Original Research

A Nation-Wide Survey of Program Directors at a Large Health Care Organization: Prevalence and Perceptions of Resident Wellness Activities

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Abstract

Background
This study evaluated wellness programs in a large hospital network to determine residency program directors' (PDs) perspectives on their wellness programs' state, including wellness prioritization, frequency of wellness activities, and wellness' influence on decision-making across organizational levels.

Methods
In 2021, 211 PDs were sent surveys on program policies, program implementation frequency, perceptions of the administration's ability to prioritize wellness, funding sources, and perceptions of resident wellness' impact on decision-making.

Results
Among 211 contacted programs, 148 surveys were completed (70.1%). The majority reported having wellness programs, committees, and funding. Fewer than 25% reported having a chief wellness officer. PDs perceived that fellow colleagues in their institution linked wellness to markers of institutional success to a greater extent than other available options (ie, Accreditation Council for Graduate Medical Education [ACGME] requirements, budgetary concerns, resident input, core faculty priorities, and education quality). Financial well-being was perceived as least connected to wellness. Perceptions of wellness were rated across 3 organizational levels: program, institution, and organization. Across all levels, ACGME requirements (31.0%-32.8%) and budgetary/financial concerns (21.9%-37.0%) were perceived as having the most significant influence on overall decision-making, whereas resident wellness was rated lower in influence (8.0%-12.2%). Most programs allowed residents to attend mental health appointments without using paid time off (87.9%) and while on duty (83.1%).

Conclusion
The frequency of wellness activities varied greatly across programs. PDs reported challenges making resident self-care and personal development a priority and perceived resident wellness as having limited importance to decision-making at higher levels.

Keywords
graduate medical education; medical education research; program director; resident wellness; survey; professional burnout; psychological burnout; psychological well-being

Introduction
Resident wellness refers to a combination of physical and mental habits that may reduce mental health issues, improve meaning at work, and contribute to a healthy work-life balance.[1,2] Factors associated with resident wellness include perceptions of autonomy, competence, and social relatedness.[1] According to Shanafelt and colleagues,[2] deficits in these factors are associated with decreased well-

ness, negatively impacting residents, patients, and institutions. Decreased wellness markers are associated with higher hospital expenses[2] and lower patient satisfaction and safety.[3] To promote resident wellness, the Accreditation Council for Graduate Medical Education (ACGME) developed wellness-specific Common Program Requirements (CPR).[4] The ACGME requires that programs show efforts to enhance residents' sense of meaning, educate residents on identifying common mental health conditions (eg, burnout), and adjust resident schedules to reduce work intensity. The current study assessed resident wellness programs in an extensive hospital network to understand the state of resident wellness programs, including the attitudes and beliefs held by program directors (PDs) administering such programs.

Methods

The organization's Institutional Review Board exempted the current study from formal review. Informed consent was obtained from all 148 participants included in the study (ie, PDs, associate program directors [APDs], and program coordinators). The survey was created for the current study in collaboration with the lead physician of the organization's national Graduate Medical Education (GME) wellness committee and researchers from HCA Healthcare.

The survey was programmed into Qualtrics, and an anonymous link was provided to organization administrators. Administrators then distributed the survey to 211 GME PDs. Data collection began on March 25, 2021, and concluded on July 2, 2021. Several reminders were sent out to potential participants via email and telephone throughout the collection. The first reminder was sent 2 weeks before the end of the collection, followed by 1 week before the end of the collection, 48 hours before the end of the collection, and 24 hours before the end of the collection. The survey was closed at the end of the collection window, and the HCA Healthcare research team processed the data.

Measures

The survey measured several aspects of resident wellness, including the frequency of wellness programming, self-care activities, and personal development training. Furthermore, frequency and utilization of evaluations, educational practices surrounding awareness of mental health (both for residents themselves and colleagues), practices for utilizing paid time off (PTO) for health appointments, and measures about perceptions of wellness' influence on decision-making at different institutional levels were investigated. Specific items and their respective response sets are represented in **Table 1**.

Program Components. We measured whether programs implemented wellness committees and the frequency with which training, such as self-care and personal development training, was made available to residents. These items were included based on Section VI.C.1.a of the CPR set forth by ACGME[4] and indications from Stansfield and colleagues[5] that the presence of wellness committees was important to achieving a culture of wellness.

