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Residents in distress: an exploration of assistance-seeking and reporting behaviors

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Abstract

BACKGROUND: This study explores assistance-seeking and reporting behaviors in surgical residents faced with stressful circumstances.

METHODS: Three surgical societies distributed a multiple choice, free-text response survey to residents.

RESULTS: One hundred sixty-four residents (39% male) responded; 58% of women (43% men) were married; and 22% of men (7% women) were international medical graduates. Residents' dominant action to colleagues' concerning behavior was to approach him/her directly. Women were more likely to report colleagues' unpredictable behavior toward staff (28% vs 10%, $P < .05$), alcohol on breath at work (53% vs 32%, $P =$ nonsignificant), and personal hygiene deterioration (15% vs 2%, $P < .05$) to an authority. Men were more likely to ignore frequent interpersonal conflicts and illnesses.

CONCLUSIONS: Male and female surgery residents adopt different strategies in dealing with perceived distress in their colleagues. These impact their response to signs of impairment. Educators should consider sex while providing residents with an understanding of their role in the recognition of personal impairment and that of their peers.

Surgical residency is challenged by rigorous and lengthy training, unpredictable duty hours, and high-stakes decision making that can impact patient safety, personal well-being, and lead to impairment.[1] In this study, impairment is defined as any physical, mental, or behavioral disorder that interferes with the ability to practice surgery with requisite skill and safety.[2] The culture of surgery attracts individuals who share an unwritten code of norms and an expectation that suffering should take place in silence.[3] Therefore, despite believing they are more resilient than their nonsurgical colleagues, surgeons are more at risk for depression, broken relationships, substance dependence, and suicide,[3–6] all of which impact women surgeons differently.[7–9] The lifetime prevalence of suicidal thoughts among residents is 43%, with job stress being one of the factors related to the occurrence of suicidal thoughts during

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the first postgraduate year.[10] Younger age is, in itself, a risk factor for suicidal ideation and psychological distress as both occur significantly more commonly among younger doctors and residents than among their older colleagues.[11] The prevalence of burnout has been reported as 17% to 76% in medical residents,[1,12,13] 15% to 90% in obstetrics and gynecology residents,[1] and 11.8% vs 24.3% among residents in general surgery and in surgical specialties, respectively.[14] Depressive symptoms have been noted in 20% to 37% of medical residents and 34% of obstetrics and gynecology residents.[1] Medical residents suffering burnout are more likely to self-report one or more suboptimal patient care practices monthly.[12] However, early recognition of burnout is impeded by a lack of association between resident well-being and competence as determined by standardized test scores.[15] In addition, physicians are reluctant to seek help from others. In a Canadian study, the most commonly employed coping strategies by surgeons to combat workplace stress were keeping stress to oneself, concentrating on what to do next, and acting as if nothing happened. Such maladaptive denial responses positively correlated with feeling emotionally exhausted.[16]

Research has focused on management of the stress associated with surgical performance[17] and coping strategies in the operating room,[18,19] with less attention paid to the responsibility of the surgeon when he or a colleague are under stress outside the operating room.[20] Thus, the early recognition of depression, substance use, and potential suicide is poor among faculty[3,21] and residents.[22–24] For these reasons, the Accreditation Council for Graduate Medical Education requires not only the education of residents and faculty to recognize and respond to the signs of impairment, but also to provide residents with an understanding of their personal role in the recognition of their own impairment and that of their peers.[25,26] Studies of physicians in practice have demonstrated that while valuing professional competence, physicians are often reluctant to seek help for an impaired colleague or for impairment that affects their own ability to practice.[27,28] This study seeks to evaluate the reporting and assistance-seeking behaviors of surgical residents, to develop or improve resident stress management strategies and prevent burnout in training and in the post-training years.

Methods

The members of the Association of Program Directors for Colon and Rectal Surgery (APDCRS),[29] the Association of Program Directors in Surgery (APDS),[30] and the Association of Women Surgeons (AWS)[31] were asked to forward an anonymous electronic survey to their residents. The survey was previously developed in a population of surgeons in practice.[32] It consisted of multiple choice, Likert scale, and free-text response fields to open-ended questions designed to explore attitudes toward impaired colleagues, personal well-being, and assistance-seeking behaviors in challenging personal and professional situations (Table 1). Institutional Review Board exemption was obtained (SCRIHS 004032).[35] Responses between male and female participants were compared using the chi-square test. Statistical significance was defined as P value less than or equal to .05. Excel 2010 was used for all quantitative analyses. Comments were analyzed for each open-ended survey question separately. Using a grounded theory approach of constant comparative analysis as described by Harris,[36] themes and subthemes were derived from the comments, and coded to facilitate analysis. The data were compared with previously coded data and analysis ceased when saturation was achieved. This process was repeated with each survey question.[36] Adjustments were made to the coding schema as appropriate. We defined a comment as a word, phrase, or sentence with a single dominant theme. The comments were coded by a researcher trained in qualitative research (H.S.). All authors read the comments and agreed that the selected quotes were representative of the opinions expressed by survey participants. Using the process outlined above, we identified a number of themes and subthemes from 313 participant entries (Table 2). Comments are reported verbatim with the correction of obvious grammatical and/or spelling errors and identified as (m) for a male resident and (f) for a female resident.

Table 1 Situations demonstrated to impact performance and lead to impaired practice[33,34]

Personal situations	Professional (workplace) situations
Behavior problems with children	Frequent interpersonal conflicts at work
Driving under the influence	Increasing number of patient complaints
Emotional distress or depression	Significant reduction in patient referrals
Frequent illnesses/ accidents	Spending time in hospital off call
Heavy drinking at social functions	Subject of hospital gossip
Isolated/withdrawn from family	Alcohol on breath at work
Unpredictable personal behavior	Locking oneself in office

Results

One hundred sixty-four residents responded. The anonymous survey distribution precluded identification of the denominator; therefore the response rate cannot be calculated. The demographics are summarized in Table 3. Women predominated overall, but there were more male residents in the postgraduate year (PGY) 1 group (P = nonsignificant [ns]). The most likely action when a resident became aware of concerning behavior in a colleague was to speak directly to that person. However, 50% of residents would ignore a colleague who was spending time in the