Original Research

A Qualitative Follow-Up to a Survey of Program Directors on Wellness Programming at a Large Healthcare Organization: Interviews of High- and Low-Exemplar Programs

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Abstract

Background
The current research used a qualitative approach to understand which factors facilitate and hinder wellness programming in residency programs.

Methods
Program directors identified from a previous quantitative study as having residency programs with notably more or less resident wellness programming than others (ie, high- and low-exemplars, respectively) were contacted. In total, semi-structured interviews were conducted over Zoom with 7 low-exemplars and 9 high-exemplars.

Results
The results of this qualitative examination suggest common themes across the 2 exemplar groups, such as wanting more resources for resident wellness with fewer barriers to implementation, viewing wellness as purpose-driven, and seeing wellness as a shared responsibility. There were also critical distinctions between the exemplar groups. Those high in wellness programming expressed more of an emphasis on connections among residents in the program and between the faculty and residents. In contrast, those low in wellness programming described more barriers, such as staffing problems (ie, turnover and lack of faculty wellness) and a lack of integration between the varying levels involved in graduate medical education (GME) operations (ie, between GME programs and sponsoring hospitals, and between GME facilities and the larger health care organization).

Conclusion
This study provides insight into program directors' experiences with wellness programming at a large health care organization. The results could point to potential next steps for investigating how the medical education community can improve resident wellness programming.

Keywords
psychological well-being; psychological wellness; qualitative research; exemplars; interviews as topic; wellness programs; graduate medical education; internship and residency

Introduction
This qualitative examination explored factors influencing the implementation of resident wellness programming. Well-being is associated with many positive outcomes for residents,[1] and its absence may have detrimental consequences for both residents and their institutions.[2] Acknowledging the need for wellness promotion within residency programs, the Accreditation Council for Graduate Medical Ed-

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ucation (ACGME) created Common Program Requirements to ensure programs demonstrate their commitment to resident well-being, both to mitigate mental health concerns, such as burnout or depression, and to promote a greater sense of meaning in work.[3] There is no single definition of wellness programming, predominantly due to the varied conceptualization of physician wellness. Physician wellness is frequently described as emotional health, physical health, spiritual health, absence of distress, work or life satisfaction, or a combination of these constructs.[4] For this study, we use the term "wellness programming" to encompass the various programs and activities deployed to improve physician wellness.

Although ACGME requires wellness programming, the frequency of content can vary drastically across programs. O'Brien and Carr[5] stated that fewer than 15% of the programs they surveyed provided mental wellness or physical activities to their residents, while Tran and colleagues[6] found that 45% of program directors (PDs) said they had a formal wellness program aimed at resident mental health. Moreover, Penwell-Waines and colleagues[7] reported that 93% of the programs surveyed offered curricular activities promoting mindfulness and resilience.

Marshburn and colleagues[8] recently surveyed PDs from a large, national health care organization to determine the frequency of wellness activities within residency programs, exploring the PDs' perceptions of the relationship between wellness and other outcomes (eg, patient safety) as well as its importance in relation to other priorities (eg, budgetary concerns). The data from this survey showed that 80.4% of PDs indicated the presence of wellness programming at their site overall. However, they also found major differences between sites in the rates at which wellness activities were offered. For example, though most programs surveyed indicated that peer support programming was offered at least annually (54.1%), only 24.3% offered such programming monthly or more frequently. Similarly, 78.5% of the programs provided training on mindfulness practices at least annually, while only 16.3% offered it at least once a month or more. To complement Marshburn and colleagues' findings,[8] we explored this variation in the frequency of wellness programming across residency programs from their study through interviews with high- and low-PD exemplars to better understand perceived facilitators and barriers in implementing resident wellness activities.

The current study seeks insight into the observed variability in wellness programming provided across residency programs within a large health care organization, as discovered in a previous quantitative examination by Marshburn and colleagues.[8] We aim to further understand what hinders some programs from providing wellness activities and what enables others.

Methods

Design

We utilized a mixed-method explanatory sequential approach (ie, a qualitative follow-up, which furthers insight into results from a quantitative study)[9] to explore the quantitative findings of Marshburn and colleagues[8] using semi-structured interviews. This approach has been used in the context of graduate medical education[10] and related fields, such as clinical nursing,[11] resident physician communication and collaboration competencies,[12] and continuing medical education.[13]

Marshburn and colleagues[8] provided a quantitative basis for identifying high- and low-exemplar cases (ie, those who provided large or small amounts of wellness activities compared to their peers within the large health care organization). The current study used data from their study to determine which exemplars should be contacted for interviews. The use of exemplar cases in qualitative medical research is not uncommon and has been used to examine organizational factors that influence performance at high and low ends.[14,15]

Participants and Procedures

The Institutional Review Board of the large health care organization deemed this study exempt. The interviews and analyses were conducted by members of a research team at Claremont Graduate University (CGU). The CGU research team often collaborates on studies with the health care organization and is well-versed in the field of resident wellness, the current study's purpose, the data from Marshburn and colleagues,[8] and interviewing practices.

Interviews were semi-structured,[16] which is common in qualitative health research.[17-19] The interview guide was developed in a collaborative, iterative process between CGU researchers and the health care organization to ensure questions used terms that interviewees would be familiar with, there was a shared understanding of the meaning of the questions, and that questions were designed to elicit responses that could explain the discrepancies found in the quantitative study from which the exemplar cases were drawn.[8] The final interview guide (see **Appendix 1**) covered topics including the PDs' roles in resident wellness, the importance of resident wellness, the causal impact of resident wellness on the hospital, motivation and logistics related to resident wellness, and how the hospital organization prioritizes resident wellness. There were also optional questions at the end (if time permitted) that asked PDs how they believed their wellness programming compared to other residency programs and the impact of COVID-19 on their wellness activities.

Using data from Marshburn and colleagues' study,[8] the potential candidate list was produced based on each program's status in relation to the average frequency of wellness-related activities reported across the health care organization. Participants with residency programs who scored at least 0.75 standard deviations above or below the average level of wellness-related program activities were selected as potential interviewees. This cutoff was selected instead of 1 standard deviation above or below the mea since it provided an adequate number of high and low exemplars to contact, anticipating that some exemplars may decline to be interviewed. PDs from 9 exemplar programs with more wellness programming and 7 exemplar programs with less wellness programming were interviewed (40% response rate); all were unaware of their exemplar status. Interviews were conducted between January 28, 2022, and March 1, 2022, via Zoom, which is often preferred over phone or face-to-face formats.[20] Interviews lasted approximately 1 hour and were recorded.