Evaluation of Outcomes. PDs were asked about the frequency with which the wellness programs were assessed, whether such assessments were used to inform decisions within the program, and whether C-suite leadership (eg, Chief Executive Officer [CEO], Chief Medical Officer [CMO], etc) were evaluated based on physician wellness.

Facilitation and Encouragement of Mental Health Access and Treatment. Based in part on ACGME's CPR Section VI.C.1.e,[4] we investigated the extent to which residents in the program were educated on identifying symptoms of burnout, depression, and other common mental health issues in themselves and their colleagues. This set of questions also asked about scheduling constraints, such as the ability to utilize mental health services while on duty or without using PTO.

Funding. Sufficient funding of wellness programs has been tied to their success.[6] In line with this finding, the survey asked participants about funding sources for their wellness programs.

Operational Decision Making. Similar to the approach by Stansfield and colleagues[5] to assessing resident wellness initiatives at various levels, PDs were asked about their perceptions of factors that influence decision-making at 3 different levels of the organization: program, institutional, and organizational.

Table 1. Survey Categories, Items, and Response Sets

Category	Question	Response set	Items
Core Elements	Please indicate whether your program has any of the following:	Yes; No, but this existed before COVID-19; No; Unsure	A formal wellness committee; A wellness program specifically focused on resident physicians; A chief wellness officer (CWO); Dedicated funding for resident wellness initiatives
Programming Frequency	In a given year, how frequently does your wellness program organize the following events specifically to impact resident wellness?	Never; Once annually; Every 6 months; Every 3 months; Once per month; More than once per month; Unsure	Offsite social events; Onsite social events; Virtual social events (eg, on Zoom); Peer support programs
Self-Care Trainings	In a given year, how frequently does your wellness program offer resident trainings in the following self-care practices specifically to impact resident wellness?	Never; Once annually; Every 6 months; Every 3 months; Once per month; More than once per month; Unsure	Mindfulness; Sleep hygiene; Healthy nutrition; Physical activity; Other (please describe the self-care practice)
Personal Development Trainings	In a given year, how frequently does your program offer residents trainings in the following personal development categories specifically to impact resident wellness?	Never; Once annually; Every 6 months; Every 3 months; Once per month; More than once per month; Unsure	Individual resiliency skills; Leadership development training; Overcoming barriers to flourishing; Teaching daily habits to foster positive mental health; Enhancing meaningful work; Enhancing professional relationships; Education on non-work-related stressors
Evaluation of Resident-Wellness-Related Outcomes			
Frequency of Evaluation	In a given year, how frequently are the following evaluated?	Never; Once annually; Every 6 months; Every 3 months; Once per month; More than once per month; Unsure	Resident satisfaction; Quality of patient care; Quality of education; Burnout; Depression; Substance use; Suicidal ideation
Utilization of Evaluations	To your knowledge, have hospital operational decisions specific to resident wellness ever been made as a result of resident wellness evaluations?	Yes; No; Unsure	Single-item question
Utilization of Evaluations	To your knowledge, have rotation-level interventions ever been designed based on resident wellness evaluations?	Yes; No; Unsure	Single-item question
Wellness as a Performance Metric	Physician wellness is evaluated as a performance metric for any of the members of the C-suite (eg, CEO, CMO, etc.)	Yes, currently; No, but it was before COVID-19; No; Unsure	Single-item question

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes the sections, items, and response sets of current collection.

Table 1. Survey Categories, Items, and Response Sets (Continued)

