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Pediatric Program Leadership's Contribution Toward Resident Wellness

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Abstract

Background: Residency program leaders are required to support resident well-being, but often they do not receive training in how to do so.

Objective: To determine frequency in which program leadership provides support for resident well-being, comfort in supporting resident well-being, and factors associated with need for additional training in supporting resident well-being.

Methods: National cross-sectional web-based survey in June 2015 of pediatric program directors, associate program directors, and coordinators about their experiences supporting resident well-being. Univariate and bivariate descriptive statistics compared responses between groups. Generalized linear modeling, adjusting for program region, size, program leadership role, and number of years in role determined factors associated with need for additional training.

Results: The response rate was 39.3% (322/820). Most respondents strongly agreed that supporting resident well-being is an important part of their role, but few reported supporting resident well-being as part of their job description. Most reported supporting residents' clinical, personal, and health issues at least annually, and in some cases weekly, with 72% spending >10%of their time on resident well-being. Most program leaders desired more training. After adjusting for level of comfort in dealing with resident well-being issues, program leaders more frequently exposed to resident well-being issues were more likely to desire additional training ($P < .02$).

Conclusions: Program leaders spend a significant amount of time supporting resident well-being. Although they think that supporting resident well-being is an important part of their job, opportunities exist for developing program leaders through including resident wellness on job descriptions and training program leaders how to support resident well-being.

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Keywords

residency leadership; residency program directors; resident wellbeing; physician burnout; physician wellness

PHYSICIAN WELL-BEING HAS been recognized as vital to assuring the delivery of the "safest, best possible care to patients."[1,2] In fact, redefining the Triple Aim as the "Quadruple Aim" and adding the goal of improving health care provider wellness to the other 3 dimensions of health care system performance has been suggested.[3,4] Physician wellbeing is a significant issue in residency training, because 24%−75% of residents report burn-out[5–9] and 21%−43% report depression or depressive symptoms,[10,11] including 39%-56% of pediatric residents reporting burn-out.[12,13] In light of these concerns, the Accreditation Council for Graduate Medical Education (ACGME) has recently charged residency programs with front-line responsibility for promoting resident well-being and support,[14] although the ACGME does not explicitly define physician well-being. Recent updates to the ACGME Common Program Requirements, which went into effect July 1, 2017, state that "programs…have the same responsibility to address well-being as they do to ensure other aspects of resident competence."[14]

Although the charge for residency programs to address resident well-being is clear, little is known about the time and effort that residency program leaders spend supporting resident well-being, nor about desire for additional training in this area. A multispecialty single-center study reported that the majority of program directors from their institution reported spending at least 3 months a year in responding to struggling residents.[15] A 2011 study of family medicine program coordinators found that they spend 14% of their time providing social support to their residents.[16] However, those studies were limited to a single institution or to program coordinators; no study has reported time spent on resident well-being and support by program directors (PDs), associate program directors (APDs), and program coordinators (PCs) nationally across pediatrics or any other specialty.

We conducted a national web-based survey of pediatric residency program leaders, defined as PDs, APDs, and PCs, to 1) determine how frequently program leaders support resident well-being, and 2) determine factors associated with comfort and need for additional training to deal with resident well-being and support. Better understanding of frequency, comfort in managing, and additional training needs in resident well-being and support may elucidate strategies for institutional support, professional development, and national standards to enhance program leaders' support of their residents.

METHOD

SURVEY ADMINISTRATION

We performed an anonymous national cross-sectional web-based survey of all United States pediatric PDs, APDs, and PCs in June 2015. We e-mailed recruitment letters with the survey link to participants in each group with 2 follow-up reminders. We received Institutional Review Board approval from the University of California Los Angeles and University of

California Davis and research approval from the Association of Pediatric Program Directors (APPD).

Survey Instrument and Study Variables

We developed the survey instrument after a literature review[17,18] and discussion with local and national PDs and PCs. The survey was revised after pilot testing with 10 PCs and 5 PDs/APDs and a peer review by the APPD Research and Scholarship Task Force. The survey consisted of multiple-choice and open-ended questions. Multiple-choice questions included program demographic questions (program region, program size), personal demographic information (length of time in program leadership: >1 y, 1 to >3 y, 3 to >5 y, 5 to >10 y, >10 y), what percentage of their time was used to support resident well-being over the past year, whether they felt that supporting resident well-being was an important part of their job, if their role in supporting resident well-being was included in their job description, frequency dealing with resident well-being issues, comfort in dealing with resident well-being, and desire for additional training in how to support resident well-being. We did not define resident well-being in our survey but rather included specific areas related to the support of well-being which were identified in a literature search and our pilot survey. Resident well-being and support issues included 3 categories: common residency issues, clinical stressors, and rare reportable issues. To support the validity of the internal structure of our survey, we performed exploratory factor analysis on frequency, comfort, and need for additional training.[19] We then calculated Cronbach α to determine the internal consistency of each factor. Open-ended questions asked for general comments regarding program leadership's role in well-being.