Analysis

The interviews were recorded on Zoom, transcribed using Otter.ai software, and checked for accuracy by 2 research team members. One interview was not recorded at the interviewee's request. In this case, we relied on detailed notes taken by 2 team members during the interview. These notes were compared for alignment. Once all transcripts and notes were reviewed, an inductive thematic analysis was conducted.

In line with previous qualitative examinations within the medical context,[18,21-23] Braun and Clarke's[24,25] recommendations were used to guide the approach. Two research team members reviewed each interview and took notes to familiarize themselves with the data. After initial code creation, they engaged in collaborative coding, utilizing the words or phrases in the quote to generate more profound insight into the data and group codes into themes and subthemes.[25] Representative quotes were then selected to help illustrate each theme. Throughout the data analysis process, the researchers reflected on codes and themes, often revisiting the original transcripts to ensure the generated findings effectively captured the data.

Results

Although the primary purpose of this qualitative study was to help understand the variance in frequency of wellness programming seen in Marshburn and colleagues' data,[8] there was a surprising amount of overlap in themes identified across high- and low-exemplar groups. We will discuss these overall themes before moving on to themes specific to each exemplar group.

Overall Themes and Sub-Themes

We extracted 3 overall themes: a desire for more resources for wellness programming with less resistance, a purpose-driven view of resident wellness, and the consideration that wellness is a shared responsibility. The results and discussion will focus on the overall theme we deemed most actionable (ie, More Resources, Less Resistance) in hopes of providing practical next steps for those involved in resident wellness programming. However, further descriptions of the other 2 themes (the purpose-driven nature of wellness and viewing it as a shared responsibility), along with their sub-themes and example quotes, can be found in **Appendix 2**. Please also see **Figure 1** for a thematic map of the overall topics.

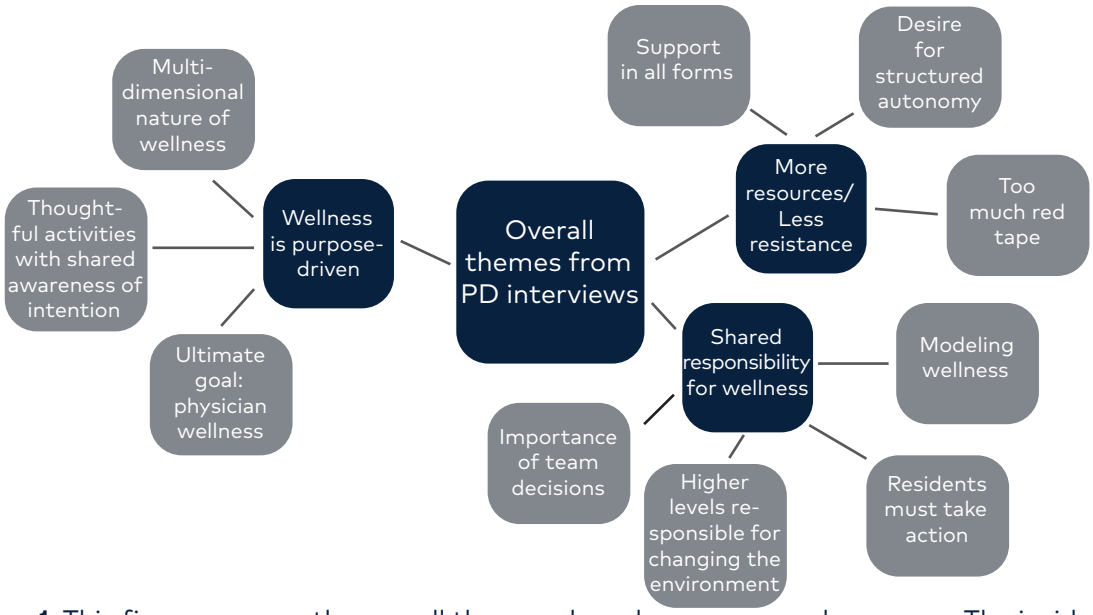

Figure 1. This figure conveys the overall themes shared across exemplar groups. The inside squares represent the overarching themes. The outer squares, which are connected to the inner squares via lines, are sub-themes for each of their respective themes. There are 3 overall themes. The first is wanting more resources for resident wellness with less resistance, which has 3 sub-themes: needing support in all forms, the desire for structured autonomy, and too much red tape. The second overall theme (shared responsibility for wellness) has 4 sub-themes: seeing higher levels as responsible for changing the environment, believing residents must take action for their own well-being, the importance of team decisions, and senior residents/faculty being responsible for modeling wellness. The final theme encompasses the belief that wellness is purpose-driven and includes 3 sub-themes: viewing the ultimate goal of wellness as physician development, the multi-dimensional nature of wellness, and the importance of thoughtful wellness activities with shared awareness of intention.

Theme 1: More Resources, Less Resistance

One of the most consistent sentiments echoed by the PDs centered on offering more resources with less opposition. Within this theme, 3 specific sub-themes emerged: the need for support in many different forms for resident wellness, a frustration with administrative barriers when it came to wellness programming, and a desire for structured autonomy to help navigate resident wellness programs. In addition to what is provided in-text, further descriptions and representative quotes can be viewed in **Table 1**.

Support Comes in Many Forms. PDs mentioned a desire for more support in various forms, ranging from funding and administrative assistance to protected time (**Table 1**). For instance, some noted that residents need to have designated time to participate in wellness activities structured into the workday to allow for full engagement:

> *It's not wellness if it's their own time. … We want to be very intentional in sending the message that we care, which means blocking them from a time that, you know, they would be under a certain amount of stress and have to work.* PD 4

Another PD mentioned:

> *… Funding is probably the biggest barrier … from my end.* PD 5

Too Much Red Tape. Another perceived barrier to resident wellness involves administrative approval processes (**Table 1**). Even with a sufficient wellness programming budget, many PDs expressed frustration with approval delays and activity restrictions:

> *There's definitely financial support. But the problem is there are so many checks and balances … so many steps. … It's very difficult to make it all happen.* PD 10