Category	Question	Response set	Items
Facilitation and Encouragement of Mental Health Access and Treatment			
Screening Education for Residents (Self)	Does your wellness program educate residents to identify the following in themselves?	Yes, currently; No, but it was before COVID-19; No; Unsure	Symptoms of burnout; Symptoms of anxiety; Symptoms of depression; Self-harm, Suicidal ideation; Symptoms of substance use
Screening Education for Residents (Colleagues)	Does your wellness program educate residents to identify the following in colleagues?	Yes, currently; No, but it was before COVID-19; No; Unsure	Symptoms of burnout; Symptoms of anxiety; Symptoms of depression; Symptoms of substance use; Self-harm; Suicidal ideation
Mental Health Communications (Self)	For each of the following, please let us know the extent to which each communication mode is used to encourage residents to seek mental health assistance.	On a scale from 0 to 100	Email correspondence; Resident didactics; On-campus printed material; Social media; Automatic screensaver messages; Other (please describe)
Mental Health Communications (Colleagues)	For each of the following, please let us know the extent to which each communication mode is used to encourage residents to identify issues that their colleagues may be facing.	On a scale from 0 to 100	Email correspondence; Resident didactics; On-campus printed material; Social media; Automatic screensaver messages; Other (please describe)
Resident Mental Health Appointments	Are residents required to use paid time off to attend mental health appointments?	Yes; No, but they did before COVID-19; No; Unsure	Single-item question
Resident Mental Health Appointments	Are residents allowed to attend mental health appointments while they are on duty (ie, can residents take time out during a day that they are working in the hospital to attend appointments)?	Yes; No, but they did before COVID-19; No; Unsure	Single-item question
Resident Mental Health Appointments	To your knowledge, does your program take an opt-in (therapy appointments are not automatically scheduled) or an opt-out (therapy appointments are automatically scheduled) approach?	Opt-in; Opt-out; Unsure	Single-item question
Sources of Funding			
Funding Sources	Roughly what percentage of overall resident wellness funding comes from each of the following:	On a scale of 0 to 100 where the sum of percentages across the categories must total 100%	Funding from the larger organization; Grant funding; Donations; Other (please describe)

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes the sections, items, and response sets of current collection.

Table 1. Survey Categories, Items, and Response Sets (Continued)

Category	Question	Response set	Items
Operational Decision Making			
Operational Decision-Making (Program-Level)	To what extent do the following influence hospital operational decision making at the program level?	On a scale of 0 to 100 where the sum of percentages across the categories must total 100%	ACGME requirements; Budgetary concerns; Core faculty priorities; Resident wellness; Education quality; Resident input; Mission-congruent operation
Operational Decision-Making (Institutional-Level)	To what extent do the following influence organizational decision making at the institutional level?	On a scale of 0 to 100 where the sum of percentages across the categories must total 100%	ACGME requirements; Resident wellness; Budgetary concerns; Resident input; Core faculty priorities; Education quality
Operational Decision-Making (Organization-Level)	To what extent do the following influence organizational decision making (at the organization) in general?	On a scale of 0 to 100 where the sum of percentages across the categories must total 100%	Quality of programs; Resident wellness; Finances; Resident input; Medical staff wellness; ACGME requirements; Responsibility to shareholders
Wellness Program Priorities	Please indicate how your wellness prioritizes the following specifically to impact resident wellness:	On a scale from 0 to 100	Changing the learning environment; Self-care practices; Social gatherings; Personal development; Leadership development; Meaning at work; Increasing the time residents spend with patients; Minimizing nonphysician obligations for residents; Taking specific steps to limit work compression; Reviewing expectations of resident workload; Adjusting resident schedules; Resident satisfaction; Quality of patient care; Quality of education
Perceived Impact of Wellness			
Perceived Impact of Wellness	To your knowledge, what impact does your institution view resident wellness has on the following?	On a scale from 0 to 100	Patient satisfaction; Patient safety; Patient care outcomes; Financial well-being of the sponsoring institution

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes the sections, items, and response sets of current collection.

Perceived Impact of Wellness. In the final section, participants were asked to indicate the perceived impact of wellness on several factors, responding on a scale from 0 to 100. These included the perceived impact of wellness on patient safety, care outcomes, and the financial well-being of the sponsoring institution. The literature indicates that these factors are improved by wellness programming.[3] **Table 1** shows the complete list of items and response sets used in the current study.

The components of the survey were selected based on previous literature on resident wellness,[3] evaluations of wellness programs,[5-7] and requirements for wellness based on the CPR set forth by ACGME.[4] Items were adapted from a survey developed by the lead physician of the organization's national GME wellness committee. The input of this key stakeholder allowed the study to address the organization's specific resident wellness components. Rather than selecting wellness components from the broader literature, adapting measures of known, extant measures of wellness components specific to the evaluated organization allowed for a more sensitive measurement of programming adherence for this organization. In collaboration with the wellness champions of the organization, several meetings were held to select the items to be used in the final survey.