A 5-point frequency scale (weekly, several times per year, annually, once every few years, and never) was used for frequency of supporting resident well-being. A 5-point agreement scale was used to assess how strongly they agreed or disagreed (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree) with the statement, "I am comfortable dealing with these situations if/when a resident comes to me for help," and how strongly they agreed or disagreed with the statement, "I need additional training in this area to function as a (PD, APD, PC)".

Analysis

All surveys with ≥2 questions completed were included in the analysis, and the response rate was calculated with the use of the American Association for Public Opinion Research's RR2 measure, which counts all partial responses.[20] We compared program characteristics of responding PDs with all programs nationally with the use of the American Medical Association's Fellowship and Residency Electronic Interactive Database (FRIEDA) website for program size (small, ≤30 residents; medium, 31–60 residents; large, >60 residents) and region (Northeast, Midwest, South, West).[21] To determine factors associated with comfort in supporting resident well-being, we used a generalized linear model adjusting for program region, size, role (PD, APD, PC), and time in role (<3 y, ≥3 y). To determine factors associated with desire for additional training in supporting resident well-being, we used a generalized linear model adjusting for frequency, comfort, program region, size, role, and time in role. We performed all quantitative analyses in SAS 9.4 software (Cary, NC).

We performed content analysis on answers to open-ended questions. Qualitative comments were independently coded by 2 coders (S.C. and M.R.) with the use of a constant comparative method and then grouped into categories. All researchers then reviewed and discussed categories until consensus was reached.

Results

The overall response rate was 39.3% (322/820), with 38.2% (76/199) of PDs, 37.5% (142/379) of APDs, and 52.5% (127/242) of PCs responding. Participating PDs were similar to nonrespondents regarding program region (Northeast: 19/58, 24%; Midwest: 22/45, 26%; South: 25/69, 33%; West: 10/27, 13%; $P = .39$) and program size (small: 24/ 72, 25%; medium: 29/80, 36%; large: 24/47, 28%; $P = .13$). Demographic representations for APDs and PCs were unable to be calculated, because this information was not available for nonrespondent APDs and PCs. Most program leaders had been in their role for ≥3 years (83% of PDs, 61% of APDs, and 81% of PCs).

The results of the exploratory factor analysis found that resident well-being issues fit into the same 3 factors (common residency issues, clinical stressors, rare reportable stressors) for frequency, comfort, and need for additional training. Physical health and mental health fell across multiple factors and were not included in the final models. Because Cronbach α showed good internal consistency, we were able to synthesize the data with the use of mean scores of the items within each of the factors. Common residency issues (Cronbach α's 0.83 for frequency, 0.89 for comfort, and 0.93 for need for additional training) included personal/professional conflicts with colleagues, life event stress (weddings, divorce, pregnancy, etc), family emergencies and/or tragedies, lapses in professionalism, compliance concerns (such as timely documentation, social networking, HIPAA compliance, etc), and not meeting clinical expectations. Clinical stressors (Cronbach α's 0.83 for frequency, 0.87 for comfort, and 0.92 for need for additional training) included physician burn-out, physician grief over poor patient outcomes, and moral distress (distress associated with situational ethical dilemmas[22]). Rare reportable issues (Cronbach α's 0.69 for frequency, 0.91 for comfort, and 0.95 for need for additional training) included domestic abuse, discrimination (racial, gender, etc), and sexual harassment.

Program leaders spend a significant proportion of their time supporting resident well-being (Table 1), with >70% of all program leaders reporting spending >10% of their time supporting resident well-being in the past year. All PDs and APDs (100%) and 93% of PCs agreed that their role in supporting resident well-being was important. In contrast, few reported that support of resident well-being was explicitly included in their job descriptions (26% of PDs, 21% of APDs, and 16% of PCs).

Most PDs dealt with common residency issues and clinical stressors several times a year, and almost one-half had dealt with a rare reportable stressor at least once (Table 2). PDs also dealt with resident mental or physical health issues at least annually (Table 2). The pattern of frequency of supporting resident well-being was similar for APDs; PCs encountered many of these issues less frequently (data not presented).

