

Chapter 62

From Medical Student to Medical Resident: Graduate Medical Education and Mental Health in the United States

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ABSTRACT

The transition from medical school to board-certified medical practice includes a period of intense, practical training known as medical residency. Medical residents are at risk for greater mental health distress than the general population. Interns, which are first year residents, are most at risk for, at worst, depression and suicidal ideation, and, at best, negative outlooks on the medical profession. Risk factors include role transition, decreased sleep, relocation, isolation, stigma toward mental health problems and treatment, and health care industry changes. Untreated mental health problems can lead to burnout later during a physician's career. Residents thrive on social and organisational support which can include systematic screening and treatment of mental health problems. Although research regarding best practices for addressing mental health problems during residency is limited, we offer four core strategies for preventing and addressing mental health problems in medical residents: education, screening, treatment, and support.

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INTRODUCTION

The purpose of graduate medical education (i.e., medical residency) is to cultivate competency, enthusiasm, and confidence within new medical school graduates and prepare these newly minted physicians for a rewarding and successful career in medicine. Residency training in the United States is primarily distinct from medical school education. Residents, unlike medical students, are fully responsible for the treatment of large panels of patients which means they order laboratory and diagnostic tests, perform surgical procedures, make referrals, and design treatment plans. In addition, residents spend long hours during inpatient and outpatient shifts including night rotations and on-call hours. This particular training is necessary for physicians to develop the skills and temperament required for medical practice. However, such training also exposes residents to isolation, role transition, fatigue, and stress.

While it is clear that residents are at greater risk for depression and suicidal ideation than the general population, researchers have not yet identified the best practises for addressing resident mental health (de Oliveira et al., 2013; Goldman, Shah, & Bernstein, 2015; Govardhan, Pinelli, & Schnatz, 2012). Some qualitative data shows that social support is crucial (Mata, Ramos, Kim, Guille, & Sen, 2016). The medical school literature shows promising results for physical activity, organisational changes and support (e.g., pass/fail grading, faculty advisors, and student retreats), and mindfulness training (Drolet & Rodgers, 2010; Kötter, Tautphäus, Obst, Voltmer, & Scherer, 2016; Slavin & Chibnall, 2016). In this chapter, the authors will describe the transition from medical school to residency training, the relationship between residency training and resident mental health, the effect of chronic stress on resident wellbeing, and a four-part programme for supporting resident mental health.

BACKGROUND

Residency selection is a long and cost-intensive process. During the fourth year of medical school in the United States, students apply to multiple residency programmes devoting significant money and time. Concurrently, residency directors and coordinators spend substantial resources recruiting and interviewing students for a limited number of slots. After interviews conclude, faculty members meet and rank all applicants according to programme fit and quality. Osteopathic students match to their respective residency programmes at the beginning of February while allopathic student match in the middle of March. Residency selection is a long and arduous process for both sides. New residents report to their programmes in June or July, complete orientation, and begin their first rotations.

First-year residents (interns) hit the ground running. Even during orientation, interns are signing medical orders and patients charts. They assume responsibility of continuity patients from recently graduated residents and make treatment decisions at the hospital. With a limited patient panel and under the watchful supervision of attending physicians, interns act like fully-functioning physicians. During the first three months of residency, incidences of depression can increase from 4% to 27% while suicidal ideation can increased nearly 400% (Sen et al., 2010).

In an effort to curb resident fatigue and distress, the Accreditation Council for Graduate Medical Education (ACGME) mandated resident duty hour reforms which, among several requirements, capped residents' weekly duty hours at 80 per week (Bolster & Rourke, 2015). There is no doubt that residents work long and hard hours; yet, it is unclear if limiting resident hours is beneficial to patient care and resident well-being (Bolster & Rourke, 2015; Lin, Lin, Auditore, & Fanning, 2016). Under long periods

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