

Brief Intervention, Measurable Change: Pilot Evidence for DistressRx™ in Women Physicians

A two-hour workshop evaluation (Study 1) and a three-month anonymous coaching field study (Study 2)

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STUDY 2 PHYSICIANS 651 Anonymous coaching, Jul-Sep 2026	COACHING SESSIONS 1,212 Pre/post stress rating each session	STUDY 1 ITEMS IMPROVED 17 / 17 Mean Cohen's d = 1.10, n = 42	SESSIONS REDUCED STRESS 84% Mean 5.3 to 2.5 on a 1-10 scale
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Summary

- Background.

Physician burnout carries an estimated U.S. cost of \$4.6 billion per year from turnover and reduced clinical effort, and women physicians report higher burnout than men.^{1,2} Most interventions tested to date are multi-session, multi-week, or contractual, and pooled effect sizes are modest.^{3,4} Brief, low-barrier formats are understudied.
- Study 1.

Forty-two women physicians completed matched pre/post surveys around a single 2-hour DistressRx workshop (framework, individual stress-subtype identification, and a matched primary coping strategy). All 17 stress-competence items improved significantly (14 of 17 at $p < .001$). Mean Cohen's d was 1.10 and 11 of 17 items met the large-effect threshold. Among the 17 participants at baseline retention risk, 11 (65%) said consistent stress-management support would reduce their intent to leave.
- Study 2.

651 physicians (98% women, 86% MDs, predominantly midcareer) used On Call for You, an anonymous coaching app built on the DistressRx engine, across 1,212 sessions. Mean self-rated stress fell from 5.3 to 2.5, and 84% of sessions ended with lower stress than they began. 64% had never worked with a coach before. Participants rated the experience 4.8 of 5 for being worth their time.
- Next step.

A waitlist-controlled randomized trial of 500 physicians using the Copenhagen Burnout Inventory as the primary outcome is designed and is the next step.

Limitations stated at the outset

Neither study is a randomized controlled trial and neither includes a control arm. All outcomes are self-reported. Study 1 participants had prior coaching exposure. Both samples are predominantly women physicians, so findings may not generalize to other groups. Participation and survey completion were voluntary, so selection effects cannot be ruled out. Comparisons to published effect sizes are descriptive and are not evidence of superiority to other interventions.

The research program

Each study was designed to answer a question the previous one could not.

STUDY	DESIGN	SAMPLE	PRIMARY MEASURE	STATUS
1. Workshop pilot	Within-subject pre/post, single 2-hour live workshop	42 women physicians	17 stress-competence Likert items, plus retention intent	Complete
2. Anonymous coaching field study	Session-level pre/post, plus surveys at entry and six weeks	651 physicians, 1,212 sessions	Self-rated stress (1–10) before and after each session	Three-month data in hand. Six-week follow-up ongoing
3. Validation trial	Waitlist-controlled randomized trial, 12 weeks	500 physicians	Copenhagen Burnout Inventory ⁵	Designed. About 9 months from launch to manuscript

How each limitation of the pilot is being addressed

STUDY 1 LIMITATION	WHERE IT STANDS
Small sample (n = 42)	Addressed by Study 2. 651 physicians and 1,212 sessions.
Participants had prior coaching exposure	Addressed by Study 2. 64% of participants had never worked with a coach, with time and cost as the main barriers.
Live, facilitator-delivered format only	Addressed by Study 2. The DistressRx engine delivered anonymously and on demand, with relief holding across career stage and practice setting.
No control or comparison arm	Addressed by Study 3. Waitlist-controlled randomization.
Outcome items not externally validated	Addressed by Study 3. Copenhagen Burnout Inventory as the primary outcome.
Retention intent is hypothetical	Not yet addressed. Longitudinal follow-up of actual employment status is needed before any attrition claim.
Predominantly women physicians	Not yet addressed. Study 2 is 98% women. This is the population the program was built for, and broader samples are needed before generalizing.

Why the two pilots matter together: Study 1 shows that a single structured exposure to the framework shifts how physicians understand and respond to their own stress. Study 2 shows that when the same framework is available on demand and anonymously, physicians use it, and their in-the-moment stress drops. Neither establishes cause. Together they justify the controlled trial.

Study 1: Sample characteristics

N = 42 women physicians who completed matched pre- and post-intervention surveys.