Table 1. Overall Group Themes: Theme 1 More Resources, Less Resistance

Sub-themes	Categories	Quotes not included in text
Support comes in many forms	Although some PDs were satisfied with their current wellness budget, others requested greater financial support.	"We want more, like more faculty, more budget, more collaboration. This all brings, you know, the question about money." PD 2
	Protected time is essential for both residents and faculty to focus on wellness without adding to their burden of responsibilities.	"We are getting you out of work; we are finding ways to cover your job that day; we're making sure you're not on call so that you can go to this event." PD 5
Too much red tape	Wellness budgets are often limited to specific activities, leading to frustration and, in some cases, out-of-pocket expenses for events.	"There's a budget, but there's not a budget. So, there's a budget that's kind of been approved. But you're really not guaranteed to be able to access it, depending on what it is that you are asking for, or the time of year that you're asking for it." PD 6
	Administrative red tape hinders program implementation and may influence perceptions of wellness prioritization.	"Mostly, when we're making a request, and there's, there's a gap in us being able to provide what we need … when pushed hard enough, it will happen. … it takes forever. And then I finally, you know, write the email that says, look, I need this to happen. Okay. And then it happens. Why can't that just happen from the beginning? Right. So, it's that kind of stuff that makes me believe that this isn't a burden. Like once you see in my subject heading wellness, like just, this is so important, let's go! Make it happen." PD 4
Desire for structured autonomy	Many PDs would benefit from a database of activities, resources, or other curriculum materials to guide them in developing their wellness programming. This may allow them to learn what has worked in other programs while also reducing their workload.	"… Some kind of like baseline expectations, maybe just a little kind of outline of what could work for any given residency, … menus that you could kind of pick and choose from." PD 3
	Guidance in program development and resource provision is desired. However, many PDs requested more autonomy.	"Every program is probably a little bit different … to support that financially, through the budget, I think it's important for people to be able to do things that they need to do." PD 13
	Resident-driven wellness programming may increase buy-in and better meet the specific needs of the residents.	"It gives [the residents] a sense of belonging and responsibility, also self-motivation. Because when everything comes from their leadership, it's theirs, [and that] is just a recipe for failure." PD 2

Desire for Structured Autonomy. Similarly, many PDs indicated a desire for structured autonomy in program design and implementation. They reported that accumulating ideas and resources in an accessible format may relieve some of the burden associated with implementing wellness programming and allow PDs to learn from the successes of other programs (**Table 1**). However, with this format, many PDs also wanted more freedom in shaping their programs:

> *Give me some curriculum items and some opportunities for doing wellness that you can suggest to us … and give me the opportunity and the freedom to use that budget in the ways that I see fit to make it work*. PD 1

This theme of autonomy was also identified in reference to the residents, with many PDs emphasizing the resident-driven nature of their wellness programming (**Table 1**).

Themes 2 and 3: Wellness is Purpose-Driven; Shared Responsibility for Wellness

Please see **Appendix 2** for information on these themes.

Distinguishing Between High- and Low-Exemplar Programs

The previous section demonstrated that a few themes spanned across participants in both exemplar groups, but there were also themes that seemed to characterize 1 group more than the other. As such, group-specific themes will be described below to get a better picture of how programs high in wellness programming and those low in wellness programming may differ. There was 1 theme that emerged as more characteristic of the high-exemplar group (emphasis on connections in the program), and 2 themes were particularly indicative of the low-exemplar group (lack of integration between levels and faculty problems). See **Figure 2** for a thematic map of these exemplar-specific topics. Please also see **Table 2** for more quotes and insight into the high-exemplar theme and **Table 3** for more on the themes for the low-exemplar group.

Theme 4: Emphasis on Connections in the Program: A Potential Facilitator

A theme that characterized the high-exemplar group was the particular importance they placed on connections in the program, both among residents and between residents and faculty.

Connections Among Residents. PDs in the high-exemplar group described how crucial it is for residents to have strong relationships. They saw these relationships as important not only for the course of residency but also for their career as a physician (**Table 2**).

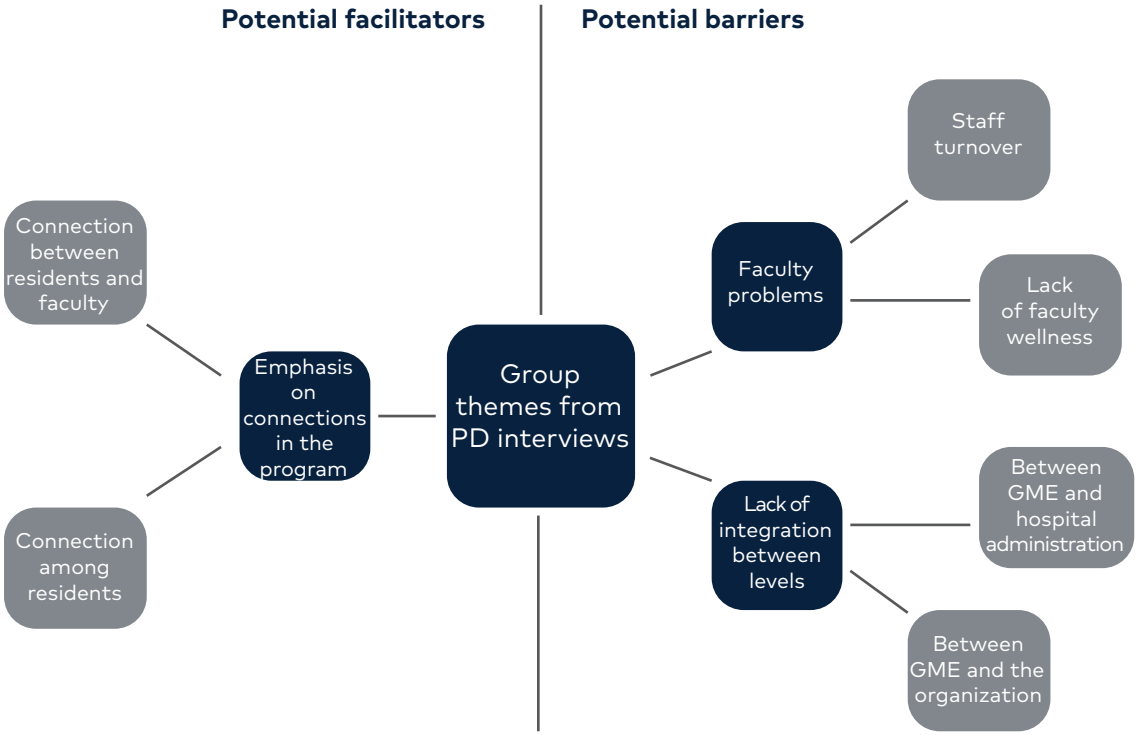

Figure 2. The right side of the diagram focuses on themes for the low-exemplar group (potential barriers to resident wellness programming), and the left side of the diagram focuses on the high-exemplar group themes (potential facilitators to resident wellness programming). For both groups, inner squares represent themes, and outer squares, connected to inner squares via lines, represent sub-themes. The only theme representative of the high-exemplar group was the emphasis placed on connections within the program, which encompasses 2 sub-themes: connections among residents and connections between residents and faculty. For the low-exemplar group, there were 2 themes found. The first was a lack of integration between levels and included 2 sub-themes describing a lack of integration between the GME department and hospital administration and between the GME department and the organization. The other sub-theme for low-exemplars was faculty problems. This theme also had 2 sub-themes: staff turnover and a lack of faculty wellness.