Participants/Data Screening

An administrator of the organization contacted all eligible programs across the hospital network to participate in the study. Programs that belonged to the hospital network and had residents actively enrolled were eligible to participate. Podiatry programs were excluded. Among the 211 programs contacted, respondents from 148 programs completed the majority of the survey (≥95%), providing us with a response rate of 70.1%. After screening the data, frequency and descriptive statistics were examined using SPSS Version 25 (IBM Corp., Armonk, NY).

Results

Most respondents identified their role as PD (81.1%, n = 120), though others identified as APDs or program coordinators. Respondents represented 13 different states across the United States (California, Nevada, Idaho, Colorado, Texas, Kansas, Louisiana, Florida, Georgia, South Carolina, North Carolina, Virginia, and New Hampshire) and 21 residency specialties (please see **Table 2** for a complete list of specialties).

Programming Components

Overall, a majority of programs reported having a wellness committee (66.9%, n = 99), a wellness program (78.4%, n = 116), and dedicated funding for wellness (64.9%, n = 96); about 1 in 4 (23.6%, n = 35) programs reported having a Chief Wellness Officer (CWO). **Table 3** lists all frequency values for wellness programming components.

As indicated in **Table 4**, the most common events hosted by wellness programs were offsite and onsite social events held every 3 or 6 months.

Table 2. Specialty of Responding Program Directors

Specialty	% (n)
Internal Medicine	19.6% (29)
Family Medicine	17.6% (26)
Surgery	12.2% (18)
Emergency Medicine	10.1% (15)
Transitional Year	10.1% (15)
Psychiatry	6.1% (9)
Obstetrics and Gynecology	5.4% (8)
Cardiovascular Disease	3.4% (5)
Anesthesiology	2.7% (4)
Neurology	2.7% (4)
Radiology	2.0% (3)
Osteopathic Neuromusculoskeletal Medicine	1.4% (2)
Sports Medicine	1.4% (2)
Dermatology	0.7% (1)
Gastroenterology	0.7% (1)
Hospice and Palliative Medicine	0.7% (1)
Pathology	0.7% (1)
Pediatrics	0.7% (1)
Physical Medicine and Rehabilitation	0.7% (1)
Pulmonary Disease and Critical Care Medicine	0.7% (1)
Surgical Critical Care	0.7% (1)

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes the specialties represented in this collection.

Table 3. Presence of Core Wellness Components

	Yes	No, but this was in place before COVID-19	Unsure	No
	% (n)	% (n)	% (n)	% (n)
Wellness committee	66.9% (99)	4.1% (6)	1.4% (2)	27.7% (41)
Wellness program	78.4% (116)	2.0% (3)	2.7% (4)	16.9% (25)
Chief Wellness Officer	23.6% (35)	0.7% (1)	12.2% (18)	63.5% (94)
Dedicated wellness funding	64.9% (96)	3.4% (5)	10.1% (15)	21.6% (32)

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes the presence of each component at program directors' residency programs.

Evaluation of Resident Wellness-Related Outcomes

Respondents indicated how often various evaluations occur (**Table 5**). When asked whether evaluations of resident wellness had ever led to specific hospital operational decisions that impacted wellness, 73.0% (n = 108) indicated that this had not happened or were unsure.

In the survey, PDs also indicated whether physician wellness was evaluated as a performance metric for C-suite members (eg, CEOs, CMOs, etc). Most participants (53.4%, n = 79) were

