For many new physicians, residency can cause fatigue and stress, which can affect their ability to take care of themselves and their patients. Recently, the ACGME added a Well-Being section to its Common Program Requirements. This topic, although not a new one, has not been addressed because of the stigma attached to it.

Resident Well-Being is a tool for residency program directors, coordinators, and faculty to teach residents to pay more attention to their self-care and understand how their wellness influences the care they give their patients. This resource will specifically address how to help residents with burnout, depression, stress, and work-life balance. Training tools are included as well as examples from various programs about the tools they have implemented for resident wellness.

This book will help you:
• Assess your program for resident wellness
• Identify signs of burnout and depression in residents
• Create a safe working and social environment for residents to excel
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About the Authors

Alicia M. Pilarski, DO, is an associate professor and clinical faculty in Emergency Medicine at the Medical College of Wisconsin (MCW)/Froedtert Hospital in Milwaukee. She completed her undergraduate studies at University of (Urbana) Illinois, completed medical school at Touro University in California, and her emergency medicine residency training at University of Nevada School of Medicine in Las Vegas. Pilarski was involved with resident wellness during her residency as chief resident and founded the MCW Emergency Medicine Wellness Committee in 2011. Since that time, the committee has been involved in wellness initiatives, building resiliency among residents, and engaging in community outreach. It continues to expand each year to encompass more institution-wide changes that affect provider well-being. Pilarski is a member of the Council of Residency Directors and is involved in its Resilience Committee and Mental Health Task Force. She is also a member of the American College of Emergency Physicians and is a member of its Wellness Committee. Pilarski is married, has two daughters, and lives in Milwaukee. She credits her family as the sources of inspiration for all that she works on related to wellness, resilience, and work-life integration.

Jill Simonson, BA, C-TAGME, has been employed by MCW for over 17 years and is currently the education program manager in the department of emergency medicine. She graduated from Alverno College with an academic focus in business and management along with computer science. She previously served on the Housestaff Health and Welfare Committee and was a member of the graduate medical education committee and the MCWAH Program Coordinator Event Planning Committee. On a national level, she is a member of the Emergency Medicine Association of Residency Coordinators and has served as a member-at-large and secretary. Simonson has written eight abstracts and presented at Surgical Education Week, the ACGME Annual Conference, and the Surgical & Surgical Specialties Residency Program Administrators/Coordinators Workshop. Additionally, she has one publication on MedEdPORTAL.
About the Contributors

Larisa Coldebella, MD, completed her undergraduate studies at North Park University in Chicago, where she majored in physics. She completed medical school at the University Of Illinois College Of Medicine in Peoria, where she developed a love for emergency medicine and teaching. She completed her emergency medicine residency at the Medical College of Wisconsin (MCW), during which she served as her program’s resident education chief and became involved in her program’s wellness committee, as well as the hospitalwide Housestaff Health and Welfare Committee. She recently accepted a faculty position at Greenville Health System in Greenville, South Carolina. Her professional interests are wellness, specifically work-life balance, burnout, resilience, and suicide prevention and awareness, as well as board review curriculum development. She now serves on AAEM’s Wellness Committee and the CORD Mental Health Task Force.

Nancy Jacobson, MD, completed her residency training at the Medical College of Wisconsin (MCW) and began her role as assistant professor of emergency medicine and faculty cochair to the Emergency Medicine Wellness Committee in August 2017. She completed medical school at MCW in 2014 after earning a Bachelor of Science degree from the University of Wisconsin-Madison, with majors in biology and honors English. She was born and raised in Milwaukee, where she now lives with her husband and daughter.

Nicole Lopez, MD, is an emergency medicine resident at MCW/Froedtert Hospital in Milwaukee. She completed medical school at the University of Illinois at Chicago College of Medicine, where she graduated with honors. During medical school, she was actively involved in the Emergency Medicine Interest Group, serving as president from 2012 to 2013; and in teaching, serving as an anatomy tutor as well as a small group leader for the Essentials of Clinical Medicine course. She has been a member of the MCW Wellness Committee for the past two years and is serving as cochair in her final year of residency. She has partnered with her fellow residents to establish a weekly resident newsletter and cowrites the weekly wellness column.
Angel Perino, Jr., MD, is a physician and professor of emergency medicine at Greenville (South Carolina) Health System. Perino was born in the northern suburbs of Chicago and grew up in Gurnee, Illinois. He attended high school at St. Bede Academy and graduated from the University of Notre Dame with a degree in science preprofessional studies. The following year he attended the University of Illinois College of Medicine. Upon graduating, he joined the Medical College of (Milwaukee) Wisconsin Emergency Medicine residency program.