Table 2. Themes From the High-Exemplar Group: Theme 4 Emphasis on Connections in the Program

Sub-themes	Categories	Quotes not included in text
Connections among residents	Social bonds among residents are important for residency and beyond.	"... One of the things I tell them is you have spent all of your life till now ... in a competition to get where you are. And now, I want you to start to understand that I have no interest in you competing about anything ever again. Okay, from this point on, your job will be defined by your ability to work together, not by the ability to be better than the people that you [work] with." PD 1
	PDs are explicit about steps they take to promote bonds among residents.	"... I think it's a lot of team-building activities. They have a very collegial group; they get along really, really well. They actually they do their own ... meetings. Here, you know, ... once they're outside from work, we do have about 4 or 5 activities. And ... it's usually some sort of sport, activity, something that is more like ... team building." PD 2
Connections between residents and faculty	PDs describe an open-door policy where residents can come to them whenever they need to.	"... You know, being supportive and [having] an open-door policy, as simple as it sounds, helps with my residents' wellness, that they can approach me for anything that they may need, or any personal problems, or one-offs that they may have. They know they can come here and come into my office and talk to me about it, and we figure it out." PD 12
	Faculty make the program feel comfortable and friendly.	"... They are grateful to us that we, you know, we spend time with them, compared to some of the other programs because my residents do go to other hospitals, you know, so they do interact with other residents, and they come back and tell us that we do things a little more, you know, differently. We are [a] more friendly program that, they use that term that they use more, you know, homely." PD 15
	Faculty make residents feel appreciated.	"We also you know, this is small, but for Doctors Day, we do something the 25th of this month as well as a national Resident Appreciation Day. We do something for them for that. And ... what we're doing, it's small things: their advisors writing them each [a] personal card, I am, and all their nurses here in clinic, and we're putting some little goodies in that, it's not big. But you know, handwritten cards, we felt like were kind of personal and nice." PD 7

PDs were also more explicit about their steps to promote bonds between residents. For instance, a participant described a resident support group their program conducts:

> ... *They talk with the psychologist about the difficulties or challenges; they help each other, you know, learning from each other, supporting each other. So, this creates also a bond among the residents*. PD 2

Connections Between Residents and Faculty. In addition to commenting on the centrality of relationships between residents, PDs also described the significance of residents' connections with their program faculty. Several of these PDs described having an "open-door policy" for residents, where they can talk to them anytime (**Table 2**). One PD even said their program has been described as "homely" by residents and more "friendly" than other programs.

Table 3. Themes From the Low-Exemplar Group: Themes 5 and 6

Lack of Integration Between Levels		
Sub-themes	**Category**	**Quotes not included in text**
Between the GME department and hospital administration	There is a lack of integration/effective communication between GME programs and the hospitals they are based in.	"... There needs to be more integration. So, education has to be integrated with the clinical enterprise. They've created 2 separate reporting structures, 2 separate groups that has to be fully integrated as partners at all levels, at all levels. And you know, I think that would help. And to be honest, there needs to be collaborative discussion as to how to transform all of this right?" PD 10
	Hospital staff lacks buy-in for resident wellness.	"I would say most of our hospitalists are more focused on their own wellness. And they haven't quite embraced this idea that they're also educating the residents." PD 9
Between the GME department and the corporation	PDs in the low-exemplar group feel national-level resident wellness initiatives and guidelines may not filter down properly to local program levels.	"[Hospital Organization] is willing to do this, but there are all these organizations working for [Hospital Organization], and there is a lack of communication between all these organizations (all have their own agenda, metrics, etc), [so it] takes a long time to get resources. This is why there needs to be clear guidelines coming from [Hospital Organization]." PD 8 (Taken from notes- non-recorded interview)
Faculty Problems		
Sub-themes	**Category**	**Quotes not included in text**
Staff turnover	Staff turnover is a barrier to implementing new wellness initiatives.	"Non-essential things are on pause right now because we're, you know, understaffed." PD 9
	Faculty members are overworked.	"... What you've got is faculty that are stretched to the limit." PD 10
Lack of faculty wellness	Faculty wellness is not a focus in GME, but staff need to be well to pass on wellness to residents.	"Faculty are getting burned out too." PD 8 (Taken from notes- non-recorded interview)
	Creating resident wellness initiatives without addressing staff wellness could create more division between faculty and residents than there already is.	"... If you increase a bunch of wellness-related activities for these residents but have the faculty ... and the nurses and everybody else working their butt off. You're going to create a greater rift, you're going to create an us against them mentality that's even greater." PD 10

Likewise, illustrating the attention paid to bonds between faculty and residents in high-exemplar groups, a PD described acts of appreciation on behalf of the faculty:

> *And I think they really liked that if you appreciate that ... and we can ... give them ... kudos, and you kind of acknowledge the fact that they did go above and beyond the call of duty to help us out.* PD 15

Theme 5: Lack of Integration Between Levels: A Potential Barrier

Within programs with less wellness programming than others, a recognized theme was the perceived lack of cohesiveness between varying levels in GME operations (between the GME department and the hospital administration and between the GME department and the corporation).

Between the GME Department and Hospital Administration. PDs described disparate priorities and reporting structures for faculty members who are more heavily involved in GME programs at the hospital and those who are solely on the clinical side (**Table 3**). One PD in particular mentioned hospital staff may not recognize their role and the importance of resident wellness, seeing it as the GME program leaders' responsibility:

> *I think when we started this program they expected for the leadership to do it. And they don't buy into [it]. They identify the problem and hand it off to us and say here, take care of this.* PD 9

Between the GME Department and the Corporation. Likewise, PDs in this group also seemed to perceive a disconnect between the national and program levels, such as additional resources and programming offered through the overall health care organization that may not reach the program level (**Table 3**).