Table 4. Event/Training Type and Frequency

	More than once per month	Once per month	Every 3 months	Every 6 months	Once annually	Unsure	Never
Social Events	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Offsite social events	2.0% (3)	6.8% (10)	29.7% (44)	31.8% (47)	16.9% (25)	6.1% (9)	6.8% (10)
Onsite social events	3.4% (5)	9.5% (14)	23.0% (34)	31.1% (46)	14.2% (21)	6.8% (10)	12.2% (18)
Virtual social events	0.7% (1)	3.4% (5)	8.8% (13)	10.8% (16)	11.5% (17)	21.6% (32)	43.2% (64)
Peer support programs	6.1% (9)	18.2% (27)	12.2% (18)	11.5% (17)	6.1% (9)	27.7% (41)	18.2% (27)
Self-Care Trainings							
Mindfulness	1.4% (2)	4.1% (6)	12.2% (18)	14.2% (21)	46.6% (69)	11.5% (17)	10.1% (15)
Sleep hygiene	0.0% (0)	2.0% (3)	6.1% (9)	10.1% (15)	60.1% (89)	10.8% (16)	10.8% (16)
Nutrition	0.7% (1)	2.7% (4)	8.1% (12)	10.8% (16)	39.2% (58)	12.2% (18)	26.4% (39)
Physical activity	2.7% (4)	3.4% (5)	10.8% (16)	14.2% (21)	33.1% (49)	12.2% (18)	23.6% (35)
Personal Development							
Resiliency skills	1.4% (2)	2.7% (4)	6.1% (9)	18.2% (27)	36.5% (54)	14.2% (21)	20.9% (31)
Leadership development	0.0% (0)	0.7% (1)	6.8% (10)	18.9% (28)	39.2% (58)	13.5% (20)	20.9% (31)
Overcoming barriers to flourishing	0.7% (1)	2.7% (4)	3.4% (5)	9.5% (14)	34.5% (51)	15.5% (23)	33.8% (50)
Daily habits to promote mental health	2.7% (4)	3.4% (5)	6.8% (10)	16.9% (25)	31.8% (47)	14.9% (22)	23.6% (35)
Enhancing meaningful work	3.4% (5)	3.4% (5)	7.4% (11)	14.9% (22)	26.4% (39)	18.9% (28)	25.7% (38)
Enhancing professional relationships	2.0% (3)	4.7% (7)	10.1% (15)	18.9% (28)	25.0% (37)	17.6% (26)	21.6% (32)
Education on outside stressors	2.0% (3)	0.7% (1)	8.1% (12)	16.2% (24)	31.8% (47)	15.5% (23)	25.7% (38)

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes the frequency of each resource provided to residents.

Table 5. Evaluation Frequency

	More than once per month	Once per month	Every 3 months	Every 6 months	Once annually	Unsure	Never
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Resident satisfaction	4.1% (6)	8.1% (12)	17.6% (26)	36.5% (54)	29.7% (44)	2.0% (3)	2.0% (3)
Quality of patient care	14.9% (22)	22.3% (33)	12.8% (19)	29.1% (43)	15.5% (23)	4.7% (7)	0.7% (1)
Quality of education	8.8% (13)	12.2% (18)	15.5% (23)	39.2% (58)	21.6% (32)	2.7% (4)	0.0% (0)
Burnout	4.1% (6)	7.4% (11)	11.5% (17)	33.8% (50)	22.3% (33)	10.8% (16)	10.1% (15)
Depression	3.4% (5)	6.1% (9)	12.2% (18)	28.4% (42)	19.6% (29)	14.2% (21)	16.2% (24)
Substance use	4.1% (6)	2.7% (4)	10.8% (16)	25.7% (38)	17.6% (26)	18.2% (27)	20.9% (31)
Suicidal ideation	3.4% (5)	4.1% (6)	10.1% (15)	23.6% (35)	18.2% (27)	18.9% (28)	21.6% (32)

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes frequency with which residents were evaluated for each of the above categories.

unsure. About one-fifth of those remaining said that wellness was evaluated for this purpose (8.8%, n = 13) or that it had been before COVID-19 (0.7%, n = 1).

Facilitation and Encouragement of Mental Health Access and Treatment

Participants reported whether their program provided self-screening education to residents for mental health issues and indicated if residents were educated in identifying mental health symptoms in their colleagues (**Table 6**). The mode of communication used to encourage residents to seek mental health assistance was also assessed, as was how residents were encouraged to identify issues their colleagues may be facing. Participants reported that the organization encouraged residents through resident didactics (ie, direct classroom teaching) for both themselves (42.8%) and their colleagues (48.7%), followed by messages sent via email correspondence for both themselves (31.7%) and colleagues (29.7%). These 2 comprised nearly three-quarters of the com-