Loice Swisher, MD, FAAEM, has been a nocturnist for two decades at Mercy Philadelphia Hospital, an inner-city community hospital associated with the Drexel Emergency Medicine Residency Program. Her plans for an academic career were radically altered when her daughter developed a malignant brain tumor and the resection surgery neurologically devastated her child. Since that life-changing event, resilience has become a personal and professional passion. Swisher participates in residency, institutional, regional, and national resilience committees. She is chair of the Mental Health Task Force for the Resilience Committee for CORD and a member of the AAEM Wellness & Burnout Committee. In addition, she is a professional member of the American Association of Suicidology, with the goal of promoting an environment in which zero suicides in medicine can become a reality.
Foreword

Recognition of physician wellness as critical to not only the well-being of an individual physician but also to the delivery of patient care has been largely hidden in the shadows and rarely discussed. Some resources have been available for those in need but often times those who would benefit from these services have unfortunately viewed utilization of them to be a sign of weakness and further, those that supervise these individuals often view those that request assistance as somehow lesser for having done so. Fortunately, the concept of housestaff and physician wellness has taken on well-deserved greater importance recently and has attracted the interest of the house of medicine, including the ACGME, AAMC, AMA and FSMB. Understanding the stressors upon our housestaff, re-evaluating old dogmas regarding resiliency and fatigue, as well as how to better identify those at risk for burnout, depression, and suicide is vitally important in order to effect the necessary changes.

Dr. Alicia Pilarski, Ms. Jill Simonson, and their team are to be commended for elucidating and addressing the critical issues that will serve all (trainees, faculty, program coordinators, and hospital staff) quite well in their efforts to improve wellness for those at risk in this excellent treatise on resident wellness. In addition to their own individual exhaustive contributions, they solicited contributions from others who are well familiar with the pressures placed on trainees in an emergency medicine training program. Each chapter is comprehensive, well organized, has helpful figures, and a thorough bibliography that includes nearly all of the pertinent references. This text will serve as a vital resource for both program directors and program coordinators as well as for all members of the healthcare team involved in training residents and fellows. Not only is this a thoughtful work that adds to the literature on the topic, but it is also critically important given the significant and new challenges placed on our trainees: enormous debt, higher expectations by all involved in healthcare (colleagues, administration, patients) and the explosion in
medical knowledge/data, the sheer volume of which has not ever been seen to this degree in recorded history.

Physician wellness is absolutely vital if we are to continue moving forward in the delivery of high quality, safe, and effective care to our patients. This guide, beyond being enlightening reading, will serve as an informative resource to all educators committed to improving trainee wellness and the healthcare system for years to come.

_Kenneth B. Simons, MD_

*Executive Director and DIO, MCWAH, Inc.*

*Sr. Associate Dean for GME and*

*Accreditation Professor of Ophthalmology and Pathology*

*Medical College of Wisconsin*
CHAPTER 1

Understanding the Importance of Wellness for the Trainee

By Jill Simonson, BA, C-TAGME

Have you seen the data? Statistics on physician burnout are alarming. Studies show that burnout can decrease a physician’s ability to adequately treat their patients. Although this issue is not a new one, it has not been adequately addressed because of the stigma attached to it. However, it is becoming increasingly clear that organizations where physicians work must step in and offer support to help physicians stay well and avoid burning out. Such organizations include residency and fellowship training programs, where physicians in training are first exposed to—and hopefully supported in addressing—the stressors associated with the job. As the first touchpoint for such physicians, residency and fellowship training programs have the potential to shape how this group responds to well-being and burnout. As a program official, you cannot idly sit by and hope that your trainees never burn out or that they find support elsewhere. Now is the time to review your program policies, committees, and other support services related to physician well-being. This book is intended to offer research, guidance, and best practices for establishing a well-being program within your training program.

