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Addressing Burnout Among Women Residents: Results from Focus Group Discussions

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ABSTRACT

Introduction. Physician burnout has been described as more common among women than men. Even if there are no gender-based differences in prevalence, risk factors, such as work/home integration/conflict and gendered biases, likely differ. Prior administrations of an annual resident wellness survey at a single urban academic institution confirmed that rates of burnout were higher among women, especially during the PGY-2 year.

Methods. A series of focus groups of PGY-3 women residents across specialties were organized in 2019 at a single urban academic medical center. Given the number of participants, demographics were not collected to maintain participant anonymity. The moderator for all groups used a discussion guide consisting of eight open-ended questions based on a review of the literature.

Results. Ten residents agreed to participate in one of four hour-long focus group discussions. While the residents identified some factors that were not gender-specific, they also discussed issues that they faced as women in medicine, including needing to work harder to prove themselves and unconscious gendered biases from faculty and patients. The residents thought that their well-being would be improved if their training programs better understood the experiences and needs of women residents and recommended a series of interventions, including improved mentoring and networking opportunities.

Conclusions. Interventions to improve well-being need to consider gender-based differences. While mentoring and networking can help all residents, these may be especially useful for women and should be considered as a component of an overarching plan to improve diversity, equity, inclusion, and belonging. ***Kans J Med 2023;16:83-87***

INTRODUCTION

Residents and medical students are significantly more likely to suffer from burnout than people of similar ages in other professions.[1] Prior studies have indicated that women physicians may be more likely than men to demonstrate signs of burnout,[2-4] especially emotional exhaustion. Yet, it is unclear if there are gender-based differences in prevalence of burnout among residents. Some studies noted that women residents were more likely to demonstrate signs of burnout, while other studies noted no differences in rates of burnout, but also found that women were more likely to suffer from fatigue and depression.[1] Even if prevalence of burnout among residents did not vary significantly among genders, risk factors likely do. A variety of personal, institutional, and societal risk factors for burnout in women physicians have been described,[5] but few studies have focused exclusively on the experiences of women residents. In addition, most studies on this topic include residents from a single specialty.

Each year, the University of Kansas Graduate Medical Education Wellness Subcommittee administers an electronic wellness survey to all residents and fellows at the University of Kansas Medical Center (KUMC). The survey, originally developed at Stanford University Medical Center, measures burnout using a single-item, self-defined burnout measure.[6-8] Well-being surveys in prior years at the same institution found that women reported higher rates of burnout, especially in the PGY-2 year (unpublished data). The association of burnout with early years in training has been identified by some studies,[9] but not all,[10] and these data are not reported usually based on gender. However, the factors impacting rates of burnout among women during their early years of residency training have not been explored at KUMC, especially the relative impacts of work-home interactions and gendered biases in the workplace. To clarify further the issues that women residents across specialties were facing at a single urban academic institution, focus groups were conducted to obtain feedback on risk factors impacting burnout and to solicit suggestions for mitigation strategies.

METHODS

To gain qualitative information about women resident burnout, the Graduate Medical Education (GME) Wellness Subcommittee at KUMC conducted a series of focus groups with PGY-3 women residents in 2019. PGY-3 residents were selected for the focus group because the previous wellness surveys (unpublished data) had shown a peak level of burnout in PGY-2 residents, and the focus groups occurred at the beginning of the academic year. All PGY-3 women residents in the institution were invited, and 10 participated in one of four, hour-long focus groups. While participants were trainees in a variety of specialties, the specialties or demographics of the participants were not recorded or their responses were not assessed based on these factors to maintain confidentiality, especially given the number of participants and the few numbers of women in some training programs. No compensation was provided to the participants.

The same person served as moderator for all groups and used a discussion guide consisting of eight open-ended questions developed by the Wellness Subcommittee based on a review of the literature and to address and explore findings from the prior resident wellness surveys to guide the discussion (Table 1). These sessions were recorded and transcribed by the facilitator, and the transcripts were assessed by thematic analysis by two of the authors (JN, KT) for common themes. Differences in interpretation of the comments were discussed and resolved with three of the authors (JN, KT, GU), although interrater reliability was not calculated. The study received Institutional Review Board approval.