Table 6. Education on Mental Health Access and Treatment

	Yes	No, but this was in place before COVID-19	Unsure	No
Self	% (n)	% (n)	% (n)	% (n)
Burnout	84.5% (125)	3.4% (5)	4.1% (6)	8.1% (12)
Depression	78.4% (116)	3.4% (5)	6.1% (9)	12.2% (18)
Substance use	73.0% (108)	3.4% (5)	10.8% (16)	12.8% (19)
Anxiety	70.3% (104)	2.0% (3)	6.8% (10)	20.9% (31)
Suicidal ideation	66.2% (98)	4.1% (6)	12.2% (18)	17.6% (26)
Self-harm	60.8% (90)	4.1% (6)	12.8% (19)	22.3% (33)
Colleagues				
Burnout	82.3% (122)	3.4% (5)	5.4% (8)	8.8% (13)
Depression	72.8% (108)	4.8% (7)	10.2% (15)	12.2% (18)
Substance use	72.8% (108)	4.8% (7)	10.9% (16)	11.6% (17)
Anxiety	66.2% (98)	3.4% (5)	11.5% (17)	18.9% (28)
Suicidal ideation	64.6% (96)	3.4% (5)	15.0% (22)	17.0% (25)
Self-harm	56.5% (84)	3.4% (5)	17.0% (25)	23.1% (34)

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes presence of education to identify the following in themselves and in colleagues.

Table 7. Description of Proportion of Program and Institution-Level Decision-Making

Level	ACGME requirements	Budgetary concerns	Resident wellness	Input from residents	Quality of programs/ Education	Core faculty priorities	Mission-congruent operation
Program	32.8%	21.9%	12.2%	12.6%	11.8%	6.1%	2.6%
Institution	31.0%	31.0%	11.4%	8.6%	7.4%	3.9%	6.6%
	ACGME requirements	**Budgetary concerns**	**Resident wellness**	**Input from residents**	**Quality of programs**	**Medical staff wellness**	**Responsibility to shareholders**
Organization	32.2%	37.0%	8.0%	6.1%	7.5%	3.1%	6.1%

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes perceived weight of above items in decision-making at different organizational levels.

munication (74.5%), and in the case of mental health communications about colleagues, these accounted for 78.4%. Printed materials ($9.8\%_{Self}$, $7.2\%_{Colleague}$), social media messages ($3.5\%_{Self}$, $3.8\%_{Colleague}$), and screen saver messages accounted for less self and colleague identification, respectively ($1.8\%_{Self}$, $1.0\%_{Colleague}$). Other modes of communication for encouraging residents to seek mental health assistance included one-on-one communication (31.6%), scheduled meetings (22.2%), mentorship/faculty meetings (11.1%), text messaging (5.6%), and therapy (2.8%). In comparison, 22.2% included a response that was not categorizable or left the field blank. Other means of communication reported to encourage colleagues to seek care included one-on-one communication (51.9%), orientations and forums (14.8%), mentorship (7.4%), and miscellaneous responses (7.4%). Likewise, 18.5% of participants provided a response that was not categorizable.

Participants also indicated whether residents must use PTO to access mental health services. Most respondents indicated that they did not require their residents to use PTO to attend these appointments, with 67.6% (n = 100) indicating that residents were not required to use PTO and 12.2% (n = 18) requiring PTO to attend appointments. The remaining 20.3% (n = 30) of respondents were unsure. A related measure asked participants whether residents could participate in mental health appointments while on duty. Among responding PDs, 83.1% (n = 123) affirmed that residents could attend such appointments while they were on duty, with the remainder indicating this was not permitted (9.5%, n = 14) or that they were unsure (7.4%, n = 11).

Regarding programs scheduling appointments for residents, more than half of the PDs reported that their program takes an opt-in approach (60.8%, n = 90), meaning that therapy appointments were not automatically scheduled for residents. Among those remaining, 8.1% (n = 12) reported an opt-out approach to scheduling therapy appointments, indicating that appointments were automatically scheduled for residents. About one-third of PDs (31.1%, n = 46) were unsure of what approach was taken.

Sources of Funding

Participants described the funding sources reported for their wellness programs. The majority of funding (71.9%) came from the larger organization directly; however, there were additional sources of funding, including donations (6.5%), grants (4.1%), and other sources (17.5%). These other sources included faculty contributions (44.4%), foundation or department funding (16.7%), or miscellaneous sources (5.6%). Some indicated no funding was provided (8.3%) or were unsure (25.0%).

Operational Decision-Making

PDs indicated their perceptions of factors influencing decision-making at 3 levels: program, institutional, and organizational. This was done to understand how influences are perceived to change at different levels of the organization. **Table 7** provides comparisons of the factors that influence operational decision-making at these 3 levels. These questions allowed participants to indicate the proportion of influence that each factor contributed to decision-making at each level, such that the sum across factors at each level totaled 100%.