What Is Wellness? And Why Is Wellness Important for Physicians?

Physician burnout is a reaction characterized by depersonalization, negative attitudes toward patients, emotional exhaustion, a feeling of decreased personal achievement, and a lack of empathy for patients. Wellness, on the other hand, consists of many elements that together lead to optimal levels of physical, emotional, and social well-being. Wellness, as defined by Dictionary.com, is “the quality or state of being healthy in body and mind, especially as the result of deliberate effort.” It is an approach to healthcare that emphasizes preventing illness.
and prolonging life, as opposed to treating diseases. Wellness is prevalent in the medical arena, because for physicians to provide excellent patient care, physicians must first take care of themselves.

Data published in 2015 by the Mayo Clinic Proceedings (Shanafelt et al., 2015) compared burnout in medical specialties between 2011 and 2014. Emergency medicine, urology, and physical medicine and rehabilitation were noted to have the highest physician burnout. Family medicine followed closely behind. These specialties continue to have the highest levels of burnout today as well.

Data collected from more than 15,800 physician responses in more than 25 specialties in the Medscape Lifestyle Report 2016: Bias and Burnout show the burnout rates in critical care, urology, and emergency medicine are all 55%, followed closely by family medicine, internal medicine, and pediatrics, where the burnout rates are 54%. These specialties continue to be reported at the top of the burnout charts. Those with the least burnout included psychiatry and mental health at 40% and ophthalmology and diabetes/endocrinology at 41%.

Additional reports show the following:

- More than 60% of practicing physicians report symptoms of burnout.
- In residency, studies show burnout rates of 41%–90%.
- Evidence suggests that residency may be the time when burnout is at its highest and wellness at its lowest, as measured by exercise, sleep, seatbelt use, substance use, and overall wellness.
- Addressing resident wellness by limiting clinical working hours has not led to improved sleep or education, nor has it led to an actual decrease in work hours or a decrease in depression and injuries.
- In the Medscape Lifestyle Report 2016, 55% of women express being burned out compared to 46% of their male counterparts, up from 45% and 37%, respectively, in 2013.
- In 2013, 40% of physicians responded that they were burned out. In 2015, that number climbed to 46%.
- Roughly 300–400 U.S. physicians die by suicide each year.
- In the United States, suicide deaths are roughly 250%–400% higher among female physicians than among females in other occupations.
- Physicians aged 35 and under have a burnout rate of 44%.

Have we reached a critical point in burnout of physicians?
Causes of Burnout

Physicians were asked to rate causes of burnout on a scale of 1–7, where 1 equals “Does not contribute at all” and 7 equals “Significantly contributes.” A 2017 Medscape Lifestyle Report on race and ethnicity, bias, and burnout indicated that “too many bureaucratic tasks” was the leading cause of physician burnout, which can lead to poor judgment in patient care decisions, create hostility toward patients, and may even cause a physician to be disengaged and cause a medical error or adverse event.

The same report asked physicians to rate their level of happiness both while at work and outside of work. The happiest physicians at work—dermatologists (43%) and ophthalmologists (42%)—were also among the happiest outside of work (both 74%). Rheumatologists and nephrologists were the least happy at work (both at 24%) and outside of work (61% and 62%, respectively).

What causes stress in our lives? Based on a report from Statista (2017), the death of a spouse (100%) is most stressful, followed by divorce (73%) and marital separation (65%). Additional stressors include the following:

- A jail term
- The death of a close family member
- A personal injury or illness
- Getting married
- Losing your job/getting fired
- Marital reconciliation
- Retiring
- A change in health of a family member
- Pregnancy
- Sex difficulties
- A new job

Members of a medicine-based career path may also experience these types of stressors:

- Physical and emotional exhaustion—being emotionally drained and worn out by work
- Depersonalization—experiencing a negative attitude toward other healthcare providers, patients, and patient families
• Having a reduced sense of personal accomplishment and feelings of incompetency
• A focus on self-perserverance, the desire for expert performance, and the denial of burnout
• Too many bureaucratic tasks
• Insufficient income to maintain a healthy home environment
• The increased computerization of patient care practices

**ACGME’s Role in Well-Being**

The Accreditation Council for Graduate Medical Education’s (ACGME) role is to set standards for residency programs and fellowships so that they create a safe learning environment that facilitates safe patient care. These standards specify that residency programs and fellowships are responsible for promoting safe patient care and resident well-being within the learning environment. In 2015, a review of ACGME Common Program Requirements highlighted the need to research and consider including requirements that support resident/fellow wellness, patient safety, safe transitions of care, supervision, teamwork, clinical experience, and education hours.