Table 1. Discussion questions.

1. What are some of the stressors for residents during the PGY-1 year?
2. What additional stressors are present during the PGY-2 year?
3. If you do not feel burnout out, why do you think some of your women colleagues may feel burned out during the PGY-2 year?
4. We have seen that increase in burnout is higher in women than men going from the PGY-1 to PGY-2 level. Why do you think that is?
5. If you were the program director of your residency program or the Dean of Graduate Medical Education, what would you do to improve this problem?
6. What interventions have you found work for you or for your colleagues?
7. If you have children at home, who is primarily responsible for childcare in the home? (Who is responsible for taking the child(ren) to childcare and picking them up?)
8. If you were to go down and look at the household chore list and compare it to that or your significant other, how would the lists look? (Are chores divided equitably?)

RESULTS

General Stressors. Participants noted that stressors reported during PGY-1 year included the sudden increase in workload when transitioning from medical school to residency, as well as getting used to a new environment, new culture, and potentially a new electronic health record system. The residents commented that the workload was multiplied many times, compared to what they had experienced previously, especially if they were covering more than one hospital.

The residents noted that they sometimes felt underprepared for the new responsibilities that come with residency. For example, they noted a stressor for PGY-2 residents was that while they were still learning, they also were responsible for the supervision and teaching of interns. Personnel management was something they were expected to do but was not something they were taught during medical school.

Participants noted that responsibilities and household chores led to additional stress. However, these are stressors that can exist no matter what career path women choose, and people need to learn to deal with them.

Why is burnout higher in women than men and other gender-related issues? The discussion in the focus groups centered on gender-related stressors and challenges and resulted in two main themes: 1) characteristics of women (especially women who go into medicine) that can lead to stress and burnout, and 2) gender issues that women deal with on a regular basis.

The participants described the characteristics that they noted among women residents that could impact their well-being. They thought that medicine "attracts a certain type of person, typically more 'Type A' personalities", which results in a group of women "who are more organized and detail-oriented". While this can be useful as a physician, they noted that it also can have "negative impacts on well-being". They also noted that when things are not done correctly, women can take it more personally than men, and that women "are more likely to take criticism to heart". The participants also stated that "many women deal with imposter syndrome".

The discussants felt that it still seemed to be a "man's world" in medicine, and women must work harder to prove themselves. They noted that some women residents felt the need to be "superwoman", while men seemed to be able to compartmentalize things more easily and just focus on one issue at a time. If a specialty had few women faculty members, participants noted that it was difficult for women residents to find a role model and/or mentor with whom to discuss or address these gendered differences.

Participants commented on gender-based biases from patients and faculty. Some biases included: women residents often were assumed to be nurses; faculty physicians remembered the names of men residents better than they did those of women residents; and research opportunities might be given to men residents first. The participants also noted additional gender-based issues that arose when a participant was the only woman in a program or residency class and that it often was pointed out to them that they were the only woman. The participants expressed that they realized that much of this was unconscious behavior, but "it is the little things that can eventually create or add to stress".

Strategies to Address Stress and Burnout Among Women Residents. The participants in the focus groups were asked what they would recommend that their departments or the institution do to decrease the stressors and the risks for burnout that they faced. There were a variety of recommendations proposed (Table 2) that emphasized the need for more and better mentoring and advising for women, especially in the area of professional development. They also recommended having more orientation and help with the transition from medical student to resident and from the PGY-1 to PGY-2 years. Participants noted that they did not expect issues with household responsibilities to be something that GME faculty would solve for them. However, they noted that it would be easier to deal with any kind of stress, whether from work or home, if GME faculty could help make the basics of residency (e.g., food availability, parking, and safety) easier for them. Overall, the participants thought that a supportive culture that better understood the needs of women residents would improve their well-being.

Table 2. Suggestions to reduce stress and avoid burnout.

