Improving Resident Use of Mental Health Resources: It's Time for an Opt-Out Strategy to Address Physician Burnout and Depression

Maneesh Batra, MD, MPH
Heather McPhillips, MD, MPH
Richard Shugerman, MD

Opting out, or auto-enrollment, is an effective strategy used across a wide range of contexts to increase uptake of behaviors. Auto-enrollment in retirement programs has been shown to dramatically increase savings for workers throughout the economy.[1] Across the United States, companies with retirement plans that have an auto-enrollment feature have a participation rate of 88%, while those that do not have an auto-enrollment feature have a participation rate of just 48%.[1]

Opt-out strategies can also be found in medical practice. For example, opt-out approaches to consent for childhood vaccinations have been adopted by some states as a measure to increase immunization rates.[2] In contrast to the standard consent model for immunizations (in which a health care provider seeks consent and is required to justify the benefits against the risks of measles immunization, for example), opt-out conveys *normalcy* and safety of immunization, rather than a medical procedure requiring consent. Vitamin K administration to prevent hemorrhagic disease of the newborn provides another example. In this example, the disease is rare though onset may occur with little warning and may be life threatening. While the number needed to treat to prevent a single death may be high, this particular intervention has little risk and is low cost.

Physician burnout has reached epidemic proportions; in some studies more than 50% of physicians self-report burnout.[3] Recent studies have reported that the prevalence of burnout is increasing among physicians compared with the general US population.[3] A great deal of attention has recently focused on improving well-being for trainees.[4,5] This serves the dual purpose of addressing a significant need and implementing preventive measures early in the careers of practicing physicians.

Over the past several years, reports of suicide among medical trainees have made national news headlines.[6] The Accreditation Council for Graduate Medical Education has called for programs to monitor and address physician well-being. Section VI.C. of the common program requirements state, "Programs, in partnership with their sponsoring institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence."[1] Similarly, the National Academy of Medicine and professional societies such as the American Academy of Pediatrics have developed physician well-being initiatives.[7,8]

For program directors and leaders in graduate medical education, the business as usual approach to addressing burnout and mental health concerns among trainees has failed. Trainees themselves are calling for action—to protect themselves and their patients and to improve their learning environment.[9–11] Evidence-based approaches such as Balint discussion groups, mindfulness training, and increased access to mental health services have shown promise, though more study is needed.[12] Is it time for an opt-out approach to this problem?

For many residents trained in the current culture of stoicism and silence, failing to perceive a need for and having a limited belief in the value of mental health services are intrinsic barriers to access.[12,13] In addition, barriers such as time, cost, stigma, possible or perceived lack of confidentiality, and time and travel burden (for off-site appointments) limit use of mental health services by residents.[12,13] While some training programs now provide free confidential access to professional mental health services, these are typically available on an opt-in basis, that is, trainees need to seek, schedule, and make the time to attend an appointment. At our institution, free confidential counseling is offered to residents on-site and with evening hours. However, our experience is that for the residents who need it most, there are barriers to accessing services, such as perceived stigma and the lack of energy and motivation to seek help that may accompany burnout or mood disorders.

DOI: http://dx.doi.org/10.4300/JGME-D-17-00941.1

In this issue of the *Journal of Graduate Medical Education*, Sofka et al tested an opt-out approach to universal well-being assessment for postgraduate year 1 (PGY-1) and PGY-2 residents in a single, medium-sized internal medicine residency program.[14] The goal of their intervention was to increase utilization of available mental health services through mitigation of common barriers. Residents were scheduled for appointments on a "wellness day" during which they were relieved from clinical duties. As those who opted out of the well-being assessment were required to work, the intervention provided the additional incentive of a day off for those who participated.

The authors report remarkable and encouraging results from this intervention,[14] with 93% of PGY-1 and PGY-2 residents attending appointments. Those who attended reported high convenience ratings and low embarrassment ratings; they also said they were likely to return for future visits if they had concerns about depression, anxiety, and burnout.

In theory, this approach would connect residents with services before a potential time of crisis, laying the groundwork for easier, and perhaps earlier, access to help when it is needed most. While the sample was small and the outcomes limited to attendance at the initial sessions and self-reports, the findings suggest that in addition to ameliorating the stigma associated with seeking help, the opt-out approach provided acknowledgment that the physical and emotional demands of physicians are real, and they may benefit from mental health services. This lesson has the potential to benefit residents long after they leave training.

