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ORIGINAL ARTICLE

Perspectives on Quiet Quitting in Family Medicine Residency Programs

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ABSTRACT

Background and Objectives: Quiet quitting, or doing only the minimum work necessary for one's job, is a phenomenon in the work environment that has been discussed widely in popular media but only recently referenced in academic literature and not formally examined in the context of residency education. This study examined the concept of quiet quitting in residency education, gathering perspectives from leaders in family medicine residency programs.

Methods: Quiet quitting and similar concepts were presented at a workshop at the 2024 Residency Leadership Summit hosted by the American Academy of Family Physicians. Participant responses were collected during the workshop from approximately 250 attendees to gather perspectives on and experiences with these behaviors in their residency programs. Investigators independently coded responses using thematic analysis.

Results: Responses from 215 participants (approximate response rate=86%) identified disengagement, professionalism concerns, and strategic time usage as quiet quitting behaviors in residency. Contributing factors to quiet quitting reflected generational shift in work values, systemic issues, faculty modeling, and lack of training or work experience. Identified consequences were primarily negative and related to decreased physician competence and poorer quality of patient care. Proposed interventions included making systemic changes, establishing clear expectations and consequences, and bolstering well-being and resilience.

Conclusions: This study provides residency leadership perspectives on quiet quitting in family medicine residency programs. Given the potential for negative consequences of quiet quitting on physician competence and patient care, developing a shared understanding of this phenomenon within residency education is important.

INTRODUCTION

Quiet quitting is an occupational phenomenon described as "the practice of doing the minimum amount of work required for one's job."[1] This term has been used increasingly on social media platforms since 2022 and has been the topic of numerous articles in popular media.[2–4] The medical field has not been spared from the ill effects of quiet quitting, yet the scientific literature on quiet quitting is only just beginning to emerge and is primarily editorial in nature.[5–7]

Residency is a particularly vulnerable time for physicians in training who are working rigorous schedules, facing routine assessment and testing, and being compensated at a lower rate than in their future profession.[8] These factors contribute to increased stress, burnout, and decreased occupational satisfaction. Additionally, considerable evidence attests that the physician workforce is experiencing increasing intended and actual attrition,[9,10] and physician burnout and moral injury are substantial.[11,12] Residents may not identify overt resignation as a viable option at this stage in their training and career development, but one can reasonably suspect that quiet quitting is occurring within residency programs.

In early 2024, the podcast *Not Otherwise Specified*, produced by the *New England Journal of Medicine*, explored aspects of a cultural shift in medical training, including perspectives on well-being, work-life balance, generational differences, moral injury, and corporate medicine.[13] A corresponding article addressed the concept of quiet quitting and posed the question, "What might quiet quitting . . . mean for clinicians, trainees, and their patients?"[14] Recent attempts to quantify quiet quitting, such as the development of the Quiet Quitting Scale (QQS) by Galanis et al, provide a structure for understanding these behaviors, particularly around detachment and lack of

motivation.[15] In addition, Kang et al published a protocol for a concept analysis and scoping review on quiet quitting among health care professionals in hospital settings.[16] However, at present, no empirical literature exists, either qualitative or quantitative, that examines quiet quitting among resident physicians.

This study aimed to collect the views of family medicine residency leadership to better understand how quiet quitting—referring to reduced work effort—appears in the context of residency training. This purpose of the study was to gain a deeper understanding of how quiet quitting is perceived among family medicine residency program leadership as well as to identify potential contributing factors, consequences, and strategies for preventing or addressing it.

METHODS

The research team conducted a thematic analysis exploring the recent experiences with and perceptions of quiet quitting behaviors within family medicine residency programs, focusing on the subjective reality of residency leadership.

Setting and Participants

Participants were recruited from a workshop presented at the 2024 Residency Leadership Summit, a conference hosted by the American Academy of Family Physicians. That workshop began with a brief informational presentation addressing the concepts of quiet quitting, bare-minimum Mondays, and other related trends reflected on social media.[17] Following the presentation, participants were asked to provide responses to discussion questions. Responses to the questions were collected using an audience participation feature on the conference's mobile application. Audience responses could be "upvoted" by fellow attendees, reflecting agreement with the statement.

Analysis

The team used a thematic analysis technique[18] to analyze the qualitative data in this study. Three researchers began this iterative process with the independent evaluation of individual responses, each identifying key concepts and potential themes. The researchers then consolidated central themes to establish preliminary codes, which were applied to the dataset. During this process, the researchers refined codes to ensure alignment with the entire dataset and to account for responses not initially captured. The team discussed and collaboratively resolved disagreements on coding. While data collection was not iterative due to the cross-sectional nature of the study, the coding process incorporated iterative refinement, allowing for a detailed and nuanced understanding of participant perspectives through continuous comparison and adaptation of the codes.