In developing new standards for wellness, the ACGME considered all available relevant literature and written comments from the graduate medical education community and the public. It created the Congress on the Resident Learning and Working Environment, which deliberated on the need to address the following three standards:

1. Emphasize that graduate medical education programs are designed to provide professional education
2. Produce standards based on the best available data
3. Support the philosophy of the ACGME preamble

Revised ACGME requirements related to resident and fellow well-being, effective July 1, 2017, include the following points:

• Help residents find meaning in work, including supporting protected time with patients; minimizing nonphysician obligations; and offering administrative support, progressive autonomy and flexibility, and enhancement of professional relationships

• Pay greater attention to scheduling, work intensity, and work compression

• Evaluate the safety of residents and faculty members in the learning and working environments
• Establish policies and programs supporting optimal resident and faculty member well-being, including the opportunity to attend appointments for personal care, even during working hours

• Offer attention to and education in resident and faculty member burnout, depression, and substance abuse in themselves and others; provision of services and resources for care and tools to identify symptoms and report them; and availability and access to confidential, affordable mental health counseling and treatment, including access to urgent and emergent care 24 hours a day, seven days a week

• Establish policies and procedures ensuring continuity of patient care in support of patient and physician safety when residents and faculty members are unable to work, including but not limited to circumstances related to fatigue, illness, and family emergencies (ACGME 2017).

The continued increase in physician burnout also led the ACGME to host the Symposium on Physician Well-Being in November 2015. A second symposium took place in 2016, and the ACGME Task Force on Physician Well-Being and the Council of Review Committee Residents were created. These two events brought together individuals from across the medical spectrum and experts in well-being to discuss what’s necessary to initiate program changes and increase physician well-being. The outcomes from these events allowed the ACGME to better understand the problem, to open a dialogue that can change the culture of the clinical learning environment, and to better address and support the well-being of healthcare professionals.

Seven Dimensions of Wellness

To combat burnout, it’s time to act and start a wellness initiative at your institution.

In this book, we cover the steps to help you formulate a plan based on the seven dimensions of wellness, quoted from the University of California, Riverside. The seven dimensions are:

1. **Social wellness:** “The ability to relate to and connect with other people in our world. Our ability to establish and maintain positive and supportive relationships with family, friends, and coworkers contributes to our social wellness.” These relationships can also be at a distance and use social media such as Facebook or Twitter to communicate. Signs of social wellness include balancing social/personal time, being engaged with people in your community, valuing diversity, treating all individuals equally, and remembering to have fun.
2. **Emotional wellness:** “The ability to understand ourselves and cope with the challenges life can bring. The ability to acknowledge and share feelings of anger, fear, sadness or stress; hope, love, joy and happiness in a manner that contributes to our emotional wellness.” The emotionally well individual shares enjoyable relationships with others.

3. **Spiritual wellness:** “The ability to establish peace and harmony in our lives. The ability to develop congruency between values and actions and to realize a common purpose that binds creation together contributes to our spiritual wellness.” The spiritually well individual feels that their existence has meaning and a purpose.

4. **Environmental wellness:** “The ability to recognize our own responsibility for the quality of the air, the water, and the land that surrounds us. The ability to make a positive impact on the quality of our environment in our homes, our communities, or our planet contributes to our environmental wellness.” Additional responsibilities exist for the environmentally well individual, such as being accountable for the needs of the environment by conserving water and other natural resources, reducing waste by reuse and recycling, and minimizing exposure to chemicals on a daily basis.

5. **Occupational wellness:** “The ability to get personal fulfillment and personal satisfaction from our jobs or our chosen career fields, and grow our careers, while still maintaining balance in our lives. Our desire to contribute in our careers and to make a positive impact on the organizations we work in and to society as a whole lead to occupational wellness.” Occupational wellness also includes an individual’s ability to identify workplace stress and practice conflict management.

