables. The mobile market offers flowers, plants, meat, and fish in addition to the traditional summer vegetable fare. Pre-purchase your orders from various vendors, and pick them up weekly at Duke Gardens, Durham Regional or Duke Raleigh.

Duke Fitness Club
The Duke Fitness Club includes a network of full-service fitness facilities in locations throughout North Carolina that offer Duke faculty, staff, retirees and their families discounted membership rates.

Duke Run/Walk Club
The Duke Run/Walk Club provides walking and running programs for all fitness levels. This 12-week program will help you improve your fitness level while having fun with your co-workers in a group setting. Independent participation options are also available.

Exercise & Fitness
Additional fitness activities and events are available at Duke to help faculty and staff who are interested in starting an exercise program or enhancing their current exercise routine.

Health Risk Assessment
Work with a Health Professional
Get started by taking a Health Risk Assessment (HRA), a questionnaire that asks about your current lifestyle and habits in various aspects of life, including physical activity, nutrition, and stress management.

1. Complete the HRA online
2. Complete the HRA in person

eHealth

eHealth is a free, personal wellness web site that enables Duke faculty and staff to track their progress toward their health and fitness goals.
The Duke University Intramural Sports Program offers a variety of fun and unique opportunities to its participants through a diversity of sports, tournaments, and special activities. Whether you’re a competitive and athletic sports enthusiast or are looking for a daily source of exercise, Intramural Sports provides a variety of activities for all areas of interest and ability. Compete with friends, colleagues, or sign up as a free agent; there are no additional fees to participate. All participants must have a current Duke ID Card to play.

In order to participate in Duke Intramural Sports you must first create an account and register here: please use your Duke Email Address when signing up. Any eligible participants without a Duke email, please contact the Intramural Sports office for assistance and approval. If you have already created your account and registered using IMLeagues, then you are ready to either create your own team, join a team, or join as a free agent by signing in with your Duke Email Address and password at www.imleagues.com.

Professional staff members are on hand to assist you with further questions and concerns:
Community - Religious Life

Religious Life at Duke creates a safe place for religious expression and student support, and promotes collaboration between Duke’s diverse faith groups.

https://chapel.duke.edu/religiouslife
Debt Management for Residents

A webinar or onsite presentation can help residents successfully navigate student loan repayment. To learn more and to arrange a debt management session, contact Julie Fresne at (202) 828-0511 or via email at jfresne@aamc.org.

The following publications can help with financial wellness and potentially alleviate some financial stress during residency. *(A limited print supply is available.)* To order the publications below, contact Denine Hales at dhales@aamc.org.

- **Next Steps** – a step by step outline to help PGY-1 residents manage their student loans
- **2016 Education Debt Manager** – a comprehensive debt management booklet for graduates
- **Tips for Managing Your Money During Residency** – financial tips to implement

**Recorded webinars and videos** can provide relevant information when a resident has available time in their schedule. To access the videos and webinars, visit [www.aamc.org/videowebinars](http://www.aamc.org/videowebinars). To access all of FIRST's resources, visit [www.aamc.org/first](http://www.aamc.org/first).
for resilience:  
https://www.stepsforward.org/modules/improving-physician-resilience

for burnout:  
https://www.stepsforward.org/modules/physician-burnout

are quite good and have a built in burnout survey. It seems the AMA is setting a goal of "zero burnout" in physicians.
Physician and Medical Student Depression and Suicide Prevention

Educational resources to address mental health conditions and suicide among physicians and medical students

These short films give the medical community the tools to recognize depression or other mental health conditions in themselves and their colleagues, and encourage help-seeking behavior. Unfortunately, physicians are more than twice as likely as the general population to die by suicide.

This program explores the subject of physician depression and suicide in a sensitive and informative manner, and encourages help-seeking behavior among physicians. – Dr. David Satcher, Director, Satcher Health and Leadership Institute and former U.S. Surgeon General

Facts about physician depression and suicide

Original Investigation

Web-Based Cognitive Behavioral Therapy Intervention for the Prevention of Suicidal Ideation in Medical Interns
A Randomized Clinical Trial

Constance Guille, MD; Zhuo Zhao, MS; John Krystal, MD; Breck Nichols, MD; Kathleen Brady, MD, PhD; Srijan Sen, MD, PhD

**IMPORTANCE** In the United States, approximately 1 physician dies by suicide every day. Training physicians are at particularly high risk, with suicidal ideation increasing more than 4-fold during the first 3 months of internship year. Despite this increase, to our knowledge, very few efforts have been made to prevent the escalation of suicidal thoughts among training physicians.