Reflexivity

At the time of data collection, authors who presented at the conference and conducted initial data collection were an associate program director (K.Y.) and a faculty member (K.I.) from two family medicine residency programs. K.J., the behavioral health consultant for a residency consortium, joined K.Y. and K.I. to complete the initial data review and organize the data. Preliminary coding was completed by K.J. and two graduate student researchers (L.A. and M.S.M.) with experience in qualitative research methodology. Both L.A. and M.S.M. work outside of residency training and are graduate students in health care-related fields. Data interpretation was collaboratively conducted with K.J. and K.Y. K.Y., K.I., and K.J. have extensive experience in medical residency education, the unique stressors and challenges faced by residency trainees,[19] as well as challenges in residency program leadership. Biases and potential impact on data interpretation were discussed within the research team, including generational status, student status, and professional roles within residency education.

The research team's collective experience in medical education likely shaped the interpretation of participant narratives with an informed sensitivity to the nuances of residency training. This background may have facilitated a deeper understanding of contextual stressors and institutional dynamics, enabling the team to identify themes that might be overlooked by researchers who are less familiar with these settings. At the same time, the team's professional roles could have led to data interpretation through a lens prioritizing systemic over individual factors. The inclusion of researchers external to residency training helped to broaden interpretive perspectives and served as a check on potential overidentification with participants or institutional norms.

This project was determined to be exempt from further review by the Institutional Review Board for Novant Health New Hanover Regional Medical Center. Participants were informed at the workshop onset that their comments in the audience response system might be used for future scholarship.

RESULTS

Participants included approximately 215 attendees of the Residency Leadership Summit, out of approximately 250 total workshop attendees (approximate response rate=86%). In the audience, 35% of participants identified as program directors, 37% as associate or assistant program directors, 15% as core faculty, and 12% as program coordinators.

In total, 192 written responses and 1,219 upvotes were provided across four discussion prompts. Individual responses varied in length from a few words to short paragraphs, for a final dataset just under 4,000 words. Responses and themes from each discussion prompt are summarized in the sections that follow. For each discussion question, the number of unique responses representing each theme as well as the total number of upvotes related to that theme were considered within the coding process. All coding was completed using the thematic analysis method.

Question 1. In what ways do you see what might be considered "quiet quitting" in your residency program?

Seventy-two participant responses were coded for themes in response to the question, "In what ways do you see what might be considered 'quiet quitting' in your residency program?" Several behaviors were identified as indicative of what might

be considered quiet quitting, with responses categorized into three main themes: disengagement, professionalism concerns, and strategic time usage (Table 1).

Disengagement was the most reported theme. Residents exhibiting disengagement were described as showing a lack of enthusiasm for activities perceived as nonessential, such as skipping didactics and performing only the minimum required tasks. This behavior extended to avoiding additional responsibilities beyond their core duties and using loopholes within the system, such as focusing solely on Accreditation Council for Graduate Medical Education requirements, as opposed to local program requirements. Professionalism concerns emerged as the second most common theme. These concerns centered around residents' communication and timeliness, such as delayed note completion and failure to respond to calls or emails. A final theme, strategic time usage, was commonly endorsed. Resident behaviors in this category were noted for prioritizing personal time and work-life balance by leaving on time, avoiding extra duties, and using sick leave strategically.

Question 2. What factors contribute to these kinds of behaviors (individual, program, institutional, cultural)?

Forty-five participant responses were coded in response to the question, "What factors contribute to these kinds of behaviors?" Several factors were identified as contributing to behaviors associated with quiet quitting among residents, encompassing individual, program, institutional, and cultural dimensions. These factors were grouped into four main themes: generational shift in work values, systemic issues, faculty modeling, and lack of training or work experience (Table 2).

The most cited factor was a generational shift in work values. This theme highlights a broader cultural change, where the younger generation of residents places a greater emphasis on work-life balance compared to previous generations. Systemic issues were another identified contributing factor to quiet quitting in residency. These issues primarily involve unmanageable workloads, excessive administrative tasks, and a lack of support, all of which lead to burnout and disengagement. Faculty modeling of disengaged behaviors also was a notable contributor. Participants observed that when faculty members display similar disengagement or prioritize personal time over professional duties, the behavior can reinforce similar behaviors in residents. Finally, lack of training or work experience was identified as contributing to quiet quitting in residency. This theme suggests that some residents may enter residency without the necessary skills or realistic expectations about the demands of the job. The lack of prior employment experience also affects their ability to cope with the volume and intensity of residency work.