6. **Intellectual wellness:** “The ability to open our minds to new ideas and experiences that can be applied to personal decisions, group interaction, and community betterment. The desire to learn new concepts, improve skills, and seek challenges in pursuit of lifelong learning contributes to our intellectual wellness.” Intellectually well individuals use any available resource to advance their knowledge, improve and master skills, and then share this knowledge with others. These individuals are organized and function in a controlled way.

7. **Physical wellness:** “The ability to maintain a healthy quality of life that allows us to get through our daily activities without undue fatigue or physical stress. The ability to recognize that our behaviors have a significant impact on our wellness and adopting healthful habits (e.g., routine checkups, a balanced diet, exercise, etc.) while avoiding destructive habits (e.g., tobacco, drugs, alcohol, etc.) will lead to optimal physical wellness.” Physical wellness encourages regular physical activity and encourages the understanding of nutrition.
In this book, we will provide you with the tools to design a custom wellness program that meets the needs of residents and faculty alike by doing the following:

- Describing key factors contributing to physician burnout
- Developing a wellness-specific program with strategies for improving resilience
- Recognizing stressors in the learning environment
- Educating learners on wellness and how to achieve it
- Identifying resources
- Providing feedback strategies

There is a moral and ethical need to reduce physician burnout and promote resilience, which in turn will improve the quality of patient care, patient safety, and overall patient satisfaction. Reducing burnout and promoting engagement are responsibilities shared by training programs and their associated institutions. National data help demonstrate the need and context for developing wellness programs. Providing physicians with strategies to prevent burnout and increase wellness will result in an engaged clinical workforce that promotes engagement and physician well-being while combating physician burnout.

*Source: University of California, Riverside, Seven Dimensions of Wellness: Retrieved from https://wellness.ucr.edu/seven_dimensions.html*
References


• Providing access to appropriate tools for self-screening.

• Providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

Suicidal Ideation and Depression

People often mention suicidal ideation and depression as a pair. Of course, not all people who struggle with one also struggle with the other. However, there is a good deal of overlap in the kinds of assistance that are helpful for either group. Note, too, that physicians tend not to disclose suicidal intent, so this population requires a high index of concern for potential suicide warning signs and higher-risk situations.

Suicidal ideation

Suicidal ideation requires special attention. Residents must be encouraged to report concerns to the program director or department chair, particularly if their colleagues make any statement about wanting to kill themselves.

Depression

One or more of your residents may have had (or still may experience) depressive disorders. The incidence of depression has increased every year since the early 20th century. One in six people in the United States experiences a depressive episode sometime during his or her lifetime. Depression can be acute and limited in its duration, or it can be chronic and require lifelong treatment. Thus, you must be able to recognize depression in your residents and support treatment initiatives.

Depression is characterized by feelings of sadness that cannot be explained by the sufferer. Depressed persons experience a significant decrease in energy, an increase in fatigue, and a lack of interest in activities that normally bring them pleasure. Depression can also lead to impaired functioning at work, at home, and in social situations. Here are some signs and symptoms of depression of which program officials should be aware:

• Depressed people feel sad or anxious every day for most or all of the day.

• Depressed people often feel worthless, hopeless, or helpless.

• Persons with depression usually experience a significant loss of energy. More than 90% of depressed persons experience a significant, devastating loss of energy, as well as feelings of
fatigue. Both can interfere with a person’s ability to work, to perform activities of daily life, or to participate in social activities.

- About 80% of depressed persons suffer from insomnia. Such lack of sleep further intensifies fatigue and loss of energy. However, some people with depression sleep too much in an effort to escape from their feelings of sadness.

- Changes in eating habits may result in weight loss or weight gain. Some depressed persons have increased appetites, while others lose their appetite.

- Depression may cause feelings of restlessness and irritability.

Are certain residents at higher risk for depression than others? Here are some risk factors for the development of depression:

- Family history of depression
- Chronic low self-esteem
- Occurrence of stressful life events (e.g., abuse, illness, bereavement)
- Distorted perceptions of life experiences and the perceptions of others
- Workplace stress
- Sexual harassment

Depression is generally a chronic illness with periodic remissions. People may go for one or two years without symptoms between episodes of depression. Only a qualified physician can diagnose depression. Persons suffering from symptoms of it must seek medical help and obtain proper treatment.