Table 8. Average Level of Program Priorities

	Level of priority **0 [Unable to prioritize at all] – 100 [Highest priority]**
Quality of education	84
Quality of care	78
Resident satisfaction	74
Adjusting resident schedules	72
Reviewing workload expectations	66
Changes to the learning environment	65
Social gatherings	60
Minimizing non-physician obligations	60
Limiting work compression	57
Leadership development	50
Time spent with patients	50
Personal development	49
Promoting meaningful work	46
Self-care practices	45

Note: 148 program directors responded to a national, digital survey in spring/summer of 2021. Table describes perceived priority placed on different aspects of resident training.

In addition to perceived factors that influence operational decision-making at different levels, participants indicated the extent to which their wellness program prioritized 14 aspects of program priorities related to resident wellness by assigning each a score out of 100 (**Table 8**).

Perceived Impact of Wellness

PDs perceived that their institutions linked resident wellness to all outcomes to some extent. Patient care outcomes and patient safety were valued at 52/100, patient satisfaction was 48/100, and the institution's financial well-being was rated as 43/100.

Discussion

The responses gathered in the current study indicated that these wellness programs are largely comparable with those described in the existing literature; however, these responses also indicated considerable variance between programs in the wellness programming offered to residents.

Comparison to Existing Literature

There are several ways in which the current data indicated that the sites surveyed compare favorably to the literature on resident wellness programming. In the current investigation, roughly 4 out of 5 respondents (ie, 78.4%, n = 116) reported currently having a wellness program. Meanwhile, other multi-site studies have reported between 45% (n = 25)[8] to 92% (n = 42).[9] Direct comparisons to other programs are difficult due to the limited amount of data available; however, the reported availability of wellness programs indicated in the current survey falls near the higher of these 2 previous findings. Furthermore, more than half (66.9%; n = 99) of the PDs reported having dedicated wellness committees. Based on the literature surrounding wellness committees,[5,6,10-15] having a committee to advocate for resident wellness is essential to the success of efforts to improve well-being. The fact that most programs surveyed had a wellness committee should be a positive development for resident well-being. Although 24% of respondents indicated that they had a CWO, we assume this was in reference to a program champion rather than someone specifically in the C-suite, as organization records indicate fewer CWOs than these data indicate. Furthermore, over 60% of PDs indicated their sites offered at least annual self-care training to residents on topics ranging from physical activity (64.2%) to mindfulness (78.5%). The rates observed in this organization are much higher than research indicating rates of 15%[7] or 14.3% for program elements such as "mental wellness activities."[8] Moreover, although some respondents indicated that their residents did

not receive mental health education training, all residents are indeed required to complete wellness programming specifically on these topics (eg, burnout, depression, anxiety, etc; **Table 6**). This likely represents a misunderstanding between what the residents are provided by faculty and the larger hospital network, and the respondents' knowledge.

It is essential to understand that exact comparisons are only possible at some levels of the current study. Based on comparisons to other investigations by programming presence and frequency metrics, the PDs from the organization surveyed appear to be providing wellness programming at a level comparable to that observed in other investigations and, in many cases, broader and more frequently. However, despite this organization's high frequency of wellness programming, our findings also revealed perceptions that may negatively impact such programming.

Prioritization of Resident Wellness

Given that the programs administered at sites within this hospital network appear to compare favorably on several aspects, we were surprised by the number of PDs who indicated an inability to prioritize resident wellness. Furthermore, many perceived resident wellness as not a top priority for the broader organization. Self-care (mean [M] = 45), promoting meaningful work (M = 46), and personal development (M = 49) received among the lowest scores (**Table 1**). Similarly, when PDs responded about their perceptions of the extent to which their institution believes resident wellness has an impact on patient and financial outcomes on a scale from "0" (no impact) to "100" (large impact), the results indicated limited confidence that their institution perceived a relationship between wellness and the financial well-being of the institution (M = 43), patient satisfaction (M = 48), patient safety (M = 52), and patient care outcomes (M = 52). Among PDs who were asked whether evaluations of resident wellness had ever led to specific hospital operational decisions to impact wellness, 73.0% (n = 108) of the PDs indicated that this had not happened or that they were unsure. In comparison, the remaining 27.0% (n = 40) indicated that operational decisions specific to resident wellness had been made based on wellness evaluations. When PDs were asked whether wellness was evaluated as a performance metric for members of the C-suite (eg, CEOs, CMOs, etc), 9.5% (n = 14) reported that such was the case. Altogether, these data indicated a discrepancy between the actions being taken (eg, 80.4% having wellness programs; n = 119) and PD's belief that resident wellness is a top priority for hospital administration. Simply, PDs did not perceive that the institution values resident wellness.