The intervention was not free. The authors report that the costs of increasing access to services above what was already available at their institution was approximately $448 per resident. It is unclear what the number needed to treat burnout would be, or the absolute total costs to prevent 1 case of major depression, suicide, or other adverse outcomes. These costs should be weighed against the costs associated with physician burnout—including turnover, lost revenue due to decreased productivity, lower quality of care, patient safety risks, and decreased patient satisfaction—all of which are linked to physician burnout.[15] Beyond costs, there are few risks to this approach: a comprehensive well-being assessment has little risk of resulting in a negative trainee attitude toward mental health services. However, this should be evaluated in larger studies across specialties and institutions.

Perhaps the time is now for a larger opt-out trial for this and other interventions to promote physician well-being.

References

1. Miller S. Employers are raising 401(k) default savings rates to 6%. Society for Human Resource Management. https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/401k-default-savings-rates.aspx. Accessed November 15, 2017.
2. Gostin LO. Law, ethics, and public health in the vaccination debates: politics of the measles outbreak. *JAMA*. 2015;313(11):1099–1100.
3. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc*. 2015;90(12):1600–1613.
4. Dyrbye LN, West CP, Satele D, et al. Burnout among US medical students, residents, and early career physicians relative to the general US population. *Acad Med*. 2014;89(3):443–451.
5. Ripp JA, Privitera MR, West CP, et al. Well-being in graduate medical education: a call for action. *Acad Med*. 2017;92(7):914–917.
6. Sinha P. Why do doctors commit suicide? *New York Times*. Sept 4, 2014. https://www.nytimes.com/2014/09/05/opinion/why-do-doctors-commit-suicide.html. Accessed November 15, 2017.
7. Dyrbye LN, Shanafelt TD, Sinsky CA, et al. Burnout among health care professionals: a call to explore and address this underrecognized threat to safe, high-quality care. July 5, 2017. National Academy of Medicine. https://nam.edu/burnout-among-health-care-professionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care. Accessed November 15, 2017.
8. Serwint JR, Bostwick S, Burke AE, et al. The AAP resilience in the face of grief and loss curriculum. *Pediatrics*. 2016;138(5). pii: e20160791. Epub 2016 Oct 10.
9. AMA Wire. Ways residents have found to conquer burnout. October 15, 2014. https://wire.ama-assn.org/education/ways-residents-have-found-conquer-burnout. Accessed November 15, 2017.
10. Pearson R. When doctors can't afford to feel. *Daily Beast*. April 30, 2017. https://www.thedailybeast.com/when-doctors-cant-afford-to-feel. Accessed November 15, 2017.
11. Gunderman R, Tilbury WG. Recognizing and surviving burnout. *NEJM* Resident 360. https://resident360.nejm.org/content_items/1374. Accessed November 15, 2017.
12. Clough BA, March S, Chan RJ, et al. Psychosocial interventions for managing occupational stress and burnout among medical doctors: a systematic review. *Syst Rev*. 2017;6(1):144.
13. Ey S, Moffit M, Kinzie JM, et al. "If you build it, they will come": attitudes of medical residents and fellows

about seeking services in a resident wellness program. *J Grad Med Educ*. 2013;5(3):486–492.
14. Sofka S, Grey C, Lerfald N, et al. Implementing a universal well-being assessment to mitigate barriers to resident utilization of mental health resources. *J Grad Med Educ*. 2018;10(1):63–66.
15. Prins JT, Gazendam-Donofrio SM, Tubben BJ, et al. Burnout in medical residents: a review. *Med Educ*. 2007;41(8):788–800.

All authors are with University of Washington School of Medicine. **Maneesh Batra, MD, MPH,** is Associate Professor of Pediatrics; **Heather McPhillips, MD, MPH,** is Professor of Pediatrics; and **Richard Shugerman, MD,** is Professor of Pediatrics.

Corresponding author: Maneesh Batra, MD, MPH, University of Washington School of Medicine, Department of Pediatrics, Division of Neonatology, Box 356320, 1959 NE Pacific Street, Seattle, WA 98195, 206.987.6556, maneesh@uw.edu