In reference to this, one PD noted:

> *… Because we hear about things that go on [on a] nationwide level that [are] then supposed to filter to division level that then are supposed to filter to local. And I think depending on where you are, those lines of communication aren't always there. And I don't know, I don't know the true infrastructure of those lines of communication …* PD 6

Theme 6: Faculty Problems: Another Potential Barrier

Furthermore, the low-exemplar group expressed faculty difficulties, both regarding staff turnover and the lack of focus on faculty wellness.

Staff Turnover. Many PDs indicated issues with staff turnover and the remaining faculty having to take on roles beyond what is required:

> *… I think everyone's sort of doing a bit beyond their job title.* PD 9

Similarly, trouble in implementing new wellness activities due to faculty turnover was also discussed:

> *We're missing a core faculty member. We've had 3 program coordinators turnover in the last year. So, we have, unfortunately, a lot of turnover, which makes it challenging to implement new things.* PD 16

Lack of Faculty Wellness. Furthermore, a sub-theme we noted was the desire for more emphasis on faculty wellness. PDs seemed to understand the need for resident wellness but stressed:

> *… what you need is wellness across the board …* PD 10

They also mentioned that increasing resident wellness initiatives might lead to more division between staff and residents if faculty wellness is not also addressed (**Table 3**).

Discussion

We used an explanatory sequential design using data obtained from Marshburn and colleagues' quantitative study,[8] which found a large amount of variance in wellness programming offered to residents across a large health care organization. Based on Marshburn and colleagues' data, we interviewed exemplar cases of PDs identified from the quantitative study as having notably more or less wellness programming. The explanatory sequential approach has been used in prior studies with medical education[10,12] and exemplar cases for qualitative examinations in the medical field.[14,15] However, literature on facilitators and barriers to implementing resident wellness programming is scarce; thus, the use of these methods for this purpose is even more novel. Results of this pursuit revealed some overlap between the groups while also revealing key differences, though future studies will be needed to determine whether these views are widespread. Also, it is essential to keep in mind that these are the perspectives of PDs in the health care organization. If members of the administration or other positions within the network were interviewed, different perspectives might be put forth.

Shared Themes Across Groups

Members of both exemplar groups described a desire for more resources (eg, time and money), which is unsurprising given that past liter-

ature has often cited a lack of administrative and financial support as barriers to wellness programming.[6,26,27] It was also found that some PDs perceived administrative resistance, expressing frustration with the approval process for wellness activities (eg, multiple approval processes, delayed decision-making, and activity restrictions). Our findings not only illuminate results from Marshburn and colleagues,[8] which indicated that some PDs do not believe the health care organization values resident wellness despite most having some form of programming, but imply that more than simply providing more resources to PDs is needed. Shared mental models and a clear definition of effective wellness programming may reduce perceived barriers as program leaders and hospital leaders would have a mutual understanding of programming that could improve wellness. However, if PDs face continued barriers to acquiring wellness resources, they might still feel a lack of support on behalf of the health care organization. Several PDs voiced concerns that the organization may want to just check a box when it comes to resident wellness. Given this, if further research indicates these perspectives are generalizable to other PDs, it could be beneficial to better these perceptions by altering the approval process or helping PDs better understand how it works. A dedicated wellness budget could be a potential next step, indicated by Penwell-Waines and colleagues,[7] as a facilitator to wellness programs and as suggested by our qualitative findings.

Moreover, given requests from some PDs for additional guidance on available resources and their desire for more independence in program implementation, it may be beneficial to take an approach of structured autonomy if these views are widespread. This could entail the hospital organization providing a framework or resource pool PDs can draw upon for inspiration, allowing them to learn from others and develop wellness programming that fits their specific residency program. This finding supports the recommendation of Ripp and colleagues to provide a "menu" of empirically supported interventions.[28] With the provision of these resources, some PDs requested more authority in deciding which activities to implement, so this resource pool may be well-received if it is presented as a source of ideas rather than a method of restricting choice. Many PDs in the current study also advocated for residents to take an active role in the development and implementation of wellness programming, mirroring wellness initiatives highlighted in previous literature.[29,30]

Disparities Between High- and Low-Exemplar Groups

Potential Facilitators. The perceived importance of social relationships in residency was a theme we identified as particularly characteristic of the high-exemplar group. Many PDs emphasized the significance of connections not only among residents but also between residents and faculty. They also described more robust programming to help support these relationships, including therapy groups for residents, acts of appreciation by faculty, and more open lines of communication between residents and PDs. Further exploration of this theme among PDs is essential to determine if those higher in wellness programming do, in fact, place more importance on communication channels available for residents to express their needs and to see if associated faculty are more willing to implement activities based on resident input.

Our results also align with another qualitative assessment of surgical residents by Price and colleagues,[31] which found resident-to-faculty communication and modification based on feedback as key themes in residents' perceptions of what creates good wellness programs. Thus, our study provides some qualitative evidence of the benefits of supporting relationships between faculty and residents for wellness programming, as this study recognized similar ideas with another group involved in residency (PDs), and this theme was identified as characteristic of high-exemplar groups.

As for social connections between residents, research has cited the benefits of social bonds among doctors-in-training, linking them to less burnout and more resident satisfaction.[32] However, the current findings add to the literature by suggesting these social connections may also facilitate wellness programming, warranting future quantitative examinations to see if these perceptions are widely shared among PDs.

Potential Barriers. Our findings from interviews with those in the low-exemplar group with less wellness programming suggest that some PDs may perceive greater limitations in their ability to implement wellness activities. PDs in this group often emphasized the misalignment between groups involved in GME, such as the hospital the program is sponsored by, the GME program, and the overall organization. This implies those with less programming could have fewer wellness activities due to competing interests and a lack of communication between these different levels.

These comments by some of the low-exemplar PDs in our study are in line with other literature, which suggests competing interests between sponsoring institutions and the GME department are not uncommon,[33,34] and an alignment between them can help further facilitate residency programs.[35,36] It has also been emphasized that effective communication between an organization and those who have boots on the ground in a residency program is important.[37] The current research expands these findings to suggest that if these views are widespread among PDs, cohesiveness between organizations involved in GME may also better facilitate wellness programming.