Question 3. What are the potential consequences to quiet quitting in residency?

Twenty-two participant responses were coded for themes in response to the question "What are the potential consequences to quiet quitting in residency?" The qualitative analysis of potential consequences of quiet quitting in residency programs revealed three primary themes: diminished education and competence, compromised patient care, and negative workforce dynamics (Table 3).

The most prominent consequence identified was diminished education and competence. Participants expressed concerns that quiet quitting may result in a generation of less-prepared primary care physicians, lacking the resilience and skills necessary for independent practice.

The second theme was impact on patient care. Quiet quitting was perceived as negatively impacting residents' ability and motivation to provide high-quality care. This disengagement could lead to increased errors and reduced patient satisfaction. Lastly, workforce dynamics emerged as another key consequence. Quiet quitting behaviors were seen as placing additional burdens on more engaged colleagues, potentially leading to burnout and creating a negative cycle of disengagement.

Question 4. What strategies can be used to prevent or address quiet quitting or the negative consequences?

Twenty-nine participant responses were coded in response to the question, "What strategies can be used to prevent or address quiet quitting or the negative consequences?" The qualitative analysis of strategies to prevent or address quiet quitting in residency programs highlighted three key themes: addressing systemic issues, setting clear expectations and consequences, and promoting resident well-being and resilience (Table 4).

The most frequently endorsed strategy was addressing systemic issues. This theme emphasized the need to promote efficient work practices and reduce unnecessary administrative burdens to prevent quiet quitting. Participants suggested that quiet quitting should be viewed as a symptom of larger systemic problems. The second theme in response to suggestions to prevent or address quiet quitting was clear expectations and consequences. This strategy focused on the importance of setting clear expectations for residents, providing consistent feedback, and enforcing accountability for their work. Finally, resident well-being and resilience was highlighted with an emphasis on promoting resident well-being. This theme emphasized addressing burnout, fostering a culture of wellness, and ensuring that residents have adequate time for rest and reflection.

DISCUSSION

This study provides an exploration of quiet quitting in residency education from the perspectives of family medicine program leadership who had much to say about this phenomenon and the ways it has impacted their programs. Noted within this group of educators were several concerning behaviors that signify quiet quitting in their residency programs, such as disengagement and professionalism issues. These behaviors were attributed not only to a growing emphasis on work-life balance and generational shifts in work values, but also to environmental contributors such as systemic inefficiencies, poor

TABLE 1. Perceived Quiet Quitting Behaviors in Family Medicine Residency Programs

Theme	Number of unique responses	Number of upvote endorsements	Representative responses
Disengagement	28	282	"Resistance to 'usual' resident duties" "Lack of initiative in patient care"
Professionalism concerns	21	197	"Delayed note completion" "Increased nonresponsiveness to the program director or administration"
Strategic time usage	15	133	"Calling in sick for a headache or cough" "Frequent or prolonged Family and Medical Leave Act (FMLA) leave for well-being."

TABLE 2. Contributing Factors to Quiet Quitting in Family Medicine Residency Programs

Theme	Number of responses	Number of upvote endorsements	Representative responses
Generational shift in work values	11	188	"A rebound phenomenon from the previous generation's 'cowboy culture' in medicine"
Systemic issues	10	34	"Workload . . . lack of support and difficulty of the work"
Faculty modeling	6	47	"Faculty modeling quiet quitting behavior" "This actually seems to be a reflection of behaviors demonstrated by some faculty."
Lack of training or work experience	5	21	"Some residents seem to come not prepared for the volume." "Many residents have never had a 'real job' before."