Future Directions and Recommendations

The current data lead us to recommend 3 complementary streams of inquiry. First, although 66.9% (n = 99) of respondents reported the presence of a wellness committee and 78.4% (n = 116) reported having a wellness program, numerous sites did not have wellness committees or programs. Likewise, although self-care training to improve resident wellness was prevalent (eg, 64.2%, n = 95 offered self-care-focused physical activity training, while 78.5%, n = 116 offered mindfulness training), numerous sites did not engage in such practices. These practices are beneficial to resident well-being.[9] As most institutions likely have variance regarding the extent to which PDs are implementing programs, future research should investigate factors that predict the presence or absence of wellness program components. For example, programs that offer robust wellness programming can be compared to programs with fewer wellness program components. Differences in responses can provide a path of positive change.

Beyond investigating differences between programs that, for example, have a wellness program and those that do not, we recommend hospitals investigate the extent to which their PDs cannot prioritize certain aspects of resident wellness. We also recommend inquiring into why this is the case, what differentiates the PDs who can prioritize resident wellness from those who cannot, and what PDs perceive would be the most effective strategies for increasing their ability to prioritize aspects of wellness, such as self-care. The data from this study suggest that some PDs did not perceive their institution or organization as prioritizing resident wellness. Future studies should investigate whether this finding is generalizable. If similar patterns are found at other institutions,

we recommend obtaining a deeper understanding of PD perceptions regarding the importance that facility administrators may place on resident wellness. As perceptions are likely to influence PD behavior, steps should be taken to understand why PDs have such impressions, what differentiates those who have such perceptions from those who do not, and the association between holding such perceptions and actions regarding resident wellness. Faculty administration (ie, C-suite leadership at the institutional level) could be surveyed to assess why such perceptions exist among PDs and to illuminate potential communication barriers. Additionally, while the current study surveyed primarily PDs, future studies may benefit from collecting mainly from those in other organizational roles related to wellness programming (eg, APDs, program coordinators, etc).

A strength of the current investigation is the 70.1% response rate. Benchmarks of acceptable response rates can greatly vary,[16] but a 70% response rate is typically considered above the bar[17,18] and has been considered very high.[19] Moreover, our 70.1% response rate can be considered relative to studies conducted with similar goals. For example, Tran and colleagues surveyed 111 PDs to assess residency-based wellness initiatives in ophthalmic GME programs, with a response rate of 50%.[8] As higher response rates can vastly reduce the likelihood of response bias and increase the reliability of the data,[20] our 70.1% response rate allows us to have greater confidence in our results than we would have otherwise.

Finally, we advocate for using measures indicating the frequency of programming over the presence of programming. In our investigation, it became clear that there was considerable variance between programs in the frequency with which wellness programming was offered in the same hospital network. This difference would not have been captured with binary indicators of wellness programming and may provide a greater understanding of the relative differences in resident well-being between programs.

Conclusion

The current study investigated PDs in various hospitals across a large health care organization. Although there were differences between programs, the prevalence and frequency of wellness activities are consistent with or exceed those reported in prior studies. Nonetheless, PDs report being unable to prioritize resident self-care and personal development and report perceiving resident wellness as being of limited importance to facility administration. Overall, the results of this study indicate that PDs approach wellness and ACGME's CPR in many different ways. This can be seen by the variation between sites in the type of programming they offer residents and the frequency with which they provide such programming. While there is no single way to address resident wellness, much of the literature supports certain beneficial program aspects that are not currently in use across all sites surveyed (eg, dedicated wellness committees).[9] As such, other multi-site organizations could benefit from conducting similar inquiries to determine if the pattern of responses indicated in the current study is generalizable to their institutions. If so, investigations into why PDs perceive that they cannot prioritize resident self-care and why the administration is perceived to place limited weight on resident wellness could offer a fruitful path for guiding positive change.

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Conflicts of Interest

The authors declare they have no conflicts of interest.

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