LETTERS TO THE EDITOR

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TO THE EDITOR:

We would like to thank Dr Mata and Mr Ramos for their thoughtful comments on our recently published article on depression and treatment behaviors in resident physicians. We agree that there is a possibility that the prevalence of depression in our population of residents sampled may be underestimated given the cross-sectional study design, as a longitudinal study design would have been able to pick up additional residents that developed depression over a longer amount of time. Prevalence of depression in resident physicians has great variability, ranging from 1% to 56%.1 Depression has been shown to increase in interns throughout their intern year, from 3.9% at the beginning of internship to 26.6% by the end of R1 year, with an overall prevalence of 19.5% during intern year.2 Some studies have shown a decrease of depression rates as residents progress through the years of residency,3,4 while others have shown no change.5,7 Our study included residents in all years of training, and the 17.7% prevalence of depression in residents found in our study is similar to other studies of overall prevalence.5,6 It is time for residency training programs to take notice of the prevalence of depression in residents and consider implementation of wellness initiatives among resident physicians.

We cannot speculate on whether or not our finding that depression was higher in primary care residents was due to discontented surgery residents who switched into primary care, as we did not ask which, if any, residency program residents had been in prior to their current training program. The suggestion put forth by Dr Mata and Mr Ramos, that a resident who was depressed during a surgical training program may continue to be depressed following transfer into a primary care residency and thus affect the percentages of depressed primary care residents in comparison to surgical residents, remains to be determined. It is also possible that depressed surgical residents, after changing into primary care, may become less depressed. Future studies could elucidate if residents, after making the switch from one type of training program to another, have a change in prevalence of depression. Our study investigated depression in residents within their current area of training (primary care, surgical specialty, or medical specialty), and the finding of elevated rates of depression in primary care residents should be considered seriously. Residents in all types of residency programs are at risk for depression, and this again highlights the need for wellness interventions that focus on all residents.

The available data on self-prescription for resident physicians is sparse. We acknowledge that it is difficult to make comparisons to prescribing trends in the past, as past studies did not specifically look at prescribing rates for antidepressants as a separate category.8,9 However, self-medication overall and specifically self-prescription for psychotropics among resident physicians has dramatically decreased from over 10 years ago, in part due to the decreased availability of medication samples from pharmaceutical representatives.10 Although the numbers we identified of all residents who self-prescribe antidepressants (1.2%), who have received informally prescribed antidepressants (5.9%), or who informally prescribe antidepressants to another resident (3.1%) were relatively low; we again assert that these numbers should ideally be 0% and that better educational, treatment, and support programs are needed for residents with depression.

Residency orientation is an opportune time to introduce the very real risks of depression in residents and to discuss the available services for support and management; however, successful programs will undoubtedly use longitudinal strategies to maximize the mental health and wellness of their residents.

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References