**OBJECTIVE** To assess the effectiveness of a web-based cognitive behavioral therapy (wCBT) program delivered prior to the start of internship year in the prevention of suicidal ideation in medical interns.

**DESIGN, SETTING, AND PARTICIPANTS** A randomized clinical trial conducted at 2 university hospitals with 199 interns from multiple specialties during academic years 2009-2010 or 2011-2012. The current study was conducted from May 2009 to June 2010 and May 2011 to June 2012, and data were analyzed using intent-to-treat principles, including last observation carried forward.

**INTERVENTIONS** Interns were randomly assigned to 2 study groups (wCBT and attention-control group [ACG]), and completed study activities lasting 30 minutes each week for 4 weeks prior to starting internship year. Participants assigned to wCBT completed online CBT modules and those assigned to ACG received emails with general information about depression, suicidal thinking, and local mental health professionals.

**MAIN OUTCOMES AND MEASURES** The Patient Health Questionnaire-9 was used to assess suicidal ideation (ie, “thoughts that you would be better off dead or hurting yourself in some way”) prior to the start of internship and at 3-month intervals throughout the year.

**RESULTS** A total of 62.2% of interns (199 of 320) agreed to take part in the study. 100 were assigned to the wCBT group and 99 to the ACG. During at least 1 point over the course of internship year, 12% of interns (12 of 100) assigned to wCBT endorsed suicidal ideation compared with 21.2% of interns (21 of 99) assigned to ACG. After adjusting for covariates identified a priori that have previously shown to increase the risk for suicidal ideation, interns assigned to wCBT were less likely to endorse suicidal ideation during internship year (relative risk, 0.40; 95% CI, 0.17-0.91; P = .03) compared with those assigned to ACG.

**CONCLUSIONS AND RELEVANCE** This study demonstrates that a free, easily accessible, brief wCBT program is associated with reduced likelihood of suicidal ideation among medical interns. Prevention programs with these characteristics could be easily disseminated to medical training programs across the country.
Suicide ideation ↓ 21.2 to 12%
The Evidence in Total

Systematic review on interventions for physician burnout, commissioned by Arnold P. Gold Foundation Research Institute (West 2015):

- 15 RCT’s, 37 non-RCT’s
  - Results similar for RCT and non-RCT studies

- 24 studies of residents (7 RCT’s totaling 308 participants)

- 19 studies of organizational/structural interventions (3 RCT’s, only 1 in residents with total n=41)
  - 10 of Duty Hour Requirements (0 RCT’s, 1 study of 2011 DHR’s)
The Evidence in Total

**Emotional exhaustion (EE):**
- -2.8 points, *p*<0.001
- Rate of High EE: -14%, *p*<0.001

**Depersonalization (DP):**
- -0.7 points, *p*=0.003
- Rate of High DP: -4%, *p*=0.04

**Overall Burnout Rate:**
- -10%, *p*<0.001

Benefits similar for individual-focused and structural interventions (but we need both)
What are two-three things you believe would BEST enhance wellbeing and resiliency among clinicians at Duke? (individual and institutional solutions)
Easy to Do

Easily achievable/Limited value

Difficult to achieve/Limited value

Difficult to Do

Easily achievable/Critical to Have

Difficult to achieve/Critical To Have
<table>
<thead>
<tr>
<th>Easily achievable/Limited value</th>
<th>Difficult to achieve/Critical To Have</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Thank YOUs – express gratitude, appreciation</td>
<td>• Time to fulfill our role with our patients—value vs productivity</td>
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<tr>
<td>• Activities/interests outside of medicine/work</td>
<td>• Sufficient protected personal time</td>
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<td></td>
<td>• Decrease work hours</td>
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<td></td>
<td>• Increase respect/recognition of non physicians—reduce pedestal</td>
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<td></td>
<td>• Schedule flexibility to accommodate family/personal concerns</td>
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<td>• Exercise</td>
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<td>• Time with support—people family friends</td>
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<td></td>
<td>• Less time on administrative tasks</td>
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<td></td>
<td>• Required resiliency course</td>
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<td>• Better work space/ more room</td>
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<td>• Better spaces for residents</td>
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<td>• Improve pay</td>
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<td>• Scribes</td>
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<td>• More epic resources/scribes</td>
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<td>• More vacation</td>
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<td>• More local control of/by practice</td>
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<td>• More residents</td>
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<td>• Early retirement</td>
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**Easy to Do**