- Have medical schools offer a resident readiness course.
- Offer an enhanced program orientation.
- Have a program to help transition residents from PGY-1 to PGY-2.
- Provide timely feedback to residents.
- Acknowledge residents' work.
- Provide easy access to healthy meals.
- Have a mentor/advisor who provides support.
- Have a supportive program director and good department culture.
- Provide opportunities for resident social interactions.

DISCUSSION

Burnout has been identified among residents in training, with variable reports of gender-based differences in prevalence.[1,11,12] In the annual wellness survey of residents conducted at our institution, we consistently have seen a significantly higher burnout rate in women residents compared with men residents, especially during the PGY-2 year (unpublished data). While higher rates of burnout have been identified among women physicians and others have indicated increased rates of burnout early in training, no prior study has focused on the intersection of gender

and year in training and on identifying why more junior women residents may be more likely to suffer from burnout. The current study was undertaken to understand this issue better and to identify what changes from the residents' perspectives could be made within the individual programs or the institution to attempt to remedy it.

Many comments made by the residents reflected the issues with imposter syndrome, which was specifically mentioned by some participants. Those with imposter syndrome think that they were not as knowledgeable or accomplished as objective evidence would indicate. While described in both women and men, this syndrome is more common in the former, including in residents.[13] The impact of this syndrome may be reflected in comments from some participants that women tended to take criticism more personally than men. This reflected the findings of Spataro et al.[14] who found that women physicians were more likely to deal with stress through self-blame. While all residents were faced with the issues of adapting to new environments with new responsibilities, these times of transition, which were noted as stressors by participants in the current study, can be especially problematic for those with imposter syndrome. The changes in responsibilities help to highlight to the sufferer that they are not adequate, placing the blame on themselves and not realizing that those changes are difficult for everyone. Elements of imposter syndrome can have negative impacts on wellbeing, increasing the risks for developing depression, anxiety, and lower self-esteem.[13] Addressing the impact of imposter syndrome, especially among women, can be addressed, in part, by changing how medicine is taught (e.g., less "pimping"), as well as by providing opportunities for residents to learn what to expect and how to deal with the major transitions that occur in their careers (e.g., from medical student to resident, from PGY-1 to PGY-2), such as through networking opportunities, and to normalize the stress that they feel during these times.

Comments that women residents tended to take criticism more personally than men may reflect issues with gendered stereotype perception, or the fear of confirming a negative stereotype about a group to which the person belongs.[15] Both women and men residents have been found to be aware of the societal stereotype that men are seen as better physicians. The perception of this stereotype has been found to impact the wellbeing of women residents negatively, but not men, especially those in fields that are primarily composed of men.[15] In the short term, discussing these perceptions may help to alleviate the impact on women and normalize their experiences. In the long run, increasing the number of women in academic medicine, especially in leadership positions, can help to change the views on the abilities of women in medicine.[15]

Participants in this study noted that many women felt the need to be "superwoman", contributing significantly at work and at home. This issue of multitasking is seen among women physicians overall and women who work, in general.[16] In part, this reflects societal gendered expectations of women to continue to fulfill the majority of work at home, despite work responsibilities. However, the association of dualities of roles at work and at home was a less pervasive theme than found by others,[17,18] perhaps reflecting the smaller number of participants in the current study.

The stated need to perform and excel at all tasks at work and at home could be alleviated, to some degree, by increased opportunities for networking, as well as advising from faculty members. The residents in this study noted that they thought there would be fewer stressors if more advisors were available to discuss issues of practice management and aspects of maintaining a practice and having a family. This type of mentoring also could help residents in developing personnel management skills that they stated they had not learned elsewhere. The impact of mentors has been noted by others: Dahlke et al.[17] noted that the lack of mentors may make women trainees less certain about how to advocate for themselves, achieve work-life integration, or choose a career path, while Elmore et al.[19] found lower levels of burnout metrics among residents who participated in a structured mentoring program.