Additionally, some PDs in the low-exemplar group conveyed difficulties with faculty and staff turnover, noting that the remaining program staff are overstretched as they try to fulfill their roles as physicians, educators, and wellness providers. It was also vocalized that little attention is paid to faculty wellness, making it hard to pass on a sense of wellness to residents when the faculty themselves are not well. Several participants mentioned a desire for faculty with specifically assigned wellness roles rather than someone with other responsibilities. A dedicated wellness faculty member would ensure that wellness is a program priority while also acting as a subject matter expert to work with hospital leadership.

These findings are akin to previous reports stating that implementing wellness programming for residents can increase burnout for program leaders and worsen staff turnover from heightened burdens.[38,39] Altogether, these findings imply that struggling programs simply may not have the workforce to implement more wellness programming without further exacerbating these issues. Thus, our study may add to the literature by providing further qualitative evidence that the wellness of program staff is critical to consider when trying to increase opportunities for resident wellness, again warranting future quantitative studies to establish this phenomenon further.

Strengths and Limitations

This study extends the literature on factors impacting the implementation of wellness programming. Few studies currently exist[7,40,41] that examine this topic, yet it is essential to provide insight to the GME community on what best facilitates these activities, especially given programs are required by the ACGME to support wellness.

Moreover, our examination used an exemplar approach, which has been highlighted for its ability to parse out influencing factors of those at the high and low ends of a spectrum.[14,15] As such, we could better see where there was overlap between groups while identifying unique sentiments that separated them. Similarly, PDs from hospitals nationwide and from several specialties were interviewed, whereas existing studies on resident wellness often focus on one institution or specialty.[5-7,40,41]

Although this study has numerous strengths, it also has limitations. Our study used a qualitative approach, interviewing 16 PDs. These findings are not intended to generalize across the institution or medical education broadly. Instead, this study provides insight into specific PDs' experiences, yielding information that may serve as the basis for future examinations of facilitators and barriers to wellness programming.

Finally, it would be remiss not to acknowledge the impact of COVID-19 on the respondent population of this study. The first case of COVID-19 in the United States occurred in mid-January of 2019[42] and continues to persist today. While there have been calls for addressing physician wellness for years, the surge of burnout associated with a pandemic emphasizes the concerns of lower morale and motivation combined with the lack of connections to the

meaning and purpose of medicine.[43] Furthermore, identifying effective wellness programming is critical in the current post-COVID-19 environment.

Conclusion

The change to the Common Program Requirements to include standards for resident wellness[3] has pushed programs to think more critically about the well-being of their residents. Yet, literature on factors influencing the implementation of wellness programming is scarce. Our study helps build the body of research in this domain using an exemplar approach where interviews were conducted with PDs of residency programs identified in a previous study[8] as having exceptionally more or less resident wellness programming than others in the hospital organization.

Our qualitative examination revealed that social ties are considered important for individual well-being, as indicated in previous literature, and may facilitate the implementation of wellness programming, as seen with the high-exemplar group. It also showed that programs with fewer wellness activities may suffer from staffing issues (ie, turnover and lack of faculty wellness) and miscommunication between organization levels, a relatively new idea when it comes to the execution of wellness programming. Further, findings from both groups indicate that these PDs want more resources, with the autonomy to select activities or tools that work best for their programs. In addition, our study extends the literature on administrative support for wellness programming, suggesting barriers to activity approval could hurt implementation as well as perceptions of organizational support.

Given these findings, we suggest that more quantitative studies be conducted to establish whether the proposed facilitators and barriers for program implementation hold for the greater population of PDs. It would also be beneficial to explore the perspectives of those who hold different positions in the health care organization, such as residents and administrative leaders, to compare viewpoints. If these perspectives are shared and causal links are supported, programs may benefit from a focus on improving social ties within their organization. For instance, programs may work on strategies to increase these bonds, such as resident appreciation events and therapy groups, as quoted in the high-exemplar group.

Following quantitative support for these perspectives, addressing the discussed barriers to program implementation would also be essential. This may encompass providing ample faculty, including those whose sole focus is wellness operations, as well as creating wellness for the entire program, including staff. Moreover, creating effective lines of communication and building buy-in to resident wellness among the whole system could aid in creating more opportunities for wellness. Finally, if the identified barriers are generalizable, it may be worthwhile to develop a dedicated wellness budget as well as a database of activities and resources that could be accessed by PDs across organizations, allowing them to share ideas while tailoring wellness programming to fit the needs of their specific residents.

Acknowledgments

The authors wish to thank Gabrielle Riazi and acknowledge her support in the data collection.

Conflicts of Interest

The authors declare they have no conflicts of interest.

Drs Guldner and Wells are employees of HCA Healthcare Graduate Medical Education, an organization affiliated with the journal's publisher.

This research was supported (in whole or in part) by HCA Healthcare and/or an HCA Healthcare-affiliated entity. The views expressed in this publication represent those of the author(s) and do not necessarily represent the official views of HCA Healthcare or any of its affiliated entities.

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Appendix 1

"Thank you again, _____ for being willing to do this interview. These interviews will aid in understanding how [Hospital organization] can best facilitate the success of resident wellness across [Hospital organization] sites, including how they can most effectively support you and your resident wellness programming."

(Note: This is not an exact script, but convey the following in a couple of sentences):

- Remind them that we will be recording.
- Remind them data will only be looked at by CGU; [Hospital organization] will not see it/hear it, but we may pull some direct lines/phrases if they encapsulate a trend we hear from multiple doctors. But, they will not be attributed to any individual/location.
- Purpose of recording is for transcription.

"First, we are going to start off with some easy questions. We are going to ask you about your role and how much time you spend on resident wellness."

Warm-Up

(Note: Again, this is not an exact script! Consider tying it to what their role is, but not necessary.)

What is your formal title?
    a. How long have you worked here?
    b. If you were to step down from all of your resident-wellness-related activities, and had to create a job listing to fill a new position to take on that role, what would that look like?
        i. Responsibilities?
        ii. Hours per week?
            1. What would be the best aspect of the job?
            2. The worst?
    c. On average, how much time do you spend on these activities? (Big or small proportion of time?)

How long have you been involved in resident wellness?

"Is there anything else you would like us to know to help us understand your role regarding resident wellness?"

Primary Questions

"Now that we have a better understanding of your role in resident wellness in your program, we are going to ask you about your perceptions of resident wellness."