- Limited value

**Difficult to Do**

- Critical to have

**Limited value**
<table>
<thead>
<tr>
<th>Key Drivers</th>
<th>Individual-focused interventions</th>
<th>Organizational/Structural Interventions</th>
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<tr>
<td><strong>Workload</strong></td>
<td>• Part time/flex time</td>
<td>• Productivity targets</td>
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<td>• Duty hour restrictions (?attendings)</td>
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<td>• Integrated career development</td>
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<td>• Shorter ICU shifts</td>
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<td><strong>Work Efficiency/Support</strong></td>
<td>• Efficiency/Skills training</td>
<td>• EMR +/-</td>
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<td>• Staff Support</td>
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<td>• Conflict management</td>
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<td><strong>Work-Life Integration/ Balance</strong></td>
<td>• Self-care</td>
<td>• Meeting schedules</td>
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<td>• Exercise</td>
<td>• Off-hours clinics</td>
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<td></td>
<td>• Mindfulness</td>
<td>• Curricula during work hours</td>
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<td>• Meditation</td>
<td>• Financial Support</td>
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<td>• Stress management/Resilience</td>
<td>• Clinician/learner engagement</td>
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<td></td>
<td>• Reflection/self-awareness</td>
<td>• Protect time with patients</td>
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<td></td>
<td>• Mindfulness</td>
<td>• Promote community</td>
</tr>
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<td></td>
<td>• Small group approaches</td>
<td>• Work/learning climate</td>
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Suggestions from trainees

- Eliminate the word “burnout” from the lexicon: Not only does burnout minimize the severity of depression, detachment and (at extremis) suicidal ideation among healthcare professionals (HCPs), it implies that those suffering post-trauma have some inherent flaw or weakness that impairs their ability to remain functional. This mindset removes the onus from the system.

- End the stigma: Remove the question, “Have you ever sought treatment for any mental illness” from the job applications. We should encourage residents, physicians at all levels, and other HCPs to actively seek out cognitive therapy as we do vaccines or PPDs.

- Decide what graduate (medical) education is: If residents are primarily learners, we must protect their time and use it solely for educational (both clinical and didactic) purposes and not to provide underpaid labor to perform all tasks for which the hospital is at a loss, no matter how menial. If residents are employees, we must provide adequate pay for educational level, protect sick leave, and outline contractual responsibilities before enrolling in the agreement.

- Stop penalizing unwellness: Physicians and HCPs are as human as our patients. We are not immune to everything. There will be times when we will be ill, physically and emotionally. We will need time and space to heal.

- Structure the system in a way that minimizes fear of retaliation: If the person creating or enforcing destructive policies is the same person who needs to write the words “excellent candidate” on the letter of recommendation that carries the weight of your future career opportunities, your best and worst interests are one and the same.

- Embrace our own fallibility: Learn to be comfortable with imperfection. Let us have an equal respect for our accomplishments and failures. Employ mentors who set this example.

- Accept that medicine is not martyrdom: The work does not stop. Let it not deplete us. Let us take care of each other and ourselves and not give away everything that we need.
Box. Guidelines to Promote Mental Health Among Residents and Fellows

Education
Devote curricular time (grand rounds, didactic conferences) to educating trainees about the continuum of distress, from burnout to depression to suicide, and the potential consequences these states have on physicians and their patients.7

Ensure that residents and fellows are aware of all local treatment options and hotline-based mental health care resources available to them.

Assure trainees that mental health treatment is confidential just like other medical treatments.

Address concerns about the potential repercussions of receiving mental health care on job security, regional licensure, malpractice insurance, and disability coverage.

Engage program leadership (training directors, department chairs, teaching faculty) in educational workshops aimed at promoting resident wellness and identifying struggling and at-risk trainees.

Screening
Include a psychiatric and substance abuse history during required annual occupational health history and physical examinations to identify those at risk.

Screen for depression and substance abuse using validated scales (Patient Health Questionnaire—9, Quick Inventory of Depressive Symptomatology, and Modified Simple Screening Instrument for Substance Abuse) within the first 3 months of training programs, given that this is known to be a high-risk period.

Ensure appropriate, confidential, and timely follow-up with mental health care professionals to trainees whose screening results are positive for depression and or substance abuse.

Treatment
Ensure that trainees have access to mental health treatment that is on par with what is available for all other medical conditions.

Provide recurring opportunities for trainees to discuss the challenges of their experiences in a confidential setting. Sharing vulnerabilities diminishes isolation by fostering connection with peers.

Require programs to develop protocols for team debriefings when a seminal event occurs, including a patient’s death, a code situation, or a serious medical error.

