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Supporting Residents through Mental Health Crises

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One in three doctors in training is currently depressed.[1] There is growing recognition among medical schools, residency programs, and even the office of the Surgeon General that this epidemic is devastating to our community. Yet, we continue to treat this as an individual problem, reaching out to trainees only when they are already suffering and further singling them out.

Recently, I wrote an article publicly discussing my own depression in residency.[2] The reaction has been supportive and warm, but in one respect very puzzling: I'm often called *brave* for speaking openly about my struggle. This feels strange to me because from what I can tell, experiencing mental health issues in residency is almost as common as drinking coffee: there are some doctors who can get through training without it, but I can count them on my fingers.

Our mental health crisis is a crisis of culture. It is the result of long hours, trauma, sleeplessness, lack of patient contact, and abuse. It will not be solved with sporadic interventions. It is a crisis of leadership, with previous generations of physicians justifying the abuses they experienced and failing to recognize how training is changing. It is a crisis of honesty, with educators and employers telling us to seek help while making it impossible for us to do so.

I commend educators for recognizing this is a serious problem and worthy of their attention. However, the solutions are not going to be simple. Here are few guiding principles for how medical education must change:

1. **We must separate wellness initiatives from mental health support.** Depression is not going to be cured with monthly mindfulness exercises.
2. **Confidentiality concerns in residency are very real and complex.** Even the appearance that a liaison may divulge personal information keeps many from seeking care in the first place. There should be prominently visible mental health liaisons at every program that are firewalled from other residency activities and in no way involved in evaluations.
3. **Residents who are still in training must feel ownership over this process and empowered to raise concerns.** We will never know if our initiatives are working if the people they are meant to help cannot evaluate them.

As educational leaders, we also need to acknowledge the ways that we penalize trainees for prioritizing self-care. Are trainees judged for taking sick days and made to make them up? When picking residents and fellows, does a history of depression or leave of absence negatively impact applicants? When picking chief residents, do we choose only those who did not struggle in training and therefore may not know how to respond to crises and burnout?

As advocates, we need to demand that license applications stop asking physicians about mental health issues that have not affected patient care. There is no evidence that mental health issues affect the quality of a physician's work when they are properly treated. Asking about mental health issues further stigmatizes these near-universal disorders and discourages doctors and medical students from seeking care. Ironically, not seeking care is what endangers our patients and colleagues.

On a more fundamental level, we need to acknowledge and change the basic structures that can make our jobs so demoralizing: endless paperwork, brief patient encounters, and the tendency of hospital administrations to squeeze every ounce of productivity out of us, even when it jeopardizes patient safety. Our profession is at a breaking point. We cannot afford to lose the joy of medicine by refusing to confront the ways that it is broken. Failing to do so will eventually break us all.

References

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