PDs were more likely to strongly agree that they are comfortable dealing with common residency issues and clinical stressors; they were least likely to strongly agree that they are comfortable dealing with rare reportable stressors (Table 3). The pattern of comfort in supporting resident well-being was similar for APDs; PCs were less comfortable in many of these issues (data not presented). Our generalized linear model found that those with more frequent exposure to these issues were more comfortable dealing with them ($P < .001$). In addition, compared with PCs, PDs and APDs were more comfortable dealing with common residency issues ($P < .001$ and $P = .02$, respectively) and rare reportable stressors ($P < .001$).

The majority of PDs strongly agreed or agreed that they desired more training in dealing with clinical stressors and rare reportable stressors (Table 4). The pattern of desired training for supporting resident well-being was similar for APDs and PCs (data not presented). Our generalized linear model found that those who were more comfortable dealing with these issues were less likely to desire additional training in common residency issues ($P < .001$), clinical stressors ($P < .001$) and rare reportable stressors ($P = .001$). In addition, after adjusting for level of comfort in supporting resident well-being, program leaders with more frequent exposure to common residency issues ($P = .004$) and clinical stressors ($P = .02$) were more likely to desire additional training in these areas.

Content Analysis

Sixty-six program leaders responded to the open-ended question regarding general comments on their role in supporting resident well-being. Content analysis of the qualitative comments in response to “additional thoughts or feelings you have regarding program [leadership] support of resident well-being” revealed 4 main categories: 1) value of supporting resident well-being, 2) time spent supporting resident well-being is significant, 3) additional training and resources are needed to support resident well-being, and 4) supporting resident well-being affects program leadership.

Program leaders often felt that resident support was “important,” with one APD stating, “I personally feel this is my primary responsibility … this is what I am focused on and make a point of addressing amongst the residents.” However, many also felt that supporting residents was unrecognized and undervalued. A PC stated, “This is one of the most rewarding aspects of my job but not directly measurable so often goes unrecognized.” A PD stated, “[I] hope more program director training in this area could be created and recognition [of] program director well-being and resident well-being both deserve more attention.” An APD stressed the understanding that supporting resident well-being is important and a group effort, but that many lack the skill set to effectively support resident well-being: “Resident wellbeing is essential for residency programs. It is not the sole responsibility of the APD, but a team effort from all in the GME department at our institution. I take the lead because I have the skill set to do so, but when I become the PD in less than a year, I will retain much of this work.” A PC wrote, “GME/national organizations fail to recognize and respond and provide training and support to a role that does provide most of the primary support in terms of well-being to residents. Being more inclusive and acknowledging the equal and vital role coordinators play will better serve residents, coordinators, and programs.”

Program leaders also voiced concerns about the amount of time that supporting residents took. A PD stated, “The time commitment has been the biggest issue. I don’t feel I have adequate time to mentor residents like I should. There is less support for physician/faculty wellness and it seems that mentoring residents in how to maintain their wellness will be very beneficial after they complete residency.” An APD commented, “It is a rewarding part of the job, but there is no real dedicated time to do it. Often residents don’t seek help, but when you pull them aside because you notice they are struggling—it all comes out. Regular check-ins are really helpful at identifying issues early, but very time consuming.” Program leaders also noted that supporting struggling residents was even more time consuming: “It is a common statement that ‘10% of residents take 90% of PD’s time.’ This is frequently true, especially in large programs.”

Program leaders suggested the need for additional training and resources at the institutional and national levels to feel prepared to adequately address resident well-being. Even experienced PDs and PCs thought that specific training to deal with resident well-being is needed. A PD stated, “This is an evolving need, as today’s resident-learner has more outwardly expressed needs and challenges. One of my strengths is counseling, but I greatly desire further formal training in specific responses.” And a PC wrote, “No matter how long you have done it, it is important to always seek more training to stay current. Every day there are new issues.” Specific suggestions included: “more information about confidentiality of the information residents give me, when and how much information to report to PD without breach in confidentiality,” “counseling techniques and in the early recognition of psychological disorders,” and “legal/HR repercussions … am I placing my program or university at risk if I don’t follow a policy correctly?”