In the first 2 months of the 2014–2015 academic year, 2 New York City medical interns died by apparent suicides. In response, an intern from Yale School of Medicine wrote an op-ed in the New York Times highlighting the link between medical training and isolation, depression, and suicide among trainees. Physician suicide is a common occurrence. According to the American Foundation for Suicide Prevention, 350 to 400 physicians commit suicide each year, approximately 1 physician per day. Medical training involves numerous-risk factors for mental illness, such as role transition, decreased sleep, relocation resulting in fewer available support systems, and feelings of isolation. A substantial body of evidence has demonstrated that trainees in particular are at high risk for depression and suicidal thinking, but many training programs have not been able to identify and provide treatment for these residents and fellows in a systematic way. National organizations, such as the Accreditation Council for Graduate Medical Education (ACGME), should address the mental health of residents and fellows by proposing strategies for comprehensive education, screening, and treatment.

The literature on physicians and trainee mental health characterizes the scope of the problem and provides guidance about opportunities for highly effective solutions. A 2010 prospective cohort study of 740 interns across 13 US hospitals found that the incidence of depression increased from 3.9% to 28.0% in the first 3 months of the internship year and the percentage of interns’ thoughts of death increased by 270%. Because suicide is rare and underreported, there are no clear data on rates of trainee suicide. However, among all physicians, men are 14.4 times more likely and women 2.27 times more likely to die by suicide than their counterparts in the general population. In addition, suicide is the second leading cause of death among adults between the ages of 25 and 34 years (the age of most interns). In 2003, ACGME published guidelines to encourage suicide prevention and depressive treatment for physicians, clearly stating: “The culture of medicine accords low priority to physician mental health despite evidence of untreated mental disorder and an increased burden of suicide... This consensus statement recommends transforming professional attitudes and changing institutional policies to encourage physicians to seek help.”

In 2020, ACGME published recommendations for increasing mental health care for trainees and provided guidelines for suicide prevention and awareness training and ensured that 80% of its members actually received this education. The program also identified leaders (supervisors in all military units, medical professionals, attorneys, and chaplains) to serve as gatekeepers charged with channeling at-risk individuals to appropriate services. Finally, the ACGME included mental health screening items in their health questionnaire for all enrollees in the military health care plan, in addition to annual follow-up. Their efforts resulted in a decreased suicide rate from 16.4 to 9.4 per 100,000 members between 1994 and 1998. Readiness to take action toward suicide prevention was established quickly because the leaders involved were easily identified and had substantial influence on the community. The ACGME experience provides a good model for hospitals and training programs where leadership designated institutional officials, training directors, faculty, and others could also serve as gatekeepers to promote mental health and well-being among trainees at all levels. Other targeted educational campaigns aimed specifically at general health care professionals have also proven effective at decreasing suicide rates in Europe.

In response to an institute-wide problem of physician depression and suicide, a faculty committee at the University of California, San Diego, drew on the ACGME model to launch its own Suicide Prevention and Depression Awareness Program in 2009. The strategy included educational outreach to destigmatize depression and remove roadblocks to treatment, as well as web-based screening, in-person assessment, and referral when appropriate. The web-based tool used in this study was developed by the American Foundation for Suicide Prevention for anonymous screening of college students and has been shown to identify individuals at high risk of suicide. Twenty-seven percent of the University of California, San Diego, respondents screened positive for depression, demonstrating the need for ongoing screening.

Twelve years later, these proposed interventions have not been widely adopted. The ACGME requires programs to have processes to assess fatigue and burnout among trainees and to provide access to confidential counseling, but these regulations should go further to require specific strategies to promote mental health among trainees.

When the US Air Force (USAF) identified suicide as a department-wide problem in the 1990s, its leadership successfully implemented a comprehensive suicide prevention and depression treatment program. The USAF required annual suicide prevention and awareness training and ensured that 80% of its members actually received this education. The program also identified leaders (supervisors in all military units, medical professionals, attorneys, and chaplains) to serve as gatekeepers charged with channeling at-risk individuals to appropriate services. Finally, the USAF included mental health screening items in their health questionnaire for all enrollees in the military health care plan, in addition to annual follow-up. Their efforts resulted in a decreased suicide rate from 16.4 to 9.4 per 100,000 members between 1994 and 1998. Readiness to take action toward suicide prevention was established quickly because the leaders involved were easily identified and had substantial influence on the community. The USAF experience provides a good model for hospitals and training programs where leadership designated institutional officials, training directors, faculty, and others could also serve as gatekeepers to promote mental health and well-being among trainees at all levels. Other targeted educational campaigns aimed specifically at general health care professionals have also proven effective at decreasing suicide rates in Europe.

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Viewpoint
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Recommendations for a National Response