Learning Under Scrutiny: Why Medical Trainees Hide Distress

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Summary

Prepared by the editorial office from the article.

Background

Medical training is a long period of continuous assessment. Disclosing distress can feel like adding to one’s record, and many trainees choose silence.

Main points

Peer-reviewed studies show depression in about a quarter of medical students and residents, low rates of treatment, and stigma that is strongest among those most affected. Concealment often outlasts training, reinforced by licensing concerns. Hidden distress usually looks like more effort, not less.

Implications

Supervisors can normalise help-seeking, separate pastoral support from assessment, make confidential routes easy to find, protect time for care and ask specific questions.

Keywords: Medical education · Help-seeking · Trainee wellbeing · Physician mental health · Workplace-based assessment · Hidden curriculum

Introduction

A second-year resident rewrites her case presentation four times the night before the ward round. She has not slept properly in weeks, she has stopped eating lunch with her colleagues, and when her consultant asks how she is, she says “fine, thanks” and asks a question about the patient in bed six. Nobody would call her unwell. Her logbook is complete, her feedback is good, and she is the first to volunteer for an extra shift on the rota. (This is a composite drawn from several people, with no identifying details.)

What she is doing is not unusual. It is a reasonable response to an environment in which almost everything a trainee says or does can feel like evidence. This reflection looks at why medical trainees hide distress, what that concealment looks like from the outside, and what supervisors and educators can change, drawing mainly on independent peer-reviewed research.

The assessed learner

Medical training is a long period of continuous assessment. Workplace-based assessments, logbooks, rota requests, supervisor reports and informal impressions all feed into progression decisions. For a trainee, the line between a conversation and an evaluation is rarely clear. Disclosing that you are struggling can feel less like asking for help and more like entering something into your record.

The research suggests that this fear is widespread and that it is strongest in the people who most need help. In a survey of 505 students at the University of Michigan Medical School, students with moderate to severe depression were far more likely than their peers to agree that faculty would view a depressed student as unable to handle their responsibilities (83.1% against 55.1%), and that fellow students would respect their opinions less (56.0% against 23.7%)[1]. In a survey across six US medical schools, only 33.9% of students with burnout had sought help for an emotional or mental health problem in the previous year, and only 26.9% of all respondents said they would definitely seek professional help for a serious emotional problem, compared with 44.3% of the general population[2]. Students with burnout who had sought help were twice as likely to report having watched supervisors judge other students negatively for seeking care[2].

The mechanism is simple. When help-seeking is visible and assessment is constant, silence becomes the safer choice. Trainees learn concealment from what they observe, not from what they are told.

How large the hidden burden is

The scale of distress in training is well documented. A meta-analysis of 183 studies from 43 countries estimated that 27.2% of medical students had depression or depressive symptoms and 11.1% reported suicidal ideation; only 15.7% of students who screened positive for depression had sought psychiatric treatment[3]. Among resident physicians, a separate meta-analysis of 54 studies found a pooled prevalence of depression or depressive symptoms of 28.8%, with a median absolute increase of 15.8% at the start of residency[4].

The transition itself matters. In a prospective study of 740 interns at 13 US hospitals, the proportion meeting PHQ-9 criteria for depression rose from 3.9% before internship to a mean of 25.7% during the internship year, with longer work hours and perceived medical errors among the factors associated with the increase[5]. In a related multisite study, 42.5% of interns screened positive for depression at some point in the year, but only 22.7% of them received

treatment. The barriers they named were time (91.5%), a preference to manage problems on their own (75.1%), lack of convenient access (61.8%) and concerns about confidentiality (57.3%)[6].

These patterns are not confined to one country. A meta-analysis of 19 Indian studies covering 5,944 MBBS students reported a pooled depression prevalence of 50.0%, with a wide confidence interval that reflects differences between colleges and instruments[7]. In a survey of 593 medical students at two medical schools, one in Thailand and one in India, Indian students with a General Health Questionnaire (GHQ-12) score of 2 or more were more likely to avoid seeking help from mental health professionals[8]. The pattern repeats: the more a trainee is struggling, the less likely they are to ask.

Why the habit outlasts training

Concealment learned in medical school does not end at graduation. In a national survey of 5,829 US physicians, nearly 40% said they would be reluctant to seek formal care for a mental health condition because of concerns about their medical licence[9]. In a convenience sample of 2,106 women physicians who were also mothers, recruited through an online group, almost half believed they had at some point met criteria for a mental illness without seeking treatment, and only 6% of those with a formal diagnosis or treatment had disclosed it to their state[10].