Treatment usually involves a combination of approaches, including antidepressant medication, cognitive behavioral therapy, and psychotherapy. The effects of antidepressant medications are the aspects of treatment that will most likely concern you as a residency program director. Antidepressants can take a few weeks to produce desired effects, depending on the individual patient and dosage administered. Physicians generally initiate medication therapy at a low dosage and gradually increase the amount (according to the patient’s tolerance level) until therapeutic effects are achieved. Residents and program officials need to understand that effects are not immediate. Therefore, suicidal residents may need to be hospitalized until the medication takes effect.

Antidepressant medication improves symptoms in about 80% of patients. Treatment may be limited to specific periods of time or may be needed on a long-term basis. If discontinuing antidepressants, the resident should do so gradually, under medical supervision. These drugs
must not be abruptly discontinued. As the body adapts to their effects, they often cause drowsiness, so residents should avoid using complex machinery or equipment until drowsiness subsides to avoid injury to themselves or others.

**Onboarding**

The mental health statistics for new interns are frightening. Medical students’ self-assessments indicate that 30% or so screen positive for depression and that as many as 10% screen positive for suicidal ideation (American Foundation for Suicide Prevention). Yet, often we do not know which residents are at risk. To complicate matters, fear and stigma seriously inhibit disclosure, and many simply will not talk about what’s happening because of a perceived risk to their job and their license.

For these reasons, it is important to make the options for and ways to access mental health services obvious without the trainee having to ask. Openly encourage those who have used mental health services before to at least be aware of, if not connected to, such services before a need arises. Suggest that those who have been on medication avoid any lapses.

**Which Resident Is at Risk?**

Dr. Thomas Joiner theorized that there were three factors necessary for a person to become suicidal (Swisher, 2017).

The first two factors foster the desire to take one’s own life. Joiner termed these factors “thwarted belongingness” and “perceived burdensomeness.” You may find it easier to think of these two items together as a sense of “isolation and failure.” Doesn’t that sound like quite a bit of internship and, perhaps, much of residency? Residents regularly move from rotation to rotation—often at different hospitals—which can lead to feelings of isolation. Additionally, the feeling of being incompetent and an imposter seems to run rampant, especially in the early years.

Residency training also provides access to the third factor—the capacity to kill one’s self. We teach our trainees about death. We give them the knowledge of a vast array of ways to die, and we help them overcome the fear of death by way of exposure. Although helpful for their professional work, such knowledge could contribute to more doctors dying at their own hands because they have seen mortality and it doesn’t scare them. Sleep deprivation and substance use make depression and suicidal ideation more difficult to handle as well.
If we look at this honestly, all residents are at risk. It may only take a bad mistake or a series of tumbles to move into crisis.

**Prophylaxis**

Suicidal ideation happens when pain exceeds coping skills (Psych Central, 2002). Because physicians tend to be nondisclosers, all trainees have risk factors for depression and suicidal ideation, and it is unlikely that you will be with a resident at the moment of crisis; making an outcome difference will almost certainly fall to prophylaxis. Your residents will likely do best with an early, open discussion of the best ways to handle the dark days (McParlane & Swisher, 2017). Most important suggestions are to do the following:

- Make a safety plan
- Identify a list of people to call
- Realize that suicidal crises do pass

**Identification**

In many ways, identification is not easy. Residency is difficult. There are long hours and sleep deprivation. Residents have learned to put on a game face and fake it until they make it. They want to be seen as competent—not as a weak link. For those reasons, nondisclosure tends to be the rule.

Perhaps the best way to identify a problem is to directly ask—and not just to accept the polite answer of “I’m good.” One can ask somewhat obliquely, as in the following questions:

- Do you feel you have time for friends and family?
- Do you feel alone?
- Do you feel that you are succeeding?
- Do you have energy?
- Do you feel hopeless?

Alternatively, you can say something like, “You haven’t seemed like yourself to me recently. Is something up?”
In addition to typical suicide warning signs, any death talk should raise immediate red flags. If you hear that a person is talking about taking a bottle of acetaminophen or that hanging would be a good way out of work, take it seriously. It might not be a joke.