Years in clinical practice			Role		
Category	n	%	Category	n	%
> 20	13	31.0	Practicing physician	26	61.9
11-20	21	50.0	Academic faculty	7	16.7
5-10	4	9.5	Physician leader / admin	5	11.9
< 5	2	4.8	Resident / fellow	1	2.4
Not applicable	2	4.8	Non-physician clinician	2	4.8

Practice setting			Clinical FTE		
Category	n	%	Category	n	%
Private practice	16	38.1	76-100%	30	71.4
Hospital-employed	13	31.0	51-75%	3	7.1
Academic medical center	9	21.4	26-50%	4	9.5
Hybrid	2	4.8	0-25%	2	4.8
Non-physician setting	1	2.4	Not applicable	3	7.1

Baseline retention intent

Q: “I am seriously considering leaving my current role in the next 6-12 months.”

YES 6 / 42 14.3%	MAYBE 11 / 42 26.2%	NO 25 / 42 59.5%
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Endorsed reasons for considering departure (multi-select, all 42 participants): poor work-life integration (14), misalignment with values (12), burnout (9), different clinical structure (8), lack of support (7).

Two in five participants (17 of 42) were at some level of retention risk at baseline, even in a sample that had already sought out coaching. The most common reasons named were structural and values-based rather than individual.

Study 1: Item-level results

Mean pre-to-post change on each of 17 stress-competence items (5-point scale), sorted by change, with Cohen's *d* on paired differences.



Horizontal axis: mean change in points on a 1–5 agreement scale (1 = strongly disagree, 5 = strongly agree).

Robustness checks

Multiple comparisons. The primary analysis applied no multiplicity correction. The 14 items significant at $p < .001$ remain significant under a Bonferroni correction for all 18 comparisons (threshold $p < .0028$).

Framework familiarity. The largest change is on familiarity with the framework itself, which is expected after any introduction. Excluding that item, the mean Cohen's *d* across the remaining 16 items is 1.02, still well above the large-effect threshold.

Ceiling effects. The smallest changes were on items with the highest baseline means, such as belief that coaching could help and presence with patients, which leaves less room to rise on a 5-point scale.

Study 1: Burnout item and retention intent

Burnout-symptom item, analyzed separately

Q: “I currently feel symptoms of burnout (emotional exhaustion, cynicism, lack of accomplishment).”

Agreement rose from a pre-mean of 3.07 to a post-mean of 4.26 (Wilcoxon $p < .001$), and 21 of 42 participants (50%) moved from a pre-rating below 4 to a post-rating of 4 or 5. This pattern is consistent with response shift, in which learning new vocabulary changes the internal standard respondents use to rate themselves.⁶ The workshop explicitly teaches burnout vocabulary, and the vocabulary item rose in parallel ($d = 1.44$). The increase is therefore interpreted as a change in symptom recognition rather than symptom severity. A true increase in severity cannot be ruled out without an external clinical measure, which is one reason Study 3 uses a validated burnout instrument.

Retention intent

The pre- and post-survey items measured different constructs and are reported separately.

PRE-INTERVENTION			POST-INTERVENTION		
“I am seriously considering leaving my current role in the next 6–12 months.”			“If I had consistent stress-management support, I would be less likely to leave my current role in the next 6–12 months.”		
Yes	6	14.3%	Yes	30	71.4%
Maybe	11	26.2%	Maybe	8	19.0%
No	25	59.5%	No	4	9.5%

Subgroup: participants at baseline retention risk (n = 17)

YES, SUPPORT WOULD REDUCE INTENT	MAYBE	NO
11 / 17	4 / 17	2 / 17
64.7%	23.5%	11.8%

Interpretive note. These findings show that physicians at risk of leaving identify consistent stress-management support as relevant to their retention decisions. They do not show that the workshop reduced actual attrition. That claim requires longitudinal follow-up of employment status.

Study 2: Anonymous coaching field study

On Call for You, an anonymous physician coaching app built on the DistressRx engine. July to September 2026.