TABLE 3. Potential Consequences to Quiet Quitting in Family Medicine Residency Programs

Theme	Number of unique responses	Number of upvote endorsements	Representative responses
Diminished education and competence	10	20	"Less resilience when taking care of others" "Not being prepared for independent practice"
Compromised patient care	8	33	"More errors in caring for patients" "Poor patient care and satisfaction due to cancellations"
Negative workforce dynamics	5	5	"Burnout and overload for the nonquitters" "Faculty fear of repercussions if not responding to resident requests exactly as they were hoping"

TABLE 4. Potential Strategies for Preventing or Addressing Quiet Quitting or the Negative Consequences

Theme	Number of responses	Number of upvote endorsements	Representative responses
Addressing systemic issues	10	22	"Treating quiet quitting like a symptom of a larger systemic or individual issue" "Build systems that minimize unnecessary stress/burden."
Setting clear expectations and consequences	7	17	"Make clear consequences, enforce them, and stick to them consistently." "Enforce accountability."
Promoting resident well-being and resilience	6	42	"We have started to focus on how to have 'wellness at work."' "Unlearning emotional reasoning and learning true resilience"

role modeling by faculty, and insufficient preparation through prior education and work experience. The consequences of these behaviors reflected challenges for personal development such as resident competence. If disengagement becomes normalized or overlooked in residency education, opportunities for professional identity formation may be diminished and result in a weakened connection to the professional role of physician, rather than a mere withdrawal from extra work. In addition to personal consequences, quiet quitting has implications for health care systems (eg, increased strain on team dynamics) and to society at large (eg, poorer patient care).

This research represents an early effort to explore quiet quitting within the specific context of medical residency programs. To date, no published literature addresses quiet quitting among physicians. Despite this gap in the literature, the themes identified in this study align with broader discussions on quiet quitting, such as those found in the *Not Otherwise Specified* podcast series, which similarly emphasizes generational shifts, the desire for work-life balance, and the adverse consequences of disengagement in health care settings. Clearly, a discussion of quiet quitting in residency education evokes strong opinions in residency leadership, and participants shared many

common ideas and perspectives on what these behaviors actually entail, what is driving these behaviors, as well as how they are potentially harming the medical field. This discourse could lead to a deeper exploration of the medical profession's responsibility to define the scope and essence of medical practice, starting in residency, rather than allowing external entities, such corporate health care, legislation, and productivity-driven policies to shape physician activities in a way that is inconsistent with the core values of medicine, potentially leading to quiet quitting and burnout.

This study had several limitations that warrant consideration. First, quiet quitting is a relatively new concept in academic discourse, with limited vetting in the scientific literature, making it challenging to define and measure consistently. This challenge is reflected in participant responses that focused on different aspects of concerning behaviors attributed to quiet quitting. The audience response system, while effective in capturing real-time data, introduced challenges in interpretation, particularly because the intended question related to responses was not always clear. Furthermore, the use of upvotes complicated interpretation because the intention behind these responses was presumed to be a sign of agreement with the statement; however, participants were not explicitly given this instruction. In addition, the anonymity of the workshop participants made determining how representative the responses were or how many times individuals contributed to the dataset impossible. Finally, given that the participants in this study were from residency programs choosing to participate in the Residency Leadership Summit and were attendees choosing to attend a session about quiet quitting over other residency-related topics, their perspectives may not be completely representative of the general population of family medicine residency leadership, who may be less interested in or concerned about this topic.

CONCLUSIONS

Despite these limitations, this study serves as a foundational exploration of quiet quitting in residency education. Future research should focus on refining the definition of quiet quitting in residency education and incorporating the perspectives and experiences of residents to better understand the root causes of disengagement. This perspective will be particularly helpful in exploring the causes behind quiet quitting behaviors as well as in evaluating viable solutions to addressing this concern. Future research should extend beyond family medicine to explore how quiet quitting manifests across medical specialties. Once a clear definition and reliable measures of quiet quitting are established, research can shift toward accurately capturing the frequency of this behavior and identifying effective strategies to address and mitigate quiet quitting among physicians. Systemic reforms, both within and external to residency education, addressing environmental contributors and fostering engagement, are likely critical for mitigating this phenomenon. Potential opportunities for evaluating systemic interventions in residency include revisiting clinical and education work hour policies, restructuring clinical responsibilities to reduce inefficiencies and noneducational tasks, carefully integrating appropriate technology such as artificial intelligence to offset the volume of tasks such as charting, and investing in faculty development to support stronger mentorship and role modeling.

Quiet quitting in medicine poses a critical challenge, with consequences that extend beyond physicians and their colleagues to directly impact quality of patient care. Because disengagement and diminished professionalism in health care can jeopardize patient safety and outcomes, and potentially compromise the profession of medicine itself, identifying the specific behaviors and underlying factors driving quiet quitting among resident physicians is essential. This study provides a novel contribution to the literature by offering an initial exploration of this phenomenon within the context of family medicine residency programs, filling a crucial gap in current understanding. By laying the groundwork for further research, this study paves the way for the development of targeted interventions aimed at fostering resident physician competency and ensuring the delivery of safe, high-quality care.

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