Program leaders expressed how they felt that supporting residents was both the most rewarding aspect of their role and the aspect most likely to lead to personal burnout in their program leadership role. A PD stated, “I personally feel optimizing resident well-being is one of the most rewarding and challenging aspects of being a PD; if you aren’t prepared for that being a major part of the role, I suspect that puts the PD at risk of burn-out themselves.” Others felt that “the increasing demand for resident mental health and well-being support is the most challenging aspect of the job and a part of the job that was never described during the interview process. While I very much enjoy the residents and sometimes feel very fulfilled being able to help them, I am not a mental health worker nor am I an expert on counseling on professionalism. This aspect of the job is what will ultimately cause me to leave the position.” Another PD stated that “being supportive for residents has made me emotionally exhausted and burnt out, as well as fitting the description of ‘compassion fatigue.’ I had no idea that it was such a component of my burn out.”

Discussion

There is mounting societal pressure on program leaders to graduate competent physicians who achieve excellence in the quality and safety of the care provided to their patients. There is also growing evidence that current clinical learning environments are associated with high rates of trainee burnout.[23] Program leaders have an obligation to assure not only the competence of our trainees but also their well-being.[23] The present study found that

pediatric program leaders valued their role in supporting resident well-being and spent a significant amount of time responding to resident well-being and support issues. Program leaders frequently manage common residency issues and clinical stressors; not uncommonly, they also manage rare reportable stressors. Program leaders were most comfortable dealing with common residency issues and least comfortable dealing with rare reportable stressors. In addition, program leaders desired additional training in how to support resident well-being.

Specifically, we found that the majority of program leaders spend a significant amount of their role supporting resident well-being (>10% of their time, with a significant minority reporting spending >25%) which is consistent with earlier literature.[15,16] However, despite the high reported prevalence of burn-out and depressive symptoms among residents, and the significant time that program leaders spend supporting resident well-being, only a minority of job descriptions explicitly included support of resident wellbeing. Because the extent of resident support is not commonly described in program leader's job descriptions, evaluation of resident support may not be included in the review and appraisal process for program leaders. In the qualitative comments, program leaders often felt that supporting resident well-being was a "part of the job that was never described during the interview process." Comments by program leadership show that they personally recognize and value their own role in supporting resident well-being, but may feel that others do not appreciate its importance. In addition, they highlight the significant time commitment, additional resources, and training desired to feel competent in supporting resident well-being, as well as the concern that supporting resident well-being may lead to their own burn-out. Including resident well-being and support on program leadership job descriptions may clarify job expectations around supporting resident well-being, promote accountability, and underscore the need for additional training in how to support resident well-being. This gap highlights the need to build a national job description for PDs, APDs, and PCs so that they can get the resources and training they need to be effective in their roles.[24] Explicit recognition of the program leader's role in individual resident support through inclusion of this role in the program leader job expectations and promotion criteria may improve the ability of program leaders to support their residents.

Program leaders who were more comfortable supporting resident well-being were less likely to desire additional training. However, after adjusting for level of comfort in supporting resident well-being, those who had more frequent exposure to common residency issues and clinical stressors were more likely to desire additional training in these areas. It is possible that appreciation for the complexity of dealing with resident well-being issues increases with frequency of dealing with those issues, prompting those with more frequent exposure (but the same level of comfort) to recognize that they needed additional training in these issues. Previous studies of residency program directors found that administrative responsibilities and time pressures contributed to their own job-related stress and burn-out.[25–29] Studies have shown that PD turnover is associated with a lack of formal training in dealing with struggling residents.[26,28] Therefore, provision of best practices, training, and resources around resident well-being and support for program leaders at the institutional and national levels may facilitate meeting the new ACGME common program requirements, improve

resident well-being and support, and improve program leadership job satisfaction and retention.

The present study has several limitations. The overall response rate was only 39% of program leaders, which may limit generalizability. Those who chose to respond to our survey could be those more interested in the subject, which could be a source of response bias. In addition, we had no national data on distribution of APDs and PCs. However, responding PDs were similar to nonrespondents nationally in terms of program size and region. Our surveys were based on self-report and therefore subject to potential recall bias. Finally, cross-sectional surveys are able to determine only associations and not causality.

Conclusion

Program leaders spend a significant amount of time supporting resident well-being. Although they think that supporting resident well-being is an important part of their job, promotion of resident well-being may require investment in the development of program leadership through explicit job descriptions including supporting resident wellness and goal alignment at the institutional and accreditation levels.