PHYSICIANS 651 98% women, 86% MDs, mostly midcareer	SESSIONS 1,212 Stress rated before and after each	MEAN STRESS 5.3 → 2.5 1-10 scale, 10 = most stressed	OF SESSIONS 84% Ended with lower stress
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Methods

Physicians used the app anonymously and on demand. Before and after each session they rated their current stress from 1 to 10 (10 = most stressed). Surveys were administered at entry and at six weeks. Nothing about an individual is tracked. Outcomes are analyzed at the session level and in aggregate.

Findings

In-session relief.	Mean stress fell 2.8 points, from 5.3 to 2.5, a reduction of roughly half. 84% of sessions ended with lower stress than they began.
Highest-distress users.	Physicians who began a session at 8 or higher dropped 4 to 6 points.
Consistency.	Relief held across career stage and practice setting.
Reach beyond the already-coached.	64% had never worked with a coach before, citing time and cost as the main barriers. This directly addresses the prior-coaching limitation of Study 1.
Unmet need.	Four in five said their current institutional wellness resources are not adequate.
Early six-week results.	Early respondents improved on every self-efficacy measure. Follow-up is ongoing.
Acceptability.	Rated 4.8 of 5 as worth their time and 4.7 of 5 that their institution should offer it.

How to read these numbers

Study 2 is uncontrolled and self-reported. Session-level ratings capture immediate relief, not lasting change in burnout. Some physicians contributed more than one session, so sessions are not independent observations. The large drops among users starting at 8 or higher are expected in part from regression toward the mean, since very high readings tend to move down on re-measurement regardless of intervention. Users chose to open the app, so they may differ from physicians who did not. A full outcomes summary is available on request.

Discussion

Principal findings

Across two pilot studies with different designs, samples, and delivery formats, physicians exposed to the DistressRx framework reported consistent short-term improvement. In Study 1, a single 2-hour workshop produced significant self-reported gains on all 17 stress-competence items, with the largest changes in vocabulary, awareness, and skill. In Study 2, anonymous on-demand coaching built on the same framework was associated with a roughly 50% drop in in-session stress across 1,212 sessions, and reached physicians who had never used coaching before.

Context within the literature

A meta-analysis of controlled interventions for physician burnout found a pooled standardized effect of about 0.29, with organization-directed programs outperforming individual-focused ones.³ A broader systematic review found that both individual and organizational strategies produced meaningful reductions in burnout.⁴ Randomized trials of professional coaching, including a six-session individual program and an online group-coaching program for women residents, reduced emotional exhaustion.^{7,8} The Study 1 effect sizes exceed these pooled estimates, but the comparison is descriptive only. Study 1 measured competence and awareness rather than burnout on a validated instrument such as the Maslach Burnout Inventory,⁹ so direct comparison is not warranted. What these pilots add is evidence that a brief, low-barrier format is feasible, acceptable, and worth testing rigorously.

Limitations

Neither study has a control group. All outcomes are self-reported. Study 1 used items developed for the pilot and not externally validated, and its participants had prior coaching exposure. Study 2 measures immediate relief rather than durable change, its sessions are not independent observations, and high-baseline improvements are partly attributable to regression toward the mean. Both samples are predominantly women. Voluntary participation introduces possible selection effects in both studies.

Study 3: Planned validation trial

Design	Waitlist-controlled randomized trial
Sample	500 physicians
Duration	12 weeks
Primary outcome	Copenhagen Burnout Inventory ⁵
Timeline	About 9 months from launch to manuscript

Implications

Brief and anonymous formats may have a useful role in physician stress education, particularly where multi-session programs are not operationally feasible or where stigma keeps physicians from seeking help. Stronger claims about burnout reduction or retention should wait for controlled data on a validated instrument with longitudinal follow-up. The program has been built to generate exactly that evidence.

References and statistical methods

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Statistical methods

Study 1. Paired comparisons by two-sided Wilcoxon signed-rank test. Effect sizes computed as Cohen's *d* on paired differences (mean of difference divided by SD of difference), with conventional thresholds of 0.2 (small), 0.5 (medium), and 0.8 (large).¹⁰ Responses were matched by email. Analyses were conducted in Python using SciPy 1.x. No multiplicity correction was applied in the primary analysis, and p-values are reported as descriptive given the pilot design. A Bonferroni sensitivity check is reported on page 4.

Study 2. Descriptive statistics on session-level pre/post stress ratings (1–10) and on entry and six-week survey responses. Sessions are the unit of analysis for in-session change. No inferential tests are reported in this summary.

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