A 2026 clinical review published by CEREVITY Health, Inc., which has not been peer reviewed, points in the same direction. It examined structured intake and clinician-documented records for 297 physicians who sought therapy through the CEREVITY network in the United States between January 2025 and July 2026. Sixty-one per cent reported postponing therapy because of licensing or credentialing concerns, and the median delay was 22 months[11]. It is a help-seeking sample with self-reported delays, so it describes physicians who eventually sought care rather than physicians in general. In the author’s clinical experience, many people in samples like this one describe the habit beginning in training.

What hidden distress looks like in a training environment

Distress in high-performing trainees rarely looks like falling apart. It tends to look like more effort, and that is why it is missed. Common signs include:

1. **Over-preparation:** rewriting presentations, re-reading notes late into the night, and arriving early to check results that have already been checked.
2. **Avoiding feedback:** changing the subject when a supervisor offers a debrief, or accepting every criticism without discussion.
3. **Emotional flatness after difficult cases:** describing a death or an error in purely procedural terms, then moving straight on.

4. **Never asking for help with a procedure,** even when a senior colleague is available and the trainee is clearly uncertain.
5. **Withdrawal from peers:** eating alone, skipping teaching sessions that are not assessed, and volunteering for shifts that keep them busy.

None of these signs is diagnostic on its own. Together, and especially when they appear in a trainee who was previously engaged, they are worth a private and unhurried conversation.

What supervisors and educators can do

The evidence on barriers points to practical changes that do not require new budgets.

1. **Normalise help-seeking in teaching.** When a senior clinician mentions, even briefly, that they have used support during a difficult rotation, it changes what trainees believe is permitted. The hidden curriculum is shaped by what is said aloud.
2. **Separate pastoral support from assessment.** The person who signs off competencies should not be the only person a trainee can talk to about how they are coping. Where possible, name a separate contact for wellbeing conversations and say clearly what is and is not shared.
3. **Make confidential routes easy to find.** Put support numbers in the induction pack, on the rota and in the departmental group, so that a trainee never has to ask anyone where to find them.
4. **Protect time.** Time was the most common barrier interns named[6]. Allow trainees to attend appointments during working hours without having to explain the reason.
5. **Ask specific questions.** “How are you sleeping?” and “What has been hardest this month?” are easier to answer honestly than “Are you okay?”

Free, confidential routes for trainees

Trainees should be able to reach help without cost and without it appearing in an assessment record. Options vary by country, and it is reasonable to ask any service how records are kept before the first conversation.

1. Your institution’s student or staff counselling service, or a college wellness cell where one exists.
2. In India, Tele MANAS, the national tele mental health programme, on the toll-free numbers 14416 or 1-800-891-4416.
3. In the United Kingdom, NHS Practitioner Health, a free and confidential NHS primary care mental health and addiction service for health and care professionals.
4. In the United States, the Physician Support Line, free and confidential support from volunteer psychiatrists for physicians and medical students, on 1 (888) 409-0141; in a crisis,

call or text 988.

Anyone in immediate danger should contact local emergency services.

A reflection from the therapist's chair

When physicians finally begin therapy, they often describe the moment in training when they decided to keep their difficulties to themselves. The examples below are composites, with no identifying details, but the themes recur.

A surgeon described being told after a first operative death that "you will get used to it" and taking that to mean that feeling anything was a weakness. A paediatric trainee said she had kept a list of every mistake she had made in her first year and read it before each shift. A medical student said he had stopped going to teaching because he was sure everyone could see how anxious he was.

What they most often wish someone had told them is short. Asking for help is a professional skill, not a confession. Exhaustion is information, not a character flaw. And the people assessing you were once trainees too, many of whom struggled in ways they never said aloud.

Medical education cannot remove scrutiny from training, and it should not try to. Patients depend on it. What it can do is make sure that the scrutiny of performance never becomes a reason to suffer in silence.

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Declarations

Author information

Martha Fernandez, LCSW, is a licensed clinical social worker based in California and co-founder of CEREVITY Health, Inc., a private-pay therapy network in the United States. She writes about help-seeking among physicians and other professionals in high-scrutiny careers.

Competing interests

The author is a co-founder of CEREVITY Health, Inc., a private-pay therapy network whose services relate to the subject of this article, and reference 11 is a CEREVITY report. The article does not promote CEREVITY.

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Patient privacy

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