Finally, be particularly aware of high-risk situations. Loss of an intimate relationship is a high-risk situation. In the military, this was the most common factor listed in their suicide-reporting database. A bad clinical case—particularly when there was an error, or a malpractice case—can also be a trigger. One suicide can be a trigger for other suicides.

Self-Screening

The ACGME now requires residencies, which may be in conjunction with their sponsoring institution, to provide residents with self-screening tools to assess aspects of mental health. Currently, there is no guidance or requirement of which tools or what format must be used. Check with your GME office if your institution is providing these self-screening tools. If it is, provide this information to your resident. If it is not, there are many self-assessment tools available. Stanford WellMD website (https://wellmd.stanford.edu/test-yourself.html) has a listing of several different self-assessment tests, from altruism to work-life balance.

Note: It is unlikely that self-assessment alone effects a positive change. It should be accompanied by directions to available resources.

Transparency

Like everyone else, residents want to know what is going to happen when they jump into a situation that may make them vulnerable and uncomfortable. It is important for you to make the process of seeking help as transparent as possible. Explain what happens if one goes to the employee assistance program. Explain what is reported to licensing boards. A yearly email may be helpful.

In addition, a new ACGME requirement asks programs to encourage faculty and residents to bring concerns about others to the attention of program leadership. Those who are working alongside a resident are likely the very best barometers of problems. To encourage them to come forward, be transparent about how this process works so that they understand how revealing their concerns will help their colleagues.
Access to Care

Every residency, under their sponsoring institution, is expected to be able to provide 24/7/365 mental health assessment, counseling, and treatment. Perhaps the best way to access this information is through the designated institutional official (DIO) and the GME office. It is likely that institutions will have this information available to residents on an intranet. The following are some examples of care resources:

- Employee assistance programs
- Institutionally supported services
  - Second victim syndrome services
  - Mental health services
- Emergency department and crisis response center
- Counseling using medical insurance
- Physician health programs
- Hotlines
  - National crisis lifeline
  - State and local hotlines

Off-Boarding

Residents look forward to graduation with excitement and trepidation. It is a time to fly on one’s own. But to fly, one leaves the nest. This transition from residency to attending status can be difficult. Some may find difficulty in developing new social supports, as there are no longer the ready-made groups that existed in medical school and residency. In addition, residents may need to find new ways to support their own care (i.e., new providers in a new location with a new insurance). Program officials should highlight the need to find connections and continue all healthcare once leaving residency.

Postvention

Although resident suicide tends to be a rare event at any given institution, when it does happen, it has immediate and devastating effects for the program, residents, program leadership,
faculty, and the institution in general. Typically, the death is unexpected, and few are pre-
pared. If you are in program leadership and find yourself in this unfortunate position, there
will be many tasks to complete. You may be contacting the next of kin, informing your resi-
dents, redoing the schedule, handling your own emotions, and more, all at the same time.

You will need help. If a crisis team does not exist in your program, develop one. At a mini-
mum, it should include the DIO, program leadership, departmental chair, the program coor-
dinator, and key staff. This team can not only navigate this unusual and emotionally charged
issue but also support each other. Communication will be key.

In 2016, the ACGME, in conjunction with the American Foundation of Suicide Prevention
and Mayo Clinic, released a postvention toolkit for residencies and fellowships (Sánchez et
al., 2015). Whether a resident death by suicide happens within your program or within your
institution, this document lists concrete recommendations to respond to the circumstance.

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For many new physicians, residency can cause fatigue and stress, which can affect their ability to take care of themselves and their patients. Recently, the ACGME added a Well-Being section to its Common Program Requirements. This topic, although not a new one, has not been addressed because of the stigma attached to it.

*Resident Well-Being* is a tool for residency program directors, coordinators, and faculty to teach residents to pay more attention to their self-care and understand how their wellness influences the care they give their patients. This resource will specifically address how to help residents with burnout, depression, stress, and work-life balance. Training tools are included as well as examples from various programs about the tools they have implemented for resident wellness.

This book will help you:

- Assess your program for resident wellness
- Identify signs of burnout and depression in residents
- Create a safe working and social environment for residents to excel