Importance of Resident Wellness

1. If you ran into a colleague and told them that you were just interviewed about resident wellness, and they asked you, "What is resident wellness?" how would you answer them?
2. What activities are currently available to your residents to foster wellness, if any?
    a. Why did you choose these activities, as opposed to other potential activities?
    b. What has guided your perspective on resident wellness and the activities you decided to implement generally? (Such as a training seminar, a theory, a book, a colleague, etc.)
        i. If a new program director wanted to start resident wellness programming at their hospital, and they asked you where they should begin, resource-wise, where would you send them?
        ii. You mentioned that you started being involved with wellness (**how long ago they mentioned in Warm-Up**). What were your first steps when you took on this responsibility?

"Okay, is there anything else you'd like us or [Hospital organization] to know about how you perceive resident wellness or the activities you're implementing?"

(Note: Compliment their answers if warranted! **Reward good answers!**)

3. Now that we know your perceptions of resident wellness, what do your residents think of resident wellness? (Overall, in general, globally, what do they think about it?)
    a. Do you think the residents perceive it as something their supervisors value? (**Why?**)
    b. What do they think about the resident wellness programming?
        i. When you hold activities, do a lot of them show up?
            1. IF NOT: Why do you think they don't show up?
                a. Do you think this is an issue of awareness?

2. IF YES: Why do they see them as helpful? As a distraction?
    a. Do you think the residents would want more of these?

"At this point, we've covered your perceptions of resident wellness and the residents' perception of wellness. Is there anything else worth noting that you would like to share with us about this topic?"

<u>The Causal Impact of Resident Wellness on the Hospital</u>

"Now, we are going to ask you some questions about the impact of resident wellness on the hospital."

4. Some directors might feel that resident wellness shouldn't be such a large focus, that the medical field has persisted for years without these programs, and that residents can take care of themselves. Others believe it is the hospital's responsibility to provide these services, and that it's a critical part of the education process.
    a. Where do you fall? (Note: For the Roman numerals below, you don't have to hit every single one, but use your best judgment and try to get as much as is reasonable using the below prompts. **We like the bold ones, though!**)
        i. Would most of your colleagues agree with you?
        ii. What are the benefits?
        iii. What are the costs? Are the costs worth it? (**Why?**)
        iv. Do you think there could be any harms or unintended negative consequences for residents?
            1. If so, how would you amend these issues?
        v. What would you say to someone who disagreed with you to convince them of your perspective?
        vi. How does this impact residents' work ethic?
        vii. How does this impact residents' ability to learn?
        viii. Willingness to stay at [Hospital organization] for residents?
        ix. How does this impact residents' patients?
    b. How is the hospital impacted if resident wellness is not addressed?
        i. Work environment itself?
        ii. Resident-supervisor relationship?
    c. If all the resident wellness programs went away, would it make a difference?
        i. If these programs were removed a year from now, what would the impact look like for residents?
        ii. How would the resident's experience be different if all the wellness activities went away?
        iii. How would patients' experience be different if all the wellness activities went away?

(Note: If you get to the end of this section and they have not volunteered information about resident mental health, ask! [eg, if they have not linked potential issues of resident wellness to things like depression, anxiety, burnout, etc].)

- Could ask, "Do you see any of the issues you've mentioned impacting the mental health of your residents?" or, "We've talked a lot about the potential costs and benefits of resident wellness programming, but before we move on, what impact, if any, do you see these programs having on your residents' mental health?")

"We just finished up a section on the impact of resident wellness on the residents, patients, and hospital. Is there anything else you would like to say?"

<u>Motivation and Logistics Related to Resident Wellness</u>

"Okay, now we are going to shift to something different." (Note: If appropriate, this could be a good time to remind them that the data being recorded will only be presented in aggregate.)

5. Some doctors would want to increase resident wellness activities, some would want to decrease resident wellness activities, some people would want to keep it the same. Where would you say you are? Where would you place yourself on that continuum? **WHY?**
    a. If they say increase and say why, ask the following:
        i.Assuming [Hospital organization] also wanted you to increase your resident wellness activities, what could they do to

facilitate your capacity to do that?
1. From a logistic standpoint?
a. (What barriers need to be removed? Resources, support, rewards, recognition, etc?)

b. If they think there are enough activities or would like to decrease:
i. If [Hospital organization] wanted you to increase the amount of wellness programs you offer, what has to happen to increase the likelihood that that would happen? What could they tell you? What would you like to know?
1. From a logistic standpoint?

c. Would you be surprised to hear that [Hospital organization] wanted more of this? **Why?**

"We just finished up a section on motivation and logistics related to resident wellness. Is there anything else you would like to say?"

<u>How [Hospital organization] Prioritizes Resident Wellness</u>

"Now, we are going to ask you about how [Hospital organization] prioritizes resident wellness."

6. Some organizations may think resident wellness programs are a good thing but put minimal effort into implementing them, others prioritize wellness activities and invest in their implementation. What is your perception about the extent to which [Hospital organization] prioritizes resident wellness? (Where do you think resident wellness falls among other priorities?)

Why do you believe they prioritize wellness the way that they do?
a. If they say that [Hospital organization] does care …
i. If you heard a doctor say [Hospital organization] does not care, why do you think they could have come to that conclusion? If you were so inclined to convince them otherwise, what would you say to them? (What specifics would you point out? Etc)

b. If they say [Hospital organization] does not care or does not care enough …
i. What changes can [Hospital organization] make to convince you that they do care about resident wellness?
ii. What can [Hospital organization] do to increase the amount of resident wellness activities that you have?
iii. Are there any barriers you would need to see removed?
iv. You're not the only one that thinks that [Hospital organization] doesn't make this a priority; however, when we looked at the number of activities offered compared to the general literature on resident programs it appears that they offer more than the average organization. Why do you think this perception about [Hospital organization] persists in spite of this?
v. Do you think resident wellness should be a higher or lower priority in operational decision-making at your program? And why?
1. If resident wellness was a higher priority in decision-making at your hospital, what would this look like?
a. What impact do you think this would have on residents?
b. How would this impact patients?
c. How would this impact the financial well-being of the institution?

(Note: Tailor to what they have told you about) ***"Before we move on, is there anything else you would like to say about [Hospital organization] prioritization of programs and what they could do to increase wellness programming?"***)

"This brings us to our final questions." (Note: if timing is right; if not [ie, you've got 25 min left], head down below and check out questions 8-10 about COVID etc first).

