UTJMS 2026 February 16, 15(S1):e1-e3 doi:10.46570/utjms-2026-1677

Mental Health in Medical Trainees: What the Data Tells Us

Sarah Toil[1*]

[1]College of Medicine and Life Sciences, The University of Toledo

Email: stoil@rockets.utoledo.edu

Received 8/1/2025

Accepted for publication 10/17/2025

Published 2/16/2026

Keywords: Medical Student Mental Health, Mental Health Stigma, Barriers to Care

UTJMS 2026 February 16, 15(S1):e1-e3 doi:10.46570/utjms-2026-1677

1. Introduction

It was my first day of clinical rotations, and I had not felt this kind of anxiety since starting medical school. For years, I had studied this world in books and lectures, but now I was caring for real people. As I entered the inpatient psychiatry unit, my mind raced. The fear of not knowing enough, the pressure to perform, and the uncertainty of what lay ahead were impossible to ignore.

Medical school is a test of intellect and emotion, often in equal measure. Global meta-analyses show that about one in three medical students (33.8%) struggles with anxiety, one in four (27.2%) screens positive for depression, and one in ten (11.1%) has contemplated suicide (1,2). These numbers are not abstract; they sit beside us in lectures and clinical rotations, quietly signaling a system under strain.

Later that morning, the attending physician in the psychiatric unit gathered us for a lecture on antidepressants. He began writing the names of SSRIs on the whiteboard: citalopram, escitalopram, sertraline, and so on. When he reached fluoxetine, he paused. “I’ve been taking fluoxetine since residency, and it’s helped me a lot,” he shared. “I try to normalize mental struggles.”

His honesty broke from the usual script of clinical instruction. It highlighted how rarely we witness such vulnerability in medicine, despite anxiety and depression among medical students occurring at rates 2 to 3 times higher than their non-medical peers (1, 2). This pattern often intensifies over time, with depressive symptoms increasing by 14% during training (2).

2. Discussion

Despite being trained to recognize and treat anxiety and depression in others, a striking disconnect exists when addressing our own mental health. Only one in six medical students (15.7%) who screen positive for depression seeks psychiatric care (2). Reluctance to seek help is often driven by fears of peer judgment, concerns about treatment appearing in official records, and worries about the impact on residency and career prospects (2-4). Unaddressed mental health concerns have been linked to poor academic performance, academic dishonesty, and increased alcohol and substance use (5). For practicing physicians, depressive symptoms are associated with a higher incidence of medical errors (6).

Stigma remains one of the most persistent barriers to mental health care in medicine, fueled by interpersonal attitudes and what educators call the hidden curriculum (3, 4, 7-9). These unspoken lessons and cultural norms within the hidden curriculum often discourage vulnerability, making trainees feel that seeking support could threaten their professional reputation (3, 4, 7, 8). Mentors may unintentionally reinforce this by rarely discussing their own mental health experiences and by modeling stoicism (7). As a result, many students and residents learn to conceal their struggles, perpetuating a cycle of silence and avoidance of support (7-9). However, research shows that when faculty are transparent about their own experiences with mental health care, it reduces stigma, encourages trainees to reach out, and fosters a more supportive learning environment (8, 9).

Beyond the hidden curriculum and interpersonal stigma, structural barriers at the policy level have further discouraged physicians from utilizing mental health services. Historically, many state medical licensure applications required physicians to disclose any history of mental health treatment, regardless of whether it impacted their ability to practice (3, 4, 7-9). A national survey of 5,829 U.S. physicians found that nearly 40% were reluctant to seek mental health care due to concerns that disclosure could negatively affect their license (3). Recently, growing recognition of these consequences has prompted meaningful reform. As of May 2025, thirty-seven state medical boards have revised their licensing applications, removed intrusive mental health questions unless directly related to current impairment (10). This aligns with recommendations from the American Medical Association and the Federation of State Medical Boards, which urge that only current impairment, not diagnosis or treatment history, should be relevant (3, 10). While further changes are needed, this is a crucial step toward giving physicians the privacy and compassion they offer to others.

3. Conclusions

The principle of “see one, do one, teach one” has long shaped how clinical skills are passed from physician to trainee. But when it comes to mental health, this tradition breaks down. If mentors do not model openness or vulnerability, students are left without a template for these behaviors and may instead learn to remain silent. That is why

my attendees' brief comment about fluoxetine mattered so much. That authenticity created space for something deeper: the possibility of a profession where honesty about mental health is not whispered but welcomed. Perhaps meaningful change begins not just in what we are taught, but in what we are willing to share. Every small act of honesty lays the groundwork for openness – shaping what future physicians see, do, and one day, teach.

References

1. Tian-Ci Quek, T., et al., *The Global Prevalence of Anxiety Among Medical Students: A Meta-Analysis.* International Journal of Environmental Research and Public Health, 2019. **16**(15): p. 2735.

2. Rotenstein, L.S., et al., *Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students.* JAMA, 2016. **316**(21): p. 2214.

3. Dyrbye, L.N., et al., *Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions.* Mayo Clinic Proceedings, 2017. **92**(10): p. 1486–1493.

4. Gold, K.J., et al., *"I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting.* General Hospital Psychiatry, 2016. **43**: p. 51–57.

5. Dyrbye, L.N., M.R. Thomas, and T.D. Shanafelt, *Systematic Review of Depression, Anxiety, and Other Indicators of Psychological Distress Among U.S. and Canadian Medical Students.* Academic Medicine, 2006. **81**(4): p. 354–373.

6. Pereira-Lima, K., et al., *Association Between Physician Depressive Symptoms and Medical Errors.* JAMA Network Open, 2019. **2**(11): p. e1916097.

7. Brower, K.J., *Professional Stigma of Mental Health Issues: Physicians Are Both the Cause and Solution.* Academic Medicine, 2021. **96**(5): p. 635–640.

8. Martin, A., et al., *Physician Self-disclosure of Lived Experience Improves Mental Health Attitudes Among Medical Students: A Randomized Study.* Journal of Medical Education and Curricular Development, 2020. **7**.

9. Vaa Stelling, B.E. and C.P. West, *Faculty Disclosure of Personal Mental Health History and Resident Physician Perceptions of Stigma Surrounding Mental Illness.* Academic Medicine, 2021. **96**(5): p. 682–685.

10. *Are licensing/credentialing bodies required to probe into past mental health or substance use?* American Medical Association July 22, 2025 [cited 2025 July 30]; Available from: https://www.ama-assn.org/practice-management/sustainability/are-licensingcredentialing-bodies-required-probe-past-mental.