In general, it can be harder for women, compared to men, in medicine to find mentors,[20] and next steps could include development of more formal mentoring programs, understanding that satisfaction with mentoring does not always require gender concordance between mentor and mentee.[21] While women and men faculty have roles to play as effective mentors for women residents, having women faculty available to discuss issues such as work-life integration and how to address gendered microaggressions that may not be as obvious to men[22] also may be impactful. Unfortunately, identifying enough women faculty as advisors to women residents at a given institution may be challenging, due to the low numbers of women in some areas, such as surgical subspecialties, as well as the number of women leaving academic medicine.[23] There needs to be continued efforts in working to recruit and retain more women into academic medicine, in addition to providing opportunities for women residents across specialties at a given institution or across institutions to network with and support each other.

Unconscious biases, often manifested as microaggressions, have been identified in multiple areas of medicine, including those targeted at residents.[24] Periyakoil et al.[22] identified six main areas of gendered microaggressions against women in medicine, and comments from the participants in the current study reflected at least two of these: 1) their abilities were underestimated, thus less likely to be given research opportunities, and 2) they likely were left feeling excluded or marginalized, as they were assumed to not be physicians or faculty were less likely to remember their names, compared to those of their men colleagues. Facing frequent microaggressions can lead to higher levels of stress, decreased feelings of belonging, and contribute to increased risks for burnout.[25,26] Raising awareness of unconscious biases needs to be accompanied by focused efforts to address and eliminate microaggressions and other more subtle manifestations of these biases. Efforts to address unconscious gender biases should be incorporated in overall diversity, equity, inclusion, and belonging initiatives and include faculty development opportunities. For these to succeed, however, support from program[18] and institutional leadership is needed.

One limitation of this study was the overall number of participants. While PGY-3 women residents at our medical center were invited to participate in the focus groups, only 10 participated. We will expand upon these focus groups of women residents to identify additional

issues and differences based on year in training. Larger focus groups also will allow opportunity to obtain input from a diverse population of women residents to assess the additional impact of race and LGBTQ+ status. In addition, larger groups will allow us to assess responses based on demographics other than gender; the inability to do so is another limitation in this study.

Another limitation of the study was that it was conducted at a single academic medical center. While many challenges to women residents will be similar across institutions, some aspects, such as culture and each individual's experience, could be different. With the increasing numbers of women attending medical school, attention needs to be paid to how they fare throughout their careers, from medical school, to residency, into practice and beyond. Efforts to improve the environment and culture for women in medicine should be included in a comprehensive approach to address concerns of diversity, equity, inclusion, and belonging for all physicians, as developing a sense of belonging is important to maintain physician well-being.[5]

The current study identified specific areas that could be addressed to improve the well-being of women residents (Table 3). These suggestions are similar to those of Ofei-Dodoo et al.[18] and those from the Accreditation Council for Graduate Medical Education[27], however, the issues and recommendations identified in the current study recognized and were focused more specifically on the needs of junior women residents and add to the recommendations in the literature related to women physician well-being.[5] Understanding the issues that they face can help to develop departmental and institutional changes and programming to support them in realizing their goals and help them feel that they belong in medicine, as well as assuring that they are happy and healthy in doing so, ultimately improving patient safety and health outcomes.

Table 3. How can your institution or program address female resident burnout?

- Improved, gender-specific mentorship/advising.
- Have mentors focus on professional development and education rather than focusing on service.
- Foster a supportive culture within the residency program and department.
- Provide a way for female residents to meet and develop supportive relationships.
- Provide resources for attending physicians who also may be suffering from burnout.

CONCLUSIONS

Women residents who participated in this study reported fewer issues with integrating residency training with responsibilities at home as contributing to burnout and focused more on gendered issues within the workplace. While some of the remedies that they suggested were not gender-specific, others focused on ways to develop a more supportive work environment and culture for women residents within and outside of their training programs. Developing interventions moving forward requires an understanding of the pressures that residents face, at work and at home, and finding out from them what changes would be beneficial. Efforts to implement awareness of issues impacting well-being realistically could begin at the time of matriculation into medical school.

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