7. Final question: We know different hospitals have different amounts of resources for resident wellness programming. Looking across all the resident programs at [Hospital organization], would your best guess be that your department offers less or more wellness programming than other hospitals?
a. If less, why do you think that is? What can [Hospital organization] do to change that?
b. If more, why do you think you've been able to do more than others? What do you think [Hospital organization] can do to get others to be more like you?

8. (Note: if time permits to ask this and the final question) There's no doubt that COVID

has been tough on everyone in the medical field. Is there anything unique about the way that COVID has impacted the experience of residents in particular?

a. What impact is it having on their training?
b. Will it have a longer-term effect on them than on others who are not in their residency?
c. Do you think more people are leaving or dropping out of residency programs because of COVID?
d. If residents have children, how are they able to handle the work-life balance and spending time at home?
e. Do you see any differences in how residents are dealing with the situation by factors like gender or age?

9. (Note: If time permits) What changes, if any, did you make in resident wellness program in response to COVID-19?

a. Has this revealed any weakness in the program?
b. Any strengths?

10. (Note: If time permits to ask this and the final question) We fully understand that you cannot implement every kind of wellness programming, and that for better or worse some types of programming take precedent over others. We would like to ask you about two different areas to see where they fall in terms of priority. For each of these, some people believe that this is a very important component of resident wellness. Others believe that while it is important, it is not a high priority in terms of resident wellness.

a. Where do you think self-care practices (examples such as Mindfulness/Meditation) falls on the list of priorities? Why do you believe this to be the case?
b. What about promoting meaningful work? Where do you think it falls on the list of priorities? Why do you believe this to be the case?

Appendix 2

Other Overall Group Themes: Themes 2 and 3

Wellness is Purpose-Driven

Sub-themes	Categories	Quotes not included in text
Ultimate goal: Physician development	If physicians are not well, they may not be able to fully engage in patient care, potentially detracting from communication, professionalism, or even patient safety.	"So I think ultimately, it's going to have better communication, better professionalism, better patient care if you have somebody in better shape taking care of their patients." PD 7
	Maintaining wellness during residency is essential for learning. Physicians must be healthy enough to develop professionally and retain academic information.	"If you can figure out a way to put wellness within the stuff that you're doing, then you'll probably leave them more competent and comfortable to do the things that you ask them to do to learn how to become a good doctor." PD 1
	Learning how to be well during residency can help prevent burnout and set physicians up to remain healthy throughout their careers.	"Resident wellness is teaching and educating residents about the importance of their own wellbeing … while also learning how to be resilient in a demanding job." PD 16
Multidimensional nature of wellness	Residency is tailored toward helping physicians grow into well-rounded doctors, so wellness encompasses many dimensions.	"Ultimately, [wellness] is being able to manage the challenges of residency so that you are able to come out after 4 years not only really well trained but also as a whole human being." PD 3
	Wellness activities ought to reflect a holistic approach to physician development, addressing different aspects of well-being.	"They read off … all the positive comments from either residents or nurses … just recognizing residents is good. And then we have like a bingo thing where you fill out like, you know, if you have a certain case that's interesting or something, you get to fill out [a] bingo space, so they seem to have fun with that. And then they try to do like a couple of activities outside of the hospital." PD 11
Thoughtful activities with shared awareness of intention	Wellness activities should be developed thoughtfully, with consideration of how they may contribute to the goal of producing healthy and competent physicians.	"We're very thoughtful about it. And it's not just going to the Top Golf and doing yoga … it can be that sometimes, but it can also … [be] learning how to be well, versus just doing wellness activities." PD 4
	Evaluation may be neces-sary to confirm that wellness activities are truly impacting physician well-being. Otherwise, they may not be worth the investment.	"With some outcomes … why would we be doing more? And are we going to somehow find a way to measure whether this is really worth all of the time and effort?" PD 3
	Establishing a shared awareness of the purpose of wellness programming may contribute to resident engagement as well as faculty support.	"I try to educate them all the time … the administrative reasons, or the requirement reasons, or the wellness reasons, whatever the reason is, I always educate them on why I'm asking you to do that. So, I think it creates a way of trust and collective interests." PD 2

Shared Responsibility for Wellness

Sub-themes	Categories	Quotes not included in text
Higher levels responsible for changing environment	Those in positions of power are responsible for providing avenues to better one's wellness.	"I think it's definitely a joint [effort]. I mean, you can say it's a resident responsibility. But if you give them no avenues to do that, because you're the one in charge, how are they going to do anything?" PD 5
	Those in positions of power are responsible for providing the tools they need to get through residency and life as a physician, which may be particularly stressful.	"... I think when people are ... feeling good about what they're doing and they're feeling like they're accomplishing things, then ... that very much guards against them kind of getting a defeatist kind of ... attitude. And the other thing is that, I think, you know, what we do is ultra-important from a standpoint of ... they're not ... only learning the technical material but they're developing as [a] physician. So I think ... this, hopefully, will follow, you know, them in their careers. And I think ... they learn ways of ... what a good culture is. They know the things to do, and ... hopefully ... that goes beyond just when they finish their residency." PD 14
Residents must take action	Residents are responsible for using the resident wellness resources provided to them.	"... It's not just from the corporations who has to provide wellness, but the individual has to also make sure that they follow the steps." PD 2
	Residents are responsible for providing feedback that helps better the program.	"In fact, the other big thing we want is for it to be totally resident-driven. You know, I think, myself and the coordinators are there to support and maybe, you know, give some guidance and some ideas, but we really want it to be whatever the residents feel that they need and want. So absolutely ... that's another super important tenet, I think." PD 3
Importance of team decisions	PDs want to take everyone's opinion into consideration when making decisions for the program.	"Don't do anything until you sit down with everybody and talk to them and get consensus. Talk to your residents, individually and in groups; talk to your program coordinator." PD 14
Modeling wellness	Faculty are responsible for modeling wellness to residents.	"... I, as a program director, need to like instill wellness on my residents. But if I can't instill wellness on myself ..." PD 12
	Senior residents are responsible for modeling wellness to junior residents.	"You know, people from the higher years third and fourth years recognize that wellness is valuable, and they, their attitude pervades the newer residents. They become involved and see it as important." PD 14
	Residents are responsible for modeling wellness to patients.	"... We are telling our patients about all these, you know, wellness concepts, right, you know, from mindfulness to nutrition ... if you can embody it yourself, then you're going to be able to, you know, express that so much more authentically, I think." PD 3