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References

1. Wu S, Tyler A, Logsdon T, et al. A quality improvement collaborative to improve the discharge process for hospitalized children. Pediatrics. 2016;138. [PubMed: 27544347]
2. Shanafelt TD, Sloan JA, Habermann TM. The well-being of physicians. Am JMed. 2003;114:513–519. [PubMed: 12727590]
3. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. Health Aff. 2008;27:759–769.
4. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med. 2014;12:573–576. [PubMed: 25384822]
5. Eckleberry-Hunt J, Lick D, Boura J, et al. An exploratory study of resident burnout and wellness. Acad Med. 2009;84:269–277. [PubMed: 19174684]
6. IsHak WW, Lederer S, Mandili C, et al. Burnout during residency training: a literature review. J Grad Med Educ. 2009;1:236–242. [PubMed: 21975985]
7. Ripp J, Fallar R, Babyatsky M, et al. Prevalence of resident burnout at the start of training. Teach Learn Med. 2010;22:172–175. [PubMed: 20563935]
8. Dyrbye LN, West CP, Satele D, et al. BurnoutAmong U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89:443–451. [PubMed: 24448053]
9. Mata DA, Ramos MA, Kim MM, et al. In their own words: an analysis of the experiences of medical interns participating in a prospective cohort study of depression. Acad Med. 2016;91:1244–1250. [PubMed: 27166863]
10. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. JAMA. 2015;314:2373–2383. [PubMed: 26647259]

11. Joules N, Williams DM, Thompson AW. Depression in resident physicians: a systematic review. Open J Depress. 2014;3:89–100.
12. Batra M, Kemper KJ, Serwint JR, et al. Burnout in pediatric residents: a national survey to inform future interventions (platform presentation). Acad Pediatr. 2017;17:e39–e40.
13. Staples BB, Serwint JR, Batra M, et al. Burnout status and milestone performance in pediatric residents (research abstract). Acad Pediatr. 2017;17:e41–e42.
14. Accreditation Council for Graduate Medical Education. Common program requirements section vi with background and intent. 2017 Available at: http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements. Accessed March 15, 2017.
15. Holmes EG, Connolly A, Putnam KT, et al. Taking care of our own: a multispecialty study of resident and program director perspectives on contributors to burnout and potential interventions. Acad Psychiatry. 2016;1–8. [PubMed: 27921265]
16. Locke M, Davis SW. Residency coordinators' social support of residents in family medicine residency programs. FamMed. 2011;43:551–555.
17. Yao DC, Wright SM. National survey of internal medicine residency program directors regarding problem residents. JAMA. 2000;284:1099–1104. [PubMed: 10974688]
18. Dupras DM, Edson RS, Halvorsen AJ, et al. "Problem residents": prevalence, problems and remediation in the era of core competencies. Am JMed. 2012;125:421–425. [PubMed: 22444106]
19. Downing SM. Reliability: on the reproducibility of assessment data. MedEduc. 2004;38:1006–1012.
20. American Association for Public Opinion Research. Final dispositions of case codes and outcome rates for surveys. Revised 2016 Oakbrook Terrace, IL: AAPOR.
21. American Medical Association Fellowship and Residency Electronic Interactive Database. FREIDA online. 2016; Available at: https://amaassn.org/go/freida. Accessed December 27, 2016.
22. Janvier A, Nadeau S, Deschenes M, et al. Moral distress in the neonatal intensive care unit: caregiver's experience. J Perinatol. 2007;27:203–208. [PubMed: 17304208]
23. West CP, Dyrbye LN, Erwin PJ, et al. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet. 2016;388:2272–2281. [PubMed: 27692469]
24. Bing-You RG, Holmboe E, Varaklis K, et al. Is it time for entrustable professional activities for residency program directors? Acad Med. 2017;92:739–742. [PubMed: 28557930]
25. Anderson KD, Mavis BE, Dean RE. Feeling the stress: perceptions of burnout among general surgery program directors. Curr Surg. 2000;57:46–50. [PubMed: 16093027]
26. Beasley BW, Kern DE, Kolodner K. Job turnover and its correlates among residency program directors in internal medicine: a three-year cohort study. Acad Med. 2001;76:1127–1135. [PubMed: 11704516]
27. De Oliveira GS, Almeida MD, Ahmad S, et al. Anesthesiology residency program director burnout. J Clin Anesth. 2011;23:176–182. [PubMed: 21458978]
28. Weiss JC, Doughty RA, Lampe R. The pediatric program director: an analysis of the role and its problems. Am J Dis Child. 1991;145:449–452. [PubMed: 2012030]
29. Barton LL, Friedman AD. Stress and the residency program director. Arch Pediatr Adolesc Med. 1994;148:101–103. [PubMed: 8143000]

What's New

Pediatric program leaders report that supporting resident well-being is an important part of their role and that they spend a significant amount of their time supporting resident well-being. However, program leaders desire additional training in how to support resident well-being.

Table 1.

Percentage of Time That Pediatric Residency Program Leaders Report Devoting to Resident Support and Well-Being in the Past Year

Percentage of Time	Program Directors (n = 76)	Associate Program Directors (n = 142)	Program Coordinators (n = 127)
<10%	21%	39%	29%
10%–24%	59%	44%	36%
25%–49%	17%	14%	17%
≥50%	3%	3%	19%

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Table 2.

Frequency That Pediatric Program Directors Report Dealing With Resident Well-Being and Support Issues

Factor	Issue	Weekly	Several Times per Year	Annually	Once Every Few Years	Never
Common residency issues (α = 0.83)	Compliance concern	2%	44%	24%	23%	8%
	Not meeting clinical expectations	6%	50%	26%	18%	0%
	Family emergency and/or tragedy	2%	65%	24%	8%	2%
	Lapses in professionalism	5%	61%	23%	11%	2%
	Life event stress	2%	86%	9%	2%	2%
	Personal/professional conflicts	18%	68%	9%	5%	0%
Clinical stressors (α = 0.83)	Moral distress; ethical clinical dilemmas	3%	45%	27%	21%	3%
	Physician grief	2%	54%	29%	14%	2%
	Physician burn-out	6%	45%	18%	20%	11%
Rare reportable issues (α = 0.69)	Sexual harassment	0%	0%	8%	36%	56%
	Domestic abuse	0%	5%	2%	32%	62%
	Discrimination (racial, gender, etc)	0%	6%	8%	38%	48%
Other	Significant physical health concern	2%	38%	41%	17%	3%
	Significant mental health concern	2%	48%	27%	18%	5%

α, Cronbach α for each factor after exploratory factor analysis.

Table 3.

Comfort of Pediatric Program Directors in Dealing With Resident Well-Being and Support Issues (n = 76)

		Comfortable Dealing with Issue				
Factor	**Issue**	**Strongly Agree**	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
Common residency issues (α = 0.89)	Compliance concern	47%	38%	12%	3%	0%
	Not meeting clinical expectations	55%	36%	6%	3%	0%
	Family emergency and/or tragedy	56%	35%	6%	3%	0%
	Lapses in professionalism	50%	45%	3%	2%	0%
	Life event stress	53%	39%	6%	2%	0%
	Personal/professional conflicts	55%	41%	3%	2%	0%
Clinical stressors (α = 0.87)	Moral distress; ethical clinical dilemmas	24%	47%	23%	6%	0%
	Physician grief	30%	42%	21%	6%	0%
	Physician burn-out	23%	45%	26%	6%	0%
Rare reportable (α = 0.91)	Sexual harassment	17%	32%	29%	17%	6%
	Domestic abuse	12%	30%	27%	21%	9%
	Discrimination (racial, gender, etc)	18%	29%	29%	18%	6%
Other	Significant physical health concern	55%	38%	8%	0%	0%
	Significant mental health concern	39%	42%	11%	5%	3%

Percentages may not add up to 100% owing to rounding. α, Cronbach α for each factor after exploratory factor analysis.

Table 4.

Pediatric Program Directors' Desired Training in Dealing With Resident Well-Being and Support Issues (n = 76)

		Desire Training				
Factor	**Issue**	**Strongly Agree**	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
Common residency issues (α = 0.93)	Compliance concern	3%	42%	20%	32%	3%
	Not meeting clinical expectations	9%	41%	19%	27%	5%
	Family emergency and/or tragedy	5%	25%	32%	34%	5%
	Lapses in professionalism	6%	44%	25%	21%	3%
	Life event stress	2%	25%	26%	40%	8%
	Personal/professional conflicts	6%	45%	23%	23%	3%
Clinical stressors (α = 0.92)	Moral distress; ethical clinical dilemmas	12%	49%	25%	11%	3%
	Physician grief	12%	51%	20%	14%	3%
	Physician burn-out	18%	52%	15%	11%	3%
Rare reportable (α = 0.95)	Sexual harassment	11%	45%	31%	11%	3%
	Domestic abuse	15%	49%	23%	9%	3%
	Discrimination (racial, gender, etc)	9%	54%	23%	11%	3%
Other	Significant physical health concern	3%	28%	29%	35%	5%
	Significant mental health concern	9%	38%	26%	22%	5%

α, Cronbach α for each factor after exploratory factor analysis.